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Policies on Health Care for Undocumented Migrants in the EU27: Towards a Comparative Framework : summary Report

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**Policies on Health Care for Undocumented Migrants in the EU27:
Towards a Comparative Framework**

Summary Report

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July 2010

Work package 4
Policy Compilation and EU Landscape
Deliverable No.6

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Preface

Undocumented migrants have gained increasing attention in the EU as a vulnerable group which is exposed to high health risks and which poses a challenge to public health. In general, undocumented migrants face considerable barriers in accessing services. The health of undocumented migrants is at great risk due to difficult living and working conditions, often characterised by uncertainty, exploitation and dependency. National regulations often severely restrict access to healthcare for undocumented migrants. At the same time, the right to healthcare has been recognised as a human right by various international instruments ratified by various European Countries (PICUM 2007; Pace 2007). This presents a paradox for healthcare providers; if they provide care, they may act against legal and financial regulations; if they don't provide care, they violate human rights and exclude the most vulnerable persons. This paradox cannot be resolved at a practical level, but must be managed such that neither human rights nor national regulations are violated.

The EU Project, "Health Care in NowHereland", works on the issue of improving healthcare services for undocumented migrants. Experts within research and the field identify and assess contextualised models of good practice within healthcare for undocumented migrants. This builds upon compilations of

- policies in the EU 27 at national level
- practices of healthcare for undocumented migrants at regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

As per its title, the project introduces the image of an invisible territory of NowHereland which is part of the European presence, "here and now". How healthcare is organised in NowHereland, which policy frameworks influence healthcare provision and who the people are that live and act in this NowHereland are the central questions raised.

Healthcare in NowHereland: Improving services for undocumented migrants in the EU

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Centre for Health and Migration at the Danube University, Krems (AT) (main coordinator)

Platform for International Cooperation on Undocumented Migrants (BE)

Azienda Unità Sanitaria Locale di Reggio Emilia (IT)

Centre for Research and Studies in Sociology (PT)

Malmö Institute for Studies of Migration, Diversity and Welfare (SE)

University of Brighton (UK)

Policies on Healthcare for Undocumented Migrants in the EU27: Towards a Comparative Framework

Undocumented migrants' access to healthcare is subject to national regulations, which differ across the EU member states, and practice models which follow different logics. The research project, *NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*, approaches this complexity. The project work package, *Policy Compilation*, delivers a report for each member state focusing on policy, introduces comparative reflections in relation to undocumented migrants' right to healthcare and offers a preliminary clustering of the member states based on collected data.¹

The term used in this project is thus, “*undocumented migrants*”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or who have violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

Intersecting Policy Realms

Undocumented migrants' rights to healthcare are dependent upon numerous aspects and processes in each country. One factor is the current basic norms and institutions of the *welfare state* in the respective country. Another factor involves how *migration*, regular as well as irregular, is dealt with.

The welfare state changes the opportunity structure and the incentive structure for individuals. Especially personal services, such as medical treatment and care, change the physical, psychological, social competencies and capacities of individuals. The basic relevance of the welfare state to the life of an individual can thus be seen in the individualised rights and services provided (Leisering 2004:210). Social policies, which can be understood as political measures with the (explicit) aim of influencing the life situation of individuals, are most pertinent (ibid). Social policy is a broad concept which involves three core fields, of which one, *risk-management*, involves health related activities, *the right to healthcare*.² However, social policies must be understood within the framework of their politico-administrative structures or institutional legacy. This legacy includes the institutional structure of implementation, providers of services, the kind of public-private partnership, regional and sectional segmentation etc. (ibid.).

¹ Country Reports can be found at <http://www.nowhereland.info/>

² The other fields are education and old-age (Leisering 2004).

The other relevant issue involves how migration, regular as well as irregular, is dealt with. This has not only a direct relevance to migrants' right to care, but also the pathways into irregularity and whether the existence of undocumented migrants is acknowledged or not. From this, follows that we are facing two intersecting policy realms, namely the *right to healthcare* and policies with regard to *migration*.

According to Midgley (1997), social welfare has to do with conditions of human well-being which exist when social problems are managed, when human needs are met, and when social opportunities are maximised. This definition provides a starting point, with the statement that what we are interested in is human (individuals) needs. As regards healthcare, there is consensus in the view that care should be distributed according to needs (Wörz et al. 2006). However, it would not be unfair to say that needs are met to differing extents, and may be understood in terms of rights.

In the EU, the principle of universal access to healthcare is indeed a governing principle. It is captured in several states' constitutions and health service founding documents, and has been incorporated into the EU Charter of Fundamental Rights, Article 35, the first part of which reads, 'Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices' (Wörz et al. 2006). Despite this, it may be argued that universal coverage tends to be universal only in principle. The entitlement status of some vulnerable groups may be unclear. Most notably, for failed asylum seekers and undocumented immigrants, coverage for healthcare may be virtually non-existent. Also, for legal residents or citizens, problems may arise from the way in which coverage is organised (ibid).

However, to put welfare systems into perspective, it is necessary to reflect upon their common challenges in relation to migration, as welfare institutions are established at the national level (ibid.:xiii). Already at this point, it becomes clear that there is a tension between universal claims and claims underpinned by particular conceptualised needs (Hall 2000). The main point is that, hypothetically, welfare systems can approach human needs differently, with different logics and rationalities, even when only regular migration is considered. Thus, it is no surprise that undocumented migration poses a dilemma to all welfare systems.

Policy Realm: The Right to Healthcare

Which indicators can be used to describe the general health system in the EU 27 such as not to preclude the analysis? The point of departure in such a consideration is that the health systems' financing systems and organisation affect the extent to which healthcare is accessible. Of special interest in this respect are organising and financing characteristics which influence access for people at risk of exclusion, as they constitute potential or actual *barriers* to access. Such characteristics involve population coverage and cost arrangements respectively, whilst broader issues, such as practical organisational limitations, can create

barriers to accessing healthcare. We have chosen, with a few exceptions, to follow the interrelated outlines made by the HealthACCESS Project (Busse et al. 2006; Wörz and Foubister 2006) and HealthQUEST Project (European Commission 2008).

As stated by HealthQUEST, in general, the rules and conditions of access to healthcare are to a large extent established by contractual arrangements between payers and providers of healthcare according to the national legal system. This is to say that the most salient characteristic of a health system relates to those who cover the cost. From the patient's perspective, whether an undocumented migrant or not, the main question as regards cost might be formulated: "Am I covered by an insurance?" The next question involves whether the care required is included in the benefit coverage (so called health basket), as disparities may exist. . And in this case, "what am I expected to pay? Is there a cost-sharing arrangement applicable to my situation?" Cost-sharing is defined as the patient's private spending without private insurance, so called "out of pocket payment" (ibid.:75). Generally, there may be "cost-ceilings", tax revenue and reimbursement systems. In terms of this theme, we must also consider the existence of informal payments (and bribes) (ibid.:89). From our perspective, those arrangements are interesting in terms of the extent to which they come into play for undocumented migrants.

As regards the characteristics related to broader issues, three main concerns are identified: 1) geographical barriers, 2) organisational barriers, and 3) supply-side responsiveness to special needs. Geographical barriers involve the allocation of resources at national level, from which follows *regional variations* within a country. Such variations involve the empowerment of local authorities, which is a common theme in many European countries in connection to an endeavour to alleviate regional disparities (ibid.:105). These variations may also be discussed in terms of differences between urban and rural areas concerning health facilities and physician density. According to the OECD report, "Regions at a Glance" (OECD 2007), the differences and disparities in resources are greater within countries than between countries. What also becomes salient is that urban areas have the main advantages, with the highest density of care providers. Furthermore, the report makes plausible that the distribution of healthcare resources is linked to the socio-economic profile of the regions (OECD 2007). As regards our immediate interest, namely undocumented migrants' access to healthcare, we can thus conclude, based on an assumption (or previous research), that they are present in urban areas, and as such, geographical differences in this study will be discussed in terms of the geopolitical position of a region (and not in terms of rural/urban differences within each country). We will thus not include this as a variable in our analysis of the health systems, but instead approach it in an additional (i.e. third) analytical step (presented elsewhere), in which we relate the issues of undocumented migrants to transversal trends. In particular, the geopolitical position of a region, the level of integration in the process of supranational unification (and through this, the access to supranational entitlements for undocumented migrants, like the European Social Charta) of the analysed nation-state, the density of implication in international organisations working in the field of advocacy and the study of irregular migration (epistemic communities), and finally, the rapidity of undocumented migrants' mobility (transnationalism).

Policy Realm: Migration

Thus far, we have been preoccupied with healthcare, and can hypothesise that the right to healthcare varies widely. Another aspect involves how migration as such, regular as well as irregular, is dealt with, as it has not only a direct relevance to migrants' right to healthcare, but also the pathways into irregularity and whether the existence of undocumented migrants is acknowledged or not. At this point, we identify corresponding indicators concerning the *context of migration*, in order to pinpoint a path dependency and to draw the contours of a context. To approach the current trends, we will identify the "magnitude" and categories of undocumented migrants. In addition, we will use indicators involving the internal control of migration and practices of regularisation of undocumented migrants (Brochmann 1999). Internal control is enacted indirectly, since an undocumented migrant does not have the necessary permits/documentation, which thus has an impact on the migrant's personal freedom. This corresponds to the ability to be in a territory without being stigmatised (excluded, hidden) and/or caught/harassed by police, and the extent to which civil rights can be enjoyed.

List of Indicators

Following these considerations, we have identified corresponding indicators forming the basis for the collection of data.³

Migration related indicators	Migration context	The historical pattern of migration 1) Historically 2) Current 3) Magnitude
	Numbers of UDM	Estimated numbers of UDM
	Categories	Pathways into irregularity a) visa/permit "overstayers" b) rejected asylum seekers c) irregular entry
	Regularisation	Practices, logics and target groups
	Internal control	Access to 1) Accommodation, 2) Work with social security and 3) Education (for children).
Healthcare related indicators	System of Financing	Financing of Healthcare a) Tax based i) National ii) Local b) Insurance based i) Statutory ii) Insurance funds
	Coverage and Services	Logic of the coverage a) Universal general logic b) categorical selective logic

³ We thank the colleagues in the Nowhereland project for their contribution. We especially want to acknowledge the contributions made by Veronika Bilger and Christina Hollomey, ICMPD, Vienna.

	Providers of Care	Providers of care in the general system in terms of public actors, private for profit actors and nongovernmental actors
	Basis of entitlement	Basis of entitlement a) Citizenship b) Residency c) Affiliation to insurance d) Presence in the territory
	Requirements for migrants	Requirements which apply to regular migrants, such as health cards, insurances and specific regulations
	Healthcare for Undocumented Migrants	Recognition of UDM within legal framework
	Access	Access to healthcare as regards 1) Emergency care 2) Primary care 3) Secondary care
	Cost-sharing	Cost of care for the patient a) No fee for service b) Moderate fee c) Full cost for care
	Variation of access	Regional and local variations in terms of entitlements
	Obligation to report	Obligation to report on the part of healthcare staff
	Providers and actors	Providers and actors 1) Providers of Healthcare 2) Advocacy Groups and Campaigns on Rights 3) Political agenda 4) International contacts

Methods

In this project, the key elements of the applied methodology were triangulation of obtained information and coherence testing. “Desk research” was conducted, involving various sources, including literature, research reports and grey literature, such as official reports and reports from nongovernmental organisations. Sources covering health systems and/or special focus on undocumented migrants, as well as of relevance to migration at EU and country level have been chosen in line with the developed indicators. Statistical information was obtained from official websites and from secondary sources. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was identified experts in the member states who have, in some cases, provided new contacts. They were identified due to membership in a research

network or project or through established contacts, and were especially important during the process of coherence testing. As regards interviews, the chosen form was a questionnaire consisting of five sections, being welfare, healthcare system in general, policies regarding undocumented migrants, healthcare for undocumented migrants and migration, with both closed and open questions, and space was provided to allow for further remarks.

Preliminary clustering

As previously mentioned, an additional aim has been to offer a clustering of the member states in terms of differing policies. In order to identify clusters, a typology has been used based on two aspects outlined in the respective report, namely 1) the right to healthcare and 2) the system of financing healthcare. In the intersection of these two aspects, six clusters have been identified.

The typology leans on the *Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants*, Article 13.1, where it is stated that emergency care should be available and that states should seek to provide more holistic care, taking into account, in particular, the needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly. Emergency care is referred to as a minimum right.

As the typology concerns policy in regards to the right to healthcare, it is important to note that obstacles in implementing actual policies, although covered in the country reports, are not considered, even if such processes might impair access in practice. Along the same line of reasoning, when the implementation of more restrictive policies gives rise to a “window of opportunity” to access care in spite of the policy, for example due to healthcare staffs’ discretions or interventions from civil society, the situation is categorised based on the legal situation (i.e. as restrictive). It is likewise important to note that when discussing the rights to healthcare, the level of co-payment for the patient is a central issue. In cases when the right to healthcare is combined with a fee corresponding to the general system, this is not understood as impairing access. However, healthcare of any kind which an undocumented migrant might have a right to, in return for payment of the full cost, is not understood as being accessible. It is not congruent with the notion of economic accessibility (affordability) outlined by the UN Committee on Economic, Social and Cultural Rights (CESCR) as one of the dimensions which constitute the notion of accessibility, which in its turn is an essential element in the right to healthcare (CESCR 2000. See Article 12 b). It should further be noted that the typology is based on policies in relation to adults.

System of Financing

In addition to policies regarding healthcare for undocumented migrants, the typology is based on the system of financing, which involves public financing such as tax and social insurance contributions, private health insurance and out-of-pocket payments (OOP) in all the member states. Here it is important to differentiate between systems which are 1) tax based and 2) social insurance based (Thomson et al. 2009). As regards the tax based systems,

a further differentiation can be made in terms of whether central taxes (Ireland, Malta, Portugal and the United Kingdom) or local taxes (Cyprus, Denmark, Finland, Italy, Spain and Sweden) are used in the collection process (ibid.:33 and 119).

As regards the social insurance based system, a distinction can be made in terms of by whom contributions are collected. In some member states, contributions are collected by a central government (Belgium, Bulgaria, Estonia, France, Hungary, Latvia, the Netherlands, Poland, Romania and Luxembourg) (ibid.:34, 149 and 167). In other member states, social insurance contributions are collected by health insurance funds directly (Austria, the Czech Republic, Germany, Greece, Lithuania, Slovakia and Slovenia) (ibid.:34).

Some member states rely heavily on out-of-pocket payments (Bulgaria, Greece, Cyprus and Latvia) (ibid.:29). These are categorised according to their second main source of funding (tax or social insurance).

Policy in regard to the rights to healthcare

The rights to healthcare laid down in policies are categorised according to three levels, namely No rights, Minimum rights and Rights.

No rights: the right to healthcare is restricted to an extent that makes emergency care inaccessible. This level also involves policies implying that, from the patient's perspective, access to care is not predictable (i.e. arbitrariness is involved) if a person seeks emergency care. In this level, member states which do not provide emergency care to a patient without asking for payment in advance or which charge the patient in a manner that can give rise to a considerable debt are also included. Collectively, nine member states can be found to be applying this level of rights.

Minimum rights: the right to healthcare involves emergency care (or care referred to as immediate, urgent or similar) and is provided without discrimination, including to an undocumented migrant. Whether or not there is a moderate fee to pay is not at stake, but rather that the provision of care is predictable from the patient's perspective, and that in terms of legislation applicable to undocumented migrants, there is no discretionary rights for healthcare staff regarding the provision of healthcare. Included in this level are also the member states where care at a more extensive level might be accessible under certain but not always predictable circumstances (such as in return for payment of the full cost or where there is a professional discretion). Collectively, thirteen member states can be found to be applying this level of rights.

Rights: the access to care involves services beyond emergency care, such as primary and secondary care. In addition, the payment of moderate fees is not relevant, with the relevant provisions laid down in legislation which is applicable to undocumented migrants. It is an empirical fact that this level of rights is associated with administrative procedures which

might impair access to healthcare in practice. As mentioned, such hindrances are not considered. Collectively, five member states can be found to be applying this level of rights.

Typology

A differentiation based on the right to healthcare and the system of financing gives rise to the aforementioned clustering. In the intersection (with no further differentiation with regard to the level of collection of contributions), the member states are grouped in six clusters.

Table 1. Right to healthcare in the EU 27 for undocumented migrants

	Tax	Insurance
No rights	Finland Ireland Malta Sweden	Bulgaria Czech Republic Latvia Luxembourg Romania
Minimum rights	Cyprus Denmark UK	Austria Belgium Estonia Germany Greece Hungary Lithuania Poland Slovak Republic Slovenia
Right	Italy Spain Portugal	France Netherlands

Member States in six clusters

No rights/tax

Finland

In Finland, undocumented migrants have no right to receive emergency care. They may access emergency care for an unclear cost. As regards funding, the system is based on local taxes.

Ireland

In Ireland, undocumented migrants have no right to receive emergency care. They may access emergency care for an unclear cost. As regards funding, the system is based on central taxes.

Malta

In Malta, undocumented migrants only have the right to state medical care and services free of charge within the framework of detention centres. This is formulated in a document outlining the relevant principles. The actual access to healthcare is open to interpretation. As regards funding, the system is based on central taxes.

Sweden

In Sweden, undocumented migrants have no right to receive emergency care. They may access emergency care in return for payment of the full cost. As regards funding, the system is based on local taxes.

Minimum rights/ tax

Cyprus

In Cyprus, undocumented migrants have the right to receive emergency care. The cost of care provided to an undocumented migrant in case of emergency is paid by the state. Undocumented migrants may in principle access primary and secondary care if they pay the full costs thereof. As regards funding, the system is based on central taxes (in addition to out-of-pocket payments).

Denmark

In Denmark, undocumented migrants have the right to receive emergency care free of charge. Undocumented migrants may in principle access primary and secondary care if they pay the full costs. As regards funding, the system is based on local taxes.

United Kingdom

In the United Kingdom, undocumented migrants have the right to receive emergency care free of charge at Accident and Emergency departments. Undocumented migrants may in principle access primary care (if accepted to register by a GP) and secondary care if they pay

the full costs or are exempted (determined on a case by case basis). Furthermore, immediately necessary treatment may not be withheld. As regards funding, the system is based on central taxes.

Rights/ tax

Italy

In Italy, undocumented migrants have the right to receive healthcare free of charge. Access involves an administrative procedure. As regards funding, the system is based on central taxes.

Portugal

In Portugal, undocumented migrants have the right to receive healthcare for no, or a moderate, fee. Access involves an administrative procedure and is subject to a prerequisite involving the period of stay. As regards funding, the system is based on central taxes.

Spain

In Spain, undocumented migrants have the right to receive healthcare for no, or a moderate, fee. Access involves an administrative procedure. If this procedure is not fulfilled, there is a minimum right to healthcare. As regards funding, the system is based on local taxes.

No rights/ social insurance

Bulgaria

In Bulgaria, undocumented migrants have no right to receive emergency care. However, they may access emergency care upon payment of the full cost. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Czech Republic

In the Czech Republic, undocumented migrants have no right to receive emergency care. However, they may access emergency care in return for payment of the full cost, or alternatively, upon purchasing a private insurance. As regards funding, the system is based on social insurance. Contributions are collected by health insurance funds directly.

Latvia

In Latvia, undocumented migrants have no right to receive emergency care. They may access emergency care upon payment of the full cost. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Luxembourg

In Luxembourg, undocumented migrants have the right to receive emergency care, provided they are affiliated to insurance, via employment or privately. However, in line with the chosen logic, which considers affordability, this must be understood as amounting to

undocumented migrants having no rights. However, it is important to note that undocumented migrants might also fall inside the system, depending on their level of income. They can access primary care as well as specialist care free of charge, in terms of the same conditions, provided they are insured by way of employment. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Romania

In Romania, undocumented migrants have no right to receive emergency care, but are entitled to free healthcare within the framework of detention centres. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Minimum rights/social insurance

Austria

In Austria, undocumented migrants have the right to receive first aid, in case of emergency, at federal hospitals. Being uninsured, they are obliged to pay the full cost of treatment. However, as the hospitals are obliged to pay the costs if the patient is unable to pay (or not identified), the situation can be interpreted as a minimum right to health care.⁴ As regards funding, the system is based on social insurance. Contributions are collected by health insurance funds directly.

Belgium

In Belgium, undocumented migrants have the right to receive what is known as urgent medical aid, which is not differentiated upon in terms of emergency, basic or universal care, but refers to a wide variety of urgent care provisions and may be both preventive and curative. Access involves an administrative procedure. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Estonia

In Estonia, undocumented migrants have the right to receive emergency care free of charge. Undocumented migrants may in principle access primary and secondary care if they pay the full costs thereof. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Germany

In Germany, undocumented migrants have the right to receive emergency care. This right was, before September 2009, impaired by the intersection with legislation involving an obligation to report, which is no longer the case. As regards funding, the system is based on social insurance. Contributions are collected by health insurance funds directly.

⁴ An alternative interpretation could be no rights, if stressing a certain possibility for a patient to get a considerate dept.

Greece

In Greece, undocumented migrants have the right to receive emergency care (in case of life-threatening conditions at emergency units). There exists legislation prohibiting the provision of healthcare beyond emergency care to undocumented migrants. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Hungary

In Hungary, undocumented migrants have the right to receive emergency care free of charge. Undocumented migrants may in principle access private general practitioners providing primary care, including to persons outside the insurance system, in return for payment of the full costs. Secondary care is provided within the framework of detention centres. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Lithuania

In Lithuania, undocumented migrants have the right to receive emergency care free of charge. In addition, they have are entitled to primary and secondary care, although only within the framework of Reception Centres. As regards funding, the system is based on social insurance. Contributions are collected by health insurance funds directly.

Poland

In Poland, undocumented migrants have the right to receive emergency care free of charge. Undocumented migrants, in so far as they are rejected asylum seekers, have overstayed their visas or are affiliated to insurance, may access primary and secondary care for free. As regards funding, the system is based on social insurance, with contributions collected by a central government.

Slovak Republic

In Slovakia, undocumented migrants have the right to receive emergency care free of charge. Undocumented migrants may in principle access primary and secondary care if they pay the full costs or purchase a voluntary insurance. As regards funding, the system is based on social insurance. Contributions are collected by health insurance funds directly.

Slovenia

In Slovenia, undocumented migrants have the right to receive emergency care free of charge. Undocumented migrants may access primary and secondary care in the Health Centres for Persons without Health Insurance. As regards funding, the system is based on social insurance. Contributions are collected by health insurance funds directly.

Rights/ social insurance

France

In France, undocumented migrants have the right to receive healthcare for no, or a moderate, fee. Access involves an administrative procedure. As regards funding, the system is based on social insurance, with contributions collected by a central government.

The Netherlands

In the Netherlands, undocumented migrants have the right to receive healthcare (defined in terms of 'directly accessible' and 'not directly accessible' services) free of charge. Access involves an administrative procedure. As regards funding, the system is based on social insurance, with contributions collected by a central government.

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