Access to health care for undocumented migrants in the EU: A first landscape of *NowHereland*

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Summary: Undocumented migrants are gaining increasing attention in the EU as a vulnerable group exposed to high health risks. Access to health care is subject to national regulations that differ within the EU27. Accordingly, practice models on how to ensure the human right to health follow different logics. The article provides a first view of the landscape on policies/regulations within 20 EU Member States and highlights examples for related practices. Access to health care ranges from none to full access. This corresponds with policy contexts that range from ignorance to acknowledgement. One practice element decisive in all contexts is the level of structural compensation provided by non-governmental organisations (NGOs).

Keywords: Undocumented migrants, access to health care, practice in context, functional ignorance, structural compensation

Undocumented migrants (UDM) in the EU are gaining increasing attention as a vulnerable group exposed to high health hazards. The health of UDM is greatly at risk due to difficult living and working conditions which are often characterised by uncertainty, exploitation and dependency. At the same time, UDM face considerable barriers in accessing health services. Reviews ask for "greater transparency in countries' approaches to responding to the health and health care utilisation inequalities experienced by this population, within the framework of human rights."[1]

Irregular foreign residents in the EU27 account for between 0.39% and 0.77% of the population, or some 1.9 to 3.8 million people. This equated to somewhere between 7% and 13% of the foreign population in 2008.[2] Routes to becoming inhabitants of what we coin here as *NowHereland, a land that is nowhere and at the same time part of a European "here and now"*, roughly can be outlined as endogenous – legal entry into a country but losing legal status (for example, from overstaying or not leaving when asylum is rejected) and exogenous (for example, when crossing borders undetected).[3] An irregular migrant has been defined as "someone, who owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorised to remain in the host country (also called clandestine/illegal/undocumented migrant or migrant in an irregular situation)."[4] To date, only estimates are available;[2] there is no official data on the number or characteristics of the inhabitants of *NowHereland*.

Health care in *NowHereland*: a management of paradox

Access to health care is defined as a fundamental human right, irrespective of legal status or financial capital,[5] a right that should protect particularly socioeconomically disadvantaged and vulnerable groups from extreme hardship.[6] All EU Member States recognise this human right. At the same time, access to health care for UDM in Europe is a national competence. Regulations are heterogeneous, in most cases access to health care is related to specific documented status. This creates a paradox with contradictory demands of inclusion within the health care system seen as a human right and exclusion from health care through national definitions of inclusion like citizenship, insurance contributions, or a specific status such as registered asylum seeker or refugee.

In practical terms, these contradictory demands create uncertainty for health care organisations and their personnel: if they provide care, they may act against legal and financial regulations; if they do not provide care, they violate human rights and exclude the most vulnerable. This paradox cannot be resolved at a practice level but has to be managed in such a way that neither human rights nor national regulations are violated.

This article therefore provides a first insight into the European Nowhereland, painting a landscape on health care regulations in twenty Member States as a frame of reference for emerging practice strategies on how to cope with the challenge of including the UDM within health care systems.

A first landscape of *NowHereland*

From a bird's eye view, countries can be grouped into three different categories

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concerning regulations on health care for UDM (See Figure).

Countries with no access to health care for UDM

This includes countries without entitlements for UDM to access health care, but where UDM do have access to emergency care. This is done for two reasons: firstly, obligations to provide emergency care exist in general and are, in most cases, not linked to any kind of status. Secondly, access to emergency care only is seen more as a kind of 'death prevention', rather than as health care in the curative sense. Countries with no access to health care for UDM make up a large part of Central and Eastern Europe, Scandinavia and the Baltic states. These countries are: Austria, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, Poland, Romania, Slovakia, Slovenia and Sweden.

Countries with partial access to health care for UDM

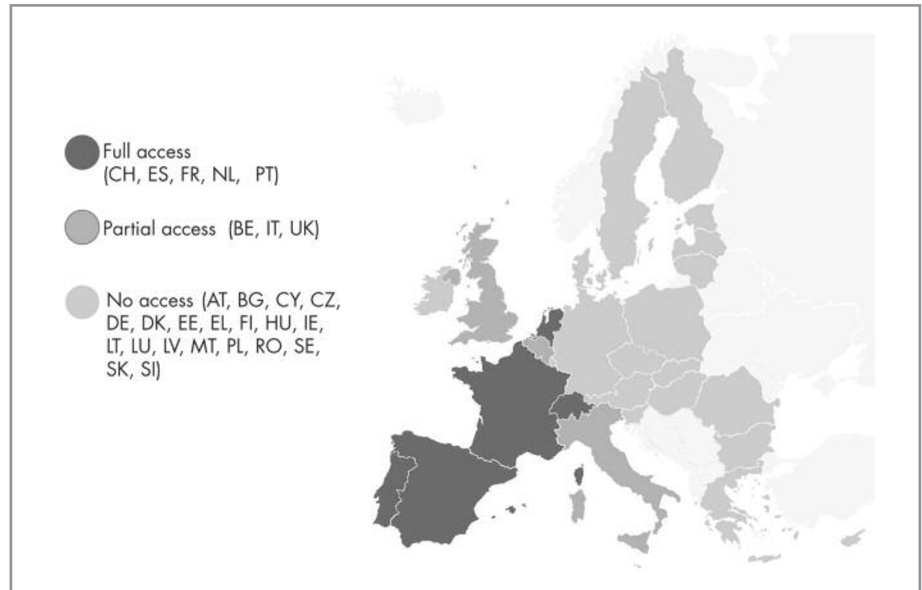
This includes countries where there are either explicit entitlements for specific services, and/or for specific sub-groups of UDM (for example, children, pregnant women) and/or for a specific diagnosis (for example, medically necessary treatment) in place. These countries are: Belgium, Italy and the UK.

In Italy, entitlements are in place for a range of services and for specific groups. In the UK, for a limited number of services access is free of charge, whereas for a range of hospital treatments and diagnoses, payment of the full cost is required (for example, for in-patient care, ante and postnatal care and medicines). In Belgium, for some specific groups of UDM (for example, unaccompanied minors) it is possible to obtain compulsory health insurance. UDM who do not fall under these groups, have the right to apply for 'urgent medical assistance' (AMU – *Aide Médicale Urgente*) free of charge. A broad range of medical services fall within this category, albeit with some minor exceptions, as in the case of some prosthetics and medications.[7]

Countries with full access to health care for UDM

Four countries that had the same range of services/entitlements to health care for UDM and nationals were included: France, the Netherlands, Portugal and Spain. In all four countries, full access is tied to a variety of pre-conditions including: proof of identity, residence, destitution and minimum duration of stay.

Figure: Undocumented migrant access to health care services across Europe



In Spain, UDM have to register in the local civil registry with a valid passport, residence proof and declaration of extreme poverty. In situations where UDM cannot meet these requirements and for certain diseases (for example, HIV and diabetes) it is still possible to access essential treatments in some regions through a specific health care document (DAS – *Documento de asistencia sanitaria*) that does not require a valid passport.

In Portugal, full access requires UDM to provide documentation indicating that they have been living in Portugal for more than 90 days. With this proof of residence it is possible to obtain a temporary registration at a health centre. For UDM who have been residing in Portugal for less than 90 days or who fail to prove residence or lack of financial means, free access is possible for a limited range of services (emergency care, treatment of contagious diseases, ante and postnatal care, vaccinations and family planning). For other services however, they have to pay the full costs of care.

Since January 2009 a special government fund has been in place in the Netherlands to pay for medical care for UDM. Under this new scheme UDM are entitled to 'directly accessible' services (primary care practitioners, midwives, dentists, physiotherapists and hospital emergency departments) and 'not directly accessible' services (in hospital departments, nursing homes and outpatient clinics). For 'directly accessible' services UDM may make use of any provider available. For 'not directly accessible' services only a limited number of specially contracted providers are able to claim back the costs of providing treatment. Between 80% and 100% of service costs (100% in respect of pregnancy and childbirth) can be reimbursed to the service provider. For the reimbursement of these health care costs service providers have to prove that the UDM patient is unable to pay, and thus must send an invoice and a reminder to every UDM.[8]

France requires eligibility to the AME (Aide Médicale État), a parallel administrative system that allows UDM access, free of charge, to the same health care services as nationals. To obtain the AME, UDM have to provide proof of residence in France for at least three months, proof of identity and evidence on their lack of financial means. UDM who do not succeed in obtaining the AME are only entitled to emergency care, screening for sexually transmitted diseases and HIV/AIDS, vaccinations, family planning, as well as screening and treatment of tuberculosis.

An important point is that although entitlements may be in place, this does not necessarily mean that access is ensured in practice. Even under conditions of full entitlement, for various reasons UDM may find it difficult to obtain health care. Conversely, countries with limited entitlements may nevertheless develop practices to provide health care services to UDM. Mapping the landscape on these different level of entitlements provides a picture of legislative contexts, but not actual practice in accessing health care services.

Practice in context

Policies and regulations are the frame of reference where practices emerge. Without knowing this frame, practice cannot be understood and evaluated in terms of its sustainability and transferability across countries. Looking at the level of practice, it appears that in different contexts different strategies have developed to manage the paradox of health care for UDM. Examples are given here from country contexts where there is no access and partial access.[9] Further examples will be available by the end of 2010 (see http://www.nowhereland.info/).

Context: no access.
Practice: functional ignorance

Austria serves to illustrate emerging practice in a system where there is no entitlement to services. Austria has a compulsory social health insurance system regulated by law, financed through income-related contributions based on occupation, supplemented in some cases by additional private health insurance. If someone without insurance undergoes medical treatment, in principle this works on a fee-for-service basis. Regardless of financial considerations, the Austrian Federal Hospitals Act obligates every hospital to provide immediate care in the case of emergencies.

Austrian legislation does not include any specific regulations for health care provision for UDM. Thus, on a regulatory level, undocumented migrants do not exist. Consequently, there are no organisations which explicitly offer health care for undocumented migrants.

Nevertheless, there are ways in which they can obtain health care, and we have already noted that hospitals can be accessed for serious life threatening emergencies. NGOs also play a critical role in providing access to a range of services. For these NGOs, the criterion for provision of health and social care relates to poverty and socioeconomic vulnerability. UDM are not mentioned as a specific target group, but instead are integrated into a definition of socially disadvantaged and particularly vulnerable people.

Since 2004, AMBER-MED (see http://amber.diakonie.at), a joint project of the refugee service of Diakonie, Austria and the Austrian Red Cross, provides outpatient treatment, social counselling and medication for people without insurance coverage in Vienna. Services are offered free of charge and anonymously and can include general medicine, gynaecological examinations, paediatric care and diabetes care among others. In 2008, 754 patients, the majority of whom were asylum seekers, refugees and homeless people, made use of AMBER-MEDs services. The work of this organisation is mainly made possible due to the volunteering of doctors, nurses and interpreters, as well as through the support of a large network of medical specialists and institutes. AMBER-MED is financed through donations/subsidies from the Federal Ministry of Health and the Fund for Social Affairs in Vienna (*Fonds Soziales Wien*), and the Vienna Health Insurance (*Wiener Gebietskrankenkasse*).

To access this service, there is no need to provide information on legal status. Monitoring on the number of UDM among patients therefore does not systematically take place. This ignorance concerning legal residence creates a paradox-free space for action that allows providers to act in accordance with the principles of human rights and professional ethics. The benefit of this strategy is that regulations, as well as practices concerning health care for UDM, need not be discussed and/or revisited. The disadvantage is that it is challenging to engage in evidence based development of policies and practices because of the lack of data.

Context: partial access.
Practice: partial acceptance

Italy can be used to illustrate emerging practice in a country with partial entitlements to health care for UDM. It is a tax-based health care system with universal coverage, with considerable regional differences following a north-south divide. Since 1998, all migrants without permission to stay have had a right to urgent or primary hospital and outpatient treatment in the case of sickness or accidents, as well as for preventive treatments. Due to the Italian legislation on “health care for foreign nationals who are not registered with the National Health care System (NHS)” (Decree 286, Article 35, 25 July 1998) access is specifically guaranteed to emergency/urgent care, prenatal and maternity care, vaccinations, preventive medicine programmes and the prevention/diagnosis/treatment of infectious diseases. Additionally, there are three categories of undocumented patients with entitlements to health care: minors up to eighteen years, pregnant women up to six months after birth and patients with diagnosed infectious diseases.

To gain access to public health and health care services, UDM need to obtain the so-called regional ‘STP-Code’ (*Straniero Temporaneamente Presente* – foreign national temporarily present). This anonymous code, available from a hospital administration department or the regional authority any time and free of charge, is valid for six months and can be renewed. It serves to identify the patient to all the health care services that he or she is entitled to and is recognised throughout Italy (Decree 394, Article 43, 31 August 1999). Together with the *Dichiarazione di Indigenza* which states that UDM have no economic means to pay for treatments, this in effect means that they can receive medical treatment free of charge.

One regional practice example is Reggio Emilia, where two services work in close cooperation to provide health care services for UDM.

1. Dedicated service: centro per la salute della famiglia straniera

Located within the Local Health Authority in Reggio Emilia, the Centre for the Health of Foreign Families provides outpatient care and medical treatment for UDM and foreign nationals without registration in the NHS (see http://tinyurl.com/39mfh5t). Services include gynaecological examinations and counselling, prenatal care and paediatric care. Services for specific target groups are offered on a project basis, for example, psychosocial support and health care for prostitutes. Health care provision is supported by cultural mediators.

The centre keeps precise statistics on patients, made possible through the STP-Code. It shares its database with the Caritas surgery *Querce di Mamre* (see below) which enables both services to make appointments for patients in the appropriate centre. In 2007, the centre had 3,189 patients; 53.7% were first time service users. For emergencies, the centre can refer UDM to the emergency unit of a local hospital, after calling the responsible doctor there in advance. Continuity of care is an important factor in these services, especially during pregnancy. Staff members therefore try to fix all appointments and steps through pregnancy in advance to assure the continuity of care.

2. NGO: Caritas surgery ‘Querce di Mamre’

Querce di Mamre is an outpatient clinic run by Caritas in cooperation with the Local Health Authority of Reggio Emilia

(see http://tinyurl.com/35uxmsc). The target group of the centre are UDM without access to the NHS and itinerant people. In 2008, the surgery had 1,411 visits. It has provision for general medicine, gynaecology, dental and emergency care. It is well equipped with various instruments like ultrasound devices and electrocardiographs. It has a well stocked pharmacy, supported by a network of several medical surgeries that offer assistance directly at their private facilities. A large number of volunteers (sixty volunteering doctors – GPs and specialists – and fifteen volunteering nurses) cover nearly all medical fields, including internal medicine, general surgery, obstetrics and gynaecology, paediatrics, otorhinolaryngology, ophthalmology, psychiatry and dental care. Communication and information are facilitated by mediators and written information materials.

The Italian case demonstrates, in contrast to Austria, a strategy of partial acceptance of UDM. Regulations are in place, and a system established that allows for the organisation and provision of health care services. Through the STP-Code, the course and history of diseases can be recorded and routes of UDM within the country can be reconstructed (given the case that UDM access services in different parts of Italy). The assignment of this specific status also facilitates the organisation of service provision, as the STP-Code serves as an administrative and organisational instrument that ensures continuity of care. The context of partial access allows a systematic approach with benefits both for UDM – who can regularly access a wider range of services – and for public health – through the systematic monitoring of patient needs, routes of patients and prevention of infectious diseases.

Conclusions and outlook

Practices in access to health care for UDM show considerable variations that can be related to the context of regulations on the national level. Two approaches that can be identified are:

Functional ignorance where the legal status of somebody who needs health care is not asked for and/or monitored;

Partial acceptance where temporary access to services is systematically provided and monitored following completion of administrative and organisational steps to obtain temporary status in connection with a declaration of extreme poverty.

A common element in both contexts is the decisive role of civil society organisations. NGOs are important service providers that compensate for the lack service provision structures within the public health system. Health professionals work as volunteers in the organisational framework of these NGOs. Both under conditions of functional ignorance and partial acceptance, support from such NGOs, as well as informal solidarity between health professionals, is needed to follow humanitarian values without violating state-control-demands.

To date, our map of *NowHereland* seems to highlight a vulnerable space, where UDM have limited chances to get the health care they need and where health care providers and policy makers have to cope with the paradoxical demand to act for the inclusion and exclusion of UDM at the same time. However this map also highlights emerging safe places of sanctuary, where UDM can get treatment in accordance with their human rights

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