Policy towards Undocumented Migrants of the EU27

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Introduction

In this chapter we focus on policies regarding the right of access to health care for undocumented migrants in the 27 Member States of the European Union (EU). Across Europe, undocumented migrants are subject to national regulations which differ among the Member States. The chapter aims at giving a characterisation of the respective policy. In addition, an emerging pattern relating to human rights standards will be identified, aiming at putting national policies in perspective. Moreover, the chapter draws upon data from the project *Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*.[1] The material, which corresponds to selected indicators, aiming at facilitating a comparative analysis as well as providing an descriptive overview, was obtained through various sources, including experts in the respective countries, literature, research reports and grey literature, such as official reports and reports from non-governmental organisations (see Björngren-Cuadra, 2011).

Definition of Undocumented Workers

The definition of *undocumented migrants* applied in this chapter follows, as stated by previous authors, the EU guidelines; i. e., the term "undocumented migrant" refers to so-called third-country nationals without a valid permit authorising them to reside in the European Union Member States. This includes those who have been unsuccessful in asylum procedures (rejected asylum seekers) or who have violated the terms of their visas ("overstayers"), as well as those who have entered the country illegally, most often to work. The type of entry (i. e., legal versus illegal border crossing) is thus not considered to be relevant in defining the concept. With this definition, recent estimates suggest that approximately one per cent of the entire population in the EU and, on average, ten per cent of the foreign-born population are undocumented (Düvell, 2010, pp. 3-8). 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.

The interest in this chapter in undocumented migrants' rights of access to health care is underpinned by the governing principle of the EU, namely the principle of universal access to health care. This is captured in several states' constitutions and health service founding documents, as well as incorporated into the EU Charter of Fundamental Rights (Article 35). The first part reads, "Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices". However, despite these formulations, it may be argued that universal coverage

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tends to be universal only in principle and that the entitlement status of some vulnerable groups may be unclear (Wörz et al., 2006). This is the case of undocumented migrants. Problems of access might arise also for residents or citizens from the way in which coverage is organised (ibid.), but, as regards undocumented migrants, we can identify a general *de jure* social exclusion and thus a relative lack of rights (Noll, 2010). These circumstances can partly be understood as an element of "internal control of migration" by withholding access to social protection, such as health care and forms of welfare benefits.This type of migration control refers to control based on administrative measures (Brochmann, 1999; Ingleby, forthcoming). Such control differs in extent and form among the European countries. For example, it is generally strong in the Scandinavian countries (Doomernik and Jandl, 2008).

Access to Social Protection

Undocumented migrants' access to social protection has not gained interest in terms of being problematic until fairly recently. A precarious nature of the situation has been articulated in public discourse by advocacy groups, as well as in research. Topics such as lack of rights, deprived living conditions, substandard working conditions and exploitation have been addressed along with issues on health care. Undocumented migrants have also gained increasing attention as a group exposed to high health risks and as posing a challenge to public health (see, for example, Cholewinski, 2005; MdM, 2005; Pace, 2007; PICUM, 2007a; Sager, 2011; Björngren-Cuadra, 2011).

When approaching undocumented migrants' rights to health care, we can assume that such rights are dependent upon numerous aspects and processes in each country. One factor is the current basic norms and institutions of the *welfare state* in the respective country. Another factor involves how *migration*, regular as well as irregular, is dealt with. This has not only a direct relevance to irregular migrants' rights to health care, but also to the pathways into irregularity. In the EU27 landscape, a variety of welfare regimes as well as national integration regimes can be identified (Papadopoulos, 2011).

Chance to Change the Opportunity and Incentive Structures

Our immediate interest in the welfare state concerns its capacity to change the opportunity structure and the incentive structure for individuals. The basic relevance of the welfare state for the life of an individual can be seen in the individualised rights and services provided (Leisering, 2004, p. 210). With reference to a more fundamental level, bearing in mind human species' vulnerability and incapacity to survive, unless it creates its own viable systems, social policies might form "ways of life to ensure survival" (Wronka, 1998, p. 25). Social policies can thus be understood as political measures with the (explicit) aim of influencing the life situation of individuals (ibid). Thus, social policy as a concept is broad and can involve different core fields, of which one, *risk-management*, involves health related activities, *the right to healthcare* (ibid.). In order to approach the empirical material, in this chapter policy is understood as "a standard that sets out a goal to be reached" (Dworkin, 1977). This fairly broad understanding is chosen in order to apply, given that policies regulating undocumented migrants' entitlement to health care differ widely between EU Member States. It applies both to countries in which legal norms are in place and countries which have not explicitly regulated these issues. In those cases, policies are to be deduced from and in the light of other regulations.

When discussing policies, the very implementation of their content might also be of certain interest, as implementation is not to be seen as a simple, straightforward process.

It has been suggested that there might be missing links in the process between an outlined policy and the practice that is enacted. This "gap" has been labelled the "implementation gap" (see, for example, Jain, 1990). Such a perspective turns our interest towards the staff. Health professionals such as doctors and nurses, labelled the *street-level bureaucrats*, are the key agents in the implementation processes (Lipsky, 1980). Health professionals can be seen as doing "politics in practice" (Brodkin, 2010). They are not doing what they want or just what they are told to do. They do what they can (Brodkin, 2008). In this process, they might invoke other references than official policies (Björngren-Cuadra, 2008). Principally, "implementation gaps" might be "negative" or "positive". If negative, in the case of undocumented migrants, staff might be ignorant of a certain policy that the migrants are likely to benefit from or may persistently fail to adhere. If positive, staff might create a "window of opportunity" for undocumented migrants in spite of restrictive regulations. This kind of implementation gap is very central when discussing substantial and concrete access, as they introduce a certain element of arbitrariness in the process of access. It is especially relevant seen from the individuals' perspective in precarious situations (PICUM, 2007b). However, this chapter is delimited to policy and leaves implementation gaps in either direction aside, and will not discuss the very access further. It will only discuss what is understood to be the right of access as outlined in principle terms.

Concerns of Undocumented Migrants

Before leaving the intricate relation between rights and actual access, it is relevant to note that empirical studies have shown that such undocumented migrants often experience a fear of being reported to police or immigration authorities by health workers or administrative staff, and that this anxiety constitutes a barrier to seeking care. To the extent that "denunciation" is governed by explicit rules (either requiring it or forbidding it), these rules can be considered as part of a country's policy on health care for undocumented migrants. This topic will not be pursued further here because an explicit obligation to denounce was only found in two of the 27 Member States: Lithuania and (in certain circumstances under the Aliens Act) Sweden. Rules prohibiting denunciation, on the other hand, are often indirect; the practice can, for example, be forbidden on the grounds of laws regulating the confidentiality of the medical encounter and the protection of privacy. Issues on denunciation provide a good illustration of the "implementation gaps" that may exist in this field. Health workers or administrators may choose to report migrants to the authorities when they are not supposed to do so – or refrain from reporting in spite of an obligation to do so. If the latter only occurs incidentally, it does not really remove the barrier to access for the migrant, because he or she cannot know in advance whether it is safe to seek medical help (PICUM, 2007b; MdM, 2005; HUMA Network, 2009).

Points of References

To put national policies into perspective and make comparisons possible requires points of references. Of special interest is to be able to differentiate between levels of rights of access in a terminology that grasps a possible variation.

The Human Rights Framework

In the discourse involving recognition of the undocumented migrants' precarious situation, as well as in research, a central reference has often been human rights standards as outlined in the human rights framework (see, for example, PICUM, 2007a and b; Pace, 2007). Human rights law will also serve as the main point of reference in this chapter, due to various reasons. First, the international code of human rights consists of legally binding international components which apply to all EU27 Member States. Second, the code gives an internationally agreed set of standards to guide and assess the conduct of governments which bear on medicine, public health, and the strengthening of health systems (Backman et al., 2010). Third, as human rights law is designed to protect disadvantaged and precarious individuals and groups such as undocumented people (Hunt, 2007), they appear as apt references.

The right of access to health care is a major concern within the human rights framework. It is outlined in a range of binding treaties. We find it in Article 25 in the Universal Declaration of Human Rights (UDHR), which provides the foundation for the international code of human rights (Backman et al., 2010). Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) affirms the right of everyone to health care without discrimination, to enjoy the highest attainable standard of physical and mental health without discrimination (United Nations, 1966). Other binding treaties incorporating the right to health include the International Convention of the Rights of the Child (CRC), and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). In addition, the right to health is stated in the Constitution of WHO, the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalised World (Backman et al., 2010).

With the objective to render the meaning of the right to health more concrete, The Committee on Economic, Social and Cultural Rights (CESCR), which monitors and interprets the ICESCR, formulates that states are "under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including […] asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; […]" (CESCR, 2000, para 34). From this advice follows that from a human rights perspective, health care clearly involves emergency, primary, secondary, as well as preventive care.

Access and Rights Interrelated

The right to health involves, according to the UN Committee on Economic, Social and Cultural Rights in its comments (GC 14) on implementing ICESCR, a notion of accessibility. Hence, the notions of *right* and *access* are interrelated. The committee proposes that the right to health entails being able to receive care which is: available, accessible, acceptable and of good quality (referred to as *AAAQ*, triple A-Q concept). "Accessibility" is further broken down into four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility. "Accessibility" is thus understood as an essential element of a "right". In this chapter, the issue of *economic accessibility* will be dealt with. Consequently, affordability for patients will be an issue when comparing policies on entitlement. Affordability involves the level of co-payment. From this follows that cost-sharing arrangements ("out-of-pocket payments") which may undermine accessibility for people at risk of exclusion are of special interest (Wörz and Foubister, 2006).

Against this background, we will find a financially conditioned right not consistent with the notion of right embodied in the human rights framework. We would consequently not regard care, which an undocumented migrant has a right to access only in return for payment of the full cost, as being "accessible" – since in most cases such care will not be affordable for the individual. Nevertheless, it is reasonable to expect a moderate fee, commensurate with that paid by other patients, as not seriously impairing accessibility. To give a concrete example: in Sweden undocumented migrants can access emergency care at a cost of 120-150 Euros (full cost). This sum implies that emergency care is deemed not accessible in the spirit of the right of access, and thus not congruent with human rights standards.

Those international instruments provide a point of reference inasmuch as the right to health is considered within a general approach. However, in order to further differentiate levels of care which undocumented migrants might have the right to access, the *Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants*, article 13.2, can serve as a point of reference (Council of Europe Parliament, 2006). In this resolution it is advised that – at least – emergency care should be available for undocumented migrants. Emergency care is referred to by the Council as a *minimum right.* It is also advised that states should seek to provide more than the mentioned minimum right and should offer more holistic care, taking into account, in particular, the needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly (ibid.).

Centred on the concept of *minimum right*, we can differentiate between three levels of rights of access to health care: 1) less than minimum rights, 2) minimum rights, and 3) more than minimum rights. In everyday language that would correspond to a right to less than (i. e., not even) emergency care, right to emergency care and right to more than emergency care (such as preventive care, primary care, secondary care). It is important to note a discrepancy between the resolution and the interpretation of the ICESCR given by the UN Committee on Economic, Social and Cultural Rights. According to the latter, access to emergency care falls far short of the full scope of the right to health.

Turning to the variety of welfare regimes that can be identified within the EU27, it can be hypothesised that the extent to which health care is accessible to individuals has to do with the financial characteristics of the system (European Commission, 2008).In addition, a further differentiation that bears upon the Member States concerns their system of financing health care, involving public financing (such as tax and social insurance contributions), private health insurance or out-of-pocket payments. In the European context, we can clearly differentiate between systems which are: 1) mainly tax-based and 2) mainly social insurance-based (Thomson et al., 2009). A further differentiation can be made in terms of whether taxes are collected centrally (Ireland, Malta, Portugal and the United Kingdom) or locally (Cyprus, Denmark, Finland, Italy, Spain and Sweden) (ibid., pp. 33 and 119). In social insurance-based systems, contributions can be collected by central government (Belgium, Bulgaria, Estonia, France, Hungary, Latvia, the Netherlands, Poland, Romania and Luxembourg) (ibid., pp. 34, 149 and 167) or directly by health insurance funds (Austria, the Czech Republic, Germany, Greece, Lithuania, Slovakia and Slovenia). Parallel to the collective system of financing, some Member States (e. g., Bulgaria, Greece, Cyprus and Latvia) rely most heavily on individual out-of-pocket payments (ibid., p. 29).

Of special interest in this respect concerning the affordability, is organising and financing characteristics which influence access for people at risk of exclusion, as they constitute

potential or actual *barriers* to access. Such characteristics involve population coverage and cost arrangements respectively, whilst broader issues, such as practical organisational limitations, can create barriers to accessing health care (European Commission, 2008), as stated by the HealthQUEST Project (ibid.). In general, the rules and conditions of access to health care are, to a large extent, established by contractual arrangements between payers and providers of health care according to the national legal system. This is to say that the most salient characteristic of a health system relates to those who cover the cost. From the patient's perspective, whether an undocumented migrant or not, the main question as regards cost might be formulated: "Am I covered by insurance?" The next question involves whether the care required is included in the benefit coverage (so-called health basket), as disparities may exist. And in this case "What am I expected to pay? Is there a cost-sharing arrangement applicable to my situation?", cost-sharing is defined as the patient's private spending without private insurance, so-called "out-of-pocket payment" (ibid., p. 75). Generally, there may be "cost-ceilings", tax revenue and reimbursement systems. In terms of this theme, we could also consider the existence of informal payments (and bribes) (ibid., p. 89). From our perspective, those arrangements are interesting in terms of the extent to which they come into play for undocumented migrants and affect access in terms of affordability.

Above we stated that the rights of migrants to health care, regular as well as irregular, depend, to a certain extent, upon the migration model and how it works. In this perspective, a look at certain national contexts of migration is interesting as far as it involves irregular migration. Previous chapters have presented the variety and "magnitude" of undocumented migrants, as well as the differing pathways into irregularity or categories of undocumented migrants realised in the respective Member States, as well as issues such as control of migration and practices of regularisation. We will return to those perspectives after drawing out the contours of the policies on the right to health care in the following section.

Results

This section will present the Member States in three groups referring to the level of entitlement of health care for adult undocumented migrants.[2] The respective method of funding the health system will be briefly referred to as tax-, respectively, insurance-based. In addition, special entitlements for identified groups such as children and women, particularly related to reproductive health, and HIV will also be briefly mentioned.

Member States Granting Less than Minimum Rights

This first identified group consists of Member States in which entitlement is restricted to an extent that makes even emergency care inaccessible. Those Member States do not have a special legislation implying that entitlements have to be deduced from the general legal framework, from policy documents (Malta) or from informal agreements (Luxembourg). As regards the inaccessibility, it can be due to the fact that the patient is charged a cost of care which makes care unaffordable. In some cases, the system makes the patient indebted to the health care providers. In other cases, a certain element of arbitrariness is introduced by the staffs' discretion (i. e., to provide or not to provide care, to charge or not to charge). In

2 The presentation draws upon the country report available at http://www.nowhereland.info/. Further references (such as literature or legal references) are provided by the respective country reports.

this group there are also Member States offering health care only within detention centres. Collectively, ten Member States are found which apply health care only at this level of rights. As this classification refers strictly to policies, and because of the "implementation gaps" mentioned above, it is possible that a better level of care is sometimes provided in practice; however, such exceptions are arbitrary and not predictable from the patients' perspective (Björngren-Cuadra, 2011).

Initially, we can also observe that in those countries there are no specific entitlements in terms of identified groups or diseases beyond that women in labour receive care (in Austria), and that HIV testing (but not treatment) might be accessible (in Malta and Austria) or accessible (in Finland and Sweden), as it is provided anonymously). Furthermore, children are dealt with specially (i. e., do not need to be identified in Romania) and are entitled to care if they are rejected asylum seekers (in Sweden).

Table 1: Member states, in alphabetic order, in which undocumented migrants have less than minimum rights of access to health care, subdivided according to financing of the health system

	Member States
Tax	Finland, Ireland, Malta, Sweden
Insurance	Austria, Bulgaria, Czech Rep. Latvia, Luxembourg, Romania

In **Finland**, the right of access to health care for undocumented migrants can be deduced from the general legal framework involving the Implementation of the Social Security Act. Accordingly, they may access emergency care as a person from a "third country" requiring urgent medical attention. Such persons shall receive care as is sufficient to allow them to return to their country of origin. However, as uninsured persons, they are required to pay for the cost of care. The extent of payment is unclear and different official documents provide different information (ranging between full costs to normal patient fee). HIV testing should be available anonymously.

Also in **Ireland**, undocumented migrants may access emergency care for an unclear cost. This relates to The Health Act, according to which the health authority may apply the full fee for any services provided to persons deemed not to be "ordinarily resident". Alternatively, they may provide urgent necessary treatment at a reduced charge or without charge (as deemed appropriate). However, the cost of urgent medical treatment is dependent on the providers' discretion. Patients are eligible to apply for reduced or waived hospital charges if they will incur a "financial hardship" (e. g., when they cannot pay). But these decisions are made at board level and on a case-by-case basis (regardless of the immigration status of the person).

In **Sweden**, undocumented migrants may access emergency care in return for payment of the full cost. This follows from The Health and Medical Services Act. Undocumented migrants are formally excluded from entitlement to health care over and above what follows from the provider's obligation to offer immediate care (in practice interpreted as emergency care) to persons present, but not resident in the country. Children are entitled to full care if they are rejected asylum seekers. As regards HIV/AIDS, undocumented migrants are entitled to testing, as the patient is entitled to remain anonymous. With respect to treatment, it is impeded by the doctors' obligation to report persons diagnosed with an HIV infection.

In **Malta**, undocumented migrants have the right to medical care free of charge within the framework of detention centres. This is formulated in a governmental policy document outlining the relevant principles, which is, in practice, understood to be a free health service, with the same coverage applying as with a Maltese citizen holding a "pink card". HIV screening and treatment are included.

In **Austria**, undocumented migrants may access emergency care in return for payment of the full cost. As uninsured people, undocumented migrants access first aid, in cases of emergency, at federal hospitals under the Federal Hospitals Act. In principle, the patient is invoiced after treatment. Unpaid bills may have consequences for undocumented migrants who manage to regularise, as these debts must then be paid. In cases where the patient cannot be identified, hospitals are obliged to cover the expenses out of their own budgets. As noted above, women in labour is a specifically identified group. As regards HIV/AIDS, tests are free of charge, but there is no subsidised access to treatment for undocumented migrants.

In **Bulgaria**, undocumented migrants' access to emergency care follows from The Law on Health Care. As foreign residents not enrolled in any insurance schemes, they are expected to pay the full costs. We find no specific entitlements in terms of identified groups or diseases in relation to undocumented migrants.

In the **Czech Republic**, undocumented migrants may access emergency care in return for payment of the full cost or, alternatively, upon purchasing a private insurance under the Act for Care for the People's Health. In the latter case, they access care in accordance with the contract. It is likely that a minority of undocumented migrants purchases a private insurance, and it can be concluded that they are expected to pay the full costs when seeking emergency care and can become indebted to the health care providers.

In **Latvia**, undocumented migrants may access emergency care upon payment of the full costs. This follows from the Constitution and the Medical Treatment Law.

Also in **Luxembourg**, we can find a conditioned right to receive emergency care. It is provided to undocumented migrants if they are affiliated to insurance, either through employment or privately. Considering the aspect of affordability, it is important to note that care is likely to be inaccessible. Those circumstances follow from an informal agreement between the Ministry of Health and the Ministry of Immigration.

In **Romania**, according to The Health Reform Law (95/2006), every person who requires medical assistance in cases of emergency must be provided care. However, as the services are accessed on the basis of a certificate (certifying payment), it is inaccessible for undocumented migrants unless they are under 18 years old, as children are not obliged to prove identity. However, health care is provided within the framework of detention centres free of charge under the Aliens Act.

Member States Granting Minimum Rights of Access to Health Care

In the second cluster we find Member States in which undocumented migrants are entitled to receive emergency care or care specified in constructs such as "immediate care" or "urgent care" which is not economically or in other ways conditioned. In some cases, the care is related to life-threatening events or referred to as life-saving. In this group of Member States, a common characteristic is that, from the patients' perspective, the provision of care can be understood as predictable due to a legislative framework. This implies that the legislation does not allow health care staff to exercise their discretion as to who will or will not receive

care. Twelve Member States were found to be applying this level of rights. In these Member States, health care of a more extensive kind might be accessed under certain unpredictable circumstances (e. g., at the discretion of the professional involved) or in return for payment of the full cost.

Initially it is noted that in this group, children are sometimes taken under special considerations (Denmark, Germany and Greece) and this is also the case for pregnant women (Germany, Greece, Hungary and UK). Furthermore, some Member States provide HIV testing (Belgium, Cyprus, Denmark, and UK), while a few also provide for treatment (Germany, Greece in principle, and Poland).

Table 2: Member States, in alphabetic order, in which undocumented migrants have minimum rights of access to health care, subdivided according to financing of the health system

	Member States
Tax	Cyprus, Denmark, UK
Insurance	Belgium, Estonia, Germany, Greece, Hungary, Lithuania, Poland, Slovakia, Slovenia

In **Cyprus**, the legislative framework as regards access to health care for undocumented migrants is provided by The General Health Care Scheme Law, but also by laws regulating the health system and health insurance. Accident and emergency departments are supposed to provide care free of charge to all persons, which applies also to undocumented migrants. Undocumented migrants may access HIV testing (not treatment).

In **Denmark**, the right to receive emergency care free of charge follows from The Health Act, according to which every person present in a region (even if not a resident) shall be provided emergency care if in need. Children are provided health care, children's vaccinations and preventive examinations at general practitioners, school health services and municipal dental care under a special law (on preventive care). As HIV testing is provided for anonymously, it might be accessed by undocumented migrants.

In the **United Kingdom**, a regulation targeting health services for so-called "overseas visitors", applicable to all non- ordinary residents, is thus applicable to undocumented migrants. Accordingly, treatment is to be provided free of charge in A&E departments, irrespective of the patient's status or ability to pay the costs. Furthermore, what is understood as "immediately necessary treatment" may not be withheld (incl. maternity treatment) for any reason or whilst awaiting payment, as is the case with "non-urgent treatment". This is regulated by way of circulars from the Department of Health. However, the patient remains liable for the costs, and the debts are to be pursued. Of interest is that undocumented migrants may in principle access primary care, however, only if accepted to register by a General Practitioner, which introduces a certain element of arbitrariness. Maternity services provided by midwives free of charge are accessible at primary care level. Children of undocumented migrants are entitled to health care in terms of the same regulations applicable to adults.

In **Belgium**, a law on urgent care outlines that emergency care is granted free of charge to everyone. Furthermore, undocumented migrants have, under a royal decree, the right to receive what is known as urgent medical aid (AMU) free of charge. AMU is not differentiated upon in terms of emergency, basic or universal care and is delivered by a designated

physician or provider. In principle, AMU refers to a wide variety of urgent care provisions and may be both preventive and curative, depending on the physicians' discretion. The admission is administrated by Social Welfare Centers involving a proven "destitution", a (by a doctor) certified "urgent" character and a home visit. In Belgium, unaccompanied minors (regardless of being documented or not) receive special attention. HIV tests and checkups for HIV-positive status are implied in the framework of the AMU system.

In **Estonia**, as established in the Health Services Organisation Act, by virtue of being inside Estonian territory, undocumented migrants may access emergency care. This care is free of charge for the patient and the cost is covered by the state, as is the case for all other persons without insurance. There are no specific entitlements in terms of identified groups or diseases.

In **Germany**, the legislative framework is provided by the Asylum Seekers' Benefits Law. 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, undocumented migrants 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, which is free of charge, comprises: treatment in cases of serious illness or acute pain and everything necessary for recovery, improvement or relief of illnesses and their consequences, postnatal care, vaccinations, preventive medical tests and anonymous counselling and screening of infectious and sexually transmitted diseases (TB, HIV). A document (Krankenschein) is required to prove entitlement beyond emergency care. Pregnant women have access to preventive medical check-ups, services concerning child delivery and related care; however, they are conditioned by an administratively granted "tolerated status". Children can access more extensive care, and traumatised persons may access what is called "appropriate care". HIV tests can be accessed anonymously while treatment is provided for, conditioned by proved entitlement.

In **Greece**, we find legislation on Entrance, Stay and Social Inclusion of Third Country Nationals, prohibiting care beyond a certain extent (emergency or life-threatening events) for adult aliens not residing legally in Greece. Childbirth is normally considered as an emergency. Normally no fee is charged, though uninsured persons are required to pay the full cost of lab tests. HIV and other infectious diseases are also considered as emergencies, and patients may benefit from free medical care and hospital admission, provided that the appropriate treatment is not available in their country of origin, in which case they are also entitled to temporary residence and employment permits. HIV testing is free in public hospitals and screening centres.

In **Hungary**, the legislative framework is found in the Health Act and related regulations which establish everyone's right to emergency and life-saving care, as well as vaccinations free of charge irrespective of citizenship or contributions to the health insurance. Pregnant women have the right to basic care in which complications related to pregnancy is included, but not further maternity care, which is conditioned by residence. Furthermore, at detention centres entitlement to care is more extensive according to the Regulation on Detention from the Department of Justice.

In **Lithuania**, the Law on Health Insurance states that all persons have the right to emergency care, even if the person has not paid the compulsory statutory insurance, implying free emergency care for undocumented migrants. In accordance with the Health Insurance Law, persons with no residency (or stateless persons) can purchase a private insurance. It is

also relevant that under the Law on the Legal Status of Aliens, health care is provided free of charge at the special centres (for Foreigners' Registration and Refugee Reception), also for undocumented migrants.

In **Poland**, the relevant legislation is found in The Law of Health Protection, according to 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. Consequently, undocumented migrants have access to emergency care, with no special requirements and free of charge. In terms of other legislation in respect to protecting foreigners within Polish territory, each person is insured in Poland if he/she is working, and this includes medical protection which might come into play in case of overstaying. HIV testing and treatment is provided in accordance with the legislation relating to foreigners within Polish territory.

In **Slovakia**, the Act on Health Care and Health Care-Related Services and the Act on Insurance apply to undocumented migrants in terms of being a person located within the territory of the Slovak Republic. All persons, even if not contributing towards the relevant health insurance, shall be given immediate medical care. At the health care provider's request and upon approval by the largest health insurance company, this will be paid by the Ministry of Health.

In **Slovenia**, the Health Care and Health Insurance Act, the Asylum Act and the Aliens Act establish that there must be a fund for providing urgent health care for individuals of unknown residence. This applies to undocumented migrants and entitles everyone to emergency care free of charge. It is also of interest that The Health Centres for Persons without Health Insurance in Ljubljana and Maribor offer general medical examinations and can also refer a person to a medical specialist.

Member States Granting More than Minimum Rights

In the third cluster we find Member States in which entitlement to health care includes services beyond emergency care, involving primary and secondary care. Those Member States are all characterised by a certain recognition of the presence of undocumented migrants. There are regulations in place and even different pathways to obtain entitlement to health care. Access to emergency care is more of a safety net in case of falling out of the system or not fulfilling certain prerequisites. The relevant provisions are laid down in legislation explicitly referring to undocumented migrants. Entitlement is associated with administrative procedures which may, in practice, impair access to care to a certain extent. Collectively, five Member States can be found to be applying this level of rights.

In those Member States, we also find that children are given special considerations as well as women in the context of reproductive health. In addition, HIV tests are provided for, as well as treatment.

Table 3: Member states, in alphabetic order, in which undocumented migrants have more than minimum rights of access to health care, subdivided according to the financing of the health system

	Member States
Tax	Italy, Portugal, Spain
Insurance	France, Netherlands

As regards **Italy**, we first note that undocumented migrants are not entitled to register in the mainstream National Health System. Due to this fact, they access "urgent" and "essential" health care by way of an alternative administrative pathway. A legislation (called Turco-Napolitano) grant them a right to seek medical assistance, free of charge, in public health institutions or accredited private facilities operating within the national health service, for urgent or primary outpatient and hospital treatment, in case of sickness or accidents, as well as for preventive medical treatment. In practice they are granted, by local administration and free of charge, a "temporary residing foreigner code" functioning as an anonymous "health card" which provides access to a wide range of health services. Furthermore, undocumented migrants are entitled to preventive care, as well as care provided for public health reasons. This includes prenatal and maternity care, care for children, vaccinations, and the diagnosis and treatment of infectious diseases, including HIV testing and treatment, TB and other contagious diseases and work accidents, which are all part of the entitlement laid down in the law referred to above.

In **Portugal**, the right to heath care is established by the constitution. Entitlements for undocumented migrants are also outlined in specific legislation and circulars. Entitlements depend upon the time residing in the country, with the exception of children and in case of certain specified diseases. The basic requirement is a stay of 90 days. However, if the stay is not officially recognised (or too short), the migrant will be entitled to access emergency care in public hospitals upon payment of the full cost of treatment, but it may not be refused if the patient lacks the means to pay. Upon proven residence (of 90 days), a document equivalent to the health card, called "temporary registration", is granted, allowing access to health care, medication and medical tests. It should be noted that all residents, regardless of their status (i. e., also undocumented migrants with less than 90 days' stay), have access to HIV screening and anti-retroviral treatments, along with other public health programmes (vaccination, dental examinations for all pregnant women). Undocumented children may, under the constitution and legislation, access public health care on equal grounds as children with Portuguese citizenship and documented children.

Also in **Spain**, access to health care is offered to all, including undocumented migrants with reference to the constitution, acknowledging the "right to health for all", but also by The General Health Care Act providing for health care, foreign citizens included. A moderate fee might occur. However, accessing universal care (primary, secondary and hospitalisation) requires registration with the city council and the possession of a "Personal Health Care Card" in accordance with a special legislation targeting foreigners. Nevertheless, regardless of status and possession of a health card, emergency treatment is provided (necessarily due to an accident or serious illness) with no specified requirements. Undocumented migrants under the age of 18 are entitled to full health care treatment under the same conditions as nationals under the general health laws. Pregnant women are entitled to treatment during

pregnancy and childbirth, as well as to postnatal treatment, even if they are not officially registered. Furthermore, HIV screening and anti-retroviral treatments are free of charge for persons in possession of the Personal Health Care Card.

In **France**, there are different laws and regulations applicable to undocumented migrants' right to health care. Entitlements for persons without regular residence status are established by law in a parallel administrative system, called "State Medical Assistance" (AME). This allows undocumented migrants and their dependants to access publicly subsidised health care under certain conditions relating to their length of stay (minimum 3 months) and income (below a certain threshold). AME involves access to all kinds of health care free of charge, including abortion. With respect to emergency care, the relevant law applies to undocumented migrants regardless of the terms of the AME and is provided through "health care centre offices". Emergency care refers to care in life-threatening situations, as well as the treatment of contagious diseases, maternity care and abortion for medical reasons. Undocumented migrants may likewise access general practitioners free of charge after a certain period of stay (3 years). In addition, health insurance obtained during legal stays might be possible to keep when losing a legal status. Children are entitled to access all kinds of health care free of charge, regardless of their eligibility for AME. Women are, to a certain degree, recognised as a specific group, as maternity care and abortion for medical or voluntary reasons are provided. Screening for sexually transmitted diseases and HIV/AIDS, family planning, vaccinations and screening and treatment of tuberculosis are provided, as are HIV tests and treatment.

In the **Netherlands**, the law targeting undocumented migrants, The Law on the Reimbursement of the Costs of Care for Illegal Aliens, does not distinguish between "primary" and "secondary" care, but between "directly accessible" and "not directly accessible" services involving a scheme for the reimbursement of providers (100 % of the cost in case of childbirth and pregnancy, in other cases 80%). To use a "not directly accessible service", a person must obtain a referral; these services provide "plannable care". For "directly accessible" services (GPs, 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. Specialised services (especially hospital care) may be covered, but only if they are included in the basic health insurance package. Undocumented migrants, who obtain (non-emergency) hospital treatment or prescription medicines from non-contracted providers, are liable to pay the entire costs themselves. As regards children, they are entitled to free preventive care and check-ups at baby clinics under the Health Insurance Act. As regards HIV, it is included in the "basket" of care defined as "basic level insurance" for all residents.

Discussion

Process of Change Is On-Going

Previous sections presented an overview of characteristics of policies which regard the right of access to health care for undocumented migrants in the respective Member State. While that kind of information is interesting in its own right, the last part of this chapter will be spent on exploring immanent conclusions. However, first a certain caution regarding the interpretation is called for, due to the nature of the empirical material and the limitations

of the study. The situation on the European scene is not static, and processes of change are on-going, driven by stakeholders such as politicians and advocacy groups. A salient example might be Sweden. In May 2011 a public inquiry launched the suggestion to grant undocumented migrants the same rights as legal residents (see SOU 2011:48). In Finland, IOM Helsinki organised a working seminar in June 2011 focusing on the development needs regarding access to health care for undocumented migrants, with the participation of public stakeholders (such as The Ministry of Health and Social Affairs and National Institute of Welfare) and prominent NGOs.

In addition, we have to draw attention to the fact that this chapter does not take fully into account changes of policies that have occurred in the Member States in the last two years. For instance, the United Kingdom, France and the Netherlands, which have been acknowledging undocumented migrants as a reality for many years, have implemented procedural changes which, in the case of UK and France, imply restrictions of rights, while the Netherlands have become more "generous" with respect to secondary care. The inclusion of those changes would have widened the scope of the paper beyond the actual objective of providing insight into the "cross section" of possible approaches in the EU. It would also go beyond the material collected and covered by the project of Nowhereland, which ended in 2010.

Further Qualifications

Another aspect to be taken into account is that the above clustering of countries is based on policies regarding adults. To focus on children would have had an impact on the groupings. We must also consider that the study was concerned with policies and did not attempt to investigate the way these policies are implemented in day-to-day practice, in substantial access to care. Neither is the full picture drawn, which would be the case if the variety of providers were included. Finally, to cluster involves differentiating between categories introducing a certain arbitrariness into the picture, as it is never so clear where to draw the line. At this point, especially Belgium should be mentioned. Belgium was referred to above as a country administering "minimum rights". However, the policies in Belgium also bear some characteristics which could let us opt for the third cluster (more than minimum), as some regulations (a decree and not a law) are in place targeting undocumented migrants and as "urgent care" can be interpreted as involving a broad range of care. However, as we also defined a prerequisite in terms of certified need (by a doctor before accessing care) in combination with an explicit means of testing (economically) the right of access to care in Belgium, in a comparative perspective, it can be interpreted as not providing for the same level of right of access as the five Member States in the third cluster. With these comments of caution, we now turn to the overall picture.

Wide Differences in Entitlements

It is clear that there are wide differences in the entitlements to health care for undocumented migrants in the EU27. When upholding the clustering regardless of its weaknesses, a first observation is that in ten Member States, the right of access to health care is less than the minimum standard outlined by the Council of Europe. In twelve Member States there is access to emergency care, thus meeting the minimum standards. However, according to the interpretation of the ICESCR given by the UN Committee on Economic, Social and Cultural Rights, access to emergency care falls far short of the full scope of the right to health. There are, therefore, 22 Member States whose policies do not conform to the right

to health as specified by the UN. It is clear that such limited access to health care affects those suffering from chronic diseases or those in need of what is referred to as preventive, primary and secondary care. It is also noteworthy that some Member States in the "minimum" cluster actually relate to life-threatening events or care which is life-saving (Greece, Hungary and Poland). The definitions and implementation of those concepts are unclear, but nevertheless run a risk of falling short of what is understood as emergency care. Even if the UN Committee on Economic, Social and Cultural Rights comment on *the right to life* as an integral component (among many) of the right to health (see GC 14, para. 3), this right is not referred to as a type (or level) of care. Finally, when turning to the five Member States not enacting the general *ex jure* exclusion from social rights and offering access to a broader range of care, we have identified weaknesses in the design and implementation of policies which may, in practice, tend to undermine their effectiveness and objectives (PICUM, 2007b; MdM, 2005; HUMA Network, 2009).

No Relation to Funding System

A second observation is that the observed variations do not seem to be associated with the system of funding health services (referred to as mainly tax-based or insurance-based). There is no immediate relation between the funding system and the level of care to which undocumented migrants are entitled. We find countries with both systems in all clusters. Intuitively, it might also be expected that strong, well-established welfare states will grant more complete entitlements than newer welfare states. However, this hypothesis is not supported when comparing, for example, Sweden, on the one hand, with Portugal and Spain, which give counter- intuitive results.

An interesting way to elaborate on this theme, which would strengthen the argument that welfare systems are not solely accountable for policies relative to undocumented migrants, would be to introduce a six-fold division of welfare systems in Europe (Papadopoulos, 2011, p. 40). Accordingly, countries with *comprehensive* systems are found in different clusters (Sweden and Finland: less than minimum; Denmark: minimum). This is also the case with the countries upholding a *conservative/corporatist* system (Austria and Luxembourg: less than minimum; Belgium and Germany; minimum; France and the Netherlands; more than minimum). United Kingdom and Ireland, with *liberal* systems, represent the minimum, respectively, the less than minimum cluster. It comes as no surprise that also the countries with *conservative/familial* systems are found in different clusters (Greece: minimum; Italy, Portugal and Spain: more than minimum). The countries referred to as *post-communist/conservative* systems uphold the impression (Hungary, Poland and Slovenia: minimum; Czech Republic: less than minimum) along with the countries found to have a *post-communist/rudimentary* system (Latvia and Slovakia: less than minimum; Estonia and Lithuania: minimum).[3] However, a rudimentary pattern must be acknowledged, involving that the most generous countries tend to be found with *conservative/familial* or *conservative/corporatist* systems. In addition, we can note that the majority of the post-communist countries grant minimum rights, while only one (out of 3) of the countries with comprehensive models (Denmark) does the same.[4] Nevertheless,

3 Bulgaria, Cyprus, Malta and Romania are not covered by Papadopoulos (2011).

4 A mathematical analysis based on the value of cluster (as 1, 2 or 3) for each country, resulting in a "mean value" for each welfare system: 1.33 for a *comprehensive* system; 2 for a *conservative/corporatist* system; 1.5 for a *liberal* system; 2.75 for a *conservative/familial* system; 1.75 for a *post-communist/conservative* system, and 1.5 for a *post-communist/rudimentary* system.

given the complex mixture of welfare systems and clusters, the bottom line of this exploration allows us to draw some conclusions in regard to the connection between welfare systems and the level of health care undocumented migrants are entitled to.

Identifying Other Patterns

Can any other patterns be identified? Above it was stated that one aspect influencing undocumented migrants' rights to health care concerns migration policy and its implementation. From this perspective, it would be interesting to draw the contours of a certain imprint of the national context of migration. From our point of view, the "magnitudes" and categories of undocumented migrants in the Member States are of main interest. In addition, practices of regularisation are also relevant, as they are related to the control of migration. Regularisation is understood as a "state procedure by which third country nationals who are illegally residing or who are otherwise in breach of national immigration rules in their current country of residence are granted legal status" (ICMPD, 2009). In order to approach this topic, at least tentatively, the volume and nature of irregular migration, as well as the approach to irregular migration embodied in practices of regularisation, will now be explored.

As regards the volume of irregular migration, it is interesting to note that all the Member States found in the third cluster have high (Italy, Spain and Portugal) or medium (France and the Netherlands) proportions of undocumented migrants in a European comparative perspective when using a low-medium-high- scale with reference to proportion of population (ICMPD, 2009). In the second cluster some countries have high proportions (Belgium, Cyprus, Germany, Greece, Hungary and UK), while others have low (Denmark, Lithuania, Poland, Slovak Republic, Slovenia) or medium (Estonia) proportions. In the most restrictive cluster, countries with low (Bulgaria, Finland, Ireland, Latvia, Malta, Romania) or medium (Austria and Sweden) rates are found, while the magnitude in Luxembourg is unclear. However, we also find a Member State with high numbers in the restrictive cluster (Czech Republic) (ibid.). From this we can conclude that the volume of irregular migration is a poor predictor of policies on access to health care.

The Nature of Irregular Migration

We can also consider the nature of irregular migration, i. e., the most common pathways into irregularity. Countries in the third (generous) cluster mainly harbour undocumented migrants whose pathways into irregularity are related to the (informal) labour market, while countries in which the undocumented migrants are largely "produced" by the asylum system (rejected asylum seekers) tend to be found in the more restrictive clusters. Also the Netherlands, with its relatively large numbers of rejected asylum seekers, fit this pattern, as the largest group of undocumented migrants consists of labour migrants (PICUM, 2007b).

A last observation concerns the differing practices of regularisation which generally tend to relate to Members States' policies of external or internal control of migration (Doomernik and Jandl, 2008). "External" control focuses on the borders and entry points of a country, while "internal" control is enacted indirectly and based on administrative measures involving restricted access to welfare benefits and public resources (Brochmann, 1999).The very fact that undocumented migrants do not have the required permits and documentation make them prime targets of internal control.

Based on findings from the REGINE (Regularisation in the European Union) study of regularisation practices in Europe, it seems as if most countries in cluster three rely on

regularisation practices (France, Italy, Spain, and Portugal) (ICMPD, 2009). Only the Netherlands use regularisation on humanitarian grounds (i. e., in relation to the asylum system). Turning to the countries found in the middle cluster, we find only one relying on regularisation programmes (Greece). The rest are new Member States using small scale regularisation (Estonia, Hungary, Lithuania, Poland, and Slovak Republic) or not at all (Cyprus and Slovenia). In this cluster we also find the UK using regularisation very sparingly, while Belgium and Denmark use regularisation on humanitarian grounds; Germany is ideologically opposed to it, yet allows it to a slight extent in practice. In the most restrictive cluster we find countries that are ideologically opposed (Austria, even though regularisation on humanitarian grounds has increasingly been granted recently), new non-regularising Member States (Bulgaria, Czech Republic, Latvia, Malta and Romania), countries that only use regularisation on humanitarian grounds (Finland, Luxembourg and Sweden), and countries that use only small-scale regularisation (Ireland) (ICMPD, 2009). It seems reasonable to say that the overall impression as regards regularisation is that countries with more restrictive policies on health care entitlement also tend not to rely on regularisation practices which might imply a tendency to enact the internal control of migration. This confirms the idea that withholding access to health care forms an element of the internal control of migration.

Health Care as Risk Management

Do further patterns emerge if relationships to the logic of social policies are explored? The basic norms and institutions of the welfare state involve redistribution over the individual's life course. The aim is security, i. e., managing risks (such as sickness, disability and old age) to which the organisation of work leaves the individual exposed (Kohli, 1987). Health care is to be understood as an activity of risk-management, one of the core fields of social policy (Leisering, 2004). Redistribution is underpinned by the collectively-shared moral assumptions that define the rules of reciprocity and determine the criteria for inclusion and exclusion in the system of social care and security (Kohli, 1987). The basic collective norms and obligations characterised as the "*moral economy*" of the society (Thompson, 1971) also concern which risks should be covered, who are eligible, and what are legitimate practices (Kohli, 1987).

The "Work Society" Norm

It is reasonable to state that the current moral economy is that of a "*work society*". This notion expresses the fact that it is above all the social organisation of work that structures welfare state interventions and norms of reciprocity (Kohli, 1987). This indicates that the relation between the labour market and irregular migration may be pivotal to health care policies. Some observations, involving the tolerance towards irregular work (i. e., work within the informal economy) in the Member States, heighten this impression. If we, as Düvell (2009) suggests, differentiate Member States as tolerant or intolerant to irregular work, we can see that only one of those States that are tolerant to irregular work (Italy, Spain, The Netherlands, Poland, Czech Republic, Slovakia, Greece) do opt for less than minimum rights (Czech Republic).[5] This suggests that undocumented migrants who are active in the irregular labour market seem to be more favourably received in the EU27 than the undocumented migrants who are rejected asylum seekers. The former tend to be more often granted the right to health care, possibly underpinned by "work society" logic, in which primacy is given to considerations in

5 Only 12 Member States are covered; Italy, Spain, United Kingdom, The Netherlands, Germany, Austria, Poland, Czech Republic, Slovak Republic, Greece, Denmark and Sweden.

regard to the needs of a work force and national economic objectives, rather than to health and social policy when determining which risks should be covered and who is eligible. Hence, to fully understand the differing policy approaches regarding undocumented migrants, it may be fruitful to consider the theoretical discussion on the welfare state and its relationship to, and role within the market economy and the labour market. In particular, the relationship between the formal and informal economy and labour markets within the context of the "moral economy" may shed some light on the situation of the undocumented migrants. As we have seen, it seems that the current moral economy in Europe of today includes "irregular workers" to some extent. As regards rejected asylum seekers, we have seen that the most "hard-nosed" countries are those in which undocumented migrants mostly consist of rejected asylum seekers. This is to say that rejected asylum seekers seem to be excluded from the norms of reciprocity maintained in the EU27, and it is rendered a perfectly legitimate practice to refuse such a person access to even emergency care.

Final Thought

In sum, given that the level of entitlements to health care for undocumented migrants falls short of human rights standards, a salient question would be, to cite Doomernik and Jandl (2008): "How far can states go in the implementation of their control, particularly in terms of human rights for migrants and refugees?" It would also be fruitful to consider the role of human rights standards within the current moral economy and its implications and implementations in intersecting policy areas.

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