# Recommendations on access to health services for migrants in an irregular situation: an expert consensus

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This document is based on work by the International Organization for Migration (IOM) conducted within the framework of the project *"Fostering health provision for migrants, the Roma, and other vulnerable groups"* (EQUI-HEALTH), in collaboration with COST Action IS1103 ADAPT "*Adapting European Health Systems to Diversity*".

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This document was produced by Prof. David Ingleby (ADAPT) and Roumyana Petrova-Benedict (IOM MHD RO Brussels).

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# INTRODUCTION

In this document the term 'irregular migrant' (abbreviated throughout as 'IM'[1]) is used to refer to the target group of migrants in an irregular situation within the EU/EAA[2], i.e. those who "do not fulfil conditions for entry, stay or residence" (FRA 2011b). Most IMs in these countries originate from outside the region and are thus referred to as 'third country nationals' (TCNs), but people migrating within the region may also find themselves in situations of irregularity. Moreover, both migrants and non-migrants (for example, some members of the Roma community) may be denied access to health services for a variety of reasons. Most of this document applies to any group excluded from the benefits of Universal Health Coverage.[3]

This document has been produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with COST Action IS1103 ADAPT *(Adapting European health systems to diversity).* The recommendations reflect a consensus that was developed in the course of a series of joint international meetings in 2012-2016 attended by experts on migration, health policy, human rights law, health economics and epidemiology, as well as by representatives of intergovernmental and civil society organisations concerned with migrant health.

The document has the following structure. Firstly, the Recommendations are presented (in bold type), followed by brief summaries of the evidence and arguments on which they are based. This is followed by an Overview giving a more complete account of the evidence and arguments (research studies, reports, international treaties, policy initiatives and debates). At the end of each recommendation, a hyperlink leads directly to the relevant section of the Overview, which has three sections:

I. The present situation and its shortcomings
II. Arguments for change
III. What is required in order to improve access?

Why are these recommendations being launched now? The global importance of this topic was underscored at the UN Summit for Refugees and Migrants, which on 19th September 2016 adopted the "New York Declaration for Refugees and Migrants".[4] Member States committed themselves to **protect the human rights of all refugees and migrants *regardless of status*** [our italics]. In the past 15 years a great deal has been written and said about the denial of IMs' right of access to affordable health services: a list of selected publications is given in the Bibliography. In the course of this work, a considerable degree of consensus has been built up regarding the nature of the problems and the solutions they call for. However, against the background of an economic crisis and hardening attitudes to migrants across

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[1] Much of the literature uses the term 'undocumented migrants' (UDMs), which denotes the same group.

[2] Because legislation in Switzerland on health and migration is to a large extent harmonised with that in the EU and EEA, this document is also relevant to that country and it is included in the reported data. See e.g.:
http://ec.europa.eu/social/main.jsp?catId=559&langId=en
http://ec.europa.eu/social/main.jsp?catId=26&langId=en

[3] See http://www.who.int/universal_health_coverage/en/

[4] See http://bit.ly/2cKFLCK

Europe, there seems to have been little improvement in the policy environment. In several countries, the situation has in fact worsened.

Although most IMs initially entered the EU regularly, using documents that only later became invalid, the steep increase in the 'mixed migration flows' entering the region irregularly since 2014[5] adds new urgency to the topic of irregular migration. Many of these migrants were fleeing organised violence and subsequently regularised their presence by claiming asylum, but an unknown number did not. Moreover, many asylum claims will be rejected, adding further to the IM population in Europe.

At the same time, governments are adopting policies which restrict even more their rights and benefits (see Section III), in the hope of encouraging existing IMs to leave and deterring new ones from arriving. The tension between these restrictions and the demands of responsible health system governance is particularly acute at the present time, when Universal Health Coverage (UHC) is increasingly recognised as a marker of development and forms a key element of the UN's 17 Sustainable Development Goals (SDGs)[6] (which include six migration-related indicators). European and other industrialized countries are often assumed to have implemented UHC, whereas in fact few provide full coverage for all migrant members of the population. In contrast, great strides have recently been made by developing countries in implementing UHC (WHO 2015). This document aims to present clearly the arguments for improving IMs' access to health services, as well as that of all other groups excluded from proper coverage.

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[5] See FRONTEX (http://frontex.europa.eu ).

[6] See the 2030 SDG Agenda adopted in September 2015: https://unobserver.iom.int/2030-agenda-sustainable-development

# RECOMMENDATIONS

1. **The principle of universal and equitable health coverage should be applied to all persons residing *de facto* in a country, regardless of their legal status.**

   The access of IMs to health services in the EU/EEA is seriously limited. The main barriers are restrictive legal entitlements together with administrative barriers to exercising them; lack of knowledge among both service providers and IMs about entitlements; lack of information for IMs about health issues and how to use the health system; inadequate provision of 'cultural mediators'; and the threat – real or perceived – of being reported to the authorities. The degree to which health systems in each country are adapted to the particular needs of migrants also varies considerably. …..Ctrl+click for more

2. **Governments should honour their obligation to implement signed and ratified treaties committing them to uphold health-related rights, and are encouraged to ratify the treaties they have signed. More prominence should be given to the health-related rights of IMs and more legal action should be undertaken to defend these rights.**

   The existing situation contravenes human rights standards that most developed countries, including all EU/EEA member states and Switzerland, have agreed to uphold. The most important of these is Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR 1966), which obliges States Parties to achieve 'full realization of the right to health' for all. In *General Comment no.14* (2000), the committee responsible for interpreting the ICESCR ruled that this includes access to 'preventive, curative and palliative health services', specifically including 'illegal immigrants' [sic]. *General Comment no.3* (1990) stressed the provision of 'essential primary care' to all. These standards are seldom met for IMs in the EU.

   European-level instruments such as the European Social Charter and the Charter of Fundamental Rights of the European Union also contain relevant provisions, on which a considerable amount of jurisprudence exists. The potential of EU directives tackling discrimination for tackling inequitable health policies should be energetically explored, while the EU should initiate infringement proceedings when transposed directives are not implemented in practice by Member States. …..Ctrl+click for more

3. **In keeping with basic principles of public health, states should grant full access for IMs to all forms of primary care available to nationals.**

   Considerations of public health underlie policies found in many countries to waive restrictions on IMs' access to care in order to allow medical assistance during childbirth or for the treatment of infectious disease. However, neither of these measures can be effective without also allowing access to primary care, in order to facilitate appropriate guidance and regular check-ups during pregnancy, or to detect the presence of infectious disease. Indeed, the notion that emergency care alone is an acceptable minimum level of provision is fundamentally at odds not only with UN

treaties, but also with basic principles of modern public health. These principles stress the importance of universal and equitable health care coverage, including easily accessible primary care, as the first priority of health systems.
…..Ctrl+click for more

4. **In keeping with basic principles of <u>cost effectiveness</u>, governments should take into consideration the increasing amount of evidence that restricting access to primary care in fact costs more money than it saves.**

   In recent years increasing attention has been paid to the economic aspects of policies that restrict the entitlements of IMs to emergency situations only. A common argument against extending entitlements to include primary care has been that the additional cost would make it politically unacceptable. However, a growing body of research suggests that denying access to primary care actually costs more money than it saves. Prevention is cheaper than cure, while the earlier a health problem is detected the more effectively it can be treated and the less the treatment costs. The practice of giving routine treatments in accident and emergency departments, which is sometimes encouraged by rules of entitlement for IMs, is particularly inappropriate. …..Ctrl+click for more

5. **In accordance with human rights treaties as well as legislation on data protection, privacy and confidentiality of information, reporting of IMs by health workers or service provider organisations to police or immigration authorities should be explicitly prohibited. This prohibition should be strictly enforced and IMs should be given explicit reassurance that such reporting will not take place.**

   While there are many arguments for improving IMs' access to health services, one obstacle that needs to be overcome is the conflict between the IM's particular need for confidentiality vis-à-vis immigration authorities and the health system's need for comprehensive and accessible medical records. This conflict can only be resolved by ensuring the strict confidentiality of medical information, except in certain situations where the law always requires information to be reported to the police (e.g. suspected crimes of violence or compulsory treatments for reasons of public health). This approach has been described by PICUM (2016) as the construction of a 'firewall' between agencies responsible for immigration and those concerned with health and welfare. …..Ctrl+click for more

6. **In accordance with the treaties and directives that Member States have signed and ratified, special attention must be paid to protecting the health-related rights of <u>particularly vulnerable groups such as children, pregnant women and trafficked persons,</u> regardless of whether such persons are residing regularly in the country.**

   A number of international and European-level treaties and directives provide for special attention to be given to the health needs of children, pregnant women and trafficked persons. In many countries this is reflected in improved entitlements for these groups, but this is not the case in all countries or to the same extent. …..Ctrl+click for more

7. **Increased research efforts are needed to identify the health problems for which IMs are particularly at risk. Existing knowledge about their help-seeking behaviour should be improved, while sound epidemiological methods should be used to estimate the health risks affecting them.**

   The social disadvantage and exclusion to which IMs are exposed is likely to increase their vulnerability to a wide range of health problems, but there is a serious shortage of good data on the prevalence of health problems among IMs. Some information is available about their use of mainstream health services and NGO clinics and the problems for which they seek help, but standard epidemiological methods for estimating prevalence can seldom be used because of the lack of control groups and demographic information. Overcoming these problems requires intensified research efforts. …..Ctrl+click for more

8. **In order to improve our understanding of the health of IMs, the serious shortage of reliable and up-to-date information about their numbers, living conditions and employment, as well as their demographic and other characteristics, must be remedied urgently by funding and carrying out more research.**

   Although several million migrants in the EU and EEA are in an irregular situation and the topic is politically highly controversial, there is an acute shortage of reliable information on this topic. Since a study carried out in 2007-2009, no comprehensive survey of numbers and trends has been made.

   Despite this lack of information, it is known that irregularity more often results from documents becoming invalid rather than unauthorised entry, notwithstanding the fact that figures for the latter have been on the increase since 2012. In most countries, IMs have far fewer entitlements of all kinds than nationals or regular migrants. They have hardly any access to social protection schemes and in many situations they will be deterred from pursuing claims for fair treatment, for fear of coming to the attention of authorities and risking detention and deportation. They generally work in informal, precarious employment and are highly vulnerable to exploitation. Some sectors of local economies are heavily dependent on their contribution. Nevertheless, greatly increased funding is required from EC and national sources to collect the information about their living situation that is needed to formulate wise policy. …… Ctrl-click for more

9. **Efforts to combat myths and misunderstandings about IMs should be intensified using all forms of media, especially in relation to health and health care utilization and alleged ‘pull’ factors. This also involves carrying out more research on the contributions of IMs to societies (for example in the health sector and in home care), and disseminating the results.**

   Widespread myths and misconceptions lie at the root of many of the existing policies on IMs. To obtain public support for improved policies, information campaigns will be required to challenge these popular beliefs. In particular, the justification often given for restricting IMs' access to health services is that it is necessary in order to encourage them to leave the country and to deter others from immigrating or residing irregularly. There is however no empirical support for the assumption that the restrictiveness of health policies affects levels of irregular entry or residence. Empirical evidence suggests that irregular migration in order to gain health benefits is extremely rare, while denial of health services – quite apart from the objections on human rights, public-health and cost-benefit grounds – does not appear to promote return to the home country. …..Ctrl+click for more

10. **In order to be equitable and politically acceptable, access to health services for IMs should be accompanied by contribution arrangements that will not be perceived as unfairly privileging this group over nationals and regular migrants. More work is required to identify appropriate modalities of contribution to services by IMs and their employers.**

    Extending health care entitlements to IMs should not be done in a way that is seen to give them an advantage over other groups who may also be disadvantaged and socially excluded. They – as well as their employers – should contribute financially to the same extent as is required for other migrants and nationals. Such 'up-front' contributions for health services by IMs should be progressive (i.e. they should take personal financial and social circumstances into account, as they do for nationals), and should not penalise those with greater needs for care. A 'one-size-fits-all' strategy for implementing better entitlements in each country does not seem realistic. ….Ctrl+click for more

11. **As well as improving effective health coverage for IMs, it is essential to ensure that health services are responsive to their special needs and to remove other barriers to reaching care.**

    Apart from restricted legal entitlements to care, many other barriers impede the access of IMs to health services. Many of these are also experienced by other migrants, as well as by some ethnic minorities and other marginalised groups. At present, however, the existence of legal barriers has made it necessary to devise special ways to deliver services to IMs. For example, because of anxieties about being reported to the authorities, IMs may be reluctant to participate in activities organised to provide migrants with information about using health services. Improving entitlements and banning reporting will in most cases remove the necessity for separate 'good practices' targeted at irregular migrants in order to facilitate access and tackle barriers of language and culture. …..Ctrl+click for more

12. **National governments, IGOs, NGOs, CSOs, public health experts and researchers must join forces and present a united front in support of the health-related rights of IMs. The aim should be to integrate IMs fully into mainstream service provisions, while CSOs can continue to perform a vital role in the development, implementation and monitoring of new policies.**

CSOs have played a central role in advocating for better health policies for IMs and in filling gaps in service provision. Improved policies will reduce the need for these services, but the experience of CSOs and their unique lines of communication with the target group make them indispensable partners in the development and monitoring of new policies. …..Ctrl+click for more

# OVERVIEW OF THE MAIN ISSUES

## I. THE PRESENT SITUATION

### 1. Current population and main characteristics of IMs in Europe

The most recent Europe-wide study of migrants in an irregular situation was undertaken by CLANDESTINO (Clandestino Project 2009) in 2007-2009. The project's subtitle, *Counting the uncountable*, sums up a basic feature of irregularity: its very nature presents great challenges for collecting reliable data. Few hard and fast statistics are available; for example, we know how many IMs are apprehended, but the number who are not can only be estimated. Nevertheless, enough is known to enable the contours of the phenomenon to be sketched.

**Types of irregularity.** Although irregularity is often equated with unauthorised entry (either clandestine or using false or invalid documents), the majority of migrants in an irregular situation in Europe have arrived through regular channels. Most are 'overstayers', i.e. they have ceased to satisfy the conditions for being allowed to reside in the country (Düvell 2009). This may be because their visa has expired, or because the conditions it imposes are no longer met, or because a claim for asylum has been rejected and the claimant is unwilling or unable to comply with orders to leave the country. A migrant granted a residence permit for purposes of marriage, who subsequently has to leave their partner because of (for example) domestic violence, may also become irregular. An overseas student permitted to work only for a certain number of hours in the year will become irregular the moment they exceed this number. Moreover, IMs who have obtained a residence permit in the context of a 'regularisation campaign' may lose it again if they become unemployed, as has happened to many migrants in Spain during the recent recession. Some IMs are 'transit migrants' on their way to a different destination country, where they may or may not intend to make an asylum application. Often this is done in an attempt to circumvent the Dublin regulations, which require them to be sent back to the first EU country they can be shown to have entered; but as Düvell (2008) points out, the intentions of so-called 'transit migrants' are largely unknown and probably subject to change *en route.* Finally, there are the children of IMs, who are born into irregularity.

Most IMs in the EU/EEA and Switzerland are TCNs who have migrated from a country outside this area, but nationals of countries within the area can also become irregular in another such country because such 'internal' migration is not free of conditions. Except for students and direct family members of regular migrants, those unable to find a job or to support themselves financially will at a certain point lose their right to stay. The situation of such irregular 'internal' migrants regarding health care coverage is complex. As long as their stay is authorised, they will normally be eligible to join the national system of health care coverage in that country. However, if this requires an application to join the system and they fail to take this step, or to pay any necessary premiums, they will be 'uninsured' – just like nationals who fail to do this. Regulations concerning health coverage for uninsured persons differ between countries, but often involve severely restricted access to services.

Nationals of EU/EEA countries and Switzerland migrating for brief periods (for example seasonal workers) will normally be covered by their country of origin, which can issue them an 'EHIC Card' (European Health Insurance Card) for this purpose. However, if their home country has a social insurance system and they do not participate in it, they will also lack coverage in the country to which they have moved. To sum up, restricted coverage is by no means a problem that only affects TCNs.

**The 'rights deficit'.** Most IMs are in precarious or informal employment and living in conditions of marginalisation and social disadvantage. Especially when unemployment runs high, as it currently does in much of the EU, the only way they can support themselves is through work that others are not prepared to do, because of its 'difficult, dangerous and demeaning' nature, unsocial hours of work, or low rates of pay. IMs are seldom entitled to forms of social protection such as sick pay or unemployment benefit, while their lack of *de jure* resident status forms a barrier to entering into formal contracts with employers or landlords. This renders them dependent on informal agreements, unprotected by contractual rights. Their lack of legal rights is compounded by the fact that they cannot, in practice, claim the few rights which they do have as human beings without bringing themselves to the attention of the authorities and risking detention and deportation. As a result, they are virtually defenceless against exploitation. Within the political system, their voice is unheard and their interests are unrepresented. It is for this reason that the responsibility for defending their interests falls on intergovernmental and civil society organisations.

**Employment.** Because IMs are generally excluded from participating in the formal labour market, they are disproportionately represented in the informal ('black') economy which exists to a greater or lesser extent in every country. The European Agency for Safety and Health at Work (EASHW 2007) states that "illegal [sic] immigrants in particular may be recruited, exploited and abused by unregistered agencies and employers, using false promises of good pay, conditions and housing. They may be forced to work extremely long hours, have low pay and substandard accommodation. Because of their precarious situation, people have no choice but to accept these jobs. Undocumented workers were more likely to rate the job they were doing as carrying major risks and assess the health and safety procedures at their work as unsatisfactory."

Sectors that are particularly hard to inspect and regulate, such as domestic work, agriculture, construction, the hotel and restaurant industries and the sex industry, may become dependent on IMs in order to remain viable. As a result of this symbiotic relationship, IMs often occupy an ambiguous position in society. Without the availability of this flexible, mobile pool of low-paid and easily exploitable labour, production would fall, prices would rise and many businesses would collapse.

The most detailed studies of the economics of irregular migration have been carried out in the USA, where the phenomenon is generally better documented than in Europe. While the findings of American studies cannot be directly extrapolated to countries with different policy regimes, they are nevertheless indicative of the potential impacts. For example, U.S. Government surveys have found that about half of all hired workers in U.S. crop agriculture are irregular (Zahniser et al. 2012:477). Implementation of a new law against irregular migration in the state of Georgia in 2011 led to estimated losses of $140 million, as crops rotted in the fields (Powell 2012).

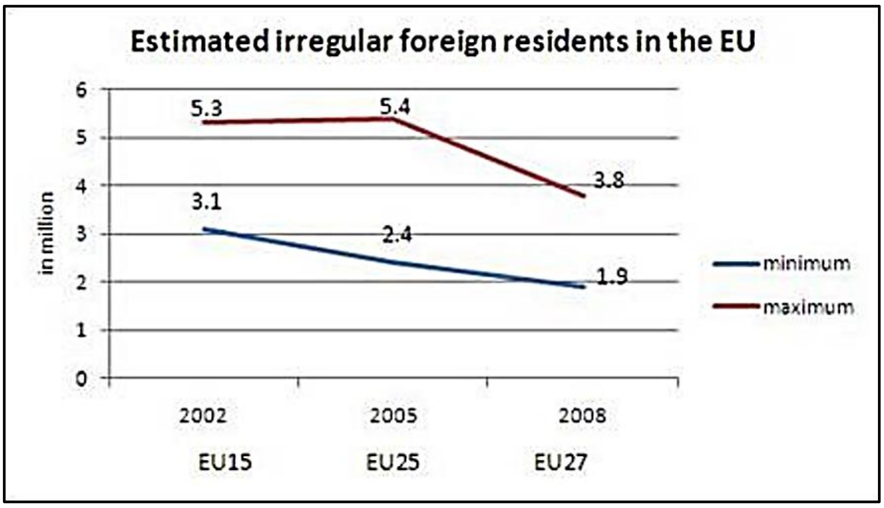
Studies carried out in Europe also demonstrate the important role of IMs in some employment sectors, particularly domestic labour and home care. PICUM (2004), OHCHR (2011), FRA (2011a) and ILO (2013, 2016) have all drawn attention to the lack of rights for regular and irregular migrant care workers and the dependence of many countries on this source of cheap labour. More specifically:

- An EU-supported study published by Soleterre/INS (2015:17-18) indicated that there are at least 830.000 family caregivers in Italy, of whom 90% are migrants and the majority have no employment contract. An estimated 26 % of the total – i.e. one-quarter of a million people – are IMs.
- In Austria, the 'care amnesty' under which 9,000 migrant care workers were regularised in 2007-2008 was argued for on the grounds of the essential nature of the work these migrants carried out. Supporters of this legislation invoked the notion of a 'care emergency' *(Pflegenotstand)*: its purpose was to benefit not the migrants, but the families that employed them. (Chauvin et al. 2013).
- A similar situation was found in Ireland (MRCI 2015), where 30% of a sample of IMs were found to be employed in the domestic work sector. Both regular and irregular migrant care workers work in an unregulated market and are exposed to conditions frequently amounting to exploitation.

The economic recession may have retarded the growth of demand for low-paid labour in this sector, but it did not slow down the ageing of the population and the corresponding increase in its care needs: the MRCI report cited above pointed out that "every 30 minutes, someone in Ireland turns 80", while "every 15 minutes, someone turns 65". At the same time, immigration policies in the EU have become steadily more restrictive (PICUM 2015). As we have seen, many European countries rely on migrant women domestic workers to look after families with children in which both parents go out to work, as well as elderly people whose offspring cannot or will not look after them (Ambrosini 2010; FRA 2011a). Because many of these countries set up quotas for the immigration of domestic workers which do not meet the real labour market needs (Kontos 2009, 2011), it is inevitable that a large part of the irregular workforce will consist of female domestic workers. Depending on the country, 70-90% of all domestic work may be undeclared (ETUC 2005). As in other sectors, these workers are vulnerable to exploitation and unprotected against loss of income. They may in turn be sending money to their country of origin to pay others to look after their own children – cf. the 'global care chain' described by Hochschild (2000). Because of their irregular status, they may not be able to risk visits to their home country to see their children growing up, thus adding to the hardships already experienced by such children and families (Wickramage 2015; Yanovich 2015).

Although domestic labour is perhaps the best documented sector in which IMs play a vital role, it is far from being the only one. President Sarkozy's campaign against *sans papiers* in France during 2008 was met with widespread protests – not only from the migrants themselves, but also from their employers in the construction, cleaning, restaurant and hotel industries (New York Times 2008). The presence of IMs is often tacitly condoned, at the same time as their exploitation is made possible by the denial of their rights.

**Numbers.** Earlier this century the CLANDESTINO project[7] estimated that numbers of IMs in the EU were decreasing, due to EU enlargement, regularisation campaigns and stricter controls. (See the graph below from Kraler and Rogoz 2011, as well as Kovacheva and Vogel 2009). However, it is unclear how numbers have changed since 2008. Morehouse and Blomfield (2011) showed that detections of both 'overstayers' and migrants entering without authorisation declined slightly between 2008 and 2011, but this only concerns a fraction of the total numbers. The European Parliament's briefing *Irregular immigration in the EU: Facts and Figures* (EP 2015) lacked up-to-date information about IMs. In view of the importance of the topic, it is striking that no work has been financed to update the CLANDESTINO project except for reports on Greece and Germany.



Whereas regular migration is usually related to economic cycles, this does not necessarily apply to irregularity (Kraler and Rogoz, ibid). Residence permits are often dependent on remaining employed, so that rising unemployment as a result of the recession will have increased the numbers of IMs. Reduced purchasing power may also lead to increasing use of the informal economy (Ambrosini, op. cit.: 36). The greatly increased number of migrants entering the EU without authorisation in 2014 and 2015 is more likely to be due to 'push' factors (wars, instability, poverty, famine, and drought) than to any recovery of the EU economy. This influx is likely to lead to an increase in the ratio of unauthorised entry to 'overstaying' as causes of irregularity.

Despite the considerable margin of uncertainty, it is likely that IMs currently form 1% or less of the total EU population, i.e. under one in ten of its migrants.

## 2. Health needs of IMs

As a starting point, it may be assumed that IMs will have the same range of everyday health needs as any other human beings, taking account of their demographic characteristics. In

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[7] See http://irregular-migration.net

this respect, it is particularly important to be aware of the different situations of irregular migrant men and women. Apart from their physiological differences, the type of work they do tends to be different, as do their living conditions and the particular hardships and health risks they are subject to.

Migrants in general tend to be younger than the non-migrant population and although exact figures are unknown, IMs do not seem to be an exception. Reference is often made to the 'healthy migrant effect', i.e. the finding that migrants are healthier than the majority population on arrival, but their health gradually declines to the national level. However, migrants coming from extremely disadvantaged backgrounds may not have such a head start, while living in the conditions that characterise IMs in Europe (precarious work, poor housing, low income and social exclusion) is more likely to cause a rapid deterioration in health than a slow one. In addition, IMs are usually excluded from health education, health promotion and preventive interventions which protect the health of nationals.

Just as little else is known about IMs, there is hardly any reliable evidence about how their state of health compares with that of nationals or other categories of migrant. One reason is that we can never know how well a sample of IMs represents the entire population of IMs, because we do not know the demographic characteristics of this population.

All other groups in society can, with varying degrees of effort, be surveyed to establish their demographic and other characteristics. Research samples can be recruited in which selection bias is kept to a minimum; complete absence of bias is not necessary, because results can be adjusted to compensate for imbalances. However, research samples of IMs can only be recruited in a limited range of settings. Their names are not to be found on any lists and when approached by post, telephone or face-to-face, they are unlikely to voluntarily disclose their irregular status.

Where is it possible to find samples of IMs? Opportunities exist in health services in countries such as Belgium, Italy or the Netherlands, where IMs have access to mainstream health care and their records are separately identifiable. Special clinics set up by NGOs for migrants are another source. In such clinics irregular status is easy to establish and data on medical problems are available. NGOs have been particularly active in collecting data on the problems for which IMs seek health at their clinics. In several studies, users of clinics have also been invited to take part in testing or screening programmes to identify problems they may not have known they had. However, the IMs who use mainstream or NGO services may not be representative of all IMs.

To estimate the prevalence of health problems in a given group epidemiologists prefer to use *population-based* samples, which have a known relationship to the whole group. In fact, the difference between clinical and population-based samples is only one of degree, not of kind: any method of sampling may be subject to selection biases which distort the results. Nevertheless, there is usually more opportunity to minimise or control for biases in samples recruited in a non-clinical setting.

Clinical data are mainly useful as an indication of the kinds of problems that services can expect to deal with, but the information they can give us about the prevalence of these problems outside the clinic is limited. As Kukull et al. (2012) point out, the problems involved in extrapolating from clinical data to an entire group are much harder to overcome than is usually realised. For example, we can take a sample of patients identified as having TB and count the cases who are IMs, regular migrants and nationals. Yet these data can tell us little about prevalence rates unless we know the size of each group in the general population – data which are not available with any precision for IMs.

Despite this, it is usually safe to assume that the number of IMs in the general population is lower than the number of nationals and other migrants. This allows us to conclude that if IMs are the largest group with TB infections in a random sample of mainstream service users, the prevalence of TB among IMs is probably higher than in the general population. Most of the time, however, we need to know to what extent selection biases have affected the proportion of IMs in the sample – or at least have a method of controlling for such biases. In general, we expect that IMs will be less well represented in a mainstream clinical sample than other groups, but the opposite will be the case in a service specially set up to reach IMs. Finally, we need some data about the demographic profile of IMs, to be sure that differences found are not due to these background variables. It would be an exaggeration to say that clinical data tell us nothing at all about the prevalence of diseases among IMs – but a great deal of informed guesswork is necessary to draw any useful conclusions from such data. More carefully constructed and elaborate research studies are required, whereas funding is usually only available for rather basic ones. In addition, distinctions must be preserved between specific groups of IMs: there is no reason to think all IMs will have a similar health profile, any more than regular migrants do.

De Vito et al. (2015) carried out a systematic review of publications on the health of IMs, but closer examination of the articles they located shows that most data were collected in clinical settings. Moreover, only estimates were available regarding the total population of IMs in each country. We are forced to conclude that given the present methodological limitations, epidemiological knowledge about IMs is extremely inadequate.

The same authors pointed out another feature of research on IMs which can create misleading impressions. Most studies focused on specific conditions rather than covering the whole range of health problems, and the topic most frequently investigated was infectious disease (16 out of 40 studies located, i.e. 40%). The fact that more data are available on this topic than on any other can give rise to the impression that infectious disease is the main health problem that IMs suffer from, when in fact it is simply the main problem that researchers look for.

Nevertheless, a lot of information is available from NGOs, as well as a small amount from regular service providers, about the problems for which IMs most often seek help from them. Complaints reported by MdM (2007) from its clinics include (in order of frequency) digestive, musculoskeletal, respiratory, gynaecological and ‘general and non-specific’ problems. PICUM (2010) reports that psychosocial problems are particularly common (especially depression, anxiety and sleeping problems) and also mentions substance dependencies. The EU-financed project *Health Care in Nowhereland* (Trummer et al. 2010) surveyed 71 governmental and non-governmental service providers and found that the main problems reported, in order of frequency, were mental health, infectious disease, sexually transmitted diseases and HIV, sexual and reproductive health, general health problems and dental health.

All in all, the methodological problems of carrying out epidemiological research on IMs prevent us from getting a clear picture of the conditions for which they are particularly at risk. More research efforts are urgently needed to improve the state of knowledge in this area of public health. But even though good data may be lacking, we can predict on the basis of what we already know about the social determinants of health (see e.g. WHO 2010:14; 2013) that the conditions in which IMs live are likely to increase the risk of a wide range of health problems. These include both non-communicable and infectious diseases, work-related illnesses and injuries, problems of sexual and reproductive health, and the negative effects of discrimination on physical as well as mental health (Pascoe and Smart Richman 2009).

## 3. IMs' access to appropriate health services

Migrants in irregular situations provide an example of what Tudor Hart (1971) termed the Inverse Care Law: "the availability of good medical care tends to vary inversely with the need for it in the population served". In high-income countries, the problem for IMs concerns not so much availability as *accessibility.* The necessary services and treatments are there, but severe limitations are placed on IMs' ability to use them.

Access to health services is determined by many different factors. The crucial issue is usually the *affordability* of care: anyone with sufficient money can obtain almost any treatment, but for most people it is necessary that the care should be 'covered' as part of the basket of services to which they are entitled. Coverage is usually determined by national legislation. However, legal entitlements can be undermined by administrative procedures which stand in the way of exercising them. These procedures are usually determined by ministries and health authorities rather than parliaments, and they can have the effect of nullifying the entitlements that lawmakers intended. To claim entitlements, documents may be required which are difficult for migrants to obtain. Another barrier is administrative discretion, which may concern the decision as to whether a health problem is sufficiently 'urgent' or 'essential', as well as whether the migrant can afford to pay for care themselves (either in cash or using private health insurance).

Starting in 2007, many studies have been published on barriers to health care access for IMs in Europe (e.g. PICUM 2007, 2009; MdM 2007, 2009, 2015a, 2015b; HUMA 2009, 2010; FRA 2011b). A problem in this area is that studies tend to involve different selections of countries, methods and criteria. This has made it difficult to develop knowledge in this field in a cumulative fashion. However, a study carried out by the EU Fundamental Rights Agency (FRA 2011c) covered all EU countries, as did the 'Nowhereland' project[8] (PICUM 2010; Björngren Cuadra and Cattacin 2011; Cuadra 2012).

The most recent comprehensive report is the study on migrant health policies carried out by IOM (EQUI-HEALTH), COST Action ADAPT and the Migration Policy Group (MPG) to enrich

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[8] www.nowhereland.info

the 2015 MIPEX (Migrant Integration Policy Index) with an additional strand on health.[9] In this collaborative undertaking a wide range of policy issues relating to migrant health was investigated in 40 mainly European countries. Thirty-eight indicators were used, grouped into four scales, using standardised scoring criteria in order to make systematic comparisons between countries possible. A list of the questions is given in the Appendix. Within each country, policies for 'legal migrants' (in effect, migrant workers from third countries), asylum seekers and IMs were scored separately, respondents adding written comments to clarify the scores given. The MIPEX survey is repeated at four-year intervals, so it will also be possible to monitor changes in migrant health policies over time. A Summary Report on the findings from this project is in preparation (IOM, in press) and 30 detailed Country Reports will be published later in 2016, both as part of the IOM's 'EQUI-HEALTH' project.[10]

An important difference should be borne in mind between first-hand reports and studies of policy such as MIPEX. Many organisations have collected narrative material on migrants' experiences while seeking and receiving health care. Other studies (such as MIPEX) focus on policies, while some combine the two types of data. MIPEX does not confine the concept of 'policy' to the level of government, but also examines policies of service providers, insurers, local administrators, professional bodies, etc. However, policies describe the rules that govern day-to-day interactions, rather than what actually happens in practice. In accounts of IMs' experiences it is sometimes difficult to judge whether a reported incident reflects rule-following or rule-breaking, and how representative it is. Health workers can deny care to IMs to which they are entitled, but they can also do the opposite. There is a shortage of reliable data in this area on the relationship between rules and reality. Below we discuss results from the four sections of the MIPEX Health strand questionnaire in turn

**Entitlement to health services** is covered by the first of the four sections of the questionnaire (Section A). The score for entitlement is made up of two components: *legal entitlements* and *freedom from administrative barriers*. A total score of 100% indicates complete parity with nationals, while 0% means that migrants are totally excluded from health care coverage.[11] Average scores for the three categories of migrants studied, based only on the EU28 plus Norway, Switzerland and Iceland (31 countries total), were as follows:

| | Migrant workers | Asylum seekers | Irregular migrants |
|---|---|---|---|
| Legal entitlements | 79 | 74 | 49 |
| Freedom from administrative barriers | 61 | 45 | 21 |
| Summed entitlement score | **70** | **59** | **35** |

We see that even regular migrant workers enjoy only 70% of full entitlement, and this percentage decreases across the categories to 35% for undocumented migrants. As the level of legal entitlements goes down, the number of administrative barriers increases. This is

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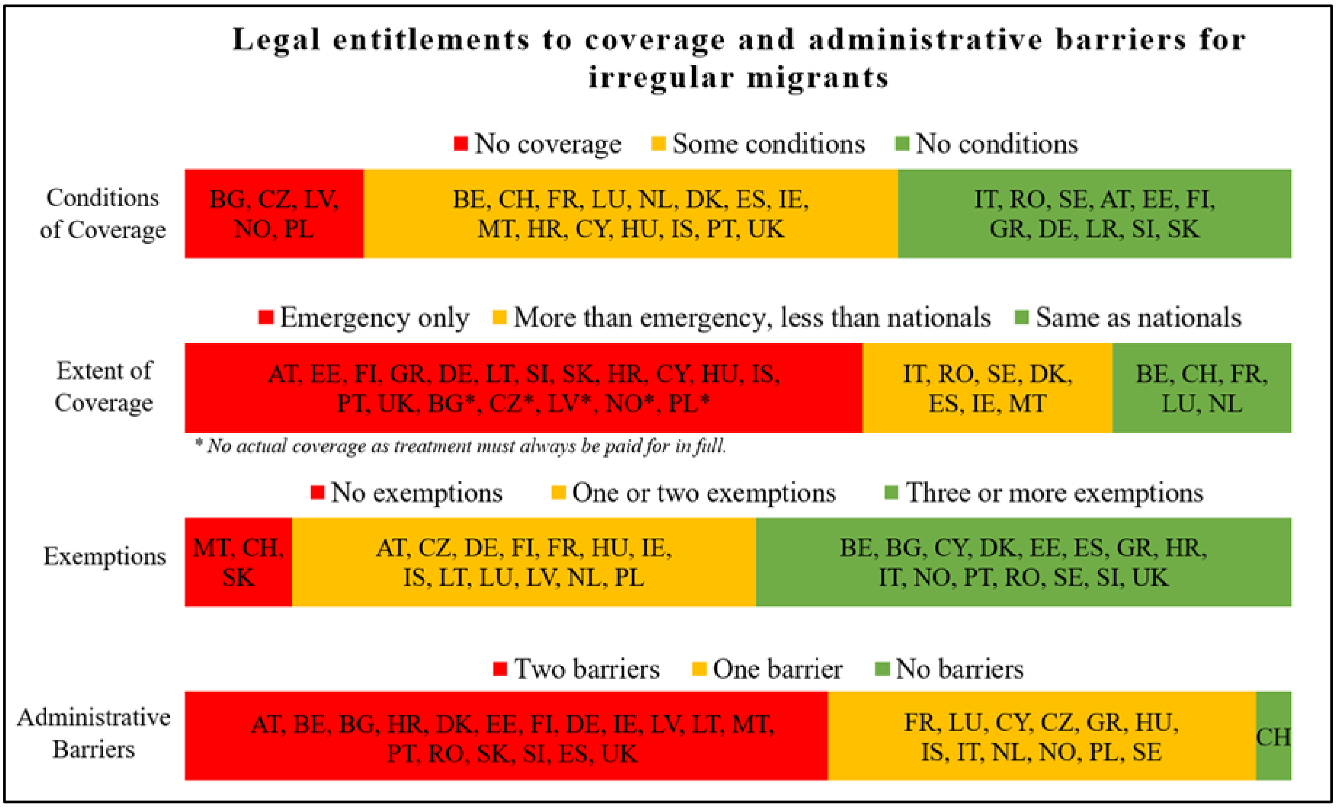
[9] www.mipex.eu

[10] See http://equi-health.eea.iom.int

[11] Like many social-scientific instruments, MIPEX combines qualitative indicators to make quantitative variables. Because this procedure involves several untested assumptions the scores should not be regarded as precise, though they do give reliable indications of trends in the data.

logical, because increasing levels of restriction are accompanied by more paperwork and opportunities to exercise administrative discretion.

A country's score for *legal entitlements* is based on the conditions for inclusion in a system of coverage, the basket of services covered, and the exemptions from restrictions which are available for 'vulnerable groups' or conditions regarded as a threat to public health. The score for *administrative barriers* relates to demands for documents that are difficult for migrants to produce, or to discretionary judgements by medical or administrative staff. The following table shows the results from the four items in Section A of the questionnaire.



**Legal entitlements to coverage and administrative barriers for irregular migrants**

Conditions of Coverage

🟥 No coverage 🟨 Some conditions 🟩 No conditions

| | No coverage | Some conditions | No conditions |
|---|---|---|---|
| Conditions of Coverage | BG, CZ, LV, NO, PL | BE, CH, FR, LU, NL, DK, ES, IE, MT, HR, CY, HU, IS, PT, UK | IT, RO, SE, AT, EE, FI, GR, DE, LR, SI, SK |

| | Emergency only | More than emergency, less than nationals | Same as nationals |
|---|---|---|---|
| Extent of Coverage | AT, EE, FI, GR, DE, LT, SI, SK, HR, CY, HU, IS, PT, UK, BG*, CZ*, LV*, NO*, PL* | IT, RO, SE, DK, ES, IE, MT | BE, CH, FR, LU, NL |

** No actual coverage as treatment must always be paid for in full.*

| | No exemptions | One or two exemptions | Three or more exemptions |
|---|---|---|---|
| Exemptions | MT, CH, SK | AT, CZ, DE, FI, FR, HU, IE, IS, LT, LU, LV, NL, PL | BE, BG, CY, DK, EE, ES, GR, HR, IT, NO, PT, RO, SE, SI, UK |

| | Two barriers | One barrier | No barriers |
|---|---|---|---|
| Administrative Barriers | AT, BE, BG, HR, DK, EE, FI, DE, IE, LV, LT, MT, PT, RO, SK, SI, ES, UK | FR, LU, CY, CZ, GR, HU, IS, IT, NL, NO, PL, SE | CH |

**Key to country codes**

| | | | |
|---|---|---|---|
| AT | Austria | IS | Iceland |
| AU | Australia | IT | Italy |
| BE | Belgium | LT | Lithuania |
| BG | Bulgaria | LU | Luxembourg |
| BH | Bosnia-Herzegovina | LV | Latvia |
| CA | Canada | MK | Former Yugoslav Republic of Macedonia |
| CH | Switzerland | MT | Malta |
| CY | Cyprus | NL | Netherlands |
| CZ | Czech Republic | NO | Norway |
| DE | Germany | NZ | New Zealand |
| DK | Denmark | PL | Poland |
| EE | Estonia | PT | Portugal |
| ES | Spain | RO | Romania |
| FI | Finland | SE | Sweden |
| FR | France | SI | Slovenia |
| GR | Greece | SK | Slovakia |
| HR | Croatia | TR | Turkey |
| HU | Hungary | UK | United Kingdom |
| IE | Ireland | US | United States of America |

What stands out in the written comments on these scores is the widespread use of adjectives such as ‘emergency’, ‘urgent’, ‘essential’, ‘acute’ (etc.) to describe the health problems for which help may be given, and the fact that administrative discretion is so frequently involved. This confirms the findings of the many other studies in this area. Health care for IMs is dominated by the concept of ‘emergency’, while criteria are elastic (often to the point of often being totally unpredictable). We will see later that providing only emergency care makes no sense in terms of public health considerations and cost-efficiency.

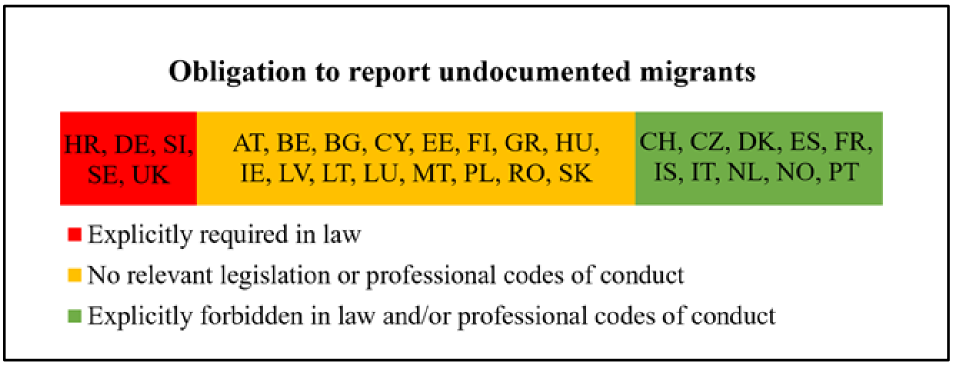
It ignores half a century of global experience concerning the importance of prevention, primary care, early intervention, good medical records and continuity of care.

In addition, the heavy reliance on administrative discretion means that entitlements to health care for IMs are seldom clear-cut and reliable, but depend on unpredictable judgements by health professionals or administrators. As a result, the risk of having to pay crippling medical bills is likely to deter many IMs from seeking help when they need it. The almost universal exercise of administrative discretion probably accounts for much of the variability in implementation of entitlements for IMs, which was identified in an EU report (EXPH 2015:102) as a major barrier to health service access for IMs.

Exemption from restrictions in the case of infectious disease and maternity care are common, though it should also be mentioned that such exemptions have limited usefulness if there is no easy and continuous access to primary care. For example, an IM may be entitled to free treatment for infectious disease, but a prior medical consultation will usually be necessary in order to reveal that they have such a disease. A pregnant woman may be entitled to free hospital delivery, but the risk of perinatal complications will be greatly increased if no opportunity is provided for free check-ups and advice from an early stage in the pregnancy (Hadrill et al. 2014).

**Accessibility of services (Section B)** relates to other kinds of access barriers which may inhibit migrants from seeking care, even when their entitlement to it has been recognised (e.g. by issuing a health card). This concerns the provision of information about entitlements and use of the health system, as well as health education and promotion and the availability of ‘cultural mediators’ or ‘patient navigators’. NGOs and other bodies have consistently reported that service provider organisations, health workers and migrants themselves are all badly informed about IMs’ entitlements to health care, while migrants seldom receive information on how to use the health system. These qualitative findings are again confirmed by the quantitative results from MIPEX. Thirteen out of the 31 countries had no policies for providing information to service providers and their employees about migrants’ entitlements. In 21 countries there was no provision of information to IMs about their entitlements and how to use them, apart from that which might be provided by NGOs. Provision of health education and health promotion was at the same low level, while ‘cultural mediators’ were only available for IMs in 11 countries. Roughly speaking, the provision of all these aids to accessibility was only about half of that found for ‘legal migrants’ and asylum seekers, which was in any case not high.

Regarding the crucial issue of **confidentiality** for IMs, the last item in this section showed that protection against reporting to the immigration authorities is extremely inadequate in the sample as a whole.



**Obligation to report undocumented migrants**

| | | |
|---|---|---|
| HR, DE, SI, SE, UK | AT, BE, BG, CY, EE, FI, GR, HU, IE, LV, LT, LU, MT, PL, RO, SK | CH, CZ, DK, ES, FR, IS, IT, NL, NO, PT |

🟥 Explicitly required in law

🟨 No relevant legislation or professional codes of conduct

🟩 Explicitly forbidden in law and/or professional codes of conduct

**Responsiveness of services (Section C)** refers to policies governing the responsiveness of services to migrants' particular needs (availability of interpreters, standards and training for 'cultural competence' or 'sensitivity to diversity', participation of migrants in service delivery, etc.) Items in this section were not answered separately for the three categories of migrants; the degree to which services are adapted was assumed to be independent of the legal status of the migrant being treated. This assumption may not be entirely justified when separate services are provided for a particular category. For example, the responsiveness of services provided on-site to IMs in detention centres might differ from that in mainstream service providers. For specialist care, however, such IMs are usually transferred to external services. The situation of migrants in detention will be covered in the forthcoming Country Reports for the EQUI-HEALTH project[12] (see also Rijks et al. 2016).

**Measures to achieve change (Section D)** include 'flanking measures' such as data collection and research, as well as measures to coordinate policies, promote collaboration between stakeholders and provide leadership. Particularly striking here was the finding that countries with a tax-based system of health financing tended to score more highly on this section than countries with a social health insurance system. It was not clear what underlies this difference.

Broadly speaking, the first two MIPEX sections (A and B) are concerned with getting those who need it into care ('access'), while the second two (C and D) concern the appropriateness ('quality') of the care given. The figure below shows the relative positions of different countries when these two variables are plotted against each other. In this figure, the scores for Section A on entitlements are those for IMs alone; the grid lines are placed at the median on each axis, so that half the countries are above the line and half below. Particularly striking is that IMs in Iceland and France have good access to services, but the degree of responsiveness to their special needs is low; in the UK the converse is true. The relative importance of 'access' and 'quality' from the migrants' point of view is hard to decide objectively, but we are inclined to conclude from this graph that in Europe, only Switzerland, Italy, Spain, Belgium, Sweden, and the Netherlands offer reasonably adequate health services to IMs. (For purposes of comparison the position of non-European countries, as well as Bosnia-Herzegovina and FYR Macedonia, is also shown in the following graph.

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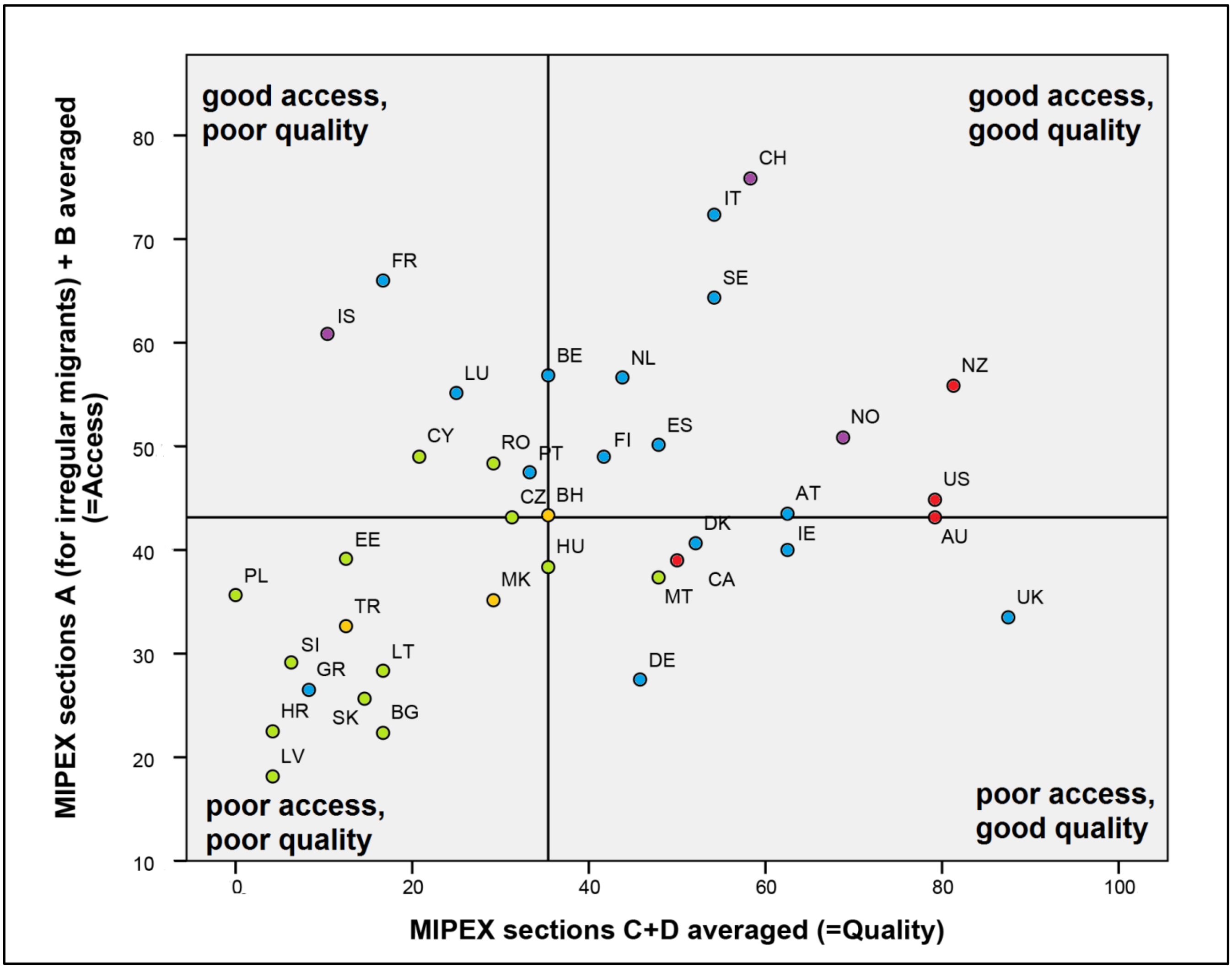
[12] See http://equi-health.eea.iom.int



**‘Access’ plotted against ‘Quality’ in 38 countries**

*Key to colours:*
Blue: EU15 countries
Purple: EEA countries and Switzerland
Green: post-2000 accession countries
Yellow: EU neighbour countries
Red: Non-European countries

Some scores reported here can be potentially misleading because they may be affected by differences in migrant health policies between different regions of the same country. (For example, PICUM (2012) has described local variations in administrative arrangements in some countries). Where a country is divided into regions, MIPEX data are drawn from two ‘migrant-rich’ ones; policies in other regions may be less adequate. This should be borne in mind when interpreting the scores of Spain, Italy, Switzerland, Belgium, Germany and Austria: there may be considerable within-country variations.

# II. ARGUMENTS FOR POLICY CHANGE

## 1. International law

The argument that has been most used to advocate for improving IMs' access to health care is that countries are obliged to bring national laws and practices into conformity with the international human rights treaties they have ratified. The three pillars of the International Bill of Human Rights are the 1948 Universal Declaration of Human Rights (UDHR), the 1966 International Covenant of Economic, Social and Cultural Rights (ICESCR), and the 1966 International Covenant on Civil and Political Rights (ICCPR).

The right to health (which includes the right to health *care)* enshrined in these and other instruments, such as the 1969 International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), is universal, fundamental and unalienable; it cannot be made dependent on conditions such as a person's nationality or legal status (Pace 2009). However, this is exactly what most national laws relating to health care for IMs do, so there is a fundamental tension between these national laws and international human rights law (in the case of conventions that have been ratified). Two questions need to be examined: (a) where precisely do the conflicts lie? And, (b) how can international human rights law be used to effect changes in national laws? Both these questions are large and complex, so only a brief summary of the issues can be presented here.

### *a. How do national policies conflict with human rights standards?*

The UDHR (Art. 25) mentions health and health care only in very general terms, as part of the right to an adequate standard of living. The ICESCR (Art. 12.1) asserts "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and specifies the measures to be taken to this end – among them "the creation of conditions which would assure to all medical service and medical attention in the event of sickness" as well as measures concerning child health, environmental and occupational health, prevention and disease control.

In 1990 the UN Committee on Economic, Social and Cultural Rights stated in *General Comment 3* (CESCR 1990) that "a State party in which any significant number of individuals is deprived of [.....] essential primary health care [....] is, prima facie, failing to discharge its obligations under the Covenant".

In 2000 the same committee elaborated Article 12.1 in *General Comment 14* (CESCR 2000). This document stressed the importance of the underlying determinants of health, as well as spelling out in more detail the obligations of states in respect of the provision of health care. Health care must be available, accessible, acceptable and of adequate quality. Access must be *equitable,* i.e. not impeded by discrimination or expense (affordability), while acceptability implies 'cultural appropriateness'. The importance of special attention for marginalised and socially disadvantaged groups was stressed, while paragraph 34 declared that "States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers *and illegal immigrants* [sic; our italics], to preventive, curative and palliative health services".

*General Comment 14* is lengthy, detailed and specific, incorporating many principles of modern public health. Unlike the ICESCR itself, it provides the basis for a point-by-point evaluation and criticism of national policies. This was indeed the mandate of the *Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health*, an office created in 2002. Some of the most trenchant criticisms of national legislation have been contained in reports of the Special Rapporteur – for example the 29-page report on Sweden (UN 2007).

In relation to national laws on IMs it is particularly significant that the above *General Comments* lay special emphasis on health care which is both *inclusive* and *equitable*. There is also no suggestion that 'emergency' or 'urgent' care can be regarded as an acceptable minimum level of health care. On the contrary, the stress throughout is on the protection of health through primary care and preventive measures. Viewed through this lens, the priorities of most countries in relation to IMs appear to be completely upside-down.

Another relevant treaty – the only one that contains an article explicitly requiring IMs to be granted access to health care – is the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW). However, this convention has not been signed, let alone ratified, by any EU/EFTA countries.

In the case of the member states of the Council of Europe and the EU, there is a further level of legislation in between international treaties and national laws that is also important.

i. **Council of Europe instruments.** The 1950 European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and the 1961 European Social Charter (ESC, revised in 1996) are complementary instruments. The ECHR is enforced by the European Court of Human Rights, while the ESC is monitored by the European Committee of Social Rights. Article 13 of the ESC contains provisions relating to health care, including equal rights for *legally* resident non-nationals and nationals. However, it has not been signed by Cyprus, Estonia, Lithuania, Poland, Romania, Slovakia and Slovenia.

ii. **European Union instruments.** The original founding treaties of the EU did not contain any provisions regarding health, so the Community had no competences in this field. However, Article 129 on Public Health in the 1992 Treaty on European Union or Maastricht Treaty (TEU) committed the Community to helping to ensure 'a high level of health protection', specifying the promotion of disease prevention, research, information and education: health care was not mentioned. The 1997 Treaty of Amsterdam revised Art. 129 and added that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care". This principle of 'subsidiarity' regarding health care was reaffirmed in the 2010 Treaty on the Functioning of the EU, which defines in Articles 52 and 168 the limits of the EU role in health policies.

> The 2000 Charter of Fundamental Rights of the European Union (CFR), which acquired legal status with the entry into force of the Lisbon Treaty in 2009, states in Article 35: “Everyone has the right of access to preventive health care and the right to benefit from medical treatment *under the conditions established by national laws and practices* [our italics]. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.” This reference to ‘national laws and practices’ was included out of respect for the principle of ‘subsidiarity’. However, as McKee et al. (2009:232) point out, “while public health and health care are discrete policy domains in EU law, in practice they are inextricably interlinked …….In practical terms, this can make it difficult to ascertain what is or is not within the scope of EU law”.

There are other EU legal instruments that potentially have a bearing on health care, such as:

- the ‘race directive’ (Council Directive 2000/43/EC of 29 June 2000)
- the ‘minimum standards directive’ (Council Directive 2003/9/EC of 27 January 2003)
- the ‘returns directive’ (Council Directive 2008/115/EC of 16 December 2008)
- the ‘qualification directive’ (Council Directive 2011/95/EU of 13 December 2011).

In 2010 the Council of the European Union issued *Conclusions on Equity and Health in All Policies: Solidarity in Health,* which urged all Member States to “consider policies to ensure that citizens, and all children, young people and pregnant woman in particular, can make full use of their rights of universal access to health care, including health promotion and disease prevention services." (CEU 2010: 7).

### b. How can human rights law be used to effect changes in national laws?

**International treaties are binding and the States Parties that ratify them are obliged to bring their legislation into conformity with them**. However, there is little that *compels* them to do this: this explains, for example, why it was possible for Sweden to continue denying health coverage to IMs until 2013, seven years after the visit of the Special Rapporteur referred to above, when changes were finally made.

As seen in the previous section, European-level instruments are less explicit than UN treaties when it comes to defending the right to health of IMs. At European level, therefore, fundamental rights instruments remain useful as guidelines and as a source of inspiration for policy-makers, but as originally formulated, they do not offer many legal remedies for IMs whose rights have been violated. McHale (2010) suggests that EU anti-discrimination legislation may hold more potential for legal remedies than legislation on health care as such. (For example, the extension of the concept of discrimination in the 2000 ‘race directive’ to include ‘indirect discrimination’ enables inequities resulting from institutional practices to be challenged.) The EU’s Fundamental Rights Agency concluded as follows:

> EU law does not address the question of access to healthcare for migrants in an irregular situation, except in situations involving individuals who have been given a period for voluntary departure and for those whose removal was formally postponed…… The limited enforceability of legally binding international law

> provisions on the right to health, the vague language used in such provisions, combined with the need to implement human rights law in countries with different healthcare systems, all has led to a divergent understanding and application of the right to health across the EU. (FRA 2015:9)

However, international law is not limited to the original texts of charters, conventions and other treaties: it also comprises the jurisprudence related to these instruments. Such decisions involve spelling out *implications* of the instruments which may not be immediately obvious from the original text. The resulting interpretations may therefore go further than the texts themselves appear to do. In recent years there have been an increasing number of successful challenges to national laws and practices on the basis of human rights law. These have provided case law which can then be applied to other situations.

- Although the ESC to a large extent explicitly excludes IMs, the European Committee of Social Rights (ECSR), the Charter's monitoring body, has addressed IMs' right to health directly. In *International Federation of Human Rights Leagues* (FIDH) *v. France* (ECSR 2004) the Committee held that "legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter".

- In Section III.2 (a) we describe the campaign in 2009 against a *proposed* law in Italy that would have required IMs seeking help to be reported to the immigration authorities. This campaign made use of the legal argument that the proposal was in conflict with the Italian constitution, which was itself influenced by international human rights treaties.

- Another ruling of the ECSR concerned the case of *European Council of Churches v. The Netherlands (*discussed further in Section III.1 below). This case concerned failed asylum seekers who did not cooperate with orders to leave the country. The Committee ruled that the right to health care also applied to them (ECSR 2014).

- Several cases concern the right of an IM to stay in a country in order to receive essential medical treatment. A ground-breaking decision in this area concerned an asylum seeker and was made in 2014 by the Grand Chamber of the Court of Justice of the European Union in the case *Centre public d'action sociale d'Ottignies-Louvain-la-Neuve v. Moussa Abdida* (EUCJ 2014). In other cases, specifically in Italy, courts have not only intervened on IMs' legal entitlements to healthcare, but also on whether they have a right to receive a residence permit – to stay on the territory – based on a health condition.

More examples of case law from European-level courts are given by Inverardi (2016). If one also takes jurisprudence into account, rather than simply examining the text of international law, it is clear that there is more scope for legal action than is implied by the rather pessimistic conclusions of the FRA quoted above. However, it remains the case that legal actions are in practice difficult to bring and may take years to decide. Moreover, member states may show great reluctance to implement the resulting decisions.

### *d. Political support for the rights of irregular migrants in Europe*

Although European-level parliamentary bodies have seldom expressed specific support for IMs' right to health care, there have been several notable exceptions:

**i.** In 2001, the Parliamentary Assembly of the Council of Europe issued Recommendation 1503 on *Health conditions of migrants and refugees in Europe.* The assembly was "greatly concerned that in many European countries there are migrants who fall outside the scope of existing health and social services" and that "few countries have developed comprehensive health policies concerning migrants and refugees". It noted that "Health care provision in the context of clandestine migration is another serious problem which requires further examination." (CoE 2001).

**ii.** In 2006 the same Parliamentary Assembly issued a report on "Human rights of irregular migrants", which asserted that in accordance with the ECHR "emergency healthcare should be available to irregular migrants and States should seek to provide more holistic health care" (CoE 2006).

**iii.** In 2011 the European Parliament adopted a resolution on reducing health inequalities in the EU (2010/2089(INI)), which included the following statements:

- Whereas in many EU countries equitable access to healthcare is not guaranteed, either in practice or in law, for undocumented migrants,

- The European Parliament calls on the Member States to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare; calls on the Member States to assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation;

- Calls on the Member States to promote access to high-quality legal advice and information in coordination with civil society organisations to help ordinary members of the public, including undocumented migrants, to learn more about their individual rights. (EP 2011)

**iv.** In 2011, the Parliamentary Assembly of the Council of Europe issued Recommendation 1985 on *Undocumented migrant children in an irregular situation: a real cause for concern,* which encourages member states to "guarantee the right to health care".

**v.** In 2013, the same Parliamentary Assembly adopted a resolution (1946) on *Equal access to health care*, calling on member states to provide equal access to health care services for undocumented migrants. The resolution included Equal access to health care, and Migrants and refugees and the fight against Aids.

**vi.** In 2013, the European Parliament adopted a resolution on the *Impact of the crisis on access to care for vulnerable groups.* This resolution stresses that groups presenting several vulnerability factors, such as Roma, persons without a valid residence permit or homeless people, are at an even higher risk of being left out of risk prevention campaigns, screening and treatment" and "urges the Member States to cooperate in seeking to implement a maximum number of programmes to improve health standards among the most vulnerable groups, in particular children and young people, in the context of mobility, this being recognised as a fundamental right within the EU".

**vii.** In 2014, the European Parliament also adopted a resolution on *Undocumented women migrants in the European Union.* This resolution "points out that the right to health is a fundamental human right and therefore encourages the Member States to delink health policies from immigration control, and consequently to refrain from imposing on healthcare practitioners the duty to report undocumented migrants" and "calls on the Member States to put an end to discriminatory practices, to combat undeclared work and labour exploitation, inter alia by means of labour inspections and allow access to basic health services".

### 2. Public health principles

Public Health has been defined as "what we as a society do collectively to assure the conditions in which people can be healthy" (IOM 1988). Health is regarded not simply as an individual right, but as essential to maintaining the resilience of society as whole: high levels of ill-health weaken the entire society by undermining its ability to function properly. The responsibility of the healthy to treat and support the sick becomes a serious burden, and ultimately the very survival of the state may be challenged by excessive morbidity and mortality. Moreover, unfair inequalities (inequities) in health undermine social justice and social cohesion.

From this standpoint the ill-health of *any* segment of the population should be treated as detrimental to society. In practice, however, public health principles are often tempered by other considerations: they may take second place, for example, to military or economic goals. In the case of a small and politically disempowered group like IMs, politicians may decide that the requirements of immigration control or perceptions of 'deservingness' outweigh the public health principle that everybody's health should be protected.

However, a variant of this argument – that illness among IMs must be combated if it threatens the health of the wider society – *does* have considerable impact on policy-makers. This argument specifically concerns infectious and vaccine preventable diseases (ECDC 2014), though it can also be applied to maternal and child health. A mother's ill-health can threaten the health of her child, not only through infection but by undermining the child's healthy development from conception onwards. (For this reason, as will be discussed in Section II.4, the Convention on the Rights of the Child contains obligations regarding prenatal and post-natal healthcare for mothers).

For the reasons described earlier (Section I.2), reliable evidence about rates of illness among IMs is extremely hard to find, but the principle that *any* carrier of infectious disease should have easy access to treatment in order to stop it spreading enjoys widespread acceptance. In the case of IMs, there are two mechanisms which may give rise to infections, which tend to intensify each other. Infections may be brought in from a country of origin where a disease is common, and they may be contracted in the host country as a result of the conditions in which IMs live. Overcrowded and unhygienic housing, inadequate nutrition and working conditions, as well as poor access to health education, preventive measures and treatment, are characteristic of socially excluded groups such as IMs. In the case of TB, lack of continuity in drug treatment is an additional risk factor. The employment conditions of sex workers carry an increased risk of sexually transmitted diseases. People living away from their families may also be more liable to such infections.

Since levels of pre-existing infection are likely to be exacerbated by living conditions in the host country, it is too simple to regard IMs as a public health threat simply because of the diseases they may import. Moreover, there is a risk of over-generalising and exaggerating this threat, thus contributing to the stereotyping and stigmatising of migrants as a 'danger to society'. Nevertheless, the risk of infectious disease is an important concern underlying health policies regarding IMs. The MIPEX survey showed that in most countries, restrictions on entitlement for IMs are waived to allow free treatment of infectious disease, though there is a great deal of variation in the diseases targeted and the services and treatments offered (see also MdM 2015). Such measures, however, are of limited value if access to primary care remains restricted, because the existence of an infectious disease may only come to light in the course of a medical consultation. Moreover, the risk of being reported to the authorities will deter many IMs from seeking care.

A recent article (DeBlonde et al 2015) highlights the inconsistencies between EU/EEA countries concerning IMs' access to antiretroviral treatment (ART) for HIV. Government sources and civil society respondents in the EU/EEA gave different answers to the question of whether ART is available for IMs in their country. According to the former, it is available in 44% of countries, but according to the latter, only in 29%. The article goes on to show that the low availability of ART for IMs undermines measures to control HIV incidence.

Tuberculosis is another condition in which restricted health care entitlements for IMs can jeopardise international efforts to control infection (Dara et al. 2012). According to Heldal et al. (2008:879), "irregular and/or inadequate treatment in the country where the immigrant has arrived may lead to anti-tuberculosis drug resistance, prolong the period of infectiousness and increase the pool of resistant TB cases. Treatment discontinuities can not only delay cure, but increase the spread of resistant forms of TB". Since this was written, the issue has become a matter of global concern.[13]

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[13] See for example:
http://www.un.org/apps/news/story.asp?NewsID=55011#.V_tz7vl96Uk
http://www.wpro.who.int/entity/drug_resistance/resources/global_action_plan_eng.pdf

Public health is not only concerned with the amount of effort put into health protection, but with the effective deployment of resources to this end. Especially in the last half-century, there has been growing recognition of the importance of prevention and early detection (including the principle of 'health in all policies'), rather than only providing treatment for existing illnesses. In the previous section we noted this shift of emphasis also in the interpretation of the fundamental human right to health by the UN Committee on Economic, Social and Cultural Rights (CESCR). The overwhelming stress on acute and emergency treatment in most national European legislation on IMs ignores this shift and leads to policies that conflict with modern principles of public health.

The notion that 'emergency care' represents an acceptable minimum level is not confined to national governments in Europe: the EC's *Communication on immigration, integration and employment* (2003:26) states only that IMs "should enjoy some basic rights e.g. emergency healthcare". However, prioritising emergency care is not simply based on ignorance. It is also informed by a moral principle, the 'rule of rescue' (Jonsen, 1986). The sufferer from acute illness is an identifiable victim whose plight calls for immediate help. Refusing help to a person in pain and struggling for their life conflicts not only with medical ethics, but also with everyday morality. By contrast, the large numbers of people who could be kept healthy by diverting resources from acute to preventive care tend to be seen only as anonymous statistics. Although such redistribution might be more efficient, helping people who are in immediate danger is usually perceived as a more compelling priority than reducing risks in the future.

Nevertheless, as Schöne-Seifert (2009) and others show, the 'rule of rescue' cannot be used to justify not providing primary care and prevention. Both approaches are necessary. Indeed, the main argument for primary care is that it can reduce the need for acute treatment to a level at which a higher proportion of people with life-threatening conditions can be 'rescued'. (This argument is bound up with economic considerations, which will be discussed in the next section.) In fact, the 'rule of rescue' is not so much concerned with protecting, restoring and maintaining health as with relieving acute suffering and danger to life. This is a laudable aim, but it is not the same as the 'full realization of the right to health' which States Parties are obliged by the ICESC to implement.

To sum up, the dominant view in public health, as reflected by UN standards and WHO guidelines,[14] has shifted during the last 50 years in favour of *universal, equitable health care coverage* with a strong focus on *easily accessible primary care* as the best way to protect the health of populations. Most countries' policies on IMs, however, do not yet reflect this shift. In 2006 the Council of the European Union issued Conclusions drawn up by 25 Health Ministers of the European Union, which affirmed a commitment to "overarching values of universality, access to good quality care, equity and solidarity" (CEU 2006). At first sight these conclusions appear to endorse the UN and WHO positions, but on closer examination we see that the text refers specifically to healthcare for 'EU citizens' – not for 'persons' or 'residents', and by implication not for IMs either. **Many governments appear to be committed to the principle of Universal Health Coverage (UHC) only in the following paradoxical sense: they support it, as long as it does not have to apply to everybody.**

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[14] See http://www.who.int/universal_health_coverage/en/

## 3. Economic arguments

Against the background of increasing hostility to IMs, arguments based on human rights or public health have recently been supplemented by arguments appealing to a country's economic self-interest. In fact the economic arguments were mentioned already by Romero-Ortuño (2004), but only in the last few years have detailed studies been carried out on them.

Economic arguments claim that inadequate care for IMs is actually more expensive to provide than adequate care. This argument assumes, of course, that no state is willing to accept direct responsibility for the death of an IM by withholding health care in a life-and-death situation. Moreover, providing adequate care is not simply a matter of expanding legal entitlements to include the full range of preventive services and primary care for IMs: all the other barriers to access that were reviewed in section I.3 also need to be tackled.

The main component of improved entitlements for IMs concerns their access to primary care, since this is the main restriction imposed on them. The economic advantages of granting such access can be deduced from the benefits accruing to entire populations from a strong primary care system. According to the EU's Expert Panel on Effective Ways of Investing in Health (EXPH 2014:8):

> Effective primary care not only prevents diseases at early stages, but also stimulates people to take up a healthy life style. Overall health is considered within primary care in a more holistic matter, paying not only attention to medical health needs, but also to other causes of ill health, such as social or employment determinants…… Strong primary care is associated with better population health, lower rates of unnecessary hospitalizations and relatively lower socioeconomic inequality in self-perceived health.

Where the IM population is denied access to primary care, it constitutes in effect a 'country within a country', in which health care is a long way below the standard of that which is used by the majority, fragmenting the health system as a whole. Restricting IMs' access to primary care increases the risk that illnesses will not be prevented or detected in an early stage, when they can be treated more effectively and less expensively. This argument can be backed up using countless actual cases: one of the most dramatic was that of the 27-year-old failed asylum seeker from China (PICUM 2012b), whose advanced hepatitis was not detected in time to avoid the necessity of a liver transplant. The total costs of such an operation have been estimated at not less than €250,000 (Erasmus MC 2010).

Economic issues also arise when urgently needed care for IMs is given in accident and emergency (A&E) departments instead of more appropriate units. In general, it would be absurd to insist that all urgent referrals must be routed via an A&E department: such departments are expensive to run and adapted to very specific needs, which may not be relevant to all 'urgent' cases, however, such misuse of emergency facilities is encouraged by laws restricting entitlements for IMs to 'emergency care'. Often, emergency services are used (not only by IMs, but also by the general population) when primary care is hard to access; a practice which is extremely wasteful and can threaten the continuity of care. The problem of continuity also arises when IMs are classified as ‘sporadic users’, as they are, for example in Portugal[15], preventing access to a family doctor and proper medical records. (See also FRA 2011b on continuity of care).

Several recent studies have provided detailed backing for these economic arguments. Some use data on actual expenditure from health service accounting systems in order to estimate the amount of money wasted by misguided policies. One of the most recent is the article by Bozorgmehr and Razum (2015), which in fact concerns asylum seekers in Germany, but is directly relevant to IMs because asylum seekers are covered by the same legislation, entitling them only to emergency care during the initial period of their stay. On the basis of official statistics covering a period of 20 years, the authors calculated that restrictive policies increased the cost of health care by €376 a year for each asylum seeker.

To carry out such a study for IMs would not be possible in most countries, because they are usually not separately registered in health service accounting systems. However, in countries where they are, there is an urgent need to carry out more research to monitor IMs’ care consumption and costs. A recent report on the costs of the Belgian system of health care for IMs (Roberfroid et al. 2015) is an excellent example of how such an analysis can be used to promote improvements and cost-saving. In theory, it would be also possible to compare patterns of consumption in regions of Spain which adopted the legal restrictions introduced by the 2012 Royal Decree with those which refused to do so (cf. Cimas et al. 2016). However, the widely-reported informal defiance of these restrictions is likely to have weakened the contrast between ‘restrictive’ and ‘non-restrictive’ regions.

Other economic analyses are based on theoretical models or estimates, for example the study commissioned by the Fundamental Rights Agency (FRA 2015). This focused on two health issues, hypertension and prenatal care, and estimated only the costs to the health system itself, using the standard tariffs applying in Germany, Greece and Sweden. The report concluded that the savings that would be generated by giving broader access to preventive and primary care were small when calculated purely from a health system perspective, but would be much larger if all social costs were factored in.

Also relevant are the results of a recent study carried out in Southern Africa, which also considered social costs. The estimated cost of not providing services to migrants was estimated as 0.16% of regional GDP, i.e. over three times more than the estimated cost of providing such services (0.05%) (Oxford Policy Management 2015).

Within the EQUI-HEALTH project, a study commissioned by IOM and carried out by the Centre for Health and Migration in Vienna (in close cooperation with IOM and primary health and hospital care providers) analysed the cost-benefit aspects of restricted access to care for irregular migrants by comparing the actual costs of timely outpatient treatment versus delayed hospital treatment of certain conditions[16] in Austria, Belgium, Italy and Spain. Carried out in 2014-2016, the Thematic Study *Cost analysis of health care provision for*

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[15] The Country Report on Portugal will be available on the website of EQUI-HEALTH later in 2016: http://equi-health.eea.iom.int/

[16] Depression, diabetes, hypertension, epilepsy and asthma.

*migrants and ethnic minorities* (IOM, 2016) examined direct medical and non-medical costs, as well as indirect ones, related to treatment in both care settings, using a vignette approach based on real-life cases. Costs were analysed from three different perspectives: the patient's, the health care system's and society's.

The additional costs of delaying adequate care may be direct (incurred by the patient and/or the health system) or indirect (incurred by the patient as loss of income or the wider society as a result of the disabilities and burdens resulting from illness). The magnitude of these costs is difficult to estimate because it depends on the particular patient characteristics and social situation concerned. However, illustrative costs to the health system can be calculated using the vignette method applied in this study.

Vignettes are short descriptions of scenarios comprising defined core elements, which can be varied systematically to develop different hypothetical cases. Based on primary data and supplemented further with register data, desk research and expert opinion, vignettes provide robust economic results and are more generalizable than single case studies. Using pre-defined selection criteria, a real-life case was selected from random samples collected at each health service provider participating in the study and served as a basis for calculations. These predicted the costs incurred by the patient, the health care system and the society related to the treatment for the chosen medical conditions in the two care settings.

Results from the study demonstrated that, as regards the conditions and settings studied, timely treatment in a primary health care setting is always cost-saving when compared to treatment in a hospital setting. This is true for direct medical and non-medical costs as well as indirect costs. At least 49% and up to 100% of direct medical and non-medical costs of hospitalisation can be saved if timely primary health care is provided to those who would otherwise be denied it.

## 4. Special arguments for vulnerable groups

Although, as we have seen, national policies on migrant health sometimes contravene international law, particular groups – often labelled as 'vulnerable' – may enjoy better protection in law. Depending on the definition of 'vulnerable group' which is adopted, the entire group of IMs may be placed in this category, but in most policies only particular sub-groups are regarded as 'vulnerable'. Like persons whose condition is regarded as a public health threat, these sub-groups may be provided with special exemptions from restrictions on non-emergency access to health services.

One of the indicators in the MIPEX study reflected the number of exemptions offered for infectious diseases and vulnerable groups. As reported in Section I.3, fifteen countries provide exemptions from restrictions for three or four such illnesses or groups, 13 countries provide them for one or two, while three countries provide no exemptions. Detailed information about the entitlements of vulnerable groups has also been provided by the FRA (2011c:78). The main groups that may be exempted from restrictions are the following:

### *a. Maternal and child care*

The rights of children are protected by the 1989 UN Convention on the Rights of the Child (CRC), which – although its provisions are regularly ignored – has been ratified by more countries (196) than any other treaty. **This Convention stresses children's special need for protection. Article 24 provides specifically for their access to healthcare services and also obliges States Parties to "ensure appropriate prenatal and post-natal healthcare for mothers".** The latter rights are reinforced by the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Article 12(2) grants women the right to "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

As far as health care surrounding childbirth is concerned, however, these rights are frequently overlooked by European national legislation. According to Spencer and Hughes (2015:2):

> …..21 EU countries provide entitlement to a level of maternity care: in a minority of cases for delivery only. Other states make no specific provision for maternity care. However, many or all will include giving birth within the definition of emergency. The question of who is liable for costs – as in countries which do allow greater access to maternity care – remains problematic.

The issue of costs is of course crucial, because we cannot speak of 'coverage' in cases where the patient has to pay the full costs of care themselves, unless there are formal arrangements for exempting patients who cannot afford to pay. **Antenatal care is of critical importance in reducing risks from birth complications and guaranteeing healthy development, yet it is precisely this type of primary care from which IMs in many countries are excluded**. Only in Spain, Portugal, Italy, the Netherlands, France, Belgium and Sweden is ante-natal care covered for IMs. Quite apart from the human rights arguments, the public health arguments against such exclusion are obvious: many countries are concerned about rates of perinatal morbidity and mortality, but apparently fail to see the connection with their policies in relation to IMs.

Concerning health care for children, in Europe (according to FRA 2011b:28) **only Greece, Portugal, Romania and Spain always allow children in irregular situations access to the same health services as nationals**. (Since 2013 this also applies to Sweden.) In Germany children have a right to health care, but this is undermined by the risk of reporting to the authorities in all except for emergency cases. In Estonia and Poland, health care coverage is dependent on attending school. In Italy the entitlements for children vary between regions. For irregular unaccompanied minors, who are usually taken into the care of the State if apprehended (and sometimes detained),[17] entitlements to health care are generally better but still vary widely (Ruiz-Caseres et al. 2010; Devi 2016).

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[17] Entitlements for migrants in detention are not considered in this document.

### b. *Trafficked persons*

EC Directive 2011/36/EU (EC 2011) on human trafficking includes under Article 11(7):

> Member States shall attend to victims with special needs, where those needs derive, in particular, from whether they are pregnant, their health, a disability, a mental or psychological disorder they have, or a serious form of psychological, physical or sexual violence they have suffered.

In addition to these special needs, “necessary medical treatment including psychological assistance, counselling and information” should be provided (EC 2013). We have no precise information on the extent to which these rights are respected by health authorities in Europe. In view of the relative powerlessness of trafficked persons, making their rights conditional on their willingness to testify against traffickers is morally indefensible.

## III. IMPROVING ACCESS

In this section we consider some problems that will need to be solved if the principle of Universal Health Coverage is to be extended to IMs. Some problems are political and involve dismantling stubborn myths about this group; others are more practical in nature, such as the issues of guaranteeing confidentiality and avoiding the risk of creating inequities for other groups. Section 4 shows that implementing UHC for IMs has to be done in a way that respects the particularities of the health system in each country: no standard solution is possible. Finally, we discuss the reduction of cultural and linguistic barriers and the role of CSOs after the introduction of UHC.

### 1. Informing public opinion

In order to promote better policies for IMs it is necessary to dismantle popular myths about them and try to counteract the negative reporting and scapegoating that is so often found in the media. Health policies are decided by governments, which in turn are elected by voters. Without a change in public attitudes the scope for improving policies will be limited. The present situation is the result of deeply-rooted misconceptions which need to be effectively unmasked: these concern for example the nature and fundamental causes of irregular migration, the costs and consequences of providing adequate care, and the self-defeating nature of existing policies.

As we have seen, strong arguments have been put forward over a number of years – from human rights, public-health and (more recently) economic perspectives – for improving IMs’ access to health services, especially primary care. Yet only a handful of the countries we have examined grant full legal entitlement to IMs, and even in those countries there remain serious barriers to access. Even the likelihood that restricted coverage may cost more than full coverage makes little impression on opponents of full access. Given the persistence of the criticisms, the objections to making improvements must be very strong. What accounts for this reluctance to change?

The main motive for restrict IMs' access to health services seems to be a desire to increase the pressure on IMs already present to leave, and to deter potential new ones from adding to their numbers, whether by unauthorised entry or 'overstaying'. PICUM (2012a) states:

> To 'tackle' irregular migration, many member states have resorted to limiting the main elements of social inclusion, namely health, shelter, education and a fair income, for its most vulnerable group of migrants. The legislative and practical barriers facing undocumented migrants in accessing these rights have the clear intent of driving them into a situation of poverty, destitution and social exclusion so intolerable, that it should compel their departure from Europe.

In the words of Johansen (2013, 263): "The main purpose of the control of work, health and welfare is to set up a situation in which the state's preferred outcome is more attractive than the alternative". This policy strategy has been labelled 'internal migration control' by sociologists such as Doomernik and Jandl (2008), to distinguish it from policies aimed at control of external borders. The increasing use of such measures is explained on the one hand by the growing pressure to restrict immigration, and on the other by the diminishing effectiveness of attempts to police approximately 90,000 kilometres of EU borders, despite exponentially increased spending.

Internal migration control involves extensive efforts to track down IMs living in a country, as well as reducing the level of their entitlements and benefits (WHO 2013:108). Measures may include compulsory registration of residence and the use of identity cards, restriction of access to work and housing, criminalisation of unauthorised residence and aid to IMs, and the use of detention. The reporting of IMs to the immigration authorities by health workers or organisations (see next section) is part of this strategy. The exclusion of IMs from social protection (welfare benefits and health care) is another: moreover, states are likely to resist any improvement in conditions for IMs because of fears that this will increase their numbers. Broders and Engberson (2007:1593) characterise 'internal' control strategies as follows:

> When it comes to irregular migrants, exclusion is now the stated aim of policy. For those illegal [sic] aliens who cannot be discouraged or deterred to come, exclusion is meant to complicate and frustrate living and working conditions to such a degree that they will turn round and try their luck elsewhere. The goal of discouraging irregular migrants has led to a shift toward internal migration control, which comprises a wide array of policy measures such as employer sanctions, exclusion from public services, surveillance by the police, incarceration, and expulsion.

Sitkin (2014) documents "measures developed to impede irregular migrants' access to regular work, justice, healthcare, education and housing" in the UK.

Not all restrictions on entitlements to benefits and services, however, are necessarily linked to 'internal migration control'. After the Second World War, welfare states in Europe were built up with the aim of guaranteeing social security, health care and education to nationals residing in the country, but not necessarily to non-nationals (Freeman 1986). Strict limitations were placed on non-nationals' access to these benefits. As the MIPEX results quoted in section I.2 show, even regular migrants and their families from third countries are not always entitled to full health care coverage: for this, they may be required to have (legal) employment and/or a permanent residence permit. Even the access of EU/EEA and Swiss nationals to benefits is subject to important limitations. Such restrictions have come to be known as 'welfare chauvinism' (Freeman 1990). They may be based on notions of 'deservingness' (Willen 2012), 'solidarity', or a simple desire to save money. Requiring migrants to pay sales and income taxes but not allowing them to access all the benefits and services the taxes pay for is a highly efficient way of increasing their economic value for the 'host' country.

When should 'welfare chauvinism' also be regarded as a form of internal migration control? Such a motive is often difficult to establish because governments tend not to make it explicit. Some, however, do so quite openly, in particular where IMs are concerned. British politicians often refer to reducing rights and benefits as a tool for reducing irregular migration. In the words of the British Home Secretary in 2007: "We need to make living and working here illegally even more uncomfortable and constrained" (Sigona and Hughes 2010:3). During the 'migration crisis' of 2015, Germany and Denmark (among other countries) rapidly implemented measures to reduce the rights and benefits of asylum seekers, many of whom would become IMs when their application was turned down. Some countries even publicised these increased restrictions abroad in order to deter refugees from coming to them (see e.g. Taylor 2015). In the majority of countries, however, deterrence is not formally acknowledged to be one of the motives behind 'welfare chauvinism', although the support of anti-migrant parties for deterrence strategies is placing the issue under the spotlight.

A rare admission of the deterrence motive was made by the Dutch Government in a recent judicial conflict. In 2013 the European Council of Churches submitted a complaint to the European Committee of Social Rights against the Dutch Government because of the latter's alleged refusal to provide accommodation and medical assistance to IMs who did not cooperate with orders to leave the country. The Committee (ECSR 2014) found the situation not to be in conformity with Article 13§4 (right to social and medical assistance) and Article 31§2 (right to housing) of the European Social Charter[18]. In its defence the Dutch Government argued that:

> ….immigration policy is directed towards the encouragement of voluntary return. This is why reception services are only provided temporarily and only to certain groups. Illegal residence is discouraged by making reception services conditional.

Concerning health, the government contested the National Ombudsman's finding that a lack of shelter was an obstacle to healthcare access. Regardless of this issue, the important point is that "the encouragement of voluntary return" was stated as the aim of policies on reception.

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[18] In April 2016 the Dutch Government had still not fully implemented the ECSR's decision (AI 2016), which it does not regard as binding.

It is important to preserve the distinction between material benefits such as subsistence or accommodation, and the right to health care. When Germany and Denmark reduced benefits for asylum seekers in 2015, entitlements to health care were not affected. This suggests that some governments make a distinction between these two kinds of rights and might therefore not be reluctant to improving health-related rights for IMs.

To sum up, the notion of 'internal migration control' implies that much of the hardship and social exclusion experienced by IMs is tolerated, perhaps even exacerbated, by governments in the hope of reducing their numbers. The stigmatisation of IMs, for example by associating them with crime, disorder and disease, fits well with this strategy. (In reality, of course, most IMs have a strong interest in *not* attracting the attention of the police.)

Against this background, advocating for an improvement in health care entitlements for IMs might seem to be swimming against the tide. Yet 'internal migration control' is only a rational policy if its central assumption is correct – that these measures do, in fact, have the intended deterrent effect. Critics of the policy argue that they do not, because for most IMs the option of going back to their home country may entail such hardships – assuming it is even possible – that they will prefer to put up with harsh living conditions in Europe rather than return. Indeed, as we will see, existing evidence suggests that any slight effect that restrictive policies may have is outweighed by the injustice of pushing IMs further into poverty, social exclusion and ill-health.

Confining ourselves only to the issue of health care, what is the empirical evidence that denial of health care entitlements to IMs will reduce their numbers? NGOs often argue that the effect is negligible, because hardly any of the IMs they encounter have migrated in search of medical care:

> 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. (MdM 2013: 28)

But although the sample on which the 1.6% figure was based was large (8,412), questions can be asked about its representativeness. It could be argued that people who migrate irregularly in search of health care are not likely to be found in NGO clinics anyway, because they will not choose destination countries where this is the only form of care available to them. Moreover, those who know they can be taken care of by mainstream services are less likely to consult voluntary ones.

Other figures have been published by the English National Health Service (NHS 2013). "People who have travelled to England with an intention of obtaining free healthcare to which they are not entitled" were estimated to cost the NHS between £70m and £300m a year, i.e. 0.06% - 0.27% of the total NHS budget of £108.9 billion. However, "travelling to England" is not the same as "migrating to England" – it was said to be sometimes just a question of “flying in and flying out”. Therefore, the NHS findings are not necessarily in conflict with those of MdM. Other research (Poduval et al. 2015; Britz and McKee 2015) also challenges the notion that any significant amount of “health tourism” by IMs exists in the UK.

The so-labelled ‘migrant crisis’ in 2015 provided another empirical challenge to the theory that generous health care provisions attract migrants. Both for asylum seekers and IMs, entitlements to health care in France are much better than in the UK or Germany.

| | Asylum Seekers | Irregular Migrants |
|---|---|---|
| France | 100 | 50 |
| UK | 50 | 25 |
| Germany | 25 | 25 |

**Scores on Section A of MIPEX Health strand (Entitlements)**

In addition, IMs in Germany and the UK run the risk of being reported to the authorities when they seek health care, but this is strictly forbidden by professional codes of conduct in France. If favourable health policies attract migrants, we would expect this difference to be reflected in the numbers coming to these three countries. Nothing could be further from the truth: Germany received 5 times more asylum applications per head of population in 2015 than France, while thousands of IMs remained in squalid camps at Calais in the hope of reaching England, rather than claiming asylum in France.

**To sum up, we have been unable to find any evidence that generous health entitlements attract IMs, or that restrictive ones encourage existing IMs to leave and deter new ones from coming. The possibility of finding work, as well as existing ties to family or networks, are likely to be much stronger ‘pull’ factors. The firm conviction of many politicians and members of the public that good entitlements to health services encourage irregular migration needs to be equally firmly challenged.**

### 2. Dealing with the confidentiality issue

Although there are many sound arguments for improving IMs’ access to health services and few for not doing so, there are nevertheless practical issues which may stand in the way of improving legal entitlements.

The first is the inherent tension between the IM’s need to remain invisible and the health system’s need for registering accurate information about patients and making it easily accessible and transferable within the system. There is widespread consensus among health professionals that the latter is an essential part of good health care and sound public health. Such data can be used not only in treatment but also for planning, advocacy and promoting change.

We should note in the first place that this tension applies not just to IMs, but to all patients: that is why the needs of the health system frequently come in conflict with laws and codes governing privacy and medical confidentiality. The widespread introduction of digital information systems at the end of the last century led to controversies and legal developments that show no sign of abating, while the use of digital information has increased apace.

For IMs, the danger of having their irregular status recorded by health service organisations is above all that the information might be communicated to the police and/or immigration authorities, leading to apprehension and possibly deportation. It is for this reason that, as already mentioned, PICUM (2016) and other organisations have argued for the construction of a 'firewall' between agencies responsible for immigration and those concerned with health and welfare. However, this is not the only reason why an IM might want to keep information about their status confidential. Such information could jeopardize their relations with employers, landlords and many others.

How can the IM's need for privacy be reconciled with the health system's need for good medical records? In countries where IMs' access to services is confined to emergency departments, treatment can be given with a minimum of stored and shared records. In Austria IMs can use the system of 'anonymous delivery', which was designed to protect the identity of the woman giving birth. A&E departments everywhere are quite accustomed to treating patients who do not have identity documents with them; some may not even be conscious. Dangerous situations arise, however, when treatment requires showing documents or electronic cards that some migrants (especially IMs) do not have. Sometimes a card may be 'borrowed' from another person, but – particularly if a blood transfusion has to be given – the results can be fatal (FRA 2011b: 37).

Some countries (e.g. Portugal, Spain, Sweden, Switzerland, Luxembourg and the Netherlands) allow IMs under certain conditions to access the regular health system, which involves recording their medical information in the usual databases. However, this is only safe for IM's if disclosure of information about the patient's legal status is effectively prohibited. Results from the MIPEX Health strand survey presented in Section I.3 showed that this is far from being the case. Five EU/EFTA countries require professionals or organisations to report undocumented migrants to the police or immigration authorities (though it is sometimes claimed that these rules are never implemented). In 10 countries such reporting is explicitly forbidden in law and/or professional codes of conduct, while in 16 there are no rules either way. In six countries (Czech Republic, Denmark, France, The Netherlands, Norway and Portugal), respondents commented that such reporting would conflict with medical codes of conduct. This, however, does not provide the IM with full security, as data can be – and in some countries must be – provided to immigration authorities by administrative staff who are not subject to a professional code of conduct. Existing laws on data privacy must be strictly implemented, but the fact that these laws are overruled in some countries by other laws requiring reporting shows that this is not enough: an explicit ban is necessary.

As long as IMs cannot be sure that their confidentiality will be respected, the perceived threat of being reported remains a serious barrier to access. In Italy, for example, Article 35 of Legislative Decree No. 286 of 25 July 1998 forbids reporting IMs' use of health services to the authorities, except in cases where such reporting is compulsory for all patients. An amendment abolishing this rule was approved by the Italian Senate in February 2009, but eventually rejected – after widespread protests – by the Chamber of Deputies two months later. However, the controversy quickly resulted in a decline in the use of health services by IMs (Geraci and Bodini 2011:157).

The only way to protect IMs from reporting to police or immigration authorities is to prohibit such reporting (preferably also in medical codes of conduct), as recommended by several organisations:

- PICUM (2016) advocates for building a 'firewall' between agencies responsible for immigration and those concerned with health and welfare.
- The FRA (2011b: 12) proposes that "EU Member States should disconnect healthcare from immigration-control policies. They should not impose a duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration. The absence of this duty to report should be clearly communicated to them."
- The Council of Europe's European Commission against Racism and Intolerance (ECRI) recommends governments to "decouple immigration control and enforcement from the provision of services" (ECRI, 2016: 7).
- The UN Special Rapporteur on the Human Rights of Migrants has argued for the establishment of such 'firewalls' and described ways in which they can be implemented (Crepeau and Hastie, 2015).
- A recent report by the *Migrants in Countries in Crisis Initiative* argues for "separation of immigration enforcement activities from access to assistance, services, administrative, judicial, and complaint mechanisms, and rights protection" in crisis situations. It also describes measures to further this aim (MICIC 2016:52).

As with all forms of 'internal migration control', the minor benefits likely to be gained from reporting as a method for reducing numbers of IMs must be weighed against the serious harm done by the existence of this barrier to access.

### 3. Addressing the issue of political acceptability and equity

Just as inequities can arise for IMs if they are denied access to health services, so they can arise for nationals and regular migrants if IMs are granted access on more favourable terms than other groups. This is undesirable, not least because it risks increasing public hostility to IMs. To understand this we must appreciate that health care, even if provided by the State, is hardly ever completely 'free'.

In a system of universal health care coverage it is essential that all who are able to do so should pay 'up-front' into the system, through taxes, social insurance contributions or both. The principle of 'horizontal solidarity' means that the healthy subsidise the medical costs of the sick, which has to be done on a compulsory, not a voluntary basis. 'Vertical solidarity' further implies that the level of contributions should depend on the ability to pay them.

This payment of ‘up-front’ contributions forms an additional risk to IMs’ confidentiality if it is not accompanied by strict protections, but as we have seen such protections can be provided where there is the political will to do so.

It is frequently argued that all IMs in any case have to pay sales (indirect) taxes, which in most countries are partly used to finance the health system. They may also pay property taxes, usually via landlords, though this fact is seldom mentioned. Some even choose to pay income tax and social security by using borrowed documents. However, the ‘up-front’ contributions and taxes which regular residents have to pay for health care will almost always be greater, even though they are usually ‘progressive’ (i.e. adjusted to take account of the individual’s financial situation). Moreover, in many countries the employers of regular migrants and nationals are also obliged to contribute towards their employees’ health care. Most IMs can only work in the ‘informal sector’ or ‘underground economy’: this undermines both their own living standards and the welfare budget, by keeping them out of the system of benefits and contributions.

The principle of equity requires[19] that *if* IMs are granted the same entitlements to health services as those residing and/or working regularly, they and their employers should pay comparable ‘up-front’ contributions. Human rights treaties insist only on the provision of *affordable* care, not *free* care.

But how can IMs contribute and under what circumstances should they be exempted from contributions? Regarding the first question, one solution which has been tried is to require payment on the spot (‘out-of-pocket’ payments) from IMs making use of services – not at cost price but at a fixed, low rate. The disadvantage of this is that such payments undermine the basic principle of universal coverage, which is that the healthy subsidise the sick. If the fixed payments are too low they do not generate enough revenue, and if they are too high they become prohibitive for IMs requiring frequent consultations. As for exemptions, IMs are almost never eligible for unemployment benefit, which is the usual criterion for being exempted from contributions in countries with a social health insurance system. Some kind of means test has to be applied if the terms on which they are given access are to be perceived as ‘fair’ and therefore politically acceptable, but this is not as easy as it sounds.

Among the 31 countries studied by the MIPEX Health strand survey, IMs in 11 countries are required by law to undergo a means test as condition of being covered for health costs. (Like other health system users, they may still have to pay a proportion of the costs out-of-pocket, though there may be exemptions from these payments.) The exact rules and procedures for means-testing vary widely between countries. However, means-testing of a sort may also be carried out tacitly in countries where health workers or officials have administrative discretion to allow or deny coverage to a patient, which is the case in 28 out of 31 countries. Even if the decision ostensibly concerns medical urgency, discretion may be exercised in such a way as to deny coverage to an IM who looks as though they should be able to afford to pay the costs themselves.

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[19] Provided also, that health care and immigration are ‘firewalled’ and all other barriers to access and accessibility are removed

Objections have been raised to means-testing for IMs on the grounds that it is a cumbersome and stigmatising procedure – objections which apply, in fact, to the many other health system users who are subject to it. However, it is difficult to see how equitability in relation to income can be maintained without some form of means testing. At the same time, a way has to be found to ensure that employers pay their share of contributions.

## 4. **Models for improving coverage**

In this section we examine briefly different strategies or models that have been used to improve access to health services for IMs. The aim is not to arrive at concrete recommendations about the 'best' model, but to show the variety of solutions that have been adopted in the context of different health systems.

Most European health systems are predominately financed either by taxation or social health insurance ('Beveridge' versus 'Bismarck' systems). It is sometimes assumed that tax-based systems promote more equitable access because entitlement is usually based on residence rather than employment or nationality, while health services are in principle free at the point of supply. However, one finding which emerged from both MIPEX and the Nowhereland study (Cuadra 2012) is the lack of association between the type of health system financing and legal entitlements to health care coverage for IMs. The explanation is simple: countries using tax-based financing can, and often do, drastically limit entitlements for IMs. Conversely, insurance-based systems can incorporate exemptions, payment ceilings and rebates in order to promote inclusiveness.

Nevertheless, the predominate source of health system financing makes a lot of difference to the strategies that can be used for improving coverage for IMs. We first consider three approaches applied in insurance-based systems.[20]

i. ***Possibility to enrol in the social health insurance system.***
**Switzerland** and **Luxembourg** allow IMs to enrol in regular SHI schemes. Officially it is claimed that no information about them is passed on to immigration authorities, although this is difficult to verify. Both IMs and their employers are supposed to pay the same contributions as nationals, but employers often evade this responsibility. As long as IMs also enjoy the same exemptions in case of low income as other groups, this solution seems the most straightforward one for 'Bismarckian' systems. However, NGO's have complained that the premiums involved are too high for many IMs. Moreover, in countries where exemption from contributions is based not on low income but on the receipt of unemployment benefit, a different criterion would have to be used to ensure equity for IMs.

ii. ***Inclusion in a parallel, state-financed system of coverage.***
By contrast **France** and **Belgium** do not admit IMs to their systems of social health insurance. IMs may use the same services as nationals, but their health costs are covered by the State. In France there are several state-financed schemes for those

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[20] For more details of the specific arrangements in each country, readers are referred to the Country Reports being prepared for the Equi-Health project (see http://equi-health.eea.iom.int/ )

who cannot afford insurance contributions (PASS, AME and CMU), in Belgium only one (AMU).The extent of coverage and any necessary co-payments are determined within these systems. Such parallel systems may make it easier to ensure confidentiality and equity, but they create an additional layer of administrative complexity which if not kept under control can lead to inconvenience, delay and extra costs (Roberfroid et al. 2015; André & Azzedine, 2016).

***iii. State-subsidised partial inclusion in the regular insurance system.***

The model adopted in **The Netherlands** since 2009 is as unique as the country's health system itself, which means that it would probably not be suitable for implementation anywhere else. IMs cannot join the nationwide system of private but state-regulated insurance schemes, but (with minor exceptions and subject to a means test) may use the same services and receive the same treatments as everyone else. For 'unplanned care' (first contacts) IMs have access to all services, but for 'planned care' (e.g. specialist care) they are restricted to certain hospitals and dispensaries. Service providers are required to attempt to recover all or part of the costs of treatment, but no formal rules govern this requirement and in practice, little effort is often put into recovering unpaid bills. A fund administered by the health insurers gives service providers 80% reimbursement for most treatments (100% for pregnancy and delivery). Confidentiality is prescribed by the medical code of practice. The system itself is in principle both secure and equitable – for nationals and regular migrants as well as IMs themselves – but there is widespread ignorance and confusion about how it is supposed to work. (For example, there is a common misconception that treatment is at the discretion of the health professional: indeed it is, but only to the same extent as for all patients.) This weakness could be remedied if there was sufficient will to do so.

Among tax-based systems, at present only Italy and Sweden offer reasonably adequate entitlements to IMs. Portugal and Spain previously granted good entitlements, but new restrictions have been introduced in the context of 'austerity measures' following the 2008 economic crisis.

***iv. Inclusion in a tax-financed National Health System***

In **Italy**, as we saw in Section II.2, national law expressly forbids the reporting of IMs to the immigration authorities. IMs have access to the same services as nationals, but to obtain coverage they must show a special 'STP' card certifying that their financial resources are limited, which has be renewed every six months. Treatment must also be 'urgent and essential' in the opinion of the doctor.

In **Sweden,** by contrast, there is no means test, but also no protection against the obligation on health workers to report to the authorities on request whether a certain person is being treated at a health care institution. Except for children (who have the same entitlements as nationals), only "care that cannot be postponed" may be provided, but there is no clear definition of what this includes: in practice, it is at the health professional's discretion.

From these examples we can see that there is no uniform way of extending Universal Health Coverage to IMs. The problem of confidentiality is solved either by national legislation (Italy), or by medical codes of conduct (France, The Netherlands), or not at all (Sweden). Fairness towards other health system users who may have difficulty paying compulsory insurance contributions is ensured by requiring normal contributions from IMs and their employers (Luxembourg and Switzerland), or by applying a means test (France, Belgium, The Netherlands, Italy). A 'one-size-fits-all' solution, even if it distinguishes between tax-based and insurance-based systems, is probably an unrealistic goal, though countries could undoubtedly learn from each other's experiences. More research and international cooperation is required to help countries design improved policies without having to 'reinvent the wheel'.

Because there may be considerable regional variations within some countries in the way in which services for IMs are administered, it can also be very instructive to consider the ways in which **local health authorities** have succeeded in improving access for this group. A review of positive measures taken in 5 countries has been undertaken by PICUM (2014).

### 5. Models for reducing non-legal barriers to access and improving quality

As we have seen in section I.3, it is not only restricted legal entitlements which create barriers to access for IMs. Administrative barriers (such as documents which are difficult to produce or discretionary decisions) often prevent IMs from exercising the entitlements that the law grants them. As we also saw, it is the countries with the most restrictive policies which also create the most administrative barriers. **If the criterion of 'emergency' or 'urgency' can be abolished, the barrier formed by this unpredictable form of discretion will disappear.**

An administrative barrier that will be harder to remove is the means-testing of IMs' incomes. To enjoy low-cost or free coverage nationals must disclose their income, and if IMs' are to be granted the same rights to use the system this will have to be accompanied by the same obligations – not only for them, but also for their employers. Methods of means-testing will have to be devised which do not entail unfair barriers for IMs (e.g. by requiring documents which are especially difficult for them to obtain, such as tax returns).

The serious barrier created by the risk of being reported to immigration authorities needs to be removed by measures to prevent such reporting taking place. Prohibition alone is not enough: all concerned – health professionals and administrative workers as well as migrants – must be clearly informed about it, and it must be strictly enforced.

Many 'good practices' have been developed in order to reduce access barriers for IMs. Overviews of these methods are available in the 'fact sheets' published by the Nowhereland project,[21] as well as by the EU project EUGATE (Dauvrin et al. 2012). It is useful to distinguish between two different sorts of 'good practices':

**i.** *Methods which are only necessary where IMs are not legally entitled to the full 'basket' of health services, and/or run the risk in mainstream services of being reported to the authorities.*

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[21] http://www.nowhereland.info/?i_ca_id=418

These mostly involve activities carried out by NGOs and volunteers, such as providing mediation and giving care. (A health worker in a mainstream service provider who gives help to IMs who are not legally entitled to it can perhaps also be regarded as such a volunteer.) Such efforts can only partially compensate for the inequities caused by legal obstacles.

**ii.** *Methods which will still be necessary if IMs are granted coverage for all services, as well as protection of their confidentiality***.**

These methods concern the provision of information about entitlements, using the health system, and health problems ('health literacy'), as well as mediation between health services and their users. In many cases, language barriers also play an important role. To a large extent these methods tackle problems that can be experienced by *all* categories of migrants, regardless of their legal status (and indeed by members of ethnic minorities who may be nationals). There would seem to be little point in developing methods for reducing these barriers separately for IMs and other groups, if the same remedies are appropriate. Moreover, the principle of inclusive care demands that the health system itself should accept responsibility for these tasks, rather than relying on voluntary organisations to carry them out.[22]

Finally, once the migrant patient has succeeded in getting access to the health care provider, special policies are necessary to ensure that the care given is adapted to his or her needs. This entails improving 'cultural competence' or 'sensitivity to diversity' and taking system-wide measures to support such improvements (which are not simply a matter of the skills of individual health workers). Measures to support such adaptations are covered by sections C and D of the MIPEX questionnaire, which are combined in the dimension 'quality' on the graph in section I.3 above. These issues, too, transcend the issue of the patient's legal status.

### 6. Rethinking the role of CSOs

Civil Society Organisations include NGOs, community-based and faith-based organisations. All have played an essential role in bringing the injustices of the present situation to light, in advocating for change as well as shaping and monitoring it, and in filling gaps in service provision. These include accessible and safe primary care services as well as the provision of information about entitlements, use of services and looking after one's own health.

What should the role of these organisations be when full health coverage is extended to IMs? While the consensus suggests that these services should be fully integrated into mainstream service provision, the experience and good contacts with the target group that CSOs have built up equip them to play an essential role in the development, implementation and monitoring of new policies.

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[22] In the MIPEX questionnaire an NGO or other organisation to which tasks are outsourced is counted as part of the health system, as long as the additional costs are covered from health system or government funds.

# APPENDIX: MIPEX HEALTH STRAND QUESTIONNAIRE

There are 23 questions comprising 38 indicators. Numbers in brackets refer to the number of indicators used in each question. The full questionnaire is available at http://bit.ly/1Yciud7

## A. ENTITLEMENT TO HEALTH SERVICES

Inclusion in health system, services covered, special exemptions

1. Legal migrants (3)
2. Asylum seekers (3)
3. Undocumented migrants (3)

Administrative barriers to obtaining entitlement

4. Legal migrants
5. Asylum seekers
6. Undocumented migrants

## B. POLICIES TO FACILITATE ACCESS

7. Information for service providers about migrants' entitlements
8. Information for migrants concerning entitlements and use of health services (3)
9. Health education and health promotion for migrants (3)
10. (omitted)
11. 'Cultural mediators' or 'patient navigators' to facilitate access for migrants (2)
12. Reporting undocumented migrants / sanctions against helping (2)

## C. RESPONSIVE HEALTH SERVICES

13. Interpretation services (3)
14. Availability of 'culturally competent' or 'diversity-sensitive' services
15. Training and education of health service staff
16. Involvement of migrants
17. Encouraging diversity in the health service workforce
18. Development of capacity and methods

## D. MEASURES TO ACHIEVE CHANGE

19. Data collection
20. Support for research
21. "Health in all policies" approach
22. Whole organisation approach
23. Leadership by government
24. Involvement of stakeholders and Migrants' contribution to health policymaking (2)

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