Policies on Health Care for Undocumented Migrants in EU27

Country Report

The Netherlands

Carin Björngren Cuadra

April 2010
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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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<th>Healthcare in NowHereland: Improving services for undocumented migrants in the EU</th>
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<td>Project funded by DG Sanco, Austrian Federal Ministry of Science and Research, Fonds Gesundes Österreich</td>
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<td>Running time: January 2008 – December 2010</td>
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<td>Partners:</td>
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<td>Platform for International Cooperation on Undocumented Migrants (BE)</td>
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**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**

The Netherlands 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: Professor David Ingleby, The European Research Centre on Migration and Ethnic Relations (ERCOMER), University of Utrecht and coordinator of Mighealth.net.
The Netherlands has experienced migration in many forms, such as Fordist mass migration (work migration) from the 1950s to 1970s, asylum migration since the 1980s, irregular migration since the 1990s and workers arriving temporarily from Eastern Europe (Questionnaire Netherlands). After World War II, the first major group to arrive originated from the former Dutch East Indies (Ingleby 2009), which makes a connection to the consequences of decolonisation salient. Many were of Dutch origin or were familiar with the Dutch language and culture (ibid.). From the 1950s up until 1970, ‘guest workers’ (gastarbeiders) were recruited and this was linked to the rapid economic expansion. These guest workers came first from Southern European countries such as Italy, Spain, Portugal, Yugoslavia and Greece, and later from Turkey and Morocco. Whilst most European ‘guest workers’ returned to their countries of origin, many from Turkey and Morocco did not; later, they acquired the right to bring family members and marriage partners to The Netherlands and thus constitute two major groups of migrants and minorities (MEM) (Ingleby 2009).

Two other major groups of MEM originate from Suriname (336 000 or 2.0% of the population) and from Aruba and the Dutch Antilles (13 000 or 0.8%). Furthermore, there are also 590 000 non-Western MEM’s present (3.6%) as well as 1 450 000 MEM’s of Western origin (8.8%). Between 1995 and 2001, about 250 000 asylum seekers came to The Netherlands. After 1970, the policy for admitting non-Western labour migrants became highly restrictive, so most of the 3.6% ‘other’ non-Western immigrants mentioned above will have entered the country in this way. After 2002, Dutch asylum policy became much more restrictive; in 2007 there were less than 10 000 applications (Ingleby 2009). However, in recent decades, most of those who have come to the country have been asylum seekers and volgmigranten (forced migration).

In 2008, 15 255 persons applied for asylum in The Netherlands (Eurostat 66/2009). Among them, 5 310 came from Iraq and 3 960 from Somalia (ibid.). The same year 11 725 decisions were issued (in the first and second instance) and the rate of recognition was 52.0 % (in the first instance) (Eurostat 175/2009).

**Total Population and Migrant Population**

By 1 January 2010, the population in The Netherlands was 16 576 800 (Eurostat)³. In 2008, the foreign-born population was 688 000 (Eurostat 94/2009). Among foreign nationals, the largest groups are Turks (93 700), Moroccans (74 900) and Germans (62 400). The second largest groups of non-nationals after Turks are in fact persons whose citizenship is unknown or who are stateless (89 268), suggesting a relatively high share of persons with unclear residency status (Bonjour et al. 2009).

³ Eurostat.
Estimated Number of Undocumented Migrants

Estimates of the number of undocumented migrants in The Netherlands range from between 60,000 to 225,000. This corresponds to 0.4% - 1.4% of the population, and thus a medium ratio within the European context (Baldwin-Edwards & Kraler 2009:41). Calculations in 2005-2006, based on the number of apprehended irregular migrants over a period of one year, place the estimate of irregular migrants in The Netherlands at almost 129,000, thereby providing an indication of the true numbers (Bonjour et al. 2009:98 with reference to Van der Heijden e.a. 2006: 14; Kromhout e.a. 2008).

Categories of Undocumented Migrants

In The Netherlands undocumented migrants have different pathways into their present situation. However, there is not sufficient information available to make a ranking possible, although there are different studies available on this topic (Questionnaire Netherlands). According to one study, more than 40% of the undocumented migrants detained come from countries which generate many asylum seekers (ibid. with reference to WODC, Ministry of Justice 2008). This implies that the asylum system has a role in “producing” undocumented migrants (Baldwin-Edwards & Kraler 2009:41). However, another study suggests that the largest group of undocumented migrants consists of labour migrants (i.e. persons who have come to The Netherlands for economic reasons) and in addition to this group, refugees living in the country illegally. A third group consists of those who have migrated for personal reasons (Questionnaire Netherlands with reference to Van den Muijsenbergh & Schoevers 2009). Yet another source suggests that most irregularly residing immigrants in The Netherlands have entered legally, which leads to the conclusion that overstaying is the main source of irregularity in the country. The largest groups are said to be labour migrants, followed by refused asylum seekers (ibid. with reference to PICUM 2007).

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5 The article "Zorg voor ongedocumenteerden" by M. van den Muijsenbergh & M. Schoevers (2009) states that the largest group of UDM’s consists of labour migrants (aliens have come to The Netherlands for economic reasons). In addition, many refugees live in illegality. A third group are those who have migrated for personal reasons.
Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups

Over the years, the number of regularization programs and the number of regularised migrants in the Netherlands has been very small (Bonjour et al. 2009: 99). Since 1997 there have been three regularization programs, in 1999, 2004 and 2007. Prior thereto there were programs in 1975 and 1995. The regularization programs in the 1990s were limited in scope; the maximum number of permits granted was 2 200, in 1999. The most recent regularization campaign in 2007 was far more significant in scale, with 27 500 aliens granted the right to stay (ibid.).

The logic of the programs can, in the case of the more recent programs, be said to follow humanitarian arguments, as the main target group was asylum seekers who had waited for a long time. For example, the program in 2004 involved the regularization of asylum seekers who had been kept waiting more than 5 years for a decision. The regularization in 2007 ('General Pardon') was confined to those who had applied for asylum. Some had been awaiting a decision since 2001, whilst others had been turned down but had not left the country (ibid.). Earlier, in 1995, a prerequisite was employment, in addition to a lengthy stay (Questionnaire Netherlands). The 'white illegals' who were regularised in the 1990s were not asylum seekers but (for the most part) irregular labour migrants who had come to work or join family members and had succeeded in building up a fairly established way of life, which was then used as their main argument; they had not done anything illegal, had regular jobs, paid taxes, and did not commit crimes. The argument was based around moral issues, as opposed to economic or humanitarian issues (ibid.).

Internal Control: Accommodation, Labour, Social Security and Education

In The Netherlands it may be possible for an undocumented migrant to sign a contract with a private landlord, but whether they would be able to enforce it in a court of law is doubtful. Even if they were technically able to, they probably couldn't afford it and wouldn't want to make themselves conspicuous to the authorities. Furthermore, a great deal of cheap rented accommodation falls into the official category of "social housing" and undocumented migrants are explicitly not allowed to rent such (Questionnaire Netherlands). They cannot access employment or the related social security (with reference to the Linkage Act 1998). However, The Netherlands explicitly permits school enrolment for the children of irregular immigrants. This is in accordance with the Dutch Constitution (European Commission 2004:33). The laws in question are: Vreemdelingenwet art 10, Wet op primair onderwijs artikel 40.1, Wet op voortgezet onderwijs artikel 27.1a (Questionnaire Netherlands). Furthermore, children up to the age of 18 are allowed to complete any schooling undertaken (Questionnaire Netherlands with reference to Basisrechten voor ongedocumenteerden: Informatie page 9, published by Stichting LOS).
Main Characteristics of the Health System

Financing, Services and Providers

The Dutch welfare system is mainly financed by state regulated insurance schemes, and the system has recently undergone changes. Until 2006, The Netherlands operated a dual system of health care financing. Most citizens were covered by statutory health insurance, but those with higher incomes had to take out private insurance. In 2006 this system was replaced by the Health Insurance Act (Zorgverzekeringswet; ZVW). This is a unique hybrid system which is entirely operated by private insurance companies but subsidised and to a large extent regulated by the government. The Dutch health care system is thus operated by private for-profit insurance companies, but is at the same time state driven. This unique situation – in some respects paradoxical and hard to fit into welfare typologies – may be illustrated by the fact that, according to the Ministry of Health website, the government only pays for 5% of health care costs. In the view of the WHO however, it in fact pays for 82% of health care costs, as the WHO appears to interpret a compulsory premium paid to a private insurer (but administered according to rules entirely laid down by the government, with premiums subsidised by the government), as being equivalent to a tax levied to pay for a national health service (Questionnaire Netherlands).

Since 2006, all residents or those paying income tax in The Netherlands are required to purchase health insurance coverage (Klazinga 2008). Those who do not purchase such insurance may face financial penalties. However, basic coverage (see below) is free for persons under 18, and the government pays out an allowance (through the Inland Revenue Service) to assist those on low incomes in paying their premiums. The premium for basic coverage consists of a ‘nominal premium’ plus an income-related contribution which the employer pays. Premiums vary between insurance companies, which thus compete with each other for customers. In 2009 the average ‘nominal premium’ for an adult was €1 125 per year. According to the Health Ministry, this covers almost half the (direct) costs of the health care system. The income-related (employers’) contribution was 6.9% of the first €32 369 of a person’s income, in other words, never more than €2 233. This is said to cover about 45% of the remaining costs of care, with 5% being covered by the government. To prevent the exclusion of people with increased health risks, insurers are obliged to accept all applicants for basic coverage on the same terms. More extensive (supplementary) coverage may be obtained by paying higher premiums; for this type of coverage, insurers are allowed to turn down ‘high-risk’ applicants. With some exceptions (e.g. the chronically ill), adults are required to pay the first €150 of their annual health costs out of their own pockets (Questionnaire Netherlands).

Despite the sanctions, in 2008 1% of the population had failed to take out even basic health insurance (CBS press release, 9 April 2009). This percentage was 9 times higher amongst migrants than amongst the native Dutch. Many of these migrants came from EU accession countries in Eastern Europe, or from the USA. Some probably fail to take out health
insurance because they do not realise that it is required by law and/or do not understand how the system works (Questionnaire Netherlands).

In terms of coverage, the standard basic benefits package covers the following: medical care, including care by general practitioners (GPs), hospitals and midwives, hospitalisation, dental care, medical aids, medicines, maternity care, ambulance and patient transport services and paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy and dietary advice). In addition to this basic benefits package, all citizens are covered by the Exceptional Medical Expenses Act (AWBZ), which provides for a scheme providing a wide range of chronic and mental health care services, such as home care and care in nursing homes (Klazinga 2008). A variety of (free) preventive health services are also financed by central government or local authorities (Questionnaire Netherlands). Dental care is included in the basic benefits package up to the age of 21; coverage after the age of 21 is confined to specialist dental care and dentures (ibid.). As regards pensions, the state pension scheme (AOW) provides a standard (low) amount. Most workers supplement this amount with supplementary pension schemes, to which employers also contribute. Some persons also put money aside in private pension or insurance schemes.

Given the combination of for-profit insurance companies and governmental regulation, the distinction between private and public does not adequately characterise the organisations which provide health services in The Netherlands. Most of these are neither fully public nor fully private; they are independent non-profit organisations, regulated by the government. Even though they may be totally dependent on government subsidies and in effect government controlled, they are legally independent entities (Questionnaire Netherlands).

**Basis of Entitlement**

In The Netherlands, the basis of entitlement to care is legal residency and insured status. Legal residents, as well as people not resident in The Netherlands but paying income tax there, must take out basic health insurance. Those who are not legally resident cannot do so (Questionnaire Netherlands).

**Special Requirements for Migrants**

As said above, non-Dutch nationals ('aliens') with a residence permit must take out health insurance. This right and subsequent obligation exists from the moment the residence permit is issued, not (in the case of a permit issued retrospectively) from the start of the period covered by the permit. As soon as they are insured, such persons enjoy exactly the same care as anyone else. From the moment their residence permit is issued they are also covered by the AWBZ (Exceptional Medical Expenses Act). Aliens waiting for their application for a residence permit to be processed must take out private health insurance, unless they are covered by an existing health insurance or a national health service in their country of origin. However, this does not apply to specific groups of "aliens in processing", such as asylum seekers or aliens seeking family reunification or seeking to form a family
with a Dutch resident. For these aliens, medical expenses are generally covered by a special scheme established by the Ministry of Justice. In this context, children, regardless of where they are born, have a similar right and obligation to be registered for health insurance. However, for those under 18 the premiums for the basic care package are waived (Questionnaire Netherlands). Persons residing illegally in The Netherlands are not entitled to health care insurance in terms of the AWBZ and ZVW (ibid.).

**Difference Sensitivity**

In The Netherlands, some adaptive structures are to be found, such as interpretation, mediation and translation services, translated materials and health services adapted to migrant specificities (for example, meals in hospitals) as well as the promotion of multicultural staff in the health sector (Questionnaire the Netherlands). The Netherlands was one of the first European countries to make special provisions for delivering health services to migrants. Free interpreter services were provided from 1986 and a comprehensive system of health promotion and health education adapted to migrants' languages and cultures was developed even earlier. The most attention to diversity is found in the mental health care sector, especially in the large cities. However, these efforts have largely been on an incidental and individual basis, rather than being incorporated in policy. The government took a short-lived interest in adapting services to migrants from 2001-2003 (Questionnaire The Netherlands with reference to Ingleby (2006)).

**Health Care for Undocumented Migrants**

**Relevant Laws and Regulations**

The relevant legislation regarding entitlement to health care is the following: The Law on the Reimbursement of the Costs of Care for Illegal Aliens, article 122 a van de Zorgverzekeringswet (Health Insurance Act) (Wet tegemoetkoming in de kosten voor de zorg voor illegale vreemdelingen). This act was published in December 2006 and came into effect on 1 January 2009.

This new scheme does not distinguish between 'primary' and 'secondary' care, but between 'directly accessible' and 'not directly accessible' services. Emergency care is a kind of 'directly accessible' care (as it is to be understood as being “medically necessary”).

**Access to Different Types of Health Care**

It is relevant to note that the entitlements to care for undocumented migrants have changed a number of times in The Netherlands. The history may be divided into three phases. In the

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first phase, prior to 1998, there were no mechanisms excluding undocumented migrants from the health and social security system. The second phase, between 1998 and 2009, was regulated by The Linking Act of 1998 and partially financed by the "Koppelingsfonds". During this period only "medically necessary care" and care that was "necessary to protect public health" could be reimbursed. The interpretation of these concepts varied between service providers (Questionnaire the Netherlands; see also HUMA Network 2009). The current phase, phase three, relates to the changes in the general system, which resulted in barriers for undocumented migrants (as regards purchasing insurance with the associated documents or the electronic pass needed when seeking care). However, efforts were made to formulate a workable system for reimbursing service providers for the costs of care for undocumented migrants. In October 2008 a new law was passed which came into force in January 2009. In some respects the new scheme is an improvement, especially with respect to secondary care, mental health care and AWBZ care (institutional or home care)(Questionnaire the Netherlands). The basic provisions are:

1) The costs of "medically necessary care" for undocumented migrants (defined as "illegale vreemdelingen", i.e. "illegal aliens") could be reimbursed (to the service provider) if steps had been taken to recover these costs from the patient. This entailed sending an invoice and a reminder, and investigating the patient’s ability to pay. The definition of "medically necessary care" was made identical to "basic health care coverage" as defined by the 2006 Health Insurance Act. This was at odds with the recommendations of the Klazinga Committee (2007), which had proposed that the doctor concerned should make the final decision as to what was "necessary" care. (This proposal would have permitted broader coverage, but it would also have been inherently unclear. One of the major criticisms of the previous situation was that there was no agreed definition of "medically necessary care").

2) The new scheme does not distinguish between 'primary' and 'secondary' care, but between 'directly accessible' and 'not directly accessible' services. The essence of the former is that they can be accessed on demand; they provide "non-planable care". To use a 'not directly accessible service', however, a person must first obtain a referral, a prescription or an indication; these services provide "planable care". For 'directly accessible' services [GP’s, midwives, dentists (for persons up to the age of 21), physiotherapists or hospital emergency departments], the undocumented migrants may make use of any provider available. As regards 'not directly accessible' services [other hospital departments, nursing homes or dispensaries], only a limited number of specially contracted providers belong to the scheme. Other providers cannot be reimbursed for care given to undocumented migrants. A possible advantage of this is that it makes a degree of specialisation possible, but a major disadvantage is that the care may be more difficult to reach. Specialised services (especially hospital care) may be covered, but only if they are included in the basic health insurance package. In the case of "planable" care, the service provider must also be contracted into the scheme. The first 9 sessions of treatment by a physiotherapist are also not reimbursed. Moreover, there is often ignorance as to which providers have been specially
contracted. Undocumented migrants who, because of their own ignorance or that of the health worker who refers them or writes a prescription, obtain (non-emergency) hospital treatment or prescription medicines from non-contracted providers, will find themselves liable to pay the entire costs themselves.

3) Only 80% of the normal fees for services can be reimbursed, except in the case of pregnancy and childbirth which are 100% covered. This means in effect that service providers are financially penalised for treating undocumented migrants.

The requirements for reimbursement of the costs of primary care are the same as for other forms of care, in other words it must be proved that the patient is unable to pay, and only 80% of the costs will be reimbursed (except in the case of pregnancy and childbirth). Prescription medicines may only be obtained from selected dispensaries.

**Costs of Care**

The costs of the new scheme are borne by the state, but administered by the health insurance companies. The system of reimbursement addresses the providers and not the patient (Baghir-Zada 2009). In order to have health care costs reimbursed under the new scheme, service providers must prove the patients’ inability to pay, which involves sending the undocumented migrant an invoice and a reminder (undocumented migrants often do not realise that the invoices are simply a formal requirement). The patient is not expected to pay if he / she is unable to do so. But in most cases the service provider only gets 80% of the fee reimbursed. It is possible that some try to extract the remaining 20% from the patient. There are also some nongovernmental organisations (in Amsterdam and Rotterdam) which provide medical care free of charge. Special funds have been set up by local authorities in Amsterdam, Utrecht, Den Haag, Rotterdam, Nijmegen and Eindhoven to help undocumented migrants who are unable to pay for dental care (Questionnaire Netherlands).

**Specific Entitlements**

All children, including undocumented migrants, are entitled to free preventive care and check-ups at baby clinics according to the Health Insurance Act. As regards children, the BMO (2009) states that although international conventions require that there should be no obstacles at all for children, even in irregular situations, to receiving health care, many obstacles remain - even in the new scenario which has applied as from 2009.

With respect to pregnant women, costs resulting from pregnancy and childbirth are reimbursed in full, instead of the usual 80%.

Legally there are no conditions which enjoy special entitlements. In practice, there are some initiatives which are specifically directed at HIV positive individuals. The Netherlands has no special legislation for contagious diseases as it is included in the “basket” of care defined
as “basic level insurance” (basispakket) for all residents. This of course includes infectious diseases.

**Regional and Local Variations**

The precise entitlements are laid down in the new law. However, there are some regional and local variations regarding entitlement to care in so far as implementing the right to care in practice (not from a legal point of view). One aspect is that only certain hospitals and dispensaries may provide care under the new regulations. Furthermore, there is still room for individual discretion in accepting or rejecting patients. Another degree of freedom which service providers possess is to decide how much pressure should be placed on an undocumented migrant to pay their own costs, before deciding whether they are unable to pay and allowing them to receive free help. Some caregivers may refuse to work for the usual 80% reimbursement. There have been complaints about gaps in the coverage, though these may be resolved as more service providers are incorporated into the scheme. However, a more fundamental criticism of the scheme is that the choice of service providers was made solely on economic grounds, without considering the users’ convenience. Coverage in a small number of (mostly remote) regions has not yet been arranged. Another factor is that even under the new system, nongovernmental organisations and informal organisations still have a crucial role to play in guiding the patients through the system. However, these organisations are confined to particular locations, creating territorial variations (Questionnaire Netherlands with reference to BMO 2009).

**Obstacles to Implementation**

There are obstacles to the practical implementation of this right. Parents, children and service providers are poorly informed about the rules relating to children. Complicated regulations and procedures requiring the completion of numerous forms create a barrier to the provision of aid. Youth care in particular is subject to special limitations (BMO, Broad Medical Coalition and Breed Medisch Overleg 2009, which is a coalition of organisations). The BMO (2009) listed the main problems and wrote a letter to Parliament in this respect in June 2009.

Generally, the main point of this letter was that there remains much confusion amongst health providers and users about what exactly the situation is and how the new scheme works. Efforts to disseminate information have been totally inadequate. Undocumented migrants who are incorrectly referred to dispensaries or hospitals which are not part of the scheme may ultimately be required to pay large sums out of their own pockets. Furthermore, service providers are required to make efforts to recover costs from the patient before claiming them from the new scheme. This can intimidate patients and undermine the relationship with the caregiver. It is not clear how far service providers are required to go in trying to get their fees paid. Another obstacle referred to involves the fact that no organisations are entrusted with the task of monitoring the health needs of undocumented migrants and the problems they experience.
As regards primary care, one problem which has been identified concerns the fact that most
dental care for those over 22 years of age, as well the first 9 sessions of physiotherapy, are
excluded from the scheme. Both exclusions can have serious consequences for the patients
concerned. As 80% of the costs will be reimbursed, one consequence is that some
caregivers refuse to give care for the reduced fee. Furthermore, the use of only selected
dispensaries, chosen purely on economic grounds regardless of their inconvenience to
users, leads to access problems. Some areas still have no designated dispensaries.
Laboratories and diagnostic centres appear to require additional proof of undocumented
migrants' inability to pay. With respect to secondary care, one problem which has been
identified involves the limited number of hospitals which may be used for "planable care".
This leads to problems in respect of access, with 4 out of 26 of the designated regions still
having no provision for such (Questionnaire Netherlands with reference to BMO 2009).

Obligation to Report

Caregivers are obliged to keep information regarding their patients confidential. They may
not collaborate with the police or Immigration and Naturalisation Services. This is
according to Article 88 of the Individual Health Care Professions Act (1996).

This rule is only broken in extreme cases, for example in case of infectious diseases or child
abuse. Recently, a hospital refused to provide information regarding rioters who had
attacked policemen and subsequently sought medical treatment.

Providers and Actors

Providers of Health Care

In the Dutch context, there are many providers of care. Among them can be found general
hospitals and emergency units as well as general practitioners both in the mainstream
system and private doctors. Rian Ederveen estimates that there are nearly 100 NGOs in The
Netherlands which provide assistance to undocumented migrants, and that most of these
NGOs receive support from local governments (Questionnaire Netherlands with reference
to PICUM Workshop report, 2009). Organisations involved in health care include: Special
centres: Kruispost (Amsterdam) and Straatdokters (Rotterdam), Médecins du Monde,
which provides accommodation, information, referrals and mediation between patients and
care providers, Lampion, which collects and provides information and advice on care for
undocumented migrants, Stichting LOS (Landelijk Ongedocumenteerden Steunpunt), which
provides information and advice to patients and others, and Defence For Children

7The article reads: “A person has a duty to maintain confidentiality in respect of everything that is confided to
him as secret during the practice of his profession in the field of individual health care, or that which has come
to his knowledge as secret or that which has come to his knowledge and the confidential nature of which must
be apparent to him.”
International (DCI), which provides information relating to children on their website\(^8\) (Questionnaire Netherlands).

The providers of health care can be found all over the country. However, the nongovernmental organisations and informal groups helping undocumented migrants are mainly to be found in the large cities (Questionnaire Netherlands). Some of them can be said to be coordinated. Two bodies are concerned with this activity:

1. Lampion (located in Pharos) is a collaboration between GGD Nederland, LHV, NVZD, GGZ Nederland, Vluchtelingenwerk Nederland, KNVC, Tuberculosefonds, NIGZ, SOAAIDS, Pharos, Johannes Wier Stichting, Dokters van de Wereld and KNOV.

2. The BMO (Broad Medical Coalition) was set up by the Breed Medisch Overleg (BMO). It is a network of organisations and individuals involved in health care for undocumented migrants. It was set up by the Landelijk Ongedocumenteerden Steunpunt (LOS). Participants include Medecins du Monde, Pharos, Lampion, Ondersteuningskomitee Illegale Arbeiders (OKIA), Samen Kerk In Nederland (SKIN), Landelijke Huisartsen Vereniging, Maria van de Muijsenberg (huisarts/ onderzoeker Universiteit Medisch Centrum St. Radboud/ Pharos), Rotterdams Ongedocumenteerden Steunpunt (ROS), Vluchtelingen in de Knel Eindhoven, Stichting Gezondheidszorg Illegalen Leiden (GIL) and organisations involved in research, policy making or service provision in health care (Questionnaire Netherlands).

**Advocacy Groups and Campaigns on Rights**

In The Netherlands, there have been campaigns regarding the rights to health held by nongovernmental organisations. Some organisations, including Lampion-Pharos, Doctors of the World, LOS and Gezondheidszorg Illegalen Leiden (GIL) make strong efforts to provide accessible information to all, to record incidents where undocumented migrants do not successfully receive medical treatment and to inform local health inspectors and other actors (PICUM 2007:66).

**Political Agenda**

The discussions on the new scheme were debated in parliament (however, this did not stir any great interest in the media). There were few right-wing arguments involved. A contributing factor may be that the complexity of the issues involved in health care policy makes it difficult for politicians to score easy points on this topic. As regards health care workers, the 2009 report of Médecins du Monde states that support from health care workers is not as strong as it used to be (Questionnaire Netherlands).

Different groups of undocumented migrants can be found on the agenda: rejected asylum seekers, children and women insofar as they are victims of trafficking, as well as

\(^8\) [www.ilegaalkind.nl](http://www.ilegaalkind.nl)
undocumented migrants in general (Questionnaire Netherlands). Health care is however not a salient topic. In the discussions which are in progress, both rights-oriented and control-oriented standpoints are represented and these have all played some part in the formulation of present policy (ibid.).

*International Contacts*

Actors in the field of health care for undocumented migrants in The Netherlands have international contacts. Established organisations such as Médecins du Monde and PICUM are active, which implies international contacts.

**Bibliography**


