



Health Care in

NOWHERELAND

*improving services for
undocumented migrants in the EU*

Policies on Health Care for Undocumented Migrants in EU27

Country Report

France

Carin Björngren Cuadra

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Preface

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

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

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

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

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

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Centre for Health and Migration at the Danube University, Krems (AT) (main coordinator)

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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

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

² For the report at hand, the person to acknowledge is: Elhadji Mbaye, PhD, Institut d'études politiques, Grenoble, France.

The General Migration Context

France is one of the founding members of the European Union and part of the Schengen and Dublin Treaties, and is situated on the border of the Schengen Area.

Since World War II, France has experienced a large amount of immigration, due to the period of the fordist economy and the consequences of decolonisation. Thus, immigration has been strongly influenced in the present day by the legacy of colonialism as well as the long tradition of recruiting foreign workers. There has been a steady increase in immigration over the last century. Furthermore, it has increasingly been perceived as the root of social problems in the political discourse. The integration policy has moved towards the centre of public attention. Moreover, immigration policy has simultaneously followed an increasingly restrictive course, with increased control with respect to the admission of immigrants (Engler 2007).

After World War II, the majority of immigrants originated from Europe (1962: 79%). The recruitment of labour in the 1950s-60s was initially from Belgium and Germany as well as from Poland, Russia, Italy, and Spain (Hamilton et al. 2004). Immigration increased during the wars of liberation and decolonisation and immigration from Africa and Asia increased significantly. Especially after 1962, France was the most important European country for sub-Saharan migration (EC 2008:61). In 1962, about 350 000 so-called "French Muslims" (from Algeria) were counted in France and the trend was seen to be increasing. Due to social changes and the oil price shock of 1973, the labour migration programs were officially ended (ibid.). However, this measure did not result in a decrease in immigration, as many immigrants brought their families to France to join them. In terms of numbers, family reunification has subsequently become the most important channel for immigration. As in other European countries, access to the labour market is regulated by the possession of residency or employment permits. In the early 1990s, numerous regulations were strengthened (e.g. waiting time for family reunification was extended) and a selective immigration policy was initiated, with the objective of fighting irregular migration. In 1997, a legalisation program was drafted in respect of migrants residing in the country without authorisation. Despite restrictive policies, immigration to France has risen constantly in recent years (Engler 2007).

By 2005, a total of 1.7 million immigrants lived in France, originating from the European Union (EU25), whilst 250 000 originated from non-EU European countries. In total, 1.5 million immigrants originated from the Maghreb region, a further 570 000 originated from sub-Saharan Africa, whilst approximately 690 000 immigrants had their roots in Asia (ibid).

Consequently, France was transformed into a pluricultural society, which was not only caused by the liberal regime with respect to naturalisation or the immigration from colonial territories, but also as a result of a proactive family policy (Revillard 2006).

The current orientation involves selective immigration, combined with instruments aiming to improve the integration of third country nationals. This orientation was confirmed by the revision of legislation in 2007 (Law 2007-1637 of 20 November 2007 on Immigration Control, Integration and Asylum). In particular, this new legislation develops a number of measures to fight illegal immigration, to increase the entry and residency requirements in France, to control family immigration (income, test on language and values, training, ensuring the integration of children in terms of the “Reception and Integration Contract for Families”, undergoing genetic testing or DNA testing for citizens of countries where there are serious doubts regarding the authenticity of birth and marriage certificates, and for foreign applicants applying for family reunifications, on a trial basis for 18 months).

Recently, restrictive policies have also increased in the asylum sector. Law 2003-1176 of 10 December 2003 reduces time limits for asylum processing and unifies the asylum procedures in order to exert greater control over the access to France by way of the asylum procedures. In 2008 the inflow of foreign workers totalled 17 100 persons (as permanent workers).³

In 2008 France received 41 800 asylum applications, mainly from citizens of Russia (3 700) and Serbia (3 400) (Eurostat 66/2009). The same year, 56 100 decisions were issued (in the first and second instance) and the rate of recognition was 16% (5 200 in the first instance) (Eurostat 175/2009).

Total Population and Migrant Population

By 1 January 2010, the population in France was 64 709 480 (Eurostat)⁴. In 2008 the foreign-born population was 3 674 000, which equalled 5.8% of the population (Eurostat 94/2009). The main countries of origin were Portugal (492 000), Algeria (477 500) and Morocco (461 500) (ibid.)⁵.

Estimated Number of Undocumented Migrants

Estimates, of the number of undocumented migrants in France, range from 300 000 to 500 000 persons, which corresponds to 0.7 % of the population, and thus a medium ratio in the European context (Baldwin-Edwards & Kraler 2009:41).

³ <http://www.oecd.org/dataoecd/38/54/43185467.xls> (2010-03-05).

⁴ Eurostat.

<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&language=en&pcode=tps00001&tableSelection=1&footnotes=yes&labeling=labels&plugin=1> (2010-03-09).

⁵ The statistics on the main countries of origin are from 2005, in the case of France (Eurostat 94/2009).

France's colonial past affects its irregular migration, by linking preferred migratory destinations to history (Courau 2009:10 with reference to Blanchard and Bancel, 1998⁶). In France's case, this involves irregular migration from the Maghreb and francophone Africa to France (Courau 2009). The irregular immigration patterns from the Maghreb and sub-Saharan Africa are closely interrelated to changes in French migration regime and the removal of regular immigration possibilities (Sohler 2009:4).

France is also a destination and transit country for organised irregular migration (via smuggling networks). The government has reported (CICI 2007 as referred to by Sohler) that the most important inflows of migrants via irregular smuggling networks are from Asia (China), the Middle East (Iraq, Iran), Northern Africa (the Maghreb), Eastern Europe (Romania, Bulgaria), Turkey and the Indian subcontinent (India, Sri Lanka and Pakistan) (ibid.: 139). For several years, significant irregular transit migration has been observed in France, mainly from regions of war and insecurity (Iraqi and Kurd migrants), and involving migrants trying to gain access to the UK and Scandinavian countries. Before the removal of barriers for new EU citizens (in 2004 and 2007), Romanian and Bulgarian citizens were targeted as specific groups of irregular migrants (Sohler 2009:4).

In the French context, there is a specific issue with respect to irregular migration, involving French Foreign Departments and territories (involving removal procedures from the territories) (Sohler 2009:5). This issue is not dealt with in this report.

Categories of Undocumented Migrants

Categorising undocumented migrants implies acknowledging the different pathways of becoming an undocumented migrant. However, due to a lack of data, it is not possible to provide precise figures and proportions in this respect. The more restrictive policies towards the admission and granting of long-term residence towards third country nationals (with recent law reforms mainly concentrated on restrictions relating to family reunification) have multiplied the pathways to irregularity in France (Sohler 2009:4). There has been a decline in the number of persons entering the territory irregularly, as a result of greater control over borders (Questionnaire France). This is an aspect of a trend leading to the externalisation of control of Migration France (Coste 2008:76). The rejected asylum seekers now constitute an important group, as only a small proportion leave the country following a negative decision (Sohler 2009:3). Persons with expired residency permits constitute a growing group of undocumented migrants. It has become easier to both identify and locate overstayers (with visas), since the administration has a record of their addresses. From this it may be suggested that persons with expired permits comprise the largest group, followed by rejected asylum seekers and persons with expired visas. Given the strengthened external border controls, persons entering France irregularly may be considered to be a diminishing group (Questionnaire France).

⁶ Blanchard, P., Bancel, N. 1998. *De l'Indigène à l'Immigré*, Paris: Gallimard. Caloz-Tschopp, M.C. 2004. *Les Etrangers aux Frontières de l'Europe et le Spectre des Camps*, Paris: La Dispute.

Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups

The logic behind regularisation in France is both economic and humanitarian in nature. Humanitarian concerns are always treated on a "case-by-case" basis. French policies have drawn upon two complementary strategies: a control-oriented and an inclusive strategy. The former has gained priority within government policies (with respect to controlling illegal immigration), whereas the latter, via regularisation, has been applied more selectively and on an individual basis (Sohler 2009:6). There have been six relevant programmes since 1973, both large and small-scale punctual, exceptional regularisation programmes (in 1973, 1980, 1981-1982, 1991, 1997-1998 and 2006). In total, approximately 282 300 persons have had their status regularised (ibid.). Of these, approximately 80 000 were regularised in 1997, 1998, and 1999 (Courau 2009:12). In 2006, 6 924 persons were regularised (30 000 files were submitted)(ibid.).

There have never been any general amnesties, as all programs were processed on the basis of specific criteria (eligibility and admission), defined by means of administrative circulars issued by the competent ministers (Ministries of Labour and Social Affairs, Interior, Immigration and Integration) and on a case-by-case basis (ibid.). Furthermore, regularisation implied short term permits and further regularisation (renewal of permit) depended then on stable labour market integration, stable family relations or the qualification of human rights situations in the home country (de facto refugees). This implies a possibility to revert to having an irregular status after one year (ibid.).

In terms of target groups, there has been a shift over time. Most salient has been a move from policies aiming at labour market inclusion towards humanitarian and social integration (of de facto immigrants), which became dominant in the regularisation programs of the 1990s (Sohler 2009:6). There has been a corresponding shift from irregular migrant workers (in 1973, 1980 and 1981-1982) towards partners and families (in 1997-1998 and 2006), and rejected asylum seekers and de facto refugees (in 1991 and 1997-1998) (ibid.). These shifts corresponded with a move from broader, large-scale regularisations towards more focused (small-scale) measures and the narrowing of target groups, a decrease in the number and rate of regularisations, and finally, the substitution of collective regularisation procedures with individual regularisation procedures (Sohler 2009:7). A "severe illness" clause was created in 1998 (by the Chevènement Law in May the 12 th, Article 313 11-11 of the Law dated 26 November 2003), based on humanitarian arguments and involving temporary residency permits.⁷

⁷ It is stated that: "Temporary permit is granted to any foreigner present in France whose state of health requires medical treatment and when the absence or interruption of such treatment would entail consequences of extreme severity; the condition is that such treatment is not accessible in his/her country of origin". The specific resident permit delivered for such humanitarian reasons is called a, " permit for private life/ family life" (Questionnaire France).

It is of interest that between 1998 (by way of legislation) and May 2006, an automatic regularisation of irregular migrants, after 10 years of residence, applied in France (Courau 2009:12). The thinking behind this was as follows: if a migrant had resided in France for more than 10 years, if he was ill or if he had children that were born in France, he would automatically be regularised. Within this framework, there were more than 25 000 people regularised each year (ibid.).

Internal Control: Accommodation, Labour, Social Security and Education

There is a trend towards externalisation of the control of migration in France (Coste 2008:76). However, there is also an implicit internal control which impacts undocumented migrants. Officially, an undocumented migrant may not sign a contract of accommodation, since the migrant does not have the necessary documents. Nevertheless, this is done as a matter of fact. It is relevant to note that undocumented migrants may register at the address of certain voluntary associations or the (public) "CCAS" (Centre communal d'action sociale), which are the local social service agencies (Questionnaire France).

Likewise, officially, undocumented migrants do not have access to employment, nor the related social security. This is again due to the fact that officially they may not be registered with the social security bodies. However, some migrants use false residence permit cards or fake identification documents in order to be integrated into the regular labour market (Questionnaire France; see also Sohler 2009:3).

Undocumented children may access education to a certain degree. France explicitly permits every child ("mineurs" less than 18 years) to attend school and be officially enrolled, including explicitly, children of undocumented parents (European Commission 2004:33). However, the effectiveness of this clause depends on schools or local authorities and on the mobilisation of parents and other organisations in support of these children (Questionnaire France).

Main Characteristics of the Health System

Financing, Services and Providers

Financial responsibility for healthcare in France is mainly borne by the statutory health insurance system, as a branch of the wider system of social security (Sandier et al. 2004:35). According to the Universal Health Coverage Act (CMU, introduced in 2000) there is universal health coverage (applying to the whole population) and there is a right to statutory health insurance coverage on the basis of residency. In the context of the CMU

participation, it depends also on levels of income, as those whose income is below a certain level are entitled to free coverage (ibid.9). As regards financing, there are a range of complementary sources of funding (ibid). The statutory health insurance scheme is financed in a manner characteristic of a tax. Social insurance contributions are paid by employers and employees by way of a personal income tax. To this can be added certain taxes levied on tobacco and alcohol, transfers from other branches of social security and state subsidies (Thomson et al. 2009:138). Patients contribute to approximately 30% of the costs of health and dental care at the point of use. Complementary voluntary health insurances, to cover the cost of statutory co-payments, are widespread (Sandier et al. 2004:133). There are also exceptions with respect to co-payments for specified groups, such as pregnant women and children (ibid.: 138). In terms of the CMU, persons with chronic conditions and those with low incomes are in practice exempt from cost sharing, by way of a complementary VHI coverage provided by CMU (Sandier et al. 2004:41; Thomson et al. 2009:138). In 2009 the specified level of income was less than €6 600 per year. (Questionnaire France Elhadji).

Participation in the statutory health insurance system occurs on the basis of professional status, through the health insurance funds of the different schemes. Any dependants of the insured person are also covered by their health insurance (Sandier et al. 2004:35). The health insurance schemes are under the supervision of the Social Security Directorate of the Ministry of Social Security. Since 1996, they have carried out their function as managers of the statutory health insurance system within the framework of an agreement on targets and management, drawn up with the state for a minimum period of 3 years (Sandier et al. 2004:36).

The coverage may be understood as being universal and involves a wide range of medical goods and services (with no specified list or limits) as well as care in case of accidents (emergency). As a general rule, patients are expected to pay the healthcare provider themselves and may then reclaim (total or partial) reimbursement of their expenses from their health insurance fund. This rule does not apply in the case of hospitalisation (the hospital is paid directly by the health insurance fund), nor does it apply to any type of care received by CMU beneficiaries (ibid.:35).

Dental care coverage is less generous, and the out-of pocket payments are larger (also varying depending on treatment). On average, the coverage amounts to 30 % of the cost (Sandier et al. 2004:51). Pension schemes are generous and related to income (Questionnaire France Elhadji). The level of unemployment benefits also vary and are related to the claimant's previous salary. The minimum amount payable is €26.66 per day, and the maximum amount should not exceed 75% over a maximum period of two years.⁸

⁸ Yeates 2009 <http://www.prlog.org/10217699-frenchpropertycom-unemployment-benefit-in-france.html> (2010-01-18).

According to the European Observatory report on France, primary and secondary healthcare which does not require hospitalisation is delivered by self-employed doctors, dentists and medical auxiliaries working in their own practices, and to a lesser extent, salaried staff in hospitals and health centres. Outpatient care and examinations in hospitals represents about 15% of all outpatient consultations. Around 1 000 health centres, usually run by local authorities or mutual insurance associations, along with some organisations offering free treatment to disadvantaged groups, are also active, albeit more marginally, in the delivery of outpatient care (Sandier et al. 2004:61). However, almost all self-employed health care professionals practice within the framework of the national agreements signed by the professionals' representatives and the health insurance funds (ibid: 62). Patients pay the healthcare provider and are subsequently reimbursed by their health insurance fund according to an agreement. The health insurance system grants persons access to the registered health care professional of their choice (ibid.38).

A ranking of providers according to their importance within the system reads as follows: most care is provided by state driven bodies, followed by private for-profit organisations and to a lesser extent, by non-profit organisations.

Basis of Entitlement

The right to statutory health insurance coverage is based on residency. Participation in the statutory health insurance is related to professional status, through the health insurance funds of the different schemes. In the context of the CMU (Universal Health Coverage Act from 2000), participation however depends on residency in France as well as levels of income. Any dependants of the insured person are also covered by their health insurance (Sandier et al. 2004:35ff).

Special Requirements for Migrants

Migrants legally employed in France are insured on a compulsory basis. Those who do not work may gain access to the general welfare system if they have regular residency status (see Basis of entitlement) (Questionnaire France).

Difference Sensitivity

Officially, there are no specific structures for migrants in respect of healthcare. However, some hospitals, linked to non-governmental organisations specialised in migrants' health, offer translation and other services sensitive to cultural issues. Cultural mediators have been introduced in some hospitals. Occasionally, healthcare providers benefit from training in respect of special cultural aspects of migrants' health, financed by their institutions (Questionnaire France).

Health Care for Undocumented Migrants

Relevant Laws and Regulations

There are different laws and regulations applicable to the right to healthcare for undocumented migrants in France. Until 1999, free access to healthcare for the poorest groups of society, irrespective of administrative status, was guaranteed. In 2010 entitlements for persons without regular residency status were removed from the Universal Health Coverage Act (CMU) and a parallel administrative system was created specifically for undocumented migrants. This system, called “State Medical Assistance” (Aide Médicale de l’Etat - AME), allows undocumented migrants and their dependants to access publicly subsidised healthcare under certain conditions relating to their length of stay and income (PICUM 2007:28). These changes were created by Article 3 of the Universal Health Coverage Act, Law n°99- 641 of 27 July 1999 (Questionnaire France).

With respect to emergency care, The Code of Social Action and Families (Articles L 254-1 and L254-2) applies to undocumented migrants regardless of the terms of the AME (PICUM 2007:28). The concept used, “soins d’urgence” (emergency care), refers to care in life threatening situations, as well as the treatment of contagious diseases (necessary to eliminate a risk to public health), all types of health care for children, maternity care and abortion for medical reasons. The treatment of chronic diseases is excluded from the concept of “emergency”.

Access to Different Types of Health Care

As stated above, undocumented migrants who do not comply with AME are entitled to emergency care. Access to emergency care for undocumented migrants is organised through the “healthcare centre offices” (Permanences d’Accès aux Soins de Santé - PASS). These offices are responsible for providing medical and social support to underprivileged persons and for facilitating their access to healthcare in public hospitals. However, according to PICUM, they are not always in place and furthermore, the physical delivery of services varies (PICUM 2007:30; see also HUMA Network 2009).

AME provides for an entitlement in respect of undocumented migrants who have been residing in France for more than three months and have an income below a certain threshold. The migrants may access all kinds of healthcare free of charge, including abortion services (elaborated on below). Dental prostheses and corrective lenses are not included (PICUM 2007:28; HUMA Network 2009).

In practice, AME is a certificate which is required to be provided to care providers, and is granted for a period of one year. The process to obtain the AME involves cooperation and communication between authorities. The individual submits an official form to one authority (most commonly the centers de sécurité sociale de quartier – CSS, but also hospitals and some NGOs) who details the case to the public body responsible for managing

the AME at departmental level (the *Caisses primaires d'assurance maladie des travailleurs salariés*). The requirements concern: a) an identification document (such as passport, ID card, birth certificate or expired residency permits) for the applicant and their dependants, b) an address (of an organisation or public institution may be adequate), c) evidence proving the required three months of stay (such as expired visas, asylum rejection notifications, gas bills, etc). The application must also contain information which proves a household income under the threshold. The law provides for the possibility of making a sworn declaration (*déclaration sur l'honneur*), but this is relatively rare in practice (PICUM 2007:30; see also HUMA Network 2009).

Undocumented migrants who have been living in France for at least three years are also eligible for “home medical assistance” (*assistance médicale à domicile*). This allows them to consult general practitioners free of charge.⁹ PICUM has noted that this right is undermined by difficulties in supplying evidence of a continuous residence of three years (PICUM 2007).

As residency in France is granted temporarily, migrants who lose their status of documented residency have specific rules applying to them. They have the right to keep their previous health insurance during an additional period of regular stay of four additional years. The first year will be covered by CMU, and thereafter they will fall under the AME regime for the remaining three years (PICUM 2007:28). The access to care for undocumented migrants is also affected by the presence of humanitarian medical associations (*Médecins du Monde*, for instance) (Questionnaire France). (see below; Providers and actors).

Costs of Care

There are no out-of-pocket expenses for patients if they are entitled to healthcare in terms of the AME (PICUM 2007:28). In the framework of CMU, there is a small out-of-pocket fee to be paid by patients. Thus, the AME does not correspond to the mainstream system as regards the patient fee. The cost of care is paid by the state. Healthcare providers providing medical assistance to undocumented migrants with an AME certificate are required to specify in their files or invoices that the services were rendered to a beneficiary of the AME, and that no payment was requested (*ibid*:29).

Since 2004, the cost of emergency care is covered by the state through a special fund, for both inpatients and outpatients who are not eligible for the AME (called the “*fonds de soins d'urgence*”). This fund is paid on a case-by-case basis by the state to hospitals, and is managed by the CNAM (*Caisse nationale d'assurance maladie*) at national level and the departmental CPAM (*Caisses primaires d'assurance maladie*) at local level. Hospitals are required to show that the patients do not have any other coverage and must advise as to the emergency character of the care provided (PICUM 2007:30).

⁹ This is in terms of the Code of Social Action and Families, Art. L 111 and Art. 38 (4) Loi Pasque.

Specific Entitlements

Children are acknowledged as a specific group in France. They are entitled to access all kinds of healthcare free of charge, regardless of their eligibility for AME, and this is implied in the notion of “emergency care” (PICUM 2007:28). Maternity care is also included, and may be considered an aspect of care for children. Additionally, “isolated minors” (unaccompanied) may access CMU if they are in the care of “Social Aid to Children” (Aide Sociale à l'Enfance) (Questionnaire France).

Women are, to a certain degree, also recognised as a specific group. As mentioned above, the notion of “emergency care” refers to maternity care as well as abortion for medical reasons. Furthermore, undocumented pregnant women may have access to abortion services regardless of the medical reason (i.e. voluntary abortion, “interruption volontaire de grossesse” (IVG). (The Law of 4 July 2001 related to IVG and contraception).

In addition, all undocumented migrants also have access to public centres providing screening for sexually transmitted diseases and HIV/Aids, family planning, vaccinations and screening and treatment of tuberculosis. These centres do not require any proof of identification to provide services (PICUM 2007:28). HIV tests are provided in terms of certain public health legislation¹⁰. HIV treatment is provided in terms of legislation relating to social security (article L 324 du code de la sécurité sociale). There is a list of AFL (“affections longue durée”, i.e. chronic diseases) from 2004 (décret n° 2004 - 1049 du 4 Octobre 2004) (Questionnaire France). Undocumented migrants also have access to medico-psychological centres and drug users’ consulting centres (ibid.).

Regional and Local Variations

It may be said that there are regional and local variations in the entitlement to care in practice. The authority at national level, CNAM (Caisse nationale d'assurance maladie) has the role of harmonising policy. However, the implementation of rights depends on authorities at a local body, CPAM (Caisse primaire d'assurance maladie) which implements regulations according to its own considerations (such as the number of immigrants). This situation may be attributed to the complexity of the regulations. In any case, there is no institutionalised legal security involving sanctions and the bringing of claims (Questionnaire France).

The competency to make decisions is generally to be found at the national level, in accordance with state regulations and the different institutions, including CNAM (Caisse nationale d'assurance maladie). However, these competencies are also to be found at the

¹⁰ Décret n° 88-61 du 18 janvier 1988 pour l'application de l'article L355-23 du code de la Santé Publique concernant le dépistage de façon anonyme et gratuit du VIH. See also: Voir the guide from the association Comede “Prise en charge médico-psycho-sociale des migrants/étrangers en situation précaires”, <http://www.comede.org/-Guide-Comede-2008> (2010-01-14).

meso level and specialised regional institutions, such as ARH (Agence Régionale d'hospitalisation) and DRASS (Direction régionale d'action sociale et sanitaire). At the local level, there is the DDASS (Direction départementale d'action sanitaire et sociale).

Obstacles to Implementation

As regards AME, there are obstacles which lead to undocumented migrants who are in principle entitled to AME, not receiving it for various reasons. Based on a study, Médecins du Monde France argue that approximately 93 % of undocumented migrants assisted in their CASO centers (Centers d'accueil, de soins et d'orientation) in 2005 were potentially entitled to the AME, but did not have their rights recognised (Médecins du Monde 2007). Another significant NGO, Comède (Comité médicale pour les exilés), similarly estimates that only 10% of undocumented migrants have their rights recognised. However, this is only in theory, and does not apply in practice (PICUM 2007: 31). The obstacles may be considered to consist of a lack of familiarity with the actual entitlements, variations in the interpretation and implementation of such at local level, as well as the administration's inability to manage the complexity of the system. The lack of knowledge leads administrators to occasionally impose conditions which go beyond the legislation, and implies a lack of legal security (i.e. the possibility to bring a claim) in case of refusal. There is also a lack of familiarity with their rights amongst undocumented migrants themselves, as well as difficulties in adhering to the administrative requirements, such as being in possession of a valid identification document or a valid address (PICUM 2007:31). A further obstacle involves healthcare professionals and pharmacies, which may deny treatment or medicine to undocumented migrants, as reported by Médecins du Monde (ibid.:32; see also HUMA Network 2009).

Obligation to Report

There is no obligation on healthcare staff to report undocumented migrants to authorities (Questionnaire France).

Providers and Actors

Providers of Health Care

Providers of healthcare for undocumented migrants may be found within different frameworks. The main providers are general hospitals, nongovernmental international organisations, as well as non-profit religious organisations. As stated previously, access to emergency care for undocumented migrants is organised through the "health care centre offices" (Permanences d'Accès aux Soins de Santé - PASS) which are responsible for providing medical and social support to underprivileged persons and facilitating their access to healthcare in public hospitals. However, according to PICUM, these bodies are not always in place (PICUM 2007:30).

NGOs, such as Comède and Médecins du Monde, operate medical centres providing assistance to undocumented migrants free of charge. However, as their objective is to

improve the mainstream system, they always try first to help their patients access the mainstream health system through the AME scheme (PICUM 2007:33). Thus, the role of NGOs may be said to be more that of a facilitator than a provider in the first instance, and they then step in as provider in cases where the mainstream system has failed.

Nongovernmental organisations and PASS in hospitals, which are in charge of helping undocumented migrants to access care, are located all over the country (Questionnaire France). Comède is active all over the country as a national resource centre (PICUM 2007:34). There is no official coordination between NGOs and hospitals, but in practice they do cooperate, particularly Médecins du Monde and PASS in hospitals (Questionnaire France).

Advocacy Groups and Campaigns on Rights

As previously stated, (See Obstacles to implementation) there are obstacles to accessing an AME certificate. This has been acknowledged by the National Human Rights Commission (Commission nationale consultative des droits de l'homme), which has thus recommended changes to the system (give full ref in PICUM 2007:32).

There are a range of nongovernmental organisations engaged in the issues relating to undocumented migrants. The main organisations are Comède, Médecins du Monde and ODSE (Observatoire du droit à la santé des étrangers), which constitute a network of organisations. Comède comprises a reference centre for undocumented migrants as well as a national resource centre in the field of access to healthcare. They have organised a telephone-based help desk, organise training sessions, conduct research and publish a newsletter and an annual guide which provides extensive information regarding the health system, the conditions and ways to access healthcare in France, the most common barriers, contact information, etc. Médecins du Monde's first priority is to facilitate access to care by providing, at their own health care centres, mobile units and damage limitation programs. The ODSE advocates equal and universal healthcare for all foreigners, particularly for undocumented migrants. They also monitor the implementation of legislation (PICUM 2007).

Furthermore, most physicians and medical unions in France are politically engaged in the issue of access to care for all migrants. There are also social workers advocating for healthcare for undocumented migrants, however this occurs at an individual level (Questionnaire France).

Political Agenda

The discussion in France may be said to involve undocumented migrants in general. In other words, the debate does not target specific groups, in part because the topic is politically sensitive. Groups such as children, women or rejected asylum seekers are however discussed by nongovernmental organisations which seek their regularisation. Since the spring of 2008, there is a social movement involving several hundred

undocumented migrant workers as well as trade unions and other associations. There were massive strikes in many areas in Paris, involving a range of sectors engaging informal workers, and their aim was to accomplish regularisation as a remedy for an inconsistent situation (Courau 2009:12).

Currently, the main political discourse in France regarding undocumented migrants is "un étranger en situation irrégulière a vocation à être reconduit dans son pays d'origine" (in short: they should go back to their country of origin). The political debate is set against the backdrop of the irregular situation of undocumented migrants, which is interpreted as meaning that they do not respect the law or sovereignty of the Republic. There are also themes involving "therapeutic immigration", "health tourism" and the "appeal of France", which are tied to a debate on the cost of healthcare (Questionnaire France). Healthcare for undocumented migrants is approached from different perspectives: A cost-oriented approach, involving concepts such as "health tourism" and "air appeal" was introduced by politicians. A rights-oriented approach was mainly introduced into the debate by NGOs and some researchers (ex. Didier Fassin). There is also an approach referring to "public health risk", introduced by NGOs (Questionnaire France).

The political struggle against undocumented migrants influences the administrations in charge of delivering healthcare. For instance, the Minister of the Interior published a circular in 2006 which granted the right to public authorities to identify healthcare facilities and nongovernmental organisations for undocumented migrants (Questionnaire France; Huma network 2009:52). These instructions were subsequently declared illegal by the courts (Huma network 2009:52). Furthermore, there has been a discussion regarding the co-payments for undocumented migrants and an attempt by the French Parliament to reduce AME coverage from 100% to 75% (PICUM 2007:28). In 2006, the State had a debt of €800 million to be paid to CNAMTS. This was interpreted by advocacy groups and NGOs as a deliberate under-budgeting of the AME system by the state in order to undermine it (Questionnaire France).

International Contacts

As is well known, Médecins du Monde has a network stretching across Europe. Other significant nongovernmental organisations are linked with PICUM, Comède, GISTI (Groupe d'Information et de Soutien des Immigrés Accès à l'Espace Privé)¹¹ and CIMADE (Service Oecuménique d'Entraide) (PICUM 2007).

¹¹ Sans-papiers mais pas sans droits. June 2006. <http://www.gisti.org/doc/publications/2006/sans-papiers/index.html> (2010-01-23).

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