



Health Care in

NOWHERELAND

*improving services for
undocumented migrants in the EU*



EXECUTIVE SUMMARY AND RECOMMENDATIONS



The issue of undocumented migrants (UDM) in the EU has been gaining increasing attention. Estimated at between 1.9 and 3.8 million people in the EU in 2008 (7-13 % of the foreign population), this is a vulnerable group, exposed to high levels of health risks. Although all EU Member States have ratified the human right to health care, heterogeneous national public health policies have different frameworks for health care provision which in many cases severely restrict UDM access to health care. Accordingly, practice models of how to ensure the human right to health follow different logics.

The European project entitled “Health Care in NowHereland” has produced the first-ever compilation of the policies and regulations in force in the EU 27¹, a database of practice models in 11 EU member states and Switzerland, and has made in-depth assessments of selected practice models and provides insights into the ‘daily lives’ of UDM and their struggle to access health care services.

¹ In addition, data on policies and regulations in Norway and Switzerland were collected and can be accessed at http://www.nowhereland.info/?i_ca_id=151

POLICIES AND REGULATIONS IN FORCE IN EU 27

A European landscape of policies can be drawn from two perspectives:

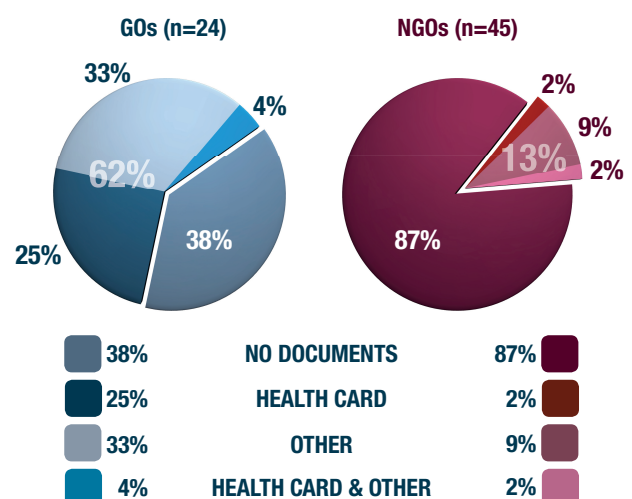
- According to Article 13.2 of Council of Europe Resolution 1509, where provision of emergency care is defined as the minimum for meeting the human right to health care, and general comment Nr.14 from the UN Committee on Economic, Social and Cultural Rights (CES-CR 2000, see Article 12 b), countries can be grouped into those that grant rights, minimum rights, or no rights to health care. In this case, five countries (ES, FR, IT, NL, PT) grant rights, 13 countries (AT, BE, CY, DE, DK, EE, EL, HU, LT, PL, SK, SI, UK) grant minimum rights, which in most cases are limited to emergency care, and nine countries (BG, CZ, FI, IE, LU, LV, MT, RO, SE) provide no rights, which means the right to healthcare is restricted to an extent that makes even emergency care inaccessible.
- From a public health approach, it can be assumed that access to emergency care alone is an inefficient way of providing health care, leading to high costs, poor out-

comes, and increased public health risks through uncontrolled infectious diseases. Therefore, access to emergency care only cannot be understood as access to health care. Seen from this perspective, the landscape changes into countries that provide full access, partial access, and no access, with countries granting only emergency care now being included in the “no access” group. Under this definition, four countries (ES, FR, NL, PT) allow full access, three countries (BE, IT, UK) partial access, and 20 countries no access (AT, BG, CY, CZ, DE, DK, EE, EL, FI, HU, IE, LT, LU, LV, MT, PL, RO, SE, SK, SI).

PRACTICES

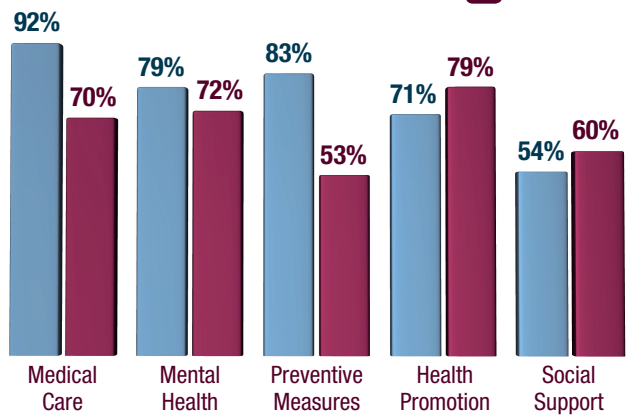
Collecting data about health care practices has been a challenge. In many cases, practices prefer to stay as invisible as their clients: sometimes because they already attract many people and are close to capacity in terms of space and resources, and often because their official target group is different (e.g. homeless people, people with no health insurance, etc.) and they fear loss of funding if they speak openly about the fact that they also serve UDM. The outcome of one year of intensive research using a number of different channels such as international experts, hospitals and NGO networks, is a collection of 71 practice models from 12 countries (AT, BE, FR, DE, EL, HU, IT, NL, PT, ES, SE, and CH) representing the logic of no access, partial access and full access in terms of levels of entitlement to health care, including 24 governmental organizations (GOs) and 47 non-governmental organizations (NGOs).

DOCUMENTS REQUIRED



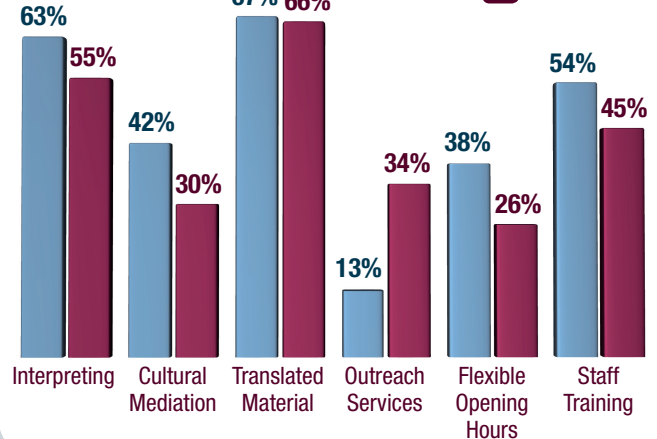
SERVICES PROVIDED

(more than one answer possible)



FACILITATING SERVICES

(more than one answer possible)



A comparative analysis of these practices shows that:

- Health care services providers, whether GOs or NGOs, find that mental health care and infectious diseases care are the most common health care needs of their UDM clients. A third big issue is sexual health, with GOs focusing on sexually transmitted diseases and HIV, and NGOs observing the need for reproductive health care, followed by work-related health problems.
- The main medical care services provided by both GOs and NGOs are general care and diagnostic services, and emergency care in the case of GOs and care for women and children in the case of NGOs. Mental health care, including psychiatric care and psychological support, is provided by about three quarters of these organisations, including both NGOs and GOs.
- 50% of GOs report increasing numbers of UDM clients, 37% stable and 13% decreasing numbers. 71% of NGOs report an increase in the numbers of UDM clients, 29% stable and 0% decreasing numbers. This difference between GOs and NGOs may be because NGOs are easier to access: only 13% of NGOs ask to see documents compared to 62% of GOs.
- When it comes to support health care services, GOs provide more structures for facilitating communication. Although translated information is available equally from GOs and NGOs (67% and 66%, respectively), GOs provide a higher level of interpreting services and cultural mediation than NGOs.

PEOPLE: 'DAILY LIVES' OF UDM AND THEIR STRUGGLE TO ACCESS HEALTH CARE SERVICES

In most cases, UDM live in conditions of extreme hardship. Health is usually not their main concern, because they are busy using all of their energies to simply survive. At the same time, good health is their main resource for survival. They need to be healthy to be able to work and to find a place to sleep (since sleeping space is often shared, a compromised immune system can jeopardize their chances of being allowed to share those sleeping spaces).

Even in countries that grant access to health care services beyond emergency and urgent care, UDM mainly seek out health care services only when they are severely ill. They often fear discovery of their irregular status and thus consequent deportation, lack information about their entitlements to health care, they find it difficult to find their way around the health care system, and to meet the administrative requirements to get access.

UDM are a heterogeneous group. That becomes obvious when we take a closer look at practice models from the in-depth assessments made in Austria, Germany, Italy, the Netherlands, and Spain. For example, the Italian model reports huge differences between their three main UDM client groups – from China, Eastern Europe (Georgia, Moldova, Ukraine) and Africa (Egypt, Morocco, Nigeria, Tunisia) in terms of concepts of health and illness as well as concerning living situations.

RECOMMENDATIONS

Based on the evidence collected and research experience within the framework of the NowHereland Project, preliminary recommendations can be formulated that address the policy frameworks and the practice level of health care provision itself as well as further research. These are:

- Increased awareness about the issue of undocumented migration is required, so that policies are based more on evidence and less on emotions/myths. This requires a more systematic use of knowledge collected in various projects and initiatives, both on practical level and on a research level.
- UDM are the most flexible and exploitable work force and undocumented migration is closely connected to informal labour market demands. Policies to shape labour markets should be included in discussions concerning UDM issues.
- The debate on how to ensure the human right to health care is undoubtedly highly relevant. Furthermore, economic conditions should be considered, which might show that the costs of excluding UDM from health care until they end up in emergency care are considerably higher than allowing (at least) partial access to mainstream services.
- The development of partnerships between public health services and NGO initiatives has proven to be a factor for successful practice. GOs and NGOs should find a way to discuss and develop frameworks for joint service provision.
- UDM are a heterogeneous group, and there are vast differences between and within UDM communities. Differences are related to working and living situations as well as social networks. On a practice level, this means that there is no standard, 'one-size-fits-all' solution. Research and practice approaches have to be aware of the dangers of stereotyping.
- In most cases, UDM leave their countries of origin because they cannot have a 'humane' life there. They are willing to work, to take care of their families and themselves in order to succeed in life, and they survive under extreme hardship. They could also be seen as a resource for Europe and not a threat. Maybe such a shift in perspective could open up new grounds for discussion.



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For further information see:
<http://www.nowhereland.info>