ACCESS TO HEALTHCARE IN EUROPE IN TIMES OF CRISIS AND RISING XENOPHOBIA

An overview of the situation of people excluded from healthcare systems

© MdM Greece

Outreach work with the homeless, Athens

MÉDECINS DU MONDE 世界医生组织 DOCTORS OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO Γιατροί του Κόσμου DOKTERS VAN DE WERELD
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EXECUTIVE SUMMARY

In this report, Doctors of the World presents its latest observations on the social health determinants and health status of people facing multiple vulnerability factors whom we helped in accessing healthcare across our 160 European programmes during 2012. The report presents some of the results of comparative data collected in 14 cities across seven countries. It covers a sample of 8,412 patients, 19,302 consultations (including 10,968 medical consultations) and 11,921 diagnoses reported by our volunteer health professionals. In order to capture the context in which this data collection took place, a concise update on the national legislations of these seven countries has been included. We also added to the quantitative data a number of qualitative reports from our field teams on the most important European trends identified by our network.

2012 has been marked by a social and economic crisis that has generated austerity measures which are having an impact on social protection schemes, including healthcare services. At the same time, rising unemployment and poverty across Europe have generated extreme right statements stigmatising migrants. We have noticed a rise in xenophobic acts and regulations in Greece and in other European countries. Another effect of the increase in poverty is a rise in internal migration. EU citizens who are destitute and have no health coverage are considered in the same way as undocumented migrants from outside the EU if they need medical care.

The patients we meet daily in our programmes – nationals and migrants, children and elderly people, pregnant women and the chronically ill – continue to be in a worse state of health overall than the general population. The social determinants that are revealed in this report shed some light on some of the reasons for this.

In its 2010 report the World Health Organization (WHO) noted, that *"Those who are most vulnerable are becoming even more vulnerable, not only in terms of access to health care services, but also with regard to other determinants of health, including the degree of social exclusion, education, housing and general living conditions, quality of diet, vulnerability to violence"*…[1].

A significant number of Member States have raised out-of-pocket expenditure for patients. Spain has legally restricted access to care for undocumented migrants. In Greece, the entire public health system is under enormous pressure due to austerity measures. And while the general population is facing increasing poverty, populist political parties are taking advantage of the situation by laying the responsibility on destitute migrants, as easy scapegoats.

At the same time, groups who were already facing numerous vulnerability factors before the crisis, such as undocumented migrants, asylum seekers, drug users, sex workers, destitute European citizens and homeless people, have seen a reduction in or a termination of social safety nets and networks which provide them with basic help.

NGOs and health providers demonstrate active solidarity but it is ultimately the responsibility of governments to ensure the protection of the most vulnerable populations, which they do not always do anymore. Patients facing multiple vulnerability factors need more protection in these times of crisis and xenophobia, not less. The results of our 2012 report include the fact that more than 80% of the patients had no possibility to access care without paying the full cost. 59% of pregnant women did not have access to antenatal care. 40% of the patients who spoke out in MdM clinics about violence had lived in a country at war; one fifth had been physically threatened, imprisoned or tortured because of their ideas. One fifth had been victims of violence by the police or armed forces. 49% had unstable or temporary housing and 26% said they were in a (very) poor overall state of health. And yet, personal health represented only 1.6% of the reasons for migration given by migrant patients, contradicting the idea that social protection mechanisms represent a pull factor for migrants.

As health professionals, we clearly demand the right to provide healthcare – in accordance with medical ethics – to all patients, regardless of their social status or ethnic origin. We call for national public health systems built on solidarity, equality and equity, open to all those living in the EU, rather than systems based on a profit rationale. We ask for a coherent EU public health policy for the prevention and treatment of infectious diseases. We demand equal access for all to national immunisation schemes and to paediatric care. We demand that all pregnant women have equal access to pre and post natal care. We demand full protection in Europe for seriously ill migrants who cannot access adequate healthcare in their country of origin.

Although "health is formally a Member State competence", the EU has an important role to play in encouraging Member States to protect health systems and social protection mechanisms during times of crisis and even rendering them more accessible.

The European Union Agency for Fundamental Rights (FRA) carries the hopes of many citizens in these times of crisis – we ask Member States to fully put into practice their opinions.

The Council of Europe has an important role to play in protecting fundamental rights throughout Europe. The European Committee of Social Rights has given strong signals by confirming that the right to healthcare as described in the European Social Charter clearly applies to all, whatever their administrative status.

[1] WHO (2010) *Equity, social determinants and public health programmes.*

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DOCTORS OF THE WORLD

WHO WE ARE AND WHAT WE DO

Médecins du Monde (MdM) – Doctors of the World have been working to improve access to healthcare and protection of human rights since 1980. We are an international aid organisation that provides medical care and aims to improve access to healthcare for people who face numerous vulnerability factors all over the world. In Europe, we work mainly with homeless people, drug users, destitute EU citizens, sex workers, undocumented migrants, asylum seekers, Roma communities, etc. Besides providing medical attention, we systematically collect data on the social determinants of health and the patients' state of health to raise awareness about the difficulties vulnerable populations face.

In 2012, we ran 312 programmes in 79 countries. Among these programmes, 165 domestic projects were run in the 14 countries where autonomous MdM organisations exist. MdM runs over 160 health programmes across Europe: in Belgium, Bulgaria, France, Germany, Greece, the Netherlands, Portugal, Romania, Spain, Sweden, Switzerland and the United Kingdom. We are also present in Georgia, the Russian Federation and Turkey.

About 20% of our programmes are centres for access to healthcare which organise referrals to the mainstream health system. The vast majority of our programmes are mobile, going to the places where the most vulnerable people live, i.e. doing street work, visiting squats or camps and going to isolated villages. We adapt our working hours to those of the people (e.g. sex workers, drug users and homeless people are more likely to be met at night). Some more specific programmes are dedicated to the fight against female genital mutilation, to homeless people with mental health problems or disabilities, to health promotion and protection for vulnerable sex workers and to working with Roma communities, asylum seekers, undocumented migrants, children and the elderly.

Whenever possible we work in partnership, creating wide alliances when needed in order to obtain social change. The philosophy and attitude of harm reduction is transversally present in practically all our programmes. Harm reduction is a pragmatic and humane, non-judgmental approach that implies an acceptance of the different practices and lifestyles of the people encountered. Harm reduction within MdM relies on the principle of adopting a low (or unconditional) threshold as one of the main means of establishing links with the most marginalised individuals. We adapt our practice to what people want and when they want it.

MdM promotes a harm reduction approach based on scientific evidence which has also demonstrated its added value in terms of cost-effectiveness. Fostering a harm reduction attitude also means that those benefiting from programmes should be offered the tools and knowledge to increase their capacity to protect themselves and others.

Our programmes are aimed at empowerment via the active participation of beneficiary groups, as a way of identifying health-related solutions and of combating the stigmatisation and exclusion of these groups. MdM supports the creation of self-support groups as a way of strengthening civil society and recognising experience-based expertise. Our activities can, in this way, lead to social change: changing laws and practices but also reinforcing equity and solidarity.

Since 2004, MdM has expanded its advocacy work towards the European Union and the Council of Europe with several international publications[2,3]. We also drafted and circulated a petition among European health professionals – declaring that they will not deny treatment to patients – that was signed by 147 health professional bodies and was submitted to the European Parliament.

In April 2012, we published a report based on the data routinely collected by five health centres in five EU cities. Today, an increasing number of MdM programmes are participating in the shared routine data collection of the MdM International Network Observatory on Access to Healthcare: this new report contains data collected in 14 cities in seven European countries in the course of 2012 and a sample of over 8,000 patients, making the results more robust than before.

Our deepest gratitude goes to the 8,412 patients who answered our questions, as well as to all our colleagues who received them and contributed to this report.

We trust that this publication will shed new light on the situation of those who, in Europe in 2012, had no possibility whatsoever to access healthcare providers in the mainstream system. **We hope that this report will inspire policy-makers and help to bring about changes in the laws and practices which deny one of the most fundamental of human rights, the right to the highest attainable standard of health.**

[2] *European Observatory on Access to Healthcare,* Chauvin P., Drouot N., Parizot I., Simonnot N., Tomasino A., published in 2007 and 2009. www.mdm-international.org

[3] *Access to healthcare and living conditions of asylum seekers and undocumented migrants in Cyprus, Malta, Poland and Romania,* available at www.huma-network.org

IMPACT OF THE ECONOMIC AND SOCIAL CRISIS ON ACCESS TO HEALTHCARE IN EUROPE FOR PEOPLE CONFRONTED WITH VULNERABILITY FACTORS

Soaring unemployment rates[4], rising child poverty, people losing their homes because of insolvency every month… The social systems in Europe are quaking under the strain. Whereas most European countries have in recent years been host countries for immigrants, an increasing number of European citizens are now pushed to economic migration, both within Europe and beyond. **The crisis has generated austerity measures that have had a deep impact on all social safety nets, including healthcare provision.**

In its 2012 report[5] *Health policy responses to the financial crisis in Europe,* the WHO classified the global financial crisis that began in 2007 as a health system shock or "an unexpected occurrence originating outside the health system that has a large negative effect on the availability of health system resources or a large positive effect on the demand for health services". The WHO further warned that *"cuts to public spending on health made in response to an economic shock typically come at a time when health systems may require more, not fewer, resources – for example, to address the adverse health effects of unemployment".* **Measures such as reducing the scope of essential services covered, reducing population coverage, increasing user charges for services and reducing the number of health providers were specifically identified as policy tools that undermine health system goals.**

Nevertheless, many Member States have raised the share of out-of-pocket expenditure for patients. As a consequence, people delay or even abandon seeking healthcare. According to a report published by the OECD in 2011, the most common reason mentioned in Greece and Portugal for self-reported unmet needs is the cost[6]. According to the OECD, 25% of the Portuguese population still reports unmet needs for dental care. In 2012, 36% of the people who came to MdM clinics had given up seeking healthcare at least once.

The Spanish Government reduced spending on health and education by seven billion euro in 2012. In its memorandum signed with the Greek government, the Troika [7] specified that public health expenditure should not exceed 6% of gross domestic product [8] (versus 10.6% in 2009 [9]).

In theory, Greece's universal public healthcare system entitles insured people on a very low income to visit general practitioners free of charge and to get medicine for free but a lot of people do not get the necessary "welfare card" allowing them not to pay upfront, mainly because of the complexity of administrative procedures in Greece. Since October 2010, all public hospitals impose a five euro entrance fee and further examinations also have to be paid for – a measure that excludes many people.

Many hospitals in Greece lack staff, basic equipment and supplies. Pharmacies often lack supplies and demand that customers pay cash upfront, as the state owes them a lot of money. According to Greek journal *Kathimerini,* these debts were as high as 250 million euro at one point last year[10].

As vaccinations now have to be paid for, many children do not get any, which not only puts their health at risk but also prohibits them from accessing school. In the MdM polyclinics in Greece[11] – which deliver healthcare to the most vulnerable – nearly half of the patients are now Greek citizens (up to 88% at one of them). Many of them have passed retirement age (at the same polyclinic up to 28% are over 60 years old). Their pensions have been cut almost in half due to the austerity measures. There is no doubt that the efficiency of Greece's healthcare system could be greatly improved. However, current austerity measures imposed by the Troika and put in place by the government seem more likely to exacerbate the general collapse of the health system instead of preventing it.

[4] According to the latest Eurostat figures, the highest increases in unemployment were registered between September 2011 and January 2013 in Greece (18.9% to 26.4%), Cyprus (9.5% to 14.7%), Spain (23.0% to 26.2%) and Portugal (14.1% to 17.6%). In November 2012, the youth unemployment rate (under 25 years old) was 23.7% in the EU-27. In Greece 57.6% of young people are out of work (September 2012), while in Spain the figure is 56.5%. See http://epp.eurostat.ec.europa.eu/

[5] See www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

[6] OECD (2011), 'Unmet health care needs', in *Health at a glance 2011: OECD indicators*, pp. 130-131, available at http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2011/unmet-health-care-needs_health_glance-2011-52-en

[7] Name given since the beginning of the crisis to the working group of the European Commission, European Central Bank and International Monetary Fund.

[8] See Government of Greece (2012), *Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding.*

[9] See *OECD Health Data 2012*, www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm

[10] See www.ekathimerini.com/4dcgi/_w_articles_wsite1_1_22/05/2012_443402

[11] MdM Greece runs five polyclinics; four of them have been collecting data since the end of September 2012.

Home visit in Spain

People confronted with numerous vulnerability factors were already facing major health inequalities before the economic and financial crisis hit Europe. Earlier MdM surveys indicated that financial inaccessibility of care for patients led to unmet needs that vastly surpassed the average level of unmet needs of the population of any EU Member State. For instance, in 2011 the MdM France medical teams[12] found that in a sample of 1,547 patients, 38% should have been treated earlier.

These figures confirm those from an earlier comparative survey across 11 EU countries (2008) that showed that 25% of the MdM patient population received treatment late (this number rose to 33% for patients with chronic health conditions, such as diabetes and hypertension).

Before the crisis, people confronted with numerous vulnerability factors already reported their perceived state of health to be up to three times poorer than that of the average population across Europe[13].

Now the MdM teams in Greece and Portugal are faced with patients who have to choose between eating and buying their medicines.

Due to the budgetary cuts, vulnerable groups are now even less likely to receive the necessary attention from healthcare providers, although the number of people facing precarious living conditions is increasing. For instance, in **Greece**, the legal entitlement to healthcare for the few asylum seekers who manage to formally apply for asylum is far from guaranteed. Undocumented migrants only have access to emergency treatment, but due to the enormous strain on the Greek health system, even this is often not possible anymore.

In 2012, **the Spanish government** excluded adult undocumented migrants (including the chronically and severely ill) from public healthcare, thereby ignoring the direct and indirect economic benefits of health promotion and prevention for the most vulnerable populations.

In Portugal, the lack of information about the new regulations reduces access to healthcare. For example, homeless people who have not declared their income have no way to prove they have a right to be exempted from the usual co-payment.

On top of all this, many NGOs taking care of the health needs of vulnerable people are also facing important budget cuts, both from private donors and from the State. Several MdM associations that partially depend on government subsidies are finding it hard to cope. For instance, MdM Portugal has had to close eight domestic programmes programmes because of lack of funding from the State. MdM Spain has had to considerably reduce the number of contracted staff and has also had to close quite a few programmes.

Patient story

Athanassis is 78 years old and has been living without electricity for the last two months with a pension of €310 per month. Three months ago he moved into a warehouse because of his financial difficulties. His three children are all unemployed. He suffers from arthritis and coronary disease. His health problems are worsened by his living conditions. He is insured but unable to pay for his medicine because of his low income.

"I feel there is no future for me or my children."

MdM Greece – Athens – August 2012

[12] See http://www.medecinsdumonde.org/Publications/Les-Rapports/En-France/Observatoire-de-l-acces-aux-soins-de-la-mission-France

[13] Baert K, De Norre B. *Perception of health and access to healthcare in the EU-25 in 2007.* Brussels, Eurostat (Statistics in focus), 2009, no 24.

ANALYSIS OF THE SOCIAL AND MEDICAL DATA COLLECTED IN 2012

KEY FIGURES

- **Data were collected in 2012 in 14 cities** (seven countries) through direct interviews with 8,412 people (19,302 contacts including 10,968 medical consultations; 11,921 diagnoses).
- **28%** reported poor or very poor mental health. Mental health was particularly badly affected in Greece where 50.8% of patients had poor or very poor perceived mental health.
- **Altogether 67%** of MdM service users reported a low standard of perceived health, which is much higher than the rate generally observed in immigrants over 50 years old in Europe (37.8%) even though the median age for our sample is 34 years.
- **49%** had unstable or temporary housing.
- Among the patients who spoke out about violence, **40%** had lived in a country at war, one fifth had been physically threatened, imprisoned or tortured because of their ideas and one fifth had been victims of violence by the police or armed forces. 40% had been beaten up, 22% had experienced psychological violence, 8% had been sexually assaulted and 5% had been raped. 26.6% reported having suffered violent acts after their arrival in the host country.
- **Only 7.6%** did not report any barriers when seeking healthcare previously.
- The main barriers to healthcare were **lack of knowledge** or understanding of the health system and administrative problems.
- **20%** reported having been denied access to care by a healthcare provider in the last 12 months (especially in Spain, 62%).
- **81%** had no possibility of accessing care without paying full costs on the day we met them.
- **59%** of pregnant women did not have access to antenatal care when we met them.
- **60%** of all patients did NOT know where to go to get vaccinations.
- **36%** of the patients had given up seeking healthcare in the last 12 months.
- **76%** of all the diagnoses required an "essential" treatment. More than half of those patients who needed essential treatment had not received any when we met them.
- **55%** of patients who were EU citizens were not permitted to reside in the host country.
- **61%** of all MdM service users were not permitted to reside in the host country (ranging from 22% in Greece to 90% in Amsterdam).
- Of the reasons given for migration, personal health reasons represented **1.6%**, escaping from war 5.8% and economic survival 42.8%.

METHODS

Routine data were collected in 14 cities located in seven European countries (except in Spain where a specific survey was conducted over the course of six weeks):

- → Brussels and Antwerp in Belgium **(BE)**,
- → Nice in France **(FR)**,
- → Munich in Germany **(DE)**,
- → Athens, Perama, Patras and Thessaloniki in Greece **(EL)**,
- → Amsterdam in the Netherlands **(NL)**,
- → Alicante, Tenerife, Valencia and Zaragoza in Spain **(ES)**,
- → London in the United Kingdom **(UK)**.

Each patient who consulted MdM in 2012 was systematically interviewed, using one of three questionnaires (social form, initial medical form, re-consultation form). This chapter on data is based on the description of 8,412 patients, **19,302** contacts (including **10,968** medical consultations) and **11,921** diagnoses reported by volunteer doctors.

The full report with complete statistical analysis of the data collected is available upon request.

BREAKDOWN OF PATIENTS BY COUNTRIES

	No	%	Survey period	
BE (2 cities)	2.027	24.1%	02/01/2012	31/12/2012
DE (1 city)	439	5.2%	09/01/2012	19/12/2012
EL (4 cities)	1.505	17.9%	24/09/2012	28/12/2012
ES (4 cities)	103	1.2%	15/11/2012	28/12/2012
FR (1 city)	2.600	30.9%	01/01/2012	31/12/2012
NL (1 city)	177	2.1%	23/01/2012	13/12/2012
UK (1 city)	1.561	18.6%	14/03/2012	31/12/2012
Total (14 cities)	**8.412**	**100.0%**		

STATISTICS

- Because of the variation in population size of the 14 clinics and the difference in missing value ratios from one centre to another and from one question to another, we chose to compute three estimates for each global figure (mostly proportions or ratios):
- **CAP** *(crude average proportion)*, i.e. without any correction;
- **WAP** *(weighted average proportion)* is the mean proportion, i.e. the global proportion if all the countries had contributed for the same number of patients;
- **MVWAP** *(missing-values-corrected weighted average proportion)* is further corrected by taking into account the rate of missing values in every site for the question analysed.

DEMOGRAPHICS AND COUNTRIES OF ORIGIN

The majority of patients were male (54%), with the exception of Munich and the Spanish clinics where women accounted for the majority of the consulting population. A similar sex ratio was also observed in Munich [15] with the 2011 data.

The mean age of the population was 35.7 years (median = 34) and 50% of the population were between 26 and 46 years old (range = [0-93]). In Greece, we observed that a quarter of the patients seen in Perama (27.7%) were over 60 years old, whereas in the other three cities in Greece this was not the case.

A small proportion of the patients interviewed were under 18 years of age (8%). This figure was much higher in Greece (19%), especially in Thessaloniki where minors represented 35% of the patients seen. The figure was 15% in Munich where paediatric consultations take place. Only the Spanish clinics did not see any minors at all. This can be explained by the fact that the Spanish health reform does not exclude minors from healthcare (although in practice, some do get excluded) and the fact that the survey in Spain lasted only six weeks.

THE ORIGINS OF THE PATIENTS VARIED CONSIDERABLY BETWEEN COUNTRIES:

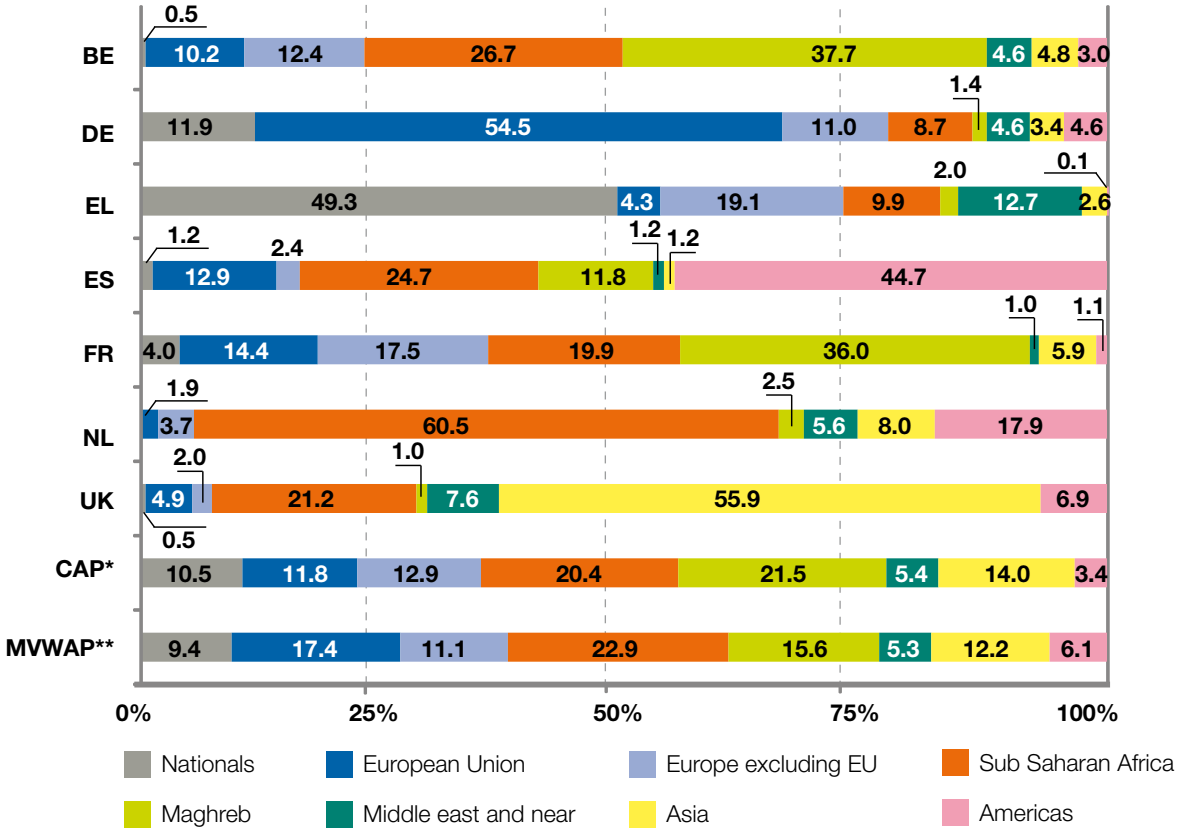
- In Munich, 66.4% of the patients were EU citizens, as were 53.6% in Greece (including Germans and Greeks, see below). In contrast, EU citizens were extremely rare in Amsterdam (<2%) and in London (5.4%), whereas they accounted for 10 to 15% of patients in Belgium and Spain and 18% in Nice.
- It is particularly noteworthy that approximately half **(49.3%) of the patients seen in the four Greek clinics in 2012 were Greek nationals.** Up to 88.0% of patients in Perama, 52.1% in Thessaloniki, 11.8% in Athens and 5.8% in Patras were Greek. The high rate of Greek nationals seeking healthcare from humanitarian NGOs is a dramatic consequence of the severe crisis which has hit Greece over the last two years. It is unique among the clinics that participated in the data collection: in the other countries, this proportion was less than 5% (except in Munich where 12% of patients were nationals) and was almost zero in Amsterdam, Antwerp, Brussels and London.

As is usually the case in MdM International Network domestic programmes, the patients' nationality varied considerably across the countries. Some of these differences may be due to the historical links that still exist between some European countries and their former colonies (e.g. 36% of the patients in Nice were from Maghreb countries and 45% of the patients in Spain were from Latin America). In Amsterdam, 60.5% of the patients were from Sub-Saharan African countries like Ghana (they also represented the majority of patients in 2011). These historical links provide much more of an explanation for the migration process than the welfare systems (which the migrants know nothing about).

Migrant patients had lived in the host country where they were interviewed for a median length of 32 months. On average, people from Asia had lived in the country of interview for the longest period of time. Europeans (either from within or outside the EU) had arrived more recently.

[15] A gynaecological consultation takes place in Munich.

PATIENT PLACE OF ORIGIN BY COUNTRY



* Crude average proportion
** Missing-values-corrected weighted average proportion

TOP EIGHT NATIONALITIES BY COUNTRY

BE
- MOROCCO (541)
- ALGERIA (152)
- GUINEA (110)
- CAMEROON (96)
- ROMANIA (80)
- CONGO (60)
- ARMENIA (44)
- BULGARIA (44)

DE
- BULGARIA (153)
- GERMANY (52)
- ROMANIA (43)
- ETHIOPIA (14)
- POLAND (9)
- SPAIN (9)
- NIGERIA (8)
- TURKEY (6)

FR
- TUNISIA (505)
- MOROCCO (207)
- CAPE VERDE (206)
- ALGERIA (200)
- RUSSIA (CHECHNYA) (187)
- ROMANIA (179)
- PHILIPPINES (124)
- FRANCE (103)

EL
- GREECE (683)
- ALBANIA (146)
- AFGHANISTAN (129)
- GEORGIA (68)
- NIGERIA (54)
- BULGARIA (41)
- BANGLADESH (26)
- ARMENIA (24)

ES
- GUINEA (8)
- MOROCCO (8)
- ARGENTINA (7)
- ROMANIA (7)
- COLOMBIA (6)
- NIGERIA (5)
- DOMINICAN REP (5)
- NICARAGUA (4)

NL
- NIGERIA (38)
- GHANA (36)
- SURINAM (12)
- BRAZIL (10)
- EGYPT (6)
- UGANDA (6)
- TURKEY (4)
- SIERRA LEONE (4)

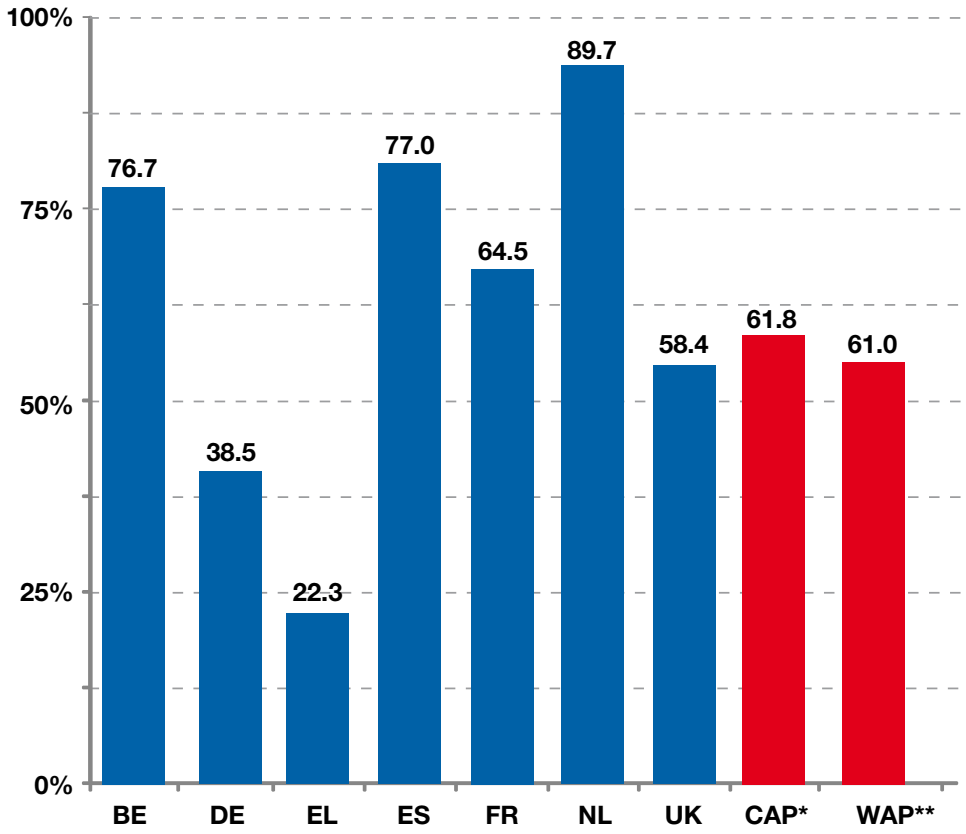
UK
- BANGLADESH (260)
- CHINA (171)
- INDIA (142)
- PHILIPPINES (139)
- UGANDA (121)
- BRAZIL (67)
- VIETNAM (55)
- NIGERIA (53)

LEGAL STATUS

Almost two thirds (WAP=61.0%) of the population were not permitted to reside in the host country; the same proportion as observed in 2011.

This proportion differed considerably, depending on the country surveyed: it ranged between 22.3% in Greece and 89.7% in Amsterdam [16], whereas London and Nice were close to the global average.

PROPORTION OF PATIENTS WHO WERE NOT PERMITTED TO RESIDE IN THE HOST COUNTRY



*Crude average proportion, **Weighted average proportion

TWO SUB-GROUPS OF PEOPLE WERE NOT PERMITTED TO RESIDE:

- Half of the patients (WAP=49.6%) were undocumented migrants from a non-EU country. This proportion was even higher in Brussels and Antwerp (72.3%), Amsterdam (89.1%) and London (57.1%), but was notably low in Munich (8.5%). It should be noted that none of the patients in Perama were undocumented, but 74% were undocumented in Patras where MdM had run a specific mobile unit for migrants in 2011[17].
- 11.4% of patients were EU citizens who had lost their legal residency status due to lack of financial resources and/or health insurance. This situation was particularly common in Munich, where 30% of the patients were in this situation, but also in Spain (35.0%). In Spain, this might be a consequence of the combined effect of the financial crisis (and the subsequent dramatic increase in unemployment that affects immigrants first) and the new law, which came into force in September 2012, stopping undocumented migrants from accessing healthcare, whether they are EU citizens or third-country nationals.

[16] The MdM support centre in Amsterdam specifically targets undocumented migrants.
[17] Chauvin P, Simonnot N. *Access to healthcare for vulnerable groups in the European Union in 2012.* Paris, Médecins du Monde International Network Observatory on Access to Health Care, 2012, p. 23.

LEGAL STATUS BY COUNTRY (%)

	BE	DE	EL	ES	FR	NL	UK	CAP*	WAP**
Missing values	5.03	6.61	54.42	2.91	3.08	1.69	6.15	13.46	
Residence permit not applicable (e.g. national, child)	0.57	13.41	53.79	4.00	9.88	0.00	0.34	9.52	11.71
Has a valid residency permit (all types except asylum seekers)	4.00	7.80	10.06	7.00	8.17	0.57	1.37	5.66	5.57
Can stay: has adequate "official" means and health insurance[1]	2.13	8.05	2.04	4.00	1.75	1.15	1.84	2.27	2.99
Asylum seeker	9.97	1.95	9.04	1.00	11.03	5.75	20.68	11.73	8.49
Tourist / short-stay visa	2.81	10.49	0.29	3.00	2.18	1.15	7.24	3.64	3.88
Does not require a residence permit: staying for < 3 months	3.27	15.37	1.02	3.00	2.46	0.00	1.71	3.06	3.83
Specific situations giving a right to stay	-	0.73	-	0.00	0.00	0.57	3.21	0.70	0.90
Student visa	0.16	2.44	-	0.00	-	0.00	0.68	0.32	0.66
Work visa	0.00	0.98	-	1.00	-	0.00	0.61	0.19	0.52
Humanitarian protection / discretionary leave	-	0.24	0.29	0.00	-	0.00	0.07	0.05	0.12
Not permitted to reside: has stayed > 3 months & no resources or no health insurance[1]	4.47	30.00	0.73	35.00	7.70	0.57	1.30	6.36	11.40
Undocumented	72.26	8.54	21.57	42.00	56.83	89.08	57.06	55.48	49.62
Unable to define status	0.36	0.00	1.17	0.00	0.00	1.15	3.89	1.02	0.94
TOTAL	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

[1] *In the host country or in the country of origin* **Crude average proportion,* ***Weighted average proportion*

Among the EU citizens seen in the MdM centres (n=878), 55% were not permitted to reside in the host country, due to their lack of resources or health insurance after three months of residence. The other 21% had been in the host country for less than three months and did not need any authorisation; 18% were permitted to reside in the host country.

Altogether, a crude proportion of 23.1% of the patients had ever requested asylum or planned to do so. Their numbers were particularly high in Amsterdam (37.3%) and London (44.0%), lower in Brussels and Antwerp (28.7%) and Nice (19.3%), and rare in Greece (5.4%), Munich (5.0%) and Spain (2.9%).

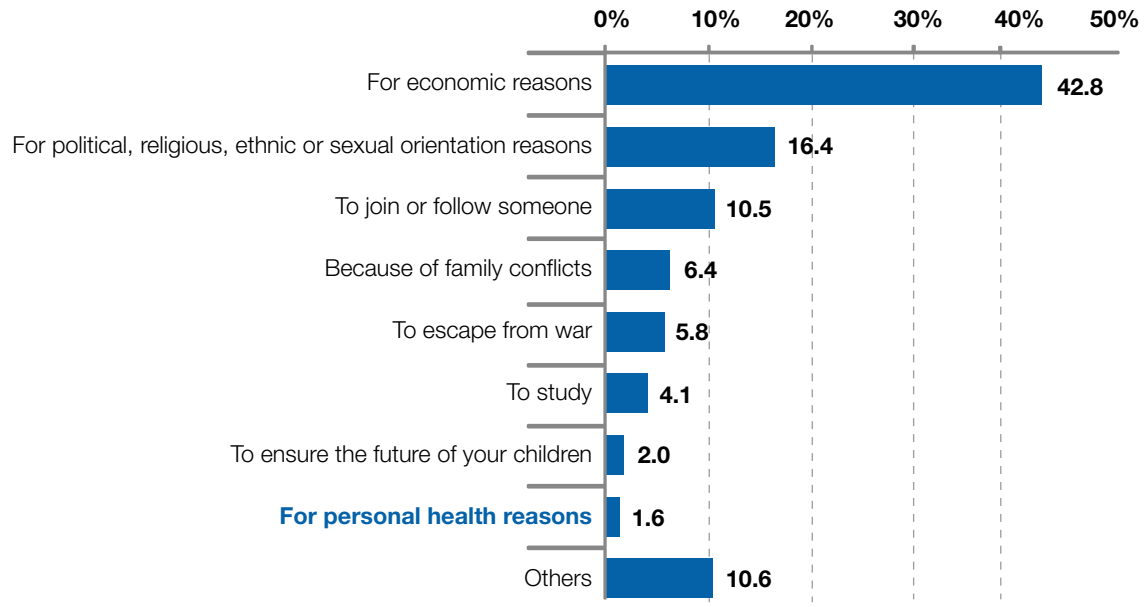
Among these, overall (MVWAP), 27.9% had formally requested asylum and were awaiting a decision, 31.9% had been denied asylum, 30.7% had not yet submitted a request, 4.3% fell within the EU Dublin II Regulation - Eurodac system[18], and **only 5.3% had been granted refugee status.**

REASONS FOR MIGRATION

In all the countries except Belgium and France, all the migrants were asked about their reasons for migrating. Multiple answers were possible. By far the most frequently cited reasons declared were economic (42.8% + 2.0% "to ensure the future of your children"), political (overall 16.4%), familial (either to escape it – 6.4% or to join someone – 10.5%) or to leave a country at war (5.8%). Health reasons were extremely rare (1.6%), even less frequent than in the 2011 results (2.2%).

[18] For UNHCR Comments on the Dublin II Regulation and Eurodac system, see http://soderkoping.org.ua/page23538.html

REASONS FOR MIGRATION DECLARED BY MIGRANTS



Usually, the fact of not being able to survive in one's country of origin is the first reason given for migration, especially among migrants in Spain. Political reasons were most frequently cited in London, where the number of asylum seekers was also high (in the London clinic sexual orientation is commonly cited, especially by homosexuals (women) from Uganda, a factor which is also illustrated by the figure for "family conflicts").

Once again our surveys reveal one of the highest scores for "personal health reasons" (although it still remains very low) in one of the countries where access to healthcare is most difficult: Germany!

REASONS FOR MIGRATION BY COUNTRY (UNDOCUMENTED MIGRANTS)

	DE (n=390)	EL (n=336)	ES (n=114)	NL (n=147)	UK (n=1681)	CAP*	WAP**
For economic reasons, to earn a living	60.24	55.08	76.00	48.41	43.13	42.77	50.10
For political, religious, ethnic or sexual orientation reasons	4.75	1.85	13.00	19.05	26.21	16.38	11.22
To join or follow someone	23.44	10.46	9.00	14.29	9.64	10.46	11.76
Because of family conflict(s)	2.37	7.08	3.00	7.14	8.81	6.37	5.04
To escape from war	5.34	16.31	3.00	8.73	4.79	5.77	6.92
To study	3.86	2.46	1.00	5.56	5.55	4.09	3.22
To ensure the future of your children	2.08	6.15	0.00	2.38	1.53	1.95	2.22
For personal health reasons	3.86	1.23	5.00	1.59	1.32	1.61	2.28
Others	9.79	2.77	4.00	9.52	15.60	10.61	7.24

*Crude average proportion, **Weighted average proportion

HOMOPHOBIA: A REASON FOR MIGRATION

This year at the MdM UK clinic, 60 individuals (3.6% of the patients) reported leaving their country because of their sexual orientation. The vast majority of these patients came from Uganda (85%) and 60% were women. As many as 98% of their asylum claims were refused on first application (as compared to 78% of all asylum claims refused on first application)[19]. The asylum interview itself is a highly traumatic experience for these men and women. They are often not accustomed to discussing their intimate sexual experiences openly with strangers and interviewers ask very intrusive questions.

Many end up spending significant periods in detention centres where the staff and other detainees often hold homophobic attitudes. As a result of their experiences, both in their country of origin and in the UK, many of these individuals are amongst the most vulnerable groups seen at the clinic and form a significant proportion of the user group for our Close Follow-Up emotional support programme. We recall the opinion of the FRA, calling for improved protection of LGBT people seeking international protection.

Patient story

Sarah, 27, has lived in the UK for more than three years. Her neighbours in Uganda reported her to the police after seeing her with her girlfriend: the two of them were arrested and tortured. As soon as she was freed, Sarah fled to the UK to stay with her sister. She never discovered what happened to her girlfriend.

"My sister told my mother in Uganda that I was a lesbian and she has refused to speak to me since."

For two years, Sarah rarely left the house. "I was terrified all the time. I thought maybe someone would look at me and see that I was a lesbian and arrest me. My sister didn't really approve of my sexuality so I didn't feel I could talk to her. I didn't claim asylum because I was so scared. I knew that if it went wrong, I would be sent home and killed. I was drinking too much because I couldn't sleep and I felt so depressed".

MdM Project London referred Sarah to the Refugee Therapy Centre in North London. She chose to attend a group session rather than individual sessions and reports that, *"It is really helping. It's a chance to talk with people who are also victims of torture. It helps me know I'm not alone, that I'm not the only one".*

Sarah spoke to her MdM clinic Close Follow-Up volunteer, Clare, regularly on the phone for six months: *"Being phoned was really great. I often felt so alone in the evenings when my sister's kids were in bed but when I spoke to Clare I felt OK. It helped me build the confidence I needed to claim asylum. When I went for the asylum interview, Clare just told me to be natural and I did. I am so happy that they believed my story."* Clare wrote a letter of support for her asylum claim outlining how Sarah had become involved in Doctors of the World. Finally, Sarah was granted full refugee status in June 2012.

"I would like to study nursing, maybe mental health nursing. There used to be so much pressure on me, I thought about all the 'what ifs' and imagined what it would be like if I were forced to go back. It was such a relief to learn that I could stay here. Just knowing I'm not going back tomorrow and that I am somewhere safe for as long as I want to be."

MdM UK – London – October 2012

LIVING CONDITIONS

HOUSING CONDITIONS

Housing conditions are **unstable or temporary for half of the patients** (MWWAP=49.2%). The highest rate was recorded in the Netherlands (71.8%), whereas there was not much difference between the patients in the other countries. This means that half of the people who went to an MdM clinic carried the heavy weight on their shoulders of not knowing where they would sleep that night. This hinders people in undertaking any preventive measures in relation to their health. Unstable housing makes it more difficult to take medication in a regular way, implement the doctor's dietary advice, enjoy regular sleep, etc. Obviously, not having a place to call "home" also has a significant impact on adults' and children's mental health and capacity to deal with daily problems.

9% of those interviewed were sleeping rough (either on the street or in emergency or short-term shelters), while 7.5% were housed in medium-term accommodation (charity housing, hotels, etc.), 1.6% in squats and a few at their workplace (0.9%) or in camps (<0.1%). Only London seems to offer relatively better housing conditions.

One third of patients felt that their housing conditions were affecting their health or their children's health. This proportion was highest in Greece where a majority of people expressed such an opinion (56.9%): 87.7% in Patras, 70.3% in Thessaloniki, 44.4% in Perama and 41.8% in Athens. These poor housing conditions can be partly explained by the new housing taxes which must be paid together with electricity bills (the electricity is cut off if the bill is not paid). The data in Greece were collected in autumn 2012, by which time heating was already a necessity.

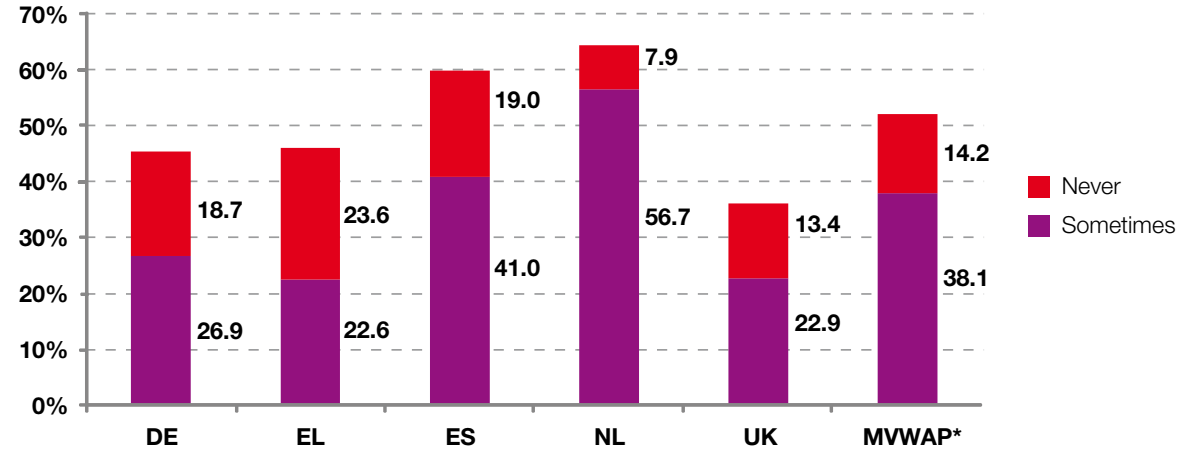
AVAILABLE EMOTIONAL SUPPORT

52.3% of people had a low level of emotional support[20], including 14.2% who were completely without support (especially in Greece). This level of isolation is similar to that observed in our previous surveys. People seemed to be more frequently isolated in Amsterdam (56.7% of people reported having emotional support only sometimes and 7.9% said they never did) and also at the Spanish centres (41% and 19% respectively).

[19] UK Lesbian and Gay Immigration Group (UKLGIG) (2010) Failing the grade – Home Office initial decisions on lesbian and gay claims for asylum, available at: http://uklgig.org.uk sitemaps, publications

[20] The question was "Here, can you rely on someone to support you emotionally, to comfort you, if needed?"

PROPORTION OF PEOPLE WITH A LOW LEVEL OF EMOTIONAL SUPPORT



*Missing-values-corrected weighted average proportion

WORK AND INCOME

Only a quarter of the patients declared that they had a job or an activity to earn a living. This proportion was the highest in Nice (34.8%). It was closer to 20% in the other countries. Nice is situated in a rich area of France with many opportunities to work in the domestic service sector (gardens, homes). Among those who declared that they were working, a vast majority in Greece (79.5%) and in Spain (73.7%) indicated that their income was not sufficient to pay for their basic needs. This was also the case for 40.9% of working people in Amsterdam, but more rarely observed in London (13.6%).[21]

Patient story

"During my last five years in Bulgaria I was working for the food industry in a packaging factory. I was responsible for the coordination of the production process. At the time, I had a good life and could go and see a doctor. I lost my job there when the company went bankrupt four years ago. I decided to go to Spain to look for a job there. My family is large and needs money. I am a grandfather. For a while I worked in greenhouses picking tomatoes. Then the crisis started in Spain and I lost my job again. I returned to Bulgaria where I had an accident which caused a hip fracture. I was operated in hospital. But at the time I had lost my insurance and I had to pay the whole bill myself.

In Bulgaria, I couldn't find any work in the food industry. So I left the country to go to Berlin where I worked in a kebab restaurant. I was able to earn my living there but it was not a good business. After I had paid for my rent, as I only earned €3 per hour, I still didn't have any health insurance. Then I decided to move to Munich. Here I do something different every week. I've worked for the maintenance of graveyards, but here also I am paid only €4 an hour instead of the promised €8. My boss refuses to answer his phone. A few months ago I had a chance to get a real contract with health insurance when I started to work as a furniture maker in a hotel. But I lost my chance when one of my colleagues (from East Germany), who didn't like foreigners like me, started to talk badly about me."

MdM Germany – Munich – December 2012

VIOLENCE

Questions relating to violence were only asked by some of the volunteer doctors. The results presented here are based on the answers of the 396 to 576 patients interviewed about these experiences (depending on the questions asked). Questions about violence were not asked in London and Brussels[22] and, at the other centres, this issue could not always be addressed during the medical consultations.

Primary healthcare professionals should play an important role in the identification of the consequences of violence. This applies not only to the well-described post-traumatic stress disorder (PTSD), but also to more unspecific symptoms[23]. Indeed, knowing the sub-acute and chronic signs and symptoms of violence enables physicians to diagnose and treat often obscure symptoms with a much clearer understanding[24].

Almost **40% of the patients who spoke out about violence in MdM clinics had lived in a country at war; one fifth had been physically threatened, imprisoned or tortured because of their ideas. One fifth had been victims of violence by the police or the armed forces. Civil or domestic violence were also frequently reported:** almost 40% of people had

[21] The question was not asked in Belgium, France and Germany.
[22] Both teams made this choice: in London this was because they cannot refer the patients who need psychological help; in Brussels the decision was made by the team to let only psychologists talk about experiences of violence.
[23] Loutan L., Berens de Haan D., Subilia L. (1997) 'La santé des demandeurs d'asile : du dépistage des maladies transmissibles à celui des séquelles post-traumatiques' in *Bull Soc Pathol Exotique;* 90: 233-7.
Vannotti M., Bodenmann P. (2003) 'Migration et violence' in *Med Hyg*; 61: 2034-8.
[24] Weinstein H.M., Dnasky L., Lacopino V. (1996) 'Torture and war trauma survivors in primary care practice' in *West J Med*; 165: 112-8.

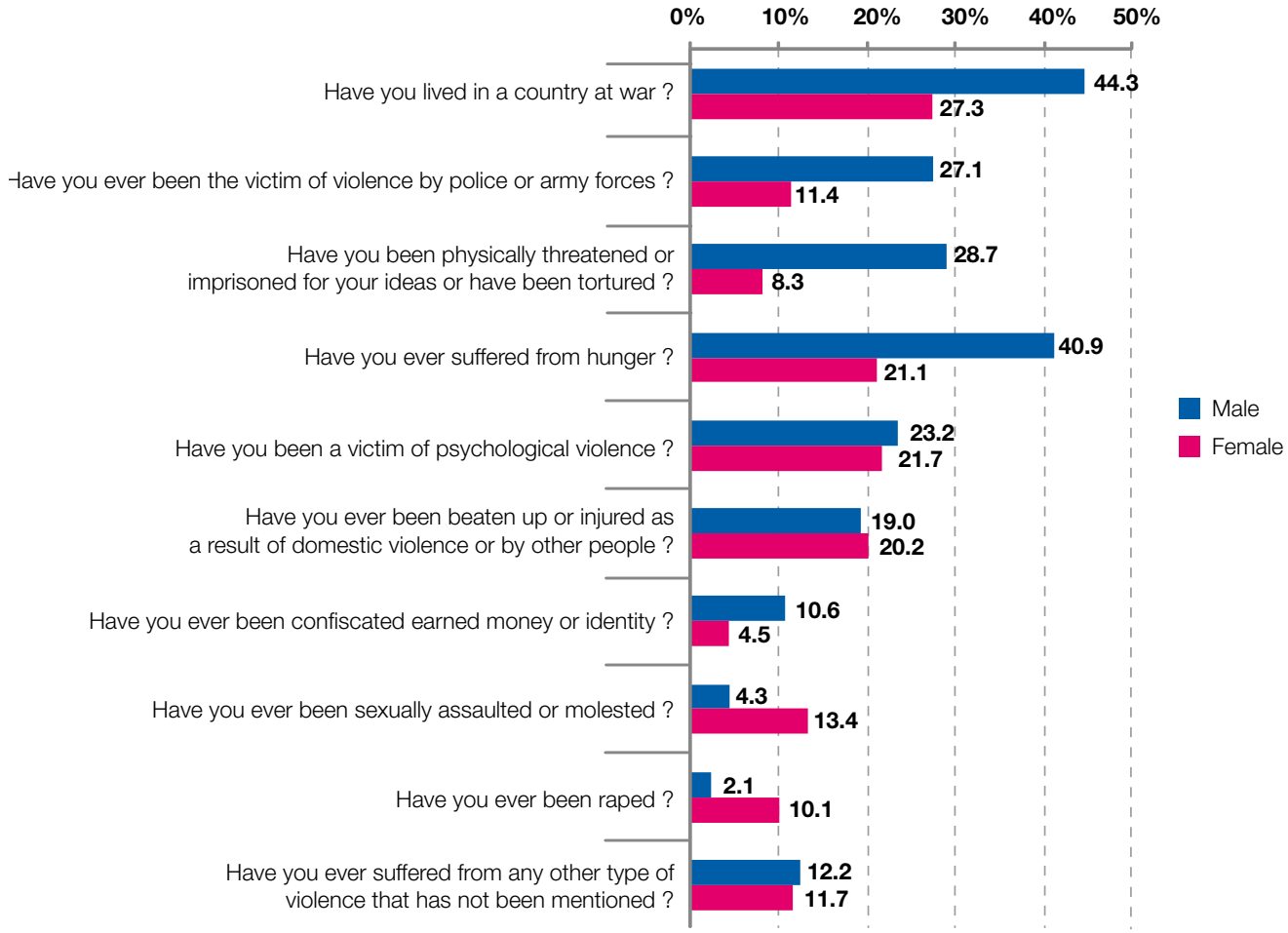
been beaten up or injured as a result of domestic violence or by other people, 22% had been victims of psychological violence, 8% had had money they had earned or identity papers confiscated, 8% had been sexually assaulted or molested and 5% had been raped. Generally speaking, men are even more reluctant than women to speak out about sexual violence they have experienced.

Patient story

Dorian is 26 years old and comes from Burkina Faso. He fled his country 10 years ago. His father used to beat him regularly. He once hit him so hard that Dorian fell to the ground unconscious. One day his mother tried to stop his father, grabbed a gun, and shot him dead. The police came to the house and arrested Dorian's mother and took her away. In a single day, Dorian lost both his parents. He fled the country and ended up in Europe. After five years of sleeping rough he arrived in the Netherlands. He applied for asylum but with no success. His asylum appeal was refused three times. He is now sleeping rough in Amsterdam.

MdM Netherlands – Amsterdam – February 2012

PREVALENCE OF VIOLENCE BY TYPE AND GENDER



A quarter (26.6%) **of the people interviewed reported that they have suffered from violence since their arrival in the host country.** Among these, the most frequently cited violence was suffering from hunger (49.5% of men and 40.0% of women). Having been a victim of violence on the part of the police or armed forces was also not exceptional (34.0% and 11.4%) and neither was having been physically threatened for their ideas (27.8% of men). **Physical violence (including domestic violence), psychological or sexual violence were cited by 20 to 25% of the women who declared they had been victims of violence in the host country.**

Our results show that migrants are particularly exposed to acts of violence, even once they have arrived in Europe, especially women. Violence has inevitable physical and psychological consequences on health.[25] Indeed, among MdM service users, perceived health status is almost always poorer among victims of violence than among other patients.

[25] Carta MG, Bernal M, Hardoy MC, Haro-Abad JM. Migration and mental health in Europe. *Clin Pract Epidemiol Mental Health* 2005; 1: 13.

Patient story

Fatima is 29 years old and from Tunisia. She lives in Athens. Last October she was attacked at night by a group of six men, as she was returning home with a friend. They were approached in a threatening way with a pit-bull dog and asked about their nationality. Four men attacked her while another one attacked her friend. The last one just watched what was happening, holding the dog. Although there were quite a few people passing by who witnessed the scene, nobody intervened to help and stop the attack. Fatima was severely injured. She mentioned that the men were dressed in black with clear gold signs and white crosses – members of Golden Dawn, the Greek neo-Nazi party.

MdM Greece – Athens – October 2012

COVERAGE OF HEALTHCARE COSTS

An assessment of each patient's level of coverage of healthcare costs was systematically made during the first visit to each centre. This data was available for more than 90% of the population, except in Greece where 61.5% of values were missing for this question.

These assessments enabled us to detect marked differences across patient populations in centres, which can be linked to the different health systems in their respective countries[26], even if the absence of any health coverage was by far the most frequent situation for the patients on the day they came to the MdM clinics (CAP=80.7%).

COVERAGE OF HEALTHCARE COSTS BY COUNTRY

	BE (n=1874)	DE (n=421)	EL (n=579)	ES (n=100)	FR (n=2319)	NL (n=172)	UK (n=1481)	CAP* (n=6946)
No health coverage at all, fully chargeable (or no GP in UK)	89.86	52.26	77.55	75.00	81.8	5.23	89.60	80.65
Full medical coverage, not chargeable	6.56	7.13	15.37	1.00	7.07	2.32	0.07	5.87
Medical coverage only for parts of costs	0.21	-	6.74	1.00	7.59	92.44	0	5.40
Insured in another European country	1.39	13.54	0.35	0.00	3.54	0	0	2.38
Free access to GP	-	-	-	0.00	-	0	10.34	2.18
Access only in emergency room	-	24.47	-	48.00	-	0	0	2.15
Access on case-by-case basis	1.97	2.61	-	1.00	-	0	0	0.70
Accessing secondary care & no access to GP yet	-	-	-	0.00	-	0	3.17	0.67

*Crude average proportion,

[26] See the chapter on the legislation in each of the countries.

- **In Belgium and France,** the vast majority of patients (90% and 82%, respectively) had no health insurance[27] on the day they came into the MdM clinics in Antwerp, Brussels and Nice. In Nice, 15% of patients were partially (8%) or fully (7%) covered by the national healthcare insurance system. People with full health coverage came to MdM clinics in order to see the social worker, a psychologist and a dentist (no real access to dental prosthesis in the mainstream health system), but also to see a medical doctor. Even though legally and financially they could access care in the mainstream system, it sometimes takes time to convince them to leave our clinic, to trust new people, to believe they will be well received, with no discrimination due to their specific health coverage. In both countries, a small number of patients were insured in another European country.

- **In Spain,** the vast majority of patients (97.0%) had no health coverage at all. In Spain the four cities where data was collected applied the new Royal Decree (passed in April 2012, it came into force in September 2012) stopping undocumented migrants from accessing healthcare, unless they pay a fee of €59.20 per month if they are under 65 years old and €155.40 per month if they are over 65[28]. Only three patients had medical coverage (full coverage, partial coverage or on a case-by-case basis). For 48% of the patients, the teams declared that they could only access accident and emergency departments (which is actually the case for all of them except the three mentioned above).

- **In London,** 89.6% of the patients had access to care only with specific free healthcare providers (this is a situation which we compared with people in other EU countries who have no health coverage at all: it means that they were not registered with a GP and could not access care until they did register). 10.3% had access to a GP without being charged (as is usual in the National Health Service). 0.07% had access to secondary care and were registered at a GP practice but came for help with other issues. 3.17% had access to secondary care (usually through the accident and emergency department, since secondary care is only accessible by GP referral), even though they had not yet registered with a GP.[29]

- **In Munich,** 76.7% of patients (52.26%+24.47%) had no health coverage at all. This means that they could only access care in an accident and emergency department, even though for some of them, as undocumented migrants, they have the right to care on the same basis as asylum seekers. However, in reality, it does not work because of the fact that all civil servants have a reporting obligation to the immigration authorities (and migrants consequently fear arrest). 13.5% were insured in another European country (Munich is the location with the highest proportion of EU citizens among its patients). 7.1% were insured but had private or student insurance which does not reimburse some costs (treatments that are not considered urgent or dental care), or had debts with their insurance and therefore only had access to emergency care, or could not pay the necessary co-payment for glasses or dental care. 2.6% had access to care on a case-by-case basis, mainly asylum seekers trying to get the "right" papers in order to consult a medical doctor.

- **In the Netherlands,** 92.4% of patients could not obtain insurance as they were undocumented migrants from outside the EU, but the costs of healthcare (80% for GP consultation to 100% for midwives) can be reimbursed to the health provider if the patient cannot pay. 5.2% could not obtain this coverage because they were uninsured EU citizens or non-EU nationals with a residency permit in another EU country (but without valid health insurance in the Netherlands) and 2.3% were insured in the Netherlands or elsewhere in the EU.

- **In Greece,** even though this question was not always answered, we noted that 78% of the patients were not covered at all: either they had no right to health coverage or they had not been able to pay the insurance fees.

It should be noted that, **in all the countries surveyed, if patients are insured in another EU country (whether they are EU citizens or not),** they are faced with a real problem because, even at state hospitals, in the majority of countries, patients often have to pay upfront. They then need to submit the proof of payment to the health insurance provider in the country where they are insured and might subsequently be reimbursed.

Once fully implemented (at the end of October 2013), a new Directive (2011/24/EU) on cross-border healthcare will guarantee patients reimbursement that is at least equivalent to the price of the service that would have been performed in their home country. However, the Directive does not specify how healthcare providers might directly bill insurance companies in the patient's home country. In practice, reimbursement protocols are very different from one country to another. Consequently, the Directive does not protect those patients who cannot afford the upfront fees. On a national level, some countries such as France have taken the initiative to put in place a system where insurance companies are (at least in theory) billed directly, which is definitely a good practice.

[27] The people who come to any of our centres, but especially in Athens, Brussels and Nice (because of the amount of people coming each day), and do have an effective health coverage are for the most part referred immediately to the mainstream healthcare system.
[28] In practice, migrants who have declared that they want to pay these insurance fees have stated that it is impossible to do so because there is no clear process to pay these sums to the public administrations.
[29] More than one answer was given in a significant number of cases in London and Spain only. In the other countries, this question was considered as a single-answer one.

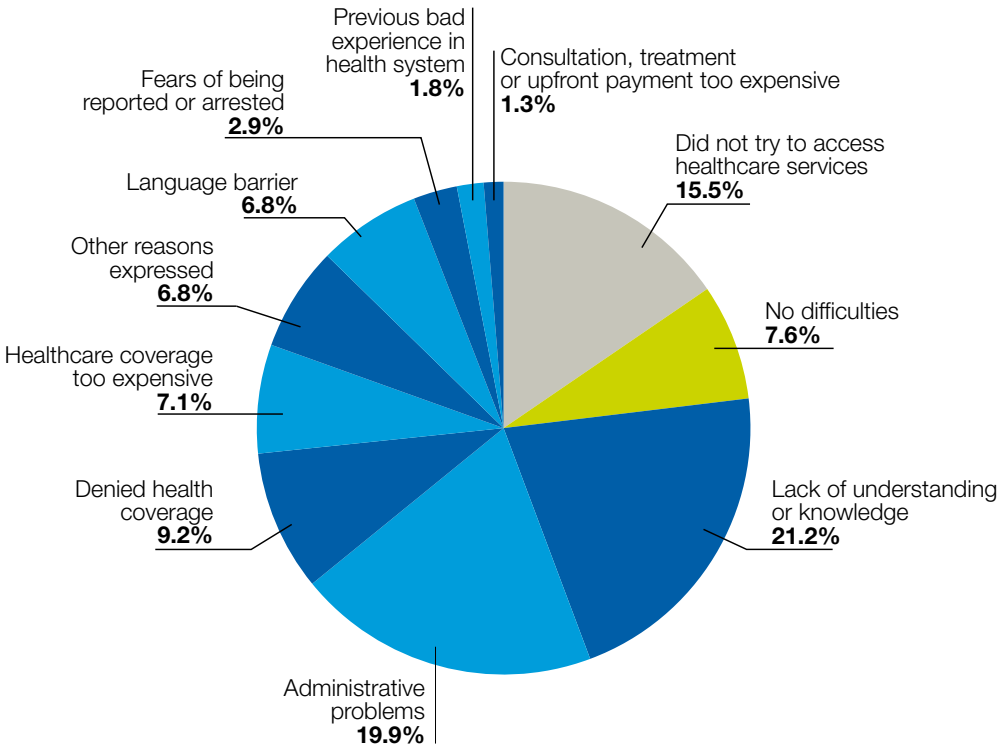
BARRIERS TO ACCESSING HEALTHCARE

Among the patients surveyed, **only 7.6% of people declared that they had not experienced any difficulty in accessing healthcare.** 15.5% said that they had not tried to access healthcare: some might have had no need or reason for seeking healthcare but others could have interiorised barriers to accessing healthcare so strongly that they did not even try to access healthcare, even though they needed to.

This means that the other **76.9% of the total population reported at least one barrier in accessing healthcare.**

The two most frequently cited barriers were, as in our previous survey, a lack of knowledge or understanding of their rights and administrative problems (including difficulties in gathering all the documentation needed to obtain any form of rights or healthcare coverage). Since the first studies by the MdM International Network's Observatory in 2006, nothing seems to have changed regarding these two issues: a majority of the patients are still frequently ignorant of their rights and/or get lost in the bureaucratic procedures of their host country. **These results clearly contradict the commonly held view that migrants come to Europe in order to benefit from social services.**

BARRIERS IN ACCESS TO HEALTHCARE (TOTAL PATIENT POPULATION, MVWAP*)



*Missing-values-corrected weighted average proportion

LANGUAGE BARRIERS

About **40% of the patients required the services of an interpreter.** This proportion was higher in London (53%) and in Munich (62% – or 48.5% if one considers that the missing values (MV) correspond to people without any need of an interpreter). Doctors of the World teams usually managed to find an interpreter[30], as only 7 to 13% of consultations were made without an interpreter (if needed). In Amsterdam, the rate of consultations without an interpreter (32.8%) has increased a lot since last year, maybe as a consequence of the State's austerity measures which mean interpreters are no longer provided in the Netherlands for medical or mental health consultations. The high proportion of consultations that required an interpreter underscores the extent to which language can constitute an obstacle to proper access to healthcare and social services.

[30] Interpreters are either professionals, members of the MdM team or people the patients brought with them to interpret.

LIMITED MOBILITY DUE TO THE FEAR OF BEING ARRESTED

At all the locations, except in Antwerp, Brussels and Nice, patients who were not permitted to reside in the host country were asked if they currently limited their activities and movements due to their fear of being arrested. Altogether, **two thirds (65.9%) of this group reported that this was the case:** either very frequently (4.2%), frequently (16.8%) or sometimes (44.9%). It seems that such fears were more often reported in Amsterdam, if all levels of frequency are added together, but similar or higher levels of frequency were (also) observed in Munich and Greece. In Patras, for example, 87.5% of the migrants limit their activities and movements.

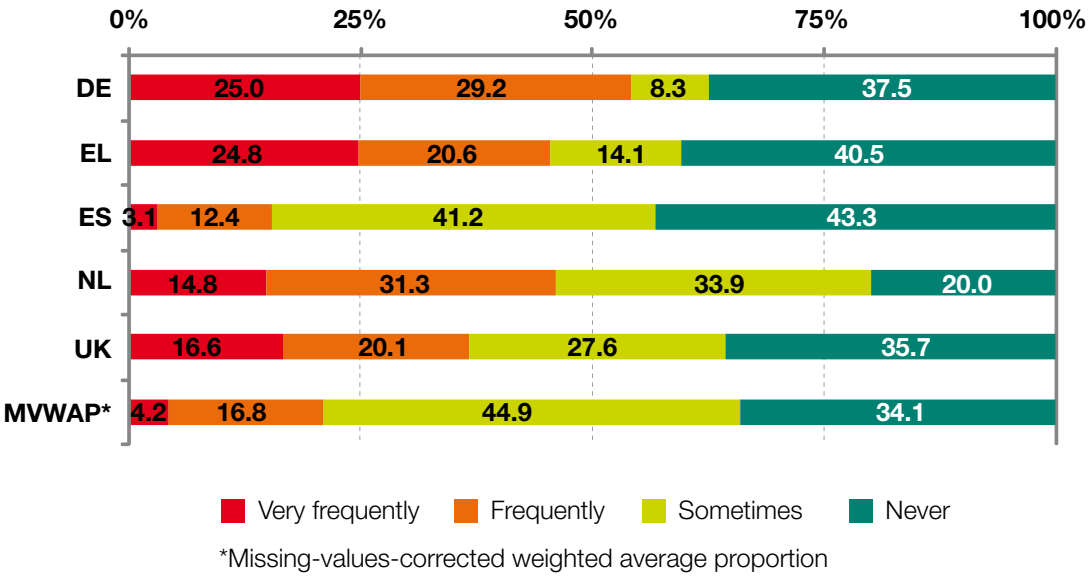
It should be recalled that, according to the Fundamental Rights Agency, *"EU Member States should disconnect healthcare from immigration control policies and should not impose a duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration"*[31].

Patient story

"I avoid many places like the shopping centre because if the policemen see me, they will put me in detention. They told me so, and they did it nine times before. I do not fight or do any criminal things. ***Just seeing my face is enough for them to put me into detention.*** *(…) I also fear where I sleep. There are many men there. They smoke, drink alcohol, and stay up late. I am worried the neighbours will call the police. Then they would put me in detention again. The situation of being without rights because you have no documents causes brain damage."*

MdM Netherlands – Amsterdam – February 2012

FREQUENCY OF THE LIMITATIONS TO ACTIVITIES OR MOVEMENTS DUE TO THE FEAR OF BEING ARRESTED AMONG UNDOCUMENTED MIGRANTS IN DIFFERENT COUNTRIES



*Missing-values-corrected weighted average proportion

DENIAL OF ACCESS TO HEALTHCARE AND RACISM

Altogether, approximately **one patient in five reported that they had been denied access to healthcare** in the last 12 months[32]. It is in Spain that this prevalence was the highest (62% of patients reported such an experience) and this is probably due to the change introduced by the new restrictive law. In Amsterdam and London, 20% of patients had experienced this. The frequency was slightly lower in the other countries.

[31] FRA (2012) *Apprehension of migrants in an irregular situation – fundamental rights considerations,* available at: http://fra.europa.eu

[32] This question was not asked in Nice.

Experiences of racism[33] in healthcare structures over the last 12 months were least frequently reported in London (1.9% of patients). This might be due to the high rate of ethnic diversity within the NHS health providers. The proportions were higher (but for a smaller number of reports) in Greece, Spain and Amsterdam, with frequencies between 6% and 7%.

If only migrants from Africa, the Middle East and Central and South America are considered, 11% of patients had faced racism in Greece and 8.5% in Spain. It should be recalled that the two previous surveys from 2006 and 2008, focussing only on undocumented migrants, showed that the prevalence of reported racism when attending healthcare facilities was the highest in Southern European countries (which are countries of more recent immigration).

GIVING UP SEEKING HEALTHCARE

Between 22% and 36% of patients reported that they had given up seeking medical care or treatment for themselves in the last 12 months (depending on the estimate chosen: CAP or MVWAP). This proportion was notably high in Spain (52%) and in Munich (42%). We already saw in the previous surveys that patients stop seeking healthcare when they believe it will be too difficult to access. Since the survey was conducted in four cities in Spain where the law had recently stopped any access to care, the patients probably gave up seeking care. The same goes for Germany, where uninsured people know that they have to pay the full costs.

Although the indicator is not exactly the same, it is interesting to compare these numbers with the mere 6.4% of the EU-25[34] population who declared in 2007 that there had been at least one time during the last 12 months when they needed a medical examination or a treatment but did not receive it. The two main reasons given for this were because it was too expensive or because they gave up seeking healthcare[35]. In France in 2008, 15.4% of the adult population reported adopting such a position for financial reasons. Within this there was a strong and significant social gradient, with immigrants, the poor and the uninsured most represented[36].

HEALTH CONDITIONS

REASONS FOR CONSULTING MDM CLINICS

People attend MdM health centres for many reasons, not only for medical care, but also for social care, psychosocial issues, help with administrative procedures or legal affairs, etc. Overall, medical care was sought at two thirds of the consultations (MVWAP=65.6%) and at over 80% of them at most sites, except in London (where they represented only half of the consultations) and, to a lesser extent, in Greece and Nice.

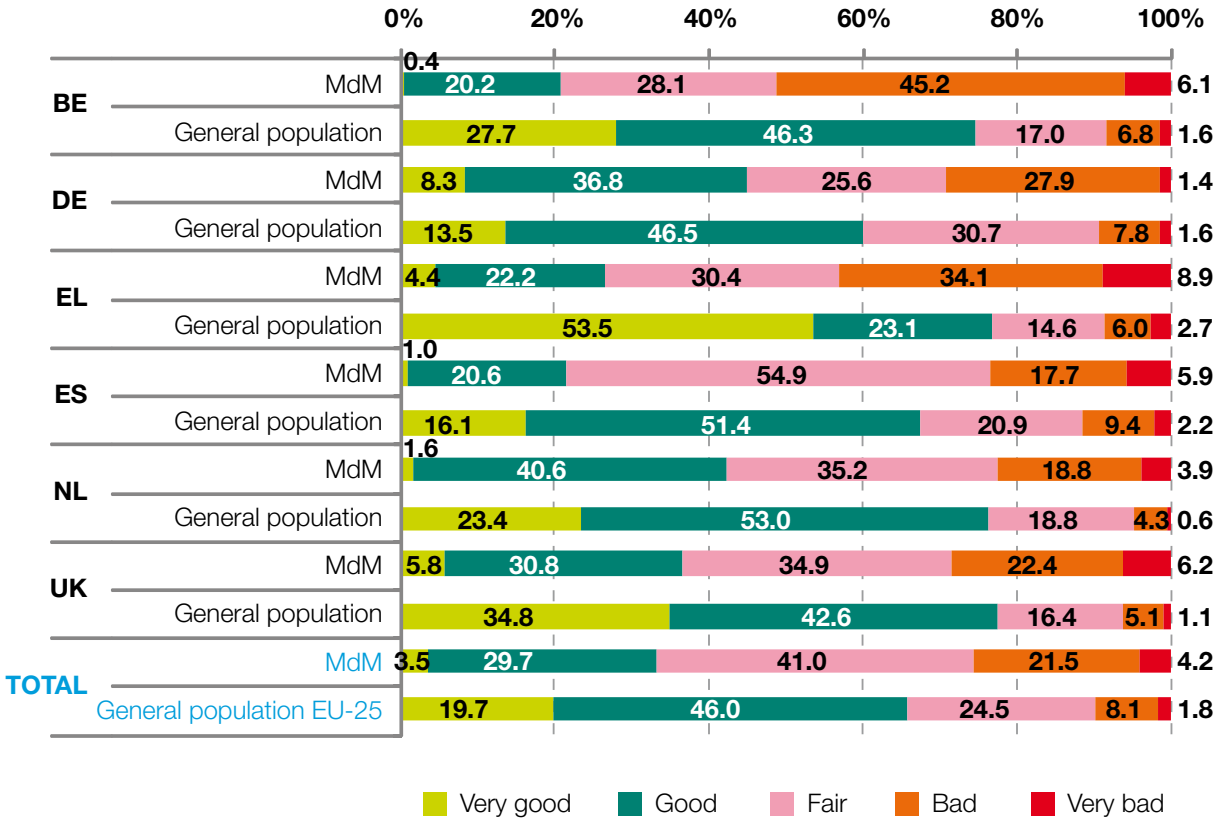
PERCEIVED HEALTH STATUS

Self-perceived health status is a common, internationally used, individual indicator of subjective general perception of health. In a population-based approach (not individually), it has been shown that it is a strong, independent and reliable predictor of morbidity, healthcare utilisation, mortality[37], and health needs[38].

A quarter (MVWAP=25.8%) **of patients perceived themselves as being in poor or very poor health. As a reminder, this figure was 10.0% for the general population of the European Union** in the European Statistics of Income and Living Conditions (EU-SILC) survey in 2007[39]. In all the countries surveyed, the general health status of the patients seen by MdM is worse than that of the general population. **Of course, it is to be expected that MdM service users would be in poor health, since two thirds of people were attending our clinics for medical care,** inducing a selection bias by definition. **But since the surveyed population is also younger** than the general population[40], these differences are valid and need to be underlined.

[33] The question about racism was: *"In the past year have you personally been a victim of racism (colour or ethnic origin) by a healthcare provider?"* It was not asked in Nice or Belgium.
[34] 25 European Union Member States (before Bulgaria and Romania joined the EU).
[35] Baert K., De Norre B. (2009) *Perception of health and access to healthcare in the EU-25 in 2007*, Brussels, Eurostat (Statistics in focus), no. 24.
[36] Renahy E., Vallée J., Parizot I., Chauvin P. (2012) 'Le renoncement aux soins pour raisons financières dans l'agglomération parisienne : déterminants sociaux et évolution entre 2005 et 2010 dans la cohorte SIRS *In*: Boisguerin B., ed. *Le renoncement aux soins.* Paris, DREES (Coll. Etudes et Statistiques), pp. 41-66.
[37] Kaplan G.A., Goldberg D.E., Everson S.A., Cohen R.D., Salonen R., Tuomilehto J., Salonen J. (1996) 'Perceived health status and morbidity and mortality: evidence from the Kuopio ischaemic heart disease risk factor study' In *Int J Epidemiol*; 25: 259-65.
[38] Stronks K., Ravelli A., Reijneveld S. (2001) 'Immigrants in the Netherlands: Equal access for equal needs?' in *J Epidemiol Community Health*; 55: 701–7.
[39] Baert K., De Norre B. (2009) *Perception of health and access to healthcare in the EU-25 in 2007*, Brussels, Eurostat (Statistics in focus), no. 24.
[40] Of the MdM patients, only 5.2% of people were aged 65 or over, versus 16.2% in the EU as a whole.

PERCEIVED GENERAL HEALTH STATUS OF RESPONDENTS BY COUNTRY, COMPARED WITH THOSE OF THE GENERAL POPULATION (SOURCE: EU-SILC SURVEY, EUROSTAT, 2007)



Mental health seemed slightly worse than physical health (respective proportions of bad or very bad health status: 28.0% and 21.2%, p<0.001[41]). **Mental health seemed particularly badly affected in Greece** where 50.8% of patients had a bad or very bad perceived mental health (versus 24.2% in Spain, 33.5% in Munich and 34.4% in Amsterdam). This may be linked with the economic crisis, since some Greek surveys have shown a recent and dramatic increase in suicidality in this difficult context[42].

In contrast, **at the Spanish locations physical health was more often perceived as bad** or very bad (41.8%, versus 27.8% in Greece and 22.2% in Amsterdam).

Patient story

George, 52, is a Greek national and is in receipt of a minor disability pension. He lives in his own home with his jobless wife and their two sons who are also unemployed. George came to the polyclinic looking for medication to treat his obsessive-compulsive and aggressive behaviour and an underlying anxiety disorder. During the previous eight months he had had to stop his very expensive psychiatric treatment because of financial problems, which made life extremely difficult for the family and their social environment.

In addition, we had to break the news that he was also suffering from a hyperglycaemic syndrome that had been aggravated by his psychiatric treatment. His condition required a second treatment for diabetes.

Over the next month and after the regulation of his blood sugar level, George's psychiatric disorder unexpectedly improved. His aggressive behaviour stopped, which was a relief for the entire family. During the third month of his treatment he confided in us: *"Doctor, I heard about your organisation thanks to my neighbours who came to you to ask for help. They told me about all your efforts. I was desperate because I was seeing my life fall apart more and more every day. You were my last hope. I was dashed to pieces".*

Today, George is able to be an active member of society again, as well as a father and a husband. But most important of all, he knows now that he is not alone.

MdM Greece – Perama – September 2012

[41] Statistical test on crude data.

[42] Madianos M., Economou M., Alexiou T., Stefanis C. (2011) 'Depression and economic hardship across Greece in 2008 and 2009: two cross-sectional surveys nationwide' in *Soc Psychiatry PsychiatrEpidemiol*; 46: 943-52.
Economou M., Madianos M., Theleritis C., Peppou L. E., Stefanis C. N. (2011) 'Increased suicidality amid economic crisis in Greece' In *The lancet*; 378: 1459.
Fountoulakis K. N., Grammatikopoulos I. A., Koupidis S. A., Siamouli M., Theodorakis P. N. (2012) 'Health and the financial crisis in Greece' in *The lancet*; 379: 1001-2.

Altogether, 66.7% of the patient population reported a low self-perceived health status (i.e. neither good nor very good). This is dramatically higher than what was observed among immigrants in representative samples of the population aged 50 and over in 11 European countries in 2004/2005 through the Survey of Health, Aging and Retirement (SHARE), even though the MdM service users are notably younger (median age is 34 years). According to SHARE, on average 37.8% of immigrants aged 50 had a low self-perceived health status[43].

HEALTH PROBLEMS

The most frequent categories of health problems observed were those usually seen in primary care: digestive, musculo-skeletal, respiratory, cardiovascular, dermatological and psychological and psychiatric. When looking at the detailed diagnosis, we observed that hypertension, diabetes, back symptoms, teeth or gum problems, abdominal pain, pregnancy, upper respiratory infection, depression and anxiety, and cough were the 10 most frequent diagnoses (among the total number of 11,921 diagnoses reported by the doctors). This means that the care activities of MdM clinics are typically those of primary care centres, although some serious diseases were also reported, happily with a much lower frequency (e.g. cancers, HIV or tuberculosis).

FREQUENCY OF SOME DIAGNOSES (AS A % OF ALL THE 11.921 DIAGNOSES REPORTED BY THE DOCTORS)

15 most frequent diagnoses	
Hypertension	7.80%
Diabetes	4.75%
Lower back/back symptoms	3.55%
Teeth/gum disease	3.18%
Abdominal pain	2.88%
Pregnancy	2.62%
Upper respiratory infection	2.43%
Depression	1.91%
Anxiety	1.84%
Cough	1.36%
Headache	1.29%
Acute bronchitis	1.17%
Asthma	1.08%
Knee symptom	1.06%
Viral hepatitis	0.89%

Frequencies of some selected diagnoses	
STI	0.50%
Cancer	0.36%
HIV	0.23%
Tuberculosis	0.08%

CHRONIC DISEASE AND NECESSARY TREATMENT

During medical consultations, **at least one chronic disease was reported for 52% of the patients** seen by a doctor (and at least one acute disease was reported for 42% of the patients).

Altogether, **chronic diseases represented 61.4% of all diagnoses made during the medical consultations,** while the remaining diagnoses concerned an acute disease in 33.4% of cases and were impossible to categorise by doctors[44] in 5.2% of cases.

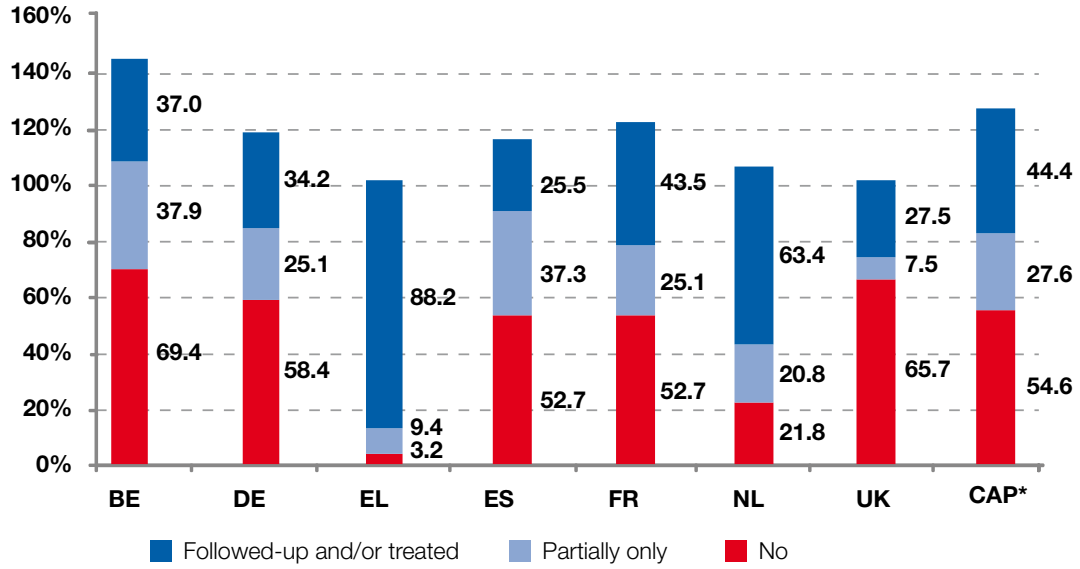
Physicians considered that 63% of people required a "necessary treatment"[45] and 23% of patients needed a "precautionary treatment". The proportion of patients requiring an essential treatment was higher in Antwerp and Brussels (corresponding to the high proportion of chronic conditions in these centres) and lower in London and Nice.

This means that 75.9% of all the diagnoses made by the doctors during the medical consultations required a "necessary treatment".

A **majority of patients (54.6%) had at least one health problem which required a necessary treatment and was not being dealt with or treated at all at the time of the consultation.** This proportion varied greatly from one country to another. It was very small in Greece, where many Greek citizens did consult and the doctors stated that these conditions had (previously) been seen and treated in the healthcare system. It was also less frequent in Amsterdam (where 22% of people with an essential treatment had been treated previously). However, at all the other sites, these patients were clearly in the majority: up to approximately two thirds of patients in need of care in Antwerp, Brussels or London had not had any previous medical attention or treatment.

[43] Solé-Auro A., Crimmins E. (2008) 'Health of immigrants in European countries' in *IntMigr Rev*; 42: 861-76.
[44] MdM medical doctors expressed their difficulty in answering this question for each diagnosis, for example for an acute episode of a chronic condition
[45] The question asked to the MdM medical doctors was to decide if a treatment was "necessary" (i.e. treatments really needed by the patients otherwise their condition would get much worse). We could also have used the words "essential treatment".

PROPORTION OF PATIENTS WITH A NECESSARY TREATMENT WHO HAD ACTUALLY BEEN TREATED AND FOLLOWED UP (AT LEAST PARTIALLY) BEFORE COMING TO MDM, BY COUNTRY



*Crude average proportion (total>100% since multiple answers were possible: a given patient might have been treated for one condition and not for another).
Key to reading the graph: in Belgium, 37% had at least one condition which required a necessary treatment that was fully followed up or treated; while 69.4% had at least one condition which required a necessary treatment but was not treated at all.

Altogether, **10.5% of migrant patients had a chronic disease that they knew of before coming to Europe.** This proportion was especially low in London and at the Greek locations (6.5% and 3.5% respectively) and higher at the Spanish and Belgian locations (20.4% and 31.0% respectively). These patients accounted for 40% of migrants with a chronic disease. We have seen before in this report that, when asked about their reasons for migration, health issues represented a very small proportion of the reasons for MdM service users (1.6%), even smaller than in the 2011 results (2.2%).

As pointed out many times in our previous reports, **the preconceived notion of major immigration flows linked to people seeking healthcare does not correspond to what we have observed** in the population surveyed.

URGENT CARE

Overall, half of the medical consultations were for urgent (18%) or fairly urgent (32%) cases, as quoted by a doctor. The proportion of emergencies was higher in London (38.5% of the medical consultations), Munich (28.7%) and Amsterdam (25.4%), whereas they were extremely rare at the Greek centres (1.9%) and in Nice (3.9%). These latter low frequencies may be for different reasons: in Greece, the MdM clinics were also used by a significant number of nationals seeking primary care; in France (but also in Belgium and Spain), medical emergencies were accepted in emergency units in state hospitals without much consideration of migration status.

ACCESS TO CARE FOR PREGNANT WOMEN

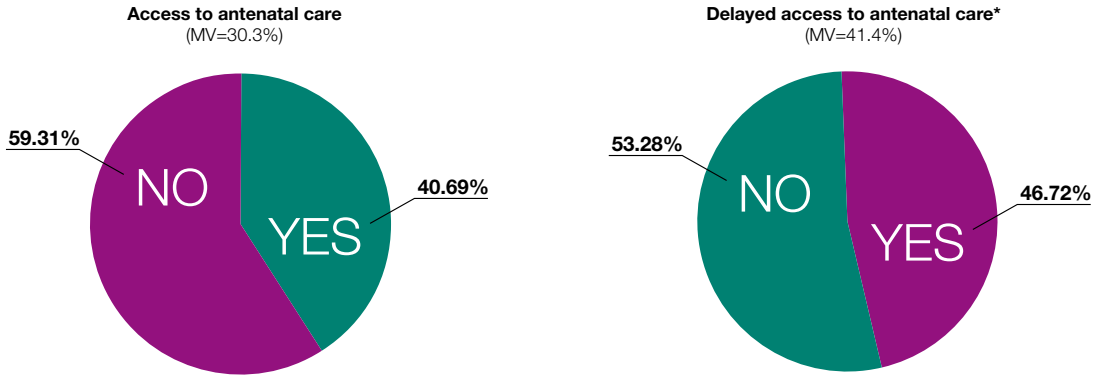
Patient story

Adamma is a 22-year-old Nigerian woman who has been living in the Netherlands for the last two years. She lives in a three-by-four-metre room with her husband. Adamma was delighted when she fell pregnant a year ago, but she never dared to visit a doctor or a midwife because she had no health insurance. Only on the day she went into labour and the contractions began did she go to the hospital. At the reception desk of the maternity unit she was told that she could only be admitted to the ward upon a payment of €500, even though she was in a great deal of pain. Her husband earns €200 a month as a cleaner, which is all they have to live on.

Her husband made a call to secure an advance on his wages, but it took many more calls to find the remainder of the money in the form of loans from various friends. Once the €500 was secured, Adamma gave birth to a healthy daughter. Just a few hours after the birth, she was forced to leave the hospital. The three of them now have to share the tiny 3x4m room. There is no postnatal follow-up. Adamma needs to keep her baby as quiet as possible to be sure not to disturb the other residents.

MdM Netherlands – Amsterdam – September 2012

ACCESS TO ANTENATAL CARE FOR PREGNANT WOMEN



*First antenatal care received after the 12th week of pregnancy
MV = missing values

Among the 3,511 women seen, 208 were pregnant (5.9%)[46]. They were mainly seen at the following locations: Munich (30.3%), Antwerp and Brussels (28.4%), London (21.2%), Nice and Amsterdam (7.7% each) and much less frequently at the Greek and Spanish centres (3.9% and 1% respectively). **59% of the pregnant women[47] did not have access to antenatal care and 46.7% of them received care too late** (that is after their 12th week of pregnancy).

We observed no statistically significant differences in access to antenatal care (or delayed access) on the basis of women's ages or geographical origins (this may have been due to the small numbers).

Patient story

Teresa is 22 years old, from Cuba, pregnant and has suffered type 1 diabetes since she was 15. She has lived in Tenerife since March 2012 and has no permit to stay in Spain.

Prior to her hospitalisation, she had been self-administering insulin which her mother sent her from Cuba. When she realised that she was pregnant, she went to the public healthcare centre, but was denied medical attention due to her irregular administrative status. The centre referred her to the social security office (INSS), where she explained her high-risk situation and requested a social security number so that she could receive medical treatment during her pregnancy. The INSS refused to issue her with a social security number on the basis of her irregular administrative status, stating that she was responsible for the consequences and advising her to consult a private medical centre.

Her first consultation with a gynaecologist came as a result of a car accident for which she was taken to the accident and emergency department of a local hospital. The doctor who attended her arranged an appointment for her in the gynaecology department. She was 20 weeks into her pregnancy when she received her first ultrasound scan (eight weeks late).

Two weeks later she did not feel well and went to the accident and emergency department where she was warned that her pregnancy fell into the **high-risk category.** The gynaecologist who attended her 20 days later referred her to the endocrinology department, where it was decided that she should receive in-patient care for "adjustment of treatment and diabetes education".

At this point, the social work unit of the hospital contacted Médicos del Mundo to request that we cover the cost of the medication the patient required. The hospital provided the necessary medications only until the scheduled appointment at MdM; therefore she arrived without having taken any medication that morning.

Considering the gravity of the situation, Médicos del Mundo Canarias covered the costs of this woman's medications for one week until her next appointment. Neither she nor her partner have a regular source of income, and both rely on sporadic employment opportunities. The couple shares a room in a friend's house.

We contacted the social worker at the hospital and requested a written statement confirming the denial of medical prescriptions for Teresa. Shortly thereafter a physician contacted MdM and said that no written statement would be provided and that she was only complying with the legislation in force. During the conversation she also made value judgements regarding the patient, her motives for coming to Spain and her pregnancy.

We then sent letters to the director of the hospital, the Regional Ministry of Health and the Director of Health Services for the Canary Islands. The Regional Minister of Health contacted MdM to apologise for the situation, recognising the patient's right to healthcare and coverage of 40% of the cost of medicines prescribed for her condition and making a commitment to resolve the matter.

MdM Spain – Canary Islands – October 2012

[46] 26 more women had a diagnosis of pregnancy in the following part of the questionnaire (leading to a proportion of 6.6% of the total number of women), unfortunately with no information given in the pregnancy section.
[47] Unfortunately, the rates of missing values were high for the questions about access to antenatal care (respectively 30% for the first question: *"Does the woman have access to antenatal care?"* and 41% for the second question: *"Has the woman received her first antenatal care after the 12th week of pregnancy?"*).

ACCESS TO VACCINATION

At all the locations except in Belgium and London patients were asked by the doctors[48] about their vaccination status in relation to tetanus, hepatitis B (HBV) and measles, mumps and rubella (MMR). Data were available for a limited number of patients due to the difficult task of asking questions about facts that sometimes happened a long time ago (in the case of adults). Furthermore, when faced with patients who seldom consult a health provider, there is a natural tendency to first and foremost respond to their expressed needs and self-perceived priorities. Any comprehensive, in-depth prevention work with patients facing accumulated factors of vulnerability requires them to be able to access low-threshold primary care services.

We nonetheless observed that only around 60% of the children who came to MdM health centres in 2012 had been vaccinated against tetanus, HBV or MMR. For adults, these figures fell to 39%, 32% and 35% respectively. This can illustrate a loss of access to healthcare very early in the course of a patient's life.

Around 10% of the children had definitely not been vaccinated against tetanus, HBV or MMR. Adults who had definitely not been vaccinated accounted for 14% for tetanus, 19% for HBV and 16% for MMR. It was reported that between 10 and 17% of the children just did not know about their vaccination status, and around 30% of the adults were in the same position (due to the lack of vaccination records that had often been lost or damaged).

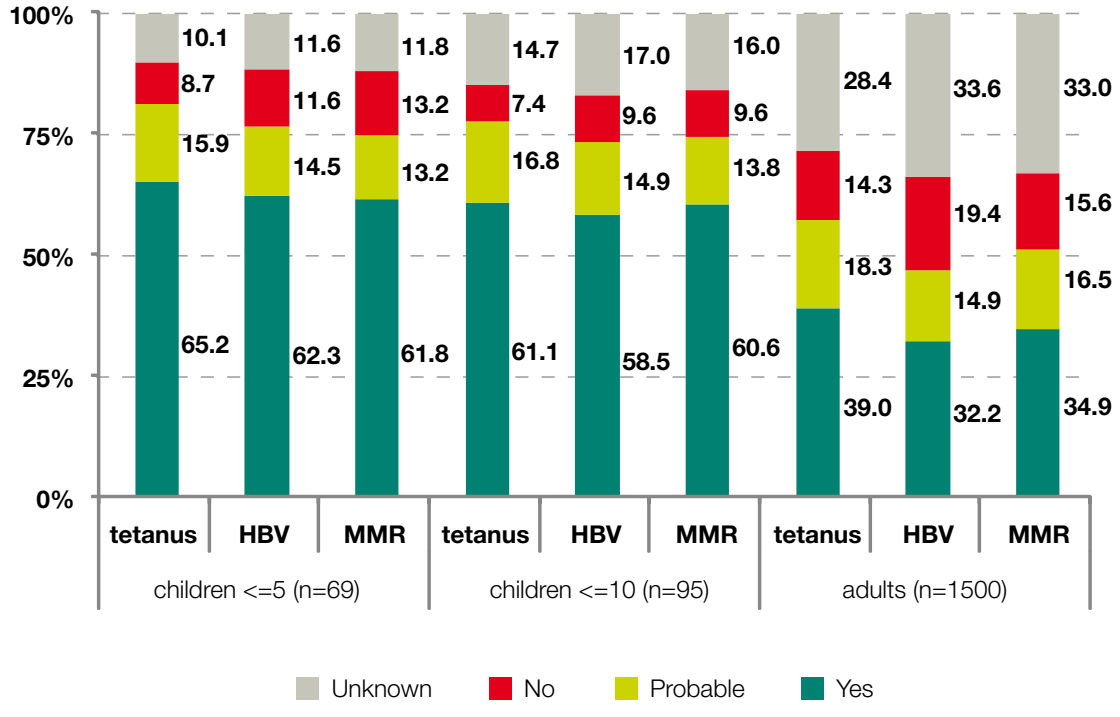
Patient story

Ms L. has just come back from France. She gave birth around two months ago and the delivery went well. She came back to Switzerland because there had been reconciliation between her and the father of the child. The child is in good health and was seen by a French doctor less than three weeks ago. But Ms L. wanted paediatric care and post-delivery follow-up for herself. This follow-up care was quickly arranged but soon the question of childhood vaccinations came up. Our team provided a free consultation, but these "strongly recommended" vaccines had a price, and she would have to pay for them.

As both parents were undocumented migrants and thus had no health insurance, their child was in the same situation due to the law in Switzerland. The paediatrician advanced the cost of the different vaccines for the child.

MdM Switzerland – November 2012

VACCINATION STATUS AMONG CHILDREN AND ADULTS (TETANUS, HVB AND MMR)



[48] Vaccination status is missing for a quarter of the patients seen in Munich, for 59% of patients in Greece, less than 10% in Spain, 79% in Nice and 28% in Amsterdam. Surprisingly, the rate of missing values is independent of the patient's age. Unfortunately, this means that the questions about vaccinations were not asked more frequently to children than to adults.

It seems that fewer people seen at the Spanish centres had been vaccinated than elsewhere. The proportions observed in Greece (which seem to indicate a better vaccination status than elsewhere) must be interpreted with caution, since the rate of missing values was particularly high.

A majority of the people interviewed (60%) did not know where to go to receive vaccination[49]. For instance, 65% of the patients seen in Nice did not know where to go to be vaccinated even though the city runs three public vaccination services that theoretically deliver free vaccinations for all. MdM teams refer patients to vaccination centres whenever possible, especially in France, Spain, Belgium and the Netherlands where vaccinations for children are free of charge. However, the high number of consultations at MdM centres where no questions about vaccination were asked certainly constitutes a missed opportunity to improve the vaccination status of patients.

In 2010 and 2011, a large European outbreak of measles was observed, despite the target for its elimination throughout Europe by 2015. More than 30,000 cases were reported by EU and EEA/EFTA countries in 2010 and 35,000 cases in 2011, a fivefold increase compared to the annual average for the preceding five years. More than eight in 10 reported patients were unvaccinated – which means that their illness would have been avoidable with vaccination. Between October 2011 and September 2012, the European Centre for Disease Prevention and Control (ECDC) reported about 8,000 case, i.e. many fewer than in the previous years but not yet in line with the 2015 target. France, Italy, Romania, Spain and the United Kingdom accounted for 93% of the total number of reported cases.

Vulnerable groups are worse hit by infectious diseases, mainly because of their poor living conditions and other social determinants of health, but also because the State health authorities fail to implement real universal public health measures such as equal access to healthcare and prevention for all. Public health policies can only be effective if they include everyone living within their geographical area. They should not exclude any segments of the population, especially not the most vulnerable groups who should constitute, on the contrary, priority target populations.

It should also be noted that the Fundamental Rights Agency is of the opinion that "every child should be entitled to the same healthcare services as nationals (including immunisations)".

Patient story

Iannis is a 13-year-old boy who lives with his mother and his younger brother in Perama. They belong to the Roma community. His mother has no income and they have no relatives to help them. Currently they are hosted in a small flat without electricity and they receive food items from MdM's Polyclinic. Iannis cannot go to school anymore because he hasn't been vaccinated and because the director doesn't want him in the school.

"I want to continue school, I like reading… I can't understand why the teacher doesn't accept me at school; all my friends are in school now". His mother told us *"I don't know what else to do, the head teacher told me that Iannis doesn't have a valid health booklet, I don't have the money to buy the necessary vaccines; she doesn't want my son at school because we are Roma."* A paediatrician from MdM examined Iannis and administered the necessary vaccines. Our social worker spoke with the head teacher and explained to her that she was obliged to enrol him in school. Finally, Iannis managed to go back to school. *"I'm so happy to have books, thank you all so much!"* His mother added: *"Even the head teacher is polite to us."*

MdM Greece – Perama – September 2012

[49] We noticed that the only people who were asked if they knew where to get vaccination were those who had answered questions about their vaccination status in Greece, Spain, Nice and Amsterdam.

DESTITUTE EUROPEAN CITIZENS AND ACCESS TO HEALTHCARE

According to Eurostat, 31% of all EU immigration concerns EU citizens migrating to another Member State[50]. In doing so, they exercise their right to move and reside freely within the territory of the EU. However, Directive 2004/38/EC states that, to obtain the right to reside for longer than three months in another Member State, EU citizens need to have sufficient resources and health insurance "to ensure that they do not become a burden on the social services of the host Member State during their stay".

Over the last decade, the European Court of Justice has issued several rulings confirming the right of patients to be treated outside their home country and reimbursed under certain conditions, but with no clear rules. Directive 2011/24/EU on cross-border healthcare – to be fully implemented by October 2013 – is supposed to provide clarity. It generally states that patients are allowed to receive healthcare in another Member State and be reimbursed up to the level of costs that would have been assumed by the Member State of affiliation, if this healthcare had been provided on its territory. One instrument in facilitating this type of cross-border access to healthcare in the EU is the European Health Insurance Card (EHIC), which has been provided free of charge by all European health insurance systems since 2004-2005 and which basically proves that a person effectively has health coverage.

The country of affiliation *may* decide to pay the healthcare provider directly, instead of reimbursing the patient, but is not obliged to. Today, in practice, in most of Member States, EU migrants are asked to pay the full cost of health services upfront. This constitutes a serious financial barrier. Furthermore, a significant number of destitute EU citizens no longer have health insurance in their country of origin.

Among the EU citizens seen in our centres, 55% were not permitted to reside in the host country, due to their lack of resources or health insurance after three months of residence. The other 21% had been in the host country for less than three months and did not need any authorisation and 18% were permitted to reside in the host country.

These EU migrants find themselves in the same situation as undocumented migrants from outside the EU. The same rules also apply to citizens of non-EU countries who have legal residency in one European country and move to another EU country.

France (and Belgium, in theory at least) have expanded their system of health coverage for undocumented migrants to include destitute EU nationals who are not permitted to reside in the host EU country.

In Spain, last year's health reform explicitly excluded EU citizens who are not permitted to reside from obtaining a health card. However, even before the economic crisis, their access to care was not straightforward, as they had to wait for a very long time for the Spanish social security services to check their rights in their country of origin.

Something similar may happen in the UK, where immigration minister Mark Harper recently declared that "limiting access to free healthcare is a key to preventing a fresh influx of migrants", concerning Romanian and Bulgarian workers who will be able to access the UK labour market by 2014[51]. However, EU citizens in the UK are currently hardly ever asked to produce their European Health Insurance Card when accessing hospital care. In Germany, EU citizens without a residence permit are "free" to take costly private health insurance[52].

Citizens from Romania and Bulgaria can work everywhere in the EU, except for some countries where there are "transitory measures" concerning access to the labour market. Romanian and Bulgarian citizens will only have access to the labour market in Austria, Belgium, France, Germany, Ireland, Luxembourg, Malta, Spain (only for Romanian citizens), the Netherlands and the UK from 2014 onwards.

Patient story

Monia, 25, is Slovakian and has been living in Brussels for nine months. She has three young children (aged seven, four and 18 months). *"My husband used to have a job here, which is why we came to Belgium. We left Slovakia because of the xenophobia and the constant violence suffered by the Roma population there. For example, I witnessed the beating of my cousin by skinheads. She was pregnant and as a result she miscarried. She is still in hospital now. There are no opportunities for us in our town in Slovakia.*

Here in Brussels we don't know anybody. We lived in a squat for eight months. But early one morning in September 2012 we were suddenly evicted by the police without any warning. For the next 30 days, I slept in a tunnel with my three children on cardboard. It smelt very bad. A lot of people passing by gave us food, nappies, etc. Even in this tunnel, the police came to expel us. Finally, the authorities gave us a return ticket to Slovakia. We went back to our town for only four days where we slept in the street until we caught a bus to come back to Brussels. Even sleeping in a tunnel is better than being in Slovakia".

MdM Belgium – Brussels – September 2012

[50] See Eurostat (the latest figures are for 2010), http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Immigration_by_main_citizenship_group,_2010_(1).png&filetimestamp=20130204085131

[51] See http://www.dailymail.co.uk/news/article-2269838/Migrants-medical-insurance-wont-NHS-care-Ministers-tough-stance-new-influx-East.html

[52] Monthly fees can be as high as €610 / month. See http://www.pkv.de/positionen/basistarif/.

RISING XENOPHOBIA AS THE CRISIS DEEPENS

The economic crisis, rising unemployment and lower levels of social protection all too often lead to the finger being pointed at groups that were already facing social exclusion before the crisis, e.g. sex workers, migrants and Roma. Throughout Europe, MdM teams are faced with alarming increases in xenophobic violence.

Anti-immigrant sentiments are a significant source of psychological stress, even if they are not always accompanied by actual physical threats. Xenophobia also represents an additional structural barrier to seeking diagnosis and treatment. It leads to fear of being refused access to medical services, fear of being reported, fear of being arrested. As a result, many migrants delay or even abandon seeking healthcare. The rise in xenophobic statements at highest level of the State leads to changes in people's attitudes and a belief that migrants should not have any rights. This is what our teams see every day: some health professionals listen to the propaganda and forget the legal entitlements for migrants in their country and go so far as to refuse care, thus also, by the way, forgetting the Hippocratic Oath.

Some governments use access to healthcare as a policy tool to regulate migration flows: this has been proved to be unethical and ineffective. In reality, access to care is not a pull or a push factor for migration. The hard data we have collected throughout the years on the reasons for migration among Doctors of the World service users in Europe show that undocumented migrants do not know their pathologies before migrating, do not know the health systems of the European countries and do not know they can be taken care of. In 2012, health represented only a 1.6% share of the reasons for migration. Health tourism does NOT concern the people that we see in the MdM centres; health tourism by undocumented migrants is a myth.

In **France,** migrants have been widely used as scapegoats in recent years. The most visible and extreme xenophobia now concerns the Roma population who continue to suffer from stigmatisation by the State and by many people. French police forces organise massive evictions of Roma camps and squats without alternative housing being provided, even during winter time. Since a permanent return to their country of origin is not an option for most, those who lose their temporary shelter seek another one, after having lost all their belongings. On top of this, sanitary risks are being used by authorities as an excuse for violent crackdowns.

Our field teams have witnessed intimidation techniques and blatantly racist remarks from police officers, use of tear gas on pregnant women and children, destruction of tents, clothing and food, etc. Essential vaccination campaigns or follow-ups of chronic health problems were interrupted, which could potentially pose a threat to public health. Medication, vaccination cards and administrative documents giving access to healthcare services are often lost during evictions.

In **Germany,** the return of the repressed, as Freud called it, happened in November 2011, when the surprised public learnt that a terror group of three people with a support network (called the National Socialist Underground), had been able to travel freely around Germany for nearly 15 years and had killed nine shopkeepers from migrant backgrounds as well as a police officer. They had also carried out several bomb attacks, including with nail bombs[53].

In many European countries, including the **Netherlands,** homeless migrants and Roma are often denied access to emergency shelters. A collective complaint against the Netherlands was submitted to the European Committee of Social Rights by the European Federation of National Organisations Working with the Homeless (FEANTSA)[54].

In the **United Kingdom**, Prime Minister David Cameron revealed on 11 February 2013 that the UK Government considered that, "access to justice was another of a growing list of public services that ministers were trying to reorganise to restrict access for new immigrants to Britain"[55], thus implying that restricting immigrants' rights could be a political objective! A BBC Freedom of Information request has found a sharp rise in the number of people being arrested on their wedding day by the UK Border Agency - an example of a rigidly insensitive bureaucracy.

After his visit to **Spain**, UN Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, Mutuma Ruteere[56], denounced a "rolling back of gains in human rights of migrants". In particular, he declared the exclusion of undocumented migrants from the healthcare system to be a "regrettable development".

He urged the Spanish authorities to make the fight against racial intolerance in the country a priority. He denounced the climate of racial hostility and violence: *"The emergence of hate speech and xenophobic discourse among*

[53] Dr. Andreas Hieronymus & Ines Fögen (March 2013) *ENAR shadow report 2011-2012*, *Racism and related discriminatory practices in Germany.* http://www.enar-eu.org

[54] See collective complaint n° 86/2012 against the Netherlands submitted to the European Committee of Social Rights by FEANTSA.

[55] *The guardian,* 14 February 2013, www.guardian.co.uk/society/2013/feb/13/justice-immigrant-david-cameron.

[56] www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12953&LangID=E

politicians and political leaders was also brought to my attention during the visit", the human rights expert said. *"Political leaders have a responsibility to strongly denounce such discourse, including when it comes from within their own ranks…."* He went on to say, *"Spain should continue to pay special attention to the protection of the rights of the most vulnerable migrants including unaccompanied minors and women"*. He added *"Respect for the dignity and human rights of the irregular migrants working in the agricultural area should be a high priority for Spain"*. Furthermore he condemned the loss of financial support for groups working on the issues of racism and xenophobia, the increasing criminalisation of migrants and the targeting of specific ethnic groups by the police.

Brutal attacks and hate crimes against ethnic minorities have become a daily phenomenon in **Greece**. Incidents were already occurring in 2010, but the seriousness of the problem has expanded in the wake of Greece's financial crisis.

The unprecedented recession has been politically exploited by xenophobic extreme right-wing groups. In the absence of formal government monitoring of the incidents, a broad civil society coalition set up a **Racist Violence Recording Network**[57]. During the first nine months of 2012, the network documented 87 incidents of racist violence against refugees and migrants. Most of these were physical attacks in public spaces. However, the true extent of the violence remains unknown due to underreporting.

The perpetrators of such attacks operate in groups, undisturbed, in a systematic and organised manner. They often wear the Golden Dawn logo (a kind of swastika). The Human Rights Watch report, *Hate on the streets: xenophobic violence in Greece*[58], documents the failure of the police and the judiciary to prevent and punish the rising numbers of attacks on migrants. Undocumented migrants who wish to report an attack to the police have to pay a €100 fee to file an official complaint. At the time this report was drafted, no-one had been convicted of a racist attack in Greece.

At the beginning of February 2013, the Council of Europe Commissioner for Human Rights, Nils Muižnieks expressed his solidarity with MdM Greece after Golden Dawn members demonstrated in front of the MdM clinic in Perama. This happened just days after he had urged the Greek authorities to tackle racism, racially motivated violence and police misconduct[59].

MdM Greece patient: golden dawn's swastika and initials have been carved on his back.

MdM calls on EU bodies and institutions to persuade national authorities and politicians to show leadership by publicly condemning xenophobic violence, monitoring it and protecting migrants against violence. The EU can also offer technical and financial assistance to national authorities and NGOs to tackle xenophobic violence.

[57] www.unhcr.gr/fileadmin/Greece/News/2012/pr/ConclusionsOctober2012EN.pdf
[58] www.hrw.org/reports/2012/07/10/hate-streets-0
[59] See Nils Muižniek's message on Youtube and his statement.

FOCUS ON MDM
GREECE, SPAIN AND PORTUGAL IN THE CRISIS

DOCTORS OF THE WORLD GREECE IN ACTION

Doctors of the World Greece has had to modify its actions in order to respond to the deep crisis in the country. The organisation has multiplied its areas of action. Two new health centres have been set up since the beginning of the crisis, one in Perama and one in Patras. There are now five polyclinics run by Doctors of the World in Greece[60]. The work of the mobile units has also been expanded. Before the crisis, they already brought access to dental and ophthalmological care in some parts of the country (remote villages and islands). Now, they also go all over the country bringing general practitioners, gynaecologist, paediatricians etc.

A new project was started with the homeless in Athens. Homelessness is a new phenomenon which is due directly to the crisis, with people being thrown out of their homes as they cannot pay the bills. A mobile unit goes to meet the homeless in different parts of the city with sleeping bags, food and physical and mental healthcare. In addition, psychologists ensure personal follow-up for some of the people encountered by the mobile unit – they go to meet the homeless on a regular basis, where they live, on the streets.

© Alessandro Grassani

MdM mobile team going to meet the homeless in Athens

A new project was started with **elderly people** in Athens and Thessaloniki as a response to the growing number of older people attending MdM health centres. Its aims are to ensure better specialised care for the elderly with the training of volunteers and staff. It also seeks to meet their basic needs, such as for food, as many of them are underfed, and to ensure home visits for those who cannot get to our centres.

© Nathalie Simonnot

Fridge in Perama polyclinic
(medicines but also feta cheese for the elderly)

Food collection and distribution never formed part of MdM's actions in its domestic projects. However, the Greek teams were deeply concerned by the amount of people asking our medical doctors for food and not only medicine. We saw people who explained that they had to choose between insulin and food, others said that their children had fainted at school. Consequently, in 2011, MdM started to collect food from companies and individual donors. In December 2011 and 2012 a Christmas tree was made out of cans of milk and other food items which were collected in the middle of the most prestigious square of Athens, in front of the University, and then given to the people attending our centres. The same action was organised in Thessaloniki in 2012.

[60] The polyclinics are in Athens, Chania (Crete), Perama (next to Pireus), Patras and Thessaloniki.

Patient story

Kostas is a 44-year-old unemployed man who visited our polyclinic in Perama 18 months ago.

"My wife is four months pregnant and I can't afford to take her to a private doctor. I lost my job a year ago, I have no income at all and we are expecting our first child. I used to work in the shipyard zone as a mechanic but the economic crisis destroyed my life. My wife has been without a job for two years but at the time we were able to live on just my salary. But now what? My wife told me that we shouldn't keep the baby, but it was already too late. I don't even know how I'll be able to feed my child once it's born."

His wife came to visit the gynaecologist throughout her pregnancy. One morning Kostas called us to tell us she had given birth to a boy. He was so happy he couldn't talk for his tears.

After two months Kostas came to the polyclinic asking for a paediatrician. He wasn't able to bring the child because of his high fever and the very cold weather. The family lives up in the mountains. We asked if we could visit the baby at their home but he first told us it was impossible. They lived without electricity, running water or heating. They didn't want us to come because they felt too ashamed and embarrassed. When we finally examined the baby, we realised that he had not been vaccinated. Kostas and his family continue to visit our polyclinic in Perama, for care and vaccinations. We also support them with food items every month.

MdM Greece – Perama – 2012

55,000 cans of milk and four tons of food collected for the people

MdM Greece also needed to react **against the rise of xenophobia** in Greek society. This is why a new project called "Enough!" was developed, together with the Greek Council for Refugees, in order to:

1. **Increase reporting of racist crimes and combat the impunity of the perpetrators**
2. **Create the first National Report on Racist Violence**
3. **Sustain networking collaboration**
4. **Release a national campaign targeting public opinion.**

This project has a specific focus on young people, who are directly targeted by right-wing extremists who involve them in criminal acts. MdM and the Greek Council for Refugees will visit state secondary schools in the areas that are most affected by racist violence to discuss these matters openly and raise awareness about the negative consequences of xenophobia for the whole society.

MÉDICOS DEL MUNDO ESPAÑA- DEFENDING UNIVERSAL HEALTH COVERAGE FOR ALL

In 2012, the Spanish government took the decision to exclude undocumented adult migrants (even the chronically and severely ill) from public healthcare through the *Royal Decree-Law 16/2012, of 20 April, on "Urgent measures to ensure the sustainability of the national health system and improve the quality and safety of its services"*. It was unilaterally voted to pass the law by the Popular Party (PP) which holds an absolute majority.

The decision of the Spanish government came at a time when the EU Fundamental Rights Agency (FRA) issued an opinion that undocumented migrants should be entitled by law to access all forms of essential healthcare (which is not restricted to emergency care and also includes mental healthcare, care for chronic conditions, etc.) and that continuity of care should be guaranteed, especially in the case of communicable diseases[61].

Vigorous protests from the Spanish medical associations and lawyers' organisations, an uncommonly explicit comment from the UN Committee on Economic, Social and Cultural Rights and numerous outcries by civil society actors, together with a profound critique by the Defensor del Pueblo (or Ombudsman) could not stop the law coming into force on 1 September 2012.

Beyond the exclusion of undocumented migrants, the Spanish government has used the austerity argument to embark on a unilateral shift from a concept of universal health coverage for all people living permanently in Spain, whatever their status, towards a social security system based on work. Furthermore, out-of-pocket payment has increased for medication. The introduction of a nationwide, harmonised, minimum healthcare package opens the door to downward harmonisation. The budget of the Ministry of Health, Social Services and Equality suffered the most severe cutbacks, with 22% in the 2013 state budget. In those regions that are governed by the party of government, namely Madrid, Castile-la Mancha and Valencia, there is a plan to introduce privatisation models.

Doctors of the World opposed the reform in an open letter to the Spanish Minister of Health and in a campaign in which health professionals reclaimed their Derecho a Curar (the right to care). It has been signed by 30 organisations, including six medical organisations and 23,000 individuals.

As a consequence of the widespread confusion, numerous pregnant women and children (who theoretically still have access to healthcare) often get refused access to care, treatment and preventive services. Furthermore, before the new law, general practitioners had access to all women, but now they are not able to see undocumented women. This has a significant gender aspect, as GPs are the main entry point for the detection of domestic violence and human trafficking.

Some communities (Aragon, Balearic Islands, Cantabria, Castile-La Mancha, Extremadura, La Rioja, Madrid and Murcia) have decided to implement the Royal Decree-Law 16/2012 "to the letter" and sometimes even go beyond the requirements of the text. Others (Canary Islands[62], Castile and León, Valencia, Galicia and Navarra) have developed specific procedures in order to ensure access to care beyond the minimum required by the Royal Decree. However, additional administrative barriers often make it impossible to join these schemes. Furthermore, certain diseases and services should continue to be provided for all people living permanently in Spain, for public health reasons, but our teams see confusion about what is included in this list of services and how to access them.

Finally, four autonomous communities, Andalucía, Asturias, the Basque Country and Catalonia, publicly opposed the decree and put mechanisms in place to ensure free access to healthcare for all – as was the case before the reform[63]. With the exception of the Principality of Asturias, these communities have also filed a constitutional complaint against the reform to the Constitutional Court.

SEMFYC, the largest national general practitioners' organisation, called for a movement of conscientious objection against the law, which has been followed by over 2,230 health professionals.

With this new measure, Spain has lost its position in the vanguard of EU Member States that guarantee universal healthcare. Whilst the government argues that it is an urgent austerity measure to guarantee the sustainability of the national health system, the measure is counter-

[61] See *Migrants in an irregular situation: access to healthcare in 10 European Union Member States* (2011), http://fra.europa.eu/sites/default/files/fra_uploads/1925-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf

[62] The Canary Islands took the decision to ensure access to care for all in January 2013, after MdM had finished its specific survey in Tenerife, but the team is still confronted with many difficulties in obtaining health cards for patients.

[63] See http://www.medicosdelmundo.org/derechoacurar/

Housing with sea view (Almeria)

productive. Indirect costs will rise as illnesses become aggravated and chronic and as the result of delayed treatment, overcrowding of emergency services and inefficient public health policy. Furthermore, restrictive health policy measures are proven not to have any significant impact on migration flows.

Finally, the reform creates ethical dilemmas for healthcare professionals who – according to their professional ethic – deliver care without any consideration of nationality, ethnic origin or administrative status.

In addition, a reform of the Penal Code is currently being debated which would criminalise any person helping undocumented migrants. Médicos del Mundo has joined a large platform of organisations in order to stop the law before it could be passed. A new campaign has been launched, signed by over 50,000 persons (as at March 2013): "Let's save hospitality".

Patient story

Verónica, aged ten and from Guinea, went with her mother to the state healthcare centre in Zaragoza to report the loss of her health card and request a replacement. Her mother (who is also her legal guardian) is an undocumented immigrant whose own health card had expired.

When they submitted their request at the healthcare centre, they were informed that the minor did not have the right to receive a healthcare card given that she had ***"received sufficient services already and the free lunch was over".***

MdM representatives accompanied the mother on a second visit to this healthcare centre with the documents required to process the healthcare card. The application was refused on the grounds that the mother should present a document issued by the Spanish National Institute of Social Security (INSS) stating that the minor had no source of income.

The following day, 26 July 2012, we went with the mother to the office of the INSS, where we were informed that because her daughter fell into the category of **unaccompanied minor(!)** and could not benefit from her mother's health coverage, given the mother's irregular administrative status, the office could not issue the requested statement.

When we declared that our organisation planned to file a formal complaint of incompetence against the staff member who had attended us, a different employee processed the healthcare card without any further delay.

MdM Spain – Zaragoza – July 2012

MEDICOS DO MUNDO – PORTUGAL FACING THE CRISIS

Times of crisis and austerity measures do not imply reducing human rights and being unfair!
Portugal has a national healthcare system that is "universal and general" and that "takes into account the economic and social conditions of citizens" (Article 64 of the Portuguese Constitution). It is based on very strong primary care services, open to all, that have enabled great progress in the past (e.g. reduction in infant mortality).

Despite the crisis, Portugal decided to keep its health system of solidarity with undocumented migrants. As before, after 90 days of residency, undocumented migrants have full access to national health services, even if there remain many practical and administrative barriers and a general lack of knowledge about this right. Before they can prove they have been resident for three months, undocumented migrants have access to a limited number of services: emergency care, maternal and child healthcare and reproductive health services.

In May 2011, Portugal signed a memorandum of understanding[64] with the Troika that involved major changes concerning healthcare. It contained important cost-containment measures (€550 million overall) and strategies to improve the overall efficiency of the health system. Among other things, the MoU called for an increase in the levels of user charges, which have doubled in value in the course of 2012.

Nonetheless, Portugal has tried to keep the principle of equity in access to healthcare by scaling up the increasing out-of-pocket expenditures parallel to income. Some categories of people have the right to exemption from user fees for healthcare (based on income or type of pathologies). The total number of people who requested exemption was estimated, at the beginning of 2012, to be only half of the expected number. The difficulty in accessing and understanding information about the possibility of exemption certainly plays a role in this.

Another austerity measure is the recent change in the monthly rate of social aid for people with no other source of income. In February 2013, the allowance went down from €189.52 to €178 a month. One of the effects of the crisis is that many young adults – even after marrying – return to live with their parents because of the high cost of living.

As the possibility of free access to care is based on a person's fiscal situation, homeless people who did not declare their income have no way to prove they have a right to be exempt. Many people also lack information about the changes in reimbursement rates for medication.

As one of the consequences of the crisis, the unemployment rate has increased, passing from 9.3% in 2009 to 17.53% in January 2013[65]. Many Portuguese people –

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Project with Elderly MdM Portugal

[64] http://ec.europa.eu/economy_finance/eu_borrower/mou/2011-05-18-mou-portugal_en.pdf
[65] European Central Bank statistics, http://sdw.ecb.europa.eu

up to 100,000 in 2012 according to some estimates – have decided to migrate to Portuguese-speaking countries, such as Mozambique, Angola or Brazil, or to other EU Member States. Another indicator of the crisis is the dramatic rise in the consumption of anxiolytics and antidepressants (a 7.7% increase between 2011 and 2012), especially among older people[66].

The MdM Portugal teams are confronted with an increasing number of patients who have to choose between buying medicines or securing their only meal of the day. Other patients choose to buy only the cheaper medicines in doctors' prescriptions and leave out the more costly ones. As we saw before, many people do not know how to access healthcare without having to pay upfront. This is the reason why, in 2012, MdM Portugal issued leaflets with information about the new regulations and the administrative procedures to follow.

Furthermore, at a time when more and more people need help, government subsidies have been reduced so that, MdM Portugal had to close eight domestic projects. In 2012, our teams even had to limit the number of condoms distributed in our harm reduction programmes because the government's stock was finished.

However, two new projects have started since January 2013 – projects that are quite revealing of the impact of the crisis. **Farmédicos** is a 'medicine bank' in Lisbon which, in collaboration with hospitals, health centres and private donors, collects drugs to redistribute them freely to vulnerable patients unable to pay for them and also supplies them to others partners who need to distribute drugs.

Like Me is a mental health project that aims to help children aged between 10 and 12 from vulnerable families with little access to healthcare to increase their self-esteem. The project will develop in accordance with the principles of non-formal education, where the activities are planned together with the group. There will be seven main topics: prevention of violence – bullying; prevention of risk behaviour (sexuality and addictions); psychosocial development; multiculturalism; human rights; interpersonal relations and self-esteem. The project has a privileged partnership with a Portuguese university that will support research. It is hoped that, at the end of the three-year project, the self-assessment which young people make of themselves will be positive, thus ensuring a better future for themselves, for the community and consequently for the country.

© Fabrice Demoulin

A resident of Vale de Chícharos waits to be seen by the MdM team, Routes for Health programme - MdM Portugal

[66] For instance, see http://expresso.sapo.pt/consumo-de-ansioliticos-por-idosos-duplicou-no-ano-passado=f788682

OUR DEMANDS
TIME FOR ACTION

In light of the lack of access to healthcare described throughout this document, **Doctors of the World invites all governments in Europe to act firmly to protect the whole population, especially the most vulnerable, living in their country.** Beyond international human rights instruments, a considerable number of recommendations concerning equal access to healthcare have recently been made on a European level. It is time for national governments to put these recommendations into practice.

Doctors of the World calls on the governments to ensure national public health systems built on solidarity, equality and equity, open to everyone living in a European Member State, rather than systems based on a profit rationale. This objective should be achieved through proactive and low-threshold medical services where all patients, including destitute nationals, EU citizens and third-country nationals, are cared for unconditionally, regardless of residence status. Despite and even because of the crisis, we demand financially accessible health coverage and co-payment systems that take into account the income of each patient, regardless of residence status.

Over the past few years, the European Centre for Disease Prevention and Control (ECDC) has published several reports in which it calls for further inclusion of vulnerable groups in prevention, immunisation, screening and treatment programmes. **We call on governments to implement ECDC recommendations and to render treatment for infectious diseases accessible to all as a minimum public health measure. All children in all European countries must have full access to national immunisation schemes and to paediatric care. In addition, all pregnant women must have equal access to pre and post natal care.**

Concerning undocumented migrants, we ask EU Member States to enforce the opinions of the Fundamental Rights Agency. This means changing restrictive legal frameworks so that everyone can access all forms of essential preventive and curative healthcare (including mental healthcare, care for chronic conditions, paediatric care, ante- and postnatal care as well as sexual and reproductive healthcare). It also means that Member States should make more effort to inform undocumented migrants and healthcare professionals about their rights to access healthcare.

As we've seen in this report, healthcare is hardly a reason to migrate among those migrants who actively come to seek treatment at one of our health centres (1.6%). Yet when a person is hit by serious illness (e.g. HIV/AIDS, renal failure, cancer, hepatitis), going back to their home country is often not an option.

During the debate on the Return Directive (2004-2008), the European Parliament voted in favour of measures aimed at protecting seriously ill migrants from deportation, but these measures were refused by the Council.

The Doctors of the World International Network urges the European Union and the Council of Europe to develop means to protect seriously ill migrants from being deported to countries where they will not be able to access healthcare. Both these institutions firmly oppose the death sentence, yet when some undocumented migrants with HIV/AIDS, renal failure, cancer, hepatitis, etc. are sent back to their country of origin, the serious deterioration in their health or even, for some of them, the possibility of their death, must be considered and avoided at all costs by protecting them in Europe.

Dental care mobil unit in a village – MdM Greece

Flashmob in front of the European Parliament – MdM International Network – April 2012

Furthermore, **national governments, the EU and the Council of Europe must actively combat hate speech and populist anti-migrant discourse.** In some countries, urgent measures must be taken to stop daily violence and impunity. In others, we count on political leaders to fight the more subtle symptoms of xenophobia. We count on them to condemn populist remarks about migrants' alleged "health tourism".

What can the EU do?

Although "health is formally a Member State competence", the EU also has an important role to play in encouraging Member States to take action, to protect health systems and social protection mechanisms during times of crisis and even to render them more accessible. Consequently, all our demands towards Member States also imply a role for the European Commission.

EU bodies and institutions and civil society, including small grassroots organisations, could strengthen dialogue even further. The EU could reinforce funding to programmes that target vulnerable groups. Member State governments also need the support of the Commission to fully utilise existing funds for vulnerable groups.

As the coordinating institution for cross-border healthcare, the Commission could play a leading role in seeking solutions to the exclusion of destitute EU citizens from access to healthcare.

"Whenever legislation, government action or any other administration or institution denies patients [their] rights, physicians should pursue appropriate means to assure or to restore them[67]."

As health professionals we demand to be able to work according to our medical ethics. In accordance with the World Medical Association's Declaration on the Rights of the Patient, we will continue to give appropriate medical care to all people without discrimination and refuse all restrictive legal measures to alter our ethics.

Administrative barriers should never stop us from taking care of the patients who need it. The need for care is the only indicator for us.

As health professionals, we refuse the use of health in order to control immigration; we refuse mandatory testing for infectious diseases, and the breach of medical confidentiality. We also follow the Royal College of Radiologists in London who stated that it is "unjustified" to undertake a radiograph examination for age estimation purposes. It is not acceptable for us, health professionals, to provide medical interventions which have no therapeutic benefit and are purely for administrative migration control.

We call on all health providers to express in acts and words their full commitment to participate in health systems that do NOT exclude anybody for administrative, financial, sexual or ethnic reasons.

[67] World Medical Association Declaration on the Rights of the Patients in Lisbon www.wma.net/en/30publications/10policies/l4/

LEGISLATION UPDATE IN SEVEN COUNTRIES (BE, DE, FR, EL, NL, ES, UK)

ACCESS TO HEALTHCARE IN BELGIUM

1. Access to healthcare for nationals and authorised residents

Legal residents in Belgium must register with one of six non-profit health insurance companies. They pay contributions for their membership as well as a fixed amount established by law for the cost of services (the "ticket modérateur" or patient contribution which takes the person's income into account). The health insurance pays or reimburses the rest of the cost of services.

Several mechanisms have been established to help people in precarious economic situations to obtain access to healthcare services. People facing extreme financial hardship can also request additional healthcare assistance from their local Public Social Welfare Centre (hereafter CPAS).

2. Access to healthcare for asylum seekers

Asylum seekers have access to the same services as authorised residents (basic package). While living in a reception centre, their medical expenses are normally covered by the Belgian Agency for the Reception of Asylum Seekers (Fedasil) or one of its partners. If they don't live in a centre, they must obtain a "payment warranty" to receive care and treatment without having to pay. The administrative procedure is quite complicated and most healthcare providers are completely unfamiliar with it.

Asylum seekers whose claims have been rejected are entitled to receive care and treatment until their expulsion order expires.

The Royal Decree of May 2009 extended the rights of foreign unaccompanied minors (MENA) who, since January 2008, have their own entitlement to insurance with a special status (no monthly premiums to pay).

3. Access to healthcare for undocumented migrants

Undocumented people have access to healthcare in Belgium through the "Urgent Medical Assistance" (AMU) system put in place in 1996. Obtaining AMU is subject to certain conditions, namely proof of medical need established by a medical certificate and a mandatory social enquiry that usually takes the form of a visit to the applicant's home. Financial hardship must be verified during this visit. One of the reasons why many migrants do not apply for AMU is in order not to impose this social visit on the homes of the people who have agreed to host them.

If the undocumented person is entitled to AMU, his/her healthcare expenses will be directly reimbursed to the health professional by the CPAS. Afterwards, the federal authorities reimburse the CPAS for all medical treatments except those that do not have an INAMI nomenclature code (basic package).

Although there is a right to access healthcare, there are many practical and administrative barriers. For instance, the legal time limit for the CPAS to take a decision is 30 days, but MdM teams report that this is not respected in the busiest CPAS centres in Brussels. Many CPAS now require identification documentation as a prerequisite. The CPAS of Antwerp often refuses AMU due to applicants' alleged "refusal to collaborate with the social enquiry", for which the criteria are purely subjective. For MdM teams, the need seems clear if the person is not entitled to a health insurance fund and has significant medical needs. Obtaining AMU can also be more difficult for homeless people who do not have an official place of residence. Lastly, the CPAS have a lot of autonomy in how they conduct their social enquiry – the exact procedures may differ from one city to another.

Various centres offer screenings for infectious diseases (such as HIV and hepatitis) upon request. The costs of the treatment fall under the common scheme for reimbursement (medical insurance or AMU). Vaccination is free of charge for all children through the postnatal and young child care programme (up to the age of six). There is no special system for antenatal appointments or care during delivery: undocumented women need to apply for AMU. The same practical and administrative barriers apply.

A separate document with the full update on the legislation in ten countries (BE, CH, DE, ES, FR, EL, NL, PT, SE and UK) and containing all the necessary references to texts of laws and regulations is available upon request. We chose here to publish short explanations about access to healthcare for the countries where the data was collected and analysed.

ACCESS TO HEALTHCARE IN FRANCE

1. Access to healthcare for authorised residents

The French national health system is funded through taxation and personal contributions. Social security health coverage is based on a system where "everyone pays according to their means and receives according to their needs". This covers approximately 65% of healthcare expenses and every person legally residing in France is entitled to it. People on low incomes (below €661 / month in March 2013) have access to the system free of charge *(Couverture maladie universelle – CMU).* Private health insurance schemes are available to meet the remaining 35% of expenses. Among these, some (called *"mutuelles"*) are non-profit schemes. People have to apply for reimbursement of the 35%.

Another mechanism helps destitute people (living above the CMU threshold up to €892.6). They receive between €100 and €500 (depending on their age) to help them finance additional private insurance.

People with low financial resources (below €661 / month in March 2013) are entitled to "complementary CMU" which covers the remaining 35%. People with CMU do not have to pay at the point of service. CMU is valid for one year.

Furthermore, in 1997 the law against social exclusion created the hospital PASS system, allowing all patients to access various medical specialties in some hospitals even before administrative procedures have been completed.

2. Access to healthcare for asylum seekers

Asylum seekers have the same access to care as authorised residents. They obtain social security health coverage upon arrival on French territory. They can also apply for "complementary CMU" which they will be granted, depending on their financial resources.

3. Access to healthcare for undocumented migrants

Undocumented people who reside for more than three months in France and who have resources of under €661 / month are entitled to State Medical Aid (*Aide Médicale d'Etat* –AME). This gives access to all healthcare providers without paying at the point of service. Costs are fully covered (except for prosthesis (dental, optic, etc.) and medically assisted reproduction). The AME is valid for one year.

In contrast, if an undocumented person has resources above the threshold (€661 / month), they are not entitled to any health coverage and must pay the full costs for themselves and their family, which is obviously impossible.

Undocumented migrants who are unable to prove that they have been resident in France for more than three months are only entitled to hospital services for care that is deemed urgent (pregnancy, VTOP, etc.).

Minors with undocumented parents are entitled to the AME scheme upon arrival in France (without the three-month residence condition), even if their parents are not eligible. The right is granted to them for one year.

Destitute EU citizens access the AME under the same conditions as any other undocumented migrant. However, they have to prove that they have no health coverage in their country of origin which is an important administrative barrier.

Police dismantling a Roma camp in Marseille – MdM France

ACCESS TO HEALTHCARE IN GERMANY

1. Access to healthcare for authorised residents

Germany's laws regarding access to healthcare are made at the national level, but Germany is a federal country and the *Länder* (states) and municipalities have specific competencies.

Everyone who lawfully resides in Germany **must** be covered by health insurance (public or private).

Public health insurance is obligatory for all citizens and authorised residents who work (as well as those in receipt of unemployment benefits) whose income is below an income ceiling. Since the 2007 reforms, people who were previously excluded from public health insurance (e.g. because they did not pay their contributions) now have to settle their debts with the insurer and retroactively pay all their contributions since 2007. Until they do so, they are only reimbursed for emergency care.

Self-employed workers or people on high incomes must take out private health insurance (same rule: they have to pay their debts since 2009). Contributions are based on income except for the self-employed and students over the age of 30 or who have spent more than 14 semesters in the university system. For them, contributions depend on their health status, age and gender.

As of 1 January 2013, patients no longer have to pay for medical consultations. For drugs, patients continue to be responsible for a co-payment of 10% of the selling price of the drug. This co-payment is at least €5 and at most €10 per prescription (maximum of 2% of gross annual household income per year and 1% for chronic diseases). Only children under 18 years are completely exempt from co-payment.

Authorised residents (except asylum seekers) can obtain help from welfare services. The homeless can get welfare benefits fairly easily and are thus insured through public health insurance, but the problem for them is the cost of drugs co-payments.

2. Access to healthcare for asylum seekers

Unlike in most European countries, asylum seekers living in Germany do not have the same access to healthcare as nationals during their first 48 months in Germany. The services they can access cover "treatment for severe illnesses or acute pain and everything necessary for curing, improving or relieving the illnesses and their consequences, pre- and post-natal care, vaccinations, preventive medical tests and anonymous counselling and screening for infectious and sexually transmitted diseases".

For non-emergency situations, asylum seekers must first request a Health Insurance Certificate *(Krankenschein)* from municipal social service departments in order to gain access to healthcare. The care provider is then reimbursed directly. It is the municipal departments that decide whether or not to authorise reimbursement for care.

For example, some departments will not issue a Health Insurance Certificate to people with chronic illnesses unless there is a severe deterioration in their health.

Children of asylum seekers are subject to the same system as adults. However, the law stipulates that children can receive other care, meeting their specific needs. The recommended vaccines are free of charge.

3. Access to healthcare for undocumented migrants

Undocumented migrants are entitled to the same healthcare services as asylum seekers. However, civil servants have an obligation to report to the immigration department any undocumented person encountered in the course of their work. As a result, the undocumented migrants often choose not to seek treatment for themselves or their children, even in severe cases, for fear of being reported.

In September 2009, the Federal Assembly *(Bundesrat)* issued a new instruction: hospital administrative and medical personnel are bound by medical confidentiality, as are social services departments, if they obtain information on the status of an undocumented migrant from someone bound by medical confidentiality. This can only happen in emergencies, since in all other cases an undocumented migrant must apply to social services to get healthcare coverage before going to the doctor.

This is why MdM Germany in Munich buys vaccines, paying all the costs, in order to vaccinate children of undocumented parents. Regarding infectious diseases, undocumented people are entitled to counselling and screening for communicable diseases and to outpatient care (for STIs, TB, hepatitis, etc.). The law also provides for free HIV/AIDS treatment. But the obligation to report prevents effective access to care. So in practice, only those with temporary structures accessible to all, regardless of legal status.

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Pediatric consultation – MdM Germany

ACCESS TO HEALTHCARE IN SPAIN

1. Access to healthcare for authorised residents

The right to access healthcare in Spain is included in Article 43 of the Spanish Constitution which states that *"the right to health protection is recognised"*. The General Health Law No. 14/1986 of 25 April 1986 completes this article by providing that *"every Spanish citizen as well as foreigners who have established their residence in the country are entitled to the protection of their health and to health care"*.

The Spanish Health System was universal and considered as "a promising example" in Europe regarding access to healthcare for the most vulnerable people[68].

The Spanish National Health System and access to healthcare in Spain underwent radical changes in 2012, in particular following the adoption of the Royal Decree-Law No. 16/2012 that came into force on 1 September 2012. Today, the individual health card (which gives access to healthcare in Spain) can only be obtained by those with working status.

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Medical consultation – MdM Spain

However, Spanish citizens, EU and EEA citizens and third-country nationals who hold a Spanish residence permit but do not belong to one of the "working" categories can nonetheless obtain an individual health card (and therefore access healthcare services free of charge) if their annual income does not exceed €100,000.

People who cannot be considered as "insured" are only able to access healthcare services if they pay for themselves or subscribe to a "special provision". This "costs €59.20 / month for those under 65 and €155.40 / month if they are over 65. Furthermore, the services included in this special provision are limited to the "basic package of services", meaning that expenses such as non-urgent medical transportation, drugs or external prosthesis (e.g. a wheelchair) are not included in the package. Most undocumented migrants cannot afford it, but those who can and do insist on paying the monthly fee are then faced with practical barriers, as the MdM teams observed.

While before the 2012 reform every working person had to pay 40% of drug costs, people whose annual income is between the broad intermediate range of €18,000 to €100,000 now have to pay 50% of the price. Below €18,000, 40% of the price still has to be paid, even for those on the lowest incomes (minimum gross salary was €645.30 / month in 2013). Chronically ill patients pay 10%, as was already the case before the reform.

The new Article 3ter, al. 4 of the Law 16/2003 (introduced by Article 1 of the Royal Decree-Law 16/2012) provides that *"in any case, foreigners who are less than 18 years old receive healthcare under the same conditions as Spanish citizens"*.

2. Access to healthcare for asylum seekers

Asylum seekers are entitled to the healthcare that they *"need, including emergency care and essential treatment of diseases"*.

3. Access to healthcare for undocumented migrants

The new Article 3ter of the Law 16/2003 provides that adult foreign nationals who are neither registered nor authorised as residents in Spain are entitled to healthcare only in the event of "emergency in case of serious disease or accident, and pregnancy, prenatal and postnatal care".

The ambiguity of this concept of "emergency" gives considerable discretionary power to health professionals by letting them decide whether some types of care should be considered as "emergency care" or not[69].

The only way for undocumented migrants to reintegrate into the Spanish National Health System and therefore benefit from healthcare free of charge is to subscribe to the "special provision" mentioned above. As a consequence of the widespread confusion, numerous pregnant women and children (who theoretically still have access to healthcare) are often refused access to care, treatment and preventive services such as vaccination.

Although the government initially announced that those patients suffering from serious chronic diseases would still be protected, the new law in no way specifically protects people with cancer, renal failure, HIV / AIDS or hepatitis, etc. With regard to those autonomous regions which do make provision for access to care for the seriously ill, healthcare providers are poorly informed about the rules. Consequently, MdM teams have been confronted with HIV-positive patients who had ceased treatment. Interruption of drug treatment makes HIV more difficult and costly to treat later on and is likely to reduce the overall life expectancy of patients.

[68] See FRA (2012), Access to healthcare for irregular migrants. Summary meeting conclusions, p. 4 (last accessed – 15 December 2012)
[69] See the Ethical analysis of the Royal Decree-Law from semFYC (in Spanish) (last accessed – 18 December 2012).

ACCESS TO HEALTHCARE IN GREECE

1. Access to healthcare for authorised residents

The National Health System was established in 1983. It relies on a mandatory health insurance which is based on work (with employer/employee contributions, which are income-related). Thus the health services are funded by individual contributions (insurance-based) but also by state subsidies (tax-based). The system is decentralised and divided between primary healthcare centres, district and regional hospitals.

Greece has engaged in substantial reforms of its National Health System in order to tackle the economic and social difficulties that the country is facing. One striking measure which has been taken is the reduction by 40% of the financing of the public hospitals.

Access to healthcare is free at the point of access for insured nationals and authorised residents. However, there is still a co-payment of 25% of drug costs. Furthermore, since 2011 and austerity measures there is a €5 entrance fee for hospitals and healthcare centres, and every medical intervention subsequent to the consultation must be paid for (e.g. €30 for a blood test).

People on a low income (below €300 / month) can also receive a "welfare card" which allows them to access healthcare services for free (even medicines) provided they have identity documents.

2. Access to healthcare for asylum seekers

Asylum seekers have the same rights as nationals and authorised residents in terms of access to healthcare, provided that they are able to prove their status. In practice, this condition is difficult to meet for asylum seekers, due to the difficulties faced by the migrants in lodging an asylum claim in Greece.

According to the new Directive of 2 May 2012, there will be no change in access to healthcare for minors, meaning they continue to have free access to healthcare services, regardless of their status.

3. Access to healthcare for undocumented migrants

Undocumented migrants can only access healthcare services in cases of emergency or if there is a risk to the patient's life. A circular from 18 August 2011 states that patients who come to the hospital are first examined by doctors who then decide whether or not the state of health of the undocumented migrant constitutes an emergency. The decision is then at the discretion of the medical professionals whether or not access to healthcare is granted.

HIV and other serious infectious diseases are considered by law to be an emergency and therefore everyone can access treatment. However, the Directive of 2 May 2012 provides that HIV treatment for undocumented migrants is accessible only until the patient's health has been "stabilised". This provision poses a real problem because nothing in the law or other regulations defines clearly the concept of "stabilisation". Once again, the decision is left to the discretion of the medical professionals.

Finally, the Directive of 2 May 2012 (amending the Law 3386/2005, §84) states clearly that public services, public corporate bodies, local authorities and social security institutions do not have to provide services to undocumented third-country nationals. There is an exception for hospitals, child care facilities and clinics in cases of emergency.

State of health has become a legal ground for the detention of undocumented persons or asylum seekers if the authorities deem that these people represent a risk to public health. Indeed, an amendment to the Presidential Decree 114/2010 states that asylum seekers and undocumented migrants can be detained if they represent a risk to public health because they are suffering from infectious diseases or belong to vulnerable groups particularly exposed to the risk of infectious disease (this "risk" is assessed depending on their country of origin, intravenous drug use, prostitution activities). According to the law, the risk may also exist if people are living in conditions that do not guarantee minimum hygiene standards. People who are identified as a "risk" (which means they are suspected of being infected) can be forced to undergo mandatory screening. In addition, since 2012 the risk to public health represented by undocumented migrants or asylum seekers has become a reason for deportation from Greece.

Patients getting medecines from the MdM Athens' pharmacy

ACCESS TO HEALTHCARE IN THE NETHERLANDS

1. Access to healthcare for authorised residents

All authorised residents and people who work/pay taxes in the Netherlands are obliged to have health insurance covering a "basic package" of healthcare services. Dutch nationals and authorised residents on a low income can apply for an allowance in order to help them pay their monthly premiums.

2. Healthcare access for asylum seekers

The Central Agency for the Reception of Asylum Seekers (COA) is responsible for fulfilling the basic needs (housing, healthcare etc.) and therefore covers asylum seekers' healthcare expenses through a non-profit insurance company called Menzis. It should also be noted that asylum seekers who file a second application do not have the right in principle to access the COA's reception centres, except if there are "special humanitarian circumstances". Subsequently, their healthcare expenses are not covered by the COA.

Asylum seekers whose applications are rejected must leave the reception centres 28 days (four weeks) following the decision (or after their appeal is rejected). After that period, they no longer have the right to live at the centres and then have the same rights as undocumented migrants.

Unaccompanied minor asylum seekers have the same access to healthcare as adult asylum seekers. However, given their vulnerability, they receive extra assistance from the COA. Furthermore, if their application is rejected, they keep their right to live in the asylum reception centres and benefit from the services (notably healthcare) until they are 18 years old.

3. Access to healthcare for undocumented migrants

Undocumented migrants are entitled to "medically necessary care" (in addition to emergency care) and care in situations where there is a risk to public health. In practice, all care which is part of the basic package (to which insured residents are entitled) is covered. According to the law, healthcare providers are responsible for determining on a case-by-case basis what is "medically necessary", taking into account the type of assistance needed and the expected length of the patient's residence in the country.

In principle, undocumented migrants must pay the full cost of services unless they are unable to pay. They are asked to pay straight away in cash or are offered the option of signing up for payment by instalments, otherwise they receive a bill (and reminders) at home. Sometimes, they even receive a visit from private officials contracted by healthcare providers who seek to get the money directly on the spot. Only if there is enough evidence that they cannot pay are individual healthcare providers, hospitals and pharmacies entitled to partial or total reimbursement of the costs. They must show (by ticking boxes on the declaration form of the financial regulation institution (CVZ) that they endeavoured to recover the costs before they are entitled to the reimbursement of their unpaid services[70]. 80% of the normal fees for services can be reimbursed to the provider, except in the case of pregnancy and childbirth which are fully covered. In the case of pregnant women, all care is considered to be medically necessary both before and during birth.

HIV and hepatitis screening and treatment are included in the basic package of the compulsory health insurance. Undocumented migrants also have access to this treatment, provided it is considered to be "medically necessary care" by the healthcare provider. As with other types of care, HIV/hepatitis treatment is free of charge if it is proven that the patient is unable to pay the costs.

Children of undocumented migrants are in the same situation as their parents, meaning that they have to pay their healthcare expenses and if they cannot pay they are entitled only to "medically necessary care", provided at the discretion of the general practitioner. However, the law makes a specific distinction regarding children: all care is considered to be essential care if related to preventive care and vaccinations.

MdM Netherlands with the ex-asylum seekers

[70] D. BISWAS *et al.*, "Access to health care for undocumented migrants from a human rights perspective: A comparative study of Denmark, Sweden, and the Netherlands", *Health and Human Rights*, vol. 14, n. 2, Dec. 2012, pp. 4-5 (last access – 15 Jan. 2013)

ACCESS TO HEALTHCARE IN THE UK

1. Access to healthcare for authorised residents

Funded centrally from national taxation, with the aim of protecting everybody's health from cradle to grave, the UK National Health Service (NHS) is divided into two sections: primary and secondary care. **Primary care** is delivered by a wide range of independent contractors, including GPs (general practitioners), dentists, pharmacists and opticians. All of these services are currently managed by local **primary care trusts (PCTs).** They are in charge of primary care and also have a major role in commissioning secondary care and providing community care services. PCTs will cease to exist after April 2013 and will be replaced by Clinical Commissioning Groups.

Secondary care is also known as acute healthcare and can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP. Secondary care is managed by different trusts: care trusts, foundation trusts, mental health trusts, etc.

As free secondary care is inaccessible for undocumented migrants (see below), it matters greatly whether a particular health problem is dealt with at primary or secondary care level. Access to NHS (hospital) care is free for "anyone who is deemed to be ordinarily resident in the UK".

As at 1 April 2012, patients[71] pay £7.65 (€9) per prescription, but patients who need more than 13 prescriptions per year or four prescriptions in three months can obtain reductions through a prescription prepayment system. However, prescriptions are still free for certain categories of vulnerable people (patients over 60, under 18, pregnant women and the chronically ill as well as people who receive some form of income support[72]).

Patients on a low income can also claim help with health costs (HC1 form). This help does not depend on immigration status. The NHS decides whether a patient receives full help with health costs (HC2) or partial help (HC3). The certificate is usually valid for one year from the date of issue.

2. Healthcare access for asylum seekers

Regulation 11(b) of the NHS Charges to Overseas Visitors Regulations 2011 states that anyone who has made a formal application to be granted temporary protection, asylum or humanitarian protection which has not yet been determined is fully exempt from charges whilst their application is being processed. This exemption will apply to the family of the asylum seeker if they are living in the UK with that person on a permanent basis. In practice, asylum seekers can register with a GP and the National Asylum Support Service, a section of the UK Border Agency, usually applies for a HC2 certificate valid for six months for asylum seekers.

Failed asylum seekers in England become liable for charges for their NHS hospital treatment, except for any hospital treatment already underway at the time the asylum seeker's claim (including any appeals) is rejected. Destitute failed asylum seekers with children under 18 continue to receive support and also receive free hospital treatment.

3. Healthcare access for undocumented migrants

Undocumented migrants are never mentioned as such in official NHS documents – they are part of a larger group of "overseas visitors" or "people from abroad" along with tourists, EU citizens, migrants with a work permit, etc.

Undocumented migrants have the right to fully access primary care and can consequently register with a GP. Nonetheless, Doctors of the World UK and partners observed that over two thirds of the PCTs in London have issued guidance to GPs that is incompatible with their legal obligations: many PCTs advise GPs they should only register people living legally in the UK for more than six months, despite the fact that the "ordinarily resident" criteria only apply to secondary care.

Regarding access to hospital treatment (secondary care), whether or not a person is *ordinarily resident* in the UK is the first and most fundamental question when determining whether or not (s)he will be charged for the care.

However, some NHS services are free to everyone regardless of the status of the patient:

- accident and emergency services
- compulsory psychiatric treatment
- family planning services
- treatment for communicable diseases such as influenza, measles, mumps, tuberculosis, HIV/Aids and viral hepatitis (HIV was removed from this list in 2004, but has been back since 1 October 2012, thanks to the influence of NGOs and health providers).

NHS maternity care is only provided free of charge to women who are considered to be "ordinarily resident" in the UK. However, Department of Health guidance states that "[…] **no woman must ever be denied, or have delayed, maternity services due to charging issues.** Although she should be informed if charges apply to her treatment, in doing so, **she should not be discouraged** from receiving the remainder of her maternity treatment". In practice, we observe that many women are being harassed by hospital debt collectors.

We would like to point out that the Fundamental Rights Agency is of the opinion that women in an irregular situation should have access to the necessary primary and secondary healthcare services for the delivery of babies, as well as to reproductive and maternal healthcare services, at the same level as nationals.

Finally, vaccination is available for all children and adult residents (including asylum seekers and undocumented migrants) through their GP and baby clinics.

[71] This only applies to England. In Scotland, Wales and Northern Ireland all prescriptions are free for those registered with a GP.
[72] See www.nhs.uk HYPERLINK "http://www.nhs.uk" www.nhs.uk

FOCUS ON SWEDEN

"Everyone in Sweden has equal access to healthcare services under a largely decentralised, taxpayer-funded system[73]", says the official government website. Life expectancy in Sweden is among the highest in the world[74]. Yet Sweden is also among the worst countries in the EU in terms of access to the health system for undocumented migrants and asylum seekers. The latter only have access to care "that cannot be postponed", ante and postnatal care, family planning, abortion and dental care "that cannot be postponed", provided that they pay the €5.70 fee for every visit to a doctor or dentist[75]. Undocumented migrants and their children only have access to emergency care that is billed afterwards.

Only children of asylum seekers have the same access to medical and dental care as the children of nationals and authorised residents, even if their application for asylum has been rejected.

The main responsibility for the provision of healthcare services lies with the county councils and several have chosen to go further than the minimum provisions of the law and provide more healthcare to undocumented migrants than the current restrictive legislation requires. For instance, in Stockholm women can get access to antenatal care through a health structure financed by the county council (but they have to pay for their delivery).

In 2011, a government inquiry presented a report detailing different policy options to improve the current restrictive system for healthcare for undocumented migrants. The conclusion of the report was to propose that undocumented migrants should be given the same legal rights to healthcare as Swedes, which would allow Sweden to fulfil its obligations according to human rights conventions and would also be the most cost-effective solution for society. In June 2012, the current government said that a new law would be drafted providing undocumented migrants with the same limited access to healthcare as asylum seekers. The legal proposal is making its way through the Swedish legislative procedure and the bill is expected to be presented to the parliament in spring and will enter into force on 1 July 2013.

The Swedish MdM team fears that the new law's impact might be rather weak. Firstly, the meaning of care that "cannot be postponed" remains very vague and for the individual undocumented migrant it will be very difficult to know if the healthcare needed is covered by the law or not. In the end, almost all symptoms and illnesses will need (much more expensive) treatment that cannot be postponed. The new law offers no guarantees for patients with serious chronic illness, e.g. diabetes, cardiovascular problems, HIV or hepatitis, etc. without "urgent" symptoms.

Secondly, the Swedish police have recently boosted their REVA operation, which aims to increase the number of deportations of undocumented migrants. They are organising crackdowns and performing so-called "random" identity checks, although these are actually based on appearance (targeted at "foreign-looking" people using public transport). The resulting climate of fear prevents migrants from coming out of their hiding places to go and seek treatment.

In 2012, MdM Sweden received 405 patients[76] in its open clinic for whom data was collected. Over 80% of them needed an interpreter, and only 1.2% could not have one. The main countries of origin are Mongolia (23.7%), followed by Romania, Chile, Bangladesh and Russia (all under 4%). In total, Asia represents 35.4% of the patients, the Americas 17.7%, Sub-Saharan Africa 14.9%, non-EU Europe 12.6%, Middle and Near East 8.6%, European Union 6.3% and Maghreb 4.5%. None of the patients had access to health coverage in Sweden due to the fact that they had no national identity number because of their administrative status. The age of the patients and their pathologies were very similar to those in the other countries (see chapter on analysis of social and medical data).

[73] See www.sweden.se/eng/Home/Society/Health-care/Facts/Health-care-in-Sweden/

[74] See Sweden 2012 in: European Observatory on Health Systems and Policies

[75] Although there is a cost ceiling of €45 for every six-month period for some visits to doctors (emergency care excluded) and medication, after which asylum seekers can get reimbursement of other out-of-pocket costs, many patients delay seeking care because of this financial barrier.

[76] We could not analyse the data collected in Sweden together with the other data due to the fact that the team only answered a few questions from the common questionnaires.

FOCUS ON SWITZERLAND

In Switzerland, (private) health insurance is compulsory for all residents, including for undocumented migrants. The most important barrier to access to care for vulnerable groups is the **elevated cost of health insurance.** On average, an adult over the age of 26 must pay a monthly premium of €321, for young adults the premium is €292.50 per month and for minors (under 18 years) €74 per month[77]. Furthermore, the insured patient must pay an annual franchise[78] which varies between €248 and €2242 for adults (€0 to €497 for children) and the patient must contribute up to 10% of the cost of every service[79]. The higher the annual franchise is, the less the monthly premium costs. Consequently, many destitute people choose the lowest monthly premiums – a choice that causes extreme difficulties in the case of serious illness. Others simply cannot afford health insurance.

A partial or complete reduction in monthly premiums is possible for patients on low income but the conditions for obtaining it are very different from one district to another. The reduction is practically impossible for undocumented migrants. Finally, in the event of non-payment of the monthly premiums, the insurance fund can start legal proceedings. Consequently, **many undocumented migrants prefer not to start paying insurance fees for fear of being reported** and deported from the country.

Finally, as in most EU countries, many migrants lack information about their right to healthcare. Health insurers frequently refuse to insure undocumented migrants, despite their legal obligation to do so. In practice, many migrants need to rely on the scarce alternative services (both public and private) that offer primary care. Even in these cases, access to specialised treatments, examinations and drugs may be possible only with a contribution or a complete payment of the medical costs. The Swiss People's Party (UDC) maintains a populist anti-migrant discourse which has led to the approval of very restrictive measures concerning asylum and migration (e.g. detention of minor migrants is allowed as soon as they are 16, obtaining a residence permit is particularly difficult, etc.).

Patient story

Ms A is accompanied by a translator because she doesn't speak French. She is in her sixties and moves very slowly. She is breathless and her gestures are slow. We help her to sit down.

The person accompanying Ms A recounts how he saw her at the supermarket, exhausted, breathless, carrying her shopping but unable to walk any longer. He approached her, and by chance they spoke the same language: Togolese. One of his friends had told him about the existence of MdM Réseau Santé Migration (Health and Migration Network) in Chaux-de-Fonds in Switzerland.

The woman had suffered from poor health since her arrival in Switzerland three years before but did not know where to go. She self-medicated due to lack of money: *"My son who lives in Togo sends me insulin for my diabetes, and I have medicine to treat hypertension which I take in case of emergencies".*

But diabetes and hypertension are chronic illnesses requiring regular follow-up, which means that she is putting her health at risk.

She currently receives follow-up care from a doctor from our network. The improvement in her health has allowed her to perform her daily activities with greater ease. She now has time for a social and family life.

MdM Switzerland – Chaux-de-Fonds – November 2012

Since 2006, MdM Switzerland has created the Migrant Health Network (Réseau Santé Migration – RSM) in Chaux-de-Fonds, to offer paramedical consultations, psychosocial and counselling activities and referral possibilities, twice a week. Of the 169 consultations, 75% were led by a nurse and 25% by a social worker. 71% of the patients spoke French.

More than 80% of the patients are undocumented. Although a majority of the migrants come from Africa (60%), around 20% come from Europe and around 15% come from Central and South America. 6% of the patients are Swiss nationals.

[77] Confédération Suisse - Office fédéral de la Santé Publique (OFSP), Primes moyennes cantonales pour 2012/2013 de l'assurance oblig. des soins (avec accident), 27 sept. 2012 [Swiss Confederation - Federal Office of Public Health (FOPH), *Average Cantonal premiums for 2012/2013 for the compulsory health insurance (with accidents)].*

[78] The franchise is the amount which has to be paid by the patient before the insurance starts paying

[79] See www.guidesocial.ch/fr/fiche/55/%23som_134251. However, there is a cost ceiling of €580 per year for adults and €290 for children.

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