Policies on Health Care for Undocumented Migrants in EU27

Country Report

Belgium

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Preface

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

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

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

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

| Healthcare in NowHereland: Improving services for undocumented migrants in the EU |
| Project funded by DG Sanco, Austrian Federal Ministry of Science and Research, Fonds Gesundes Österreich |
| Running time: January 2008 – December 2010 |
| Partners: |
| Centre for Health and Migration at the Danube University, Krems (AT) (main coordinator) |
| Platform for International Cooperation on Undocumented Migrants (BE) |
| Azienda Unità Sanitaria Locale di Reggio Emilia (IT) |
| Centre for Research and Studies in Sociology (PT) |
| Malmö Institute for Studies of Migration, Diversity and Welfare (SE) |
| University of Brighton (UK) |
Introduction

This report is written within the framework of the research project, *NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*, and one of its work packages. The focus of this work package – *policy compilation* – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.¹

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

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.²

The General Migration Context

Belgium is a founding member of the European Union.

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¹ Information regarding the project and all 27 Country Reports can be found at [http://www.nowhereland.info/](http://www.nowhereland.info/). Here, an *Introduction* can also be found which outlines the theoretical framework and method as well as a clustering of the states.

² For the report at hand, the person to acknowledge is: Research fellow FNRS Marie Dauvrin, Institute of Health and Society, Catholic University of Louvain and researcher for Mighealth.ne in Belgium.
With an eye to history, Belgium experienced massive internal migration in the 19th century. It was after World War I and due to industrialization recruitment of foreign workers in surrounding countries, and later in Poland and Italy, took place. Already between 1920 and 1930 170,000 foreigners settled in Belgium. Following World War II, and best understood in the context of the European "coal battle", the government pursued several bilateral agreements (with Italy, Spain, Greece, Morocco, Turkey, Tunisia, Algeria and Yugoslavia). By 1968, 62 % of the foreign workers were nationals of member countries of the European Community. Until the end of the 60s immigration was fairly uncontrolled. However, from thereon, immigration to Belgium was related to the emerging united Europe (the free movement of workers) and its categorization of migrants (Martiniello & Rea 2003). Later on, in 1974, the government put a strict limit on new immigrants. Only people with qualifications that were not already available in the country were allowed to enter. This decision, which was similar to the official ban on immigration, was also accompanied by a policy on legalizing foreigners residing clandestinely in Belgium (ibid.).

In Belgium, as in other European countries, the official ban on immigration did not result in immigration ceasing. It simply changed with regard to types and national origins (ibid.). Today, European nationals account for a significant share of the increasing number of foreigners in Belgium and most of them (66 %) are from France, the Netherlands, and Germany (Questionnaire Belgium). Furthermore, many work permits are granted to persons from outside the European Union, more often to qualified persons along with family reunification (Martiniello & Rea 2003). During the 1980s and especially in the 1990s, the number of asylum seekers grew (with a peak during the war in the former Republic of Yugoslavia) (ibid.). In 2000 there were over 42,000 asylum applications and the number has since then dropped. In 2008 there were 15,940 asylum applicants (Eurostat 66/2009). The main nationalities were Russian (2,765), Serbian (1,695) and Iraqi (1,180) (ibid.). In 2009 (i.e. January–May), the main nationalities were Afghan, Iraqi and Russian (incl. Tchetchenian), in total 4,188 applications (Questionnaire Belgium with reference to FEDASIL).³ Regarding patterns of migration, the colonial past explains the bias towards some countries (Democratic Republic of Congo, Rwanda, and Burundi) (Questionnaire Belgium). This can also be said to be based on statistics on countries of origin of migrants being regularized (see below) as well as long-standing migratory links (in respect to Turkey and Morocco) (Kraler et al.: 17).

Total Population and Migrant Population

The total population in Belgium was by 1st January, 2008, in total 10,666,866 (Eurostat).⁴ In 2008, 971,000 persons were registered as foreigners (Eurostat 94/2009). The corresponding figure in 2007 was 932,161 persons, which equals 8.8 % (i.e. foreign born

⁴ Eurostat.
persons). Main non-European countries of origin were Morocco (80,602), Turkey (39,664) and the Democratic Republic of Congo (13,454) (Kraler et al. 2009:14). The corresponding figures for all countries were Italy (169,000), France (130,600) and the Netherlands (123,500) (Eurostat 94/2009) in 2008.

**Estimated Number of Undocumented Migrants**

With regard to undocumented migrants in Belgium there are comparatively high numbers. The estimates range from between 90,000 and 150,000 corresponding to 1.2 % of the total population (Baldwin-Edwards & Kraler 2009:41). As mentioned earlier, the countries of origin among persons being regularized (see below) suggest an impact of colonial links (Democratic Republic of Congo) (Kraler et al. 2009:17).

**Categories of Undocumented Migrants**

In terms of different categories of undocumented migrants, the most important group in Belgium is most likely the rejected asylum seekers, based on statistics on applicants in a regularization programme (see below) (Kraler et. al 2009: 15). This shows that the asylum process plays a role in “producing” undocumented migrants (Baldwin-Edwards & Kraler, 2009:41). However, a significant part of these are persons who entered clandestinely (which might overlap in considerable part with failed asylum seekers). This indicates that there are different pathways into irregularity. The same statistics showed that one out of four persons had an expired visa (ibid.:16).

**Policies Regarding Undocumented Migrants**

**Regularization Practice, its Logic and Target Groups**

There has been one programme conducted in Belgium (since 1997), in 2000 (Kraler et al. 2009: 14) which formed part of the Belgian migration policies together with regularization mechanisms (ibid.:22). The number of applicants in 2000 were 46,000, coming both from sending countries of asylum seekers and from other countries. Most came from Congo, Serbia, Russia, Turkey and Morocco (ibid.). Between 2001 and 2007 a total number of 77,500 were regularized, half of them in 2000, the rest due to other regularization mechanisms. The logic of the regularization is based on humanitarian and human rights arguments (ibid.:16). Regularization is regarded as an exceptional measure that is granted on a case by case basis and, wherever possible, the government uses alternative policy options such as voluntary return; increasing the numbers of forced returns (ibid.). The groups targeted consist of persons who do not qualify for a regular residence permit but cannot be removed to their country of origin. From this follows that it involves all persons with temporary status as well as asylum seekers still waiting for a decision and thus not technically staying illegally (Kraler et al. 2009:17).
A new regularization campaign took place from 19th July, 2009, to 15th December, 2009. There is no data on numbers of undocumented migrants who were regularized and some processes are still (February, 2010) ongoing. Furthermore, the whole procedure has been declared illegal by the State’s Council (Questionnaire Belgium).

**Internal Control: Accommodation, Labour, Social Security and Education**

In Belgium, undocumented migrants cannot sign a contract for accommodation nor have access to work with related social security. Regarding accommodation, there is a concept called "slumlords", that refers to persons who lets unhealthy accommodation charging high rents. Regarding school, Belgium explicitly permits school enrolment for undocumented children with reference to the Belgium Constitution, Article 24, Paragraph 3 (European Commission 2004:33). These children have the same "school obligation" as other children (from 6 to 18 years old) (Questionnaire Belgium).

**Main Characteristics of the Health System**

**Financing, Services and Providers**

The welfare system in Belgium is mainly financed by state driven insurances. Health care is financed mainly through social security contributions and taxation. Public sector funding as a percentage of total expenditure on health care fluctuates around 70 % (Corens 2007:xvi). It is based on the principles of equal access and freedom of choice and can be characterised as of Bismarckian-type (implying a link to labour and paid by contributions). A compulsory health insurance, according to the Health Insurance Reform Act (from 1993) is combined with a mostly private system of health care delivery, based on independent medical practices, free choice of physician and predominantly fee-for-service payment. All individuals entitled to health insurance must join or register with a sickness fund (ibid.:xvi). Almost 99 % of the population is covered by compulsory health insurance (ibid.:59), the AMI-Assurance Maladie-Invalidité or Illness and Disability Insurance (Dauvrin et al. 2010, HUMA Network 2009).

The compulsory national health insurance has a broad benefits package which can be understood as universal. There are two main schemes: (i) the general scheme, which covers major and minor risks for the whole population (except for the self-employed), and (ii) the scheme for the self-employed, which from 2008, covers both major and minor risks (Corens 2007:59). Major risks are; hospital care, child delivery, elective surgery, dialysis, rehabilitation, implants and specialist care. Minor are: physicians’ visits, dental care, minor surgery, home care and pharmaceuticals for outpatient care. The basic principle for health insurance coverage in both schemes is that people benefit in accordance with their actual or past professional activity. Both schemes cover active and non-active people and their dependants (ibid.:59). Regarding mental health care, it can be provided within the primary health sector or within the framework of associations or isolated practices. It can also be
provided in a general hospital or a hospital specialized in the psychiatry field (Dauvrin et al. 2010).

The system of delivery is private. However, in the Belgian context, providers can never be considered private in a legal sense and all health care associations are non-profit organizations. Physicians are mostly self-employed and can apply for a convention with the National Institute for Health and Disability Insurance (which implies a fixed tariff in the reimbursement system). The majority of hospitals (70%) are private. Most of them are owned by religious charitable orders, while the remainder are owned by universities or sickness funds. Public hospitals are, for the most part, owned by a municipality, a province, a community or an inter-municipal association, however, not by the state (Corens 2007:85).

Basis of Entitlement

The grounds for entitlement are legal residence and affiliation to insurance (your own or as a dependant). Dependents are covered on the basis of their relationship with the main entitled person: a member of the family of the entitled person living in the same main place of residence has the right to health care only if contributions have been paid (Corens 2007:85).

Special Requirements for Migrants

There are no differences between Belgian citizens and regular immigrants in regard of entitlement to care. Each person with a legal status in Belgium has the same obligations concerning health care insurance, and the right to health care with the same coverage. Regarding family reunification (also at the state of acceptance or with recourse against decision or right of residence), they get entitlement as dependents to beneficiaries (Questionnaire Belgium; Dauvrin et al. 2010:15).

Modalities are different for asylum seekers. Some categories of asylum seekers have the right to the mainstream Illness and Disability Insurance if; they work (legally), are a dependant to a beneficiary (including children under 25 years), are a student registered in a high school or university. Newly arrived asylum seekers can choose to stay at a federal reception centre for asylum seekers or any habitation of their choice. In the first case, health care is accessed at the centre free of charge. If they don’t stay in a centre, they must have had a previous contact with the health care costs cell of Fedasil to receive a payment guarantee. In case of emergency, the cell takes the costs charged if it receives an attestation from the health care provider (Dauvrin et al. 2010). This is all administrated by the Federal Agency for the Reception of Asylum Seekers (FEDASIL) or the social welfare centre (CPAS/OCMW) (Dauvrin et al. 2010). Taken together, asylum seekers have the right to free social, legal, medical and psychological support (Médecins du Monde 2009, see also HUMA Network 2009).

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5 CPAS/OCMW is the acronym for the public center for social action in French respectively in Dutch.
**Difference Sensitivity**

In Belgium, some adaptive structures are to be found such as mediation and translation services, translated materials and health services adapted to migrant specifics (for example, meals in hospitals). These measures are not compulsory. Each hospital or health care service decides itself to organize this, so it wouldn’t be considered a general measure.

Intercultural mediation (dealing with issues related to cultural aspects and language) is officially used in about 50 hospitals (Questionnaire Belgium). General hospitals and psychiatric hospitals can introduce a request for the financing of an intercultural mediator and/or a coordinator for intercultural mediation to the General Direction of the Organisation for Healthcare establishments (DG1) of the federal public service Public Health, Food Chain Safety and Environment. The coordination cell of Intercultural Mediation ensures the follow-up of the requests, the evaluation and the supervision of the initiatives of intercultural mediation (Dauvrin et al. 2010). Currently, a pilot project is being conducted to implement intercultural mediation in primary care services, especially with general practitioners. Another project, in 2010, is using internet interpreting to ensure a more efficient translation in medical interactions (Questionnaire Belgium).

**Health Care for Undocumented Migrants**

**Relevant Laws and Regulations**

In the context of health care, there are different laws and regulation that apply to the right of care for undocumented migrants in Belgium. Most salient is the Royal Decree of 12th December, 1996, on Urgent Medical Aid, which states that foreigners who stay illegally in the Kingdom are entitled to what is called “urgent medical aid” granted by the public centres of social action (Dauvrin et al. 2010; Questionnaire Belgium with reference to Belgian Monitor, Brussels, 31st December, 1996). It was revised on 13th January, 2003, and published on 17th January, 2003 (ibid.). Urgent medical help is referred to as AMU (Aide Médicale Urgente). The decree has to be considered in connection with the Organic Law on Social Welfare Centers (Loi organique des Centres Publics d’Action Sociale) of 8th July, 1976. This law determines the competences of the local level to organize and provide social aid to all the residents in Belgium (national and non-national). The legislation is administrated by social services centres (i.e. a CPAS/OCMW).

Also relevant is the law of 8th July, 1964, [the] Urgent Medical Aid, last modified on 10th December, 2009, 88 Decrees of Application, which regulates aid and emergency care.
Emergency care is defined more restrictively than “urgent medical help” and is granted free of charge to everyone, including undocumented migrants. 

With regard to unaccompanied minors in health care (regardless if documented or not) the National Health Law of 13th December, 2006 (Loi du 13 Décembre 2006 portant dispositions diverses en matière de santé) is relevant; stating entitlement to health insurance. 

Also The Royal Decree on the Prophylaxis of Transmissible Diseases, 1st March, 1971, is relevant in the Dutch context.

Access to Different Types of Health Care

According to the Royal Decree (R.D.) of 12th December, 1996, “destitute” undocumented migrants living in Belgium who need medical care can request urgent medical aid (AMU) from a social services centre (i.e. a CPAS/OCMW) where they are registered. In this system it is not differentiated between emergency care, basic care and universal care and the concept does not refer to emergency care. In contrary, the R.D. defines that ‘Urgent Medical Aid’ can be both preventative and curative. Therefore, ‘Urgent Medical Aid’ refers to a wide variety of urgent care provisions (Questionnaire Belgium). The R.D. makes no distinction between public and private institutions. In addition, the CPAS/OCMW has to supervise that the ‘Urgent Medical Aid’ is available and accessible to illegal residents. The R.D. does not provide a concrete definition but says that: a) the assistance provided should be exclusively of a medical nature; ii) the “urgent” character must be certified by a doctor; iii) health care provided can be preventive and curative; iv) the medical help given can be both mobile or provided in a health centre; v) the assistance cannot consist of financial help, housing or any other provision of service in kind (PICUM 2007). Furthermore, additional to the requirements (urgency) the individual must be able to receive a home inspection visit of a social assistant from the CPAS/OCMW (Médecins du Monde 2009; see also HUMA Network 2009). 

As said, urgent medical aid must be differentiated from emergency medical assistance. Indeed, emergency medical assistance is the assistance required immediately in case of an accident or grave illness. Emergency medical assistance is specifically regulated by another law and applies to everyone, including illegal residents. The terminology used has brought on confusion. The word “urgent” gives the impression that only accurate or emergency

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6 “Urgent” is the verbatim English translation. The two legislations referred to have the same name in French. Urgent Medical Aid in this law encompasses the first aid care but also the aid and emergency services in hospitals. The difference between the legislations is the nature of the text: a decree for AMU and a law for the second.
cases are taken into account. However, the concept is much broader and encompasses a wide variety of care provisions, such as medical examinations, operations, childbirth, physiotherapy, medications, tests and exams, etc. The only exceptions are medical materials such as dental prosthesis, wheelchairs, etc., as well as some types of medicine (Questionnaire Belgium). It is left to the health care provider to decide on a case by case basis what is to be considered “urgent.”

There exists no sole procedure for receiving “urgent medical aid” but many different ones. The process is initiated when undocumented migrants visit the CPAS/OCMW in the municipality where they live which initiates a social inquiry (verifying irregular stay and precarious economic situation) which will take a maximum of 30 days. In case of a positive decision – to pay medical assistance – a document is issued corresponding to a fixed amount of consultation and an expiry date. This document must be brought to the provider (recognized by both the National Institute for Health and Disability Insurance (INAMI - Institut national d'assurance maladie-invalidité) and the respective CPAS/OCMW. The provider sends back an “urgent medical assistance certificate” to the administration (PICUM 2007:21–22).

There are variations of administrative procedures, aiming to fight barriers for care. In the Brussels Capital and Molenbeek municipalities a “medical card” has been introduced, valid for a certain period which secures their treatment or receipt of medicine for a certain period (usually for three months) (PICUM 2007:24). The main problem is that the undocumented migrant is obliged to go to the designated physician or physiotherapist or pharmacy. He doesn't have the right to choose his caregiver, which is in opposition to the main practice in Belgium. Patients in the “legal” system have the right to choose the provider, it is a basic principle of the health care system in Belgium.

As stated above, insurance schemes also cover the holders’ dependants (Corens 2007:59). From this follows, that an undocumented migrant can be insured as a dependant (as child or spouse). Furthermore, undocumented migrants can, at least in theory, also get private health insurance that gives full reimbursement of medical costs. However, since these premiums are always very expensive, few undocumented migrants can afford this kind of insurance (Questionnaire Belgium). Other conditions that can result in entitlement is if the person was once documented, paying all social contributions and when he/she lost legal status the employer kept paying the contribution (PICUM 2007:21–22). There are also possibilities for students at certain higher educations.

Costs of Care

Regarding cost of care, undocumented migrants are not supposed to pay anything out of pocket for care. This does not correspond to the mainstream system as, in Belgium, patients participate in health care financing via co-payments (either direct or via a reimbursement system) (Corens, 2007). The Centre for Social Welfare has the obligation to pay the costs of ‘urgent medical aid’. The Ministry of Health, in accordance with fixed
tariffs, will in turn reimburse the Centre for Social Welfare. As will be clear below, there are non-governmental organisations providing care for free to undocumented migrants (Questionnaire Belgium, see also PICUM 2007).

**Specific Entitlements**

In regard of entitlement to healthcare for undocumented migrants there are not specifically identified groups. However, there is specific attention to unaccompanied minors in health care (regardless of documented or not) and also the reception conditions and entitlement to health insurance (Questionnaire Belgium; PICUM 2007 with reference to National Health Law of 13th December, 2006, Loi du 13 Décembre 2006 portant dispositions diverses en matière de santé).

Also TB is treated specifically in the context of irregular migration. In this respect it is relevant that asylum seekers are tested for TB by radiograph. This leaves undocumented migrants who never were asylum seekers aside. There is a body, the Funds of the Respiratory Affections and the Health Education (FARES/VRGT) which regularly organizes TB tracking in strategic places where you can find undocumented migrants: night asylums, squats, health care associations. In case of a diagnosed TB, i.e. the undocumented migrant is infected; the treatment will be paid by the FARES/VRGT, including hospitalization. By experience, the main difficulty is to convince the undocumented migrant to accept the treatment (Questionnaire Belgium).

In regards to HIV tests and checkups for HIV-positive patients there are no specific legislation (Questionnaire Belgium) but it is implied in the framework of the AMU-system (Médecins du Monde 2009/HUMA Network 2009). In practice there are various local initiatives (such as free and anonymous HIV testing) available, especially in Brussels, Namur, Liège, Antwerpen, and other cities in Belgium. Anonymous and free tests are available for the whole population in Belgium. The accessibility for undocumented migrants is not known (ibid.).

**Regional and Local Variations**

There are local variations in entitlements to care, not from a legal sense but in terms of implementation. This is due to the room for discretion both within the administrative process and in encounters with the provider of care. As made clear (under obstacles) there are, at the municipality level, differences in interpretation and implementation of the concept “urgent medical aid” which in the end contribute to different access depending on location.

**Obstacles to Implementation**

There are some obstacles to implementation of the specific legislation targeting undocumented migrants involving three main problems. First the definition of "urgent medical aid" as described above which leaves room for discrepancy to the administration
and provider of care. The second problem concerns the lack of knowledge on or the misuse of, by some professionals, the urgent medical aid (Questionnaire Belgium). Some are not even aware of the existence or meaning of a law on urgent medical assistance. Others are unwilling to cooperate and follow the administrative procedure due to ideological reasons or assumption that the reimbursement system will not function (PICUM 2007:23). The autonomy of the local municipalities could also be considered a problem (Questionnaire Belgium). Each municipality has their own procedures, routines, criteria to determine “destitute” and other relevant aspects, political trends and budgetary situations, which is an obstacle to make some common measures (for instance agreeing upon a common list of medications among 19 municipalities took two years) (Questionnaire Belgium; see also Médecins du Monde 2009; HUMA Network 2009). From the perspective of the undocumented migrants, the existence of a parallel administrative system with a highly complex and long procedure implies that the right of access to health care is not guaranteed (PICUM 2007:22). One problem from the patients’ perspective is that they might not know that not all providers are approved by the system (ibid.).

Obligation to Report

There is no obligation for the staff to report a patient to authorities like police or, in the Belgium case, Immigration Services. The Royal Decree of 12th December, 1996, Article 4, guarantees that any information which appears on medical certificates will be treated confidentially. The information will not be used for any other purpose than repayment. Members of the (para)medical profession are bound by a duty of professional confidentiality. Social assistants from the CPAS/OCMW are also covered by the professional confidentiality when they receive applications for assistance from undocumented migrants (Questionnaire Belgium).

Providers and Actors

Providers of Health Care

Providers of health care for undocumented migrants can be found within different frameworks. The main providers are general hospitals as well as emergency units, general practitioners, non-profit organisations (both local and international) as well as religious organisations. For undocumented migrants, only providers recognized by both the National Institute for Health and Disability Insurance (INAMI -Institut national d’assurance maladie-invalidité) and the respective CPAS/OCMW are available. Examples of non-profit religious organizations are the Order of Malta and the Sisters of Charity. Examples of local non-profit organizations are Medical Houses. An organisation with international scope is Médecins du Monde.

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Medical houses are primary care services providing integrated care. To be a recognized Medical House, you need an association between a physician, a physiotherapist and a nurse. They provide primary care and often social support (Questionnaire Belgium).
Monde (MdM) which provides free care, in particular primary care (especially in Brussels and Antwerpen) (Questionnaire Belgium).

The providers of care can be found mainly in the main cities. There is informal coordination at the local level (e.g. in a municipality). Furthermore, there are examples of institutionalised cooperation as well. Some religious organisations are in the administration council of some hospitals.

Advocacy Groups and Campaigns on Rights
There are a range of non-governmental organizations engaged in the situation for undocumented migrants and there have been campaigns on their right to health. One example is Medimmigrant (in Brussels) which provides information to undocumented migrants about their rights and the procedure to access 'urgent medical assistance' in Belgium. They also act as mediators in the administrative process at the social services (PICUM 2007).

Political Agenda
In Belgium, there is an ongoing debate concerning undocumented migrants in general. As there are rights in place in regard of care, discussions are oriented towards the interpretation of the rights as well as the implementation. The discussion also involves regularization and related procedures (fuelled by hunger strikes and occupations of buildings by undocumented migrants) (Questionnaire Belgium).

International Contacts
Actors in the field of health care for undocumented migrants in Belgium have international contacts. Médecins du Monde and Médecins sans Frontières have local bodies and are active there (in Brussels). Furthermore, PICUM has its administration located in Brussels.

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