



HEALTH CARE FOR UNDOCUMENTED MIGRANTS

GERMANY, BELGIUM, THE NETHERLANDS, UNITED KINGDOM

Edited by

Nele Verbruggen (PICUM coordinator)

In cooperation with

Adriaan van Es (GP Utrecht, Secretary IFHHRO), Kea Fogelberg (GP Leiden, Johannes Wierstichting), René Grotenhuis (Director Stichting PHAROS), Wil Voogt (Health Care Inspectorate The Netherlands), Gisela Penteker (GP Lower Saxony, Förderverein Niedersächsischer Flüchtlingsrat e.V., IPPNW), Tanja Braun (GP Berlin, Büro für medizinische Flüchtlingshilfe), Wiebke Würflinger (Psychologist Berlin, Büro für medizinische Flüchtlingshilfe), Rachel Crowther (Oxfordshire Health Authority), Liz Peretz (Oxfordshire Health Authority), Angela Burnett (GP, London), Ellen Druyts (Medisch Steunpunt Mensen Zonder Papieren Belgium), Pierre Ryckmans (Médecins Sans Frontières Belgium), Dominique van Huystee (ASKV-SV Amsterdam, PICUM Excom), Pieter Muller (PICUM Chair), Didier Vanderslycke (Steunpunt Mensen Zonder Papieren Belgium, PICUM Excom)

Lay-out Cover

Jo Adriaens

Printed by

De Wrikker – Antwerp (Belgium)

June 2001

All parts of this publication may be reproduced or utilised without permission of the authors. PICUM kindly requests to be kept informed of the use that is made of this material.

To order this publication, please contact:

PICUM / Gaucheretstraat 164 / 1030 Brussels (Belgium) / Tel: + 32
(2) 274.14.39 / Fax: + 32 (2) 274.14.48/ info@picum.org/
www.picum.org

PREFACE

The present publication results from an International Experts Seminar on the theme of Health Care organised by PICUM, the 'Platform for International Cooperation on Undocumented Migrants' on 22 and 23 March 2001 in Brussels. The immediate aim of this Seminar was to bring about an exchange of experience and views of medical experts dealing with 'sans papiers' in their countries, in view of an improvement of prevailing highly unsatisfactory situations. Then NGOs, civil society at large as well as local and national politicians are to be alerted to these situations, and encouraged to take action for improvement. This is the purpose of this publication. We sincerely hope that it will be read, then used for further steps towards full basic social rights of undocumented migrants in Europe.

On behalf of the PICUM Executive Committee

Pieter Muller, Chairman
May 2001

ACKNOWLEDGMENTS

All the participants of the Seminar in Brussels on 22 and 23 March 2001 deserve proper thanks for their contributions during the Seminar and also for the composition of this publication. The days of the Seminar in Brussels were intensive and, thanks to the competence of the Chair of the Seminar Bart Bode, highly productive.

ASKV-SV from Amsterdam devoted a great deal of their precious time to prepare, both practically and thematically, this Health Care Seminar. Also Ronald Burchi is thanked for his valuable support during the Seminar. Furthermore we want to thank Evert Bloemen, Walter Leenders, Veerle Evenepoel, Sister Joan, Jenny Monahan, Hildegard Grosse and Rachel Bryers.

The Seminar and this publication could not have been realised without the financial support of Cordaid, PIN, Haëlla Stichting, the Boyd & Morland Charitable Trust, Steunpunt Mensen zonder Papieren, the Freudenberg Stiftung, and an anonymous foundation.

TABLE OF CONTENTS

Preface	3
Acknowledgments	4
Table of contents	5
Chapter I: INTRODUCTION	10
• AIMS AND OBJECTIVES	10
- The Platform for International Cooperation on Undocumented Migrants	10
- Experts Seminar on Access to Health Care for Undocumented Migrants	11
• PARTICIPANTS	12
Chapter II: BELGIUM	22
ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN BELGIUM	22
• HEALTH INSURANCE	22
• URGENT MEDICAL CARE	23
- Term	23
- Procedure	24
- Problems	25
• DIFFERENT ASPECTS OF HEALTH CARE	26
- Medication	26
- Specialists	26
- Mental Health Care	26
- Dental Care	26
- Maternity care	27
- Minors	27
• CONCLUSION / GENERAL REMARKS	27

RESIDENCE PERMITS ON MEDICAL GROUNDS IN BELGIUM	28
• REGULARISATION CAMPAIGN	28
• ARTICLE 9 § 3.....	28
• PROCEDURE	29
• PROBLEMATIC POINTS	30

Chapter III: GERMANY **32**

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN GERMANY..... **32**

• MIGRATION	32
- Political Background	32
- Illegalised Migrants in Germany	34
• LEGAL CONDITIONS	35
• HEALTH	37
- Epidemiological Data	37
- Seeking Treatment	37
- Public Health and Infectious Diseases	38
- Health Insurances.....	39
- Emergency and Hospital Care.....	39
- General Practitioners, Specialists and Dentists	41
- Provision of Drugs	42
- Pregnancy and Maternity Care	42
- Abortion	42
- Mental Health	43
• POLITICAL PERSPECTIVES	43

RESIDENCE PERMITS ON MEDICAL GROUNDS IN GERMANY **46**

• ‘DULDUNG’.....	46
• GROUNDS	46
• SPECIFIC SITUATIONS	47
- Post Traumatic Stress Disorder	47
- HIV / AIDS	48
- Maternity Care	49
- Carers	50
• JURISDICTION	50

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN THE NETHERLANDS	51
• CATEGORIES	51
• THE LINKAGE LAW	52
- The Law	52
- Urgent Medical Care	52
- The Linkage Fund	53
• ACCESS TO GPs AND HOSPITALS	54
- GPs	55
- Hospitals	55
• DIFFERENT ASPECTS OF HEALTH CARE	56
- Midwives	56
- Mental Health Care	57
- Tuberculosis	57
- Others	57
• CONCLUSIVE REMARKS	57

RESIDENCE PERMITS ON MEDICAL GROUNDS IN THE NETHERLANDS	58
• PROCEDURE	58
• ROLE OF HEALTH CARE PROFESSIONALS	59
• PROBLEMATIC POINTS	60
- Difficulties in Obtaining a Medical Report	60
- Trauma	61
• EARLY FORENSIC STANDARD	61
• EVOLUTION	62

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN THE UNITED KINGDOM	64
• GENERAL CONTEXT	64
- Undocumented Migrants	64
- Health Care	64
• PRIMARY MEDICAL CARE	66

- SECONDARY MEDICAL CARE 67
 - Exempt Categories of People 67
 - Exempt Services 68
- PROBLEMATIC AREAS 69

RESIDENCE PERMITS ON MEDICAL GROUNDS IN THE UNITED KINGDOM 70

- IMMIGRATION REGULATIONS AND HEALTH 70
- SPECIFIC SITUATIONS 72
 - Torture 72
 - AIDS/HIV 72
- EUROPEAN COURT OF HUMAN RIGHTS 73

Chapter VI: DISCUSSIONS 75

- INTRODUCTION 75
- LEGAL FRAMEWORK / STANDARDISATION OF REGULATIONS 75
 - Need 75
 - Rational Arguments 77
 - Negative Incentives for Migrants: an Irrational Argument? 78
 - Details of the Proposed European Standard 79
- REPORTING AND MONITORING 79
 - Committee on Economic, Social and Cultural Rights 79
 - Reporting Points 82
- MEDICAL DATABASE 84
 - Importance 84
 - MSF Database 85
 - Governmental or Non-governmental? 86
- EDUCATION 87
 - Importance 87
 - Methodology 87
 - Content of Training Programmes 88

- PROFESSIONAL CONFIDENTIALITY 89
 - The Problem 89
 - Defining Professional Confidentiality..... 90
 - Action Points 90

Chapter VII: CONCLUSIONS AND RECOMMENDATIONS **92**

BIBLIOGRAPHY **94**

Chapter I : INTRODUCTION

AIMS AND OBJECTIVES

The Platform for International Cooperation on Undocumented Migrants

PICUM, the 'Platform for International Cooperation on Undocumented Migrants', resulted from informal meetings of several persons from Germany, Belgium and the Netherlands involved in the topic of 'sans papiers'. They felt the need for exchanging information and experience on a broader, European level. Thanks to financial support by several Dutch and Belgian foundations the PICUM-platform has since November 2000 a secretariat on a temporary basis with a full-time coordinator.

The aim of PICUM is threefold:

- 1) To promote respect for the basic Social Rights (such as the right to education and training, the right to healthcare, the right to a minimum income, the right to family life, the right to moral and psychological integrity, and the right to legal aid) of undocumented migrants
- 2) To promote respect for human rights in the detention and expulsion of undocumented migrants
- 3) To investigate the possibilities of, and to promote regularisation of the residence of undocumented migrants

PICUM seeks to achieve this aim by:

1. Gathering information on law and practice regarding Social Rights, detention and expulsion of irregular immigrants, and the possibilities of regularisation of their residence.
2. Developing a centre of expertise in these fields with a view to providing the members of PICUM and other interested parties with expertise, advice and support.
3. Strengthening networking between organisations dealing with undocumented migrants in Europe.

4. Formulating recommendations for improving the legal and social position of these immigrants, in accordance with the national constitutions and international treaties. These recommendations are to be presented to the relevant authorities, to other organisations and to the public at large.

The member organisations of PICUM are of different kinds: some are involved in the grass root work with 'sans papiers', others are more policy-orientated, be it on the national or the European level. (For a list of participating organisations, see PICUM Mission Statement). PICUM-Assembly meetings, uniting all the participating organisations, are held twice a year. Between the Assemblies an Executive Committee functions as the governing body.

Experts Seminar on Access to Health Care for Undocumented Migrants

The first aim of the Platform, as mentioned above, is promoting the respect for the basic Social Rights of undocumented migrants. One of these rights is the Right to Health Care. The situation, both in law and in practice, relating to this right differs considerably in the different European countries. In some, undocumented migrants have (legally) no access at all to Medical Care, in others, the policy is less restrictive and health provisions tend to be more accessible for this group of migrants.

A comparison of the situation in different countries provides valuable information and opportunities. Arguments and opinions can be exchanged to influence national policy, views and recommendations can be assembled for communication to the relevant European policy makers. To encourage this information exchange, PICUM organised an International Experts Seminar on 'Access to Health Care for Undocumented Migrants' on 22 and 23 March 2001, in Brussels. The Seminar brought together experts in health care for undocumented migrants from the Netherlands, Belgium, Germany and Great Britain for a day and a half, to discuss both law and practice concerning access to doctors and hospitals,

access to specialists like dentists, access to mental health care, and health insurance. Also the theme of (temporary) residence permits for medical reasons has been addressed. What is laid down in the law, what are the problems, what are possible solutions, what can be learnt from each other's countries?

The present publication contains information about the situation in the participating countries, together with written reports of the Seminar discussions, and the final conclusions and recommendations. It has been composed to help further disseminating the results of the Seminar: to communicate our points of view and concerns to relevant policy makers, to contribute to the work of scientists involved, and to provide information to non-governmental organisations (NGOs) working with undocumented migrants. In this way PICUM hopes to contribute substantially to existing knowledge on the theme, which so far is limited.

Following the presentation of the participants of the Seminar in the next section, chapter 2 to chapter 5 contain descriptions of health care for undocumented migrants in the four participating countries. For each country, both the access to health care and the possibilities of obtaining a residence permit on medical grounds will be described. Chapter 6 contains an extensive report of the Seminar discussions. In the last chapter, the conclusions and recommendations that were formulated at the end of the Seminar are presented.

PARTICIPANTS

Ms. Liz Peretz (GB)

Liz Peretz is currently Partnerships Project Manager with the Oxfordshire Health Authority. She has experience in developing social welfare services for refugees in Oxfordshire and Slough (a town with high social deprivation and a large ethnic minority population) as well as in health services. She is also involved in voluntary and political work around asylum seekers, particularly

those in Immigration Detention, in a private capacity. (Both Slough and Oxfordshire have unusually high numbers of asylum seekers for Britain, outside London and the Kent ports.) She is currently engaged with Dr. Rachel Crowther in developing an Oxfordshire Health Strategy with and for refugees and asylum seekers in Oxfordshire.

Dr. Rachel Crowther (GB)

Rachel Crowther is a doctor currently engaged in higher specialist training in Public Health Medicine and has recently completed an MSc in Public Health at the London School of Hygiene and Tropical Medicine, where her dissertation was on the health needs of asylum seekers. She works for Oxfordshire Health Authority as a Specialist Registrar in Public Health, and her main areas of work are children's services and asylum seekers and refugees. She has been closely involved in drawing up and now in implementing Oxfordshire's local strategy for refugees and asylum seekers, including attempts to improve health care provision in Campsfield House, a local Immigration Detention Centre.

OXFORDSHIRE HEALTH AUTHORITY

The Oxfordshire Health Authority is responsible for commissioning health services for the population of Oxfordshire, a relatively prosperous district of 600,000 people in southern England with a mix of urban and rural areas. It has a relatively high number of asylum seekers and refugees, and presumably also of undocumented migrants. The main statutory agencies in the county (health, social services, education, police, employment service) have recently developed a Joint Agency Strategy to support asylum seekers and refugees, together with voluntary organisations concerned with the welfare of these groups, and work is underway to implement the many areas of the strategy. The health section (which is currently being revised) covers primary care, secondary care, mental health, communicable disease, health promotion, information and communication, interpreting and advocacy and staff education and training.

Dr. Angela Burnett (GB)

Dr. Burnett is a family doctor, and worked for 10 years in the East End of London. This community is very multicultural and includes many refugees. For the last 5 years she has been working with people who are survivors of torture and organised violence. Ms. Burnett works also with doctors who are refugees, providing mentoring and career support in order to enable them to get work.

Ms. Burnett works in varying capacities – clinically, training and in policy issues, both in the voluntary and in the statutory sectors.

Dr. Gisela Penteker (D)

Dr. Gisela Penteker is since 20 years working as a family doctor in a rural area of Lower Saxony. She is not working with refugees on a professional level, her work with refugees rather stems from a private interest as citizen of a country, where their rights are mistreated. Dr. Penteker is a member of the German working group ‘Refugees and Asylum’ from IPPNW (International Physicians for the Prevention of Nuclear War), and of the Förderverein Niedersächsischer Flüchtlingsrat.

INTERNATIONAL PHYSICIANS FOR THE PREVENTION OF NUCLEAR WAR

IPPNW – International Physicians for the Prevention of Nuclear War /Physicians in Social Responsibility – understands itself as a profession bound organisation of the peace movement. The organisation stands for three goals: a world without nuclear threat, a world without war, and a world in social responsibility. In 1984 IPPNW received the UNESCO Peace Prize, in 1985 the Nobel peace prize. The German working group ‘Refugees and Asylum’ has as its main activity the campaign "Residence Title for Traumatized Refugees".

FORDERVEREIN NIEDERSACHSISCHER FLUCHTLINGSRAT

Förderverein Niedersächsischer Flüchtlingsrat e.V., founded in 1984, is a network and service institution for different

groups, organisations and clubs working with refugees. The Flüchtlingsrat participates in different political bodies and in the network 'Asylum in the Church' of Lower Saxony. It is also member of the federal working pool Pro Asyl e.V.

Ms. Tanja Braun (D)

Tanja Braun is a medical doctor and student of Public Health. She works in a hospital, at the department of Neurology. She is also a member of the 'Büro für medizinische Flüchtlingshilfe'.

Ms. Wiebke Würflinger (D)

Ms. Würflinger is psychologist, her focal point is 'Critical Psychology'. She works with handicapped children and their parents. She is also a member of the 'Büro für medizinische Flüchtlingshilfe'.

BURO FÜR MEDIZINISCHE FLÜCHTLINGSHILFE

The Büro für medizinische Flüchtlingshilfe (Bureau for medical aid for refugees) mediates anonymous medical treatment for free for refugees and undocumented migrants twice a week. The bureau is a non-governmental, self organised project within the anti-racist movement. It is independent of any political party and does not receive any state funding. Everyone participating – the mediators in the office, the translators and doctors – works without payment. Additional costs for medication, x-rays, glasses etc. are covered by donated money.

Since the asylum law has been nearly abrogated in 1993, the number of those who do not receive a kind of residence permit has risen, too. That includes also the number of undocumented migrants who do not have any access to medical aid. The bureau has been founded as a reaction to the changed political situation in Germany, with the aim of combining practical solidarity and political work.

The Bureau for medical aid for refugees understands its work as anti-racist and sees itself as part of the campaign “No One is Illegal” and the ‘Forschungsstelle Flucht und Migration’. They also have a loose cooperation with other initiatives. The people working in the bureau share the opinion that every human being must be allowed to choose freely where to live and work. Apart from the mediation of ill people, they also take part in various actions against governmental discrimination of foreigners (discrimination of foreigners by national or local authorities) and against racist thinking and acting of the population.

Dr. Kea Fogelberg (NL)

Dr. Fogelberg is a general practitioner since 1979. In the region where she lives and works, she is the Chairman of a local foundation, concerning ‘access to health care for undocumented migrants’. Furthermore she is a member of a working group of the Johannes Wier Foundation with special attention for the human rights concerning access to health care for undocumented migrants.

JOHANNES WIER FOUNDATION

The Johannes Wier Foundation was established in the Netherlands 1986. Similar initiatives were taken in other countries about the same time. The Foundation is a human rights organisation for physicians, nurses and other health professionals. Each of these professionals has its own specific responsibility in the protection of human rights. The Johannes Wier Foundation provides medical expertise to detect and investigate human rights violations, and promotes research and education in the field of health and human rights. It supports colleagues who encounter problems as a result of their efforts in this field . Furthermore, the Johannes Wier Foundation conducts investigations into the collaboration of health professionals in human rights violations, such as torture, corporal and capital punishment, and its campaigns against these violations.

Collaboration with international sister organisations has been formalised in the International Federation of Health and Human Rights Organisations (IFHHRO). Countries such as the United States, Israel, Palestine, South Africa, Britain, Denmark and India are associated. Amnesty International, the International Red Cross, the World Medical Association, and the British and Turkish Medical Associations are official observers.

The Johannes Wier Foundation uses various means to achieve its objectives: education, research missions and reports, conferences and workshops, writing campaigns and lobbying, etc.

Ms. Wil Voogt (NL)

Ms. Voogt is a sociologist working at the Chief Inspectorate for Health Care in The Hague since 1995. She is one of the inspectors having special expertise in the particular field of health care for minorities: immigrants, asylum seekers, and refugees. In the capacity of being a law-student, Ms. Voogt recently wrote an essay on health care for undocumented immigrants.

Health Care Inspectorate

The Health Care Inspectorate is part of the State Inspectorate of Health, which is an autonomous part of the Ministry of Health, Welfare and Sport. The Inspectorate has two main areas of activity in the public health supervisory service: care and protection. It has a central office: the Chief Inspectorate in The Hague, and four regional services. At the central level the inspectors have special expertise in a particular field of health care. The function of the Inspectorate can be summed up as follows: supervision of public health, including care systems and care provided at both individual and collective levels, on the basis of existing legislation; reporting and advising on findings to the authorities and other parties with

the aim of improving and protecting public health and the health of the individual.

The tasks and powers of the Inspectorate are laid down in the 1956 Health Act, section 36:

- a. Enforcing statutory regulations relating to public health;
- b. Advising and informing the Minister and the Director-General of Public Health on matters relating to public health either on request or on its own initiative.

Formally the Minister of Health is responsible for the activities of the Inspectorate. However, the Health Act does not describe the relationship between the Minister and the Inspectorate; it suffices with giving the Minister the 'power to designate'. This means that the Inspectorate is able to conduct its activities rather independently and autonomously.

Mr. René Grotenhuis (NL)

Mr. R.B.M. Grotenhuis is the Director of PHAROS.

PHAROS

PHAROS is a national institute with the general purpose of contributing to the health and well-being (social, mental, and physical) of refugees and asylum seekers. Within this general purpose the main objective is to improve the accessibility of the Dutch health service to refugees and asylum seekers. The major tasks of PHAROS are the support of regular health services and the provision of care.

Main activities of PHAROS are in the first place treatment: refugees and asylum seekers come to PHAROS for special treatment of serious mental problems caused by organised violence or due to acculturation problems. Besides this, PHAROS is continually organising training and education

activities, and is collecting and registering data that may be used for research on the health problems of refugees and the evaluation of health care policies. PHAROS also has a documentation department that collects literature, in particular on medical and psychosocial consequences of organised violence, and published numerous books on subjects concerning health and health care for refugees. PHAROS engages also in networking both on the national and the international level.

Ms. Ellen Druyts (B)

Ellen Druyts is a social worker, and works since 1994 as the coordinator of the Medisch Steunpunt Mensen Zonder Papieren.

MEDISCH STEUNPUNT MENSEN ZONDER PAPIEREN

The 'Medisch Steunpunt Mensen Zonder Papieren' (Medical Support for Undocumented Migrants) is an organisation that wants to guarantee access to health care for foreigners staying illegally in the region of Brussels. One part of the working of the organisation is centred on case-work (individual counselling of undocumented migrants). Another part of the work of the Medisch Steunpunt is structural action related to access to health care and to obtaining (or maintaining) a residence permit for medical reasons. In this respect it communicates with various action groups, mutual aid associations and other social institutes.

Dr. Pierre Ryckmans (B)

Dr. Ryckmans is a doctor at Médecins Sans Frontières. He is working at the Department for 'Belgian Projects'.

MEDECINS SANS FRONTIERES / DOCTORS WITHOUT FRONTIERS

Médecins Sans Frontières is a humanitarian NGO providing medical support in more than 80 countries. While MSF is mostly known for its work in developing countries, also in the Western World they are more and more confronted with the

consequences of the decline of the social climate, a situation which leads automatically to exclusion. For this reason MSF decided to expand its work area to the groups that have no access to health care infrastructure.

Since October 1991, MSF is organising, in cooperation with 'Pharmacists without Frontiers' medical-social consultancies for everybody without access to health care and with difficulties accessing the different systems of social protection (homeless, refugees, undocumented migrants,...).

Dr. Adriaan van Es (NL)

Dr. Adriaan van Es is the Secretary of the International Federation of Health and Human Rights Organisations.

INTERNATIONAL FEDERATION OF HEALTH AND HUMAN RIGHTS ORGANISATIONS

The International Federation of Health and Human Rights Organisations (IFHHRO) was established as a 'loose' network of organisations with similar human rights agendas, upon an initiative of the Johannes Wier Foundation (the Netherlands) and Physicians for Human Rights (USA) in 1989.

The IFHHRO promotes the international cooperation of its affiliated and observer organisations.

The objectives of the Federation are the protection and promotion of health related human rights, the mobilisation of medical expertise in the investigation of human rights violations, and the protection of health workers seeking the promotion of human rights. The affiliated organisations pursue these goals by means of advocacy, fact-finding missions, research and publications, education and special projects, such as the International Forensic Program, the International Landmine Campaign, the project for the promotion of the appointment of a UN Special Rapporteur on the Independence and Integrity of the Health Professionals,

projects on Prison Health, on Medical Neutrality and on Human Rights Education.

Affiliated organisations have developed expertise on a variety of subjects such as hunger strikes, patient's rights and psychiatry, health and human rights under political violence.

Mr. Bart Bode (President of the Seminar)

Mr. Bart Bode is the head of the 'Research and Lobby' Department of Broederlijk Delen, a Belgian non-governmental Development Organisation. Priorities of Broederlijk Delen are human rights in Colombia, Peace in Central-Africa, some macro-economical topics (e.g. lobbying in the framework of the 'Tobin Tax', monitoring the Social Summit of the UN in Copenhagen in 1995), rights of children and youngsters, sustainable development, and the rights of indigenous people. This Research and Lobby Department monitors international and Belgian policies, formulates standpoints and undertakes action. In his capacity as head of this Department, Mr. Bode has experience in moderating meetings, especially in international contexts.

Ms. Dominique van Huystee (NL)

ASKV Steunpunt Vluchtelingen

Member of PICUM Executive Committee

Mr. Didier Vanderslycke (B)

Steunpunt Mensen Zonder Papieren

Member of PICUM Executive Committee

Mr. Pieter Muller (NL)

Council of Churches (The Netherlands)

President of PICUM

Chapter II: BELGIUM

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN BELGIUM

HEALTH INSURANCE

Theoretically, it is always possible for an undocumented migrant to pay the costs of medical care him/herself. Since these costs are mostly very high, there are three ways in which a reimbursement can be obtained: via the health insurance company, via the private insurance company and via the Social Welfare Centre.

Private insurance in Belgium is merely supplementary to the amount reimbursed by the health insurance company. Therefore it is not possible most of the time to subscribe to such a private insurance contract, if one is not in order with the normal (public) health insurance company. With some insurance companies however, it is possible to conclude an insurance that gives you the right to full reimbursement of your medical costs. Since those premiums are always very expensive, not many undocumented migrants can afford such an insurance.

For undocumented migrants, it is also almost impossible to become a member of a health insurance company. There are some situations however in which it is possible:

- If a person with a legal status had a declared job (paying all social contributions), but then at a certain moment lost his/her legal status, while the employer kept on paying the contributions. In this case the employee will continue to be health-insured for a while, since there is a run-off of several years.
- For the same run-off reason, a person that has been a member of a health insurance company but loses his/her legal status can continue to be insured.

- If a person is working while being in the Regularisation Campaign (see below), and the employer pays the social contributions.
- If a person is studying at a recognized school for higher education.
- If a person is a parent/ child/ spouse/ ... of a person that is entitled to health insurance.

The third way in which one can have health care expenses reimbursed is by way of the Social Welfare Centre, called the 'Openbaar Centrum voor Maatschappelijk Welzijn' (OCMW)/ 'Centre Publique pour Aid Social' (CPAS). The aim of the OCMW/CPAS is to assure a decent existence for everybody staying in Belgium. The OCMW/CPAS only reimburses the medical expenses of a person when it gets that money back from the Ministry. The Ministry in its turn only wants to refund health care for undocumented migrants in the case of 'urgent medical care'. The exact ruling concerning this urgent medical care is laid down in the Royal Decree of 12 December 1996.

URGENT MEDICAL CARE

Term

In the Royal Decree of 12 December 1996 urgent medical care is described as follows: 'Medical aid which can be both of a preventive and of a curative nature and which can be given both in ambulant care and in an institution/hospital.'

In the past there has been considerable confusion about the term 'urgent'. Mostly doctors are rather restrictive when first confronted with the procedure. However, it seems that the more the doctors use it, the more they enlarge the term. One can say that the common interpretation of the term 'urgent' is evolving towards 'necessary'. Doctors consider e.g. regular follow ups as urgent medical help, as well as vaccinations. In this way, the rather inaccurate description in the law gives in the end the possibility to a broad interpretation,

which is also the experience of Médecins Sans Frontières (MSF) and the Medisch Steunpunt Mensen Zonder Papieren.

There seems to exist confusion between this law and the law regulating ‘emergency medical care’ for everybody. In case of an emergency everybody will be helped, without their insurance being checked first. Yet this is another law, which has nothing to do with the Royal Decree of 1996.

Organisations working for undocumented migrants like MSF and the Medisch Steunpunt see it as their task to inform hospitals and doctors on the term of Urgent Medical Care. MSF for example had a project in Verviers (a small town in the east of Belgium), informing the general practitioners (GPs) in the region on the Royal Decree and access to health care in general. After some time, MSF stopped the project since all the GPs and the regional hospital understood the law and acquired some experience in practicing and applying it. Also in the city of Ghent there are good experiences, but in places like Brussels, Antwerp or Liege it seems to be more complicated.

Procedure

Undocumented Migrants can get urgent medical help through the social service, if it is advised by the doctor and social worker. The doctor decides whether urgent medical help is needed¹.

The social service will have to find out if the person has no other access to any kind of health insurance, and whether he/she is really undocumented (or has for example a visa²). They must also check if

¹ Since attestation has to be made by a doctor, the patient must pay the first consultation to ask the doctor to make the attestation in order for the next consultations to be free. This means that the undocumented migrant always has to pay somehow.

² In Belgium undocumented migrants sometimes have better access to certain social services than people that have a visa. There are a lot of Latin Americans living in Belgium with a visa, and paradoxically for them there exist legally less possibilities to get access to e.g. health care services.

the person actually lives in their commune, and if the medical help was registered as urgent.

If the OCMW communicates all this information in time to the Ministry of Public Health, it will be paid back the costs. It is important to note that this system can be seen as a parallel system, leading back to the official system in the end. The OCMW/CPAS is after all paid by the government.

Problems

The main problem in this procedure is that it takes a long time for the Social Welfare Centres to gather all the information they need to decide whether or not to grant the care. There is a council within each commune which comes together every month to discuss each case. As a consequence it might take about three weeks before one officially gets the urgent medical help that is needed.

Another problem is that different centres have different ways of applying this decree. Brussels has 19 different communes and every commune has more or less different requirements. Some will ask for a lot of documentation, others will agree more easily.

If the OCMW pays the urgent medical health treatment, it should do this for both private and public institutions and persons. In practice however, the OCMW often refuses to reimburse costs made in a private hospital. This can cause problems if people are taken to a private hospital by an ambulance after e.g. an accident in the street. Sometimes people are just not well informed and go to a private hospital instead of a public one.

It can happen that a public hospital delays in beginning the procedure. They have up to 30 days during which they must introduce their application. When people have had an accident at night for example, or on the weekend when the social services in the hospital are closed, the procedure is not started immediately, and might eventually be completely forgotten.

DIFFERENT ASPECTS OF HEALTH CARE

Medication

Obtaining the necessary medication can be problematic, because the procedure is rather complicated. The patient needs first of all a receipt mentioning urgent medical care. It is then recommended to take this receipt to the OCMW/CPAS, to obtain a certificate that they will defray the costs. Only then is it guaranteed that the costs for medication will be reimbursed. Yet sometimes people need their medication urgently.

Specialists

As for access to specialists there are generally no problems. The only difficulties that might be encountered are rather 'personal': some doctors and services have a more restrictive view on access to social provisions for undocumented migrants.

Mental Health Care

Access to mental health care for undocumented migrants is problematic, since in Belgium this is provided mostly by psychologists and not by psychiatrists. Psychologists however are not allowed to sign for urgent medical care, and as a consequence medication can not be provided.

According to the Royal Decree on urgent medical help psychiatric clinics are not regarded as 'health institutions', nor are the shelters and clinics which supply follow-up psychiatric care. Therefore undocumented migrants have no access to these places, and can only be treated in the psychiatric units of general clinics. More and more of these general clinics are refusing preventive treatment, because they are aware of the fact that the necessary follow up care will not be available.

Dental Care

Also dentists are not allowed to sign for urgent medical care. Many doctors, however, are willing to sign an attestation for dental care.

Maternity Care

The only problem that is met with maternity care, is that undocumented migrants are on the average not very well informed on the existing possibilities. Therefore they tend for example to ask for help only in the very last stages of the pregnancy.

Minors

There are no special regulations for undocumented minors. In practice it turns out to be much easier to get access to health care and other social services for children. Unaccompanied minors are generally taken into special centres.

CONCLUSION / GENERAL REMARKS

MSF and the Medisch Steunpunt have a few experiences with people who are afraid, who are reluctant to come forward. However, this is not comparable to the situation in Germany, since in Belgium these people can be genuinely convinced that they will not be denounced by hospitals, doctors or social services.

One evolution that MSF tries to bring about, is to introduce these undocumented migrants into the normal system of access to health care. Certain OCMW/CPAS offices distribute 'medical cards' to poor Belgians, stating that the OCMW/CPAS will pay for any consultation. This eliminates the need for a new certificate every time the person goes to the doctor. MSF tries to apply this 'medical card system' to undocumented migrants as well. It is already done systematically for families with children. Their medical card serves for medical care, for medication and for normal follow ups. The most important, and unfortunately the most difficult, is to find a OCMW/CPAS that is willing to collaborate.

Lastly, MSF notes that there is a lack of appropriate services tuned to the specific population of newcomers. For migrants who have been here for several years there are many possibilities, but for newcomers it is often very difficult to find help, even if they can pay

for it. They are confronted with language, social and cultural problems, and very often with an incompetence regarding their specific pathologies.

As a conclusion it can be stated that the Belgian system of access to health care for undocumented migrants is in general well appreciated. The problems that are met are rather 'practical': very often it is a matter of being informed. Once people know how it works, the system creates a lot of possibilities.

RESIDENCE PERMITS ON MEDICAL GROUNDS IN BELGIUM

REGULARISATION CAMPAIGN

The 'Regularisation Law' of 22.01.2000 installed a single 'punctual' regularisation procedure, referred to as the 'Regularisation Campaign'. In the period from the 10th until the 30th of January 2000, all undocumented migrants living in Belgium and answering to certain conditions had the possibility to file a demand for regularisation.

One of the four qualification criteria for this regularisation was 'serious illness'. The final decisions on those files are still being made, but there is –so far – generally a positive outcome for those who are seriously ill.

ARTICLE 9 § 3

There exists also a 'permanent' possibility to obtain a residence permit on medical grounds. The legal insecurity on this part is however considerably great.

Article 9 §3 of the Belgian Aliens Law provides the possibility for permanent regularisation on certain humanitarian grounds. This article was clarified in a Circular of 15.12.1998, which consists of two parts. The first part explained the procedures and the rules, and

the second part dealt with the possible reasons for regularisation, i.e. serious illness. This second part however, has been suspended by the Regularisation Law of 22.01.2000 (Regularisation Campaign). Only the first part remains, which is in fact very vague and leaves (too) much space for discretionary jurisdiction. There is no specific procedure for those who are seriously ill. They can still apply on the basis of humanitarian reasons, but only through a rather unclear procedure. It is not clear as to when and how a file must be introduced, and when it will be treated. However, in practice, the old procedure is still living in the minds of everyone, the administration included.

Since article 9 §3 deals with regularisation from 3 months to indefinite, there is no legal text on residence permits for less than 3 months.

PROCEDURE

Concerning the procedure of article 9 §3, an advising doctor attached to the Foreign Office is deciding on extending the stay of a sick person. This doctor sometimes meets the patients and looks at the documents of their doctor. He checks both the medical diagnosis and the availability of the treatment in the home country. For this information his main sources are the embassies of the home countries. The Medisch Steunpunt for example would ask the undocumented migrants to prepare their own medical file and address non-governmental organisations such as MSF to obtain alternative reports. Sometimes the attestations of the doctors attached to the Foreign Office are not sufficiently clear, because the embassies are not always cooperative. There have been some court decisions where it was stated that the report of the Foreign Office did not contain enough details, and an alternative report was followed.

Article 9 only provides the possibility to obtain an extension of more than three months. The duration of the extension depends upon the

treatment or the illness. Normally, obtaining an extension is in itself not so difficult, it is rather the long waiting period before a decision is taken that is problematic. Sometimes a person has to wait for years, other times it goes quite quickly. There is mostly no explanation as to why one person's case goes very fast whereas another case, in the same circumstances (with the same illness), takes much more time.

When asking for an extension of less than three months, no procedure exists. In practice this can be asked for at the Foreign Office. Whether you obtain it or not, and the length of time you have to wait for it, is again very difficult to determine.

The experience with the decisions of the Foreign Office is that the outcome is mostly negative, but most decisions can be successfully contested: jurisdiction in this matter seems to be more positive than the practice at the Foreign Office. The European Court of Human Rights appears to be moving in the same direction.

PROBLEMATIC POINTS

One difficulty with article 9 § 3 is that the undocumented migrant makes known his/her name and address. There are no cases known however of the Foreign Office abusing this information.

Another difficulty is the professional discretion of the doctors. Many doctors refer to this confidentiality refusing to supply extensive medical reports for the regularisation application. Before the Regularisation Law of 22.01.2000 changed the procedure, things were more clear. Doctors would put their medical reports in a closed envelope, and that envelope would be treated by a professional doctor. In the present situation, there is no guarantee anymore that the dossier will be treated by a professional doctor, it could as well be a lay worker who analyses the file. The doctors have the possibility to fill out a 'standard form', not mentioning the diagnosis but only giving some discrete directions. However, this is not an

optimal solution since in that case the final decision can be wrong because of being based on vague and inadequate information.

Problems are met with psychiatric patients. Their applications are mostly treated with a considerable delay, if treated at all. Due to an inadequate medico-social follow-up, it is rather difficult to compose a file for these patients.

Lastly two groups should be mentioned that are in a particularly complicated situation: 'tourists' and (certain categories of) people that received an order to leave the territory. Their situation is extremely paradoxical. Tourists, as mentioned above, have in general no right to health care. They can not have a normal health insurance, nor are they eligible for support of the OCMW/CPAS, meaning 'urgent medical care'. When they ask for a residence permit based on medical grounds, their visa will be extended, meaning that their access to health care is still not assured.³ The same counts for people who received an order to leave the territory. When asking for a residence on medical grounds, they will receive an extension of this order. This means that they are still 'illegal' in the eyes of the regular health insurance, but 'legal' in the eyes of the OCMW/CPAS, and as a consequence ineligible to apply for urgent medical care.

There is some debate if those categories actually do have the right to health care or not. In practice, their right to 'urgent medical care' will be recognized if they go to court. But again, if the help needed is really 'urgent', it is not possible to follow the long court procedure.

As long as the decision is not clear as to whether a person will receive treatment, he maintains his previous status; if he was a tourist he remains a tourist, if he was illegal he remains illegal.

³ This means that it might be wiser for tourists to let their visa expire, and then apply for 'urgent medical help' as an 'undocumented migrant'.

Chapter III: Germany

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN GERMANY

MIGRATION

For further understanding, a brief description of the foreigners law and the different kinds of legal residence permits for asylum seekers and other migrants will be given in the following.

Political Background

In 1993, the basic right to seek asylum in Germany was factually abrogated by an amendment to the Asylum Act under the conservative government. This amendment was an official response to the rising number of people seeking political asylum from crisis areas all over the world, whilst at the same time accommodating the more hard-line values of a society marked by a history of racism.

Mass media publications have ignored, and continue to do so, the reasons and often tragic circumstances by which one becomes a refugee, speaking instead of an 'overflow of foreigners' and 'over-foreignisation' ('Überfremdung'). Although the Federal Republic has been a country of immigration since the 1960s, this fact is denied in public and political discourse.

German immigration and asylum legislation distinguishes between a number of residential statuses⁴, and between two offices being responsible for the practical affairs of foreigners (healthcare, housing, etc.): the 'Ausländerbehörde' (Office for Foreign Affairs),

⁴ Different kinds of residence permits in descending order of rights: Aufenthaltsgenehmigung (Residence Authorisation), Aufenthaltsbewilligung (Residence title for special purposes); Aufenthaltserlaubnis (Residence title for exceptional purposes); Aufenthaltserlaubnis (Residence permit); Duldung (Temporary Suspension of Deportation)

which is connected to the local authorities, and the 'Bundesamt für die Anerkennung ausländischer Flüchtlinge' (State Department for the Recognition of Foreign Refugees).

Asylum Seekers

In 1993 the Conservative Government passed § 1a 'Asylbewerberleistungsgesetz' (material asylum law) which decrees that benefits for foreigners who had entered Germany only in order to obtain welfare support, were to be cancelled. The criteria of how to differentiate between bogus claimants and people in need were not specified. This selection process places the entirety of an ethical evaluation in the hands of an office clerk trained to administer, decisions are merely based on the grounds of a personal and ultimately arbitrary opinion.

There is strong evidence that many migrants prefer not to apply for asylum at all, considering the extreme low rate of recognition (about 4%) of political or humanitarian refugees as promoted by the restrictive legislature of the modified Asylum Act.

Benefits for asylum seekers are paid in accordance with the 'Asylbewerberleistungsgesetz' and only amount to 80% of the comparable level of welfare support available to full status residents. Applicants are usually eligible to 40 Euros in pocket money a month. Housing is provided, with up to six people sharing a room, each of them entitled to 6 square meters of space and food provisions. Medical care is provided only for 'acute diseases'.

Temporary Suspension of Deportation ('Duldung')

'Temporary Suspension of Deportation' is a residence status given to migrants whose application for asylum has not been accepted but can not return or be sent back e. g. to a country where there is a civil war, or to migrants who can not be sent back due to medical reasons. A refugee living on a 'Duldung' is excluded from obtaining a work permit and must not leave the county of placement.

With regard to the various status of registration available, the 'Duldung' is the most regulated type of residence permit and gives the fewest rights and consequently the worst living conditions. It is time-limited and has to be renewed every 3 to 6 months. Refugees and migrants on a 'Duldung' should, in theory, have access to medical care by collecting an insurance form at their local Social Welfare Centre (see 'Asylbewerberleistungsgesetz'). However, especially in Berlin, clerks often refuse to hand out the relevant form, a practice that is both prominent and illegal⁵. Medical care is equally restricted to 'acute disease'.

Illegalised Migrants in Germany

An estimated number of five hundred thousand to one million illegalised migrants are currently living in Germany, a figure repeatedly quoted by welfare institutions and politicians alike. Illegalised migrants possess neither a residence permit nor the most elementary administrative status, that of the 'Duldung'. Other than e.g. using the term 'Sans Papiers' in France, migrants without any status of residency are classified as 'illegal' in Germany. Within public discourse the media, as well as some political parties, reiterate the association of 'illegal' and 'criminal' with reference to this group. Therefore, supporting groups talk consciously about 'illegalised' to accentuate the administrative process of the deprivation of rights.

The living conditions in 'illegality' are principally marked by the wholesale relinquishment of all legal rights. Adults work in the building and catering trades, as cleaning contractors, in the care services or in prostitution, without social security, health insurance, and for a cut-rate wage. Working hours as well as health and safety regulations are rarely taken into consideration, and wages are often not paid at all. Despite a ten-year compulsory education laid down in the German law (as well as in the Geneva Convention) children do not have an official right of access to nursery schools or education.

⁵ Georg Classen (2000): Krankenhilfe nach dem Asylbewerberleistungsgesetz

Housing conditions are dismal and unsafe, because they are usually organised by third parties: the rents are far too expensive, the living space is too small and of a bad standard. Malnutrition is due to the bad economical situation. Illegal immigrants lack any form of social and cultural support and are precluded from the most elementary social and political rights. In addition, they live in constant fear of being denounced as illegal immigrants by neighbours, during a ticket control in public transport etc. A simple ID-card control, a measure of repression which German police carries out regularly on persons not corresponding to the northern European visual type found in public places without any grounds of suspicion for criminal activity, always leads to detention and subsequent deportation. Every step in public is guided by fear and insecurity.

LEGAL CONDITIONS

There are two 'problematic' parts in the German Aliens Law (Ausländergesetz) with reference to undocumented migrants. Firstly the section on 'denunciation' and secondly the paragraph referring to 'smuggling in of foreigners'.

Concerning the first, the section on 'denunciation', paragraph 76 says that any member of an official board must pass on any data regarding individuals without permit of residence to the relevant sections of the ministry of the interior.⁶ Any member of any public office is obliged to do this, immediately and without being asked.

⁶ '§76 AuslG: Transmission to registration office for foreigners:

(2) Public boards have to inform the registration office of foreigners at once if they receive knowledge of:

- a) the stay of a foreigner who does not have any kind of residence permit or '„Duldung' (Convenience of Authorities)',
- b) the offence against a local restriction or
- c) any other reason for deportation, (...)

(5) The federal ministry of the Interior lays down (...) that all

- a. registration offices
- b. offices for state-affairs
- c. passport offices

That means that even though undocumented migrants can theoretically apply for money at the social welfare centre (since they are legally considered as ‘persons obligated to leave the country’ whose rights are mentioned in § 53 AuslG) this centre is obliged to denounce them, which will lead to deportation.

Regarding state hospitals, the situation is rather unclear. In a recent publication on the status of undocumented migrants in German law, Rolf Fodor stated that hospitals are not seen as ‘public offices’. However, these hospitals are only refunded for people without insurance from the day they report it to the social welfare centre.

Secondly, there is another paragraph within the Aliens Law, which refers to ‘smuggling in of foreigners’. Article 92a, Abs.1 states clearly that anyone that helps people without documents can be punished.⁷

So even though medical doctors are bound by the Hippocratic oath to give medical treatment to people in need, it is punishable for them to help undocumented migrants.

The living conditions of migrants without any legal residence permit are a factual contravention of the Human Right to medical care.⁸

-
- d. Social Welfare Centres and youth boards
 - e. justice-, police- and offices for regulations.
 - f. Jobcentres
 - g. Revenue and declaration offices
 - h. Trading offices

must, without any request of the registration office for foreigners, inform them about all personal facts of any foreigner...

⁷ Notorious are the ‘taxi driver trials’. Taxi drivers transporting undocumented migrants near the border of Poland were condemned and imprisoned. They had their licences taken away. Since these trials, taxi drivers now always check papers of the people they are transporting, unless these people are clearly German.

⁸ ‘Everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing, and medical care and necessary social services.’ Universal Declaration of Human Rights, article 25 (1).

This basic right was formalised in the General Comment to art. 12 (2) of the International Covenant on Economic, Social and Cultural Laws. The right to a maximum level of health care for everyone obliges the ratifying states to provide an infrastructure, and access to that infrastructure, securing medical aid for everybody in need.

HEALTH

Health status and access to medical care is subject to many speculations. The following section is based on the experience of projects and information centres working for 'illegalised migrants'.

Epidemiological Data

So far, no epidemiological data concerning the health situation of undocumented migrants living in Germany has been collected. According to the experience of advisory boards, the spectrum of diseases affecting this group is similar to that of other Western European populations. Tropical diseases or infectious viruses and other exotic illnesses are exceptional.

According to the 'healthy migrant effect', it is alleged that the younger and healthier persons are, the more likely they are to migrate. In view of this effect, undocumented migrants are usually healthier upon entering the country than their comparable German counterpart. Yet the factors of both the unfavourable living conditions of 'illegality' and of not having access to the health care system gives way to a negative influence on the overall health of migrants. This disadvantage is not only compensating for the 'healthy migrant effect', but builds up to a comparably worse health status and thus higher social inequality in the future.

Seeking Treatment

In the event of an illness most undocumented migrants initially try to solve the problem on their own by self-medication or by referring to other non-professionals within their community. It seems that

some communities have access to health professionals of their own origin. If patients cannot organise treatment within their community or if the treatment fails to cure, only then do they seek professional assistance, thus delaying treatment at a considerable risk to their own health.

Stepping out of anonymity and into the public health care system is accompanied by the danger of looming deportation. A small number of undocumented migrants have supporting friends or are aware of the existence of networks like 'Büro für medizinische Flüchtlingshilfe'. Therefore only a minority has easy and safe access to professional medical treatment.

Additionally the German health care system is not hospitable to foreigners. The experiences of the first migrant workers in the 1960's highlighted a variety of cultural and linguistic deficits in communication and understanding. On the one hand, it is extremely difficult to give an accurate report about one's health complaints in a foreign language. Physicians will only call for professional medical interpreters in exceptional situations, relying on the patient's family members or non-trained members of staff instead. Written information is usually available only in German. On the other hand, the people themselves adhere to different subjective or culturally based concepts of health, not all of them are compatible to Western views of medicine.

Public Health and Infectious Diseases

The public health system in Germany is not a national affair, although the State covers certain subjects when there is an interest in public health (infectious diseases, hygiene, etc.) through public health offices ('Gesundheitsämter'). The new Law for Contagious Diseases ('Infektionsschutzgesetz') regulates that some infectious diseases, such as Tuberculosis, are diagnosed and treated anonymously and free of charge at public health offices. Vaccinations for children are offered by some cooperating public health services ('Öffentlicher Gesundheitsdienst') without verification

of residence status. Sexually transmitted diseases (STD) such as Syphilis, Gonorrhoea etc. are diagnosed anonymously and free of charge, some are also treated by the STD departments of the public health offices. HIV and AIDS diagnosis is also anonymous and free of charge. Treatment, however, is not paid for unless migrants qualify for at least the minimal status of residence, the 'Duldung'.

Besides these institutions the public health systems divides clients into in- and outpatients. Outpatients are usually treated in private practices by general practitioners or specialists.

Health Insurances

About 90% of the population participate in one of various 'Krankenkassen' in an obligatory health insurance system. Others have access to private health insurance due to their professional self-employment or their high income. In either case a residence permit is a precondition for access to any health insurance scheme. The obligatory health insurance system is linked to employment or to the family where at least one person is legally employed, studying or temporarily unemployed. For the long-term unemployed, homeless persons, asylum seekers and refugees, the Social Welfare Centre covers the cost of health insurance.

Emergency and Hospital Care

In case of an emergency⁹, all hospitals, emergency units and general practitioners are obliged by law to provide medical treatment. This law of obligation does not differentiate between patients with a residence permit or health insurance and those without and is frequently cited by politicians and councils alike as proof of the adequacy of medical care available to undocumented migrants.

⁹ Emergency by definition is 'an acute, life-threatening situation (disturbance of respiration, cardio circulatory function, consciousness, water-, electrolyte- and acid-base balance) or danger of irreversible damage of organs because of trauma, acute illness or intoxication'. Nevertheless, the definition of an emergency is widely dependent upon the treating physician, even in emergency units.

The reality, however, is different. If a person does not hold an insurance card, hospitals usually try to find a substitute person or institution that can be held responsible for medical costs, usually before treatment has even commenced. Hospital staff are instructed to insist on signed documentation by patients or accompanying persons, agreeing to cost coverage. Often this is sidestepped by patients accidentally declaring themselves as private patients, this in turn increases the cost of treatment by a factor of 2,3. When emergency treatment is followed up by an operation or long-term hospitalisation, bills can easily rise to thousands of Deutsche Marks.¹⁰ There have been reports of hospitals retaining personal documents such as the passports of patients in order to enforce payment. Some hospitals do not hesitate to call the police at the point of admission in order to clarify uncertain status of residence and insurance before treatment commences.¹¹ As a consequence, patients are threatened with deportation after treatment has been completed. In other cases hospitals may arrange the 'deportation' of patients at their own cost, i.e. in an ambulance to countries such as Poland or Ukraine, as this transportation is less expensive than treatment in a German hospital.¹²

¹⁰ A 30-year-old man from Latin America came to the emergency unit of a hospital in Berlin, suffering severe stomach pain. The physician diagnosed a perforated stomach ulcer, which had to be operated on urgently. During the emergency situation his family had signed to pay the costs. Some days later he received a bill of about 10.000 Euro.

¹¹ An African woman had been treated in the emergency department of a university hospital for fever, infection and weakness. Since upon entering the hospital she had shown the wrong insurance card, the hospital administration became suspicious and they called the police to clarify the situation. The police took her to the police station, and a few hours later she was brought to another emergency department with a broken arm. The arm was fixed and plastered for the night and an operation was planned for the next day. The woman, however, left before the operation because she feared she would be deported immediately afterwards.

¹²The hospital 'Charité' in Berlin forced a woman with a caesarean section to go back to Poland right after the operation since she could not afford the treatment. Regardless of her protest, she was forced to leave the hospital and made to sign a document stating that she was leaving of her own free will, to avoid that the hospital would be sued. Afterwards the hospital admitted that this was a standard procedure.

Other physicians and hospitals have admitted that they lower their standards of treatment in cases where insurance status could not be clarified in advance, for example by treating a fracture with a plaster dressing rather than fixing the fractured bone surgically. Fearing deportation, hospitalised undocumented migrants tend to discharge themselves from hospital before treatment has been completed.

In a study of the 'Berliner Flüchtlingsrat'¹³ hospitals were asked about unpaid bills from undocumented migrants. The result indicated that the outstanding debts were negligibly small.

Hospitals have the possibility to ask the Social Welfare Centre to refund the expenses for non-insured persons regardless of residential status. Complicated administration procedures and the reluctance of the social welfare centres to cover these costs make this inquiry very time consuming and of an uncertain outcome. Furthermore, not every hospital administration seems to know about this possibility. When social welfare centres are asked to cover expenses for treatment, they usually only refund the cost from the day of notification and not for the entirety of the patients stay. If a hospital notifies the Social Welfare Centre in case of an undocumented migrant, the institution is held by law (§ 76 AuslG) to inform the office for foreign affairs. The office for foreign affairs will inform the police, thus triggering the likely event of deportation.

Planned hospital treatments such as operations, treatment of chronic diseases, etc. are not available to 'illegals'. However a few exceptions exist of hospitals that have created social funds or special agreements for undocumented migrants.

General Practitioners, Specialists and Dentists

Outpatient care is usually performed in private offices by GPs, specialists and dentists. Upon their arrival patients have to present their medical insurance card or social security agreement from the

¹³ Berliner Flüchtlingsrat (Berlin refugee council) in E. Vorbroth „Kosten in Millionenhöhe“

Social Welfare Centre in order to receive medical treatment. Another possibility is to pay the treatment on a private basis. For illegalised migrants usually none of the above is possible. They might be treated with goodwill, but this does not seem very frequent. Even physicians willing to provide medical treatment free of charge, encounter problems in more complex treatments especially when laboratory diagnosis, x-ray or further consultations of specialists are needed.

Provision of Drugs

Except for Tuberculosis treatment, no other drugs are provided by the state for illegalised outpatients. Some low threshold medical treatment centres for the homeless ran by churches or non-governmental organisations might be able to distribute essential drugs.

Pregnancy and Maternity Care

Pregnant migrant women live in particularly complicated circumstances. Because of the severe social and psychological burden inflicted by a life in illegality, pregnancies of illegalised migrants are considered as high risk pregnancies by gynaecologists. The risk of an involuntary abortion or premature birth is increased dramatically among this group. Pregnant women are therefore in need of intensive pre- and postnatal care, as well as medical support during delivery. This topic will be further examined in the chapter on Residence Permits on medical grounds in Germany.

Abortion

If a pregnant woman decides not to have her child, she requires access to a medically accurate and safe abortion. According to German law abortion under 'social indication' is lawful until the 12th week of pregnancy¹⁴. A medical examination and a consultation, informing the mother about her legal rights to social security and other forms of child support is obligatory, and must be given at

¹⁴ §218 Strafgesetzbuch

least three days in advance of the date of the abortion. Meeting these requirements poses extraordinary organisational difficulties and psychological stress for undocumented women. In general, the state covers all expenses for an abortion, if the woman's income is below a fixed level, regardless of nationality or status of residence. Yet accessing the benefit system or asking a state institution for help and advice will again mean that the migration office will be notified.

Mental Health

For illegalised migrants suffering from mental illness no treatment possibilities exist, except for some psychiatrists or psychologists treating in their private consultation rooms. Refugees suffering from the physical and psychological effects of war and torture are to be considered as a special group. Post-traumatic stress disorder (PTSD) is widely accepted as a reason of acceptance for political asylum. Nevertheless, PTSD may not be accepted as a qualifying criterion for the granting of asylum, depending on political assessment and foreign policy¹⁵. If asylum is not granted on the basis of PTSD, migrants are likely to move into illegality, where they are unlikely to receive adequate treatment. Under these conditions an adequate therapeutic setting is not likely to be given. Furthermore one can foresee re-traumatizing effects, which can occur due to inhumane living conditions in asylum homes. The few existing therapy centres¹⁶ have only limited human and financial resources. Often one is on the waiting list for several months.

POLITICAL PERSPECTIVES

The presence of undocumented migrants, has been denied in public discourses in Germany for many years. It seems rather cynical when Barbara John, commissioner for migration in the Berlin Senate (CDU) cites 'Büro für medizinische Flüchtlingshilfe' in an official statement when questioned about health care for 'illegalised' migrants. With

¹⁵ Refugio München (1997), p. 87, Lützel, A. (1999)

¹⁶ e.g. Behandlungszentrum für Folteropfer, Berlin; Xenion, Berlin

reference to the service that had already been put in place by private initiatives like 'Büro für medizinische Flüchtlingshilfe', she asserted that there was no need for the government administration to intervene, thus effectively relinquishing her office from any further responsibility in the matter. In a more hard-line view, some politicians seem convinced that providing no health care for undocumented migrants will discourage other migrants to enter the country.

However, since 1999/2000 the first steps toward an official political discourse have been secured. In 1999 the public health office of the state of North Rhine Westphalia and Ms. Marie Luise Beck, the German commissioner for migration (Green party), organised a conference on health care for undocumented migrants. The Green party also held an experts Seminar about 'people without a residence permit'. At the 'Poverty and Health' congress held in Berlin in December 2000, the former minister of Health Andrea Fischer announced that health care for undocumented migrants was on her agenda. Since then, a special department of the Ministry of Health has committed itself to finding an adequate solution. Also in December 2000 the Berlin parliament called an expert hearing regarding the health and social situation of undocumented migrants in Berlin. In Berlin, Sr. Bührle, the commissioner for migration of the archiepiscopal ordinate of Berlin as well as the 'Berliner Flüchtlingsrat', the 'Polnischer Sozialrat' and some charity organisations are publicising the situation of undocumented migrants and are lobbying in order to introduce the issue on political boards. J. Alt and Sr. Bührle and a widespread alliance of people from universities, political parties and churches handed over a petition to the German parliament concerning the rights of undocumented migrants.

So far, all existing projects and concepts are of a more symbolic character, and are neither capable nor are intended to grant sufficient medical care for undocumented migrants. Other political and institutionalised solutions have to be found. Today, a variety of

proposals for the practical implementation of equal health care have been presented.

The solution seemingly favoured by the authorities tends toward an integration of undocumented migrants into the low threshold ambulatories for the homeless. Regardless of the fact that such ambulatories are fairly rare especially in more rural areas and do not have sufficient personnel and financial resources to meet the demand for health care assistance, this 'solution' is de facto, promoting a two class system of medical care.

Similarly, the proposed 'poverty fund' favoured by the Green party in Berlin appears unlikely to succeed, as the financing of such a fund will not be sustainable for as long as the status of illegalised migrants is not decriminalised at the same time. Funds tend to be very limited, so this solution would certainly lead towards a low budget migrant medical care. Funds already existing in Holland show that there are complicated application requirements that prevent some physicians and institutions from using it. The implementation of a parallel system is not necessary since laws already regulate that illegalised migrants are subject to the 'Asylbewerberleistungsgesetz'. Another proposal, the assignment of designated hospital beds for illegalised migrants is also flawed, as it cannot guarantee an equivalent and thus give adequate medical treatment.

All of the above mentioned solutions only make sense if §76 and §92a are abolished. Safe and equal access to medical health care can only exist when social and legal rights are guaranteed independently of a person's residence status. The central point of the difficulty in creating a health care system capable of serving both the eligible and the ineligible, then, seems to be the problem of rightful or unlawful residence, which ultimately will only be improved by a reversal and subsequent amendment of German immigration law and policy.

RESIDENCE PERMITS ON MEDICAL GROUNDS IN GERMANY

‘DULDUNG’

German immigration and asylum legislation distinguishes between a number of residential statuses: Aufenthaltsgenehmigung (Residence Authorisation), Aufenthaltsbewilligung (Residence title for special purposes); Aufenthaltbefugnis (Residence title for exceptional purposes); Aufenthaltserlaubnis (Residence permit) and Duldung (Temporary Suspension of Deportation).

Seriously mentally and physically ill illegalised migrants can apply for the lowest residence permit, a ‘Duldung’ issued by the Office for Foreign Affairs. This permit is not given for the duration of the treatment, but is valid for up to six months and usually has to be renewed every three months by a doctor’s certificate, stating that the treatment is still necessary. The holders of these permits are not allowed to work or leave the community where they are registered. It does includes benefits such as vouchers, living in homes.

A first problematic point that is met when qualifying for a residence permit because of an illness, is that the person has to prove his identity. Especially for rejected asylum seekers who don’t possess any identity documents anymore, this can be rather complicated. In practice this identity proof can only be delivered successfully with the help of a specialised lawyer. Apart from the identity certificate, other documents are needed depending on the ground on which a residence permit is asked.

GROUND

Juridical distinction is drawn between the ‘inability to travel’ on the one hand, and ‘threatening danger to someone’s body, life or health due to inadequate access to medical treatment in the country of origin’ on the other hand (§53 AuslG). As to access to treatment in

the country of origin, it is rather vague on which basis the decisions are taken. Some specific grounds will be highlighted below.

Concerning the inability to travel a valid medical certificate of the treating doctor is needed. Obtaining this could be problematic since the doctor might not have sufficient knowledge about how to write a proper medical certificate according to guidelines of the Office for Foreign Affairs.

Before deportation, an official doctor investigates whether the person to be deported is able to travel. No investigation is made into other aspects, since it is assumed that everything has been dealt with in the asylum process. The central question is whether or not the person will arrive in his country alive.

SPECIFIC SITUATIONS

Post Traumatic Stress Disorder

People who suffer from a post traumatic stress disorder (PTSD) are able to get a 'Duldung' if they have a medical certificate proving their illness. The problem is that PTSD is not a diagnosis you can see at once, it rather reveals itself during further treatment. The fact that people suffer from their living conditions, has a re-traumatizing effect. This doubles the problems.

It is difficult to have PTSD recognized. In Berlin for example special police doctors, having no psychiatric qualification, would examine the patient again, often coming to different conclusions. Against the specialist who made the first certificate, it is then held that he acted dishonestly in favour of the refugee. The centres for treating torture victims that exist in certain parts of Germany have formed a working group, which tries to make rules as to how a certificate should be formulated, in order to set a standard for the whole federal republic.

Due to political campaigns, supported by the IPPNW and others, refugees from the former Yugoslavia/Bosnia who are diagnosed with

a PTSD¹⁷ can apply for a residence permit which allows all members of a family to work legally, to choose their place to live and in case of unemployment, to claim benefits. This progress is, however, applicable only to this limited group of people. Political intentions behind become obvious, considering the fact that Kurdish people from Turkey with PTSD do not easily obtain any kind of residence permit¹⁸.

HIV / AIDS

In case of an HIV infection or AIDS a 'Duldung' can be given. Yet treatment on a 3 up to 6 months basis, as well as the living conditions of a 'Duldung' are inappropriate for these patients. If a HIV-positive person for this reason applies for a residence permit for special purposes ('Aufenthaltsbefugnis') at the Office for Foreign Affairs due to the absence of medical facilities in his country of origin, or due to his inability to pay for treatment in that country, then he will be referred to the 'State Department for Recognition of Foreign Refugees'. At this State Department the refugee needs to apply for a 'clarification of status of deportability' referring to the above mentioned article 53 AuslG. Usually this application is refused on the grounds that HIV-infection does not concern the refugee as an individual but afflicts a larger group within the relevant country of origin. Statements of this kind are backed by figures verifying the degree of 'epidemic penetration' in that country's population. For the entire population of that country who, arguably, are all endangered, to enter the country would require a general political decision (§ 54 AuslG), which in most cases is obsolete. So usually, if a person is not in danger of life, he will be sent back.

Also the treatment standards in each country are addressed. If there is no treatment in a certain country, than the argument again is that in that country, there is usually no treatment, so it is not possible to make an exception for one person. This means that a person coming from Congo with AIDS, could not stay in Germany because there is

¹⁷ Summerfield 1997, Lützel 1999

¹⁸ Medico international 1997

no law that allows all HIV persons to stay. Even with a certificate, which says there is no treatment in Congo, the person will not be allowed to stay because it is 'normal' that nobody gets treated in Congo.

Maternity Care

During the period of maternity, which has a juridical duration of 6 weeks before until 8 weeks¹⁹ after delivery, undocumented pregnant women have the possibility to legalise their status of residence. They need to register and apply for a residence status at the migration office. The most basic form of a residence permit the 'Duldung' is granted on the grounds of their inability to travel due to medical reasons. The 'Duldung' authorizes access to medical treatment such as preventive care and care after delivery in a hospital. The newborn child will receive a birth certificate if the mother holds a valid residence permit. After the period of legally protected maternity, woman and child are stripped of their residence status and, since the authorities know their names and address of residency, deportation is very likely.

If a pregnant woman decides not to apply for a legal status of residence, delivering her child at home instead or as a private, self-paying patient in a hospital, the child too is born into illegality, as it is impossible to obtain a birth certificate due to the unregistered status of its mother. Without a birth certificate, the mother cannot prove parenthood and the child may subsequently be taken away from her (e.g. in case of deportation). A birth certificate is only handed out to parents with a valid passport, residence permit and current address. If a birth certificate is not collected at the registry office within 4 weeks, data concerning the mother is passed on to office of foreign affairs (§76 Abs. 2AuslG). Hospitals automatically transmit data of the mother and the newborn child to the registry office regardless of residence status.

¹⁹ Up to 12 weeks in case of premature birth or twins

Carers

For a person visiting somebody with a terminal illness (and the right to remain in Germany), it is mostly rather easy to obtain an extension of the residence permit to stay with the ill person.

JURISDICTION

There are various rulings by administrative courts, supreme administrative courts and even by the High Court relevant to this subject. The tenor of these decisions is that an assessment of individual cases is carried out only in situations of extreme danger to the applicant, in which case detention or deportation would conflict with German constitutional law. Such individual assessment is rarely granted and feasible only in cases where the patient's health has deteriorated significantly already.

Furthermore, the German High Court ruled (Dec. 8th 1998) that a differentiation in protection from deportation, which assesses an applicant's status of endangerment with regard to him being threatened as a group member or as an individual, is in accordance with German law.²⁰

²⁰ Fluchtpunkt Hamburg (2000)

Chapter IV: The Netherlands

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN THE NETHERLANDS

CATEGORIES

‘Undocumented migrants’ are considered to be those people from abroad without a permit to stay in the Netherlands. When addressing the topic of access to health care however, there are some other groups that face difficulties based on their residence status. Both the so called ‘Dublin Claimants’²¹ and people who make a second asylum request, based on new evidence, are put on the street without any rights to health care, money or housing. People who are in the procedure for a residence permit face the same problems.

For people who are in the asylum procedure, a special insurance organisation exists. Apart from IVF and transsexual operations, they have access to all medical care. As soon as their asylum claim is rejected, asylum seekers lose this right. Although a rejected asylum seeker is supposed to return to the country of origin, in some cases it is recognized by the Dutch authorities that this return is (due to various reasons) not possible. As a consequence, these people stay in the Netherlands without having the right to stay and without the possibility to leave.

All minors coming alone to the Netherlands are automatically taken into the asylum procedure, and they receive both housing and legal protection up to eighteen years of age. Last year there were 6.000 unaccompanied minors; now there are some 15.000 minors in the custody of the national organisation which is taking care of them.

²¹ The Dublin Convention (1990) states that a person can apply for asylum only once, and this has to happen in the first ‘safe’ country where this person arrives. ‘Dublin Claimants’ are asylum seekers that are denied access to the asylum procedure based on this Convention.

THE LINKAGE LAW

The Law

The 'Koppelingswet', translated as the 'Linkage Law', which entered into force on 1 July 1998, deprives undocumented migrants of the right to health insurance. The law links this right, together with all other claims to collectively financed provisions, to the residence status.

It took a few years for this law to be passed mainly due to the resistance of human rights organisations and organisations of physicians (such as the Royal Dutch Doctors Organisation). All these organisations realised that denying the right to insurance for undocumented migrants would cause problems with accessing health care. In addition, there has been a critical review of the first draft of the law in the light of children's and women's rights.

Urgent Medical Care

The 'Koppelingswet' changed article 8b of the Dutch Aliens Act. This article says in its new version that undocumented migrants are only entitled to collectively financed provisions in case of 'urgent medical care' or for the prevention of breaches of public health. It was a precondition in the implementation of the Law that urgent medical care would still be available, and that the costs of this would not be on the providers.

Due to strong resistance, the minister responsible has changed the definition of 'urgent medical care', and stated on many occasions that every doctor has an obligation to help anybody regardless of his or her position in society, race, belief, etc. Instead of the word 'urgent', the term 'necessary' is used.

The official description of 'urgent medical care' is the following:

- In case – or for prevention – of life threatening situations, or in case – or for prevention – of situations of permanent loss of essential functions.

- In case there is a danger for a third party, e.g. certain contagious diseases (in particular TB) and for psychological disturbances and consequent aggressive behaviour.
- Pregnancy care (before and during birth).
- Access for children without a status to preventive Health Care and to a vaccination programme similar to the national vaccination programme.

Since the passing of the law, there have been a lot of misunderstandings of the meaning of ‘urgent medical care’ among doctors but especially by the financial departments of the hospitals. Human rights organisations such as the Johannes Wier Stichting see it as their task to inform health service staff of the exact meaning of the term.

The Linkage Fund

Two provisions have been taken to ensure that the costs for health care do not fall on the shoulders of the providers. The first provision is for the most costly part of the health care system, which is hospitalisation. Hospitals have a special write-off for unpaid bills (‘dubieuze debiteuren’). Since the entering into force of the Linkage Law, the amount of the budget of ‘dubieuze debiteuren’ is determined every year; before this happened on a three-yearly basis. It should be noted that the costs for hospitalisation of undocumented migrants are, by way of this provision of ‘dubieuze debiteuren’, in fact paid from the collectively financed provisions.

The second provision is the ‘Linkage Fund’ (Koppelingsfonds), installed for ‘first line aid’ (like doctors, obstetricians, pharmacies). This Fund, which contains 5 million Euro, does not serve to pay the bills of the patients, but rather to compensate the doctors for a loss of earnings. The 5 million Euro of the Fund are basically the savings from the other part of the law. The savings from social security, child support etc, were estimated at 5 million. It was a neutral budget solution, not based on an estimated need.

The Fund has been used now for two years. At first NGOs were fearing that 5 million Euro would not be enough, but it turns out that even these 5 million are not fully used. The problem is that it is very difficult to get an application accepted by the Fund. First, there are several cumulative conditions that have to be fulfilled. The health care provider should prove that the person is actually undocumented, that the costs for the health care cannot be claimed in any other way, that the provided care was urgent, and that the financial burden on the provider was 'excessive'. Furthermore, it is not possible for individual doctors to 'declare' unpaid bills of their patients. Applying for money from this Fund has to be seen as applying for subsidies. Applications have to be made by an institution, in the framework of a regional cooperation²². The money applied for should be an estimation of the costs in the coming year, based on the costs in previous years. In practice NGOs found the GGDs (Gemeentelijke Gezondheidsdiensten/ Communal Health Services) prepared to organise admission to health care.

Volunteer organisations (such as the Johannes Wier Stichting and many more) have done a lot of work on emphasising the difficulties of accessing this money. As a consequence, some adaptations have been made. The method of sending in financial claims to the fund is getting easier and the criteria of the board of the fund are becoming looser and looser. The tendency is toward a more normal claims system.

ACCES TO GPs AND HOSPITALS

The system in the Netherlands requires that every law has to be evaluated after 3, 4 or 5 years. For this reason, the government has commissioned some investigations on access to medical care for undocumented migrants. Based on the results of these investigations, the following can be stated.

²² Health providers from regions where such a regional cooperation does not exist can not apply for the Fund.

GPs

For access to general practitioners, the last investigation was done only very recently. (NIVEL, 2000) Interviews were held with general practitioners, midwives and first aid departments of hospitals in order to get an overview of this access. The conclusion of that investigation was that GPs are in general easily accessible. It is noted however that in certain areas in big cities with a concentration of foreigners (more than 10%), a limited percentage of GPs (5%) very regularly have undocumented patients in their consultations. Often there are a few GPs that have a reputation for rendering services to undocumented migrants; as a consequence the share of uninsured patients in their practice can be huge. (NIVEL, 2000:38)

As it is the individual care giver who decides whether they take a patient or not, patients themselves have no possibility to argue or to complain to any institution about not getting the help needed. Undocumented migrants are becoming more and more dependent on the few people who are willing and able to render these services, even though there are no juridical or financial obstacles.

In this context it has to be mentioned that 'De Witte Jas Health Centre' in Amsterdam, which has been providing medical care for undocumented migrants, announced that it would close down. Among the reasons given it was said that it was time that GPs took over responsibility for treating uninsured persons. By putting an end to its services, the Health Centre hopes to force members of the medical profession to provide care to clandestine immigrants and uninsured persons. (MNS, March 2001)

Hospitals

In practice access to hospitals is rather difficult. It might happen that the financial advisor of the hospital has an interview with the undocumented migrant as soon as they arrive to make an agreement on the bills. If they cannot agree and there is no life-threatening situation, the hospitals will not help. Certain hospitals accept payment in instalments afterwards. Some keep sending bills but

never really pursue them; however it may happen that a person who did not pay earlier bills is refused further treatment.

According to research cited above, 20 percent of all referrals to hospital are unsuccessful. (NIVEL, 2000: 39) Three reasons are given: the patient refuses to go to the hospital, the GP decides to treat the patient himself because of their uninsured status, or the hospital asks for a financial guarantee. These facts prove that sufficient knowledge of the existence of the 'dubieuze debiteuren' is still lacking. It is still necessary for the doctor who makes the referral to phone the financial directors of the hospitals, to inform them that this system exists.

In his extensive study on the life of undocumented migrants in the city of Rotterdam, Prof. Engbersen notes that the method of entering the hospital is crucial. (Engbersen and Burgers, 1999) If the patient enters via an outpatients' clinic, help can be refused, whereas if the person comes in via the emergency care, help is always given. Engbersen states furthermore that access to hospitals is more problematic than to general practitioners, since the tension between medical-ethical and financial-administrative aspects is bigger when they are not (like for a GP) united in one person.

DIFFERENT ASPECTS OF HEALTH CARE

Midwives

The results of the interviews with midwives are worrying. 50 percent of all midwives state that they have, at least once in their career, been called to a pregnant woman during delivery where there had been no prenatal check-up. That means that a lot of pregnant women do not seek help. However, every midwife (if she knows how to overcome this bureaucratic system) has the right to receive money from the Linkage Fund for her consultations and support during the delivery. Midwifery in the Netherlands is an independent service, having its own way to the Fund, separated from the general practitioners. (NIVEL, 2000: 54,55)

Mental Health Care

For mental health care there is officially no problem. It is paid for by another special fund that is similar to that of the National Health Service programme in the UK. It is accessible to everybody regardless of the type of insurance possessed. However, here as well problems exist. As most mental health problems are caused by social problems, many mental health care professionals consider it not worthwhile to treat somebody without changing the circumstances in which this person lives.

Tuberculosis

For TB patients it is possible, by way of a 'secret code' system, to stay anonymous in the public health service. The aim is to avoid a situation where individuals stop their treatment and in this way cause a danger to society. The person obtains as well a residence permit for the duration of the treatment. A lot of doctors are still unaware of the existence of this regulation.

Others

Dentists can get money from the Linkage Fund, but here the problem is that the Netherlands has a shortage of dentists. Physiotherapy, homecare, and maternity care are all officially paid for by the Fund if the care is considered by the doctor to be medically necessary. But again it must be stressed that many providers do not know how to find their way through the bureaucratic procedures.

CONCLUSIVE REMARKS

The Linkage Law has its advantages, one of which is a better monitoring and awareness of the situation. The public health regions already existing in the country see it now as their task to oversee access to health care for undocumented migrants. This 'institutionalisation' is a positive side effect of the rather negative law.

There have never before been so many studies on health care and undocumented migrants as since the latter have been deprived of health insurance: definitely a positive point. However, most research only takes into account those people who actually go to hospitals and GPs. It is still difficult to gain insight into the real health needs of undocumented migrants.

RESIDENCE PERMITS ON MEDICAL GROUNDS IN THE NETHERLANDS

PROCEDURE

There are several possibilities to get a residence permit on medical grounds in the Netherlands.

The Dutch Aliens Law states that people in an urgent medical situation cannot be sent back to their country of origin. They are given a temporary extension of the order to leave the country. When they have recovered, the order to leave the country is reinstated.

It is also possible to get a residence permit on medical grounds for the duration of the treatment (medical status). This can be changed into a permanent residence permit on humanitarian grounds if the disease is of a serious nature, and if the treatment is of longer duration and not available in the home country (humanitarian status).

In the Netherlands it is stated in law that the Minister of Justice, who handles the entire asylum procedure, has a discretionary authority to give permits for humanitarian reasons, including medical reasons. The medical advisors of the IND (Immigration and Naturalisation Service) assess the medical situation of a person and will then give positive or negative advice to the IND. The latter decides on the extension. Only 5 % of the asylum seekers are seen individually by the doctors of the medical advisory board; 95% of the advices are based on information provided by treatment providers as doctors,

psychologists, etc. Not all of the information submitting doctors are aware of the criteria, and certainly not all the treating doctors discuss the written reports with their client before sending in this document.

Regarding the grounds on which one can receive a residence permit, the medical advisory board must advise on 'availability' of medical treatment in the country of origin. They do not so easily make use of alternative reports on the situation. Moreover, their understanding of availability tends to be merely 'physical', there is no reference made to economic affordability and only exceptionally the political availability is mentioned, which was the case for example for the Kurds in western Turkey.

ROLE OF HEALTH CARE PROFESSIONALS

The fact that there is a medical authority, a medical advisory desk of the immigration service, means that the treating health professionals themselves do not have to advise. They are asked by lawyers to give their view on the treatment, as well as its effectiveness and length, but the formal advice is made by the medical advisory desk of the immigration service.

One sees an increasing discussion between professionals in health care on what role they should play in these types of questions. There are doctors who refuse to give this information, feeling that since the decision is made by the immigration service they would be used as chess pieces by lawyers and the immigration service. Others, who advocate it, see it as their chance to play an active role, to plea for their clients to get the permits granted.

Occasionally there is discussion on the contradiction within the role of the doctor, since effectiveness in treatment means an order to leave the country. It is thus not in the interest of the asylum seeker to get cured. As a professional the aim is recovery, but on the other hand it is important for the client to be unwell and to find someone

who can attest to the fact that it will take a long time to be cured. This contradiction also creates, especially in psychiatry, confusion between the aim and the ethic of work as a psychiatrist or psychotherapist. There are even in Holland a few psychiatrists who the immigration service knows offer the advice that an asylum seeker wants. The asylum seeker pays, and the professional writes positive advice to help them stay: one of the more cynical aspects of this medical process.

PROBLEMATIC POINTS

Difficulties in Obtaining a Medical Report

One of the problems that are met regarding residence permits on medical grounds is that both doctors and lawyers are insufficiently informed. Many people now suffer unnecessarily in the illegal circuit, living in fear. This could be avoided if doctors and lawyers knew the possibilities of obtaining residence permits.

Even when doctors are informed about the possibilities, it is not self evident to the illegal patient that they should obtain a medical report. Treatment is not automatically reported, sometimes because doctors refuse to do it, or because the report is too brief. In Holland many NGOs would take illegal patients to Amnesty International for medical treatment, or to another official institution, SMAK (Stichting Medisch Advies Kollektief). These organisations write medical reports. It is proven that a proper input makes a very big difference to the result. For example, there is the category of refugees who have been rejected in the first instance, and are identified by the Amnesty International refugee department as a high-risk group. They are given a medical assessment by a group of specialised Amnesty doctors and they are seen for about two to four hours; their whole history is reviewed and a proper lengthy and up-to-date report is written. Of the people that have such a report, between 50 and 80 percent actually obtain a residence permit, which compared to those with a non-specialised report, where the rate of success is below 10 percent, is very good.

Trauma

In Holland especially, but also in other counties, obtaining a medical report (as a basis for a residence permit) seems to be especially problematic for traumatised patients. Very often trauma only emerges after some time. A lot of people live quite normally for a long time and, at the moment when they are threatened with deportation back to the country where they have suffered, it will surface. Furthermore, the difficulty with psychological problems is that people react in very different ways.²³ There are also lots of incidents, particularly in the case of rape, where it is very hard to provide medical evidence.

EARLY FORENSIC STANDARD

PHAROS has a specific concern in relation to the question of residence permits on medical grounds and to the importance of medical information in individual cases. There seems to exist a suspicion in the immigration service and also in the courtroom towards the medical evidence given by asylum seekers. Conservative right wing politicians in the Netherlands tend to see permits for medical reasons as a loophole in the system. They have come to be seen as a way out, for people who cannot find a normal solution based on the Geneva Convention.

It is indeed true that medical aspects are mostly brought in only at the end of the asylum procedure. It happens very often that one's asylum claim is rejected, and then in a final stage the medical aspect is raised. PHAROS states that the main problem here is that medical problems are overlooked in the asylum procedure; medical aspects are not mentioned in the Geneva Convention of 1951. The first procedure is carried out by civil servants who are not trained in medical questions, and who have no training in questions such as

²³ For somebody who has been politically active and has been detained and tortured, it is almost expected. Often they will be able to deal with it far better than somebody who has had that experience in an arbitrary way and is thinking "why me?".

trauma. These are mostly overlooked. When the decision is negative one appeals, and must try to make a new point in the procedure. Medical problems such as trauma often come up as new evidence. PHAROS sees this as a structural failure in the procedure itself.

It is very important to integrate questions of medical situations into the beginning of the process of examining asylum requests. There is a lack of a standardised forensic examination early in the asylum procedure, which can be beneficial both for the treatment and for the legal aspect.

It has to be noted, that in the rather restrictive asylum procedure as it exists in the Netherlands, medical grounds can be perceived as a way out for *politicians*. When asylum is denied, but a residence permit is granted on medical grounds, that is a very efficient way for politicians to sail round difficult decisions. It allows the politicians a way to declare to the world that they have a humanitarian system. But it makes one question the role of the medical establishment in the asylum procedure.

EVOLUTION

About 5 or 6 years ago, if human rights abuses were reported, a humanitarian status was given. An evolution occurred however in the direction of giving victims of such abuses only a medical status, which is a temporary status and must be renewed or prolonged every year for the duration of the treatment. This tendency seemed also to correlate with the prolonged period of waiting for a decision from the IND and prolonged stay in crowded reception centres. The latest tendency is that people who are traumatised and who do get treatment are sent back to their country, to have their treatment there.

It seems that the whole trauma policy has been going downhill during recent years. There is some hope however, since trauma as a ground for asylum recently received more attention within the IND.

This growing awareness of the importance of trauma and its consequences might create possibilities to bring this topic on the political agenda.

Chapter V: United Kingdom

ACCESS TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN THE UNITED KINGDOM

GENERAL CONTEXT

Undocumented Migrants

The restrictions on entrance in the UK have got tighter over the last decades. Only twenty years ago people who were members of the commonwealth had a British passport, and could freely move in and out. This also applied to their families. Until quite recently it has been very easy to come in and out across borders, which has become very difficult now.

In official National Health Service documents, the term ‘illegal migrant’ is never mentioned. Undocumented and other migrants are talked about as ‘overseas visitors’, along with tourists and those coming to work in the UK. Several categories of people might be considered undocumented migrants, including economic migrants, rejected asylum seekers, people who have overstayed on work visas or visitors visas, etc. A new group of potential undocumented migrants are the ‘dispersed’ asylum seekers. The UK since recently has a policy of ‘dispersing’ asylum seekers around the country to try to relieve the burdens on London and other high density areas. There are an increasing number of people who have made an asylum claim but have left the area in which they are receiving support to rejoin family and friends in other areas, and are therefore no longer known to the agencies. This is likely to be an increasing problem.

Health Care

Contrary to the situation in many European countries, there is very little bureaucracy surrounding access to and payment for National Health Service (NHS) services. The principle set down in NHS regulations is that you always treat people first and think about charging them later. There is no requirement to ask someone how

the bill will be paid before admitting them to hospital. Besides this, prices are generally quite low in the UK.

The assumption in the UK is that health care is free at the point of delivery. There are some exceptions to that: some services you have to pay for (but it is usually a rather low fee).

The issue of health insurance is not very relevant. Although the UK does have some private health insurance schemes, people almost invariably have that as a 'top up' to NHS care just to help them to avoid the waiting lists, and to be treated at a convenient time.

The boundaries between health and social care in the UK are financially and politically constructed, and are moving the whole time. This is largely because social care is something that has to be paid for in the UK and which is means tested, whereas health care is free. As a consequence, it is very important to know what is health care and what is social care.

A 1999 government circular about eligibility of 'overseas visitors' to receive free health care says that the NHS is primarily for the benefit of people who live in the UK. It is therefore considered that eligibility to receive free medical treatment should relate to whether a person is 'ordinarily resident' in the UK and not to nationality, the payment of national insurance contributions or taxes. The important term throughout this discussion is whether somebody is ordinarily resident under English law, which is a matter to be decided by the courts rather than by the government. The courts have decided that somebody is ordinarily resident in the UK if they are lawfully living in the UK, voluntarily and for a settled purpose as part of the regular order of their lives for the time being. This wording is both precise and ambiguous, leaving a lot of scope to challenge the decisions. There is an idea that people who are coming to live in the UK for more than six months count as ordinarily resident. But this 'six months' is an arbitrary figure and it is not laid down in law.

PRIMARY MEDICAL CARE

General Practitioners (GPs) are independent practitioners, organised under the NHS, and provide primary medical care. GPs take people onto their list and receive a payment for having that person on their list from central funds. This 'capitation fee' is one of the main ways that GPs are paid.

The important fact is that GPs have absolute discretion to accept anybody on their list as an NHS patient. Although there are rules about who is eligible (see above), in fact it is entirely up to an individual doctor as to whether they accept someone or not. If they accept the patient, they must provide free treatment. They can either accept the patient as a permanent or as a temporary patient on the list. Temporary (meaning for less than three months) patients will not be offered a new patient screening check on registration, nor access to routine immunisation or cervical screening.

If an individual GP or GP practice does not want to accept a patient on their list, this patient is entirely free to go to another GP and see if they will accept him/her on their list. In practice a few GPs do a lot of work with asylum seekers, refugees and other ethnic minority groups including undocumented migrants, and locally one generally knows who they are.

GPs are encouraged by the government to accept patients on a paying basis if they do not want to accept them as NHS patients. If a GP takes on a private patient on their list, they keep the charges for themselves and their practice. There is therefore no benefit to the state in the GP doing that, there is only benefit to the individual GP.

Anybody who is a refugee, or who has made an application for refugee status, is treated as ordinarily resident and therefore they have access to all health care on the same basis as any other resident.

Urgent medical care is defined as ‘essential treatment, which cannot reasonably be delayed until the patient returns to his or her own country.’ Again, there is a lot of scope for people to interpret that as they will and it is left entirely up to the individual doctor.

The situation for dentists is a bit different to the situation for GPs in that there is no obligation on dentists in the UK to treat anyone, even someone with an urgent dental condition. Although officially you can get dentistry through the NHS, there are actually very few NHS dentists available at all in the UK now. For example Oxfordshire, which has a population of 600.000, has approximately 20 NHS dentists in the whole area. However if one can find a dental practice which is accepting NHS patients, they are very unlikely to ask any questions about immigration status. The only thing they are likely to ask is whether you are exempt from charges, since dentistry is one of the few things in the NHS that is charged for. Usually, the charges are rather low.

SECONDARY MEDICAL CARE

For specialists and hospitals the rules are slightly different. The basic rule is that ‘overseas visitors’ are charged for hospital treatment in the UK. However, there are two kinds of exemption from charges; one applies to particular categories of people and the other applies to particular categories of illness or treatment.

Exempt Categories of People

People are exempt of charges if they have been in the UK for twelve months. This may well apply to a lot of undocumented migrants, although they may not want to prove they have been here for twelve months. Also exempt is anyone who has come to the UK to take up permanent residence. These are obviously rather loose requirements. A patient who has been in the UK for less than twelve months, can always state he/she wishes to stay for good.

There are two more interesting categories of people exempt from charges. There is a list of countries with which the UK has reciprocal agreements to provide free hospital care for the residents of each. There is also a list which includes i.a. Romania and Poland, where residents, *irrespective of nationality*, can get free treatment in the UK. This means that people who are stateless but who have been living in that other country get free care in the UK. The other category of people exempt from charges is that of refugees and others who have 'sought refuge' in the UK. Since the hospital regulations do not specify 'claimed asylum', almost anybody could say they have sought refuge in the UK.

Exempt Services

Accident and emergency departments are free of charge. This extends to people admitted over night for observation. If people are admitted for longer than that there is a possibility of them being charged.

The diagnosis and treatment of communicable diseases and sexually transmitted diseases is free. There is a long list of diseases that qualify.

Another service that is free, is compulsory psychiatric treatment. If somebody is detained under the Mental Health Act, and forced to have treatment for a psychiatric condition, they get it free. If they come as a voluntary person they don't. There are two possible consequences of that. The first is that people (if they understand the regulations) will wait until there is a real crisis, the other is that doctors will collude in admitting people as a compulsory patient which, of course, has many human rights implications.

There are no NHS charges for district nursing (which is a sort of home visiting nursing), midwifery or health visiting (prenatal and post-natal care and care for young children), ambulance services or family planning services. However, there are some worrying anomalies: for example, midwives can treat any overseas visitor free,

and can go on carrying out regular checks for the first eighteen weeks of the baby's life. However, a patient is liable for charges for both deliveries in hospital and home delivery or community hospital delivery, so that covers any kind of delivery. The only situation whereby a pregnant woman of overseas residence will not be charged for a home delivery is if it not planned and became an emergency.

HIV and Aids are special cases in the UK, and the regulations are very complicated. Essentially, a person that does not fall into any of the categories of exempt people, is only allowed to have free a diagnostic test for HIV and the counselling associated with it. This person is not allowed to have any kind of hospital treatment or drug treatment for HIV and Aids. There is a lot of concern about this at the moment and the Terrence Higgins Trust, which is the major HIV charity in the UK, is actively involved in lobbying on this matter.

An increasing number of undocumented migrants are detained. There were 1500 places in detention centres in the UK but this is set to increase to four thousand within the next couple of years. Anybody who is detained, whether they are regarded as an illegal immigrant or not, has a right to free health care; however in practice access to health care (especially secondary health care) for detainees is extremely problematic at present. Similarly, anybody in a UK prison has a right to the prison health care system, which is currently different from the NHS.

PROBLEMATIC AREAS

Anybody who gets treatment on the NHS – especially hospital treatment – is subject to the same problems of waiting lists, staff shortages, closed wards (due to problems with recruiting nurses) and so on. So although undocumented migrants and others potentially have access to NHS services they may have to wait to get some of them, as do UK citizens.

Another problem, already mentioned above, is the policy of dispersal. Under this policy refugees and asylum seekers are being forced to go to areas of the country where the health service is inexperienced in caring for refugees; in these areas there is often very poor access to interpreters, and a lack of services tailored to their needs. These people are also cut off from their means of social support and that has a bearing on health in its widest sense. This dispersal system has created considerable difficulties for those trying to offer support to asylum seekers and others.

The fact that a district like Oxfordshire needed to develop a strategy to improve health and health care for asylum seekers goes to show that whatever is written in the official regulations, in practice it is often very hard for people to get access to care. In Oxford, a weekly open access health session has started. Such initiatives are necessary because of the institutionalised racism which is endemic in many public services in Britain.

RESIDENCE PERMITS ON MEDICAL GROUNDS IN THE UNITED KINGDOM

IMMIGRATION REGULATIONS AND HEALTH

The regulation of entry into and stay in the United Kingdom is governed by Part 1 of the Immigration Act 1971. The practice to be followed in the administration of the Act for regulating entry and stay is contained in statements of the rules laid by the Secretary of State before Parliament ('the Immigration Rules').

Section 3 (1) provides that a person who is not a British citizen shall not enter the United Kingdom unless given leave to do so in accordance with the provisions of the Act. Leave to enter may be granted for a limited or for an indefinite period.

Under section 4 (1) of the Act the power to grant or refuse leave to enter is exercised by immigration officers whereas the power to

grant leave to remain in the United Kingdom is exercised by the Secretary of State. These powers are exercisable by notice in writing given to the person affected.

Applicants may seek asylum, in which case they can stay in the UK while their case is decided. If it is turned down by the special immigration courts, applicants can appeal to the normal British judiciary through the High Court. (This process was 'streamlined' by the 1999 Immigration Act, which effectively shortened the number of appeals applicants could make through the Courts.) Applicants who successfully seek asylum may be given 'temporary leave to remain', 'exceptional leave to remain', 'indefinite leave to remain' or be given full refugee status.

Most undocumented migrants are either asylum seekers who have exhausted the appeal process above, or have had a visitor's visa (for travel or visiting family), a student visa (to study) or a work permit (to work) which has run out and not been renewed. They are known as 'overstayers' and liable to deportation if found.²⁴

There is no special law granting or extending residence for medical reasons. Ministers decide case by case. In some cases, when there is evidence that the absence of appropriate medical treatment will threaten the life of a person, people can obtain 'exceptional leave to remain' (ELR). ELR may be for a short period such as 6 or 12 months, or may be for the maximum period of 4 years, after which indefinite leave to remain is usually given.

The experience of lawyers working in this field is that people held in detention centres who have serious health problems are sometimes given exceptional leave to remain.

²⁴ [The best description of Immigration Controls current in the UK is 'Immigration Controls, The Family and the Welfare State', by Steve Cohen, 2001](#)

Also before deporting a person, the Home Office has to take account of any ‘compassionate circumstances’ including illness. (Part 13 of the ‘Immigration Rules’)

Those who have access to specialist lawyers who understand the system, have a better chance of getting special leave to remain. However, it is still rarely granted. Many people who might apply do not have the right lawyer, do not speak the language or do not know how to make the claim.

Establishing the lack of availability of the relevant medical treatment in the home country is usually a key issue, although there are cases where permission has been granted for health reasons on other grounds.²⁵ A case is known of a Canadian who got permission to stay in the UK. Obviously medical treatment would have been available to him in Canada, but all his friends were in the UK, his doctor, his counsellor, etc. as the person had lived in the UK for a long time.

SPECIFIC SITUATIONS

Torture

Establishing evidence of torture is part of the immigration decision making process around a person’s right to asylum. Each side can call their expert witnesses, advisors and specialists. There is no system of special ‘government doctors’ for this purpose, such as exist in other European countries.

AIDS/HIV

There are some clear policy guidelines on how to proceed in cases in which persons seeking to enter or remain in the United Kingdom are suffering from AIDS or are HIV-positive.

²⁵ It is unclear as to whether ‘not available’ is strictly not available or not affordable.

The Immigration and Nationality Department of the Home Office issued a policy document (BDI 3/95) on this subject in August 1995. A distinction is made between applications for leave to enter and applications for leave to remain. On applications for leave to enter (paragraph 4 of the guidelines), where the person is suffering from AIDS, the policy and practice is to adhere to the provisions of the Immigration Rules in the normal way. Where such a person does not qualify under the Rules, entry is refused.

On applications for leave to remain (paragraph 5 of the guidelines), the application should be dealt with normally on its merits under the applicable Rules. However, there is a discretion outside the Rules which can be exercised in strong compassionate circumstances. Paragraph 5.4 states that: "... there may be cases where it is apparent that there are no facilities for treatment available in the applicant's own country. Where evidence suggests that this absence of treatment significantly shortens the life expectancy of the applicant it will normally be appropriate to grant leave to remain."

People who can show that they are in an advanced state of the illness have a better chance of getting leave to remain. If the NHS has made a commitment to treating a certain person, that also strengthens his/her position, since the course of treatment should not be interrupted.

EUROPEAN COURT OF HUMAN RIGHTS

One example of a successful challenge in the European Court of Human Rights. is the case of 'D. v. the United Kingdom' (May 1997), where a person of St Kitts (Caribbean States) was imprisoned in the UK for drug trafficking. He turned out to be HIV positive. When he was released, he was due to be removed to St Kitts. The applicant's solicitors requested that the Secretary of State grant the applicant leave to remain on compassionate grounds since his removal to St Kitts would entail the loss of the medical treatment which he was currently receiving, thereby shortening his life expectancy. This

request was refused. In his letter of refusal addressed to the applicant's solicitors the Chief Immigration Officer stated:

"... While we are saddened to learn of Mr. D[...]s medical circumstances we do not accept, in line with Departmental Policy, that it is right generally or in the individual circumstances of this case, to allow an AIDS sufferer to remain here exceptionally when, as here, treatment in this country is carried out at public expense, under the National Health Service. Nor would it be fair to treat AIDS sufferers any differently from others suffering medical conditions ..."

The applicant applied unsuccessfully to the High Court for leave to apply for judicial review of the decision to refuse him leave to enter. Reports on the applicant's medical condition, treatment and prognosis were submitted in support of the application. The High Commission for the Eastern Caribbean States informed the doctor treating the applicant in prison that the medical facilities in St Kitts did not have the capacity to provide the medical treatment that he would require.

The applicant maintained that his removal to St Kitts would expose him to inhuman and degrading treatment in breach of Article 3 of the Convention, which provides: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." The European Court of Human Rights decided that "in the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, it must be concluded that the implementation of the decision to remove the applicant would be a violation of Article 3".

Chapter VI: DISCUSSION

INTRODUCTION

This chapter presents an account of the discussion which took place at the Experts Seminar on Healthcare for Undocumented Migrants held in Brussels on 22 and 23 March 2001. Following presentations from each country on access to health care and the possibility or otherwise of obtaining residence permits on medical grounds, several themes for discussion were identified:

- The need to standardise the regulations governing access to health care in different countries, and the development of a legal framework to support this.
- The need for central reporting and monitoring of arrangements for health care for undocumented migrants.
- The potential uses of an international medical database.
- The need for education on human rights and their application to undocumented migrants.
- The importance of professional confidentiality for those caring for undocumented migrants.
- The potential uses of 'Reporting Points' (a system to provide advice and collect information on the experience of health care professionals working with undocumented migrants).

LEGAL FRAMEWORK / STANDARDISATION OF REGULATIONS

Need

In the light of significant differences in the legal situation in different countries, and the shortcomings of some, there is a need to develop and promote an international legal framework to govern access to health care for undocumented migrants.

Because asylum and migration policy was moved from the third to the first pillar with the Amsterdam Treaty, European policy in this area is now developing rapidly. After a transitional period of 5 years,

asylum and migration (including issues related to illegal migration²⁶) will fall completely within the remit of the EU. It therefore follows that the issue of standardising national policies on access to health care for undocumented migrants should be addressed at the European level.

So far, EU rules have focused largely on the details of deportation arrangements, paying only limited attention to the status and the rights of illegalised migrants.²⁷ The Seminar delegates therefore agreed that it was important to draw up proposals for European regulations on the social rights of undocumented migrants. The need for such regulations was underlined by the German participants, who feel strongly that international regulations are the best remedy for the current dissension between different states within Germany.

There was some concern that the quest for a European standard on access to health care for undocumented migrants might result in a 'levelling down' of all countries to the lowest current standard. It was emphasised, therefore, that any such standard must respect basic social rights and the human dignity of undocumented migrants. (T.Braun)

The UK delegates made another point in support of the need for international regulations, explaining that the needs of undocumented migrants have, as yet, hardly been considered at all in this country, and that provision for asylum seekers and other documented migrants is not yet as far advanced in the UK as elsewhere. There is currently considerable political debate and negative publicity about asylum seekers, and the potential for this to escalate if the issue of undocumented migrants becomes more

²⁶ Article 63 (3)(b) of the Amsterdam Treaty states that the European Community has the power to adopt legislation concerning illegal migrants.

²⁷ The discussion among the participants of the Seminar focused for some time on terminology, and the negative connotations of the phrase 'illegal migrants.' The participants agreed that 'illegalised' or 'extralegal' were preferable, since it is laws which make people illegal rather than they themselves.

prominent. Although current UK regulations allow considerable scope for healthcare professionals to treat undocumented migrants, it is possible that the government may decide to tighten up the rules if too much attention is drawn to the possibilities which exist at present. (L. Peretz, A. Burnett) [In fact, since the Seminar took place, the UK government has announced a review of the regulations governing health care for 'overseas visitors'.]

Rational Arguments

The participants agreed that rational arguments are needed to support and promote the proposed regulations. When the reasons for excluding undocumented migrants from the health care system are examined, it is clear that there is some irrationality in government thinking.

In several countries undocumented migrants are denied access to mainstream health care, but there is often a separate system in place to provide for their health care needs. The Dutch system described in an earlier chapter is one example where such a 'bypass' generates a considerable amount of extra bureaucratic work. (R. Grotenhuis)

In Belgium, the cost of keeping sections of the population out of the health insurance system has been studied. At the time of the study, 200,000 Belgians were denied health insurance, for various reasons. It transpired that it was more expensive to exclude such people than to include them in the system. This led to a change in the rules, which now admit nearly all Belgians to health care insurance. (P. Ryckmans)

A study in Italy calculated that it would only cost 30 million Euros to provide all undocumented migrants with health care. As a consequence, the health care system in Italy has recently been opened up to everyone. (T. Braun) However, the openness of the new Italian system must be seen in the context of Italy's migration history. Unlike such countries as Belgium and the United Kingdom,

immigration into Italy and Spain has begun on a serious scale only recently. Attitudes in Italy might well evolve over time in the same restrictive direction as in other countries with a longer tradition of immigration.

Because of the difficulty undocumented migrants face in accessing health care, they often wait too long to go and see a doctor. As a result, their medical problems may get worse, and they may end up requiring more expensive treatment. This clearly increases the cost of health care unnecessarily and represents an inefficient use of resources.

These points illustrate the extra work and the extra costs associated with excluding certain groups from the health care system, and demonstrate that it is not rational to do so. The rational arguments in favour of providing health care for undocumented migrants should be drawn to the attention of the relevant authorities.

Negative Incentives for Migrants: an Irrational Argument?

The political argument that is frequently used to justify denying access to health care for undocumented migrants is that the better your welfare system is, the more migrants you attract.

The Seminar participants, who between them have considerable experience in working with undocumented migrants and have extensive personal contact with them, challenged the assumptions on which this argument is based. Very rarely do migrants chose a particular country because the health care system is better, and it is even less likely that potential migrants would stay away because of the absence of a good health care system. Furthermore, since it is often so complicated for individuals such as social workers (and indeed health care professionals) to find out about access to health care in their own country, it is hard to imagine that migrants coming from the other side of the globe have a clear idea on the availability of health care and the often subtle differences between European

countries. Nonetheless, this remains a favourite line of reasoning among politicians. (T. Braun, D. van Huystee)

Politicians and policy makers put a great deal of effort into prohibiting access to health care, but much less is done to prohibit undocumented migrants from working. As part of a honest and decent approach of the informal workers, one would expect that the resistance of decision makers against better access to health care would lose a bit of its harshness. The economic benefits resulting from these clandestine workers can not be double punished by excluding them from the basic social right to health care. (D. van Huystee, T. Braun)

Apart from being irrational, it is inhumane to deter potential migrants by denying their basic social rights. Governments have many other mechanisms available for controlling migration, and should not resort to violating human rights. (K. Fogelberg)

Details of the Proposed European Standard

Lastly, the content of the proposed international regulations governing access to health care was briefly addressed. Rather than encouraging the development of specific regulations on health care for undocumented migrants, it was agreed that these regulations should cover all categories and groups of people, emphasising the basic social rights of *all* people, regardless of their status.

REPORTING AND MONITORING

Closely related to the issues discussed in the preceding section is the question of how to establish and strengthen reporting and monitoring mechanisms.

Committee on Economic, Social and Cultural Rights

Shadow Reports

The International Covenant on Economic, Social and Cultural Rights, a UN Treaty that has been ratified or signed by more than 150

nations, includes a comprehensive statement on the right to health in international human rights law. According to Article 12(1), State parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” while article 12(2) enumerates, by way of illustration, a number of “steps to be taken by the State parties [...] to achieve the full realisation of this right”.²⁸

With a view to assisting State parties' implementation of the Covenant and the fulfilment of their reporting obligations, the General Comment focuses on the normative content of Article 12 (Part I), State Parties' obligations (Part II), violations (Part III), and implementation at the national level (Part IV), while Part V deals with the obligations of actors other than State Parties.²⁹

Paragraph 12 of the General Comment is of particular relevance to the issue of access to health care:

(1) Availability – functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary according to numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by WHO's Action Programme on Essential Drugs.

(2) Accessibility – health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

(i) Non-discrimination – health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections

²⁸ General Comment 14, UN Doc. E/C. 12/2000/4, art 2

²⁹ General Comment 14, UN Doc. E/C. 12/2000/4, art 6

of the population, in law and fact, without discrimination on any of the prohibited grounds.

(ii) Physical accessibility – health facilities, goods and services must be within safe physical reach for all parts of the population, especially for vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitary facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

(iii) Economic accessibility (affordability) – health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, have to be based on the principle of equity ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

(iv) Information accessibility – Accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(3) *Acceptability* – All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(4) *Quality* – As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”³⁰

³⁰ General Comment 14, UN Doc. E/C. 12/2000/4, para.12

All governments are invited to submit reports to the Committee responsible for Article 12 every 4 years, detailing the health care situation in their country. The committee also welcomes ‘shadow’ reports from other sources, such as non-governmental organisations. The General Comment gives such organisations the opportunity to call into question government reports on issues of importance, challenging human rights organisations to submit authoritative shadow reports, preferably in a standardised form. (A. van Es)

Guidelines for Health Care Workers

The Johannes Wier Foundation in Holland has produced draft guidelines for health care workers based on the contents of the General Comment. In the introduction, it states that “health professionals concerned about human rights can play a role, not only in protecting civil and political rights implicated in health issues, but also in ensuring that the right to health is fully implemented. The (...) Guidelines are intended to help health professionals understand the right to health and explore their own possible action to further its protection.”³¹

Reporting Points

The Johannes Wier Foundation has had a system of ‘Reporting Points’ (Meldpunten) for several years. Those who encounter problems or who have questions relating to health care for undocumented migrants can contact the organisation by phone or by e-mail. This system has several purposes:

1. Gathering examples of problems concerning access to health care for undocumented migrants.
2. Supporting individual workers in finding medical help for clients. This support ranges from advice to actively looking for the right medical help.
3. Analysing the examples gathered to find patterns and detect problems.

³¹ The Right to Health – Guidelines for Health Workers – draft March 2001

4. Undertaking action or encouraging others to take action where necessary, to address the problems identified.
5. Publishing the collected data. In case of serious problems JWS informs the Inspectorate of Health Care, which thereupon tries to solve the problem. The Dutch Parliament is informed about this procedure.³²

The Medisch Steunpunt Mensen Zonder Papieren in Belgium can be seen as a Belgian 'Reporting Point'. This organisation also addresses the issues arising from its experience with individual cases, and takes action where necessary at both the practical and the policy level.

The participants in the Seminar agreed that 'Reporting Points' could be extremely useful, and wished to encourage the development of similar systems in other countries. It would be valuable for 'Reporting Points' to share and disseminate their experiences, perhaps in the form of an exchange of Annual Reports. It was also suggested that these Reports be submitted to the Committee on Economic, Social and Cultural Rights.

In countries such as the UK, where no reporting system currently exists, the challenge might be to identify existing groups who might function as such, e.g. Physicians for Human Rights. (A. van Es)

Finally, the issue of individuals' access to the legal system was addressed. The European Court on Human Rights (ECHR) can rule in favour of undocumented migrants who have had difficulty in accessing health care, but it is not likely that many will avail themselves of this option. It is hardly a priority for most undocumented migrants to challenge national legislation, and moreover cases brought to the ECHR take a long time and cannot be

³² 'Meldpunt van Misstanden & Advisering bij Complexe hulpvragen mbt toegang en kwaliteit van de medische zorg voor illegaal in Nederland verblijvende vreemdelingen' (Johannes Wierstichting)

heard anonymously. Nonetheless, this option should be borne in mind by health professionals and lawyers.

MEDICAL DATABASE

Importance

Another topic covered during the discussion was the development of a medical database containing information on the availability and accessibility of medical care in different countries in the world, including those from which undocumented migrants come.

Based on her experience in the Medisch Steunpunt Mensen Zonder Papieren, Ellen Druyts gave several reasons why such a database is useful:

1. In Belgium, the official procedure for applying to extend residence permits on medical grounds requires that information is provided on the medical treatments available in applicant's home country.
2. When migrants resident in Belgium wish to bring their relatives to Belgium, the Medisch Steunpunt always checks initially what the health care situation is in the home country.
3. Migrants in Belgium but considering returning home voluntarily need to know whether they can have the same medical treatment in their home country as in Belgium.

In all these cases, reliable information on health care in other countries is essential.

In addition, Dr. Ryckmans from Médecins Sans Frontières (MSF) pointed out that information on health care in different countries gives MSF a clear idea as to what and where the problems are around the world, which helps with planning new projects. Thus the development of a medical database could have the long-term effect of improving health care in undocumented migrants' countries of origin.

MSF Database (P. Ryckmans)

Médecins Sans Frontières in Belgium has already set up a database which, though still at an early stage of development, covers more than forty countries thus far. MSF would like to see the database managed by another organisation eventually, but for the moment consider themselves in the best position to run it.

Anyone with a question about health care abroad (including the financial aspects of access to treatment) can interrogate the database. So far, requests have been received from countries like France, Belgium, the Netherlands and Switzerland. Standardisation is an important issue: contributors to the database need to know what kind of information is required, and in what format, by different countries. MSF takes into account the requirements of immigration services, whether they will accept information from the database and what their specifications are.

In Belgium, information from the database is well accepted in court. In Germany, such information is also regarded as important and is occasionally decisive.

At the moment, the database relies entirely on information from MSF field missions around the world,³³ which they can guarantee is reliable. MSF hopes to extend the database to include information on the local political situation, security matters and so on.

Practical information

Requests for information from the database should be sent by fax to:

Liesbeth Schockaert (MSF Belgium)

Fax: 00 32 (2) 474 75 75

The request should state clearly the country and the diagnosis of the client in question (as precisely as possible) and also the medical

³³ MSF is operational in about 80 countries

treatment and follow-up needed (including laboratory investigations, X-rays and so on). The name of the patient and his or her personal or medical history are not relevant and should not be included. The response will be sent by mail, and the request should indicate clearly to whom it should be addressed. If the treatment is not available, a certificate signed by the medical person responsible for the particular country will be sent. MSF asks expressly to be informed afterwards of the impact this certificate has had.

Governmental or Non-governmental?

The participants in the Seminar all agreed that the establishment and management of such a database should be a non-governmental, rather than a governmental, responsibility. It is essential to have not only official information, but also reports from alternative sources on the actual situation. Rachel Crowther gave the example of immunisation programmes: whilst the World Health Organisation has lists of official programmes in different countries, health care professionals need to know not what the official programme is, but what has actually been happening on the ground during periods of conflict and so on.

WHO cannot make unfavourable statements about health care in specific countries, for political reasons. NGOs therefore need their own, independent information network, which should safeguard the ability of observers to make a critical assessment of the local situation. (R. Grotenhuis)

The importance of such a database was endorsed by all present, and it was decided that funds should be sought to fund a report on the development of a more extensive database.

EDUCATION

Importance

The need to educate health care workers and the public at large about human rights, and to sensitise them to the importance of human rights issues, was recognised by all participants.

Such education should not only focus on medical and nursing students. Paramedics and administrative personnel also have an important role in promoting respect for human rights, despite a perception that only doctors and managers have any influence. (T.Braun)

It is also important to support people working with undocumented migrants, and to let them know that they are not alone. (P.Ryckmans)

Methodology

The Medisch Steunpunt offers training sessions in many settings, including high schools, and have also made an educational video. Video testimonies always have a tremendous impact. PICUM should explore the possibility of producing such a video, which could be subtitled in different languages.

The Johannes Wier Foundation has ten years experience of delivering a human rights education programme. As a consequence of their efforts to disseminate this programme, at least two universities in Holland will introduce human rights education in their formal curriculum. The experience of the Johannes Wier Foundation is that it is very useful to enlist the co-operation of medical faculties and medical students' organisations in promoting human rights education.

In the UK, Medact has promoted the teaching of Global Health Studies, including Human Rights, to students and is producing an updated version of its teaching pack. This includes social and

economic development, environmental change and pollution and the health implications of conflict.³⁴

The mass media represents a very effective way to reach a large audience. It is important to encourage the media to focus on human rights issues: this campaign should be taken up by large, authoritative organisations such as MSF, as well as smaller grass roots organisations, perhaps acting as a coalition.

Content of Training Programmes

Especially when working with medical professionals, it is important not just to present an ABC of Human Rights but to link the issues to concrete problems, such as: What to do with unpaid bills? How to manage hunger strikers? Students can be very enthusiastic if they have real issues to focus on, and PICUM should promote such an approach and encourage universities to take it up. (K. Fogelberg)

Besides education, sensitisation and the provision of information are important. There are many misconceptions about health and undocumented migrants, including the assumption that they spread disease. The Annual Reports mentioned above could include a list of the medical conditions experienced by undocumented migrants, in order to demonstrate that they are similar to those of other migrants (or indeed the host population). (T. Braun, D. Vanderslycke)

Ellen Druyts pointed out that the legal world, and the training of lawyers, should be considered as well. It would be very useful to circulate court rulings, for example.

The 'World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide' is an important reference in this context. The

³⁴ Contact Mike Rowson for further details at: Medact 601 Holloway Road, London, N19 4DJ / Tel 0207 272 2020 Fax 0207 281 5717 /E-mail: mikerowson@medact.org

51st World Medical Assembly, in Tel Aviv adopted this Resolution in October 1999:

- “1. Whereas Medical Ethics and Human Rights form an integral part of the work and culture of the medical profession; and
2. Whereas Medical Ethics and Human Rights form an integral part of the history, structure and objectives of the World Medical Association;
3. It is hereby resolved that the WMA strongly recommends to Medical Schools world-wide that the teaching of Medical Ethics and Human Rights be included as an obligatory course in their curricula.”

PROFESSIONAL CONFIDENTIALITY

A discussion about the meaning and importance of professional confidentiality was initiated by the German delegation. As mentioned in the earlier section describing the German presentation, it is unclear whether doctors are obliged to report undocumented migrants to the authorities, but it is clear that some do.

The Problem

Wiebke Würflinger gave an example which illustrates current political practices in Germany. Two doctors from Serbo-Croatia practicing in Berlin had treated a lot of people from Bosnia and, where appropriate, written medical reports attesting to the existence of post-traumatic stress disorder. However, they were eventually accused by the relevant police department of writing such certificates merely to please their patients, and not on the basis of genuine medical evidence. The police subsequently confiscated all the doctors' records. The doctors immediately made a legal claim to stop this practice, but the case is still pending and unfortunately did not arouse much protest among their medical colleagues. (W. Würflinger, G. Penteker)

The main problem in Germany is that, although doctors are bound by professional confidentiality, they are obliged to give patients' names if they want to be refunded for providing care for them. This means that bureaucratic regulations force them to give their patients away in the end. Doctors in public health offices, and therefore working for official bodies, are, moreover, obliged to report patients who are undocumented migrants at the outset. (W. Würflinger)

Defining Professional Confidentiality

In practice it is often the case that whilst doctors and other health workers might be reluctant to disclose medical details, they are prepared to reveal the name of someone they are treating. It is vital, therefore, to clarify what confidentiality means. (A. Burnett)

To avoid bureaucratic problems such as those encountered in Germany, professional confidentiality should extend to administrative staff. (T. Braun) W. Voogt pointed out that in the Netherlands doctors also have to follow bureaucratic procedures in order to be paid for treating patients, but do not have to give the names of patients.

Action Points

During the discussion, several suggestions were made as to the action that could be taken to address this important problem.

Judicial Action

Adriaan van Es observed that most countries have some legal provision exempting health professionals, and certainly doctors, from betraying patients, on grounds of professional secrecy. Even in Germany, a doctor can not be forced by law to report an illegal alien or undocumented worker. This legal protection is very important, and it needs to be reinforced through case law. Given victims who are willing to testify and a good lawyer, there would soon be a ruling in favour of professional confidentiality rather than in favour of reporting. Such cases could be taken as far as the European Court of Human Rights if necessary.

It could be very useful to have a 'chain of vigilance', comprising a lawyer or a group of lawyers who are prepared to take immediate action against those violating such rulings.

Ellen Druyts has drawn up a legal inventory of reasons why doctors are obliged to help undocumented migrants. This list can be helpful in supporting doctors in case of doubt about the legal aspects of the situation they find themselves in. Wil Voogt did the same for the Netherlands.

The Medical Profession

Another action point is to challenge the organisations within the medical profession. The profession itself needs to declare that health care is sacred, and not in any way connected to politics. In Belgian Law, professional confidentiality is a principle which is clearly accepted by government. (D. Vanderslycke)

In Belgium there is a Bio-Ethics Committee which has already taken a stand on this matter, declaring their agreement with the broad interpretation of medical confidentiality. Similar professional organisations in other countries should be brought together: PICUM could help to promote this. (D. Vanderslycke)

It should be made clear to health care staff that their position is one of independence. Current political discussion frequently creates an atmosphere in which it appears to be dangerous to help undocumented migrants, encouraging doctors and others to shy away from involvement. Instead, we should emphasise the responsibility of health care workers to look after all those who need their help. (R. Grotenhuis)

Chapter VII: Conclusions and Recommendations
PICUM Experts Seminar
‘Access to Health Care for Undocumented Migrants’
Brussels, 22 & 23 March 2001

Preamble

Acknowledging

The restrictive European policies which socially and administratively exclude undocumented migrants

Emphasizing

The right that the highest attainable standard of health for undocumented migrants should be accepted as a basic social right irrespective of their residence status

Recognizing

The importance of commitment of health and social care professionals to protect and promote human rights, especially the right to the highest attainable standard of health

Aware of

The importance of the principle of professional confidentiality for health professionals and the need to uphold this principle

The participants of the Seminar recommend:

1. The development and promotion of legal frameworks facilitating access to health care for undocumented migrants, aiming at full and equitable access as a common standard in accordance with the principle of non-discrimination and supported by article 12 of the International Covenant on Economic, Social and Cultural Rights and the General Comment of the Committee of this Covenant.

Any national or international administrative measures which restrict full and equitable access should be abolished.

2. That all those working with undocumented migrants actively participate in regular reporting to the committee of the ICESCR as part of the monitoring of article 12.
3. The promotion of education on human rights issues for health and social care workers, especially with respect to undocumented migrants.
4. The development and coordination of medical databases, detailing the availability of health care in different countries from which migrants come, under the auspices of independent organisations.
5. That professional confidentiality be respected and protected by law, and that professional organisations and other relevant bodies support individual health workers in maintaining confidentiality in their work with undocumented migrants.
6. That existing good practice in the development of advisory and monitoring projects for those working with undocumented migrants, such as those in the Netherlands and Belgium, be extended to other countries.

The participants of this Seminar are committed to engaging other professionals and the public in support of the rights of undocumented migrants.

BIBLIOGRAPHY

- Alt, J. SJ** (1999): *Illegal in Deutschland*. Von Loeper Literatur Verlag, p.170–182.
- Anderson, P.**: In a Twilight World – Undocumented Migrants in the United Kingdom, <http://www.geocities.com/Paris/Chateau/5532/Twilight.html>
- AutorInnenkollektiv** (2000): *Ohne Papiere in Europa. Schwarze Risse–Rote Straße–VLA*: Berlin–Hamburg.
- Bade, K. J.** (2001): Migration und Asyl im geteilten und vereinigten Deutschland. In: *Blätter für deutsche und internationale Politik* 2/2001. p. 230–240.
- BDI 3/95**, Immigration and Nationality Department B Division Instructions (Aids and HIV positive cases)
- Böselager von, W.** (2000): Und wenn der Blinddarm bricht? Gesundheitliche Versorgung der illegal in Deutschland lebenden Menschen. In: *Menschsein ohne Aufenthaltsstatus, Bündnis 90/Die Grünen, Info–Dienst*. p. 29–35.
- Braun, T. & Würflinger, W.** (2001): Access to medical health care for undocumented migrants in Germany, Berlin, (unpublished).
- Bühning, P.** (2001): Menschenrechte – Das Problem wird einfach ausgeblendet. *Deutsches Ärzteblatt*, Jg.98, Heft 9, 2. März 2001, p. 428–429.
- Bührle, C. rscj** (2000): Juristische Fragestellungen rund um die Statuslosigkeit in den Bereichen ‘Gesundheit’, ‘Beschulung’ und ‘Lohngerechtigkeit’. In: *Menschsein ohne Aufenthaltsstatus, Bündnis 90/Die Grünen, Info–Dienst*. p. 48–51.
- Burnett, A., Peel, M.** (2001): The health of survivors of torture and organised violence, in: *BMJ*, Volume 322, p. 606–609.
- Burnett, A., Peel, M.** (2001): Health needs of asylum seekers and refugees, in: *BMJ* Volume 322, p.544 – 547.
- Classen, G.** (2000): Krankenhilfe nach dem Asylbewerberleistungsgesetz. In: *Asylmagazin* 11/2000.
- Classen, G** (2000²): *Menschenwürde mit Rabatt*. Loeper Literaturverlag: Karlsruhe.
- Cohen, S.** (2001): *Immigration Controls, the Family and the Welfare State*. Jessica Kingsley, United Kingdom.

- Costa, G** (1999): Rechtliche Situation von Flüchtlingen in Italien. In: Geene, Raimund; Gold, Carola (Hrsg.): Gesundheit für alle, b_books: Berlin. Kapitel 6: Migration und Gesundheit, p.251–255.
- David, M., Borde, T., Kentenich, H.,** (1999): Migration und Gesundheit. Mabuse Verlag, Frankfurt am Main
- Deutsches Ausländerrecht**, Beck-Texte im dtv, 14. Auflage 2001, München
- Deutsche Aidshilfe** (1998): Handbuch Migration. Dt. AIDS Hilfe, Berlin
- De witte Jas** (1995): Gezondheidszorg en illegalen: delen in de zorg?, Amsterdam.
- Eichenhofer, E. (Hg.)** (1999): Migration und Illegalität. Schriften des Instituts für Migrationsforschung und Interkulturelle Studien (IMIS) der Universität Osnabrück; Band 7. Universitätsverlag Rasch: Münster.
- Engbersen, G, Burgers, J. (red.)** (1999): Illegale vreemdelingen in Rotterdam, De ongekende stad I, Boom, Amsterdam.
- Erzbischöfliches Ordinariat Berlin** (1997): migration: illegal. Rechtlos in Deutschland. Heft Nr. 3, November 1997.
- Fluchtpunkt Hamburg** (2000): Problemaufriß HIV- positiver Flüchtlinge, unveröffentlichtes Manuskript
- Flüchtlingsrat Berlin, Ärztekammer Berlin, Pro Asyl Hrsg.** (1998): Gefesselte Medizin- Ärztliches Handeln – unabhängig von Aufenthaltsrechten?
- Franke, U.** (2001): Ohne Papiere und krank in Frankreich, unveröffentlichtes Manuskript.
- Gardemann, J., Müller, W., Remmers, A. (Hg.)** (2000): Migration und Gesundheit: Perspektiven für Gesundheitssysteme und öffentliches Gesundheitswesen. 23. bis 25.3.2000 Hilden. Tagesdokumentation und Handbuch. Akademie für öffentliches Gesundheitswesen Düsseldorf. (www.afoeg.nrw.de)
- Gaserow, V., Hauptmeiler, A.** (1998): Heimlich in Deutschland. Die Zeit, Nr.27, 25.6.1998, S.13–15.
- Geene, R., Gold, C. (Hg.)** (2000): Gesundheit für alle! Wie können arme Menschen von kurativer und präventiver Gesundheitsversorgung erreicht werden? b_books: Berlin. Kapitel 6: Migration und Gesundheit.

General Comment 14, UN Doc. E/C. 12/2000/4

Hartmann, B. (1999): Denkanstöße zum Spannungsfeld zwischen Illegalität und Menschenrechten. In: *Betrifft: migration*. Nr. 4, Dezember 1999. S. 10–23

Johannes Wierstichting, Meldpunt van Misstanden & Advisering bij Complexe hulpvragen mbt toegang en kwaliteit van de medische zorg voor illegaal in Nederland verblijvende vreemdelingen.

Johannes Wierstichting (2001): *The Right to Health : Guidelines for Health Workers*, draft March 2001

Jurado Guerro, T. (ed.)(2000): *Easy Scapegoats: Sans Papiers Immigrants in Europe*. Freudenberg Stiftung. ISBN 3–00–007369–8

Lützel, A. (1999): PTSD: Analyse eines diagnostischen Konzeptes und dessen gesellschaftspolitischen Implikationen. Unveröffentlichtes Manuskript einer Diplomarbeit. Fachbereich Erziehungswissenschaft, Psychologie und Sportwissenschaft an der FU Berlin. Studiengang Psychologie.

Médecins Sans frontieres France (2000): *Fiche préparatoire sur le Royaume Uni*, Unpublished.

Medisch Steunpunt Mensen Zonder Papieren (1998): *Ziek en Zonder Papieren: Een praktische handleiding over gezondheidszorg voor vreemdelingen zonder wettig verblijf*, Brussel.

Medisch Steunpunt Mensen Zonder Papieren (1999): *Toegang tot de gezondheidszorg voor mensen zonder wettig verblijf: Resultaten van een eerste denkoefing*, Brussel, Unpublished.

Medisch Steunpunt Mensen Zonder Papieren (2000): *Migratie en gezondheidszorg*, Brussel, Unpublished.

Mehlem, U. (1998): Wer zahlt bei Krankheit? In: *Berliner Ärzte*. Heft 4, April 1998, 35. Jahrgang. p. 11–14

Migration News Sheet, A. Cruz (ed.), Migration Policy Group, March 2000.

NIVEL (2000): *Illegalen aan de ‘poort’ van de gezondheidszorg: Toegankelijkheid en knelpunten in de zorg van huisartsen, verloskundigen en spoedeisende hulpafdelingen*, Utrecht, December 2000.

Naumann, J. (1997): Rücktransport billiger als Behandlung – Kritik an Charité wegen ‘Abschiebung’ kranker Illegaler. *taz*, 20.2.1997, p. 21

PICUM (1999): 'PICUM document on Basic Social Rights', unpublished, Amsterdam.

Refugio München (1997): Report einer Abschiebung. In: medico report 20 (1997): Schnelle Eingreiftruppe 'Seele' – auf dem Weg in die therapeutische Weltgesellschaft. p. 87–93.

Schreiber, M. (1998): Medizinische Versorgung 'Illegaler'. In: Berliner Ärzte. Heft 4, April 1998, 35. Jahrgang. p. 15–17

Steunpunt Begeleiders Uitgeprocedeerden, (1997): A legal Guide for People in Illegal Stay, Brussel.

Toebes, B. (1999): The Right to Health as a Human Right in International Law, Intersentia – Hart, Antwerpen/ Groningen/ Oxford.

Van Krieken, P.J. (ed.) (2001): Health, Migration and Return, A Handbook for a Multidisciplinary Approach, TMC Asser Press, The Hague.

Voogt, W.C (2000): Gedogen met andermans veren, scriptie, 2000.

Vorbrodt, E. (1998): Kosten in Millionenhöhe? In: Berliner Ärzte. Heft 4, April 1998, 35. Jahrgang. p. 18–19

Vorbrodt, E. (2000): Gesundheitliche Versorgung von Ausländern ohne Aufenthaltsrecht. In: Flüchtlingsrat. Zeitschrift für Flüchtlingspolitik in Niedersachsen. Heft 68, Ausgabe 3/00, Mai 2000. p. 18–23

World Medical Association, 'World Medical Association Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide', 51st World Medical Assembly, Tel Aviv, October 1999.