Policies on Health Care for Undocumented Migrants in EU27

Country Report

Poland

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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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- 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

Poland entered the European Union in 2004 and is situated on the border of the Schengen Area. Schengen requirements have an impact on the migration regime, which is fairly strict. Visas are required for persons travelling from Poland’s eastern neighbours (Ukraine, Belarus and Russia) (Iglicka and Gmaj 2008).

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 persons to acknowledge are: Ela Czapka, Senior Lecture, Marie Curie-Skłodowska University Lublin and Dawid Sikora, PhD student in Jagiellonian University University Medical College, Cracow. They are also researcher for Mighealth.net in Poland.
In Poland, emigration is more of an issue than immigration. Poland was previously one of the largest sources of emigration in Central Europe, but has, since the beginning of the 1990s, gradually shifted towards a net immigration and transit-migration. This trend was strengthened by the entrance into the EU in 2004 (Dzhengozova 2009:107). However, the migration balances in Poland have remained negative since the beginning of the 1990s (Iglicka and Gmaj 2008) and Poland is not considered to be an attractive destination for either legal or irregular immigrants, due to its comparatively poor economic situation (ibid.). Furthermore, the migration regime is fairly strict, largely as a result of the requirements for EU accession and for entering the Schengen zone, and to a lesser degree, underpinned by the economic need for immigrant labour and inflows of asylum seekers (ibid.). Poland has what is referred to as shuttle and circular labour migration, mainly from former Soviet Union countries (Iglicka and Gmaj 2008). A relevant factor in the context of migration is that Polish society is tolerant of illegal employment (ibid.). In Poland there are many persons legally residing but unlawfully working in the country (ibid.).

Thus, Poland has a relatively short history of immigration. During the period from 1945 – 1989, restrictive passport and exit- and entry visa policies were upheld and these were not geared towards immigration (Iglicka and Gmaj 2008). During the last decade of the 20th century, Poland accommodated a non-visa mass movement of petty traders and circular migrants from neighbouring countries, mainly Ukraine, Byelorussia and Russia (regulated by agreements since the collapse of the Soviet Union) until visas were once again reintroduced for non-EU nationals. Since EU enlargement, migrants arriving in Poland from either its eastern neighbours (Ukraine, Belarus and Russia) or from East Asia (Vietnam, China, and Korea) have also started to be perceived as potential saviours in the face of Poland’s economic problems, which include labour shortages and stagnation. Over the last few years, immigrants came spontaneously from the closest geographical neighbourhood, i.e. Ukraine, Belarus and Russia. The only new and reasonably established ethnic group in Poland are the Vietnamese. Their mobility was also spontaneous and related to Polish-Vietnamese political and economic cooperation and student and personnel exchanges in the 1970s. The nature of migration flows into Poland during the transition period was related to the global division of labour. At the beginning of the economic transformation, highly skilled labour from the West and Asia and only a small part of the Eastern migrants could find employment within the primary labour market. The majority of migrants from the East were unskilled workers, who then found illegal employment in the secondary labour market (ibid.).

The largest non-EU national groups present in Poland (both legal and illegal) stem from its eastern neighbours and Asia, namely Ukraine, Belarus, Vietnam and Armenia. Russian and Moldovan nationals also form part of the stable core (Iglicka and Gmaj 2008). The number of immigrants working illegally in Poland varies from 50 000 up to 500 000 (Iglicka and Gmaj 2008). There is no valid data, but estimates are available. One such estimate states that in 2004, 50 000–300 000 immigrants were working illegally in Poland. The Office for Repatriation and Aliens stated that 450 000 foreigners worked illegally (of which 250 000 were Ukrainian, 150 000 Belarusian or Russian, 40 000 Vietnamese and 8 000 Armenian) (ibid. with further references). As regards Vietnamese citizens, the estimated figures range
between 25 000 and 60 000, with every second Vietnamese national residing illegally (ibid.)
Perhaps a more realistic figure would be between 12 000 – 22 000 (ibid.). As regards
irregular migration, Poland is unable to attract larger groups of irregular migrants, in spite
of its growing economy (Iglicka and Gmaj 2008). Interestingly, 12 063 work permits were
issued in 2006 (Czapka and Sikora 2009). After the collapse of the communistic regime,
Poland began attracting asylum seekers. In 2007, there were 4 563 new asylum
applications and the total number of ongoing cases was 10 048 (Czapka and Sikora 2009).

In 2008, Poland received 8 515 asylum applications, mainly from citizens of Russia (7 760)
(Eurostat 66/2009). The second and third largest group of applicants came from Georgia
(70) and Iraq (70) (ibid.). The same year, 4 425 decisions were issued (in the first and
second instance) and the rate of recognition was 65% (2 770 in the first instance) (Eurostat
175/2009).

Total Population and Migrant Population

By 1 January 2010, the population in Poland was 38 163 895 (Eurostat). In 2007, there
were 548 830 foreign nationals in Poland (Clandestino database). According to the 2002
National Census, foreigners constituted 0.2 per cent of the population, which implies a
rather homogenous population with regard to nationality. In this context, it is relevant that
Poland has nine national minorities and four ethnic minorities. The national minorities
include Germans (147 094), Ukrainians (27 172), Belarusians (47 640), Lithuanians (5
639), Slovaks (1 710), Russians (3 244), Jews (1 055), Armenians (262) and Czechs (386).
The ethnic minorities are: Roma (12 731), Tartars (447), Lemkos (5 850) and Karaites (43)
(Czapka and Sikora 2009).

According to statistics from Eurostat, in 2008 the foreign-born population was 58 000,
which represented 0.2% of Poland’s population (Eurostat 94/2009). The main countries of
origin were Germany (11 800), Ukraine (6 100) and Russia (3 700) (ibid.).

Estimated Number of Undocumented Migrants

Estimates of the number of undocumented migrants in Poland, range from between 45 000
to 50 000. This corresponds to 0.1 % of the population and thus represents a relatively low
ratio in terms of the European context (Baldwin-Edwards & Kraler 2009:41).

3 Eurostat.
&footnotes=yes&labeling=labels&plugin=1 (09-03-2010)
4 http://clandestino.eliamep.gr/database-on-irregular-migration/ (10-03-2010)
Categories of Undocumented Migrants

In Poland, there are undocumented migrants who took different pathways to their present situation and the asylum system does have a role in “producing” undocumented migrants (Baldwin-Edwards & Kraler 2009:41). The main categories of undocumented migrants consist of persons who entered the country illegally or are “overstayers”. These may have crossed the border illegally with fake or remade documents or, in the case of human trafficking and smuggling, by crossing the “green” border. A prominent group of undocumented migrants consists of persons who arrive in Poland on tourist visas with the intention of seeking employment and ultimately overstay their visas. (Dzhengozova 2009:107).

Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups

Since 1997, there have been 3 regularisation programs; in 2003 (twice) and in 2007, targeting undocumented migrants with major familial or other ties in the country. In 2003, the programs aimed at Armenians, Vietnamese and Ukrainians, providing them with 1 year permits, together with the option to extend such. Of 3 500 applications, 277 were approved. In 2007, the same groups continued to be targeted. 2 000 persons applied and 177 had their applications approved. In 2003, a second program also targeted persons wanting to leave without consequences (e.g. prohibited entry). The prerequisites included having resided in Poland uninterruptedly since 1997, "legal housing" and the promise of a work permit from authorities or a declaration confirming an intention to employ or similar (Dzhengozova 2009:107). Thus the focus of the programs may be interpreted as having been economical. Regularisation programs in Poland have been fairly limited (ibid. 112). One interpretation thereof may be that Poland aims for strong external control (ibid. 112-3). In exceptional cases, such as medical treatments or personal interest and for victims of trafficking (to allow these to cooperate with authorities), visas are issued for a period of three months (ibid.111).

Internal Control: Accommodation, Labour, Social Security and Education

In Poland, it is possible for an undocumented migrant to sign a contract for accommodation, but they cannot access employment nor the related social security (Questionnaire Poland).
Main Characteristics of the Health System

Financing, Services and Providers

Poland has a mostly state-run welfare system and it may be said to be a mixed system, with public and private financing, although it is mainly financed through the fiscal (tax) system. It is based on an insurance model; the public financing derives from social health insurance contributions. The budgetary expenditures derive from the state budget and the budgets of county and municipal authorities and private financing, which includes both formal and informal sources of payments, as well as some pre-paid plans. The health care insurance is public, and there are both compulsory and elective insurances. Thus, the main source of the health care budget is the mandatory contribution for health insurance, which is a so-called designated tax. The contribution is collected from citizens at 9% of their income, and then distributed by the state-owned National Health Fund and its regional branches. The health system is also supplemented by the State general budget and the budgets of local government units (Czapka and Sikora 2009). The social health insurance scheme is administered by The National Health Fund (NHF) with its regional branches (Kuszewski and Gericke 2005). The system is decentralised in nature, with local governments having their own health policies.

The 1997 General Health Insurance Law, together with later amendments thereto, provide for universal coverage of the population and full entitlement irrespective of risk. Certain treatments are excluded, such as cosmetic surgery and non-disease related treatments in health resorts and non-standard dental care (Kuszewski and Gericke 2005:27). The Law on Universal Health Insurance and the Law on Health Insurance, together with the National Health Fund, define a wide range of health services covered by the insurance scheme. These include health services aimed at maintaining and restoring human health and preventing diseases and injuries, early diagnosis, medical treatment and the prevention and alleviation of disabilities. Insured persons are entitled to medical examinations and consultations, diagnostic examinations, preventive care, outpatient health care, hospital care, medical emergency services, medical rehabilitation, nursing, the supply of drugs and medical devices, the supply of orthopedic devices and aids, prenatal care during pregnancy and childbirth, palliative care, the certification of temporary or permanent disability and a standard “basket” of dental care (ibid.). As regards primary care, citizens have free choice of family doctors, provided the doctors are contracted to the National Health Fund. This is also the case with respect to specialist hospitals. The family doctor assumes responsibility for both preventive and basic care and the supervision of the specialist treatment process. The doctor directs the patients to specialists via referral. Exceptions are: gynaecological, obstetric, eye, cancer, psychiatric, venereal and dental specialist clinics, which can be accessed directly (Czapka and Sikora 2009).

In Poland, most hospitals are public and are operated by the government (Kuszewski and Gericke 2005). In addition, the local government owns a number of healthcare facilities (Czapka and Sikora 2009). In 2003, there were 732 public hospitals and 72 non-
governmental and private hospitals. There is a strict separation between outpatient specialised care and inpatient care. Outpatient specialised care is mostly based at private medical practices in large cities and at independent health care institutions in other areas (Kuszewski and Gericke 2005:xvi).

**Basis of Entitlement**

In Poland, the basis of entitlement to care may generally be said to be citizenship. This is in accordance with Article 68 of the Constitution of the Republic of Poland, in terms of which the public authorities are obliged to ensure that all citizens have equal access to health services, irrespective of their ability to pay. The state is consequently responsible for the protection of health and the health services. Furthermore, some specifically mentioned groups include: children, pregnant women, handicapped persons and the elderly (Kuszewski and Gericke 2005:16).

**Special Requirements for Migrants**

Legal migrants have the same entitlements as Polish citizens. The Act on Health Care Benefits Financed by Public Funds of 27 August 2004, refers to the fact that aliens, namely citizens of countries other than the EU Members States or the EFTA, are entitled to receive health care benefits financed by public funds, and include those who: have a residency visa for the purpose of pursuing employment, a residency permit for an unspecified period of time, a settlement permit, a residency permit for a specific period, refugee status in the Republic of Poland or persons enjoying temporary protection in the territory of the Republic of Poland (Ministry of Social Policy 2005). The prerequisite is that they are liable for the health insurance or that they are covered by voluntary insurance under the principles laid down in Article 68 of the Act. Persons entitled to health care under EEA rules on the coordination of social security systems are thus entitled to free care during a temporary stay in the country (Ministry of Social Policy 2005).

According to official information, asylum seekers receive health care coverage, financed by the Office for Foreigners, for up to 2 months after the final decision with respect to their applications is announced. Foreigners in detention institutions receive health care coverage financed by the Border Guards. Furthermore, refugees and foreigners under subsidiary protection in the territory of Poland are eligible for medical coverage if they participate in the 12 month long integration program in cooperation with the regional family help center. The regional family help center pays their premium coverage to NHF during the integration program. At the end of the 12 month period, these individuals can either get insurance from work (if they are employed) or the Labour Bureau (if they are registered as unemployed). Otherwise, they can purchase individual voluntary insurance via NHF.5

**Difference Sensitivity**

To date, there are no adaptive structures in Poland. Generally, staff are not prepared for diversity (Questionnaire Poland; Barbara Niedzwiedzka, presentation at MIGHEALTHNET 15 April 2008, Brussels).

**Health Care for Undocumented Migrants**

**Relevant Laws and Regulations**

As regards entitlements to care for undocumented migrants, there is no specific legislation targeting this issue. Undocumented migrants’ right to health care is provided for in terms of The Law of Health Protection and legislation dealing with foreigners within Polish territory and the protection provided to them.

**Access to Different Types of Health Care**

Undocumented migrants have access to emergency care, with no special requirements applying in this respect. This is in terms of The Law of Health Protection, article 7, in terms of which organisations responsible for health protection (public as well as private) cannot refuse to provide care to a person in need of care or whose health or life is threatened (Questionnaire Poland with reference). In terms of other legislation (from 13 June 2006, in respect of foreigners within Polish territory and the protection provided them), each person is insured in Poland if he/she is working, and this includes medical protection. Based on this, undocumented migrants can access primary and specialist care in so far as they are rejected asylum seekers, have overstayed their visas or are affiliated to an insurance (ibid.).

**Costs of Care**

In Poland, undocumented migrants are not required to pay for emergency care nor any other care provided (Questionnaire Poland). This is in accordance with the current co-payment regulations, which relate mainly to drugs (Kuszewski and Gericke 2005:12).

**Specific Entitlements**

In Poland, there are no specifically identified groups in terms of entitlement (such as children or pregnant women or persons living with HIV/Aids) (Questionnaire Poland). However, there are specific entitlements relevant to undocumented migrants with respect to HIV-testing and treatment, TB and some contagious diseases. This is accordance with the legislation from 13 June 2006 relating to foreigners within Polish territory and the protection provided to them.
Regional and Local Variations

In Poland, there cannot be said to exist regional and local variations with respect to the entitlement to care, since the competence to make such decisions is centralised (Questionnaire Poland).

Obstacles to Implementation

This topic is not relevant as there is no specific legislation.

Obligation to Report

In Poland, there is no duty to denounce undocumented migrants to authorities.

Providers and Actors

Providers of Health Care

The main providers of health care in the case of undocumented migrants must be said to be the general hospitals. In addition, private institutions and doctors, who are not contracted to the National Health Fund and are thus operating on a for-profit basis, may provide care at full cost (Questionnaire Poland).

The providers of health care are located in the main cities and are not coordinated (Questionnaire Poland).

Advocacy Groups and Campaigns on Rights

In Poland, there are bodies advocating undocumented migrants’ rights, such as humanitarian and religious organisations and associations working for marginalised persons. There have been campaigns regarding the right to health care for undocumented migrants, led by government ministries (e.g. The Ministry of Social Policy) and non-government organisations (humanitarian organisations and bodies led by the Catholic Church) (Questionnaire Poland).

Political Agenda

In Poland, there is an ongoing political discussion regarding undocumented migrants in general. One discussion topic relates to the problems concerning the entitlement to health care and focuses on undocumented migrants' rights. One argument in public debates (involving rights) is oriented towards politicians’ obligations with respect to the public health financial funds and thus the cost of care (Questionnaire Poland).

6 For a list of relevant Polish NGOs, see http://mighealth.net/pl/index.php/Instytucje_i_o%C5%9Brodk (08-03-2010).
International Contacts

Currently, actors in the field of health care for undocumented migrants in Poland have no international contacts.

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