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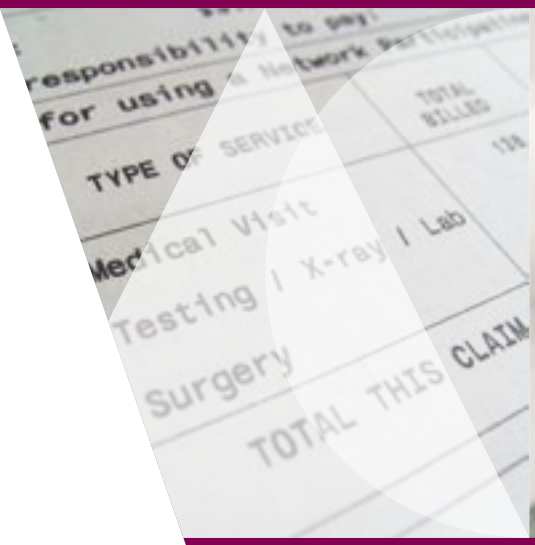

Migrants in an irregular situation: access to healthcare in 10 European Union Member States

FRA
EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

The report addresses matters related to human dignity (Article 1) and healthcare (Article 35) falling under the Chapters I 'Dignity' and IV 'Solidarity' of the Charter of Fundamental Rights of the European Union.

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Migrants in an irregular situation: access to healthcare in 10 European Union Member States

Foreword

The right to health is enshrined in several human rights instruments, but migrants in an irregular situation and particularly vulnerable groups among them, such as pregnant women and children, benefit from this right to differing degrees across the European Union (EU). Most European countries entitle irregular migrants to emergency care only and this is not always granted cost-free. For instance, in some European countries a pregnant migrant woman in an irregular situation might be charged thousands of euros to give birth.

European healthcare systems are struggling to balance the conflicting considerations of costs and public health concerns. Due to the economic crisis and an ageing population, European countries are faced with the need to contain public expenditure in health. In this process, the right to health for all, irrespective of legal status, should always remain a key concern.

This report explores the access to healthcare granted to irregular migrants in 10 EU Member States. It focuses on migrants who are present in an irregular situation, namely those who do not fulfil conditions for entry, stay or residence. Through interviews with a range of different sources including public authorities at the national and local level, health professionals, non-governmental organisations (NGOs) providing healthcare and irregular migrants themselves, this report documents the legal, economic and practical obstacles that hinder irregular migrants' access to healthcare.

Whereas it is true that other groups such as the poor and the uninsured might also be excluded from full access to healthcare in some countries, the particular conditions of migrants in an irregular situation expose them to specific health risks. These migrants can fall victim to racist crime and violence that put their lives at risk; they are also often exposed to health-impairing or life-threatening working conditions. They are more likely to work in sectors such as construction and domestic work, which have a higher incidence of workplace accidents, and are more vulnerable to exploitative working conditions and precarious housing, which in turn undermine their physical and psychological well-being.

The European Union Agency for Fundamental Rights (FRA) finds in particular that the risk of detection and deportation prevents migrants in an irregular situation from seeking healthcare, even in the countries where this is legally available.

Based on fieldwork and desk research, this report sets out to highlight some of the obstacles and problems that migrants in an irregular situation face when attempting to secure their fundamental right to access and receive essential healthcare.

Morten Kjaerum
Director

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Executive summary

This report looks at the law and practice concerning access to healthcare for migrants in an irregular situation in 10 EU Member States, namely Belgium, France, Germany, Greece, Hungary, Ireland, Italy, Poland, Spain and Sweden.

European healthcare systems are struggling to balance considerations relating to costs and public health in a manner which adequately implements existing human rights standards. While all those residing in a country should have access to certain basic forms of healthcare – such as emergency healthcare and the possibility to see a doctor in case of serious illness or a gynaecologist in case of pregnancy – in practice such access is not always guaranteed.

A concern often voiced is that increasing entitlements for migrants in an irregular situation will encourage more persons to enter or stay irregularly in a country. A recent Swedish government inquiry found that notwithstanding some uncertainties, experience suggests that the availability of health and medical services drives neither such migrants' decisions to enter a particular country nor their decision to leave it.

In broad terms and without considering healthcare entitlements for specific groups, such as children, or in the case of specific illnesses, such as tuberculosis (TB), in six of the 10 countries studied destitute migrants in an irregular situation do not have cost-free access to public healthcare services beyond emergency care. In some countries, migrants in an irregular situation are only entitled to emergency healthcare or to some services, such as laboratory tests, upon payment. This means that they will be billed and also that healthcare providers may require pre-treatment verification of ability to pay.

In the remaining four countries, Belgium, Italy, France and Spain, migrants in an irregular situation may access healthcare beyond emergency care services if they fulfil specific conditions. In Belgium, France and Spain, they may access primary and secondary care, and specialist and inpatient treatment. In Italy, migrants are entitled to access secondary care, but access to a general practitioner is not granted.

The report also looks at four specific issues — namely maternal healthcare, child healthcare, in particular immunisations, mental healthcare and care for chronic diseases — providing an overview for the 10 EU Member States covered. The situation is diverse with, at times, obstacles in accessing the most basic services, such as immunisation for children or antenatal care for pregnant women. Access to mental healthcare is limited for migrants in an irregular situation.

Through desk research and 221 interviews conducted with migrants in an irregular situation, healthcare providers, public authorities and civil society across the 10 EU Member States studied, it emerged that there is often a disconnect between national legislation and what happens in practice. In countries with broad healthcare coverage, practical obstacles may keep a certain share of migrants in an irregular situation from benefiting from it, whereas in countries with limited entitlements, local level initiatives, often implemented by or through NGOs, can alleviate the situation.

Five main barriers were identified as challenges in receiving and providing care to this specific group of migrants: costs of care and complex reimbursement procedures; unawareness of entitlements by health providers and beneficiaries; fear of detection due to information passed on to the police; discretionary power of public and healthcare authorities; and quality and continuity of care. Some of these obstacles often also concern emergency healthcare.

Excluding migrants in an irregular situation from healthcare endangers their lives and well-being, increases the cost of future emergency treatment and can also potentially pose a health risk to the wider community.

Opinions

The European Union Agency for Fundamental Rights (FRA) has formulated the following opinions based on the findings and comparative analysis in this report. These opinions are restricted to those matters covered by the research.

Legal entitlement to treatment

Migrants in an irregular situation should, at a minimum, be entitled by law to access necessary healthcare. Such healthcare provisions should not be limited to emergency care only, but should also include other forms of essential healthcare, such as the possibility to see a doctor or to receive necessary medicines.

Qualifying conditions, such as the need to prove a fixed residence or prolonged stay over a certain period of time, should be reviewed in order to ensure that these do not lead to the exclusion of persons in need of necessary medical care.

The same rules for payment of fees and exemption from payment should apply to migrants in an irregular situation as to nationals. To cover the costs, public health insurance should be extended to migrants in an irregular situation or a separate fund should be created.

Antenatal, natal and post-natal care

Article 24 of the Convention on the Rights of the Child (CRC) and Article 12 (2) of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) call for the provision of ante- and post-natal healthcare services. However, healthcare entitlements for pregnant women and mothers vary across EU Member States.

Women in an irregular situation should have access to the necessary primary and secondary healthcare service in case of delivery, as well as to reproductive and maternal healthcare services, at the same level as nationals. These should include primary and secondary ante and post-natal care, such as the possibility to visit a gynaecologist and access essential tests, family planning assistance or counselling.

Child healthcare

Children who have an irregular migration status continue to face legal and practical obstacles to accessing healthcare.

In light of Article 24 of the CRC, every child present on the territory of an EU Member State is entitled to the same healthcare services as nationals. This should include immunisations, which are a major preventive healthcare measure.

Mental healthcare

The Convention on the Rights of Persons with Disabilities (CRPD) also applies to migrants in an irregular situation.

They should, therefore, be included in ongoing European initiatives targeting mental health, including the follow-up to the European Pact for Mental Health and Well-being.

Chronic conditions

Chronic diseases are increasingly becoming a focus of healthcare systems in Europe, due to general public health concerns, the impact they have on the individuals affected and the high costs of treatment.

The concepts of emergency or necessary healthcare should be applied flexibly, so as to endeavour to ensure that the healthcare needs of all persons with severe chronic diseases – including irregular migrants – do not go unattended.

Public reimbursement procedures

Healthcare staff report that they must initiate a complex process if they are to get reimbursement from public funds for healthcare services provided to migrants in an irregular situation.

EU Member States should establish simple and effective reimbursement procedures. Requests for reimbursement should be processed quickly.

Awareness raising

Authorities working with migrants in an irregular situation, healthcare providers, civil society actors and migrants themselves are not necessarily aware of rules and entitlements concerning healthcare for migrants in an irregular situation. Migrants fear that approaching healthcare services may expose them to the risk of being deported, even when there is no such risk.

EU Member States should, therefore, find ways of addressing the lack of accurate information among migrants, healthcare providers and public authorities – such as increasing funding for training, information campaigns and outreach activities in migrant communities, and fostering partnerships between healthcare providers and civil society.

Precise information about which type of information can and cannot be communicated to immigration enforcement authorities should be provided to healthcare providers and migrants.

Reporting migrants to immigration enforcement bodies

Fear of being detected based on real or perceived exchange of data between healthcare providers and immigration enforcement bodies means that migrants in an irregular situation delay seeking healthcare until an emergency arises. This has negative consequences for the health of the individual and results in more expensive interventions.

EU Member States should disconnect healthcare from immigration control policies and should not impose a duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration.

Continuity of care

Migrants in an irregular situation are often treated informally and hence no medical records are kept.

Healthcare systems should find ways of overcoming the main challenges to providing continuity of care. In addition, measures should be taken to ensure continuation of care in case of communicable diseases, such as the creation of an EU-wide referral system for tuberculosis (TB) patients.

Introduction

The right to health

International Covenant on Economic, Social and Cultural Rights Article 12 (1)

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The right to health is a basic social right. The most inclusive definition of the right to health can be found in Article 12 of the 1966 United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR), which has been ratified by all 27 EU Member States. The text is cited in the box above.

Article 24 of the UN's 1989 CRC stresses that "State Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services". Furthermore, it obliges states to take appropriate measures "to ensure appropriate pre-natal and post-natal healthcare for mothers".

The need to provide healthcare in emergencies is also part of the right to life and the prohibition of inhuman treatment under the European Convention on Human Rights (ECHR).[1] In addition, according to Article 13 (1) of the European Social Charter (ESC)/ revised European Social Charter (rev ESC) state parties undertake to ensure adequate healthcare in case of sickness, explicitly stressing the duty of states to provide adequate assistance to persons without resources.

The 61st World Health Assembly held in Geneva in May 2008 adopted Resolution WHA61.17 on the health of immigrants, which calls on Member States to "devise mechanisms for improving the health of all populations, including immigrants, in particular through identifying and filling gaps in health service delivery".

Article 168 of the Treaty on the Functioning of the European Union (TFEU) highlights that a "high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities". Action by the EU "shall complement national policies" and "be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health".

The right to healthcare is also included in the Charter of Fundamental Rights of the European Union. According to Article 35, the right to healthcare includes the right of every person to access "preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws". According to Article 51, EU institutions and Member States must apply the Charter when they are implementing Union law.

In June 2006, the Council of the European Union adopted common values for EU healthcare systems which include universality, access to good quality care, as well as equity and solidarity.[2] The 2007 Council

1 See European Court of Human Rights (ECtHR), *Gagiu v. Romania*, No. 63258/00, 24 February 2009, paragraph 57; *Taïs v. France*, No. 39922/03, 1 June 2006, paragraph 98, both of which concern persons in detention.

2 Council of the European Union (2006), *Council conclusions on common values and principles in European Union health systems*, OJ 2006 C 146, p. 1.

conclusions on health and migration in the EU[3] stressed that "addressing the health of migrants is fundamental to attaining the best level of health and well-being for everybody living in the EU".

The right to health for migrants in an irregular situation

Article 12 (1) of the ICESCR on the right to health also applies to migrants in an irregular situation. In 1985 the UN Declaration on 'The human rights of individuals who are not nationals of the country in which they live' limited the application of social rights only to migrants **lawfully** residing in the territory of a state. However, the Committee on Economic, Social and Cultural Rights (CESCR) later specified in two general comments that migrants in an irregular situation are entitled to the right of healthcare.[4] The CESCR highlighted that "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 immigrants, to preventive, curative and palliative health services".[5] Determining the core obligations deriving from this right is more complex. According to the Committee "all persons, irrespective of their nationality, residency or immigration status, are entitled to primary and emergency medical care".[6] General Comments give non-binding guidance to Member States on how to interpret the right to health under the ICESCR.

European human rights provisions allow some differentiation in the provision of healthcare between migrants in a regular and those in an irregular situation. The provision on the right to social and medical assistance of the ESC is, according to its appendix, limited to lawfully resident foreigners. However, in 2004 and 2006 the European Committee for Social Rights found on two occasions that migrants in an irregular situation have a right to emergency care under Article 13 (4) ESC/revESC.[7] The Committee concluded in *FIDH v. France* that any legislation or practice which denies entitlement to medical assistance, regardless of the migrant's legal status in the country, was contrary to Article 13 (4) ESC.[8] The particular case concerned healthcare for undocumented migrant children where the Committee made a direct link "with the right to life itself and [...] the very dignity of the human being". However, eight EU Member States have not signed up to Article 13 (4) ESC/revESC. These Member States include Bulgaria, Cyprus, Estonia, Lithuania, Poland, Romania, Slovakia and Slovenia.

As a result, among Council of Europe instruments, the only safeguard on access to healthcare which is enforceable for migrants in an irregular situation and is binding for all EU Member States remains the state obligation to provide emergency healthcare deriving from the right to life and the prohibition of inhuman treatment under the European Convention on Human Rights (ECHR).

International human rights instruments also acknowledge the need for protection of groups with specific needs, particularly children, pregnant women and mothers.[9] As mentioned above, Article 24 of the CRC obliges states to ensure children's access to healthcare as well as appropriate antenatal and post-natal healthcare for mothers. The CRC has been ratified by all EU Member States and applies to all children within their jurisdiction.

Article 12 (2) of the 1979 CEDAW specifically requires states to grant women "appropriate services in connection with pregnancy, confinement and the post-natal period, granting cost-free services where necessary, as well as adequate nutrition during pregnancy and lactation". Such rights can be considered part of those basic human rights that the Committee established by the CEDAW considers must be guaranteed to all, including undocumented migrant women.[10]

The limited enforceability of legally binding international law provisions on the right to health, the vague language used (such as adequate care) combined with the need

3 Council of the European Union, Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) (2007), *Health and migration in the EU*, Council conclusions adopted at the EPSCO meeting in December 2007, available at: http://register.consilium.europa.eu/pdf/en/07/st15/st15609.en07.pdf (All hyperlinks referred to in this report were accessed on 29 June 2011).

4 See CESCR, General Comment No.14: the right to the highest attainable standard of health (Article 12), E/C.12/2000/4, paragraph 34; CESCR, General Comment No.19: the right to social security (Article 9), E/C.12/GC/19, paragraph 37. General comments contain the interpretation of the content of the human rights provisions by the Committee.

5 CESCR (2000), General Comment No. 14, The right to the highest attainable standard of health, paragraph 34.

6 CESCR, General Comment No. 19, The right to social security, 4 February 2008, E/C.12/GC/19, paragraph 37.

7 Complaint No. 14/2003, *International federation of Human Rights Leagues (FIDH) v. France*, (Decision on the merits of 8 September 2004, Conclusions XVIII-1 and 2006, General Introduction, Article 13 paragraph 4.

8 See the European Committee on Social Rights, *International Federation for Human Rights (FIDH) v. France*, Collective Complaint No. 14/2003, Decision on the merits of 8 September 2004, available at: www.coe.int/t/dghl/monitoring/socialcharter/Complaints/CC14Merits_en.pdf.

9 Universal Declaration of Human Rights (UDHR) of 10 December 1948, Article 25.

10 Committee on the Elimination of Discrimination against Women, Recommendation No. 26 on women migrant workers, 5 December 2008, CEDAW/C/2009/WP.1/R at I.

to implement international and European standards in countries with very different healthcare systems, has led to a divergent understanding and application of the existing legal framework across the EU and resulted in different healthcare services offered to migrants in an irregular situation.

Secondary EU law contains references to healthcare of migrants in an irregular situation. The transposition of this law must be handled in accordance with the Charter of Fundamental Rights of the European Union. Article 14 of the EU Returns Directive specifically provides that "emergency healthcare and essential treatment of illnesses" should be provided to those migrants in an irregular situation during the period given for voluntary departure and for those whose removal has been postponed.[11] In the light of the effort to harmonise legislation under the Returns Directive, the findings of this report invite a critical reading of the current divergent national measures.

In March 2011, the European Parliament addressed for the first time the fundamental right to health of migrants in an irregular situation. In a Resolution on health inequalities, it acknowledged that healthcare is not guaranteed, either in practice or in law, for undocumented migrants. It called on EU Member States to assess the feasibility of supporting healthcare for migrants in an irregular situation by providing a definition based on common principles for basic elements of healthcare as set forth in their national legislation. It also called on Member States to ensure that all pregnant women and children, regardless of their status, are entitled to social protection under national legislation and actually receive it.[12]

In its Communication on *Solidarity in health: reducing health inequalities in the EU*,[13] the European Commission foresees a possible role for the FRA in collecting information on the extent to which vulnerable groups may suffer from health inequalities in the EU. By illustrating the specific challenges concerning migrants in an irregular situation, this report seeks to contribute to finding ways to meet the healthcare needs of individuals who face a heightened risk of being unable to access healthcare services.

Excluding migrants in an irregular situation from healthcare endangers their lives and well-being, increases the cost of future emergency treatment and can potentially also pose a health risk to the wider community.

Research by the FRA

Although certain aspects of the right to health apply to all, including persons present in the territory in an irregular manner, implementation of international and European human right standards remains highly diverse and complex.[14]

This thematic report looks at the fundamental rights in theory and practice of migrants in an irregular situation in 10 EU Member States, namely Belgium, France, Germany, Greece, Hungary, Ireland, Italy, Poland, Spain and Sweden. These countries were selected to cover different geographic regions of the EU and different health systems, and because they were appropriate for a second thematic report on fundamental rights challenges for migrants in an irregular situation working in the domestic work sector.

While the research presents findings from interviews in 10 EU Member States, its results point towards fundamental rights challenges that are probably also applicable in other Member States. This thematic report does not cover access to health services for persons in detention.

This report focuses on the legal and practical barriers that hinder access to healthcare for migrants in an irregular situation. It does not analyse the role of other barriers that may well influence the way healthcare is sought or could better be provided, such as cultural or communication barriers or the impact of gender norms and values. Among the barriers described, some are specific to migrants in an irregular situation, whereas others are also typical for other disadvantaged groups.

This report is part of a FRA project on the fundamental rights of migrants in an irregular situation in the 27 EU Member States. A first thematic report relating to migrants in an irregular situation employed in the domestic work sector was published in July 2011.[15] This second thematic report, as well as the first one, complement a more comprehensive overview of the fundamental rights situation of such migrants EU-wide, which will be issued at the end of 2011.

11 Article 14 (1b) and Article 16 (3) of the Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

12 See European Parliament (2011), *Resolution on reducing health inequalities in the EU*, P7_TA(2011)0081, Brussels, 8 March 2011, paragraphs 5 and 22.

13 European Commission (2009), *Solidarity in health: reducing health inequalities in the EU*, COM(2009) 567 final, Brussels, p. 8.

14 See for the non-discrimination principle enshrined in the human rights treaties: PICUM (2007), *Undocumented Migrants Have Rights! An Overview of the International Human Rights Framework*, pp. 10-11, available at: www.picum.org/sites/default/files/data/UndocumentedMigrantsHaveRights!.pdf.

15 FRA (2011), *Migrants in an irregular situation employed in domestic work: fundamental rights challenges for the European Union and its Member States*, Luxembourg, Publications Office of the European Union.

This report is primarily based on interviews with migrants, public authorities, healthcare staff and civil society. Altogether, the fieldwork involved 221 semi-structured qualitative interviews: 36 with public authorities, 43 with civil society representatives, 67 with health staff, and 75 with migrants in an irregular situation. The resulting information was analysed in light of materials gathered through desk research and questionnaires. As part of the broader project on the situation of migrants in an irregular situation, questionnaires were sent out to national and local authorities and civil society representatives in the 27 EU Member States (see Annexes for research design, methodology and interview guidelines). This report does not provide statistics on how often migrants can or cannot access public health services. Instead, it describes, based on the interviews, the type of challenges that migrants and health professionals face and how they deal with those challenges.

The empirical research was conducted in 21 cities of the 10 EU Member States studied, where it was hoped that examples of interesting practices could be found. Interviews were conducted in: Antwerp, Brussels and Ghent (Belgium); Dublin and Lacken (Ireland); Paris and surrounding suburbs (France); Bochum, Bissendorf, Bremen, Cologne, Dortmund and Wuppertal (Germany); Stockholm (Sweden); Athens (Greece); Budapest (Hungary); Barcelona (Spain); Brescia, Milan and Legnano (Italy); and Warsaw and Piastów (Poland). The situation described in this report does not aim to provide a complete picture of the situation in each country as a whole, nor can it express the situation across the EU. Rather, it intends to highlight challenges that migrants as well as health professionals typically face.

The research work for this publication was carried out by national experts coordinated by the International Centre for Migration Policy Development (ICMPD) and the Platform for International Cooperation on Undocumented Migrants (PICUM). The draft report was shared for comments with authorities in the 10 countries covered as well as with other selected stakeholders, including the World Health Organization (WHO), the International Organization for Migration (IOM), the Office of the High Commissioner for Human Rights (OHCHR) and the European Commission. All organisations as well as some national authorities provided feedback.

The report builds on the findings of other research projects relating to healthcare for migrants in an irregular situation, including the project NowHereLand,[16] the work by PICUM,[17] the Health for Undocumented Migrants and Asylum Seekers Network (HUMA network),[18] as well as the European survey on undocumented migrants' access to healthcare by *Médecins du Monde*.[19] The FRA report provides added value in that it considers a different set of countries and focuses on the entitlements and the barriers encountered by specific vulnerable groups of irregular migrants such as women and children. In addition, it provides the most recent comparative update on the right to health for irregular migrants across Europe.

The body of this report is structured in four chapters. The first describes the national legal framework, followed by a look at regional and local policies on access to healthcare for migrants in an irregular situation. The third and fourth chapters deal with the effects of exclusion from healthcare and with practical obstacles and challenges. The report is not drafted on the basis of agreed-upon indicators; however, the considerations it sets forth together with the results of the project on multiple discrimination in the area of healthcare will be used by the FRA in its work to develop structural, process and outcome indicators in the area of healthcare.[20]

16 See Healthcare in NowHereLand, 'Improving services for undocumented migrants in the EU', available at: www.nowhereland.info/.

17 See PICUM (2007), *Access to health care for undocumented migrants in Europe,* available at: picum.org/picum.org/uploads/file_/Access_to_Health_Care_for_Undocumented_Migrants.pdf.

18 See HUMA network webpage, initiated by *Médécins du Monde*, available at: www.huma-network.org/.

19 See *Médecins du Monde, European survey on undocumented migrants access to health care* (2009), *Access to healthcare for undocumented migrants in 11 European countries*, available at: www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf.

20 See the description of the project at: fra.europa.eu/fraWebsite/research/projects/proj_multiplediscriminationhealthcare_en.htm.

1 The national legal framework

1.1 General entitlements to healthcare

1.1.1. Access to treatment

There are marked differences in the national legal frameworks of the 10 countries studied regarding access to healthcare for migrants in an irregular situation.

Depending on the type of health system, the requirements to access public health services – such as citizenship, residence, membership in an insurance scheme – as well as the range of health services available to the beneficiaries with or without charge varies.[21] In broad terms, of the 10 EU Member States examined, five operate with insurance-based health systems (Belgium, France, Germany, Hungary, Poland), four have tax-based national health systems (Ireland, Italy, Spain, Sweden), while the health system in Greece is both insurance and tax-based.[22]

Six of the 10 countries studied (all except Hungary, Ireland, Poland, Sweden) have introduced express legal provisions relating to access to healthcare for migrants in an irregular situation.[23] In the case of Sweden, specific rules exist for rejected asylum seekers who remain at the disposal of the authorities as well as for all children whose asylum application are rejected.[24] However, the level of access to healthcare services by migrants in an irregular situation does not necessarily depend on whether such explicit provisions exist. They may, however, contribute to legal clarity.

In order to compare the degree of access to healthcare for migrants in an irregular situation, the FRA distinguishes three forms of healthcare: emergency, primary and secondary healthcare services (and beyond). Emergency care includes life-saving measures as well as medical treatment necessary to prevent serious damage to a person's health. Primary care includes essential treatments of relatively common minor illnesses provided on an outpatient or community basis (such as services by general practitioners). Secondary care comprises medical treatment provided by specialists and some inpatient care.[25]

21 E. Mossialos, S. Allin, J. Figueras (eds.) (2006), *Health Systems in Transition Template, European Systems of Health Systems and Policy*, available at: www.mig.tu-berlin.de/fileadmin/a38331600/2006.publications/2006.allin_HS.pdf.

22 European Observatory on Health Systems and Policies, *Health System in Transition – HiT country profiles*, available at: www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/full-list-of-hits.

23 Germany, *Asylbewerberleistungsgesetz*, BGBl. I S. 2022 (5 August 1997), Section 1; Greece, Law on Entry, residence and social integration of third-country nationals in the Hellenic Territory, No. 3386/2005 (23 August 2005), Article 84 (1); Italy, Legislative Decree 1998/286 (*Decreto Legislativo 25 luglio 1998, n. 286*), as amended, Article 35.3; France, *Code de l'action sociale et des familles*, Articles L251-1, L254-1; Spain, *Ley Organica 4/2000 sobre derechos y libertades de los extranjeros en Espana y su integracion social* (11 January 2000) Article 12; Belgium, *Loi organique des CPAS* (8 juillet 1976) Article 57.

24 Law on Health and medical services for asylum seekers and others (*Lag om hälso- och sjukvård åt asylsökande m.fl.*) 2008:344, Article 4, last paragraph, available at: www.notisum.se/rnp/sls/lag/20080344.htm.

25 See WHO (2009), Health Promotion Glossary, available at: www.who.int/hpr/NPH/docs/hp_glossary_en.pdf; Committee on Economic, Social and Cultural Rights, General Comment No. 14, 2000, footnote 9. Other projects use different categorisations based on a slightly different rationale, see for example the HUMA Network (2009) or the NowHereLand project, available at: www.nowhereland.info/?i_ca_id=368.

Based on these categories and depending on whether full payment is required or not, the FRA has grouped EU Member States into three broad categories (see Table 1). Exceptions regarding access to healthcare for specific categories (such as children) or certain diseases (for example TB) as well as local-level initiatives are not considered here but are dealt with separately below.

As illustrated in Table 1, in five of the 10 EU Member States studied destitute migrants in an irregular situation are entitled to emergency healthcare only, although other public healthcare services may be accessible against full payment.[26]

In Germany, migrants in an irregular situation are afforded by law the same access to healthcare as asylum seekers. In principle, this coverage extends beyond emergency services;[27] in practice, however, coverage is limited to emergency services because the procedure to reimburse migrants for the costs of emergency care is confidential, while the one used for non-emergency care is not. For emergency care reimbursements, the healthcare provider applies post-treatment to the social welfare office, a process which extends medical confidentiality to the welfare office.[28] For non-emergencies, migrants in an irregular situation seeking reimbursement must themselves approach the social welfare office, whose staff then have a duty to report such migrants to the police. This risk renders access to non-emergency healthcare meaningless. The social welfare office has the duty to report migrants in an irregular situation to the police if the migrants obtain healthcare services which cannot be regarded as emergency care.[29]

In those countries studied which limit entitlements to emergency healthcare, emergency interventions may only be available against **payment**. This means not only that migrants in an irregular situation will be billed, but also that healthcare providers may require pre-treatment verification of an individual's ability to pay.

In Sweden, although doctors are required to provide care in cases of emergency, such services are not free of charge for undocumented patients. Migrants in an irregular situation thus are presented a bill after they have received emergency treatment. In Greece,

Table 1: Access of migrants in an irregular situation to healthcare by law, 10 EU Member States

	Access to emergency care (with payment components)	Access beyond emergency care cost-free, but duty to report	Access beyond emergency care cost-free
Belgium			X
France			X
Germany		X	
Greece	X		
Hungary	X		
Ireland	X		
Italy			X
Poland	X		
Spain			X
Sweden	X		

Notes: The term 'cost-free' does not exclude means tests or payments at a symbolic or reduced price.
Source: FRA, based on national legal provisions

26 See, for Germany, Asylum Seekers Benefit Act *(Asylbewerberleistungsgesetz)*, BGBl. I S. 2022 (5 August 1997), Sections 1 and 4; for Greece, Law on 'Entry, residence and social integration of third-country nationals in the Hellenic Territory', No. 3386/2005 (23 August 2005), Article 84 (1); for Hungary, Act on Health, Act CLIV of 1997 (23. December 1997), Articles 94 (1) and 142 (2) see also Regulation 52/2006 which contains a list of 31 situations which are considered as emergencies; for Ireland, Immigration, Residence and Protection Bill, Bill Number 2 of 2008 (14 January 2008); and for Poland, Law on healthcare services financed by public funds (27. August 2004), *Ustawa z 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych, Dz. U. 2004, poz. 2135.*

27 Germany, Asylum Seekers Benefit Act *(Asylbewerberleistungsgesetz)*, BGBl. I S. 2022 (5 August 1997), Section 1.

28 See German Residence Act (*Aufenthaltsgesetz*), BGBl. I S. 162 (30 July 2004), Section 88 (2) and Regulation on the Residence Act (*Allgemeine Verwaltungsvorschrift zum Aufenthaltsgesetz,* VwV-AufenthG)), GMBl. I S. 878 (26 October 2009) Section 87.1.5 and 88.2.3.

29 See German Residence Act *(Aufenthaltsgesetz)*, BGBl. I S. 162 (30 July 2004), Section 87 (2) and Regulation on the Residence Act *(Allgemeine Verwaltungsvorschrift zum Aufenthaltsgesetz*, VwV-AufenthG)), GMBl. I S. 878 (26 October 2009) Section 87.0.4.

irregular migrants are required to pay the full costs of laboratory tests.[30] In Ireland, access to emergency treatment is not granted cost-free, but payment depends on the provider's discretion.[31] In Hungary, undocumented migrants are not entitled to compulsory insurance;[32] they must, in principle, cover the costs. However, if the migrant is unable to pay for emergency care, the bill is categorised as non-returnable and the healthcare provider is eligible to be reimbursed by the state.[33] In Poland, services provided by emergency medical teams outside hospitals are free of charge, while payment requirements for other emergency treatments remain unclear. According to the Polish Supreme Court, hospitals can also request cost coverage in case of emergency treatment. However, it remains unclear if and how cost coverage applies to migrants.[34]

In Sweden, the limitation of healthcare services to emergency services threw up questions which led the government to launch an inquiry into how to more effectively regulate healthcare services for asylum seekers and migrants in an irregular situation. A committee of inquiry, whose terms of reference were limited to proposals which did not encourage irregular migration, was appointed to study government options. It presented its recommendations at the end of May 2011 in a report published in the Swedish Government Official Report series (*Statens Offentliga Utredningar*, SOU).[35] The committee recommended that asylum seekers and undocumented migrants, regardless of age, be offered subsidised health and medical services by the county council of the area in which they are living or staying. The care should be offered to the same extent and under the same conditions as that offered to permanent residents. The government is currently considering the inquiry's recommendations.

In Belgium, France, Italy and Spain migrants in an irregular situation are, broadly speaking, entitled, beyond emergency care, to primary and secondary healthcare services, albeit under certain conditions. Access to services is either cost-free or fee-based, though the latter does not generally amount to the full cost. In Belgium and Italy, domestic legislation refers to 'essential' or 'urgent' care, terms that might well be misleading as they generally encompass a broad range of preventive, primary, and even secondary health services as well as maternal care and basic medicines. In Belgium, the National Institute for Health and Disability Insurance *(Institut national d'assurance maladie-invalidite*, INAMI / *Rijksinstituut Voor Ziekte- en Invaliditeitsverzekering,* RIZIV) has drafted a list of refundable medical services. In Italy, migrants in an irregular situation have access to preventive, urgent, and essential treatment of illness and care considered necessary for public health reasons (e.g. maternal care, treatment of infectious diseases).[36]

In Belgium, migrants in an irregular situation may access preventive, primary and secondary healthcare services by applying for urgent medical aid *(Aide Médicale Urgente*, AMU) at the social welfare office (*Centre public d'aide sociale,* CPAS / *Openbaar centrum voor maatschappelijk,* OCMW). They must demonstrate that they are living in the district where they are applying and have insufficient financial means to pay for healthcare. In addition, the 'necessity' of care must be certified by a medical professional. After these criteria have been checked, the social welfare office issues a health card valid for three months, which is renewable.

Similarly, in France, migrants in an irregular situation may access all the basic healthcare services under a parallel administrative system of state medical aid *(Aide médicale d'État*, AME) once they have: proven they have been resident in France for more than three months; provided an identity document and an address; and shown that they lack sufficient financial means. If a person does not qualify for or has not yet received an AME, she/he can access urgent and basic healthcare at a healthcare access department (*Permanences d'Accès aux Soins de Santé*, PASS), which every hospital is at least in theory obliged to establish.[37] Until recently, access to healthcare under the AME system was granted free of charge to persons earning less than €634 per month, but an annual fee of €30 has now been introduced, triggering significant opposition from NGOs working in this sector.[38] In addition, a person who was enrolled in the national social security system may keep the social benefits

30 See Nowhereland (2010), country report for Greece, *Policies on Health Care for Undocumented Migrants in EU27*, p. 12.

31 Björngren-Cuadra, C. (2010), country report for Ireland, in: Health Care in Nowhereland, *Policies on Health Care for Undocumented Migrants in EU27*, p. 11.

32 Decree 87/2004 (X.4.) ESZCSM on the regulations of healthcare for people staying in Hungary, which lists categories of persons entitled to compulsory insurance.

33 Information provided to the FRA in June 2011 by the Department of Public Health of the Hungarian Ministry of National Resources.

34 See HUMA network (2011), *Access to healthcare and living conditions of asylum seekers and undocumented migrants in Cyprus, Malta, Poland and Romania*, pp. 100-1. See the Supreme Court, 8 August 2007, I CSK 125/07, available at: LexPolonica, Serwis Prawniczy LexisNexis, http://lexpolonica.lexisnexis.pl/.

35 For the results of this inquiry, see SOU (2011), *Vård efter behov och på lika villkor – en mänsklig rättighet*, Stockholm, available at www.regeringen.se/content/1/c6/16/98/15/1ce2f996.pdf. The SOU report includes an extended summary in English.

36 Legislative Decree 1998/286, as amended, Article 35 (3).

37 France, Loi n° 98-657 du 29 Juillet 1998 (law against social exclusion), Article 76; Public Authority Interview, France.

38 See related discussions in the French Parliament (*Assemblée nationale*) session of 2 November 2010: www.assemblee-nationale.fr/13/cri/2010-2011/20110036.asp, and the joint comment by French civil society organisations on the amendment: www.ldh-france.org/IMG/pdf/Dossier_parlementaire_AME_octobre_2010.pdf.

for another 12 months[39] even if he/she no longer fulfils the conditions, for example, his/her authorisation to stay has expired.

In Italy, migrants in an irregular situation must state in written form that they cannot afford to pay for treatment in order to access 'urgent' or 'essential' care free of charge. This includes primary and secondary care offered by institutions, but not the right to visit a general practitioner.[40] To access such essential care, migrants in an irregular situation need to obtain a temporary foreign resident code (*Stranieri Temporaneamente Presenti*, STP). The STP code is issued by a medical professional or administrative personnel and is used to trace the person to ensure continuity of care. It is valid for six months, renewable and also covers preventive care. The migrant may also sign a declaration of poverty that allows him or her to access care free of charge, except for the co-payment that is required from every citizen. In some cases, migrants are completely exempted from co-payments. In addition to an STP code for essential care, some regions have made specific legal provisions to grant migrants in an irregular situation broader access to healthcare.[41]

In Spain, migrants in an irregular situation enjoy full access to all services provided by the national health system under the same conditions as nationals.[42] To access the health system, migrants in an irregular situation must obtain an individual health card under the same conditions as regular residents. This means registering at the local civil registry, which requires showing a valid identity document and confirmation of residence/address, although children and pregnant women are exempt from these requirements. The health card is then issued and is valid for two years.

Each of these four countries (Belgium, France, Italy and Spain) has a different application process to access healthcare and certain conditions must be met, often the same as those set up for indigents. Typically, these include the need to demonstrate: the absence of sufficient means, a fixed address and an identity document, as outlined in Table 2.

To register for healthcare services in three of these countries, migrants in an irregular situation need to demonstrate that they have insufficient financial means to pay for healthcare and that they are living below a certain economic threshold. In Italy, the migrant is only required to sign a declaration to that effect. In Belgium, a representative of the social welfare office noted that it was necessary for migrants to demonstrate that they have insufficient financial means. For example, a migrant in an irregular situation in Brussels said that a representative of the social welfare office came to inspect her home to determine her economic conditions. The representative checked on the number of rooms and television sets and also took a look at electricity and gas bills. A civil society representative attributed the requirement to check up on economic conditions as well as the blockage of some applications to the fact that people covered by AMU health insurance, including migrants in an irregular situation, may actually have enough financial means to pay for healthcare themselves as they often work informally. Alternatively, their access is blocked because they may be living with someone, such as a family member, who has shown the financial means to cover his/her healthcare needs. There is an inherent contradiction in this requirement to demonstrate a lack of financial means: although legally not allowed to work, migrants in an irregular

Table 2: Requirements to receive healthcare, four EU Member States

	Proof of lack of financial means	Identification	Factual residence (area or country)
Belgium	✔		✔
France	✔	✔	✔
Italy	✔		
Spain		✔	✔

Source: Information based on PICUM (2007), Access to healthcare for undocumented migrants in Europe*; HUMA Network (2009),* Access to healthcare for undocumented migrants and asylum seekers in 10 EU countries.

39 See PICUM (2007), *Access to Health Care for Undocumented Migrants in Europe*, p. 28.
40 See Legislative Decree 1998/286, as amended, Article 35 (3). See also www.stranieriinitalia.it/guida_alla_salute_in_otto_lingue-guida_alla_salute_in_italiano_1794.html.
41 *Ibid.*
42 Spain, *Ley Organica 4/2000 sobre derechos y libertades de los extranjeros en Espana y su integracion social* (11 January 2000).

situation are thereby required to show an income that they legally should not have.

Proof of identity (that is, a passport), is required in France and Spain. A migrant living in Barcelona whose removal was suspended explained that not having a passport was an important barrier whose absence prevented him from registering at the local registry. The NGO Spanish Commission Helping Refugees (CEAR) assisted him, finally allowing him to register. However, since relocating to another city in Spain, he has again been unsuccessful in registering without a passport.

In some countries, it is necessary to provide proof of factual stay in the country or in a particular city, covering a certain number of days or months. For example, in France, migrants in an irregular situation must prove that they have established a 'habitual residence' (*résidence habituelle*) in France for at least three months. A social worker in a Paris health centre said that many people are unable to fulfil this requirement either because they have just arrived in France or because they are unable to provide documentation proving three-month residence such as a stamp in a passport, an expired visa, an electricity or gas bill. If this proof is not provided, the public authorities might refuse the request for public health insurance (*Aide médicale d'État,* AME), on the assumption that the person does not live in France permanently. In the health staff interviews it was mentioned that prior to 2004 there was no need to prove the three-month stay, but the government changed requirements to make access to care more complex. A civil society representative noted that one of the issues lies in the lack of a definition in a legal provision for 'habitual residence' *(résidence habituelle)*. Although a state council judgment has defined the term, the interviewee said that the administration had opted not to use the definition, choosing instead a more restrictive one.

Lack of a fixed address is another barrier to obtaining care. In some countries migrants in an irregular situation must have their factual residence in the area in order to apply for healthcare. In Belgium and Spain, many migrants in an irregular situation have difficulty proving such 'factual residence', particularly when they stay with friends, in churches, in shelters, or are homeless. Often there is considerable discretion at local level to decide what constitutes sufficient evidence of factual residence.

As an illustration, in April 2008 in the Ixelles district of Brussels a group of migrants in an irregular situation waged a hunger strike in a church, protesting against the Belgian government's lack of fulfilment of a March 2008 promise to establish regularisation criteria. One of the protestors had been staying at the church since his arrival some weeks earlier. During the strike, he suffered strong stomach pains but did not have a medical card entitling him to cost-free hospital treatment. To help, some of the other hunger strikers accompanied him to the Ixelles social welfare office in order to make an application for urgent medical care (AMU). But the Ixelles social welfare office rejected the request, saying the church was not considered a place of residence. According to the office, the applicant was not living within the jurisdiction of Ixelles and was therefore supposed to find other ways of receiving medical assistance.[43]

1.1.2. Access to medicines

The effectiveness of medical treatment also depends upon the accessibility of medicines. In some countries, if migrants in an irregular situation qualify for access to healthcare, they are able to obtain certain medicines at a reduced rate or free of charge, whereas in others, they must buy them at prices the same, or higher, than those nationals pay. This section provides a brief overview of access to medicines. It does not cover, however, special rules that may exist for children or specific illnesses (e.g. TB or antiretroviral treatment).

As shown in Table 3 adult migrants in an irregular situation can receive selected medicines at reduced or at no cost in Belgium, France, Germany, Italy and Spain. In Belgium and France, migrants in an irregular situation who receive access to public health insurance mechanisms will also be able to get certain medicines free of charge. In Italy, STP (*Stranieri Temporaneamente Presenti*) code holders must cover a certain amount of the cost, depending on the type of medication, as is the case for nationals. In Spain, migrants in an irregular situation holding an individual health card may access medicines at the same co-payment (40%, except for specific chronic diseases) as nationals. In Germany, to obtain cost-free medications, a migrant in an irregular situation must apply for and obtain a health insurance voucher *(Krankenschein)* from the social welfare office. But office staff are required to report migrants in an irregular situation to police, hindering in practice their access to cost-free medication. Hence, only those with a toleration permit *(Duldung)* are likely in reality to be able to access medicines free of charge.[44]

43 While in the case of *Cisse v. France* (9 April 2002, No. 51346/99), the ECtHR accepted that protection of public health can justify an intervention to disperse a similar gathering in a church, this should not affect the rights of migrants to receive heathcare.

44 HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries. Law and Practice*, p. 68.

Table 3: Access to medicine for adult migrants in an irregular situation, 10 EU Member States

	Costs of medicines partially or fully covered	Cost of medicines generally borne by the migrant
Belgium	✔	
France	✔	
Germany	✔	
Greece		✔
Hungary		✔
Ireland		✔
Italy	✔	
Poland		✔
Spain	✔	
Sweden		✔

Source: The information for this table was gathered from HUMA (2009), Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries and compiled with findings from interviews by the FRA.

In the other countries, the migrant must pay for medicine. Health staff interviewed in Greece, Hungary and Poland indicated that migrants in an irregular situation would normally not be able to access medicines cost-free or at a reduced rate, unless these are provided by NGOs. In Greece, public authorities confirmed that if people are not working and do not have a Social Security number (IKA), they may not have medical-pharmaceutical care, except for services offered by NGOs. In Hungary, health staff said that the doctor would inform the patient that he is not able to prescribe medication at the reduced payment rate (partially funded by insurance), and that the patient would have to pay the full price of the medicines. According to health staff in Poland, if persons have no documents, they have to pay for the services delivered, including screenings, treatment and medicines. In Ireland, migrants in an irregular situation are not granted the medical card which entitles the holder to cost-free medical services. In Sweden, migrants in an irregular situation actually have to pay more for their medicines and medical treatment than Swedish citizens as they are charged a 'tourist fee', a fee, as it sounds, charged tourists visiting Sweden for healthcare needs during their stay.[45]

1.1.3. Regional and local implementation of national law

There are marked differences in the way regions and municipalities implement existing national legislation with the effect that migrants in an irregular situation may not benefit equally from healthcare services throughout the country. This section shows the diverse approaches of regional and local governments in interpreting national law and promoting health inclusion that also embrace migrants in an irregular situation. It illustrates which types of public healthcare services are available to migrants in an irregular situation in the cities researched, without aiming to provide a comprehensive overview of all public health services available to migrants in an irregular situation.

In a generally restrictive context, the local authorities of the German cities of Bremen, Cologne, and Frankfurt am Main and the Swedish city of Stockholm have chosen a more favourable health policy towards migrants in an irregular situation as compared to the situation in the two countries as a whole.

In Sweden, migrants in an irregular situation have access to emergency healthcare but have to pay for it. However, several county councils have decided to provide healthcare to rejected asylum seekers and/or all migrants in an irregular situation, or have extended the scope of emergency care provided to migrants in an irregular situation to include also 'immediate necessary care'.[46]

45 Note made by fieldworker in Sweden.

46 E. Sigvardsdotter (2009), *Vård för papperslösa i Sveriges landsting - lokala riktlinjer och Tillämpningsanvisningar*, available at: http://erikasigvardsdotter.files.wordpress.com/2009/11/vard-for-papperslosa-i-sverige2.pdf.

Promising practice

Encouraging healthcare access at the local level

In January 2009, the Stockholm city council issued guidelines for the treatment of undocumented persons in healthcare facilities in Stockholm. The guidelines advise health providers to provide emergency and immediate necessary healthcare, including life-threatening situations, cancer or other systemic disease and serious mental conditions, to migrants in an irregular situation. In addition, to prevent emergency births and complications during pregnancy, maternity care should be provided to migrant women in an irregular situation under the same conditions as for all other women. However, the policy document does not explicitly tackle the issue of payment, which can be considered one of the main obstacles for migrants in an irregular situation to accessing healthcare in Sweden.

See policy document by the Stockholm county council of 1 January 2009: www.rosengrenska.org/pdfs/CheflakVerstallighetBeslutGomda.pdf.

In countries where migrants in an irregular situation are entitled to primary and secondary healthcare services, such as Italy, Belgium, or Spain, there are also regional and local differences in the way national law is implemented. In Italy, although migrants in an irregular situation are by law entitled to access all preventive, urgent, and essential treatment of illness as well as care considered necessary for public health reasons, some regions, such as Lombardy, are known to apply a very restrictive interpretation of the law and limit access of migrants in an irregular situation to emergency services, while other regions, such as Lazio, interpret the law more liberally and provide access to a far broader range of public health services.[47] This was highlighted by a public authority representative as follows:

"The problem in Italy is not the right, but how to organise the right, and this is [the responsibility] of the regions. The Piedmont region believes that this right should be organised in way A, Lombardy believes that that right should be organised in way C, and so on. Some regions have opened ambulatory healthcare centres for migrants in an irregular situation, some have assigned them to a family doctor, other regions have stipulated collaboration with voluntary and charity organisations. This is not established by law but each region organised this in a way it thought appropriate."

Regional authority, Italy

Although some local governments see the need to act, their hands may be tied by more restrictive national regulations. An Irish health official gave an example. Ireland, the official said, would be unable to set up programmes for migrants in an irregular situation as they are not entitled under Irish legislation to healthcare services apart from emergency services. In Ireland, healthcare provision to migrants in an irregular situation would thus depend mainly on a 'practical response' by healthcare providers who came into contact with them. Public authorities in Athens shared this view.

In cities that are embedded in a more favourable national context such as Italy, France, or Belgium, not every city administration regards it as their responsibility to introduce complementary measures to facilitate access to healthcare in practice. In Italy, for example, the Lombardy region's official approach towards healthcare for migrants in an irregular situation is that there is no need to establish dedicated services as the emergency wards already satisfactorily ensure the assistance foreseen by national legislation. In Brussels, only some of the local social welfare centres (*Centre Public d'Action Sociale*, CPAS / *Openbaar Centrum voor Maatschappelijk Welzijn van Brussel*, OCMW) responsible for administering access to the health system for migrants in an irregular situation under the urgent medical assistance programme (*Aide Médicale Urgente,* AMU) have, according to authorities interviewed, introduced specific working groups dealing with their difficulties in accessing the system.

47 See www.stranieriinitalia.it/guida_alla_salute_in_otto_lingue- and *Assistenza Sanitaria – Scheda a cura di Giulia Perin* as well as PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries. Country report Italy*, available at: www.nowhereland.info/?i_ca_id=389, p.10.

Promising practice

Establishing a social welfare competence centre to assist irregular migrants

The social welfare office (*Centre Public d'Action Sociale*, CPAS / *Openbaar Centrum voor Maatschappelijk Welzijn van Brussel*, OCMW) of Molenbeek, a district in Brussels, Belgium, has created a specific unit within social welfare centres dedicated to the healthcare assistance of migrants in an irregular situation. The unit is seen as a good starting point to improve the implementation process of Belgian national law related to migrants in an irregular situation and healthcare. The district mayor gave his political support to help create the unit – political support that also helps ease the unit's relations with public authorities and target groups such as migrants in an irregular situation and helps it achieve its goal of allowing people of any social and legal status to live in dignity.

Public authorities in Sweden explained that if no authority at the national, regional or local level assumes responsibility to protect the right to healthcare for migrants in an irregular situation, then solutions have to be found on an informal and ad hoc basis which depend exclusively on the goodwill of the person who happens to be the first point of contact for migrants in an irregular situation seeking healthcare, usually hospital administration workers, nurses or doctors.

Awareness by health-providing institutions and health staff on the situation and the rights of migrants in an irregular situation is crucial to allowing them to benefit in practice from public health services. Low awareness by public authorities on the specific situation of migrants in an irregular situation and their access to healthcare hinder the effective implementation in practice of the right to healthcare. In Poland and Hungary, for example, the public officials interviewed were not able to identify any government approach or programmes dealing with healthcare access of migrants in an irregular situation and, further, did not assign specific relevance to this issue. Instead, they were of the view that uninsured persons in general present a much larger challenge for the health system than migrants in an irregular situation.

Implementation of health policies is sometimes influenced by the perception that broadening healthcare services for migrants in an irregular situation would encourage more persons to come or stay irregularly, although the FRA could find no evidence confirming such an assumption. In the Belgian context, for example, a representative of a social welfare office raised the issue of creating a possible magnet effect if specific health programmes or services for migrants in an irregular situation were established. In one city, for example, an interviewee said that applications are examined more rigorously than elsewhere in Belgium in order to ensure that only those who already live in the city are provided with an AMU health card. Another contradiction was raised by a Brussels district health department official. He pointed out that by requiring migrants in an irregular situation to pay for care if they have sufficient means, the social welfare offices promote irregular work activities they should instead combat.

In other situations, the interests of a country's health and immigration departments may directly contradict each other. This is illustrated by *Médecins du Monde*'s experience, who reported that a country's health ministry might support their work, while the home office opposes it. In France, for example, they said that the Ministry of Health had printed its logo on the needle-exchange kits distributed by the NGO to keep the police from destroying them when inspecting recipients. In a similar case, a Spanish civil society organisation said that staff in a facility providing HIV prevention to sex workers discovered that they were no longer receiving patients because police were arresting them en route to the facility.

1.2 Entitlements for specific diseases

Specific healthcare entitlements may exist for persons suffering from infectious diseases, such as HIV/Aids, TB or hepatitis. Such entitlements are often based on public health considerations.

In all 10 countries, migrants in an irregular situation can receive **screening** for certain infectious diseases. In Hungary, for example, treatment is free of charge and accessible for everyone. In Ireland, according to public authorities interviewed, screenings for HIV, Hepatitis, and sexually transmitted diseases (STDs) are available through government-funded sexual health services, such as the Women's Health Project, which works with women in prostitution, some of whom have been trafficked to Ireland. These services are generally offered free of charge. For instance, cost-free anonymous HIV *testing* is available in all 10 countries.[48]

Treatment for HIV infection may be accessed without any conditions in France at special centres[49] and, if

48 Mounier-Jack, Nielson, Coker,(2008), *HIV testing strategies across European countries*, British HIV Association, HIV Medicine, 9 (Suppl.2), pp. 13–19

49 Centres for infectious diseases, CIDAG.

migrants in an irregular situation fulfil the requirements to access healthcare coverage, they can also access such treatment in Belgium, Spain, and Italy.[50] In Sweden, however, migrants in an irregular situation have to pay the full costs for HIV/Aids treatment and doctors are not obliged to provide such treatment.

According to the HUMA network, HIV treatment can be obtained in Belgium, France, Italy and Spain through the various systems allowing migrants in an irregular situation to access healthcare, while in Sweden treatment is not granted, and in Germany access to HIV treatment is provided in theory, but discouraged by existing reporting duties.[51] In Germany, because of police reporting requirements linked to non-emergency healthcare reimbursement explained in section 2.1.1., it is primarily migrants who fear neither being reported to police nor removal, such as those who hold a toleration permit *(Duldung),* who make use of the right to access treatment for HIV infection or other infectious diseases. However, in the German city of Cologne, for example, authorities announced that the health office had established a special counselling centre for persons with sexually transmitted diseases (*Beratungsstelle für sexuell übertragbare Krankheiten*) accessible to all regardless of legal status or insurance.

1.3 Entitlements for specific groups

This section deals with four groups of migrants in an irregular situation with specific healthcare needs, namely children, women in need of maternal and reproductive care, persons with mental health problems and persons with chronic diseases. All four have specific healthcare needs. For the first two groups special entitlements to healthcare exist under international human rights law.

The first part of this thematic report pointed out that in four countries, Belgium, France, Italy and Spain, healthcare coverage of migrants in an irregular situation includes primary and/or secondary care. In the six remaining countries the general rule is to grant access only for emergency treatment. Some of these latter countries have, however, adopted special measures, in particular concerning pregnancy, maternity and child healthcare.

50 HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries. Law and Practice.*

51 HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries. Law and Practice.*

1.3.1. Maternal and reproductive care

Women require specific healthcare services, particularly in relation to maternal and reproductive care. These include a range of antenatal, natal and post-natal services. Acknowledging such needs, the UN CRC as well as the CEDAW contain specific provisions on reproductive and maternal care. Article 24 of the CRC obliges states to take appropriate measures "to ensure appropriate pre-natal and post-natal healthcare for mothers". Article 12 (2) of the CEDAW specifically requires states to grant women "appropriate services in connection with pregnancy, confinement and the post-natal period, granting cost-free services where necessary, as well as adequate nutrition during pregnancy and lactation".

The kind of care provided to women may vary from country to country and depends on the general services offered to pregnant women or mothers under the overall health system. Table 4 provides a broad overview on the access of migrant women in an irregular situation to antenatal and post-natal healthcare services. Typically, such health services include ante- and post-natal counselling, access to tests (such as ultrasound, urine or blood test), regular gynaecological visits as well as assistance during delivery.

Evidence collected for this report shows that **delivery** is considered an emergency in all of the countries studied and thus medical staff may not refuse to treat migrant women in an irregular situation who are in labour.

The need to pay for the care provided presents a major obstacle. Giving birth can become unaffordable. In Sweden, for example, the price for giving birth can cost up to €2,684.[52] In Sweden, migrant women in an irregular situation are generally billed for hospital costs and in Ireland billing depends upon the healthcare provider. In Poland and Hungary, the situation regarding payment remains unclear. In Hungary, delivery is included in the list of 31 situations which are to be treated as emergencies:[53] Evidence collected from migrant interviews suggested that migrant women in an irregular situation are expected to pay the costs of delivery. However, if a patient cannot afford it, the bill is categorised as non-returnable and the healthcare provider is eligible for state reimbursement. In some countries where migrants are billed, there are systems to write off the costs in case of non-payment.

Table 4 provides an overview of the policies of the 10 EU Member States concerning **ante- and post-natal care**. It is based on a broad categorisation.

52 Public authority interview, Sweden.

53 See Regulation 52/2006.

Table 4: Access to cost-free ante- and post-natal care, 10 EU Member States

Country	Access and Conditions
Belgium	If entitled to AMU
France	Via AME or PASS
Germany	Care granted, but risk of being reported to authorities
Greece	Visits at outpatient first aid clinics, but tests/examinations normally not provided for free
Hungary	no
Ireland	no
Italy	If holding an STP code
Poland	no
Spain	yes
Sweden	no

Note: Emergency treatment is not included in this table, nor are regional or local policies that depart from national policies.
Source: FRA[54]

Full access to ante- and post-natal care is granted in only four of the 10 countries reviewed in this study, namely Belgium, France, Italy and Spain. In Greece, access to ambulatory care is possible, but hospitalisation is limited to emergencies. In Germany, because of reporting requirements linked to non-emergency healthcare reimbursement explained in Section 2.1.1., the risk of being reported to immigration authorities restricts, in practice, cost-free healthcare services provided in principle to pregnant women and mothers to emergency care only.[55]

In Spain, migrant women in an irregular situation are granted unconditional and cost-free access to maternal and reproductive care under the same conditions as nationals. In Italy, they are granted cost-free access to ante- and post-natal care upon obtaining an STP code. In France, migrant women in an irregular situation who do not qualify for state medical aid (AME) may access antenatal examinations and birth assistance in PASS facilities irrespective of length of stay or income.[56] Similarly, in Belgium, migrant women in an irregular situation who qualify for the AMU system have access to reproductive care. Moreover, the Birth and Childhood Office (*Office de la Naissance et de l'Enfance/Kind en Gezin*) provides free-of-charge healthcare for pregnant women and families with infants (counselling, check-ups, immunisations) irrespective of nationality, origin or social background.[57] In Greece, a surgeon working in a first-aid clinic explained that although the migrants are entitled only to emergency care by national law, doctors at such clinics can provide low-cost ambulatory care to pregnant women. In other words, doctors can provide regular pregnancy check-ups but cannot perform any tests, such as urine tests, as only outpatient care is covered.

In the remaining four countries (Hungary, Ireland, Poland and Sweden) migrant women in an irregular situation receive treatment during pregnancy only in emergency cases.

"[N]on-acute cases will not be treated [...]. This means that antenatal care, for example, will not be provided to non-paying uninsured persons."

Health professional, Hungary

'Emergency' is a vague term that must be assessed by a doctor on a case-by-case basis. In general, migrant women in an irregular situation only receive cost-free care if complications, such as bleeding, occur during pregnancy. Other forms of antenatal or post-natal care are not typically considered emergencies and are therefore only provided upon payment. In Sweden, some cities, such as Stockholm, apply more favourable policies. A policy document by the Stockholm city council clarifies that health staff should attend migrant women in an irregular situation seeking ante- or post-natal healthcare; however, the question of costs is not explicitly addressed.[58]

54 Health staff interviews and HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries: Law and Practice.*
55 Asylum Seekers Benefit Act (*Asylbewerberleistungsgesetz*), Section 4 (2).
56 PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries*. Country report France, available at: www.nowhereland.info/?i_ca_id=389.
57 See www.one.be/index.php?id=5 and HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries. Law and Practice*, p. 27.
58 Policy document by the Stockholm county council of 1 January 2009: www.rosengrenska.org/pdfs/CheflakVerstallighetBeslutGomda.pdf.

Promising practice

Health centre caters to migrant women's health needs

The Centre for health and assistance for migrant women (*Centro di salute e ascolto per le donne immigrate)* offers medical support to all migrant women and girls, both regular and irregular, who are pregnant. A department of the San Carlo Borromeo hospital in Milan, Italy, the centre is the result of cooperation between the social cooperative Crinali (www.crinali.org/index.html) and the public health sector and was initially funded by the Lombardy region. The centre has multilingual, exclusively female medical staff (gynaecologists, obstetricians, paediatriacians) employed by the hospital and cultural mediators employed by Crinali. Upon their first visit to the centre, patients are asked to provide their identity so that an accurate medical history can be kept. After initial consultations with a doctor, psychologist and mediator, the women are given an appointment and a prescription for any medications needed. With this information, they are eligible for an STP code.[59] A similar centre also exists at the San Paolo hospital in Milan.

Some countries, such as Greece, Germany and Italy, have introduced the option of **suspending the removal** of migrant women in an irregular situation **during pregnancy.**[60] This does not, however, lead automatically to a right to healthcare in all these countries. In Greece for example, pregnant women may be granted suspension of removal for a specified period before and after giving birth, but they are not granted cost-free access to maternal care during this period.[61] In Germany, because of police reporting requirements linked to non-emergency healthcare reimbursement explained in Section 2.1.1, only migrants with a toleration permit (*Duldung*) can, without fear, access healthcare services during and after pregnancy. NGOs therefore assist migrant women in an irregular situation needing help during pregnancy to obtain this permit. However, this status is granted only for a limited time period when the woman is considered 'unfit for travel' – generally six weeks prior and eight weeks after delivery.[62]

Victims of trafficking represent a particularly vulnerable group. Among the support measures for victims of trafficking established by Article 11 of the new anti-trafficking directive,[63] Member States are requested to provide "necessary medical treatment including psychological assistance, counselling and information, and translation and interpretation services where appropriate". Support measures shall be guaranteed also to victims who are unwilling to cooperate in a criminal investigation, prosecution or trial (Article 11).

Civil society actors may provide specific healthcare services for trafficking victims, often supported by the national government. Related services may also benefit migrant women in an irregular situation. In Ireland, for example, a dedicated unit set up in 2010 in the Health Service Executive (HSE) develops individual care plans for all (male and female) potential and suspected victims of human trafficking, irrespective of their legal status. The care plans cover, depending on individual need, general health screening, sexual health services, mental/psychological health services and counselling intervention, relationship and family counselling, assistance with social and spiritual issues including voodoo and juju; assistance with financial management, assistance and advice in relation to education/training and to immigration status as well as an explanation of the criminal investigation process and an escort to police interviews. In addition, the HSE Women's Health Project, a state-funded non-governmental organisation, provides testing for sexually transmitted diseases, vaccinations, counselling, contraception, pregnancy testing and advice, as well as social support to women who may possibly be victims of human trafficking.[64]. Similarly, in Poland, La Strada said that amongst its services it also offers healthcare services to trafficked women.

According to migrants, NGOs serve a variety of functions, from providing information, serving as an alternative healthcare provider, to acting as a mediator between the migrant in an irregular situation and healthcare providers. A migrant in an irregular situation living in Warsaw said she would not have found a doctor without the help of an NGO that specifically assists women:

59 Health staff interview, Italy.

60 Germany, Residence Act *(Aufenthaltsgesetz)*, Section 60 a (2) 3rd sentence (pregnancy is considered – with discretion – as urgent personal grounds); Greece: Law 3386/2005 (as amended), Article 79 (1) e. second sentence; Italy, D. LGS. 286/1998 (as amended), Article 19 (2) d). For a broader overview of national protection statuses granted on medical grounds see European Migration Network (2010), *The different national practices concerning granting of non-EU harmonised protection statuses*, p. 28.

61 National authority questionnaire, Greece.

62 See PICUM, *Access to Healthcare for Undocumented Migrants*, p. 38.

63 Directive 2011/36/EU of the European Parliament and of the Council, published on 5 April 2011.

64 Health staff interview, Ireland, Women's Health Project; for Women's Health Project, see www.hse.ie/eng/services/Find_a_Service/Sexualhealth/Women%27s_Health_Project/.

"When I was pregnant I had no documents, no insurance, nothing. My child was born in February 2006. I went to the doctor, to the hospital in Praga Północ or Południe. I got the phone numbers and address from my friend who works in the sex-business and who is a charge of La Strada Foundation. They take care of prostitutes and they give them everything for free: gynaecologists, medicines. I asked my friend whether [...] they would help me and she promised to ask at the foundation. And this foundation gave me a phone number for a doctor. I went to see this doctor and during the first visit I had blood tests, ultra-sonogram, everything for free."

31-40, Poland, from eastern Europe

In some countries, irregular women migrants also access healthcare via programmes targeting the general population or through dedicated facilities. In France, for example, women and children up to the age of 21 are offered cost-free healthcare, family planning, ante- and post-natal care, children's immunisations, and assistance at birth at mother- and childhood protection health centres (*Service de protection maternelle et infantile*, PMI). In Cologne, migrants in an irregular situation may receive counselling during pregnancy as well as basic check-ups in the humanitarian consultation hour offered by the city's health office, while the health office in Bremen organises healthcare during pregnancy through a network of voluntary gynaecologists. In Cologne, however, the women must cover a portion of the costs.[65]

FRA opinion

Antenatal, natal and post-natal care

Article 24 of the CRC and Article 12 (2) of CEDAW call for the provision of ante- and post-natal healthcare services. However, healthcare entitlements for pregnant women and mothers vary across the EU.

Women in an irregular situation should have access to the necessary primary and secondary healthcare service in case of delivery as well as to reproductive and maternal healthcare services at the same conditions as nationals. These should include primary and secondary ante- and post-natal care, such as the possibility to visit a gynaecologist, access essential tests, family planning assistance or counselling.

1.3.2. Healthcare for migrant children in an irregular situation

Children constitute one of the most vulnerable social groups in need of specific protection. Article 24 of the CRC recognises "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". Furthermore, "State Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services".

In reality, though, access to healthcare for migrant children in an irregular situation is not systematically available.[66] Table 5 provides a broad overview of national policies.

In only two of the 10 countries surveyed, Spain and Greece, are migrant children in an irregular situation (at least up to a certain age) entitled by law to receive the same healthcare under the same conditions as national children. In Spain, from the day of birth, all children are assigned to a paediatrician.[67] In Greece, all children up to the age of 14 may access healthcare at clinics for children that are accessible irrespective of residence status.[68] In Athens, about 20 such clinics exist. According to health staff interviewed, these are mainly used by migrants.

Three countries, France, Belgium, and Italy, make a distinction between unaccompanied migrant children in an irregular situation and those children living with their families, providing to the former a higher level of access, comparable with that of nationals.[69]

In France, irregular unaccompanied children have access in principle to universal health coverage (CMU),[70] while irregular children with families must qualify for the system for state medical aid (AME).[71] However, they are covered from the first day of residence; they do not have to prove, as is the case for adults, that they have stayed three months in France. In Belgium, unaccompanied migrant children in an irregular situation are covered by health insurance if they stay in reception or welfare centres. If they are living outside such a centre, they are covered by health insurance if they had attended school in Belgium for at least three months.[72] Migrant children in an irregular situation who stay with their families are treated like adult migrants in an irregular situation and must apply for an AMU health card in order to receive

65 Public authorities interview, Germany.

66 For the situation of separated children seeking asylum, see FRA (2010), *Separated, asylum-seeking children in European Union Member States – Comparative Report,* pp. 45-49.

67 Spain, *Ley Organica 4/2000 sobre derechos y libertades de los extranjeros en Espana y su integracion social* (11 January 2000) Article 12 (3) and interviews with health staff.

68 Codification of Legislation on the Entry, Residence and Social Integration of Third-Country Nationals on Greek Territory, Law 3386/2005 (Government Gazette-GG A 212), Article 84 (1).

69 See FRA (2010), *Separated, asylum-seeking children in European Union Member States – Comparative Report*.

70 Code de l'action sociale et des familles, Article L111-2.

71 Code de l'action sociale et des familles, Article L254-1, HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries. Law and Practice*, p. 51.

72 Loi relative à l'assurance obligatoire soins de santé et indemnités (14 juillet 1994), Article 32 1st alinea No. 22; for unaccompanied minors in Wallonia see for example circulaire OA Nr. 2008/198 (9 mai 2008).

Table 5: Cost-free healthcare entitlements for migrant children in an irregular situation, 10 EU Member States

	Same access as nationals	Same access as nationals for some services	Similar to nationals for unaccompanied minors	Access beyond emergency care for specific categories	Emergency care only
Belgium		–	✔		
France		–	✔		
Germany		–		Tolerated children*	
Greece	✔	–			
Hungary		–			✔
Ireland		–			✔
Italy		–	✔		
Poland		–		Children in schools	
Spain	✔	–			
Sweden		–		Failed asylum seekers	

Note: * *Undetected children, though legally entitled to healthcare, in practice risk being reported to immigration law enforcement.*

Source: FRA, compiled from Björngren-Cuadra, C. (2010), Policies on Healthcare for Undocumented Migrants in EU27. Country report, Lithuania*, available at: www.nowhereland.info/?i_ca_id=369; PICUM (2009),* Undocumented Children in in Europe: Invisible Victims of Immigration Restrictions, *Brussels: PICUM; HUMA Network (2009),* Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries. Law and Practice; *health staff interviews.*

healthcare.[73] In Italy, according to a social assistant working at a hospital, migrant children in an irregular situation living with their families receive essential treatment and immunisations but are not allowed to consult a paediatrician. In contrast, unaccompanied migrant children in an irregular situation are granted the same rights as Italian children.

In Germany, migrants in an irregular situation have the same access to healthcare as asylum seekers.[74] This includes child healthcare. However, the police reporting requirements linked to non-emergency healthcare reimbursement explained in Section 2.1.1 hinder them from seeking out non-emergency healthcare. In Sweden, only migrant children in an irregular situation under the age of 18 whose asylum claim has been rejected are entitled to receive healthcare under the national health system. In Poland, migrant children in an irregular situation receive healthcare only while they attend public schools.[75]

In Hungary and Ireland no specific protection mechanisms could be identified pertaining to healthcare access for migrant children in an irregular situation. Like adults, children in these countries have access only to emergency healthcare.

Early **childhood immunisations** are part of a basic healthcare package for children in many countries. FRA research showed that immunisations are provided cost-free in eight of the 10 countries studied, namely Belgium, France, Greece, Hungary, Ireland, Italy, Spain and Sweden. In Ireland, no specific provision on vaccinations could be found. It is therefore assumed that, based on the general duty to provide urgent care, children would receive those vaccines which the healthcare provider considers as such. Immunisations are provided to migrant children in an irregular situation in Germany cost-free under the Asylum Seekers Benefit Act, but police reporting requirements related to the reimbursement of such non-emergency medical care explained in Section 2.1.1. put those children seeking immunisations at risk of being reported to immigration authorities.[76] Immunisations are available in Poland only if parents pay for the vaccinations, although migrant children in an irregular situation also have access

73 Loi organique des CPAS (8 juillet 1976), Article 57 paragraph 2; PICUM (2009), *Undocumented children in Europe: Invisible Victims of Immigration Restrictions*, available at: http://picum.org/article/reports, p.50-51.

74 Asylum Seeker Benefit Act (*Asylbewerberleistungsgesetz*), Sections 1 and 4.

75 See HUMA network (2011), *Access to Healthcare and Living Conditions of Asylum Seekers and Undocumented Migrants in Cyprus, Malta, Poland and Romania*, p. 101; Law on education system (7 September 1991), Articles 92 (1) and (2) and Regulation of the Minister of Health on the organisation of the prophylactic healthcare for children and youths of 28 August 2009.

76 Asylum Seeker Benefit Act (*Asylbewerberleistungsgesetz*) Section 4 paragraph 3.

to mandatory vaccinations through provisions that generally target school children.[77]

Where immunisations are not provided through the public healthcare system, children rely on informal practices by doctors, or on specific services that offer healthcare without any conditions. In Germany, for example, Maltese Migrant Medicine *(Malteser Migranten Medizin),* a non-governmental religious hospital in Cologne, said that it offers vaccinations anonymously and without payment. In Poland, health staff of a general hospital in Warsaw said that they always administer immunisations to children, although state policy does not provide cost-free healthcare access. Civil society organisations in Poland reported, however, that they have regularly debated with health staff over the right of children to receive cost-free immunisations. In Poland, only undocumented children of school age are provided with preventive care, including protective immunisations, which are available at schools.[78]

When access is granted by law, an additional obstacle that prevents access to health services in practice is **lack of awareness** about entitlements.[79] For example, children and young adults up to the age of 21 in France may access cost-free healthcare and immunisations at special motherhood and childhood protection health centres (PMI) that target the general population. However, migrants in an irregular situation are often not sufficiently informed about the accessibility of these and similar services, according to a city of Paris official responsible for childhood and health. In Sweden, according to the health staff interviews, migrant children who are in an irregular situation have a right to receive immunisations; however, health providers as well as migrants are often unaware of this. In Stockholm, a vaccination programme against H1N1 (swine flu) explicitly targeted children of irregular migrants.[80] Children of migrants in an irregular situation may also fall victim to general health expenditure cuts which do not target migrants. In Greece, for example, the Ministry of Health stopped the distribution of vaccines to children's clinics at the beginning of 2010, and hospitals thus generally face serious difficulties to provide children with basic vaccinations. Instead, they try to organise cost-free vaccines via NGOs, such as Caritas or the Red Cross.

77 See HUMA network (2011), *Access to Healthcare and Living Conditions of Asylum Seekers and Undocumented Migrants in Cyprus, Malta, Poland and Romania*, p. 101; Law on education system (7 September 1991), Articles 92 (1) and (2) and Regulation of the Minister of Health on the organisation of the prophylactic healthcare for children and youths of 28 August 2009.

78 Attending schools is obligatory for all children between 7 and 18 living in Poland, available at: www.migrant.info.pl/pl/edukacja/edukacja_przedszkolna_i_szkolna/.

79 For mental healthcare, see also FRA (2010), *Separated, asylum-seeking children in European Union Member States – Comparative Report,* p. 47.

80 Background information report provided by Patricia de Palma and Lena Karlsson who did the case study research in Sweden.

FRA opinion

Child healthcare

Children who have an irregular migration status continue to face legal and practical obstacles to accessing healthcare.

In light of Article 24 of the CRC, every child present on the territory of an EU Member State is entitled to the same healthcare services as nationals. This should also include immunisations, which are a major preventive healthcare measure.

1.3.3. Mental healthcare

Mental, physical and social problems are strongly interrelated.[81] Mental health problems among migrants in an irregular situation may result from violence and persecution experienced in the country of origin. Irregular migrants may also be burdened by issues in the host country, such as precarious living conditions, detention experiences, lack of future prospects, stigmatisation and isolation as well as the constant fear of arrest. In their interviews, migrants in an irregular situation mentioned a host of reasons and circumstances which put further strain on their psychological well-being, such as pressure from family in the country of origin in need of economic support, anxiety and stress from waiting to receive a response to an asylum application and depression stemming from living conditions and lack of status.

"Because of my poor current living conditions, I feel sad and nervous. And, although it is true that I can receive medical treatment free of charge, how can you live in health if you don't have money to eat or to buy normal things?"

21-30, Belgium, from West Africa

According to the health professionals interviewed, mental health problems among migrants in an irregular situation range from psychosomatic problems such as headaches, insomnia or anxiety, through psychological problems related to drug or alcohol use, to very severe conditions, such as post-traumatic stress syndromes, psychosis or depression.[82]

Mental health problems are frequently left untreated, according to information given by health providers and NGOs.

81 Wahlbeck, K., Huber, M. (2009), *Access to Healthcare for People with Mental Disorders in Europe*, Policy Brief, European Centre.

82 PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries*. Country reports in the framework of the project Healthcare in Nowhereland, available at: www.nowhereland.info/?i_ca_id=389.

"There is no psychological support accessible for undocumented migrants. And psychological assistance is really needed. Sometimes if we have people with mental health or, emotional problems, we do not know what to do. This is often related to legal problems […] if there is a lack of identity documents, there is no way to help such a person. Besides, there are no doctors who would take care of such patients, although we have befriended physicians who are more sensitive to problems that irregular Vietnamese migrants may have."

Civil society organisation, Poland

Table 6 provides an overview of state practices regarding mental healthcare services. In general, access to mental healthcare is very limited for migrants in an irregular situation. In only four of the 10 countries studied (Belgium, France, Italy and Spain) do migrants in an irregular situation have, at least formally, access to mental healthcare services, such as medication and treatment for depression, stress, psychosis and anxiety-related disorders. In all other countries, migrants in an irregular situation are only treated in emergency cases, such as a suicidal state of mind or if they are considered to be a threat to themselves or to others (e.g. psychosis). Health staff in Hungary pointed out that this suggests that following stabilisation, there is no further treatment provided.

Table 6: Access by migrants in an irregular situation to mental healthcare, 10 EU Member States

Country	Access and conditions
Belgium	YES If entitled to AMU
France	YES If entitled to AME, if not entitled to AME access via PASS facilities
Germany	NO[1]
Greece	NO but: examinations possible via municipal clinics and first aid centres
Hungary	NO
Ireland	NO
Italy	YES with STP code
Poland	NO
Spain	YES with health card
Sweden	NO

Source: FRA (interviews with health providers and public authorities)

However, even if the entitlement to healthcare includes mental healthcare services, practical obstacles may limit access. Obstacles may be of a general nature and affect the population as a whole, or be specific to migrants in an irregular situation.

The health staff interviewed identified a general **lack of mental healthcare services including for the general population**. However, while difficulties may affect the population at large, irregular status often exacerbates these. As an illustration, a doctor working in Budapest said that mental health treatment is one of the Hungarian healthcare system's major shortcomings; for the uninsured, the chance of receiving treatment for a mental health problem is even worse. Civil society interviewees in Germany shared a similar sentiment on mental healthcare, noting that the insured face treatment waiting times of up to six months, while for the irregular or those with a toleration permit *(Duldung)* those waits can take a full year. Health staff in Spain pointed to issues affecting migrants more generally, such as the reluctance of doctors to take on such patients, given worries about language and concerns that having an interpreter present would alter the therapy and treatment setting.

Health staff in Spain said that awareness among health professionals about the specific mental health issues facing migrants in an irregular situation is low. Mental health conditions are often only diagnosed in the course of treatment for a related somatic health concern. In order to access healthcare, migrants in an irregular situation must first obtain a referral from a general practitioner or hospital. A health professional in France saw this as a possible additional barrier for persons with mental health problems. In Belgium, health staff noted that a referral is issued if the first attending doctor considers the treatment 'necessary'; similarly, long-term regular treatment is granted if a medical professional considers it medically necessary.

Continuity of care poses another challenge. In Paris mental healthcare is offered by psychological care centres (*Centre Médico Psychologiques*, CMP), while those living in non-stable conditions may receive services from a mobile team *(L'Équipe mobile psychiatrie et précarité),* health staff interviewed said. A doctor in a Paris hospital highlighted the difficulties of follow-up care for migrants in an irregular situation with mental health problems, stressing that many psychological care centres do not react appropriately to the situations of precarious persons. Moreover, medical teams change often – inappropriate for a population which needs stability. Finally, in order to benefit from the services, patients must provide a fixed address, which is often problematic:

"The situation of mental healthcare is a nightmare and it's not specific to migrants in an irregular situation as homeless persons face the same situation."

Health professional, France

Although this research shows that it is generally very difficult for migrants in an irregular situation to receive mental healthcare services, structures which facilitate their access to mental healthcare do exist. In Belgium, the city of Ghent has set up community mental healthcare centres, which offer psychological counselling at a cost dependent on the financial situation of the individual. However, given large demand, accessing this service requires a waiting period of up to six months.

Promising practice

Finding innovative ways to address mental health concerns of irregular migrants

The Belgian East Flemish Diversity Centre *(Oost-Vlaamse diversiteitscentrum)*, launched in October 2010, is a one-year pilot project with a special programme dedicated to the mental healthcare (psycho-education) of refugees, asylum seekers and migrants in an irregular situation. The centre, which is affiliated with the public authorities of the province of East Flanders located in Ghent and those of the province of Limburg, aims to promote access to mental healthcare services for this target group and broaden the services provided to include intercultural preventive counselling and therapy. Recognised refugees with academic or professional backgrounds related to psychology who live in Flanders are trained to interact with and support refugees, asylum seekers and people without residence papers in need of basic mental healthcare. The goal is to create support groups where refugees, asylum seekers and migrants in an irregular situation can meet and discuss the mental health problems they are experiencing, enabling them to benefit from comprehensible psychological support from people who speak their language, come from the same culture and who might have been in a similar situation of solitude and unemployment.[83] These meetings are coordinated by a professional care worker.

In Greece, apart from emergency treatment, migrants in an irregular situation may consult a psychiatrist through the first-aid outpatient services of hospitals accessible to all against a fee of about €3. However, health staff noted that sustainable treatment of a mental health problem is generally not possible as the patient can only buy prescribed medication at full price.

In addition, mental healthcare may be accessed through services targeting specific groups, such as migrant women. Targeted services are better suited to address men's and women's different needs and problems with respect to health issues such as mental health. For example, in Barcelona, the NGO Health and Family *(Salud y Familia)* established a programme that offers legal orientation and psychological support especially to women. The centre aims to offer support for mental health issues deriving from difficult life situations or family conflicts in Barcelona. In Italy, the Centre of health and counselling for migrant women, a specific hospital department in the Italian city of Milan (see also the text box entitled Health centre caters to migrant women's health needs) offers some limited support for psychological problems related to pregnancy or abortion but cannot provide treatment for more severe conditions.

Mental healthcare services for migrants in an irregular situation rely heavily on **voluntary or NGO initiatives**. Health staff in France reported that if it were not for the intervention of NGOs or the dedication of some doctors, migrants in an irregular situation would have trouble getting an appointment at a specialised mental health provider.

NGOs are often the sole providers of unconditional specialised treatment to migrants in an irregular situation. The service of the Italian NGO *Opera San Franscesco* provides a good example in this regard. This NGO service, which is fully funded by private sources, offers a broad range of services including mental healthcare through a network of doctors working voluntarily. Staff working at the NGO receive training in transcultural psychotherapy so that they are prepared to deal with the specific situation of migrants. Many of the public health providers interviewed said they would direct migrants in an irregular situation without any healthcare access to non-governmental organisations such as *Médecins du Monde*, who provide treatment unconditionally (for example in France, Belgium and Greece). However, voluntary or private initiatives generally have limited resources, and cannot offer specialist or long-term treatment, as was witnessed especially by private health providers in Germany, Sweden and Hungary.[84] While treatment for minor health problems can be provided, counselling or therapy with the aim of easing the problem in a sustainable way is not accessible.[85]

83 See www.odice.be/page.php?id=1.

84 See also: PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries*. Country reports in the framework of the project Healthcare in Nowhereland, available at: www.nowhereland.info/?i_ca_id=389.

85 Civil society interviews, Belgium and Germany.

FRA opinion

Mental healthcare

The Convention on the Rights of Persons with Disabilities (CRPD) also applies to migrants in an irregular situation.

They should, therefore, be included in ongoing European initiatives targeting mental health including the follow-up to the European Pact for Mental Health and Well-being.

1.3.4. Healthcare for chronic conditions

Chronic diseases and conditions such as diabetes, respiratory diseases, high blood pressure, cardiovascular diseases, cancer and health problems arising from hard living and working conditions and unhealthy lifestyles pose serious and also frequent health concerns among migrants in an irregular situation. In addition, migrants in an irregular situation may develop severe chronic conditions because they lack adequate access to preventive healthcare services.[86] According to a survey by *Médecins du Monde*, one-third of the migrants in an irregular situation that come for a consultation say they are suffering from one or more chronic conditions.[87] Chronic diseases tend to increase with age. The same survey indicates that 20% of men and 31% of women over 55 years of age perceive their health status as very bad.[88] EU income and living conditions (EU-SILC) data collected in 2009 show that of the general European population over 55 years of age, 5% of men and 6% of women perceive their health status as very bad.[89] Thus, compared to the general population, older irregular migrant workers, particularly women, report poorer health conditions.

In principle, migrants in an irregular situation with chronic conditions are granted access to treatment only in those countries where they are entitled to receive at least primary healthcare (Belgium, France, Italy, Spain). If a migrant in an irregular situation suffering from a chronic illness seeks help at a public health provider in these countries, they will often try to register with the public health system (apply for AME in France, for AMU in Belgium, for an STP code in Italy, or seek advice on how to receive a health card in Spain). In France, persons without health coverage also have access to treatment at a hospital's PASS facility, if available.

Continuity of care poses a major challenge for migrants in an irregular situation suffering from chronic conditions. Chronic diseases require long-term, continuous and often costly medication. The lack of legal entitlements, limited economic resources of migrants in an irregular situation as well as their unstable living conditions make continuous treatment over a longer time period difficult or unaffordable. The often temporary nature of their health cards or similar documents poses a major challenge for continuous treatment. In Belgium or France, for example, treatment for chronic diseases may be disrupted if eligibility for the state medical aid system expires and the application has to be filed anew.[90]

If access for migrants in an irregular situation is restricted to emergency care, they may only receive treatment for chronic diseases if the chronic condition results in an acute or life-threatening situation or is interpreted by the healthcare provider as such. This is the case in Hungary, Poland, Greece, Sweden and Ireland.[91] In Greece however, at public first aid and municipal clinics migrants in an irregular situation can not only receive examinations in case of emergency (such as diabetes crisis, high blood pressure presenting a risk of stroke), but may also consult with doctors in non-emergency situations and receive follow-up treatment for diabetes. However, as is the case for mental healthcare, doctors may write prescriptions for medication, but migrants in an irregular situation must pay the purchase price themselves. Thus, health staff in Greece reported that they would send migrants in an irregular situation in need of medication to *Médecins du Monde* which provides cost-free medication where possible.

Informal practices of healthcare providers as well as services provided by non-governmental actors are crucial for migrants in an irregular situation in need of treatment for chronic health problems. In order to receive basic treatment or medication for chronic conditions, migrants in an irregular situation often depend completely on the good will of doctors and the assistance of NGOs. Yet, organising essential medication or remedies on a regular basis, such as test strips for measuring blood sugar for diabetes, presents a major challenge for NGOs. German NGOs

86 See evidence from Austria or Sweden in PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries*. Country reports in the framework of the project Healthcare in Nowhereland, available at: www.nowhereland.info/?i_ca_id=389.

87 See European Observatory on Access to Healthcare of *Médecins du Monde* (2009), *Access to healthcare for undocumented migrants in 11 European countries*, p. 11; 1,125 people in total were surveyed, and 8% were above 55 years of age.

88 *Ibid* at 74.

89 FRA's elaboration on the Income and Living Condition survey, wave 2009, available on Eurostat's website at: http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/data_public_health/database.

90 PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries*. Country reports in the framework of the project Healthcare in Nowhereland, available at: www.nowhereland.info/?i_ca_id=389.

91 See above at Figure 1.

reported, for example, that they rely on cooperation with specialist doctors and pharmacies that collect medicines left over by other patients, given the practical obstacles that bar irregular migrants from access to healthcare described in Section 2.1.1. This and similar cooperation models are highly informal and fragile and do not allow for systematic and regular treatment; yet they are often the only means available to receive treatment.[92]

Evidence collected from health providers in Stockholm illustrates such a cooperation scheme: people with diabetes, for example, are examined by doctors working off-duty at a general hospital. To ensure there is no paper trail, the doctors write prescriptions for necessary medication only on paper and not on a computer and document cases only with handwritten notes. For basic check-ups or needles for insulin injections, the doctors collaborate closely with the Red Cross, which operates a privately financed dedicated health service in Stockholm. Such informal practices are however limited in the case of chronic diseases, as a doctor working at a general hospital in Germany highlighted. For example, dialysis treatment cannot be given without the hospital registering it and moreover, would cost €100 per session.

FRA opinion

Chronic conditions

Chronic diseases are increasingly becoming a focus of healthcare systems in Europe, due to general public health concerns, the impact they have on the individuals affected and the high costs of treatment.

The concepts of emergency or necessary healthcare should be applied flexibly, so as to endeavour to ensure that the healthcare needs of all persons with severe chronic diseases – including irregular migrants – do not go unattended.

92 PICUM (2010), *Undocumented Migrants' Health Needs and Strategies to Access Healthcare in 17 EU countries*. Country reports in the framework of the project Healthcare in Nowhereland, available at: www.nowhereland.info/?i_ca_id=389.

2

Regional and local health policies

The existence of a legal entitlement to healthcare for migrants in an irregular situation is an important precondition for protecting the right to healthcare, but it is not enough in practice. Supplementary measures such as national strategies on migration and health or training of health staff are important to facilitate access to healthcare of migrants in an irregular situation. Implementation of such measures takes place at the regional or local level and ultimately by health staff.

Therefore, regional and local governments play a decisive role in implementing the right to healthcare of migrants in an irregular situation. They often enjoy considerable leeway within the framework set by national regulations. Regions and cities define policies and programmes to respond to the most pressing health issues identified among the local population, and may initiate measures facilitating health inclusion for those groups considered most vulnerable. Such policies may directly or indirectly also target migrants in an irregular situation.

Some of the cities under study (for example, Cologne, Bremen, Barcelona, Paris) chose to address the situation of migrants in an irregular situation, usually in the broader context of promoting migrants' health. In Barcelona, for example, access to healthcare of migrants in an irregular situation is addressed in the 'Immigration Director Plan in the Health Area', passed in 2006.[93] Similarly, in Germany, the Department for Migration and Health in the city of Bremen in 2008 started addressing the situation of migrants in an irregular situation along with other vulnerable groups, such as asylum seekers, persons with STDs, or pregnant women, in 10 working groups aimed at promoting migrants' health in general. In order to guarantee a 'minimum level of welfare to everyone' the city of Brussels, for example, opted to create a specific department dealing with migrants in an irregular situation within the local health office in one of the city's poorest districts. This initiative draws attention to the intersection of poverty and legal status, which may be an impediment to the health inclusion of migrants in an irregular situation.

The public authority officers interviewed for this report gave manifold reasons why cities should be active in supporting access to healthcare for migrants in an irregular situation. The three main arguments mentioned are public health considerations, cost effectiveness and human rights.

One of the strongest arguments favouring health provision to migrants in an irregular situation that was put forward by public officials in almost all of the countries studied was disease prevention. The risk of certain diseases such as HIV/Aids, TB, or hepatitis was considered higher by public officials among the migrant population in general, and more particularly among migrants from Sub-Saharan Africa. From a public health perspective, opening health prevention programmes to migrants in an irregular situation reduces **health risks for the general population.**

Another argument in favour of opening healthcare services to migrants in an irregular situation is related to the **costs of treatment**. Officials in France and Ireland, for example, said that it is less expensive to offer preventive care than to pay for expensive emergency treatments**.** In countries that grant migrants in an irregular situation access cost-free to emergency care only, migrants often have to wait until a health concern becomes a crisis before seeking

93 Generalitat de Catalunya, Departament de Salut (2006), *Pla Director d'Immigració en l'Àmbit de la Salut*, available at: www.gencat.cat/salut/depsalut/pdf/immidefini2006.pdf.

healthcare. In times of cutbacks in social expenditure, services for socially and economically marginalised groups are likely to be those first cut. A recurring difficulty mentioned by authorities interviewed in France, Germany and Greece with regard to setting up health programmes for migrants in an irregular situation or other vulnerable groups were the related costs. In Greece, for example, a social welfare official of the city of Athens considered it unfeasible to cover the basic health needs of persons without legal residence. Health staff noted that at the beginning of 2010, the government cut the distribution of vaccines to state children's clinics.

The duty of states to 'fulfil' the rights of persons to health as stipulated in the human rights framework[94] is another argument mentioned by officials in Germany, Greece and Spain for enabling access of migrants in an irregular situation to healthcare, including on a local level. In Spain, an official underlined that given their **human rights obligations**, local governments should not be concerned about a person's legal status with regard to access to basic health services. Giving access to healthcare to migrants in an irregular situation also responds to the social inclusion strategy of some municipalities:

"The local council's philosophy is not to segment people, to do programmes for some immigrants and not for others. If you register at the local registry you get the health card. The fact of being regular or irregular is not important. [...] Fortunately, the [...] consciousness in this country is very strong regarding the fundamental rights of people".

Local authority, Spain

Those cities researched in France, Germany and Italy that actively support basic healthcare access for migrants in an irregular situation often referred to a mix of reasons, including humanitarian, public health, economic and other considerations. To take one example, the German city of Bremen based its policies on migrants in an irregular situation on diverse grounds: apart from risk reduction, the human rights of the inhabitants play a major role. The city has a 'responsibility towards the health of persons living there'. The first priority of city health policies is to respond to the most pressing issues at the local level. The city administration cannot simply ignore migrants in an irregular situation, who are as a matter of fact also part of a local population. The aim of promoting the health of the general population is strongly connected to promoting equal access to the health system for all the local population, a view that was expressed by several city administrations in Belgium, France, Germany and Spain.

Despite the variety of reasons given in favour of facilitating access to healthcare for migrants in an irregular situation, the introduction of concrete measures at the local level runs into a number of obstacles. Generally, the existence of a national framework defining minimum standards and guidelines regarding entitlements to healthcare, an inclusive approach of local health policies, as well as an active civil society, will positively impact on the activities that city administrations undertake in this area. However, healthcare access for migrants in an irregular situation remains a contested issue.

2.1.1. Community-based healthcare facilities

Apart from these general regulations, several countries have public community-based healthcare facilities which are accessible to all. These may be part of national policies, although they are implemented differently in different parts of the country.

In France and Greece, low-threshold services that offer urgent or basic health coverage for the general population exist. Such services can also benefit migrants in an irregular situation, although they do not constitute an explicit target group. These facilities are usually accessible with few or no conditions. No documentation or insurance is required, and treatments are offered either free of charge or at very low cost.

The city of Athens, for example, operates seven municipal community health centres that receive patients from the catchment area without distinction of legal status. The clinics offer preventive medical care and basic examinations and were established primarily for disease prevention but also to promote human rights and to reduce public health costs. Moreover, at outpatient first-aid centres patients are provided with emergency and urgent care, as well as basic general care (such as prescription of medication, treatment of hypertension, diabetes). The doctors working at first-aid centres examine each patient, recording his/her name, age, address and telephone. If the patient has no insurance, treatment is provided free of charge.

In France, every hospital is required to establish a PASS-centre (*Permanences d'Accès aux Soins de Santé*), where those in a precarious situation are provided immediately with necessary medical care or assisted in receiving it. Social counselling is also offered there.[95] Health staff said, however, that not every hospital has established a PASS facility. Those that do exist are often not overly effective due to

94 See General Comment No. 14, 2000.

95 France, Loi n° 98-657 (29 July 1998) (law against social exclusion).

a lack of resources and funding.[96] The city of Paris also operates health and social centres (*Centres Médico-Sociaux,* CMS) that offer cost-free preventive care, TB and HIV testing, as well as basic check-ups to the general population, including migrants in an irregular situation.

2.1.2. Programmes for groups with specific needs

Local or regional authorities may introduce specific programmes which directly or indirectly also benefit migrants in an irregular situation.

Dedicated health services were found, for example, in different countries for **homeless persons**. Services set up for the homeless population are usually low-threshold, mobile outreach services that may also be accessed by migrants in an irregular situation without fixed residence. In Paris, one official interviewed noted that homeless persons can access very basic treatments and legal counselling, if needed, at low-threshold drop-in centres (*Espace solidarité insertion*, ESI). Similar services for the homeless, such as mobile outreach medical teams or low-threshold drop-in centres, were also mentioned by officials in Cologne, Stockholm, Warsaw and Brussels.

Interviewees said, however, that these services reach migrants in an irregular situation only in isolated instances. Often migrants in an irregular situation are not informed that these services exist or are open to them. In Budapest, a hospital for homeless and poor persons, run by an NGO and co-financed by the state, is the only place where migrants in an irregular situation can also be attended free of charge and without any conditions. The director of the hospital, however, said that the number of patients it receives who are migrants in an irregular situation is low.

In other places, specific services for **migrants** have been set up, often in collaboration with NGOs. Specific services were identified in Germany (Bremen, Cologne, Frankfurt am Main), Spain (Barcelona), Belgium (Brussels), Ireland, Greece, Italy (Milan) and France (Paris). Public authority representatives of Paris, Athens, Brussels and Dublin, for example, confirmed that they fund action by non-governmental organisations such as *Médecins du Monde* who work with vulnerable groups such as migrants in an irregular situation. These facilities are mainly supported for their general work, with the city not necessarily interested in whether the service also targets migrants in an irregular situation.[97] Similarly, in Ireland, the Irish Health Service Executive funds services, such as the Women's Health Project, which targets trafficked women whether documented or undocumented, or the organisations Spirasi, which works with asylum seekers, refugees and other disadvantaged migrant groups, and Cairde, which tackles health inequalities among ethnic minority communities, provide healthcare to vulnerable migrant populations, amongst others migrants in an irregular situation. The Irish National Intercultural Health Strategy 2007–2012 benefits migrants in an irregular situation, even though the strategy does not target them as a group. The strategy supports services to persons from diverse ethnic and cultural backgrounds and aims especially at providing information to migrants and training for staff assuring intercultural competence.

Sometimes services have been especially designed **for migrants in an irregular situation**. In Barcelona, the city council signed an agreement with a local NGO working in the area of migration and health. The NGO operates a programme targeting migrants in an irregular situation who, because they do not have a national health card, do not have access to the Spanish health system. The city tries to provide those services the NGO is not able to offer, a civil society representative noted.

Specific services for migrants in an irregular situation may also be offered directly by local health authorities, a model found, for example, in Germany. The local health offices have established facilities that directly offer medical consultation and basic healthcare to migrants in an irregular situation through doctors employed by the local health office (see text box entitled Pro-active city healthcare initiatives in a generally restrictive context). Such services enable a targeted and systematic response to the health needs of migrants in an irregular situation. They also allow local governments to assess the situation of migrants in an irregular situation on the ground and identify gaps in the health coverage of this particular population.

96 Health staff interviews, France.
97 Public authority interviews, France and Ireland.

Promising practice

Pro-active city healthcare initiatives in a generally restrictive context

In Germany, the health departments of three cities, Cologne, Bremen and Frankfurt am Main, have established humanitarian consultation hours (*Humanitäre Sprechstunde*), at drop-in centres that offer medical consultation and basic health services to migrants in an irregular situation. Consultation is offered free of charge, with patients expected to contribute to treatment according to their means. In cases of serious health problems, the centres either refer patients to a cooperating network of specialists and/or check whether regularisation based on medical grounds is possible. The services also cooperate closely with local NGOs, which try to offer services complementary to those of the health offices. These services are, however, not representative of the overall German context, but are positive examples of proactive initiatives taken by some local health offices.

Source: Public authorities and health staff interviews in Germany

2.1.3. Cooperation with NGOs

Apart from national and local governments, civil society actors are in practice extremely important stakeholders in granting access to healthcare to migrants in an irregular situation. NGOs provide assistance to migrants in an irregular situation on the ground if the government fails to do so. Through their advocacy activities, they are also an important spur to initiate policy changes.

Public authorities interviewed in most countries widely acknowledged the importance of civil society actors, a view which sometimes results in cooperation schemes. **NGOs are considered experts on the most pressing issues on the ground, as well as the key outreach tool for migrants** in an irregular situation, as they are more trusted than official bodies. Exploiting these advantages can prove fruitful for cities.

"What enables NGOs to work is the fact that they are not an authority and are better welcomed by migrants in an irregular situation. This is an advantage they have and that we don't have. [...] They have a very privileged position to detect [...] the major problems."

Local authority, Spain

Well-functioning cooperation between public authorities and NGOs can also monitor and improve the implementation of national regulations. In Barcelona, one local NGO said it would inform the regional health service if an irregular immigrant faced barriers in receiving a health card. The health service would then take action and check "which mechanism was not working". Local authorities may also benefit directly from the experience NGOs acquire in their work: in Bremen a health office involved a local NGO when initiating a programme offering medical counselling and basic healthcare to migrants in an irregular situation. An official clarified that the city relied on NGO experience to identify the main issues and needs on the ground. Close cooperation between city administrations and NGOs also enables them to organise complementary services.

Although NGOs are very important actors in providing services to migrants in an irregular situation or other vulnerable groups, there is an inherent tension in the relationship between NGOs and authorities. NGOs usually see their mission as a provider of services the state does not offer and thus as complementary to the state but they also see themselves as critics of state policies and local policy makers. At the same time, there is a risk that authorities shift all responsibilities to civil society organisations. Finally, in many instances, NGOs depend on state funding, and costs, in order to realise their mission and hence need to cooperate.

3 The effects of exclusion from healthcare

The interviews revealed a number of strategies migrants in an irregular situation as well as health professionals employ to overcome migrants' exclusion from healthcare. Migrants might use the health card of a friend or flee a hospital to avoid payment. Health professionals might send migrants in an irregular situation to another healthcare provider or provide them with healthcare cost-free.

Such coping strategies were found in all the countries studied. They were identified in cases where migrants in an irregular situation were excluded from access to public health services or could not meet the costs of healthcare. They were also used when migrants in an irregular situation could not provide the documentation required to access services in countries that grant access to non-emergency healthcare: an illustration of administrative barriers to accessing care.

When migrants in an irregular situation do not have access to subsidised care and are unable to pay for services, they may **flee the hospital to avoid payment:**

"Sometimes I see people who don't have any money, no documents, and the only way is to run away from the hospital secretly so that they [do not have to] pay.... And after[ward the hospitals] will say that they are thieves. This is not right."

21-30, Greece, from the Middle East

In Athens, an NGO representative noted that in order to avoid payment after giving birth, women were absconding with their babies at night from the hospital. In a case that prompted public discussion nurses kept a child in the maternity ward, unwilling to hand him/her over to the mother until she had paid for treatment. But usually, the representative said, there was someone on staff willing to give the baby to the mother. Civil society interviewees said that it was typical for hospitals in Greece to want the mother to leave as soon as possible with the baby, in order to keep the costs of hospitalisation down.

In countries where access to public health services depends on having health insurance, migrants in an irregular situation may **use the relevant health card of a friend or relative**. As an illustration, a migrant in Warsaw felt that because of his irregular status it was impossible to benefit from public healthcare. He said that in case of need he would simply take his brother's identity card, go to the doctor and if he received a prescription, it would be in his brother's name. Another migrant in an irregular situation also living in Warsaw followed the same procedure for his child:

Risks of exclusion from healthcare

Migrants in an irregular situation at times resort to high-risk coping strategies to overcome exclusion from healthcare. A hospital coordinator in Brussels recalled the case of a migrant woman in an irregular situation who used to come to the hospital using a friend's medical card. It is unknown why the woman did not apply for her own AMU health card; perhaps she was unaware of her entitlement or thought using her friend's card was less time consuming than registering herself. The woman was later involved in a car accident and was brought to the hospital with her friend's medical card on her. The staff therefore mistook her for her friend, whose medical file was already on record at the hospital. As a consequence she received a blood transfusion that did not match her own blood group. The woman died a few hours later.

In their interviews, healthcare staff and NGO representatives in Germany noted the danger of the practice of borrowing health cards and using other people's identities to access care. A doctor in Germany said that there was a need to show who would pay, such as a health insurance company, before treatment is given. As a result, in his experience, people with a toleration permit would bring a declaration of cost

coverage *(Kostenübernahmeerklärung)* from the social welfare office while migrants in an irregular situation would often come with another person's insurance card. Either because the place of residence was different or because the age or blood type failed to match, he would often notice that an insurance card did not belong to the patient he was treating. Such a practice was very dangerous if complications arose in treatment because of conflicting information, he said.

"My son was ill, with smallpox, and he had no insurance. My friend had a son [who was two years] older [...] than my son and she took my son to the doctor. And my son [...] impersonated her son. The doctor saw him, examined him, all normal. But he thought that he was examining the son of this friend of mine. The service was received under another name and that's all. It is usually like this when people live by their wits."

31-40, Poland, from eastern Europe/Central Asia

Some of the health staff interviewed pointed out that without proper documentation a migrant in an irregular situation would be sent to another healthcare provider. A doctor in Athens who works at a hospital that accepts only persons with Greek state insurance IKA, noted that, in most cases, the other provider would be a hospital with an emergency outpatient service that accepted persons who did not have insurance (for about €3 a visit), a municipality health clinic or an NGO. IKA is mandatory for employees and employers have to pay for it. Since migrants in an irregular situation are not allowed to work unless they have the proper documentation, they are not eligible for IKA insurance. A similar sentiment was shared by doctors in Brussels. One said that if a person cannot afford the cost of treatment, is not covered by private health insurance or AMU, and the treatment was not urgent, then the person would most likely be sent to other facilities for free-of-charge treatment, such as to *Médecins du Monde*. The other noted that he would treat the migrant in an irregular situation for the first three or four times but would then require the person to pay or refer him/her to *Médecins du Monde*. In Poland, one migrant reported that he had to take his brother to four different public hospitals before one agreed to treat his broken leg (21-30, Poland, from Southeast Asia).

In France, migrants in an irregular situation who are unable to fulfil the requirements to receive AME are typically sent to a hospital with a *Permanences d'Accès aux Soins de Santé* (PASS) service conceived to provide healthcare to those without insurance. Although legally required to offer such a service, not all hospitals have established it. Health staff interviewed noted that some hospitals regard PASS service as a priority, while others do not. It is up to each hospital what level of care it wishes to provide. A lack of funding is often also a problem. As a result, many PASS services were not effective because of the lack of resources devoted to them.

A number of the health staff and civil society interviews noted the **informal provision of healthcare** to migrants in an irregular situation, as well as other uninsured patients, as an alternative to turning people away. Such practices were performed either to avoid the complicated state reimbursement system (see section 5.1.) or as a stop-gap where there was no programme in place to administer care to irregular migrants. Informal healthcare provision can be described as providing the service cost-free or noting the service under a payment section which allows unclaimed fees, such as emergency care provided in a hospital.

A migrant in an irregular situation in Greece would only have access to emergency care, so some hospitals do not actively seek fee collection, a representative of an Athens NGO explained. Sometimes the doctors issue the treatment in a hospital financial account that is used for unclaimed fees. There are about two million uninsured persons in Greece, so access to healthcare is also a problem for Greeks, the Athens NGO said. Health staff and NGOs in Poland made similar comments regarding the number of documented and uninsured people. A public authority representative in Dublin said that she was aware of a number of general practitioners who treated migrants in an irregular situation outside the mainstream system. She added that doctors from specific migrant communities also provided a number of healthcare services. A migrant in an irregular situation living in Warsaw needed to visit a gastroenterologist for an ulcer. She describes how she received treatment:

"When I talked to the doctor on the phone, I told her that I was a foreigner and asked whether I could come or not. She said: Yes, you can come, but you will have to pay for the visit. And that was all. I gave her PLN 100 [in cash, right], into her pocket. She wrote a prescription using somebody's surname, so I could get cheaper medicines. Let's say that they cost PLN 700, and I bought them for PLN 300. No one noted down the history of my illness. My personal data are not noted down anywhere."

31-40, Poland from eastern Europe

A doctor in Germany assumed that most doctors would provide treatment, even if they noticed a patient had the wrong insurance card, in an effort to avoid the resulting extensive bureaucratic paperwork. In large public hospitals, he said that it was generally easier for doctors to treat patients 'under the table' and of

their own accord. Similarly, a healthcare provider in Sweden noted:

"The hospital manager knows about it and accepts our work with the migrants in an irregular situation, which we carry out in our spare time."

Health professional, Sweden

Healthcare staff dealing with irregular migrants face not only awkward financial situations but also ones that can be dangerous to the health of their patients. A doctor in Germany had an irregular migrant patient who suffered from a rare disease that caused great pain. She needed pain killers, but because of her irregular status, she was not eligible for the targeted medication and instead received something less effective. Later, she returned to the hospital with another person's insurance card to access further treatment. However, there were complications during treatment, because the health card contained information about another person. A doctor in Budapest mentioned a similar experience, in which a friend or another doctor contacted her to assist a migrant in an irregular situation in obtaining medication by prescribing it under the Hungarian friend's name and social security registration number. She acknowledged the risk but said that it was necessary in exceptional cases.

FRA opinion

Legal entitlement to treatment

Migrants in an irregular situation should, at a minimum, be entitled by law to access necessary healthcare. Such healthcare provisions should not be limited to emergency care only, but also include other forms of essential healthcare, such as the possibility to see a doctor or to receive necessary medicines.

Qualifying conditions, such as the need to prove a fixed residence or prolonged stay over a certain period of time, should be reviewed in order to ensure that these do not lead to the exclusion of persons in need of necessary medical care.

The same rules for payment of fees and exemption from payment should apply to migrants in an irregular situation as to nationals. In order to cover the costs public health insurance should be extended to migrants in an irregular situation or a separate fund should be created.

4 Practical obstacles and challenges

The interviews with migrants, NGOs and healthcare providers identified a number of obstacles that hinder their access to healthcare, even when migrants in an irregular situation have entitlements. Specific examples gathered from the interviews highlight the disconnect between national legislation and what happens in practice when migrants in an irregular situation attempt to access healthcare as well as barriers that exist in providing healthcare.

The interviewees identified five main challenges in receiving or providing healthcare. These themes, as well as the legal and practical barriers that exist for migrants in an irregular situation in accessing healthcare, were noted in previous research.[98] Some present a practical challenge for both migrants and healthcare providers (costs and reimbursements; unawareness of entitlements); others affect particularly migrants in an irregular situation (fear due to data exchanges with police) and some concern health professionals and/or local authorities (margin of discretion, quality and continuity of care). These are discussed in more detail in the following sections.

4.1 Costs and reimbursements

The cost of health services can be a major obstacle to accessing healthcare. Hospitalisation and laboratory fees as well as costs for specialist doctors and especially medicines can be high and range from several hundred to several thousand euros, amounts which are difficult for many people to afford.

Costs can also be a relevant obstacle for the health professionals and public authorities that provide healthcare. Where migrants in an irregular situation are entitled to access primary and secondary care for free, there are costs resulting from the provision of healthcare and the provider must charge someone, whether it is the state, an insurance provider or the patient.

"A hospital is a business and like every other business, someone must pay for the services delivered. So, if there are patients who are uninsured the hospital must claim payments from them [..]. When people go to the shop and they have no money, no one will give them bread for free. It is the same in the hospital. However, if there is direct threat to life, the hospital must act; the patient must be admitted and served like every other patient."

Health professional, Poland

A study conducted by *Médecins du Monde* in 11 countries shows that in countries that lack regulations on financing the treatment costs for migrants in an irregular situation, the individuals concerned encounter severe obstacles when trying to access health services even in emergency cases.[99]

Cost of healthcare services is more likely to be a burden on migrants in an irregular situation. If they work, they can be dismissed more easily than regular workers and may earn less than the minimum wage. They often work in dangerous and tiring jobs which are challenging both physically and mentally, such

98 See PICUM (2007), *Access to Healthcare for Undocumented Migrants in Europe*; HUMA Network (2009), *Access to Healthcare for Undocumented Migrants and Asylum Seekers in 10 EU Countries: Law and Practice*; and European Observatory on Access to Healthcare of Médecins du Monde (2009), *Access to healthcare for undocumented migrants in 11 European countries*.

99 See European Observatory on Access to Healthcare of *Médecins du Monde* (2009), *Access to healthcare for undocumented migrants in 11 European countries*. These include 10 EU Member States: Belgium, France, Italy, the Netherlands, Portugal and Spain, Germany, Greece, Sweden and the United Kingdom, as well as Switzerland.

as working in construction, on a farm or as live-in domestic work.

Examples of situations mentioned by migrants interviewed included an undocumented worker in construction who severely cut his hand with a circular saw. Another experienced painful stomach aches while working with cast iron in a foundry, and a third migrant injured his ankle and leg when he fell off a horse at the farm at which he worked. Another suffered a concussion after slipping and hitting her head while cleaning house.[100] In this context it may be worth underlining that the 1989 Directive on Safety and Health at Work obliges employers to take a number of measures (first aid courses, surveillance of workers' health, etc) to safeguard workers. The directive defines 'worker' as 'any person employed' and therefore applies to every worker, not only to those who are regular.[101]

Some healthcare providers mentioned that if a migrant in an irregular situation did not have the required documentation to access their services, they would be able to receive care but, as a matter of institutional practice, would have to **guarantee payment for the services**. A doctor at a general hospital in Germany said that no treatment would be given unless someone pledged to meet the costs.

"If they cannot pay, they don't receive services. They will receive healthcare services if someone guarantees payment – it could be an NGO or there could be a special provision made to cover the cost. If it is, of course, a serious incident, which is decided by the hospital or the Ministry of Health. then the treatment would be covered."

Health professional, Greece

Similar 'cost-ensuring' guarantees were mentioned by other medical professionals. A doctor in Budapest said he would occasionally see patients without official referral, but noted this was not only against the rules but also risky, because if he did not record the treatment or made a professional error, the hospital and its insurance policy could opt to deny him coverage.

Other healthcare providers in Germany, Greece, Hungary, Ireland and Sweden said that treatment would be given but it would be **necessary to send a bill for payment**. For example, a receptionist at a Dublin hospital said that if a migrant in an irregular situation enters the hospital for care and has no medical card or letter from a general practitioner, the hospital is obliged to enter their information for a bill.

Hospital bills: receiving care but unable to pay

One of the interviewees in Dublin is a migrant whose removal was suspended. He suffers from diabetes, Hepatitis B and C and had had TB. Because of his illnesses he goes to the doctor and hospital at least four to five times a month, particularly for his diabetes. The hospital provided him assistance in applying for a medical card but because of his status and inability to legally work, he has been unable to pay his medical bills. He has received a number of letters from a debt collector in relation to unpaid hospital bills. He says he cannot afford to pay these bills and it causes him a great deal of stress, which further undermines his health.

Source: Health professional interview, Ireland

The state reimbursement procedure to the healthcare provider affects healthcare providers and facilities and ultimately migrants in an irregular situation. Healthcare providers in Belgium, France, Greece, Hungary and Italy mentioned a complicated and time-consuming reimbursement procedure required by the state for care provided to migrants in an irregular situation. Each country has a different system and, depending on the country, there are special documents to be filled out and reimbursement of payment is often delayed. The provider's main concern is to be reimbursed by the government for the care that is administered. The state's main concern is not to issue reimbursements for individuals that do not fall within the defined category of assistance.

The administrative burden on healthcare providers, the lack of information about entitlements and the procedure to recover money from the state pose obstacles many healthcare providers prefer to avoid. As a result, **migrants** in an irregular situation **are sometimes turned away and refused care**. The issue of refusing care was noted as well in a report by *Médécins du Monde* that looked at 11 EU countries. Out of the respondents, 14% of people said that they had been refused healthcare the last time that they were ill.[102] An NGO in Paris noted that they were seeing a very high care refusal rate for AME beneficiaries.[103] As mentioned by a health professional in France:

100 See also *Médecins du Monde* European observatory survey on access to healthcare (2009), *Access to healthcare for undocumented migrants in 11 European countries*, available at www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf at pp. 65ff.

101 Council Directive 89/391/EEC (12.06.1989) on the introduction of measures to encourage improvements in the safety and health of workers at work, OJ L 183/1, 29.06.1989.

102 *Médécins du Monde* (2009), *Access to Healthcare for Undocumented Migrants in 11 European Countries*, available at: www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf.

103 A study conducted in 2005 by *Médécins du Monde* among 700 health professionals in 10 cities in France showed that 37% of the health professionals refused to treat *l'Aide Médical d'Etat's* (AME) recipients whereas 10% refused to treat *Couverture maladie universelle* (CMU) recipients. *Médécins du Monde, Testing sur les refus de soins des médecins généralistes pour les bénéficiaires de la Couverture Maladie Universelle ou de l'Aide Médicale Etat dans 10 villes de France*, 2006.

"The payment system is very complicated in France. Even I, as a practitioner, don't really understand the different fees. What about a migrant in an irregular situation! Some specialised practitioners refuse to take care of AME recipients, because they have problems in being reimbursed by the state. In addition to the reimbursement, the AME often does not pay for the specialised fees that some specialist doctors are eligible to charge."

General practioner, France

Refusal of care to universal health coverage (CMU) and AME recipients is forbidden by law.[104] The *Haute autorité de lutte contre les discriminations et pour l'égalité* (HALDE) concluded in 2006 in a complaint related to six villages in Val-de-Marne, lodged by the French association of general practitioners *(Collectif des médecins généralistes pour l'accès aux soins,* COMEGAS), that denial of access represented discrimination.[105] According to a study of six villages in Val-de-Marne, 4.8% of beneficiaries of CMU are denied access to care by general practitioners and 41% by specialists providing secondary care, which amounts to discrimination forbidden by law.

Some providers also engage in cost-cutting measures to save money. For example, an NGO in Paris noted that they were aware of cases where patients were asked to leave a hospital earlier than the normal length of care, because the hospital was afraid that it would not be paid. A doctor at a general hospital in Germany said that basic diagnostic services, such as blood samples, would be performed. Expensive examinations, however, such as computer tomography (which is used for instance in cancer screening) would be avoided given the question of payment and cost reimbursement.

In Belgium, because migrants in an irregular situation approved for AMU coverage do not pay for treatment, the only way for health providers to be reimbursed is to receive payment from an agreed social welfare centre (CPAS/OCMW). Often **healthcare providers are afraid that the state will not reimburse them.** A healthcare provider in Brussels said that it was difficult to decide whether or not to treat a migrant in an irregular situation who has a medical card granted from a CPAS/OCMW in another region, because that regional centre might not reimburse the costs of care. A doctor in Germany said that when providing care to persons with a toleration permit *(Duldung)*, it was often necessary to check with the social welfare office to confirm and clarify that the costs of treatment would be met. This also meant that the healthcare provider would be required to fill out additional paperwork. A doctor in Budapest commented that it was not so much the issue of checking residence status when providing treatment, but more the issue of insurance, because the National Healthcare Fund checks entitlement to treatment rigorously.

Another doctor in Budapest as well as a healthcare staff person interviewed in Germany said that in practice it is easier to register the migrant in an irregular situation as uninsured than to attempt to reimburse the costs of treatment due to the legal and bureaucratic hurdles. This was seen as a practical solution for some providers in Budapest since the National Health Fund paid such a low fee for each medical examination that it was not worth the paperwork to file for the reimbursement. In addition, the number of migrants in an irregular situation in that particular hospital was so insignificant that it had yet to pose a problem.

FRA opinion

Public reimbursement procedures

Healthcare staff report that they must initiate a complex process if they are to get reimbursement from public funds for healthcare services provided to migrants in an irregular situation.

EU Member States should establish simple and effective reimbursement procedures. Requests for reimbursement should be processed quickly.

4.2 Unawareness of entitlements

Lack of information on health rights of migrants in an irregular situation among both healthcare users and health providers is a major barrier to accessing healthcare.

"People don't know what to do, where to go or how the system works [..]."

Civil society organisation, Greece

This section will first discuss unawareness of entitlements among migrants in an irregular situation and then among healthcare professionals and public authorities.

People are often unaware of what services actually entail. After receiving medical services in a hospital, a **migrant in an irregular situation** living in Brussels was not informed that his AMU entitlement was wider than just medical services and emergency care. He was not aware that he could receive certain medicines cost-free as well as access preventive treatment.

104 Article L1110-3 du Code de la Santé publique.

105 Délibération relative au refus d'accès à la prévention ou aux soins opposé par un professionnel de santé aux bénéficiaires de la CMU n° 2006-232 du 06/11/2006, available at www.halde.fr/Deliberation-relative-au-refus-d,12889.html

With the exception of migrants holding a toleration permit in Germany who receive information from the social welfare office, irregular migrants said their two most popular ways to gain information on access to healthcare were by word of mouth and from NGOs. Taking into consideration the fear that many migrants in an irregular situation have in approaching authorities (see section 3.2.1), information shared by word of mouth through the various migrant communities is an approach which is seen by migrants as a relatively safe way of gathering information about their rights. Word-of-mouth information can teach them, for example, about which hospital treats migrants in an irregular situation with ease, which NGO offers medical assistance and which public authority to visit for a particular form. This method of information sharing has its limits, however, as there are vulnerable groups that are more difficult to reach, such as migrant domestic workers in an irregular situation, who may work in private households with little or no contact with outside communities.[106]

Information shared by word of mouth is sometimes, but not always, correct. Migrants in an irregular situation are largely unaware of their rights, so there is scope for rumours and speculation. For instance, many migrants in an irregular situation in Italy were too afraid to visit a hospital, because they had heard from friends that doctors could report them to the police. This fear could have been avoided if more outreach to migrants in an irregular situation had been done, not just by NGOs but also particularly by public authorities.

Healthcare staff may also be unaware of entitlements and find the legislation providing access too complex. An NGO in Paris noted cases where migrants in an irregular situation were not properly informed of their rights by the hospital's social workers when they entered the hospital for treatment. As a consequence, the hospital would ask them to pay fees for services when the migrant in an irregular situation (if they have AME) should not have to. Similar situations were mentioned by migrants in Sweden, where children of rejected asylum seekers have, by law, access to healthcare free of charge.[107] A representative from another NGO in Paris explained that most practitioners did not know the legislation for migrants in an irregular situation, because the population represented such a small percentage of their patients and the laws were so complex:

"The situation is completely crazy: a complex, exceptional, ever-changing law targets a very small number of persons."

Civil society organisation, France

A public authority representative in Barcelona noted the difficulty in ensuring that all healthcare staff are aware of the rights to access healthcare of migrants in an irregular situation. In Barcelona, for example, he said there are more than 30 hospitals, all of which maintain a large staff with a regular turnover. Given the sheer number of healthcare workers, he said he thought there would always be someone who would say: "You have no right". Most important, he said, was the public authorities resolve in detecting such a lack of awareness and addressing it, "But to [keep this from] happening is not possible".

Hospital workers unaware of entitlements

In Sweden, a woman whose asylum claim had been rejected took her 10-year-old son to the hospital after he developed a high fever and a rash on his arm. Although the children of rejected asylum seekers who are under 18 years of age are entitled to access care free of charge in Sweden, the woman was told that she would have to pay the full price before her son received treatment. The total bill amounted to around SEK 1,700 (€183 as of 19 September 2011). She did not have the money to pay the bill, so an administrator suggested that she talk to one of the nurses in the hospital, to see if she would take pity on her son and take a look at him. The nurse said that she would still have to charge half of the amount and medicines prescribed would not be included. Again, the woman told her that even if it was half price, she was not able to afford the bill. The nurse then agreed to see her son 'unofficially', so no paperwork was filled out. She advised the woman to monitor her son's condition and return to consult the doctor if his temperature did not go down in three days.The woman would, however, still be expected to pay the full amount for her son's examination, although she would be allowed 30 days in which to pay it.

An NGO in Barcelona said that whenever they encounter a migrant in an irregular situation who is having trouble accessing care, they immediately contact the Catalan Health Service's customer service line in order to determine together which mechanism is not working. One doctor voiced his appreciation for the Ministry and the Catalan Health Department in offering training for professionals on how the health system works, including 'cultural competence' courses and mediator training. He felt that training was essential in raising awareness among professionals of other cultures.

106 For more information on migrants in an irregular situation in domestic work, see FRA, *Migrants in an irregular situation employed in domestic work: Fundamental rights challenges for the European Union and its Member States*.

107 See footnote 28.

Promising practice

Training social workers on the rights of migrants in an irregular situation

The Immigrant Council of Ireland in Dublin is a national, independent NGO that promotes the rights of migrants through advocacy, lobbying and research. In addition to the work that they do directly with migrants in an irregular situation, they conduct outreach with hospital social workers, training them on immigration issues and entitlements. The training is the NGOs response to a series of hospital queries it received on, for example, what the legal entitlements were for migrants in an irregular situation with chronic illnesses. The training and the good relationship developed with social workers in a number of hospitals has helped improve healthcare access for migrants in an irregular situation.

Source: Immigrant Council Ireland, see: www.immigrantcouncil.ie/services/education-and-training.

Awareness of public authorities varied from country to country. It was not always easy to find a public official who could discuss healthcare access and entitlements for migrants in an irregular situation. One public authority representative in Paris interviewed for the study went so far as to claim that AME was only accessible for regular migrants and nationals and that there were no healthcare options in France available for migrants in an irregular situation. Another public authority from Warsaw noted that the subject of access to healthcare for migrants in an irregular situation had never been discussed at work, even though healthcare was the department's sphere of responsibility. The interviewee was unaware that migrant women in an irregular situation had to pay to give birth in hospitals.

FRA opinion

Awareness raising

Authorities working with migrants in an irregular situation, healthcare providers, civil society actors and migrants themselves are not necessarily aware of rules and entitlements concerning healthcare for migrants in an irregular situation. Migrants fear that approaching healthcare services may expose them to the risk of being deported, even when there is no such risk.

EU Member States should, therefore, find ways of addressing the lack of information among migrants, healthcare providers and public authorities, such as increasing funding for training, information campaigns and outreach activities in migrant communities and fostering partnerships between healthcare providers and civil society.

Precise information about which information can and cannot be communicated to immigration enforcement authorities should be provided to healthcare providers and migrants.

4.3 Reporting migrants to the police

EU Member States should disconnect healthcare from immigration control policies, ensuring that healthcare providers or authorities in charge of healthcare administration have no duty to report. Policies of fear based on real or perceived exchange of data between healthcare providers and immigration enforcement keep migrants in an irregular situation from seeking healthcare until an emergency situation arises, which undermines the individual's health and raises public costs.

Fear of accessing healthcare is an overarching theme in all of the interviews conducted and represents a significant barrier in accessing and administering healthcare to migrants in an irregular situation. It was mentioned by the migrants interviewed in Belgium, Germany, Italy and Poland as a reason for not approaching a public service or healthcare provider until urgently necessary. It was also mentioned by healthcare providers and civil society as the reason why migrants in an irregular situation would provide false information or choose to visit an NGO service rather than a public service. Fear is mentioned more often in some countries than in others, particularly countries that were debating additions and/or changes to legislation which concerned migrants in an irregular situation.

Some of the healthcare staff in Germany and civil society actors in France and Poland who were interviewed said that they had heard stories or knew of instances in which migrants in an irregular situation who went to hospitals to seek treatment were reported to the authorities.

Because of the fear that migrants in an irregular situation have in accessing healthcare and of public authorities, many migrants in an irregular situation avoid healthcare providers at all costs or delay until serious health conditions arise. This is not only detrimental to the person's health but also increases the usage of emergency rooms and the overall cost of care for healthcare providers.

A migrant in an irregular situation living in Stockholm said that he was afraid of being referred to police and would do anything in order to avoid an emergency room. Civil society respondents in Ireland indicated that migrants in an irregular situation would associate contact with any authority (healthcare, social or social services) with the risk of being reported to immigration authorities. A social worker at a health centre in Paris commented that sometimes migrants in an irregular situation were quite reluctant to visit their centre,

because they were afraid of healthcare professionals. She gave the example of TB, saying that the only way that health professionals could reach out to an ill migrant in an irregular situation would be through a relative who came in with symptoms. In her work she has found that migrants in an irregular situation often think that healthcare providers are linked with the police, but she also stressed the professional code that healthcare providers honour.

Even if the migrant in an irregular situation is granted the right to healthcare there are still many who are afraid to access care. One migrant in an irregular situation in Brussels whose removal was suspended suffers from a stomach disease, which requires regular doctor's visits. Although he has AMU health coverage, he says that he is scared of going to the hospital too often because of the fear of discovery and arrest.

In Germany, a new administrative regulation of the Residence Act *(Aufenthaltsgesetz)* was introduced in September 2009.[108] The regulation emphasises the principle of proportionality when submitting data identifying migrants in an irregular situation.[109] This implies that, when justified, authorities like the youth or social welfare office, which can cover healthcare expenses, may refrain from the duty to pass on information about undocumented migrants to the immigration authorities. The regulation clarifies that in cases of emergency, medical confidentiality is extended from the doctors or personnel performing healthcare services to the social welfare office.[110] An NGO noted that the interpretation of what constitutes such an emergency depends on the person in charge, however, leaving room for discretion. For non-emergencies, an irregular migrant must himself/herself lodge an application for cost coverage at the welfare office, in which case, social welfare officers remain bound by a reporting duty. [111]

According to Germany's federal medical chamber *(Bundesärztekammer)*, this barrier leads to a treatment delay for many patients, whose health conditions worsen or become chronic. The chamber is, therefore, lobbying for a change of the reporting policy for irregular migrants in need of primary or secondary care. In May 2010, the chamber's plenary conference voted to put forward a request to the legislature to introduce an anonymous health insurance card *(anonymer Krankenschein)*.[112]

In Ireland, Section 8 of the Immigration Act 2003 contains a duty for public authorities to share information concerning non-nationals for the purposes of implementing the law on entry and removal. In October 2003, Ireland established an interface between the information system of the Department of Social and Family Affairs and that of the immigration authorities.[113]

When the Security Package was discussed in Italy in July 2009, an obligation for healthcare professionals to report migrants in an irregular situation to the immigration authorities was proposed. Several civil society and medical professionals' organisations condemned the proposal, stating that the duty to report would create a barrier to healthcare provision for migrants in an irregular situation. They launched the campaign 'Forbidden to report: We are doctors and nurses, not spies!' *(Divieto di segnalzione. Siamo medici ed infermieri, non siamo spie!)*.[114] This reporting obligation was not included in the final version of the bill.

These examples show the varying degree to which legislation introduced and implemented can affect migrants in an irregular situation and their access to care. In Germany, legislation has brought about some improvements for migrants in an irregular situation. It removes healthcare professionals' duty to report, but leaves that duty intact for public officials dealing with irregular migrants in need of primary or secondary healthcare. In Italy, during the discussion of such legislative measures, it was common for migrants in an irregular situation to avoid contact with public and healthcare authorities for fear of being reported. The fear of migrants in an irregular situation was very evident in Italy. The fieldworker for this research said it was difficult to find migrants in an irregular situation with whom to conduct interviews as they even avoided contact with NGOs. A recently regularised migrant discussed her fear and the security package legislation:

108 Residence Act of 30.07.2004 (*Aufenthaltsgesetz in der Fassung der Bekanntmachung vom 25. Februar 2008 (BGBl. I S. 162), das zuletzt durch Artikel 1 des Gesetzes vom 12. April 2011 (BGBl. I S. 610) geändert worden ist*) § 87 paragraph 2.

109 Regulation on the Residence Act of 26.10.2009 (*Allgemeine Verwaltungsvorschrift zum Aufenthaltsgesetz (VwV-AufenthG) vom 26.10.2009, GMBl. I S. 878*), Section 87.0.4.

110 Regulation on the Residence Act of 26.10.2009 (*Allgemeine Verwaltungsvorschrift zum Aufenthaltsgesetz (VwV-AufenthG) vom 26.10.2009, GMBl. I S. 878*), Section 88.2.4.0.

111 Katholisches Forum *‚Leben in der Illegalität' (2010), Erläuterung zu ausgewählten Vorschriften aus der „Allgemeinen Verwaltungsvorschrift zum Aufenthaltsgesetz vom 18.09.2009 (Drucksache 669/09)"*, Berlin. For more information on the law and its effect on access to healthcare for migrants in an irregular situation in Germany, see PICUM (2010), NowHereLand Country Report Germany, http://files.nowhereland.info/709.pdf.

112 Resolution of the federal medical chamber *(Bundesärztekammer)*, available at: www.bundesaerztekammer.de/page.asp?his=0.2.6578.8260.8265.8506.8507.

113 See Quinn and Hughes, *Illegally Resident Third-County Nationals in Ireland: State Approaches Towards Their Situation*, Dublin, ESRI, 2005, p., 20, available at www.esri.ie/pdf/BKMNEXT073.pdf.

114 For more information on the organisations involved and the campaign, please visit the website of the Italian Society for Migrants' Health *(Società italiana di Medicina delle Migrazioni*, S.I.M.M), available at: www.simmweb.it/index.php?id=358.

"I arrived here on 12 November 2006 and I was irregular. I was always afraid and I never went to a hospital. [More recently], after [the Security Package] people said that if you went to a hospital, the doctors could report you."

21-30, Italy, from Eastern Europe

A migrant in an irregular situation remarked on her fear of approaching healthcare providers:

"I always worked in the black economy, and I was always afraid [...] I was afraid of illness. too.,[...] I was afraid to be visited and taken care of. Here if you are a migrant in an irregular situation you commit a crime, but it is not right! We are all human beings!"

41-50, Italy, from Latin America

Migrants in an irregular situation avoided contact with authorities while the new legislation was under consideration, risking their health and safety, and healthcare providers noticed the decline in visits. A doctor in Brescia estimated that the security package prevented up to half of her patients who were migrants in an irregular situation from seeking healthcare. She said that patients told staff that they had avoided seeking treatment in previous months because of the fear of being reported to police. A mediator at a healthcare centre in Milan noted that once the security package was introduced the centre noticed a decline in the number of migrants in an irregular situation visiting so, in response, they organised a campaign to inform people that they were against the security package. A doctor at an NGO in Milan providing healthcare to migrants in an irregular situation said that during the consultation with the migrants in an irregular situation many said that they were afraid of arrest. In the opinion of the doctor, "Our patients are informed about the Italian legislation!"

Healthcare providers in Germany and Ireland also noticed the apprehension of migrants in an irregular situation in accessing care. Speaking on a proposed change to Irish legislation, an NGO in Dublin said:

"When the bill first came out we got a lot of calls from [migrants in an irregular situation] worried about what it meant [...] I'm sure we will have to reassure people and encourage people to still access hospitals."

NGO, Ireland

A representative from a German NGO felt that the application of the German legislation depended largely on the persons and agencies involved. She said the concern for most healthcare providers was the question of payment, so if the service was not reported for reimbursement by the authorities, then the healthcare provider would not be reimbursed. A migrant in an irregular situation from West Africa living in Dortmund said that if she was conscious, she would not go to a hospital for fear that the police and immigration officials would detect and arrest her.

FRA opinion

Reporting migrants to immigration enforcement bodies

Fear of being detected based on real or perceived exchange of data between healthcare providers and immigration enforcement bodies means that migrants delay seeking healthcare until an emergency arises. This has negative consequences both for the health of the individual and results in more expensive interventions.

EU Member States should disconnect healthcare from immigration control policies and should not impose a duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration.

4.4 Discretionary power of public and healthcare authorities

In the countries covered by this study there were many examples that highlighted the discretionary power of public or healthcare authorities. This discretion concerned not only access to primary and secondary but also to emergency care. Application requirements are applied at varying levels of strictness, depending on the regional location of the public authority and the healthcare provider at which the migrant in an irregular situation is attempting to access services.

Discretion of public authorities is a very important factor in enabling access to healthcare for migrants in an irregular situation. In the interviews, it was evident that some public authorities were known to use exclusionary practices with migrants in an irregular situation. More documents would be required or migrants would have longer waiting times to meet with a social worker. For example, a civil society actor in Barcelona said his organisation had intervened in situations where a local authority administrative worker, reluctant to register an irregular migrant for a health card, had asked for further documents that were not required, such as proof that the person had economic resources. But the interviewee thought that "the majority of the cases are related to lack of information among civil servants or administrative workers". Similarly, an NGO representative in Paris noted that each local health insurance office (*Caisse Primaire d'Assurance Maladie*, CPAM) assesses a migrant's length of stay and level of income differently. A CPAS/OCMW staff member in

Belgium described the detailed process the Belgian federal government expects to be followed for AMU applications and the high monetary penalty that CPAS/OCMWs face if they grant an AMU health card to an unqualified individual. A doctor in Paris also mentioned geographical differences: the waiting time for an AME application depends upon which part of the city the social welfare office is located in. For example, in the city centre, the waiting time ranged between one and one and a half months, while in one particular suburb it was three months. Waiting times to access the system were also reported for AMU in Belgium.

In Germany, if a person with a toleration permit *(Duldung)* turns to a social service office that interprets the definition of 'acute' care narrowly, he/she runs the risk that his/her healthcare expenses will not be covered. In fact, an NGO representative in Bochum believed that the chances of acceptance were small and that "the personal assessment would differ from one employee to another". The NGO representative gave an example of such an incident involving a woman who had been living in Germany for six years, during four of which she had a toleration permit (*Duldung*). The woman had teeth and jaw problems which caused her extreme headaches and sleeplessness. According to the medical specialist an operation was necessary. Nevertheless, the social services department refused to bear the costs, despite legislation entitling persons with such toleration permits to necessary and urgent care. The department argued that the woman was only 'tolerated' and her deportation was, in theory, possible at any moment. In another example, the NGO representative said the social services department had again declined to bear the costs, in this case for a person with hepatitis B, although it had been made clear that the illness was serious. This case was brought to court and after 14 months it was decided that the department should bear the expenses.

Discretion of healthcare staff (doctors, nurses, receptionists, and emergency medical technicians) is another important factor in enabling access to healthcare for migrants in an irregular situation. It is the healthcare provider who decides whether or not a condition qualifies as an 'emergency' and what is, or is not, 'acute' or 'urgent'. Such a decision in some countries determines if a migrant in an irregular situation receives treatment and if he/she has to pay for the service. An NGO representative in Athens commented that a doctor decides what constitutes an 'emergency' – a victim of a car accident alone, or also an HIV-positive person or one with TB who is unable to access medicines. If the irregular migrants do not have documents, they do not have the right to follow-up treatment. Civil society respondents in France, Germany, Hungary and Sweden noted varying interpretations of what is considered an 'emergency', 'acute' or 'urgent' care. An NGO in Budapest said that it was the doctor who determined 'urgent' need, with social workers often finding a need 'urgent' only if the person was bleeding. So access to emergency care for a migrant without documents who fails to show signs of an 'urgent' need may depend on the doctor's discretion.

In Belgium, as part of the application process to receive urgent medical care (AMU), a migrant in an irregular situation must receive a document from a doctor indicating that he/she is indeed in need of 'urgent' care. A healthcare provider at a hospital in Brussels and a civil society respondent in Belgium said that it was possible, even with medical cards, that some doctors within approved health structures refuse to treat migrants in an irregular situation, because they do not know if the services provided would be reimbursed. As a result, migrants in an irregular situation may find it difficult to identify a doctor of reference. A cultural mediator working at a health centre in Milan noted the discretionary power of healthcare staff as well:

"…[T]he rules of the STP code could be interpreted in different ways and the policy adopted by the health provider influences the way the STP code is issued and used. The issue of the STP code is discretionary, and it depends on the single doctor, on the hospital (and its policy), and finally on the administrative staff."

Health professional, Italy

In conclusion, it would seem useful to define criteria for authorising or refusing different kinds of healthcare service (such as emergency, essential, basic, urgent, necessary) so to make care more predictable and equitable within a single country. These criteria would clarify entitlements and reduce the discretionary power of public officers. They would reduce health professionals' uncertainties about how the law should be applied without taking over the role of professional judgment.

4.5 Quality and continuity of care

Lack of legal entitlement to public healthcare, fear of the cost of healthcare and/or the impossibility of paying the cost required creates a large problem for providing quality and continuity of care. This section discusses the difficulty of providing quality and continuity of care, focusing on the specific challenges experienced by health professionals, namely keeping medical records and providing adequate treatment when migrant patients in an irregular situation do not have access to specific examinations and medicines.

Difficulties faced by migrants in an irregular situation in receiving quality care are often similar to those of other foreigners. This is the case, for example, of linguistic and cultural barriers, which inhibit migrants from receiving a certain standard and quality of healthcare service. From the health staff interviews in Germany, Hungary, Ireland, Italy and Spain, it was clear that problems can arise when the patient does not understand the diagnosis, or a staff translator is not available. The patient may suffer a loss of privacy when a third person, in the form of someone working at the hospital – such as cleaning staff or security – are brought in to translate.

Other difficulties are, however, specific to migrants in an irregular situation. According to health professionals in most countries interviewed, this is particularly the case for continuity of care, i.e. the ability for a patient to visit a healthcare provider continually over a period of time in an effort to cure the patient's ailment. In countries where migrants in an irregular situation have access to emergency care only, they will have to cover the costs of other treatments. Even in countries that provide basic care to those migrants in an irregular situation that meet the established requirements there are costs that need to be considered (i.e. medicines) which can impinge on the level of care that can be reached. The results of this research show that these costs can be a daunting expense for a migrant in an irregular situation.

As already documented in the FRA report on separated children, difficulties in obtaining a medical history from children, as well as the absence of **medical records,** are additional obstacles.[115] According to health staff in Belgium a particular challenge relates to the ability to maintain medical records. In public hospitals, maintenance of a medical record will depend on the legal access to primary and secondary care that the migrant in an irregular situation has in the country. Medical staff in Belgium, Germany, Greece and Italy said that if he or she is able to access care through a programme, and his or her expenses are covered, a medical record will be maintained as for any other patient. However, medical staff in Greece noted that if the migrant does not have legal access or is unable to pay for the service, he or she will either be sent a bill and have a medical record maintained or the doctor may suggest treatment 'off the books' and will not have a medical record made of the visit.

In the interviews, healthcare staff in Ireland mentioned the difficulty in maintaining records as migrants in an irregular situation often provide incorrect phone numbers, addresses or insurance cards, making it complicated for providers to follow-up on changed appointments. As previously discussed, many migrants in an irregular situation do so because they are afraid to give contact information to authorities, even if the information will only be used for medical purposes. A doctor in Dublin commented on how very easy it was for people to enter the Accident and Emergency Department of the hospital by registering under another name and remain anonymous in the medical system. In this case, however, there is a risk that health staff confuse the person on a return visit and provide treatment with an incorrect blood group or one that prompts an allergic reaction, which, as described in Chapter 4, can have fatal consequences.

The precarious living conditions of migrants in an irregular situation are another obstacle when providing follow-up treatment, as irregular migrants, fearing detection, may have difficulty reaching health services. Healthcare providers that worked in NGOs in France, Italy and Sweden confirmed that medical records were kept for their migrant patients in an irregular situation. However, efforts are also made by public services, as a health professional in Italy stressed that:

"As a hospital our aim is to provide care continually; even if the doctor who takes care of the patient is not always the same. Many patients who have been irregular for years come here again and again!"

Health professional, Italy

Another limitation to continuity of care is the additional cost of buying medicines, which may limit the healthcare providers treatment options for a particular ailment. Finally, in countries where migrants in an irregular situation only have access to emergency care services, it can be very difficult to arrange for additional examinations or services, as the migrant will be expected to pay.

Arranging for additional examinations or services is a challenge not only for migrants in an irregular situation but also for healthcare providers. A doctor in Germany noted that all procedures are not always covered for those that have a tolerated status, such as rehabilitation, medication intake and the provision of insulin. Healthcare staff in Hungary mentioned a similar situation regarding patients who needed dialysis. Another doctor in Germany said that rehabilitation or similar care was neither covered by the social welfare office nor, because of the expense, could it be taken from the budget of the care provider, so the patient would not receive the most suitable therapy. A healthcare provider in Warsaw confirmed that if the care is not related to emergency situations, then the patient will have to pay for the follow-up treatment. A public authority representative in Stockholm noted that migrants in an irregular situation with a chronic

115 FRA (2010), *Separated, asylum-seeking children in European Union Member States - Comparative Report,* p. 46.

disease, such as diabetes, would be expected to pay for laboratory analysis.

One important consideration is the difficulty to ensure continuity of care in cases of communicable diseases, TB in particular. Migrants move across borders, but no referral system among countries exists. When migrants move, this can likely lead to interruption of treatment with the risk that they develop drug resistance.

FRA opinion

Continuity of care

Migrants in an irregular situation are often treated informally and hence no medical records are kept.

Healthcare systems should find ways of overcoming the main challenges to providing continuity of care. In addition, measures should be taken to ensure continuation of care in case of communicable diseases, such as for example, the creation of an EU wide referral system for tuberculosis (TB) patients.

Conclusions

Access to certain basic forms of healthcare cannot depend on a person's legal status. If certain categories of persons living in a country are excluded from healthcare for reasons of costs or other concerns, such as the wish to avoid detection, this also raises a public health issue. Furthermore, if access to primary or preventive healthcare services is excluded or limited, this is likely to increase costs for emergency healthcare.

Countries included in this study differ greatly in the level of access to healthcare they grant to migrants in an irregular situation. Without considering healthcare entitlements for specific groups (such as children) or in the case of specific illnesses (such as TB), in six out of the 10 countries studied migrants in an irregular situation are granted access to public healthcare only in emergency situations.

In the remaining four countries (Belgium, Italy, France and Spain) migrants in an irregular situation may access healthcare beyond emergency care if they fulfil specific qualifying conditions i.e. factual residency in the host country or a particular area, presentation of identification documents, proof of lack of means.

Most countries included in this study struggle to find the most appropriate way to deal with the healthcare needs of migrants in an irregular situation. Costs, public health considerations, respect for human rights but also migration management considerations influence national policy choices.

The fact that legally binding international law provisions on the right to health have limited enforceability, the vague language used (such as 'adequate care') combined with the need to implement international and European standards in countries with very different healthcare systems, leads to a divergent understanding and application of the existing legal framework across the EU with different outcomes in terms of healthcare services offered to migrants who are in an irregular situation, not all of which are in line with existing standards.

Annexes

Annex 1: Terms of use

Table A1: Explanation of terms of use and EU Member State

Acronym	Term	EU Member State
AMU	*Aide Médicale Urgente*, urgent medical assistance	Belgium
AME	*Aide Médicale d'Etat*, state medical assistance	France
CPAM	*Caisse Primaire d'Assurance Maladie*, health insurance office	France
CPAS	*Centre public d'aide sociale*, social welfare centre	Belgium
CMP	*Centre Médico-Psychologique, psychological care centre*	France
CMS	*Centres Médico Sociaux, social health centre*	France
Duldung	Authorisation to stay for persons whose removal is suspended	Germany
ESI	*Espace solidarité insertion*	France
IKA		Greece
INAMI	*Institut national d'assurance maladie-invalidite*, National Institute for Health and Disability Insurance	Belgium
LEA	*Livelli Essenziali di Assistenza,* essential levels of assistance	Italy
NHS	National Health System	
OCMW	*Openbaar centrum voor maatschappelijk*, social welfare centre	Belgium
PASS	*Permanences d'Accès aux Soins de Santé, cost-free healthcare centre offices in hospitals*	France
STP code	*Stranieri Temporaneamente Presenti,* temporary foreign resident code	Italy
RIZIV	*Rijksinstituut Voor Ziekte- en Invaliditeitsverzekering,* National Institute for Health and Disability Insurance	Belgium

Annex 2: Research design and methodology

Information for this report was mainly gathered from three sources. First, desk research was conducted on the most recent and relevant studies on both access to healthcare for migrants in an irregular situation in the European context as well as the country situations. Second, a survey was carried out for the larger project on the fundamental rights of migrants in an irregular situation which included questions on access to healthcare. Questionnaires were distributed in spring 2010 to national and local authorities as well as to civil society organisations in the 27 EU Member States. Third, empirical field work in 10 countries was carried out.

Such field work is the main source of this report. The empirical research included qualitative interviews with four main groups of respondents: migrants in an irregular situation, health staff, civil society actors and public authorities. The research was coordinated by PICUM and ICMPD, and carried out by 10 researchers who were selected according to their expertise and previous work experience on the issues of migration in an irregular situation and/or health. In each country the number of interviews envisaged ranged from 17 to 32 interviews: migrant in an irregular situation (5–10); healthcare staff (5–10); civil society (2–5) and public authorities (2–3). The exact number depended on the saturation of the sample as assessed by the local researchers. The interviews were carried out mainly between April and June 2010.

Altogether, the fieldwork involved 221 semi-structured qualitative interviews across 10 EU Member States: 36 with public authorities, 43 with civil society representatives, 67 interviews with health staff, and 75 with migrants in an irregular situation. The total number of interviewees involved in the research is slightly higher, as some interviews involved more than one respondent. The four interview categories were not always clearly divisible, as in some cases public authorities or civil society organisations were at the same time acting as health providers. The empirical research was conducted in 21 cities (see Table A1) that were preferably the capital or other cities which could reveal interesting local practices.

The interviews with public authorities aimed at collecting the different national, regional, and local policies on access to healthcare for migrants in an irregular situation and the rationale for such policies. They also served to gather information on the awareness by city officials, on programmes initiated, as well as challenges identified by local administrations and policy makers. The sample included local (19), national (9) and regional authorities (8) competent on health issues, social welfare and/or immigration.

The civil society interviews aimed at giving an overview on the implementation of national and local policies, to collect information on the role of the different stakeholders, and to identify the main challenges in practice. The majority of the civil society representatives interviewed was actively providing healthcare to migrants in an irregular situation or vulnerable groups in general. Over half were targeting

Table A2: Cities researched and number of interviews conducted

Country	City	Number of interviews				
		Public authority	*Civil society*	*Health staff*	*Migrants*	*Total number*
BE	Brussels, Antwerp, Ghent	5	3	5	7	20
IE	Dublin, Lacken	4	5	5	7	21
IT	Milan, Brescia, Legnano	3	3	8	10	24
FR	Paris	5	6	7	8	26
DE	Bremen, Cologne, Bochum, Dortmund, Wuppertal, Bissendorf	2	7	6	8	23
GR	Athens	4	5	6	10	25
HU	Budapest	2	3	5	2	12
PL	Warsaw, Piastow	3	5	11	10	29
ES	Barcelona	5	4	6	9	24
SE	Stockholm	3	2	6	6	19
	n=21	**36**	**43**	**65**	**77**	**221**

migrants in general, while for about a third of the organisations migrants in an irregular situation were the main target group.

Interviews with health staff aimed at: revealing how access to healthcare works in practice; which access requirements might hinder access; how healthcare providers receive migrant patients in an irregular situation (for example, existence of institutional guidelines); and which challenges they identify. The interviewed health professionals included doctors, nurses, administrative personnel and social workers. The focus of the interviews was: health providers within the mainstream system, such persons working at general hospitals; specialised hospital departments or specialist hospitals; community medical centres or general practitioners working in individual or group practices. Only five of all facilities covered (nine interviews) were specifically targeting migrants in an irregular situation, which were different in form (non-governmental, governmental, state-subsidized, etc.) and in the type of services offered (basic counselling to broad coverage of all types of care).

Interviews with migrants in an irregular situation intended to reveal strategies of migrants in an irregular situation to access healthcare in case of need, their assessment of accessibility and quality of care by public providers, as well as the main challenges identified by them concerning entitlements to access services and related costs. Interviewed migrants included third country nationals who were irregularly residing in the countries studied. Most of them were third country nationals who were living undetected at the time of the interview (68% of interviews). However, some migrants in an irregular situation were known to the authorities who had suspended or postponed removal. These included persons who were in a regularisation procedure, women whose deportation was delayed due to pregnancy or other health reasons, or rejected asylum seekers who could not be deported due to lack of identity documents or other reasons.

Regarding the countries of origin of the interviewees, 35% of the interviewees came from an African country, 23% from an Asian country, 21% from a European country, and 20% from Latin America and the Caribbean.

Slightly more than half of the interviewees were men. Over half of the interviewees were aged between 30 and 49. The majority of the migrants in an irregular situation interviewed (50 persons) worked, most of them unregistered. Of those interviewed, 40% were single and/or did not have children, 36% had children who were living with them in the current country of residence, while 13% of the interviewees had a family (spouse and/or children) in their country of origin.

In addition, the sample aimed at collecting information on five specific health scenarios selected for the case study (accidents, ante-and post-natal care, child immunisation, chronic diseases, mental conditions). Thus, the researchers tried to find interviewees who either had experienced one of the listed health problems, or knew someone who had had a related problem. Accidents were not described as a separate scenario in the final report, as this situation was largely subsumed under emergency healthcare.

Interview guidelines, which are reproduced at the end of this publication, were developed to ensure consistency during the research. Interviewers received training on these guidelines in Brussels, Belgium, on 8-9 April 2010. The field research took place between April and June 2010.

Most of the interviews were conducted in each country's national language. However, a number of interviews were also conducted in English or in the interviewee's mother tongue with the assistance of interpreters.

One of the research project's main challenges was accessing interviewees. In some countries, the researchers had major difficulties in contacting public officials, while in Hungary and Poland it was difficult to identify a department or person competent on the research issue.

Furthermore, access to migrants in an irregular situation posed some major difficulties. Apart from individual contacts, or snowballing, the main access strategy followed was approaching migrants in an irregular situation through NGOs. Interviews often took place at NGO facilities which the migrants already knew and felt comfortable at. However, the interviews were sometimes disrupted by the daily business of the NGO (such as people coming in, room needed because a course would start), or by the limited time the interviewees were able to provide.

Based on the interviewees' consent, the interviews were audio-taped or notes were taken during the conversation. Thematic coding supported by a software that facilitates qualitative interview analysis (Maxqda) were used to analyse the interviews. Based on the guiding questions for the entire research project, as well as on preliminary analysis of some interviews, a code list was developed for each of the four interview groups and then applied for the analysis of all interviews in the same category.

A case study was provided by ICMPD (Veronica Bilger and Christina Hollomey) and PICUM (Devin Cahill) to the FRA together with the data set on the basis of which the FRA prepared this thematic report.

Interview guidelines for migrants

I. Information on the interview

Interviewer: NAME

Date (dd/mm/yyyy):

Time (9.00 or 21.00):

Duration of interview:

Contacted via (i.e. NGO, private contact etc.):

Language of interview:

Place where interview took place (i.e. NGO, bar, home of the person etc.):

Protocol (i.e. based on audio tape, taken notes):

Interview situation (short narrative description on the general atmosphere, setting, any particularities etc):

II. Data of interviewee

Interviewee (not real name, for internal purposes):

Gender:

Age:

Nationality/country of origin/or ethnicity:

Current legal status (i.e. undocumented, living in limbo, etc.):

Previous legal status:

Any other remark on interviewee:

III. Personal information of the interviewee

1. What is your living situation (i.e. alone, with a partner, relatives, friends, with children)?
2. Do you have any children (under 18 years)?
3. How long have you been living in the current legal situation? How did it happen?
4. Are you employed?
5. If YES, what sort of work do you do (i.e. construction, cleaning, landscaping, etc.)?
6. What sort of accommodation do you have (i.e. shelter, private housing with/without friends, no home)? And what are the conditions of the housing (i.e. in good state, clean, dirty, safe, etc.)?

Interview protocol (questions and text)

IV. Personal experience of the interviewee regarding access to healthcare

7. Have you ever been sick and needed professional care? What did you do?
8. Have you ever gone to a hospital for a healthcare need (i.e. emergency, maternal care, chronic health problem, mental health, etc.)?
9. If NO, why not?
10. If NO, would you try and seek assistance in another facility in your city (i.e. outreach clinic, etc.)?
11. If NO, what did you do? Do you still have the injury/or is the health concern still bothering you?
12. If NO, (has not personally visited a hospital), do you know an irregular migrant who has? What was their experience?
13. If YES, under what conditions do you have access (i.e. showing documents, etc.)?
14. If YES, what would be the method of payment for the care (i.e. free access, payment in full, etc.)?
15. If YES, can you describe to me what it was like for you to receive healthcare (i.e. the obstacles, hardships, success, the treatment from staff, etc.)?
16. Have you ever needed a translator during a consultation?
17. If YES, was the hospital able to provide someone? If not, what happened?
18. What is the greatest barrier to accessing healthcare?
19. Is there a major health concern that you see in your community that is not being addressed?
20. Do you know an example of an irregular migrant who has a child (children) and tried to access healthcare services for them? What is the procedure?
21. If an irregular migrant had to give birth, what would they do? Have you come across such a situation?
22. If an irregular migrant had a mental health issue (i.e. depressive disorder, anxiety-stress disorder, etc), what would they do? Have you come across such a situation?
23. If an irregular migrant had a chronic disease (i.e. diabetes), what would they do? Have you come across such a situation?
24. If you would have an accident at the workplace, what would happen? Would the employer organise healthcare? Have you come across such a situation?
25. Do you feel that you would be well cared for in this country in event of sickness?

Interview guidelines for public authorities

I. Information on the interview

Interviewer: NAME

Date (dd/mm/yyyy):

Time (9.00 or 21.00):

Duration of interview:

Contacted via (i.e. questionnaire, private contact etc.):

Language of interview:

Place where interview took place (i.e. office, etc.):

Protocol (i.e. based on audio tape, taken notes):

Interview situation (short narrative description on the general atmosphere, setting, any particularities etc.):

II. Contact information of interviewee

Name of organisation:

Level of government (i.e. city, national, regional, etc.):

Address:

Contact person:

Tel.:

Email:

III. Approach and awareness on the political-administrative level

1. Which groups of irregular migrants in particular need for care are identified in your city in general (e.g. mothers, pregnant women, children etc.)?
2. Depending on the group, how is this translated into public health policies at the city level (i.e. any particular programmes focusing on particular groups, action plan, etc.)?
3. Are there any particular public health policy/programme/measure at the city level targeting irregular migrants/ persons living in limbo (i.e. unsuccessful asylum seekers)?
   - If yes, what is the rationale behind the measures (e.g. human rights, costs reducing, disease prevention, health promotion etc.)?
   - If not, why not?
4. Are there any specific health programmes for groups with particular health needs? Can irregular migrants (persons without documentation (undetected)) access these programmes?
5. Can person in a limbo situation access these programmes?
6. Which programme do you consider particularly successful in your city and why?

7. In every city there is a number of NGOs involved in providing healthcare to irregular migrants.
    - How is the cooperation with this NGOs organised (i.e. actively supported by funding them, ignored, nothing beyond acknowledging their presence, etc.)?
8. How do you deal with irregular migrants' access to healthcare? (i.e. Focus on including them best possible in the mainstream system or Focus on assisting NGOs in improving their capacities etc. to support irregular migrants.)
9. Do you consider the particular approach in your city successful? Why/why not?
10. In many countries/cities there is conflicting interest between immigration control and health provision. How do you deal with this conflicting interest?
11. In your city, is it common practice for healthcare providers or administration workers to report irregular migrants to the authorities?
12. What should be changed in order to improve access to healthcare for irregular migrants/persons living in limbo (i.e. national policy, local policy, administrative changes, programmes, services, etc.)?
    - List the 3-5 most important changes you think would be necessary.
13. How is the detailed procedure in the following situations of **irregular migrants** seeking healthcare (treatment, costs, reporting, etc.)?
    - A person who has suffered a workplace accident and needs emergency care
    - A pregnant woman (access to pre-natal care, delivery, and post-natal care)
    - A person with a chronic condition (diabetes or asthma in need of treatment)
    - A person with mental health problems (e.g. traumatised, psychosis, (drug) addict, alcoholism) in need of treatment

Interview guidelines for health staff

Generally, bear in mind that there might be differences in the way 'undetected' irregular immigrants and persons in a limbo situation can access care.

I. Information on interview

Name:

Function:

Name of organisation/institution:

City:

Contact details of interviewee (if applicable):

II. Information on health provider

1. Type of healthcare provider
   - General hospital
   - Specific department within hospital: (e.g. emergency unit, gynaecology)
   - Dedicated service for IM within hospital
   - Dedicated service for IM outside hospital
   - Specialised care outside hospital
   - General practitioner
   - Network of practitioners (including specialists)
   - Other
2. Type of funding of healthcare provider
   - State funded
   - Non-governmental/ privately financed
   - Non-governmental/ state-subsidised
   - Private/ for profit
   - Other
3. Target groups of the service
   - No specific target group
   - Women
   - Children
   - Persons with chronic diseases
   - Persons with mental health problems
   - Migrants
   - Irregular migrants
   - Asylum seekers
   - Other

III. Access to healthcare for irregular migrants

4. What are the required administrative steps if an irregular migrant asks for care?
5. Which documents are needed in order to access care?
   - Identity card
   - Health card (insurance)
   - Address confirmation
   - Document on immigration status
   - Bank account number
   - Other
6. Does an irregular migrant have to pay to access care?
7. Who covers treatment costs if a patient cannot pay?
   - Insurance
   - City
   - Hospital
   - Other
8. What happens if a person cannot pay the costs for treatment? E.g.:
   - Checked beforehand – no treatment if no money
   - Reported to supervisor/ third party (police, immigration authority,...)
9. Is there an official policy of your organisation/department regarding the treatment of irregular migrants?
10. Do irregular migrants receive care to the same conditions everywhere in the city/country, or is the way your organisation provides healthcare specific?
11. If your organisation does not provide healthcare for irregular migrants, can you send them to other facilities where they receive the necessary treatment?

IV. Quality of services

12. What kind of services do irregular migrants receive?
    - Preventive care: screenings
    - Diagnostic services
    - Emergency care
    - General care
    - Surgical services
    - Inpatient-care
    - Ambulant care
    - Other
13. Are there any differences regarding the treatment irregular migrants receive compared to other patients? (Also in regard to persons in a limbo situation!!!)
    - They receive only limited medical services

- Treated by special personnel
- Treated in a specific unit
- Other

14. Language: Are there any interpretation services offered to IM or migrants in general?
15. Are there any specific adapted structures in place specifically for irregular migrants? E.g.:
    - a person of reference for irregular migrants
    - specifically trained persons for dealing with IM
    - translation services
    - specific payment arrangements
    - social worker
    - Other

V. Continuity of care

16. Do you record a patient history of irregular migrants?
17. Is it possible for irregular migrants to receive follow-up treatment?
18. Do irregular migrants have the possibility to consult one and the same doctor several times?

VI. Information about irregular migrant patients

19. Do you record administrative information (e.g. legal status, address, name) on irregular migrant patients?
20. Is the administrative information shared with/processed to third parties?
21. Do you know how many irregular migrants used your services within the last month/year?
    - Exact number: .....
    - Estimate: ....% of patients

VII. Specific situations of irregular migrants in need of healthcare

22. How is the detailed procedure in the following situations of **irregular migrants** seeking healthcare (treatment, costs, reporting, etc.)?
    - A person who has suffered a workplace accident and needs emergency care
    - A pregnant woman (access to pre-natal care, delivery, and post-natal care)
    - A person with a chronic condition (diabetes or asthma in need of treatment)
    - A person with mental health problems (e.g. traumatised, psychosis, (drug) addict, alcoholism) in need of treatment

Interview guidelines for civil society representatives

I. Information on interview

Interviewer: NAME

Date (dd/mm/yyyy):

Time (9.00 or 21.00):

Duration of interview:

Contacted via (i.e. questionnaire, private contact etc.):

Language of interview:

Place where interview took place (i.e. office, etc.):

Protocol (i.e. based on audio tape, taken notes):

Interview situation (short narrative description on the general atmosphere, setting, any particularities etc.):

II. Contact information of interviewee

Name of organisation:

Address:

Contact person:

Tel.:

Email:

III. Civil society information

1. What geographical area does your NGO work in (i.e. city, national, etc.)?
2. What types of services does your NGO provide to irregular migrants?
3. What is the main situation of the irregular migrants that you work with regarding their status (i.e. undetected, persons living in limbo situations, etc.)?
4. What countries do the majority of the irregular migrants in contact with your organisation come from?
5. In your work, do you feel supported by the local/regional/national government?

6. Depending on the country that you are in, this question may differ:

Countries with legislation regarding irregular migrants and access to healthcare – be sure to bring a copy of the legislation with you!	**Countries without legislation** regarding irregular migrants and access to healthcare
Question: Your country has legislation on access to healthcare for irregular migrants; do you think that there are any troubles in interpreting it (i.e. clear, ambiguous, etc.)? How is the legislation interpreted in your city (i.e. broad, narrow)?	Question: Your country does not have legislation regarding irregular migrants and access to healthcare. Have there been any discussions within the government to change this? In your personal opinion, do you think it is a change that will take place? Why/why not?

7. In your city, is it common practice for healthcare providers or administration workers to report irregular migrants to the authorities?

IV. Medical situations

Depending on the expertise of the interviewee, you will ask one section from either Situation 1-4. Ideally in your grouping of interviews, you should have a mix of situation respondents (i.e. not all of your interviews should focus on only an emergency situation).

8. How is the detailed procedure in the following situations of **irregular migrants** seeking healthcare (treatment, costs, reporting, etc.)?
   - A person who has suffered a workplace accident and needs emergency care
   - A pregnant woman (access to pre-natal care, delivery, and post-natal care)
   - A person with a chronic condition (diabetes or asthma in need of treatment)
   - A person with mental health problems (e.g. traumatised, psychosis, (drug) addict, alcoholism) in need of treatment

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It can be accessed through the FRA website at fra.europa.eu.

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FRA
EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

HELPING TO MAKE FUNDAMENTAL RIGHTS A REALITY FOR EVERYONE IN THE EUROPEAN UNION

Migrants in an irregular situation in the European Union (EU), namely those who do not fulfil conditions for entry, stay or residence, often suffer from specific health risks, such as those resulting from exploitative working conditions or precarious housing. As EU Member States, faced with an ageing population and the repercussions of a global economic crisis, struggle to contain public health expenditure, the right to health for all – regardless of legal status – must remain a key concern. This report of the European Union Agency for Fundamental Rights (FRA) documents the legal, economic and practical obstacles that migrants in an irregular situation face in accessing healthcare in 10 EU Member States and proposes a number of ways to improve this access. The FRA found in particular that the risk of detection and deportation prevents migrants in an irregular situation from seeking healthcare, even in those countries where it is legally available, and suggests, among other improvements, disconnecting healthcare from immigration control policies.

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