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# Migrants' (ill)health - migrant health policies in the European Union

**Thesis submitted for the Master degree in**

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**Migrants' (ill)health - migrant health policies in the European Union**

*Thesis submitted for the Master degree in International Social Welfare and Health Policy*


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## Preface

When I started studying the Master degree in International Social Welfare and Health Policy my daughter was just turning five months old. By the time her first birthday was approaching, deadline for submitting a preliminary research idea was approaching as well. And exactly some plans regarding her first birthday led, quiet accidently, to the topic of my thesis. Namely, for us from Bosnia it is quite common for baby girls to get their first earrings for their first birthday. So, without thinking much about ear piercing, we got her a pair of earrings. And as we asked at jewelry shops, tattoo parlors and hairdresser saloons, they looked at us in disbelief and recommended us to wait till she turns 12 or at least 6 years old.

These apparent cultural differences and different cultural understandings lead me to consider what kind of cultural differences must exist in health care and how these cultural understandings could affect health care and health in general. Finally, quite complicated line of thought concerning cultural sensitive health care - vulnerable groups - migrants - health policy led to the topic of this thesis.

I would like to thank my mentor Halvor Hanisch for guidance and helping me keep focus and direction in writing this thesis. Furthermore, thanks goes to our teachers who were always open for discussions and new interpretations and other staff helping us on our journey through semesters. I would like to thank my fellow students for all the e-mails, Skype conferences, work on course requirements and invaluable cooperation throughout this degree.

My special thanks goes to my family, my precious Sara (yes, she proudly wore her earrings in her first birthday party) for being my light and inspiration, my dear husband Ismar for being my strength and support, my husband's mother and brother for playing with Sara as I was rushing to presentations and last but not least my brother and parents for always being there.

Oslo, Sept. 10th 2013

Mirela Slomic

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## Summary

As the migration trends seem to go towards an increased proportion of migrants in the EU countries, there is an increased interest in research concerning migrant health care and migrant health policies. Often, specific needs in migrant health care are not recognized and there is a lack of adequate responses from health care systems and health policy-makers.

This study focuses on exploring and reviewing barriers that migrant health care is facing in the increasingly diverse European Union. Further it focuses on exploring migrant health policies on international and national levels and analyzing how these policies promote or remove barriers in migrant health care. Nevertheless, it is important to keep in mind that health in general is influenced by other factors and not just by health care.

The most common barriers when it comes to health care access are language and communication barriers, while great importance is given to barriers in cultural understanding, health care providers' attitudes, stigmatization and discrimination. Major barriers are also found in administrative procedures and various practical obstacles. Asylum seekers and undocumented migrants are additionally burdened by legal restrictions.

International policy on human rights clearly recognizes the right to health as a human right. All the European Union countries are bound by those documents. Policy-making and decisions concerning health care are a national responsibility within the EU, and legislation as well as implementation remain extremely variable. Still, there are initiatives and examples of good practice and positive policy-making.

However, there are setbacks in positive developments in part as a result of the international economic crisis. Austerity measures and increasing xenophobia pose a continuous threat to migrant health policy leading to stagnation or even reversal of positive trends.

*Keywords*: migrant health policy, migrant health care, Europe, the European Union, inequalities in health care, health care access

# 1. Introduction

Migrant population is estimated to 1 billion people worldwide, including 214 million international migrants (WHO 2013a). 31.9 million non-EU nationals reside in the European Union (EU) - a majority of them in Germany, Spain, the United Kingdom (UK) and France (IOM 2013). Wide range of migrant population presents with largely different health determinants, needs and levels of vulnerability (WHO 2013a). This increasing diversity gives rise to new challenges for health care and health care systems in Europe that must also adapt in order to meet those new needs and provide adequate responses for migrant population (Rechel et al. 2011, 3).

Although migrants can be comparatively healthy[1] known as the 'healthy migrant effect', there are a number of issues and disadvantages that they are facing. Their specific needs in health care are poorly understood, while major communication issues and generally inadequate health care system response cause further difficulties for migrant population. Those challenges are deepened by problems migrants experience in realizing their own human rights and lack of comprehensive and comparable data on migrants and migrant health (Rechel et al. 2011, 4), as there is still a gap in availability of high-quality research on migrant health (Padilla 2009, 17).

Migrants can face obstacles in achieving good health care through communication and cultural barriers, discrimination, legal status and other socio-economic factors (WHO 2003). They are found to experience inequality in health and health care access (Padilla 2009, 17). Furthermore there is a lack of analysis of policies that would target or that do target those inequalities in health (Mladovsky 2009, 55). Needs of migrants in health care should be addressed at all levels of health systems in order to prevent discrimination and inequality in rights realization (Rechel et al. 2011, 6). Comprehensive and systematic research is needed in order to enable comparison and inform evidence-based decision making (Padilla 2009, 17).

## 1.1. Research topic and research questions

Recently, attention has been rising towards issues of migrant health and migrant health policy as European population has been becoming increasingly diverse (Rechel et al. 2011, 6). This study focuses on exploring and reviewing the barriers that migrant health care is facing in the increasingly diverse European Union. Further it focuses on exploring migrant health policies on international and national levels and analyzing how these policies promote or remove

[1] At least compared to the population remaining in the countries of departure

barriers to migrant health care. In this study I attempt to offer a comprehensive review of today's barriers to good migrant health care and an overview of the existing migrant health policies that either cause or attempt to resolve those issues.

This study explores the issues of migrant health care and the efforts to create successful policies that would deal with those issues at international and national levels. However as the global, worldwide situation in this area is quite complex and well beyond the scope of a master thesis, I deal with the challenges set before migrant health care in the European Union and the policy-making efforts in this area. The research questions are:

> *Question 1:* What are the main barriers that migrant health care is facing in the EU?
>
> *Question 2:* How current health policies create those barriers in the EU?
>
> *Question 3:* How current health policies can contribute to remove those barriers in the EU?

### 1.2. Aims and objectives

In recent years there has been noticeably increased interest in studying migration and its different aspects. One of those aspects is certainly health as it impacts so many other areas of human existence and well-being (IOM 2013). It is in essence one of the most important preconditions for human life and human capabilities (Sen 2002, 660). Migrant health has been the focus of the Portuguese (2007) EU Presidency followed by the Spanish (2010) EU Presidency and the focus on health inequalities (IOM 2013).

The aim of this study is to explore the interplay between migration as a health determinant, migrant health care and migrant health policy in the European Union. The study explores the ways in which migrant health care challenges and barriers to migrant health care are understood and how this understanding influences health policies in the European Union.

Migrant health care is of interest not only because of a growing number of migrants in Europe, but also because ill-health can negatively affect integration processes and lead to further social isolation and exclusion. Furthermore, the right to health is a legal as well as a moral obligation grounded in a number of international policy documents and equity in health care is a fundamental goal for many health care systems in the European Union (Nørredam 2011, 67).

### 1.3. Theoretical background and key terms

In this section I provide a more precise definition of the key terms in this study and theoretical background for the concepts used throughout this paper. Those are migration, health and health policy.

*1.3.1. Health and health policy*

World Health Organization (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Although this definition might be regarded as impractical, it covers a full range of human existence and as such offers an idealistic goal to strive to. For the purposes of this study I will attempt to keep in mind this broad definition of health.

Health and illness can be viewed through the medical model which is predominant in the medical world, although questioned by some doctors - especially in the areas such as public health, pediatrics and family practice - and assumes that illness is an objective deviation from normal biological processes. On the other hand one finds the sociological model of health and illness where illness is assumed to be a subjective notion that involves predominantly personally and socially created ideas about what abnormal is (Weitz 2010, 110).

Health and illness are a major topic for discussion in the area of social equity and justice (Sen 2002, 659). Health is regarded as a special good as it is closely connected to human well-being and functioning (Anand 2002, 485). In such a way inequalities in health are attached to inequalities in basic human freedoms and opportunities (Anand 2002, 485). Exploring inter-group inequalities in health allows for uncovering groups that are at higher risk and directing policies towards those groups. At the same time it aids in uncovering particularly unjust inequalities in health such as racial, ethnic or gender inequalities that allow for the suspicion that those inequalities are caused by social rather than natural factors. However, this type of inequality in health is possibly solvable by the means of public interventions (Anand 2002, 487).

Health policy 'refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society'. Health policy defines a vision and goals to be achieved and establishes targets and points of reference for further work. It points out priorities and defines roles for different groups in order to achieve previously set goals. It informs people and further decision-making (WHO, 2013b). In other words health policy has a direct impact

on priorities of service providers (Ingleby 2006, 7-8). However, policy issues in health care are a matter of general allocations of resources to health as opposed to arrangements of health care alone. One example is that different social arrangements can improve health of vulnerable populations and improve equity in health (Sen 2002, 661-662). It is also possible to distinguish between two levels of health policy, one level being legislative level in which rights are established, while the other one is the level of specific responses to this legislation by the health care systems (Vazquez 2010, 71).

### *1.3.2. Migration theory and migrant categories*

A wide range of theories is proposed in order to explain some of the reasons for starting international migration and migration in general. Although all of the theories attempt to explain the same concept, their approach and focus are widely variable. Neoclassical economics focuses on income and employment benefits and places decision-making on individual level. The 'new economics of migration' sets focus not only on labor market, but on a range of other factors. All of those factors are valued at household level and decisions are based on lowering risks to family income. Dual market theory explains migration through intrinsic labor demands of contemporary industrial societies. World system theory assumes an even broader view explaining migration not only by national factors, but by the structure of the world market. Those theories are not necessarily incompatible since they focus on causal processes at different levels - individual, household, national and international (Massey et al. 1993).

All of the above mentioned theories involve 'push - pull factors', and this is the most common approach to understanding causes that initiate migration. 'Push factors' include different economic, social and political hardships faced in the country of origin, while 'pull factors' represent comparative advantages in the countries toward which migration flows are directed (Portes and Borocz 1989, 607).

Migrants are not a homogenous group, but quite contrary a widely variable population in terms of country of origin, ethnicity, language, religion and culture. In addition there are differences in migrants' legal and residency status (Rechel et al. 2011, 246). A major distinction is made between 'forced' and 'voluntary' migrants. The former group includes internationally displaced people (refugees), internally displaced people and those displaced by natural and environmental disasters, development projects and famine (WHO 2003).

# 2. Methodology

This study is a systematic literature review. Systematic literature review is a method making sense of a large amount of literature, outlining areas that are uncertain and that require further research (Petticrew and Roberts 2006, 2). Particularly in still immature fields of research systematic review underlines a lack of data (ibid, 35). This type of review attempts to comprehensively identify, evaluate and objectively synthesize all the studies that are relevant to the topic in question using transparent methods throughout research process (ibid, 266). Systematic approach attempts to reduce the bias in the synthesis process as it adheres to scientific methods in an attempt to identify and critically appraise all relevant studies (ibid, 9). Final synthesizing can be done through narrative approach when primary studies are evaluated and their heterogeneity is explored in a narrative rather than in a statistical manner (ibid, 19). Narrative synthesis approach is a method of synthesizing findings from multiple studies that can be both qualitative and quantitative in nature and it is based on using words and text. This type of synthesis and analysis is interpretive and is based on exploring relationship between different studies or within a single study (Pope et al. 2007).

This study deals with the articles relevant to the topic of migrant health care and migrant health policy in the European Union. A systematic literature review method is appropriate for this study as it offers a cumulative view of the relationship between some of the specific issues that migrant population is facing when it comes to health and health care services and health policies that attempt to solve those issues.

Using systematic literature reviews can be of value when there is a range of research on a particular subject that does not fully answer key questions (for example questions about human experiences) or in those cases when a general overview of past research can direct further efforts (Petticrew and Roberts 2006, 21). Systematic review can also be used as a tool in order to inform policy and practice and to assist evidence based decision-making (ibid, 11).

## 2.1. Data sources and selection

Main data sources analyzed are scientific articles and various reports published in the period between 2003 and 2013. I searched for journals and articles relevant to the study topic in several databases: Academic Search Premier, Medline, Google Scholar and Social Sciences Citation Index. The initial data search was conducted in June 2013. Reference lists of relevant studies and articles were also used.

A new search was conducted in July 2013. Keywords used in the searches were migrant health policy + migrant health + Europe. In advanced search I also searched for terms related to the keywords and for the keywords within the full text of the articles in order to include also articles that did not have the keywords in their titles. Search in Academic Search Premier and Medline using EBSCOhost platform returned 43 hits for the period between 2003 and 2013, while search in Google Scholar yielded 96 and search in Social Sciences Citation Index 53 hits for the same period. Most of the search results appeared in multiple databases. Also related terms such as migrant health policy + migrant health + access to health care, migrant health policy + migrant health + health care utilization, policy analysis + migrant health + health policy were used in the search. However those terms did not seem to yield new results. As additional variation in search terms did not offer any new results, further searches were not conducted and focus was shifted to selection and inclusion of articles and their analysis.

Additionally 'grey' literature was searched, primarily official reports and reports from non-governmental organizations (NGOs), briefings and policy documents available via WHO, IOM, the EU and their different agencies. A number of 'grey' literature documents that were especially relevant in answering the research questions were included in the final analysis.

In an attempt to answer the first study question articles that were published in reputable scholarly (peer-reviewed) journals were included in the study. Inclusion criteria were that they dealt with one or more of the issues that migrants are facing when it comes to health and health care and that those articles included also the policy implications and policy recommendations for dealing with migrant health issues. Only studies using primary data were included in the research. Studies with very variable study design were included in the study and I attempted to overcome those differences during synthesizing of the findings. Both research using qualitative and that using quantitative or combined methods was included in this study. It is often necessary to include a broad range of evidence from previous research in order to gain a 'broad' focus on the topic in question (Petticrew and Roberts 2006, 74).

In order to answer the second study question articles analyzing, describing and comparing migrant health policy were included. Both case study articles - describing current situation and trends in one country or comparative studies of migrant health policy in 2 or more countries were included in this study. Also several reports by governmental and nongovernmental organizations were included in this study in the section on migrant health policies.

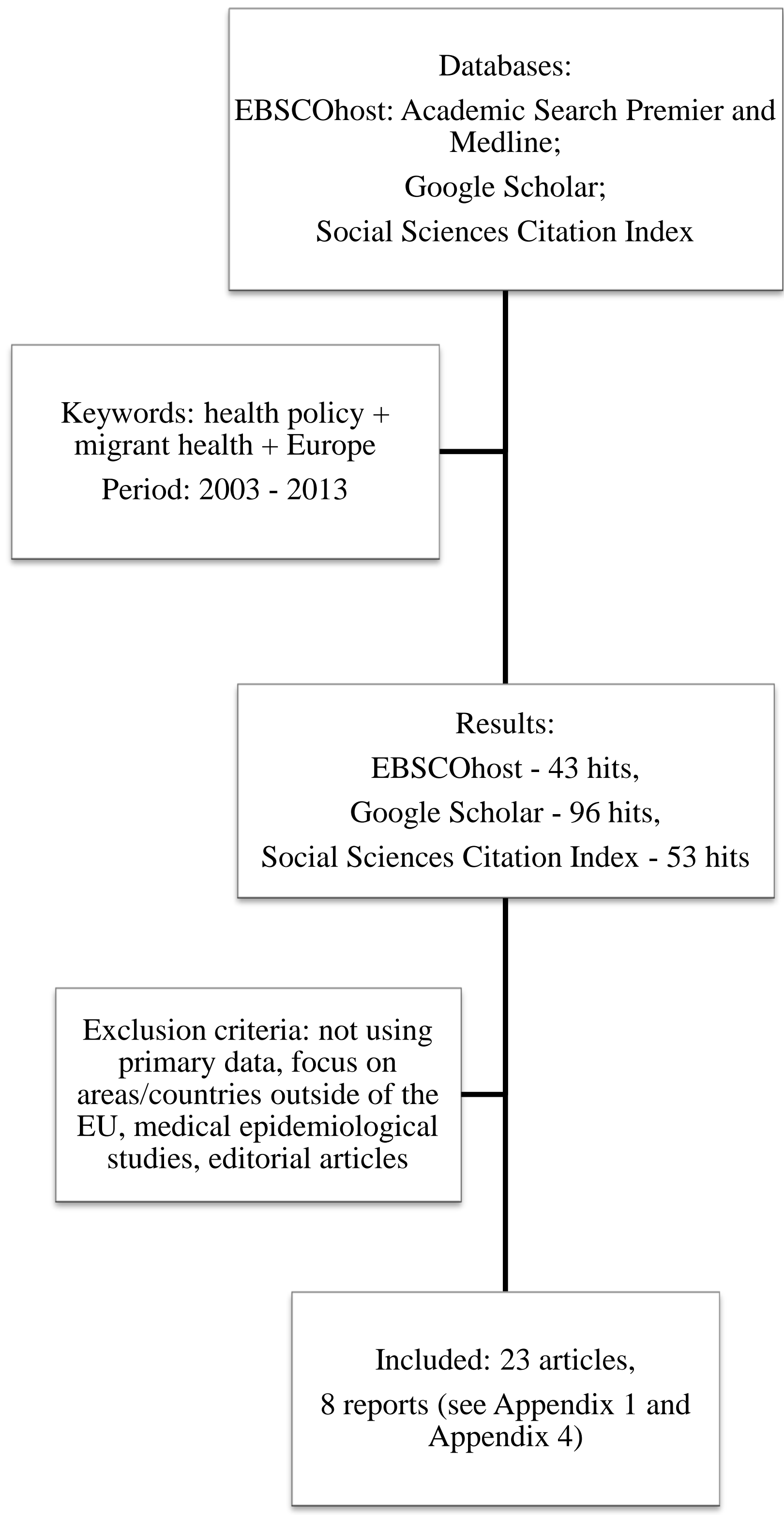


*Chart 1. Literature search and selection process*

In general three main groups of articles were included in the study, relevant to one or more of three research questions in this study:

- Articles dealing with migrants/users' experiences and their perception of barriers in migrant health care,
- Articles dealing with providers/experts' experiences and their perception of barriers in migrant health care and
- Articles describing, comparing and analyzing existing migrant health policies.

Articles focusing on areas and countries outside of the Europe Union (EU) were excluded from the study as well as articles with focus on mapping inequalities in health such as differences between migrant and host-country population in prevalence and incidence of certain medical conditions that is to say studies that were primarily epidemiological. Existence of such differences, in part due to migrant status, was assumed for the purposes of this study. Editorial articles were excluded from the study.

**2.2. Analytic strategy**

In the analysis I attempted to synthesize the findings of the studies included in this research and examine the relationship among studies and within each of the studies in relation to the research questions. The main analytic strategy was that of text analysis with focus on interpretation and meanings given to certain concepts. In order to do this I conducted data coding according to themes and clustering of data according to those themes analyzing them within each of the included articles or documents as well as among them.

In order to answer the research questions, findings are grouped in three sections. The first section attempts to answer the following question: *'What are the main barriers that migrant health care is facing in the EU?'* describing migrants' and providers/experts' experiences and their perception of barriers and issues that migrant health is facing in the European Union. The second and the third section include findings from policy analysis research and an overview of major policies at international and national levels within the European Union and attempt to answer to the second and the third research questions: *'How current health policies create those barriers in the EU?'* and '*How current health policies can contribute to remove those barriers in the EU?'*

### 2.3. Limitations

Systematic literature reviews can hardly offer final answers on their own, but rather propose partial answers (Petticrew and Roberts 2006, 45). Most of the literature on migrant health policy is quite recent as also is the interest in researching migrant health and migrant health policy. Consequently there is still a lot of diversity in approaches and lack of comprehensiveness when it comes to those topics. Different studies are based on different methodologies and research premises and as such they prove difficult to analyze and compare. However, literature review can prove to be the best tool in synthesizing diverse types of evidence.

Another limitation is that the literature reviewed is limited to literature published in English and that might be a source of bias. However, as there are data on a range of countries and migrant populations within Europe it should be possible to reach some level of conclusion, even if not a final one that could be generalized to all migrant populations in all settings in Europe.

### 2.4. Ethical considerations

As the research is a systematic review, only literature is used in the study and therefore I do not expect any challenges when it comes to ethics regarding the research process itself. It means that the study does not require approval from an ethical committee or institution dealing with research ethics. Anonymity, confidentiality and consent do not present an issue due to this study design.

Ethical concerns, in the case of this study, are primarily directed towards proper citation and referencing and avoiding misquoting of other authors' work. It is essential to be clear over which interpretations are my own and which ones are those of the other researches.

## 3. Findings

This part describes the findings in detail, focusing on answering the research questions. The findings are grouped under three headings. The first one attempting to answer the first research question: '*What are the main barriers that migrant health care is facing in the EU?'* While in the second and the third part I give an overview of current developments, existing policy documents and review the existing literature on policy analysis in an attempt to answer the second and the third research question: *'How current health policies create those barriers in the EU?'* and *'How current health policies can contribute to remove those barriers in the EU?'*

*Table 1. Overview of included literature relevant to each of the research questions*

| Included literature | Relevant to research question 1 | Relevant to research question 2 | Relevant to research question 3 |
|---|---|---|---|
| Articles (number) | 10 | 13 | 13 |
| Reports (number) | 2 | 8 | 8 |

### 3.1. Main issues and barriers to migrant health care

After detailed examination of the literature search results, 10 articles and two reports were included for review in this section of the thesis. Although online search included period from 2003 to 2013, most of the included articles (9/10) were published in 2007 or later. This might be in line with the increased interest in migrant health during and after Portuguese EU Presidency (2007) that had a major focus on migrant health.

Out of 10 included articles seven focused on different migrant populations, two had focus on health professionals, while one of the studies included both migrants' and health professionals' perspectives. A range of study design applied varied from combination of self-administered questionnaires and in-depth interviews, semi-structured individual and group interviews, focus groups and structured interviews. A wide variety of migrant populations was included in individual studies - ranging from a single ethnic group with Aung et al. focusing on Burmanese migrants in London, Boateng et al. focusing on Ghanaians in Amsterdam, Torress-Cantero et al. focusing on Equadorian migrants in Madrid to including diverse migrant populations or focusing on groups with certain legal status such as undocumented

migrants, asylum seekers and refugees. Studies with health professionals as participants included general practitioners (GPs), emergency room (ER) physicians and emergency room (ER) nurses (Appendix 1). Two reports included in this part of the study were based on survey analysis and interviews with patients that sought health care help with voluntary health care services offered by Médecins de Monde (MDM) in a range of the EU countries. One report focused on undocumented migrants, while the other one included different vulnerable groups (Chauvin et al. 2013, Chauvin et al. 2009).

All of the studies included in this research attempted to map some of the barriers in migrant health care either perceived from migrants/patients' point of view or from perspective of health care providers. Further they offered recommendations and policy implications following the analysis of the results of the respective studies. Although targeted populations, study design and participant selection strategies differed, there were some recurring themes appearing in the results and consequently in the conclusions (Appendix 2).

Most commonly mentioned barrier to migrant health was language barrier. It was one of the major perceived obstacles in all of the studies, with exception of Torres-Cantero et al. study that was conducted with Equadorian (Spanish-speaking) participants in Spain. Both the migrants and the health care professionals perceived communication problems due to language barriers (Appendix 2). Even relatively young, well-educated respondents with a fair level of English language communication skills reported some level of language barrier, 'being afraid to speak English', in contact with health care services. This might suggest that the issue of language and communication might be of even greater importance for those less educated and with worse language skills (Aung et al. 2010). Language barriers prove to be especially underlined in communication between vulnerable groups such as undocumented migrants, asylum seekers and refugees and migrants with mental distress and problems (Biswas et al. 2011, Palmer et al. 2007). However language and communication issues are evident in other areas as well, such as chronic diseases management and when it comes to negative experiences in health care in general (Rhodes et al. 2003, Suurmond et al. 2011). Health professional reported concern for language barrier also in terms of using children or family members as interpreters. However, even when using professional interpreters the question remains concerning developing of a patient-practitioner relationship and confidentiality (Priebe et al. 2011).

Language barriers seem no more important than barriers revolving around providers' attitudes, stigma, mistrust and discrimination (Chauvin et al. 2009, 93-103, Chauvin et al. 2013, 18-19). In the study where migrants of African, South American and East European origin participated providers' attitudes where perceived as limiting health care access regardless of the country of origin. Providers' stereotypes concerning migrants' health can play an important role in not providing the best possible health care (Dias et al. 2008). On the other hand providers' attitudes towards treating undocumented migrants are often arbitrary due to lack of official policies and guidelines (Biswas et al. 2011). Health care providers' attitudes can give rise to fears of discrimination that are often based on previous or current experiences and media coverage of migrant issues (Priebe et al. 2011). This can be part of the reason for negative attitudes and mistrust in health care providers on the part of migrant patients (ibid, Boateng et al. 2012).

Stigma is particularly important in the cases of accessing mental health services. Stigmatizing comes often from own communities and families as cultural understanding of mental health varies dramatically. However, varying levels of stigma can also exist within the majority population (Palmer et al. 2007). Discrimination can be a major challenge in accessing health care. Even so, it seems that as long as there are no legal barriers in accessing health care, there is no significant difference in health care access and utilization between legal and illegal migrants, although both categories might be discriminated against (Torres-Cantero et al. 2007).

Various administrative and practical barriers can also limit or prevent access to health care. Long waiting times for consultation or referrals were also common reasons preventing timely access to health care (Aung et al. 2010, Palmer et al. 2007). Asylum seekers and refugees were markedly subjects to long waiting before being referred (Palmer et al. 2007). Even when migrants are legally entitled to health care, limitations arise in form of difficulties in registering with GPs' offices and other administrative difficulties (Aung et al. 2010, Torres-Cantero et al. 2007). Practical barriers that were not directly related to health care organization and system included difficulties with job insecurity (Dias et al. 2008), distance to health care facilities, available and affordable transportation (ibid, Rhodes et al. 2003).

Additionally, lack of knowledge about the health care system in host countries and in the case of undocumented migrants lack of knowledge about informal networks of health care professionals prove to be additional challenges (Biswas et al. 2011). Those issues prevent

migrants from using health care provision that are already in place. At the same time health care professionals lack knowledge on cultural understanding of illness and treatment, religious norms and taboos related to health and migrant specific diseases (Palmer et al. 2007).

Undocumented migrants are additionally affected as they face formal barriers in health care access and provisions. In a number of European countries their rights are restricted by law also in the area of the right to health care (Aung et al. 2010, Biswas et al. 2011). In those countries undocumented migrants fear being reported to the police (Biswas et al. 2011), while also health care providers remain in doubt on whether they should or should not report those patients (Jensen et al. 2011). However, it seems that health care access and utilization remains equal for legal and illegal migrants when formal and legal obstacles are removed (Torres-Cantero et al. 2007). Although different design and different focus of the articles emphasized somewhat different areas of migrant health care, general policy implications pointed in the direction of need for improved strategies and action (Appendix 2).

The articles included in this study differed in their range, design and primary focus, but their results still pointed in the same direction. Questions regarding limitations of each of the articles dealt with possible bias in participant selection and number of participants. Furthermore quantitative and qualitative methods used were noted and their possible weaknesses in terms of generalizing the results were discussed. However their goal was not necessarily generalizing the results to all migrant populations or even to one population of migrants, but rather opening the area of understanding challenges of migrant health care from users' and providers' point of view and offering recommendations for further action.

### 3.2. Migrant health policy as a cause of barriers to migrant health care

In the previous section I attempted to describe some of the barriers to migrant health care in the EU by exploring original research articles and reports published in the period between 2003 and 2013 and covering a range of migrant populations. In this section I attempt to describe how migrant health care barriers are created by health policies or shortcomings in existing policies.

Acceleration of migration through globalization and faster communication and growing diversity pose a challenge to existing systems, including also health care system. Further development of health care systems and health policy relies on pre-existing general logic of

that particular health care system. This is a translation of two main distinctions: the first one regarding health system financing, the second one dealing with basic values shaping the inclusion of differences. In the area of health care financing one approach is universalistic, tax-based approach also referred to as a Beveridgian system, while the other one is insurance based or categorical approach that is also known as Bismarckian system. General approach to inclusion of differences in a society can be described as either communitarian - based on differences or republican - difference 'blind' (Chimienti 2009, 83). Those two distinctions regarding approach to financing and inclusion of differences are important as pointers and predictors in analyzing migrant health policies.

Another key predictor of a course that migrant health policy takes in a country is also related to diverse immigration and integration policies. Although all of them are based on the common European principles they take quite different shapes in practice with three main models appearing in research: the assimilation model[2], the differential exclusion model[3] and the pluralist model[4]. Those models can be found in combination in specific nation societies and are not static in nature, but rather open to change due to political change (Fernandes et al. 2009, 23). The main difference is between active approaches seeking to adapt health care services to migrants and passive approaches where it is expected of migrants to adapt to existing services (Mladovsky 2012b, 2). In this section I present the findings on health care policy by analyzing articles and reports listed in Appendix 4.

*Austria:* In Austria policy on undocumented migrants tends to be very restrictive and translates into denying access to social services including health care services. However, as law on hospital states that they should admit any patient with injury and whose health is in serious danger, it opens for a possibility of undocumented migrants receiving health care services. They need to pay for the full costs of the services used. Hospitals can apply for reimbursement to the District Social Welfare in the case of unpaid bills. Undocumented migrants can be tested for HIV free of charge, but again any treatment must be paid in full (Collantes 2007, 13-15).

*Belgium:* Even though asylum seekers are legally entitled to the same level of health care as the nationals, limitations are connected to administrative procedures required in order to

[2] Migrants are to adopt the social and cultural practices of the host communities and abandon their own.
[3] Associated with guest worker programs - migrants not encouraged to develop ties and bring their families.
[4] Nations are not homogenous or mono-cultural, so migrants can also keep their own culture and organize local communities.

obtain health care access (Collantes 2010, 5). Asylum seekers living out of the reception centers are required to present a 'payment warranty' in order to get free health care services. This involves a complicated administrative procedure that is largely not known by health care providers (Chauvin et al. 2013, 38). For undocumented migrants the administrative procedure in order to access health care is quite complicated and not taking into account socio-economic characteristics of this migrant group (Romero-Ortuno 2004, 265-266, Collantes 2007, 23). Financial as well as medical needs must be documented and this involves a home visit from social services. Application might be refused on the grounds of alleged 'refusal to cooperate with social enquiry' - a purely subjective decision. Pregnant women need also to apply for the 'urgent medical assistance' (AMU) in order to obtain pre- and post-natal care. Vaccination is free of charge only for children below 6 years of age (Chauvin 2013, 38).

*Cyprus:* In contrast to the most of the other EU countries health care coverage for legal migrant workers varies according to their professional area and can be barely minimal. For example women in job as domestic workers must pay 50% of their private health insurance and are not entitled even to gynecological and maternal care (Collantes 2010, 5).

*Czech Republic:* In Czech Republic certain administrative and financial barriers still exist in access to health care for asylum seekers. A 'regulation fee' at the point of seeking health care, also applicable to all insured people, can pose a barrier even if it is relatively low at €1.20 since asylum seekers are not allowed to work or receive welfare benefits during the first year in the country. Additionally they are not issued the usual insurance card, but a certificate that the majority of health professionals are not familiar with (Collantes 2010, 6).

*Estonia:* In principle they have access to primary and secondary health care, but in that case they have to cover for full costs of the health care services provided (Cuadra and Cattacin 2011, 16).

*France:* Initiatives were mentioned attempting to lower coverage for undocumented migrants from 100% to 75% (Collantes 2007, 29) and undocumented migrants with income above €661 must pay full price for health care services (Chauvin et al. 2013, 39). Numerous obstacles in obtaining even those rights that are granted by law include administration barriers, social stigmatization and discriminatory practices (Larchanche 2012, 861-862).

*Germany:* Migrant health is not addressed at the national level, but rather it is dependent on local initiatives. This negligence of migrant issues is related to the predominant view

connecting migration and criminality (Chimienti 2009, 87-88). Germany has a rather restrictive policy regarding asylum seekers and health care. During the first four years (48 months) of stay in the country they are only entitled to free emergency ('serious illness and acute pain') and necessary ('recovery, improvement or relief of illness and their consequences') treatment (Collantes 2009, 61). In order to obtain health care beyond 'emergency' and 'necessary treatment' asylum seekers must apply for a Health Insurance Certificate (Krankenschein) (Chauvin et al. 2013, 40). As illegal immigration is considered a criminal offence, undocumented migrants are in a particularly difficult situation. Additionally, Article 76 of the Aliens Act (Ausländergesetz) obliges all public servants to report to the authorities any illegal migrants that they might encounter during their work (Romero-Ortuno 2004, 256). So even if this is not applicable to medical staff due to professional obligation to secrecy, the obligation of other staff working in public health services to denounce undocumented migrant poses a major barrier in obtaining access to health care (Romero-Ortuno 2004, 264). In principle undocumented migrants are entitled to the same level of health care as asylum seekers, but in practice it is hardly relevant due to the obligation to denounce and also the penalization of assisting undocumented migrants (Collantes 2007, 37-39, Chauvin et al. 2013, 40). The Federal Assembly (Bundesrat) issued an instruction in September 2009 that hospital, both medical and administrative, staff is obliged to medical confidentiality, as well as social services staff receiving information from those bound by medical confidentiality. However, this did not have major practical implications as for all care beyond emergency the first contact is with social services and they still have the duty to denounce (Chauvin 2013, 40).

*Greece:* Due to the economic crisis the National Health System was targeted by major reforms that led to 40% cut in public hospitals financing. Co-payment for drugs is set at 25%, while en entrance fee of €5 is introduced for hospitals and health care centers and all services except the first consultation are charged (e.g. €30 for blood tests) (Chauvin et al. 2013, 42). Almost all types of medical care and medications are free of charge for asylum seekers as long as they can prove lack of financial means. However HIV treatment is not included under free medical care. They are entitled to access health care only in public health facilities if not working. Even though legal framework is in place it is hardly applicable in practice due to the government's incapability in managing asylum applications and ensuring minimum standards for asylum seekers (Collantes 2010, 7-8, Chauvin et al. 2013, 42). Undocumented migrants in Greece are granted health care only in emergency and life-threatening conditions. Since a

circular from 18 August 2011 requires a doctor's examination before deciding on seriousness of a medical condition it is left to the attending doctor to decide on whether a patient is entitled to medical care. Similar situation is in the area of HIV treatment. The Directive of 2 May 2012 clearly states that public and social security institutions are not obliged to provide services to undocumented migrants with the exception of emergency care and child care facilities. Furthermore, state of health and unsanitary living conditions have become a legal reason for detention of undocumented migrants (and asylum seekers) according to an amendment to the Presidential Decree 114/2010 and even a reason for deportation since 2012 (Chauvin et al. 2013, 42).

*Hungary:* In Hungary undocumented migrants can access emergency care that is not clearly defined by legislation. As a result it is up to health care providers to decide on whether a medical condition can be considered emergency or not. As undocumented migrants are excluded from the national insurance scheme, they may obtain other health care services only by full payment (Collantes 2007, 49).

*Italy:* Although Italy has rather well-developed policy on migrant health care, it is difficult to come to conclusion regarding implementation, partly due to decentralization of the system and shared responsibilities between the national and local governments. However, at the regional level there are implementation differences and priority lies in diminishing the gap in services provided in different regions. Collecting data on migrant health and health care is rather scarce and non-comprehensive, although some data is available (Giannoni and Mladovsky 2007, 5-6). Administratively undocumented migrants have to declare lack of financial means and register for Straniero Temporaneamente Presente, a regional identity code (Romero-Ortuno 2004, 259-260). For some services (specialized outpatient care and outpatient treatment of chronic and communicable diseases including HIV/AIDS) a participation fee must be paid. Although broad coverage is legally defined, some differences in implementation still exist among regions (Collantes 2007, 51-53).

*Lithuania:* Undocumented migrants are granted access to primary and secondary health care. However, this remains limited to the Reception centers and undocumented migrants living in those centers (Cuadra and Cattacin 2011, 17).

*Malta:* Although asylum seekers are entitled to access health care, in practice it is highly dependent on arbitrary decisions by health care providers (Collantes 2010, 9). Also the fact

that most of the asylum seekers in Malta live in detention centers leaves it to good-will of managing and guarding employees to allow asylum seekers access to health care facilities and services (Collantes 2009, 94).

*Netherlands:* Basic obligatory insurance does not cover all types of treatment (Chimienti 2009, 85; Chauvin et al. 2013, 43). Furthermore, as opposition towards cultural pluralism increased the government renounced the idea of intercultural health care (Chimienti 2009, 85-86; Suurmond et al. 2007, 3; Mladovsky et al. 2012b, 5). Since 2002 policies related to migrant health care have been almost exclusively regressive (Mladovsky 2012b, 7). The government moved in favor of the concept of migrants being responsible for adapting to health care system. However the Secretary of State for health recognized that at least older immigrants must be targeted with new programs in order to improve long-term care (Suurmond et al. 2007, 3). Recently the central government discontinued financing the 'immigrant health promoters', so it remains on the local authorities to finance those services if they are to remain active (Mladovsky et al. 2012b, 6). In Netherlands undocumented migrants were legally denied access to health insurance and health care by the Linkage Law (Koppelingswet) adopted in 1998. This principle was included in later legislation and the Aliens Act of 2000 (Romero-Ortuno 2004, 256-257, Collantes 2007, 61). Even when it comes to free care that is legally available it remains providers' arbitrary decision what is to be considered 'necessary treatment' (Romero-Ortuno 2004, 264, Chauvin et al. 2013, 43). In principle undocumented migrants have to pay for other health care services provided. If they can prove lack of resources to pay, health care providers might apply for reimbursement (since 2009) that amounts to 80% of usual fees. Children are in the same situation as adults except regarding preventive care and vaccination which is considered necessary (Chauvin et al. 2013, 43).

*Poland:* Access to the statutory health insurance is not granted for asylum seekers, but they are offered health care services at specific institutions. Although this provision is not officially clarified, it is understood as entitlement to all services as insured, but remains arbitrary (Collantes 2010, 9).

*Portugal:* Common barriers for undocumented migrants' access to health care are administrative and practical in nature, although access is granted in principle (Collantes 2007, 72-73).

*Romania:* Although asylum seekers are in principle granted access to health care through health care insurance, in practice this means that they are often uninsured due to a lack of resources (Collantes 2010, 10).

*Slovak Republic:* In principle undocumented migrants have access to primary and secondary health care if they pay full costs for the health care services provided or if they purchase a voluntary insurance (Cuadra and Cattacin 2011, 17).

*Slovenia:* A decision on whether a treatment is to be considered emergency and essential treatment, that asylum seekers are entitled to legally, remains an arbitrary decision of attending doctors (Collantes 2010, 11). Special institutions for the health care of uninsured - the Health Centers for Persons without Health Insurance may be also accessed by undocumented migrants in order to obtain primary and secondary health care (Cuadra and Cattacin 2011, 17).

*Spain:* Data collection on migrant health is quite recent and still not comprehensive enough (Stoyanova and Mladovsky 2007, 7). Decentralized system in Spain translates into regional differences in priorities and focus concerning certain aspects of migrant health care (Mladovsky et al. 2012b). The promising universal coverage system suffered a setback in 2012 after the adoption of the Royal-Decree Law No. 16/2012 setting limits to obtaining the individual health card that grants access to health care and increasing co-payment for medications for certain groups (Chauvin et al. 2013, 41). Although asylum seekers are entitled to health care, it is necessary to register at the local authorities (Padron) with a valid passport and a proof of residence, something that sets barriers for asylum seekers (Collantes 2009, 134). In Spain undocumented migrants who register at their local census (Padron), and go through a means-testing procedure, are entitled to full health care under the same conditions as the nationals (Romero-Ortuno 2004, 258). Registration at the local census might be challenging due to requirement for valid passport and the proof of residence (Collantes 2007, 80). As a consequence of confusion regarding the obligation to register many pregnant women and minors are also refused care, although they are officially entitled to health care services without registering (Chauvin et al. 2013, 41).

*Sweden:* Sweden's efforts regarding the right to health are in contrast to Sweden's neglecting the right to health care of asylum seekers and undocumented migrants (Alexander 2010, 216). Asylum seekers suffer discrimination in the area of access to health care services. They are

only entitled to free medical care that cannot be postponed, maternal care, family planning and abortion. Even for some of these services a contribution is required (Collantes 2010, 11, Chauvin et al. 2013, 45). Undocumented migrants in Sweden are not entitled to any benefit from the public health care system. Exception is undocumented children below 18 who have the same rights as the nationals when health care is concerned (Collantes 2007, 88, Alexander 2010, 226). Those rights are not granted by law, but rather they are the result of an agreement on financial provisions. Other groups of undocumented migrants can in principle use health care services, but at full charging fees even in cases of emergency care (Collantes 2007, 88-89).

*UK:* It is at discretion of the general practitioners (GPs) that undocumented migrants can register on their list (Chauvin et al 2013, 40). Earlier HIV treatment was excluded for undocumented migrants' health care coverage since 2004[5] (Romero-Ortuno 2004, 257-258, Collantes 2007, 98-99). Furthermore, hospitals must ensure that the patients have resident status before providing services or ensure that the patients can pay for the services in the case of undocumented migrants (Grit et al. 2012, 47).

Although migrants with resident status are usually granted the same status regarding health care and access to health care services[6], a number of limiting factors can prevent them from fully using this right. Such barriers can relate to fee requirements and different administrative procedures in obtaining health care (Mladovsky et al. 2012b, 1-2). Facing economic crisis many Member States of the EU increased out-of-pocket payments and some drastically reduced financing in the health care sector (e.g. Greece). Austerity measures included reducing coverage in terms of services, populations covered and reducing the number of health care providers. Increasing poverty and dissatisfaction among the general population are used by populist political parties and migrants are often presented as easy scape-goats (Chauvin et al. 2013, 2). Under those circumstances an already vulnerable migrant population becomes even more disadvantaged as it faces further problems in addition to the general hardships brought by the economic crisis. Many previously adopted or proposed policies on improvements in communication including interpreter and 'cultural mediator' services, education for health care providers and information on health and health care system to migrants stagnate or are limited.

[5] Until 2012

[6] Only exception found in this study was Cyprus, although data on some of the EU countries (primarily East European) was not available in the included literature.

Asylum seekers and in particular undocumented migrants find themselves in a much less favorable situation as they are not often granted even the minimum of the rights (WHO Regional Office for Europe 2010, 16). The UK grants only emergency care to undocumented migrants, while it remains at the discretion of individual GPs that undocumented migrants can register as patients (Mladovsky 2012a, 249). It is important to note that in the absence of legal restrictions there are still barriers that might prevent asylum seekers from accessing health care services (Nørredam et al. 2005, 287-288).

*Table 2. Access to health care for asylum seeker and undocumented migrants*

| Country | Health care access | | | |
|---|---|---|---|---|
| | Asylum seekers | | Undocumented migrants | |
| | No access/ Emergency only[7] | Access[8] | No access/ Emergency only | Access |
| Belgium | | X | | X |
| France | | X | | X |
| Germany | X | | X (social services - 'duty to denounce') | |
| Greece | X (difficulties in asylum application process) | | X | |
| Italy | | X | | X |
| Netherlands | | X | X | |
| Poland | X | | X | |
| Portugal | | X | | X |
| Slovenia | X | | X | |
| Spain | | X | | X |
| Sweden | X (even emergency care charged) | | X (even emergency care charged) | |
| UK | | X | | X |

Even though asylum seekers and their right to health care are mentioned in international as well as national policies, there is still a variable level of services provided to asylum seekers across the EU. In some countries such as Germany they are facing restrictive policies, while

[7] Some additional service may be offered to e.g. minors, pregnant women or for infectious diseases
[8] There may be administrative barriers or minor charges

other countries provide health care rights on the paper, but they are hardly translated in practice. This is due to a number of barriers including unfamiliarity with own rights and entitlements, complicated administrative procedures and arbitrariness on the side of health care providers. Somewhat better range of services is usually offered to asylum-seeking children.

Access to health care for asylum seekers and particularly for undocumented migrants remains a matter of numerous problems. Health care coverage and conditions vary enormously among the European Union countries. Even in those cases where legislation is in place and the right to health care is guaranteed, numerous obstacles prevent implementation in practice for both asylum seekers and undocumented migrants. Although asylum seekers meet with some limitations in health care access, undocumented migrants are especially suffering as they are often not entitled to any health care including emergency without having to pay for it - such is the case in Sweden or they are practically prohibited from accessing health care institution as public servants are legally obliged to report them - as in Germany.

Policy context for undocumented migrants range from complete ignorance to acknowledgment and in turn access to health care ranges from none to full coverage (Karl-Trummer et al. 2010, 13). As illegal immigration to Europe was increasing, focus was set on immigration policies that became rather restrictive. Part of this fight against illegal immigration was restricting or denying the access to publicly funded health care for undocumented migrants. Even if limited access to health care is granted it remains under the shadow of strong barriers (Romero-Ortuno 2004, 245). Increasing link between health care access and immigration control policies is in direct opposition to fundamental human rights and represents an additional social exclusion factor for those already excluded (Collantes 2007, 7). Besides providing health care services does not seem to be a strong motive for migration (Grit et al. 2012, 39).

Even when undocumented migrants are entitled to certain level of health care, research shows that one quarter of them is unaware of their rights. Even those who know about the right might lack knowledge of the steps needed to obtain those rights or meet further barriers in fulfilling those steps. This leads to a minority of those who are theoretically entitled to health care coverage to actually use that right - approximately 10% in Belgium and France. Situation is somewhat better in some of those countries that are the most open to providing health care to undocumented migrants - approximately 60% effective health coverage in Spain and Italy

(MDM 2009, 68-70). Effectively undocumented migrants cannot access health care if they have to pay for it, since that is in most cases unaffordable. That is to say that even if the right to access health care is granted, it does not necessarily mean that it is practically accessible (Cuadra 2011, 2).

Those who stay out of regular health care system are in some cases provided for by non-governmental organizations (NGOs) that often have much better contact and insight into those vulnerable populations' needs. However, a few issues arise related to NGOs - it is often difficult to guarantee sustainability and quality control of services over time and social exclusion of the users might even increase (WHO Regional Office for Europe 2010, 16).

### 3.3. Migrant health policies as means of removing barriers to health care

Legal entitlements are of utmost importance as a precondition if the right to health care is to be protected (FRA 2011). Furthermore, need for policies that would lead to creating culturally responsive health care was acknowledged (Aung et al., Priebe et al. 2011, Rhodes et al. 2003, Suurmond et al. 2011). It was implied that although cultural sensitivity in health care is of utmost importance, battling common weaknesses in health care provisions must be addressed as well (Rhodes et al. 2003). Additional policy implications included promoting health care access in general (Boateng et al. 2012), strategies addressing barriers especially in the case of recent and undocumented migrants (Dias et al. 2008) and generally creating policies in line with international human rights legislation (Biswas et al. 2011). It was also suggested that policy changes were needed not just in health care, but in other areas of social well-being with focus on social concept of ill-health (Palmer et al. 2007).

At first I will present an overview over main international documents related to migrant health care and the right to health and later on I will describe and analyze examples of positive developments in health policy-making and migrant health care in some of the EU countries.

#### *3.3.1. Migrants and the right to health*

International policy documents grant the right to the highest attainable standard of health to everyone (UNCHR[9] 2003, Pace 2011, 57) as first enunciated by the World Health Organization (WHO) in its 1946 Constitution. The Universal Declaration of Human Rights (UDHR) was adopted in 1948 partly as the result of the atrocities and suffering of the Second World War (UN, 2013a). It set the declarative foundations for further development of legal

[9] United Nations Commission on Human Rights

framework in the area of the right to health in Article 25 stating that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services' (UN 2013b, UNCHR 2013). Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides legal basis for the protection of the right to health stating that 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (UNCHR 2013, OHCHR[10] 2013). The right to the highest attainable standard of health is also reflected in a number of other documents including article 24 of the Convention on the Rights of the Child (CRC), article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), as well as in in article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (UNCHR 2013). The right to health is acknowledged in regional treaties including the European Social Charter[11] (ibid).

The right to health acknowledged in Article 12 of the International Covenant on Economic, Social and Cultural Rights is further elaborated in General Comment no. 14 and it implies government obligation in providing conditions for achieving the highest standard of health for everybody. The mentioned conditions include not only timely and adequate access to health care services, but also a range of other condition that include adequate environmental and occupational conditions, housing, safe water and nutrition (CESCR 2000). In addition the Committee on Economic, Social and Cultural Rights and Committee on the Elimination of Racial Discrimination stated that governments have a legal obligation in granting the right to health also to undocumented migrants and asylum seekers (Pace 2011, 58). The European Committee on Social Rights recognizes denial of medical assistance to foreign nationals as a breach of the European Social Charter even if those foreign nationals are illegally within the territory of one of the States bound by the Charter (Pace 2011, 61).

Concern for migrant health led to the Resolution on the health of migrants adopted by the 61st World Health Assembly (WHA) in 2008. The resolution calls for, among other steps, migrant-sensitive health policies, equitable access and no discrimination, health information systems that are able to analyze trends in migrant health, providers' education in cultural and gender sensitivity and migrant health issues and bilateral and multilateral cooperation (WHO 2008).

[10] Office of the High Commissioner for Human Rights
[11] A Council of Europe (47 member states) treaty that guarantees social and economic rights

In the EU the main instrument of protecting health as a human right is the Charter of fundamental rights of the European Union (Fernandes et al. 2009, 28). Recent developments include adopting the Lisbon treaty in 2007 that emphasizes respect for human rights as one of the basic grounds on which the European Union was founded. The Treaty entered into force in 2009. However, although some of the law-giving and enforcement is based at the EU level, health services are still primarily a matter of national level decisions and policy-making (Pace 2011, 62). Nevertheless, direct EU influence is increasing and the Lisbon treaty provides the Charter of fundamental rights of the EU with legally binding power (Pace 2011, 63).

At the EU level attention to migrant health care has been greatly influenced by the Portuguese (2007) and the Spanish (2010) EU Presidencies. The case of the Portuguese Presidency proves that interest at a governmental level can lead to major developments and provide impulses for future initiatives and policy developments. It was in part due to Portuguese initiative that the Resolution on the health of migrants was adopted in 2008 (Peiro and Benedict 2010, 1-2). However, it was already in 2006 that the Council of Europe issued recommendations in order to prioritize health care in a multicultural society. Among other points the Recommendations focused on health care access, intersectoral and multidisciplinary approach and the necessity of health policies acknowledging multicultural setting (Council of Europe, 2006). Furthermore Bratislava Declaration on health, human rights and migration adopted by the Council of Europe in 2007 acknowledged the need for creating health policies with regards to ethical and human rights aspect (Council of Europe 2011a). Another recommendation in 2011 brought to focus migration and health care. In this recommendation emphasis was on migrant health and removing barriers in access to health care (Council of Europe, 2011b).

The rights of asylum seekers are addressed in the Council of the EU directive 2003/9/EC stating the minimum standards for the reception of asylum seekers. Under Article 15 of the Directive member states are obliged to provide the necessary health care - at least emergency and essential treatment of illness as well as necessary medical and other assistance to those with special needs (Council of the European Union 2003, 22-23).

Table 2 provides a list of some of the major international policy documents relevant to the topic of the right to health.

*Table 3. International legal instruments (WHO Regional Office for Europe 2010, 3)*

| Institution/level | Legal instrument/policy document |
|---|---|
| United Nations (UN) | • Universal Declaration of Human Rights (1948)<br>• International Convention on the Elimination of All Forms of Racial Discrimination (1969)<br>• International Covenant on Economic, Social and Cultural Rights (1966)<br>• Convention on the Elimination of All Forms of Discrimination Against Women (1979)<br>• Convention on the Rights of the Child (1989)<br>• Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)<br>• The right to the highest attainable standard of health. General Comment No. 14, Committee on Economic, Social and Cultural Rights (2000) |
| Council of Europe (CE) | • European Convention on Human Rights (1950)<br>• European Social Charter (1961, revised 1996) |
| European Union (EU) | • Directive combating discrimination (2000) (the “racial equality directive”)<br>• Charter of Fundamental Rights of the European Union (2000) |

Interest in research topics connected to migration and migrant health care increases at international level and the European Cooperation in Science and Technology (COST) is involved with ISCH[12] COST Action IS0603: Health and social care for migrants and ethnic minorities in Europe (HOME) (COST, 2013a) and ISCH COST Action IS1103 Adapting European health systems to diversity (ADAPT) (COST 2013b). Another initiative is the MIGHEALTHNET project - Information network on good practice in health care for migrants and minorities in Europe (MIGHEALTHNET, 2013).

At the same time, legal provisions and policies relevant to migrant health care exist at national levels and within nations at regional and local levels. Some states recognize the right to health in their constitutions, while others rely on more general provisions concerning human rights. Examples of good legislation are present in some of the EU member states regulating migrant health provisions for both regular and irregular migrants, but there are still steps to be taken in granting the right to health for migrants (Pace 2011, 63-64).

[12] Individuals, Societies, Cultures and Health

*3.3.2. Positive migrant health policy developments in the EU*

In the EU countries regular migrants are generally entitled to all or to the most of the health care provisions as ordinary citizens. In some cases those rights might be conditioned by the length of stay in the host-country or by the employment status in those countries relying on health insurance via employer (WHO Regional Office for Europe 2010, 16). National governments can have a major impact on improving migrant health and the most important step in that direction is entitling migrants with the same rights that other residents already have (Mladovsky 2012a, 249).

*Austria:* In Austria resident migrants are entitled to full health care. Initiatives addressing migrant health are based on a ‘bottom-up’ approach and the main initiatives originate from civil society at local levels. In 2005 the Ministry of Health created a working group to report on the main issues in health care of migrants. Rather declarative report was published ‘Interkulturelle Kompetanz in Gesundheitswesen’[13] (Chimienti 2009, 87).

*Belgium:* In Belgium migrant health care and health inequalities are not specifically addressed in governmental policies, but for example interpreter services are available although limited to hospital settings. Cultural mediators are also involved in helping patients in contact with health services and understanding of the health care system (Lorant 2010, 237). Legal residents have the same right to health care and must register with one of the health insurance companies. Those are non-profit organizations and registering is based on contributions for a membership. There is also a state-regulated direct payment for services that takes into account patients’ income. Additional possibility for those in financially vulnerable situation is to apply for assistance from a local Public Social Welfare Center (Collantes 2009, 22, Chauvin et al. 2013, 38). Asylum seekers are entitled to the same level of health care as Belgian citizens including both preventive and curative services (Collantes 2010, 5). Only asylum seekers who are students at a recognize higher education institution are entitled to register for the compulsory health insurance. Otherwise health care expenses are covered by the public reception centers for asylum seekers who live in those centers or the Federal Agency for the Reception of Asylum Seekers (Fedasil) or the competent Social Welfare Centers reimburses costs to health care providers (Collantes 2009, 23). The Royal Decree of 12 December 1996 granted the possibility for undocumented migrants’ health care costs being reimbursed to the service providers by the local Social Welfare Center and stated that all personal patient

[13] Intercultural competence in health care system

information remains confidential (Romero-Ortuno 2004, 255). Undocumented migrants are entitled to ‘urgent medical assistance’ (AMU) that can include preventive and curative measures (Collantes 2007, 20, Chauvin et al. 38).

*Cyprus:* Free of charge services in emergency care and necessary treatment are available for asylum seekers living in reception centers, receiving welfare benefits and able to prove insufficient means. Those able to prove that they belong to one of the recognized ‘vulnerable groups’ (defined as minors, persons with special needs, the elderly, pregnant women and victims of violence) are entitled to free other health care services, regardless of circumstances, in addition to emergency and necessary treatment (Collantes 2010, 5).

*Czech Republic:* Access to health care is granted to asylum seekers as they are entitled to public health insurance and can access both primary and secondary care. Unaccompanied children under 18 are not required to pay the regulation fee as it is usually paid by the accommodating centers for minors (Collantes 2010, 6).

*Estonia:* Undocumented migrants are granted emergency care free of charge (Cuadra and Cattacin 2011, 16).

*France:* France grants the same rights regarding health care to migrants and other residents (Chimienti 2009, 88). Basic principle guiding social security health coverage in France is solidarity - from everyone according to their means and to everyone according to their needs and this coverage amounts to 65% of total expenses. Those on income lower than €661 (data from March 2013) are entitled to health care services free of charge (Couverture maladie universelle - CMU[14]). The rest of health care expenses 35% can be covered through health insurance schemes where it is necessary to apply for reimbursement and some of them operate as non-profit companies. People having income above the CMU limit, but lower than €892.6 can receive, depending on their age, between €100 and €500 in order to obtain this additional health insurance. For income below the CMU limit there is an entitlement to complimentary CMU covering for the remaining 35% of the health care expenses and payment at the point of services is not required for this group (Chauvin et al. 2013, 39). Asylum seekers are entitled to health care in line with French citizens. This includes the same coverage and conditions and includes the rights of unaccompanied children supported by the social services (Collantes 2010, 6). In other words asylum seekers are entitled to the basic health insurance as well as to

[14] Universal illness coverage

the additional CMU (Collantes 2009, 42, Chauvin et al. 2013, 39). Free access to health care was an entitlement for the poorest in the society until 1999, when irregular immigrants were excluded from this provision by the Universal Health Coverage Act (CMU). However a parallel system to CMU was instated, called State Medical Assistance (Aide Médicale de l'Etat - AME), granting free health care access to undocumented migrants after fulfilling conditions of living in France in over three months and having income below a certain limit (€661 as of March 2013[15]). For those not complying with the mentioned conditions there is still coverage for emergency care, STDs and HIV, tuberculosis, vaccination and family planning (Collantes 2007, 28-29). Minors are exempted from three month residence requirement in order to register for AME and this right is valid for one year (Chauvin et al. 2013, 39).

*Germany:* Migrant residents in Germany have the same right to health care as other residents. In 1995 an official voluntary working group was established with a goal of opening institutions to migrant needs (Chimienti 2009, 87-88). Certain migrant health issues are addressed by the National Integration Plan primarily concerning the situation of women and girls and gender equity (Mladovsky et al. 2012b, 5). The public health insurance is obligatory for the citizens and other legal residents who either work or receive unemployment benefits below certain income limit, while those with higher income must obtain a private insurance. Reforms in 2007 obliged those without access to health care who did not pay insurance, to pay their debts retroactively since 2007 for public health insurance and since 2009 for private insurance. Until debt is settled only emergency health care is included in reimbursement. Since the 1st of January 2013 there is no direct payment for consultations, but there is 10% co-payment for drugs. However the maximum amount for drugs-related expenses is limited by national regulations. Children bellow 18 receive services free of charge including medications. Welfare services help is available to some vulnerable groups such as migrant residents in need and homeless people (Chauvin et al. 2013, 40). Asylum seekers get coverage for maternal health and HIV treatment. Children have a more extended coverage (Collantes 2010, 7). This extended coverage for children is based on a law stating that they have the right to benefit from 'other care depending on their specific needs. Similar formulation addresses the right of traumatized people to access 'appropriate care' (Collantes 2009, 61).

[15] Chauvin et al. 2013

*Greece:* The National Health System established in 1983 is based on the obligatory health insurance based on work and additional state subsidies. Patients with income below €416 are entitled to a 'welfare card' and free-of-charge health care including medications. Resident migrants are entitled to the same coverage (Chauvin et al. 2013, 42). Asylum seekers that work contribute also to insurance and have the rights as all the insured residents and nationals (Collantes 2010, 7-8, Chauvin et al. 2013, 42).

*Italy:* Italy has a relatively well-developed policy on migrant health care. The overall responsibility in achieving migrant health goals of 'Livelli Essenziali di Assistenza – LEA'[16] rests at the national level, while practical implementation and provision is a local responsibility. In addition, migrant health care was targeted by health policy since early 1990s and a special program addressing migrants and their needs in health care 'Saluti degli Immigranti'[17] was established (Giannoni and Mladovsky 2007, 5-6). Collecting data on migrant health and health care is targeted for improvement as well as providers' training in culturally sensitive health care. Particular focus is in adapting existing health care programs to migrants' language and cultural understanding especially in the areas that are considered to be more of an issue for migrants such as maternal and child health (including vaccination) and communicable diseases. Additionally, providing information on health care system and administrative procedures in registering for health care services is emphasized as well as cultural mediation (Vazquez 2011, 73-74). Asylum seekers, including unaccompanied children are entitled to the same coverage as the nationals (Collantes 2010, 8). Broad health care access is granted to undocumented migrants in Italy. They have access to broadly defined urgent and essential primary and hospital care with guaranteed continuity of care, maternity care, full health care for minors, vaccinations and health care concerning infectious diseases and toxic dependencies (Romero-Ortuno 2004, 259-260)..

*Lithuania:* In Lithuania emergency health care is granted to undocumented migrants free of charge (Cuadra and Cattacin 2011, 17).

*Malta:* Legally the right to access 'state medical care and services' is acknowledged for asylum seekers (Collantes 2010, 8).

*Netherlands:* Since 2006 all residents in the Netherlands are obliged to be insured. It is possibly to be reimbursed for those who are the poorest after going through an administrative

[16] Essential levels of care - services to be delivered uniformly across the country
[17] Health of migrants

process of registration and means-testing (Chimienti 2009, 85; Chauvin et al. 2013, 43). In the response to two critical reports by the Council for Public Health and Health Care (RvZ) on migrant health and access to health care (2000), the Minister of Health initiated a Project Group that worked on 'interculturalizing' health care. An intercultural mental health center of expertize' - MIKADO was established as well (ibid, Mladovsky et al 2012b, 5). Existing specific programs on migrant health care include 'immigrant health promoters' and free interpreter services. National surveys included also information on migrant health and health care access (Suurmond et al. 2007, 3). Asylum seekers can access health care services free of charge. Conditions somewhat differ from those affecting Dutch nationals as asylum seekers are not allowed to choose and register with the regular health insurance. In practice, this causes no implications on health care received (Collantes 2010, 9). Asylum seekers' health care expenses are covered by the Central Agency for the Reception of Asylum Seekers through the insurance company Menzis which operates as a non-profit company (Collantes 2009, 107-108). Unaccompanied minors are entitled to the same rights as adults and besides they are provided with additional help from the Central Agency for the Reception of Asylum Seekers (Chauvin et al. 2013, 43). Undocumented migrants are only entitled emergency and medically necessary treatment (including also pregnancy and maternal care and vaccination) and treatment for conditions threatening public health (Romero-Ortuno 2004, 256-257, Collantes 2007, 61). Pregnancy and childbirth remain 100% covered by reimbursement as well as vaccination and preventive care for children (Chauvin et al. 2013, 43).

*Poland:* The right to emergency health care that is free of charge is granted to undocumented migrants. Certain groups of undocumented migrants: failed asylum seekers, those who overstayed their visas and those affiliated to health insurance may also access primary and secondary health care (Cuadra and Cattacin 2011, 17).

*Portugal:* The 'Plan for the integration of immigrants 2007-2009' in Portugal proposes programs targeting migrants and aiming to improve and encourage the use of the national health care services (Mladovsky 2012b, 6). In Portugal health care services are provided to asylum seekers in line with services provided to Portuguese nationals including the same coverage level and conditions (Collantes 2010, 10). Undocumented migrants are entitled to health care after proving more than three months of living in Portugal. A (moderate) fee is charged with exemption of tuberculosis, HIV/AIDS and STDs care, vaccination, maternity care and family planning. Undocumented children do not fall under the same rules and they

share the same level of rights as the nationals and documented children (Collantes 2007, 72-73).

*Romania:* Theoretically asylum seekers are entitled to the statutory health insurance if working or they can pay for facultative insurance. If uninsured, under the Asylum legislation, they are entitled to free primary care, emergency care and treatment of serious chronic diseases, posing immediate danger to life and also including HIV treatment. Furthermore, free treatment for potentially epidemic diseases, as well as maternal care and family planning services are granted (Collantes 2010, 10).

*Slovak Republic:* In Slovak Republic undocumented migrants are entitled to emergency care free of charge (Cuadra and Cattacin 2011, 17).

*Slovenia:* Asylum seekers are entitled to emergency and essential medical care. The term 'essential' treatment can be used in a broad definition. In addition, extremely serious medical conditions, maternal care, family planning and abortion assistance are covered for asylum seekers. Furthermore vulnerable groups including children, unaccompanied minors, pregnant women and violence victims are offered 'additional medical services' (Collantes 2010, 11). Undocumented migrants in Slovenia have the right emergency health care free of charge (Cuadra and Cattacin 2011, 17).

*Spain:* Spain includes migrant health care as a part of integration plans nationally and regionally. The Citizenship and Integration Strategic Plan 2007–2010 was directed towards social cohesion and creating equality of opportunity, as well as of rights and duties (Stoyanova and Mladovsky 2007, 7). Similar to Italy the focus is on those health care areas that are considered specific for migrant population including maternal and child health care and communicable diseases and cultural mediators are included in health services. Exchanging best practices between national and regional actors as well as between primary and specialist health care services is considered. Cultural mediator services are available and specific training for professionals is planned detailing the inclusion of training on health determinants and migrant health problems (Vazquez 2011, 73-74). Health care access is granted to asylum seekers under the same conditions and including the same coverage as for the nationals (Collantes 2010, 11). Even those undocumented migrants who are not registered at their local census (Padron) have the access to full health care services including health care for minors, maternal and emergency care (Romero-Ortuno 2004, 258-259). Undocumented

children under 18 and undocumented pregnant women have the right to free care under same conditions as the nationals. However, due to decentralization some regions provide access to health care without registration for all (Collantes 2007, 80).

*Sweden:* Migrants with a residence permit in Sweden have the right to health care in line with that of other residents (Chimienti 2009, 86). The 'National agreement on health and the first years' attempts to insure that migrants' access to information on health care system improves (Mladovsky et al. 2012b, 6). Children asylum seekers are entitled to the same level of health care access in line with Swedish nationals (Collantes 2009, 149-150, Chauvin et al. 2013, 45). Special concerns regarding undocumented pregnant women or women in need of contraceptive services and demands to pay before services are provided led to more flexibility and providing of services at low cost or free of charge (Alexander 2010, 233). In 2011 the government considered policies options that would address undocumented migrants' access to health care and improve current system that is one of the worst in Europe. In June 2012 a new law was planned to be drafted and it is expected to be adopted in 2013 (Chauvin et al. 2013).

*UK:* Access to basic health care and GPs is free for all residents, including migrants, living in the UK for at least a year and for those who applied to be on a GPs list of patients (Chimienti 2009, 84). On the 1st of April 2012 payment of £7.65 (€9) per prescription was introduced. However, it is limited and can be reduced through a prescription prepayment system for more than 13 prescriptions per year or more than four in three months. Patients with low income are entitled to help in covering their health care expenses (Chauvin et al. 2013, 44). The institution dealing with migrant health is the Department of Equality and Human Rights which is a part of the Department of Health. The Race Relations Act was amended in 2000 setting a legal requirement for every institution and organization dealing with health in the country to develop an action plan in order to tackle inequalities and discrimination. Implementation is a responsibility of local organizations (Chimienti 2009, 84-85). Also in different parts of the UK attention is paid to minority health. For example the Scottish Government established the National Resource for Ethnic Minority Health (NRCEMH) with duties in supporting service delivery to minority populations. Interpreter services are available at both hospital level and in contact with GPs (Lorant 2010, 237). In England there are special focus areas including early discovery and risk factors reduction for diseases with high incidence among migrants as well as inclusion in programs targeting problems with the highest prevalence among population in general. Further focus is on providing more information on health and health care services, increasing the offer of services in

disadvantaged areas and adapting services to migrant population needs for example by providing appropriate hospital menus, offering the possibility to choose the sex of attending professionals and providers' training in cultural aspects (Vazquez et al. 2011, 73-74). Particular attention regarding cultural aspects of health is given to mental health care (Mladovsky 2012b, 5). Asylum seekers are entitled to the same level of health care services as British nationals (Collantes 2010, 11). Regulation 11(b) of the NHS Charges to Overseas Visitors Regulations 2011 grants full exemption from charges for health care services while asylum application is processed. They can register with the National Asylum support Service as well as with a GP office (Chauvin et al. 2013, 44). In the UK undocumented migrants are allowed to register on GPs' list of patients (Collantes 2007, 98). Certain treatments are free of charge such as emergency care and certain infectious diseases and STDs (sexually transmitted disease) treatment. HIV treatment is also included on this list since 1 October 2012 following great efforts from NGOs and health care providers (Chauvin et al. 2013, 40). Vaccination is available free of charge for both undocumented children and adults (Chauvin et al. 2013, 40).

## 5. Conclusion and recommendations

In the area of migrant health care there is still a research gap in many areas. Firstly, including data on migrant health care in national registries and surveys is highly insufficient. Secondly, comparison becomes almost impossible as defining migrant groups is very variable. However, in the last decade interest in researching migrant health care has been increasing, following increase in migration flows. Some of the research was related to specific countries while other researches worked across borders and several international research projects were established. Despite some positive developments, it seems that this is often a bottom-up approach, with health care providers being the first to point to certain issues, while many governments remain silent.

Health care provisions for migrants are often denied due to administrative and bureaucratic barriers and this represents an additional issue for migrants' access to health care. Together with practical obstacles such as job insecurity, distance and transportation issues and housing problems those prove that achieving good health is not just a matter of resources to health care, but also a matter of general provisions including a range of social arrangements.

Migrant health suffers as migrants face plenty of barriers in access to health care. Although research presented in this thesis was quite variable when it comes to targeted populations, areas and study design, certain themes were reoccurring in multiple studies and they seem to be rather universal as barriers to migrant health care.

Undocumented migrants are those who are hardest hit since their irregular status often causes them to lose the right to health care already at legislative level. At the same time they are in constant fear of persecution, detention and deportation which prevents them from using health care services even when they are, in principle, entitled to such services. Positive health policies, even when principally established, become intersected by restrictive policies on migration. Although even undocumented migrants should be entitled to health care as derived from the international human rights' obligations and moral considerations, their right to health care is neglected or even completely denied.

Asylum seekers are in a somewhat better position as health care provisions are granted to them at least in principle. But this principle is more often than not hardly translated to practice as a number of administrative and financial barriers arise before health care could be granted.

On the other hand regular/resident migrants are most commonly entitled to the same health care coverage and under the same conditions as nationals/citizens.

However, all of the migrant group experience barriers in access to health care. Most commonly obstacles arise in the area of language and communication. Many migrants, particularly recent migrants, experience difficulties because they do not speak a language of their host country or at least they do not feel to have good enough language knowledge to be able to effectively communicate topics related to their symptoms and health problems. Family members, often children, are used as interpreters, but this poses additional challenges in terms of confidentiality and sensitivity of information. In some countries free interpreter services are available (e.g. UK, Netherlands), but often underused and there is a continuing discussion on whether they should be charged for certain groups.

Communication problems arise not purely because of language, but also as a result of lack of cultural understanding and culturally different meanings and expectations in questions of health and illness. On the part of migrants there is often insufficient knowledge of health care systems and health care services in their host-countries. In addition to previously mentioned barriers also negative attitudes from health care providers were noted and this led to growing mistrust to the health care providers. Stigma and discrimination are among obstacles often faced in access to health care. This is often the case when there are no precise definitions of available provisions and it is left to arbitrary decisions of medical or administrative professionals to decide whether a patient is entitled to some type of health care services. Stigmatizing patients does not only come from health care providers, but also from their local communities that might have a completely different understanding of certain medical conditions, especially in the area of mental health.

Dedication to human rights and the recognition of the right to health as one of the crucial rights is unquestionable in a range of international policy documents starting with the Universal Declaration of Human Rights (UDHR) adopted in 1948 and followed by the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), as well as the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (UNCHR 2013). The European Social Charter also acknowledges the right to health as a human right. At the European Union

level the Charter of fundamental rights of the European Union guards the right to health and with adopting of the Lisbon treaty it became a legally binding document.

The European Union countries are bounded by this range of international documents that protect the right to health as a human right. However, health care remains a national level concern and all of the European countries have their health care systems that are different to some extent. Those differences range from differences in financing systems - relying on taxes or on insurance contributions, with a certain amount of out-of-pocket payments. Other differences might be in division of work between primary and specialist health care and so on. An important point is that any further development and changes of a health care system tend to rely on already existing system and policies. Furthermore and concerning migrant health care, general attitudes towards differences and they inclusion in a society can also have impact on development of health policy.

In most of the European Union countries resident migrants are entitled to the same level of health care and under the same conditions as the nationals. The only noted exception in this study was Cyprus that had somewhat different health care coverage and conditions based on migrant workers' professions. However, it must be noted that in the literature selected data was not available for all of the EU countries, but for only 12 (out of 28 as of 1. July 2013).

Asylum seekers and particularly undocumented migrants tend to be in a far worse situation. Those already vulnerable and largely social excluded groups are often restricted from obtaining the right to health care through a range of barriers, included legal barriers, but also a number of administrative and financial barriers. Due to those barriers most of asylum seekers and migrants cannot access health care services even when they are legally entitled to those services. Particularly negative is the example of Germany where undocumented migrants must be reported to the authorities by public servants working at a social services office. This prevents them from using any health care services beyond emergency as the first step in accessing health care is registering at a social service office. Other negative examples include unreasonably complicated administrative procedures that are practically based on arbitrary decisions of administrative workers and that do not consider vulnerable position of the population groups targeted, such as for example in Belgium. Other policy decisions granted the right to access health care, but at full charges, something that seems quite unreasonable if keeping in mind that asylum seekers and undocumented migrants have legally restricted right to work.

As migrant health care barriers and migrants' specific needs in health care become recognized, positive developments in migrant health policy must be acknowledged. In general, it seems that in those countries where health issues regarding migrant health care are recognized, a consequence is policy-making that addresses those issues. Positive examples of policy that has already started to show effect in practice can be seen for example in Portugal and Spain.

The importance of top-down approach could be seen through the example of the Portuguese (2007) EU presidency that set on agenda migrant health in the European Union and led to advances in research and policy-making. Even bottom-up approach has its role in leading to improvements in health care policy. Examples of health care professionals and NGOs contributing to positive development by call to action and adhering to the best of ethical standards are noted. An example is UK where HIV treatment was granted to undocumented migrants in 2012 as pressure increased by NGOs, health care professionals and general public, and after such treatment had been denied to this group for years. Measures to improve communications are also taken by introducing interpreter and 'cultural mediator' services and education in culturally sensitive health care for health care professional.

Reasons for hope are there as several countries have considered specific needs of migrant health care in order to provide solutions and it is necessary to learn from those encouraging examples and adapt them to other settings as well. Even so, this is far from being enough and it often seems that for every step forward in the area of migrant health there is one taken backwards or at least sideways - towards xenophobia and discrimination. Furthermore, it seems that so far migrant health policy development was rather arbitrary, following daily politics.

Unfortunately, previous positive developments are in danger of reversing in part due to the international economic crisis. Austerity measures tend to affect health care systems by increasing out-of-pocket payments, reducing services coverage and reducing coverage for some populations. This is often targeting especially undocumented migrants and asylum seekers, although other segments of population are affected as well. This is quite regrettable as it led to stagnation or even reversed flow in some positive initiatives.

In the light of those considerations, implications for policy-making include the necessity to not only declaratively recognize the right to health as a human right for all, but also to

implement this recognition through policy making in the area of health care. Restrictions to health care access must not be used as a punishment or in connection with immigration issues. Nationally there is a need for adequate policies that could be responsive to changing needs for health care systems. National level policy simply granting access to health care in vague terms and without any practical application is quite hypocritical and it is to be condemned. Also regionally and locally those positive national policies should be implemented without discrimination. In order to be effective health policies must address every level of health care including administrative and financial issues.

Priorities regarding migrant health policy for asylum seekers and undocumented migrants are in legislatively granting access to health care that is practically applicable, that is to say including removing of administrative and financial barriers. Generally for all migrant groups, health policies that would overcome communication, discrimination and practical barriers are necessary in order to improve access to health care and they should be introduced where missing and implemented in practice. Measures must be directed both toward health care professionals and toward migrants that use services. In addition, administrative officials and public servants working in health care systems must be addressed by health policies. On their side health care professionals must adhere to the highest standards of human rights and professional ethics and in that way influence policy-makers in recognizing and mending shortcomings in health policy. Of course neither migrants nor health care systems are a static category, so every policy must be created keeping in mind future developments and possible problems.

Although research efforts in migrant health care are increasing and knowledge base is expending, with increased understanding of migrant health care needs and recognition of migrants' rights, there are new issues threating to reverse positive health policy developments. Austerity measures brought about by the economic crisis, as well as xenophobia - that never seems to be far behind, represent a perpetual risk for migrant health policy deterioration.

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## Appendix 1 - Overview of study designs

| Study | Year | Population | Study design |
|---|---|---|---|
| Aung et al. Access to and utilization of GP services among Burmese migrants in London | 2010 | Burmanese migrants in London | A cross-sectional descriptive study, self-administered questionnaire (n=137, 57% RR[18]), in-depth interview (n=11), snowball sampling |
| Biswas et al. Access to healthcare and alternative health-seeking strategies among undocumented migrants in Denmark | 2011 | Undocumented migrants in Denmark and ER nurses | Semi-structured interview and observation: 10 migrants-convenience sample, 8 ER nurses, snowball sampling |
| Boateng et al. An exploration of the enablers and barriers in access to the Dutch healthcare system among Ghanaians in Amsterdam | 2012 | Ghanaian migrants in Amsterdam | Semi-structured interview with 6 focus groups, 51 participant, community-based recruiting, convenience sample |
| Dias et al. Determinants of health care utilization by immigrants in Portugal | 2008 | Immigrants in Portugal (Lisbon) | Interview using questionnaire (n=1513) |
| Jensen et al. Providing medical care for undocumented migrants in Denmark: what are the challenges for health professionals? | 2011 | General practitioners and ER physicians | Semi-structured interview (n=12) |
| Palmer et al. 'Lost': listening to the voices and mental health needs of forced migrants in London | 2007 | Refugees and asylum seekers | Semi-structured interviews (n=21) |
| Priebe et al. Good practice in health care for migrants: views and experiences of care professionals in 16 European countries | 2011 | Health professionals | Structured interviews with open questions and case vignettes (n=240) |
| Rhodes et al. Access to diabetes services: the experiences of Bangladeshi people in Bradford, UK | 2003 | Bangladeshi with diabetes | Interview (n=12) |
| Suurmond et al. Negative health care experiences of immigrant patients | 2011 | Immigrants in Netherlands | Semi-structured individual and group interviews (n=22) |
| Torres-Cantero et al. Health care provision for illegal migrants: may health policy make a difference? | 2007 | Equadorian migrants in Madrid | Interview (n=380) |

[18] Response rate

## Appendix 2 - Overview of study results and policy implications

| Study | Issues identified | Policy implications |
|---|---|---|
| Aung et al. Access to and utilization of GP services among Burmese migrants in London | Informal: difficulties in registering, long waiting times, language barriers | Needed proactive steps, culturally responsive health services |
| Biswas et al. Access to healthcare and alternative health-seeking strategies among undocumented migrants in Denmark | Formal: limited medical rights; informal: providers' attitudes, fear of being reported to police, language barriers, lack of knowledge about health care system, informal networks and networks with Danish citizens | Needed policies and guidelines in line with international human rights law |
| Boateng et al. An exploration of the enablers and barriers in access to the Dutch healthcare system among Ghanaians in Amsterdam | Mistrust in health care provider, language barriers; enablers: knowledge of disease and health care system, perceived quality, family and community and social support, community initiatives | Needed policies in promoting health care access |
| Dias et al. Determinants of health care utilization by immigrants in Portugal | Waiting times, providers' attitudes, cost, distance and transportation and language | Needed comprehensive strategies to address barriers, special focus on recent and undocumented migrants |
| Jensen et al. Providing medical care for undocumented migrants in Denmark: what are the challenges for health professionals? | Formal barriers, language barriers, financial aspect for practitioners, uncertainty about further referrals and police involvement, lack of previous records and contact persons | Needed official policies on the delivery of health care to undocumented migrants |
| Palmer et al. 'Lost': listening to the voices and mental health needs of forced migrants in London | Referral waiting times, language barriers, lack of information on health care system, stigma, cultural differences in health beliefs | Policy changes needed in other areas as well, with focus on social model of ill-health |
| Priebe et al. Good practice in health care for migrants: views and experiences of care professionals in 16 European countries | Language barriers, lack of health care coverage and familiarity with the health care system, cultural differences in understanding illness and treatment, negative attitudes among staff and patients, lack of previous records, social deprivation and traumatic experiences | Needed sufficient resources and organizational flexibility, positive attitudes, training for staff including cultural sensitivity and the provision of information |
| Rhodes et al. Access to diabetes services: the experiences of Bangladeshi people in Bradford, UK | Language barriers, lack of access to private or public transportation, inability to recognize and report symptoms, lack of quality in care | Important - culturally sensitive services, but also battling general problems in health care provision |
| Suurmond et al. Negative health care experiences of immigrant patients | Inadequate information exchange-language barriers, different expectations about medical procedures, providers prejudice | Cross-cultural health care, professional interpreter services, patients' empowerment |
| Torres-Cantero et al. Health care provision for illegal migrants: may health policy make a difference? | Fear to lose ones job or job instability, administrative barriers, discrimination, denial of services | Policy changes removing barriers may be effective |

## Appendix 3 - Some of the main international policy documents on the right to health related to the European Union

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|---|---|
| **Universal declaration of human rights** | **Article 25**<br>Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond this control. |
| **International convention on economic, social and cultural rights** | **Article 12**<br>1. The States Parties to the present Convention recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.<br>2. The steps to be taken by the States Parties to the present Convention to achieve the full realization of this right shall include those necessary for:<br>(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;<br>(b) The improvement of all aspects of environmental and industrial hygiene;<br>(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;<br>(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness. |
| **Committee of economic, social and cultural rights, comment no. 14** (2000) | **The right to the highest attainable standard of health (article 12 of the International Convention on Economic, Social and Cultural Rights)**<br>3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.<br>4. In drafting article 12 of the Convention, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.<br>However, the reference in article 12.1 of the Convention to “the highest attainable standard of physical and mental health” is not confined to the right to healthcare. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. |
| **Charter of fundamental rights of the European Union** (2000/C 364/01) | **Article 34 – Social security and social assistance**<br>1. The Union recognizes and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices.<br>2. Everyone residing and moving legally within the European Union is entitled to social security benefits and social advantages in accordance with Community law and national laws and practices. |

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|---|---|
|  | 3. In order to combat social exclusion and poverty, the Union recognizes and respects the right to social and housing assistance so as to ensure a decent existence for all those who lack sufficient resources, in accordance with the rules laid down by Community law and national laws and practices.<br>**Article 35 – Healthcare**<br>Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. |

## Appendix 4. Articles and reports on migrant health policies included in the study

| Author | Year | Publication |
|---|---|---|
| Alexander, S. | 2010 | Humanitarian Bottom League? Sweden and the Right to Health for Undocumented Migrants |
| Chauvin et al. | 2013 | Access to healthcare in Europe in times of crisis and rising xenophobia |
| Chimienti, M. | 2009 | Chapter 6: Migration and Health: National Policies Compared in Fernandes, A. and Pereira, M.J. (eds). Health and Migration in the European Union: Better Health for All in an Inclusive Society |
| Collantes, S. | 2007 | Access to Health Care for Undocumented Migrants in Europe |
| Collantes, S. | 2009 | Access to health care for undocumented migrants and asylum seekers in 10 EU countries: law and practice |
| Collantes, S. | 2010 | Are undocumented migrants and asylum seekers entitled to access health care in the EU? |
| Cuadra C.B. | 2011 | Right of access to health care for undocumented migrants in EU: a comparative study of national policies |
| Cuadra, C.B. and Cattacin, S. | 2011 | Policies on Health Care for Undocumented Migrants in the EU27 and Switzerland: Towards a Comparative Framework |
| FRA | 2011 | Migrants in an irregular situation: access to healthcare in 10 European Union Member States |
| Giannoni, M. and Mladovsky, P. | 2007 | Migrant health policies in Italy |
| Grit, K. et al. | 2012 | Access to Health Care for Undocumented Migrants: A Comparative Policy Analysis of England and the Netherlands |
| Karl-Trummer et al. | 2010 | Access to health care for undocumented migrants in the EU: A first landscape of NowHereland |
| Larchanche, S. | 2012 | Intangible obstacles: Health implications of stigmatization, structural violence, and fear among undocumented immigrants in France |
| Lorant, V. and Bhopal R. | 2010 | Comparing policies to tackle ethnic inequalities in health: Belgium 1 Scotland 4 |
| MDM | 2009 | Access to health care for undocumented migrants in 11 European countries |
| Mladovsky et al. | 2012 | Responding to diversity: An exploratory study of migrant health policies in Europe |
| Nørredam et al. | 2005 | Access to health care for asylum seekers in the European Union—a comparative study of country policies |
| Romero-Ortuno, R. | 2004 | Access to health care for illegal immigrants in the EU: should we be concerned? |
| Stoyanova, A. and Mladovsky, | 2007 | Migrant health policies in Spain |
| Suurmond et al. | 2007 | Migrant health policies in the Netherlands |
| Vazquez et. al. | 2011 | Health policies for migrant populations in three European countries: England; Italy and Spain |

## List of abbreviations

ADAPT - Adapting European Health Systems to Diversity

AIDS - acquired immunodeficiency syndrome

AMAC project - Assisting Migrants and Communities Project

AME - 'Aide Médicale de l'Etat' - State medical assistance

BME - black and minority ethnic

CE - Council of Europe

CEDAW - Convention on the Elimination of All Forms of Discrimination against Women

CMU - 'Couverture maladie universelle' - Universal illness coverage

COST - European Cooperation in Science and Technology

COST - European Cooperation in Science and Technology

CRC - Convention on the Rights of the Child (CRC)

ER - emergency room

EU - European Union

FRA - European Union Agency for Fundamental Rights

GCIM - Global Commission on International Migration

GP - general practitioner

HIV - human immunodeficiency virus

HOME - Health and Social Care for Migrants and Ethnic Minorities in Europe

HUMA - Health for Undocumented Migrants and Asylum Seekers

ICERD - International Convention on the Elimination of All Forms of Racial Discrimination

IOM - International Organization for Migration

LEA - 'Livelli Essenziali di Assistenza' - Essential levels of care

NGO - non-governmental organization

NRCEMH - National Resource for Ethnic Minority Health

PICUM - Platform for International Cooperation on Undocumented Migrants

UDHR - Universal Declaration of Human Rights

UK - United Kingdom

UNCHR - United Nations Commission on Human Rights

WHA - World Health Assembly

WHO - World Health Organization