Policies on Health Care for Undocumented Migrants in EU27

Country Report

Germany

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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.

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**Healthcare in NowHereland: Improving services for undocumented migrants in the EU**

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*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

Germany is a founding member of EU and is situated on the border of the Schengen Area.

Historically, migration to Germany occurred when large numbers of Polish workers were imported to work in the mining sector at the turn of the last century. Previously, during the 19th century, Germany was a country of emigration. During World War II, millions of foreign workers from occupied territories were forced to work in the German heavy

¹ Information regarding the project and all 27 Country Reports can be found at 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: Eva Berens, Epidemiologie & International Public Health, School of Public Health, University of Bielefeld, and researcher for Mighealth.net in Germany.
manufacturing sector. Since the mid-1950s, Germany has been, as with other industrialised countries, an important destination for immigrants. Germany's post-World War II immigration history is distinguished by the nature of its two parallel flows: one of ethnic Germans returning from abroad, and another of foreigners with no German ancestry. The distinction has been of varying importance, especially in terms of the privileges granted to ethnic Germans (Oezcan 2004).

The most important immigration patterns over the last six decades were the following: Between 1945 and 1961, millions of German nationals originated from European countries. Between 1955 and 1973, and within recruitment frameworks, an estimated 14 million guest workers arrived from Mediterranean countries. Following this period, Germany had about 2.7 million guest workers (Cyrus 2008:5). This period was then followed by family-related permanent immigration. To give an impression of the magnitude of such immigration, in 2002 the German authorities issued 85,305 visas, and 53,213 in 2007. Another pattern comprises Jewish quota refugees who originated exclusively from the area of the former Soviet Union. The reception of asylum seekers and civil war refugees contributed to a further increase in the immigrant population. Between 1990 and 2007, Germany received approximately 2.86 million asylum applications, of which 1.87 million were rejected. The most common countries of origin of asylum seekers between 2000 and 2005 were Iraq (13%), Turkey (12%), Serbia and Montenegro (10%), the Russian Federation (6%) and Afghanistan (4%) (Berens et al. 2008 with reference to Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration 2005). In 2008, Germany received 26,900 asylum applications, mainly from citizens of Iraq (8,200) and Serbia (2,300) (Eurostat 66/2009). The same year, 30,400 decisions were issued (in the first and second instance) and the rate of recognition was 41% (7,900 in the first instance) (Eurostat 175/2009).

Many rejected applicants remain in Germany as undocumented migrants (Berens et al. 2008 with reference to Migrationsbericht 2004:46). Another immigration pattern concerns temporarily admitted migrant workers and students (ibid.) The large majority of third country nationals are admitted within the framework of family reunification (Kraler et al. 2009:52).

Irregular migration increased sharply in the second half of the 1990s, in the wake of the reunification of the Federal Republic of Germany and the German Democratic Republic, and since control of Germany’s eastern borders was almost non-existent. In addition, asylum laws had been tightened and there were few legal options available. However, since the late 1990s, the number of illegally staying third country nationals in Germany appears to be stagnating and, because of the effects of EU enlargement, appears in fact to be decreasing (Kraler et al. 2009 with reference to Schönwalder et al. 2006:30-333).

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**Total Population and Migrant Population**

By 1 January 2010, the population in Germany was 81,757,595 (Eurostat). In 2006, 8.2%, or 6.7 million people, were not German citizens. By far the largest group of foreigners living in Germany were citizens of Turkey (1.7 million), followed by Italians (0.5 million) and Poles (0.36 million). Collectively, “second generation migrants” and persons with “migrant backgrounds” comprised 19% of Germany’s population in 2006 (Berens et al. 2008 with reference to Statistisches Bundesamt 2006).

In 2008, the foreign-born population was 7,255,000, which equalled 8.8% of the total population (Eurostat 94/2009). The main countries of origin were Turkey (1,830,100), Italy (570,200) and Poland (413,000) (ibid.).

**Estimated Number of Undocumented Migrants**

There is no data available in respect of undocumented migrants (Baldwin-Edwards & Kraler 2009:41). However, estimates range from between 500,000 to 1,500,000 undocumented migrants, which are comparatively high numbers within the EU context (ibid.). Alternative estimates refer to between 100,000 and 1 million persons (Cyrus 2008:5). Furthermore, estimates which circulate in the media and amongst researchers range from 100,000 to at least a million (Sinn et al. 2006: 58-59; Beckers 2006; Cyrus 2008).

**Categories of Undocumented Migrants**

In the German context, there are undocumented migrants with different pathways into their present situation. The asylum process plays a role in “producing” undocumented migrants (Baldwin-Edwards & Kraler 2009:41). There is no reliable information on the numbers of former asylum seekers or refugee related groups, and consequently no estimates of how many of these persons are included among irregular immigrants. In addition, it can be said that this group had more relevance during the 1990s, due to higher numbers of asylum seekers and backlogs in applications. Until the 2000s, this category has probably lost its relevance (Cyrus 2008:62). The group which is most salient comprises those who entered the country irregularly (ibid.:44). Of these, the largest group consists of migrant workers from Central and Eastern Europe who require a work permit (interim regulations). The second category consists of nationals originating from countries with visa requirements (e.g. Turkey, the former Yugoslavia, the Russian Federation, Ukraine and Vietnam). A third group of undocumented migrants consists of nationals of distant countries with visa requirements (e.g. China, Iraq, Afghanistan, India, and also Africa and Latin America). Some of these migrants submit an asylum petition after entering the country illegally (Cyrus 2008:47; Sinn et al. 2005:35).

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4 Eurostat.

It should also be noted that in the German context (statistics and public discourse), the term “irregular migrant” (as the equivalent to undocumented migrant) has a different scope. In its narrow sense, it refers only to third-country nationals who do not possess the required residency permits. However, it is also understood in a broader sense as referring to EU citizens (non-German) who do not possess the required permits (including work permits) (Cyrus 2008:20). Furthermore, in Germany there is the concept of “toleration”, which introduces a kind of “in between”. Immigration laws and regulations create a residency status which is not a legal residency, nor irregular or undocumented; the so-called “Duldung” ("toleration"). Toleration refers to being granted a “toleration certificate”, implying a suspension of deportation, whilst still under a legal obligation to leave the country, where expulsion or deportation cannot be enforced for factual or legal reasons. As toleration certificates merely suspend deportation procedures, they do not constitute legal residency status (Sinn et al. 2005:14). In August 2007, this group totalled 154,780 persons, and half of these had lived in Germany for more than six years (Kraler et al. 2009:53).

Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups

Officially, there is no regularisation program in Germany, as this is considered to encourage irregular migrants. However, since 1997 there have been four programs specifically targeting long-term tolerated persons. Those programs have not been considered by the German government as constituting regularisation (Kraler et al. 2009:53). Nevertheless, Germany has, in the past one-and-a-half decades, effectively regularised (received residence permits) a significant number of illegally staying third country nationals. The programs have targeted persons who had long been tolerated and who could prove their integration into German society (income, housing, language skills). To fulfill the criteria, the great majority only received “toleration status” (still legally obliged to leave the country). The majority have to a large extent never benefitted from a full status adjustment (Cyrus 2008:57). The relevant documents are issued for a period of days, weeks or a few months, and may be prolonged indefinitely, each time for a short period, as long as the obstacle to deportation persists. Tolerated persons have only limited access to the German labour market and receive basic social assistance (ibid.). Due to regularisation programs and regularisations through various mechanisms, the number of tolerated persons was reduced as at 30 September 2008, to some 110,000 (ibid.). The logic of the regularisation cannot be said to be clear cut. The German response to irregular migration has been in the form of intermediate solutions (toleration). In addition, there are a series of ad-hoc measures targeting specific groups, often with specific protection needs (war refugees, temporary refugees, etc.). However, permanent residence permits appear to be granted to a minority of applicants on humanitarian grounds. The vast majority of persons covered by these programs have received “toleration status”, and this process can be said to involve economic considerations.
Internal Control: Accommodation, Labour, Social Security and Education

In Germany it is virtually impossible for an undocumented migrant to sign a contract for accommodation, as this requires being a legal resident. In terms of the Law on Compulsory Registration, registration of residency is compulsory for all residents in Germany. Registration is done at a local registry office, irrespective of citizenship or residency status. The registered address is reflected in identification papers. As part of the registration, personal data is collected, which in the case of foreigners is forwarded to the foreign-resident authorities. By law, landlords are obliged to cooperate with the registration authorities in enforcing the compulsory registration, and must ensure that the tenant registers, which is usually confirmed by the tenant presenting his or her registration certificate (Sinn et al. 2005:52).

Undocumented migrants cannot access employment, nor the related social security, as employment requires a permit. In accordance with §§ 284ff. SGB III (German Social Code), employment is considered illegal if no work permit was obtained prior to commencing such. There are checks on the labour market which include the screening of social security cards (Sinn et al. 2005:4). As regards schooling, the right to education can be considered to be implicit, as there is no impediment to the enrolment of children who do not have legal residency status, as there is no clear link to status (European Commission 2004:33). However, due to an unclear situation (varying interpretations as to whether schools have an obligation to forward information), the decision is left to the individual schools. In addition, it is unclear as to who has liability with respect to insurances and the costs of schooling (Sinn et al. 2005:64). The basis of this internal control lies in the requirement of schools to report non-residency status to foreign-resident authorities, or any other information requested by these authorities, as provided for in The Residence Act (§ 87 AufenthG). This requirement is primarily effective where social welfare services are claimed (e.g. in health care and education) (ibid:8). (On health care, see below).

Main Characteristics of the Health System

Financing, Services and Providers

The welfare system in Germany is mainly financed by state driven insurances. The public (also called “social” or “statuary”) health insurance (SHI) is compulsory for employees earning up to a certain amount and also covers their dependants. Civil servants and employees with earnings above a certain amount may choose to remain in the publicly financed scheme or they may select a private scheme (Thomson et al. 2009:141). As from 2009, health insurance in Germany is compulsory for all persons (ibid.). As regards the statutory health insurance, paid contributions are dependent on income and not on health risk. Employers and employees share the health insurance contributions almost equally. The unemployed are covered by the social welfare system (ibid.). Private health insurances have a mixed complementary and supplementary role (Busse 2009). The publicly financed
scheme is operated by over 200 competing, non-profit health insurance funds, regulated by the Government. It is thus characterised by a pluralistic funding system. As from 2009, all fund revenues are pooled centrally and allocated based on capitation, adjusted for age, sex and health risk. There is also cost-sharing on the part of the patient (children and pregnant women are exempted) (Busse and Riesberg 2004).

The German system may be characterised as a corporatist system. The statutory health insurance, sickness funds, their associations and associations of SHI-affiliated physicians, have assumed the status of quasi-public corporations. These corporatist bodies, based on membership, constitute the self regulated structures which operate the financing and delivery of benefits (services) covered by statutory health insurance within the legal framework (Busse and Riesberg 2004:29). Decision making is delegated by the government to these bodies (ibid.).

The Statutory Health Insurance (SHI) covers all essential medical benefits as it provides a comprehensive package of benefits for the beneficiaries and their dependants (Thomson et al. 2009:141). SHI benefit packages cover preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, prescription drugs, medical aids, rehabilitation, and sick leave compensation. Since 1995, long-term care is covered by a separate insurance scheme, which is mandatory for the whole population (Busse 2009). Dental care is also partially covered (Busse and Riesberg 2004:76). Furthermore, there are generous pension and unemployment schemes (Questionnaire Germany).

The German health care delivery system is clearly divided into the public health services, primary and secondary ambulatory care and hospital care (Busse and Riesberg 2004:91). Individuals have free choice of provider. Ambulatory care in all specialties is mainly delivered by physicians. They are for the most part self employed, although a few work at polyclinic-type ambulatory care centres. General practitioners have no formal gatekeeper function (Busse 2009). Hospitals are mainly non-profit, both public (approximately half of all beds) and private (around one-third of all beds). The private, for-profit segment has been growing over the last years (around one-sixth of all beds). Irrespective of ownership, hospitals are principally staffed by salaried doctors. Furthermore, senior doctors may treat privately-insured patients on a fee-for-service basis. Doctors in hospitals are typically not allowed to treat outpatients. Since 2004, hospitals may provide certain highly specialised services on an outpatient basis (ibid.). There are also the public health service and the Länder level (federal states). They are (apart from supervision and health reporting) responsible for the surveillance of communicable diseases such as tuberculosis and sexually transmittable diseases, providing community-oriented psychiatric services and health education and promotion (Busse and Riesberg 2004:33).
Basis of Entitlement

The basis of entitlement to health care in the German system is affiliation to insurance (Busse 2009:39, Thomson et al. 2009).

Special Requirements for Migrants

Self-employed foreign nationals are required to buy a private or statutory health insurance, as with German nationals who are self-employed. Persons without a residence permit cannot buy a private insurance, as the insurance system is linked to employment (Questionnaire Germany). This implies that entitlement to health care involves legal residency.

Difference Sensitivity

Generally speaking, there are no adaptive structures for migrants in health care in Germany. However, in some regions there are interpreter services, but this is more the exception than the norm (Questionnaire Germany). The City of Frankfurt introduced Afrikasprechstunde (Africa consulting hours), during which medical and psycho-social consultation is offered, as well as Roma-Sprechstunde (Roma consulting hours) (PICUM 2007).

Interventions to combat health inequalities have also not been given a high priority. However, a national integration plan from 2007 (Nationaler Integrationsplan), which contains the objective (and procedure) to improve integration, states that the federal states should support programs and initiatives which reduce barriers to health care for migrants and minorities (Berens et al. 2008 with reference to Bundesregierung 2007).

Health Care for Undocumented Migrants

Relevant Laws and Regulations

In the context of health care, the legislation regulating the right to health care for undocumented migrants is the same as that applying to asylum seekers, namely the Asylum Seekers Benefits Law, Asylbewerberleistungsgesetz (AsylbLG) of 5 August 1997. Section 1 defines the scope of the act. Section 1 No. 1 applies to "foreigners with a residence permit according to the Asylum Seekers Act. Section 1 No. 5 applies to "foreigners, who have the enforceable duty to leave the country, although this duty cannot not yet been enforced or is too late to be enforced" and section 1 No. 6 to "husbands, spouses or children under age..."

5 For examples of "good practices", see http://mighealth.net/de/index.php/5._Qualit%C3%A4t_der_Behandlung:_Entwicklung_von_Ans%C3%A4tzen_zur_good_practice_bei_der_Verbesserung_und_Anpassung_von_Leistungen_der_Gesundheitsversorgung_an_di_e_Anforderungen_von_Menschen_mit_Migrationshintergrund (05-03-2010).
associated to the persons according to [Section 1] No. 1 to No. 5, although not themselves fulfilling the requirements defined in that numbers.\(^6\)

In addition, the Act on the Prevention and Control of Infectious Diseases in Man, § 19 (Gesetz zur Verhütung und Bekämpfung von Infektionskrankheiten beim Menschen of 20 July 2000, last modified on 31 October 2006 – IfSG.) is also applicable.

The Residency Act (Aufenthaltsgesetz Gesetz über den Aufenthalt, die Erwerbstätigkeit und die Integration von Ausländern im Bundesgebiet) Section 87 and 88 provide for a duty to denounce (87) as well as an incentive normally not to denounce (88) undocumented migrants to the authorities of the Länder, which are in charge of executing the Residence Act. This act applies to public administration, health workers and administrators are explicitly excluded. Furthermore, it does not apply to emergency care.

Also relevant is section 323 c of the German Penal Code (StGB) which reads that each citizen who does not help another citizen in case of that citizen having an accident or other endangering situation or other urgent need, especially if the helping citizen is able to do so without endangering himself or due to not to neglect his own important legal or moral obligations, will be penalised with imprisonment up to one year or with a fine.

**Access to Different Types of Health Care**

In cases of emergency, undocumented migrants can access health care at a hospital or from a general practitioner, who is obliged by law to provide medical treatment. Beyond that and in short: undocumented migrants – as well as those with a “Duldung“, are officially entitled to the same health care benefits as asylum seekers residing in Germany for less than forty-eight months. This time line involves a restriction of care in relation to regular health insurance. The care comprises: treatment in cases of serious illness or acute pain and everything necessary for recovery, improvement or relief of illnesses and their consequences, post natal care, vaccinations, preventive medical tests and anonymous counselling and screening of infectious and sexually transmitted diseases (TB, HIV) (HUMA Network 2009:62). To prove entitlement, a document, “Krankenschein“, is required. This is not required in the case of emergency care, as implied by the Penal Code with respect to the right to access emergency care (ibid., see also Berens et al. 2008). From this follows that undocumented migrants are not entitled to secondary (specialist) care. According to Médecins du Monde Germany (Ärzte der Welt), undocumented migrants can access health care only from doctors willing to forego payment of fees and the obligation to report (see below). This situation entails limits with respect to referrals and further tests and examinations (PICUM 2007:41).

\(^6\) Information from the Federal Ministry for Labour Affairs and Social Security.
**Costs of Care**

Undocumented migrants do not pay a fee for the (limited) care they are entitled to if they possess the required document, “Krankenschein”. For some providers of care, it is possible to receive reimbursement for the costs of emergency treatment from the tax-funded social welfare office, according to the regulations of the Social Code. In order to obtain such a reimbursement, the service provider must have ensured that the patient is neither insured nor able to pay for the treatment (§ 4 and § 6 AsylbLG). (PICUM 2007:38).

**Specific Entitlements**

As regards the entitlement to health care for undocumented migrants, there are specifically identified groups, namely children and pregnant women. Children have the same (restricted) access as adults, however the Asylum Seekers Benefits Law states that children can, over and above this benefit, receive “other care depending on their specific needs” (HUMA Network 2009:61). The same provision also recognises traumatised persons as being able to access “appropriate care” (ibid.). Also, pregnant women have access to preventive medical check-ups, services concerning child delivery and related care. However, access to maternity care and care for the child is only possible if they successfully apply for a Duldung. This “tolerated status” is usually granted during the so-called “period of maternity” (from 6 weeks prior to delivery to 8-12 weeks after delivery) (PICUM 2007:38ff).

Furthermore, the Law of Infectious Diseases provides for anonymous check-up counselling, which is also available for undocumented migrants - in cases involving tuberculosis and sexually transmitted diseases. These services are organised by public health providers (also as ambulatory care) or in private medical centres (PICUM 2007:37). Undocumented migrants can receive free and anonymous testing at public health offices with respect to HIV/AIDS in terms of the Law of Infectious Diseases, 19 §. Treatment is provided under the condition that the person provides the document which proves entitlement (“Krankenschein”). HIV/AIDS are thus understood as constituting "serious illness or acute pain“(HUMA Network 2009:70).

There is one more option to access care, given that the statutory accident insurance must cover payments in cases of accidents in the workplace or on the way to the workplace, even if the employer has never paid the contributions and the injured person is neither still employed nor in possession of a residence permit. In theory, this also applies to undocumented migrants, however it is difficult to enforce due to their weak position (PICUM 2007:38).
Regional and Local Variations

The legal entitlements are laid down in the legislation and do not vary. However, there are some regional and local variations regarding entitlement to care with respect to implementing the right to care (not from a legal point of view). The routines and practices vary in different federal states, which imply a regional variation.

Obstacles to Implementation

According to the Asylum Seekers Benefits Law, undocumented migrants have (limited) access to care. However, in the German context, a certain duty to denounce undocumented migrants which applies to all public administration bodies has to be taken into considerations as this duty concerns health workers indirectly. Furthermore, in this regard, there have been recent changes (see below). Another identified obstacle involves fear of being discovered and deported which prevents undocumented migrants with tuberculosis or other serious contagious diseases from claiming their legal right to check-ups, counselling and seeking treatment in public health offices (PICUM 2007; HUMA Network 2009:78).

Obligation to Report

As previously stated, public administration bodies have a duty to denounce (Section 87 AufenthG.) undocumented migrants to the authorities of the Länder, which are in charge of executing the Residence Act. However, as the law refers to “public administrative institutions”, health workers, including administrative hospital staff, are explicitly excluded. Yet, providers of care are sometimes involved indirectly, as providers who have treated undocumented migrants claim reimbursement from social assistance officials, and the latter is then obliged to report the undocumented migrants to immigration authorities. Since 18th September 2009 when The Bundesrat issued new instructions, an interdiction to denounce laid down in section 88 apply to social services involved in the reimbursement of hospitals. Taken together, the legal situation today is as follows; Hospital-Staff is not required to transmit personal data to the authorities of the Länder (due to professional confidentiality). This is also the case for staff or authorities, which are in charge for the reimbursement of costs to the health providers which have delivered medical treatment to persons without documents.7

7 The amendment is available at http://www.huma-network.org/News-Press-Releases/GERMANY-The-prohibition-to-denounce-the-undocumented-migrants-extension-to-the-welfare-services (22-04-2010). The formulation of the legislation seems to be leaving room to be interpreted as aiming at emergency care.
Providers and Actors

Providers of Health Care

Given the limited entitlement to care and the restrictive legal framework, the main providers can be found amongst the general hospital emergency units. There are also a range of nongovernmental organisations providing care. Some of them have a confessional profile, and include: Büro für medizinische Flüchtlingshilfe, Malteser Migranten Medizin (MMM) and Café 104 (in Munich) (PICUM 2007:43-44).

Since July 2006, “Café 104”, in cooperation with Ärzte der Welt (Médecins du Monde Germany) has offered, in Munich, direct health care twice weekly for persons without health insurance. This recent cooperation provides the opportunity to combine direct medical treatments with social and legal counselling. An emergency telephone line assures daily accessibility.

The nongovernmental providers are mostly localised in the main cities, including Berlin, Munich, Darmstadt, Cologne, Frankfurt, Hamburg, Hanover and Stuttgart (PICUM 2007).

There are also some public initiatives (Dusseldorf, Frankfurt). For example, the Gesundheitsamt der Stadt Frankfurt (Department of Health of the City of Frankfurt) offers anonymous medical consultation and treatment. The City of Frankfurt has called for the opening of an intercultural health service, as the residency status of migrants, in addition to the fear of undocumented migrants of being detected, should be taken into account when planning such health care services (PICUM 2007:46).

Advocacy Groups and Campaigns on Rights

There are advocacy groups concerned with the rights of undocumented migrants, found among human rights groups, churches and welfare associations. They have improved their situation and experience and have demanded legal reforms in favour of humanitarian concerns (Cyrus 2008:16).

Political Agenda

In Germany, irregular migration is an issue which has received attention for some decades. For the last ten years, the issue has been continuously discussed in Germany. However, it remained mainly a topic for specialised actors and only rarely became a “hot issue” in the public debate (Cyrus 2008:16). Generally, the public debate is framed by two positions, namely the humanitarian concerns (the unauthorised refugee) and by the public order issue (the criminally unauthorised) (ibid. with reference to Vogel 1999\(^8\)). The ministries of

the interior approach the issue predominantly as an issue of border and migration control and as a security concern. As a result of the public attention created by the advocacy groups, irregular immigration is a sensitive issue for public authorities. Irregular immigration is mentioned in a number of official reports and several ministries at federal and national level deal, or have dealt, with it. Some special reports on irregular immigration were published by public authorities and academic institutions upon being commissioned by public authorities (to review information, data and information collected by public authorities in contact with undocumented migrants) (ibid).

International Contacts

Actors in the field of health care for undocumented migrants in Germany have international contacts. Organisations such as Médicos del Mundo and PICUM have emerged and are active, which implies international contacts.

Bibliography


