CITIES OF RIGHTS:
ENSURING HEALTH CARE FOR UNDOCUMENTED RESIDENTS

APRIL 2017

PICUM
PLATFORM FOR INTERNATIONAL COOPERATION ON
UNDOCUMENTED MIGRANTS

The Platform for International Cooperation on Undocumented Migrants (PICUM) was founded in 2001 as an initiative of grassroots organisations. Now representing a network of 155 organisations working with undocumented migrants in 30 countries, primarily in Europe as well as in other world regions, PICUM has built a comprehensive evidence base regarding the gap between international human rights law and the policies and practices existing at national level. With 15 years of evidence, experience and expertise on undocumented migrants, PICUM promotes recognition of their fundamental rights, providing an essential link between local realities and the debates at policy level.

By Alyna C. Smith, Advocacy Officer, and Michele LeVoy, Director

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FOREWORD

Our vision for integration is one where all city residents can develop their full potential and live a safe and dignified life. Cities do not discriminate based on residence status or migration background, with many choosing to open their services to undocumented migrants.

The reasoning is both ethical and pragmatic. Cities consider universal service provision a sound investment in terms of integration, social cohesion and public health. We can't afford to ignore the growing numbers of undocumented migrants in our cities, nor can we approach the issue solely from the angle of detention and forced return, as is often the case in EU member states. Excluding undocumented migrants from service provision is detrimental to social inclusion, public health and protection of fundamental human rights, including those of children.

The political leaders of 37 major European cities have signed our Integrating Cities Charter, committing to the integration of migrants and promoting well-managed migration in increasingly diverse societies. Many of our members have developed their own policies and practices to ensure that undocumented migrants benefit equally from access to city services. Sometimes they are treated as 'future citizens', needing integration, education, healthcare or labour market inclusion measures. Our collaboration with PICUM has enabled many of our members to benefit from expert advice and promote knowledge exchange and capacity building on service provision for undocumented migrants.

Cooperation between PICUM and our working group on migration and integration has helped raise the profile of this issue on the political agenda, and resulted in the creation of a sub-group of cities keen to address the challenge of irregular migration. Led by Utrecht, with support from PICUM, Oxford University and Open Society Foundations, a two-year process beginning in 2017 will see eight of our members working on this topic in depth, prioritising replicability of policies and practices in municipalities with irregular migrant populations of varying scales around Europe.

This pilot project comes at an important moment for European cities. The challenge of providing services for undocumented migrants will only become more pressing, as many of the asylum seekers arriving in cities will not ultimately be granted refugee status.

Reforms to the Common European Asylum System are heading in a worrying direction. Aiming to remove incentives for secondary movement of asylum seekers and restrict the rights of those attempting to abuse the system, the new proposals risk leaving people destitute pending their forced or voluntary return to their 'first country of asylum' or 'safe third country'. Asylum seekers found irregularly in a member state could end up impoverished in large cities, without legal access to material reception conditions, employment or even education for their children. Possibly in need of international protection, asylum seekers leaving the member state they have been assigned to, would thus join thousands of undocumented migrants living without rights or prospects in large European cities.

Cities can't choose between dealing with those residents who do or don't have the right to be on their territories. They must act when nobody else will. Working with civil society organisations and expert networks such as PICUM helps us build more inclusive and open cities, and maintain the principles of solidarity, humanity and dignity upon which the European Union is founded.

Anna Lisa Boni
Secretary General, EUROCITIES

PREFACE

In discussions of migration, it is easy to get swept up in questions that seem remote, and to think in terms of people and issues that are foreign, distant.

But migration's impact is local, it is intimate. Each of us has a story of migration, whether it is our own or a relative's; a neighbour, a friend, a colleague, who was born in another place. Cities in particular are places where people of diverse backgrounds and nationalities coexist and interact on a daily basis.

It is perhaps unsurprising, then, that cities are often at the forefront in crafting policies and practices responsive to the needs of their residents, recognising the advantages of diversity and acting with pragmatism to address the interests of their communities. In the face of national laws that are often restrictive and that may be driven more by political considerations than social realities, cities have found ways to ensure basic regard and protection of the rights of their residents, whatever their status.

People who are undocumented are often excluded from national health systems, and must turn to volunteers and humanitarian organisations for help. This report builds on research that PICUM initially conducted in 2014 on cities' responses to improve health care for their undocumented residents. Our aim with this updated report is to give visibility to a selection of cities that have, in various ways, taken steps – often in close partnership with civil society – to mitigate the impact of restrictive national policies that define access to services based on residence status.

The focus of this report is on cities' efforts in the area of health care – but there are also examples of city-level initiatives to ensure access to other services, such as access to emergency shelters, safe police reporting, and education, irrespective of residence status.

In a policy environment that is too often characterized by divisive rhetoric and by laws that use access to basic services as an instrument of border management, these efforts by cities reflect a commitment to upholding human rights and human dignity. They are beacons of light in a sometimes dim landscape, and show what is possible when there is political forethought, and political will.

What is needed to improve the situation of undocumented residents is reform of nationals laws and systems that exclude them. We must not stop pressing toward this goal, and holding states accountable for their obligations under international law. In the meantime, we welcome cities and their work to advance the rights of all within their communities, and echo calls for cities to be given a larger voice in national policy-making on migration.

Michele LeVoy
Director, PICUM

SUMMARY:

City-level Responses Across Europe

Across Europe, people who are undocumented have great difficulty accessing health systems. Sometimes this is because of cost barriers, or barriers stemming from services being poorly adapted to the needs of diverse populations; sometimes because of policies designed to restrict migrants' use of public services. In the midst of a highly restrictive legal environment nationally, a growing number of cities and regions have taken steps, for both principled and pragmatic reasons, to address the shortfall between the aspiration of universality and the reality for millions excluded from the public health system because of their migration status. Using whatever authority they have to legislate or otherwise act in the field of health policy or delivery, including as funders, cities and regions are supporting initiatives that facilitate improved access to basic services for their undocumented residents.

The Molenbeek district of **Brussels** is addressing administrative barriers to accessing services by arranging to pay for the initial medical consultation required to certify need for assistance – a precondition for coverage under the national health scheme.

Ghent goes above and beyond what is required by Belgian law by providing a medical card to undocumented patients valid for 3 months from the time it is requested, and by being flexible about the type of evidence it accepts to show residence in the city.

Helsinki adopted an official policy to improve protection of the basic rights of undocumented people living in their city, and provides health services to them through public health centres and hospitals.

Frankfurt partners directly with a community-based NGO to provide free and confidential care to uninsured residents, irrespective of their migration status.

Kiel cooperates with a network of volunteer doctors to provide childhood vaccines to undocumented children and care to pregnant women.

Düsseldorf funds the provision of medical assistance to undocumented migrants, bypassing the need for them to approach the national administration for coverage, which would expose them to being reported to immigration authorities as required by law.

Amsterdam, **Utrecht**, **Eindhoven**, and **Nijmegen** provide financial support to local organisations assisting undocumented migrants, including to cover the costs of health services and medicines for which reimbursement is not available under national law.

Warsaw funds an organisation of volunteer doctors that provides services to uninsured residents, irrespective of their migration status.

Madrid runs a campaign to inform undocumented migrants of their right to access the public health system, and to inform health professionals of their duty to provide care to all patients, regardless of their residence status. In October 2016, it approved the creation of an ID card for undocumented residents to ensure their access to public services offered by the city, including health care.

Barcelona launched an active registration policy that encourages all undocumented residents to register in the municipal register and gives them access to the public health system.

INTRODUCTION

Who is undocumented?

Someone who is undocumented does not have a valid permit to stay in the country in which they live. Often, people become undocumented because they no longer meet one or more of the conditions of their visa, due to job loss, administrative delays in processing an immigration application, expired documents, separation from a spouse, a failed asylum claim, being convicted of certain offenses, or being born to undocumented parents, among others. In most countries in the European Union, crossing the border irregularly or residing without papers is not a criminal offence.[1] And in all countries that have ratified the majority of the core international human rights treaties – which includes all 28 EU member states – being undocumented has no bearing on an individual's ability to hold states accountable for their respect for and protection of their basic human rights – including the right to health, the right to privacy and the right to life.[2]

There are no exact figures on the number of people residing irregularly in Europe. Evidence suggests that the majority have entered the EU in recent decades through regular channels – that is, with a valid permit to study or work, to seek family reunification or asylum – and later lose that status.[3] In recent years, the number of irregular border crossings in Europe has increased substantially, such as in 2011 in response to instability across the Middle East and North Africa, and again in 2015 due to ongoing conflicts in Syria and elsewhere, as well as due to global economic inequality.[4] While many of these new arrivals apply for asylum, many do not; there is also a substantial number of asylum applicants who are not successful in their applications and who remain, increasing the number of people in an irregular situation living, working, and raising families in Europe.

TERMINOLOGY

Why "undocumented" and not "illegal"?

Throughout this brief, we refer to people who are without a valid residence permit "undocumented" (or, alternatively, as having "irregular" status), and not "illegal." The term "illegal" is discriminatory and implies criminality. A person can never be 'illegal'. Migration is not a crime. 'Illegality' as a status is only applied to migrants and used to deny them their rights. It also has a real impact on policy and public perception. Inaccurate language leads society to accept that people should be prosecuted and punished.

PICUM Terminology Leaflet, available at http://picum.org/en/resources/picum-terminology-leaflet/

1 EU Agency for Fundamental Rights (FRA) (2014), Criminalisation of Migrants in an Irregular Situation and of Persons Engaging with Them.

2 Several international human rights treaties protect the right to health and impose obligations on states to respect and guarantee this right without discrimination, including on the basis of migration. They include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Convention on the Elimination of Racial Discrimination (ICERD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC). For more information, see footnote 5, below, as well as PICUM (2016), Sexual & Reproductive Health Rights of Undocumented Migrants: Narrowing the Gap Between their Rights and the Reality in the EU, pp 9-11.

3 Reliable figures are not available on the number of undocumented migrants in the EU, because there are no systematic mechanisms of data collection on irregular migration in the EU, but estimates using existing data at the time indicate that between 1.9 million and 3.8 million undocumented migrants lived in the 27 EU member states in 2008, accounting for between 0.39% and 0.77% of the total population at the time. See A. Triandafyllidou, CLANDESTINO Project Final Report, November 2009 at pp 11-12.

4 B. Milanovic, "Global Inequality: From Class to Location, from Proletarians to Migrants," *Global* Policy, Vol. 3 Iss. 2 (May 2012).

SPOTLIGHT
Cities Mobilising Globally

The **Global Mayoral Forum on Mobility, Migration and Development** is an initiative sponsored by the United Nations Institute for Training and Research (UNITAR) and other partners that gathers representatives from cities from around world to consider issues of urban governance in the face of increasing diversity. A basic premise of the forum is that migration is a largely positive phenomenon that benefits development. At the first global forum, held in June 2014, mayors adopted the Barcelona Declaration, which called on authorities to assure the "same rights, duties and opportunities to all persons residing in their territory," and for minimizing exclusion of migrants in an irregular situation, and stressed the need to strengthen the "voice and role" of cities in defining migration policies. At its second forum in November 2015, mayors adopted the Quito Local Agenda for Migration and Development, which underscored that cities are at the forefront of integration and of service delivery to an increasingly diverse populace, and called for specific action to guarantee access to health service for all, regardless of residence status.

The **UN Conference on Housing and Sustainable Urban Development (Habitat)** adopted, in October 2016, a New UN Urban Agenda, which recognizes the multiple forms of discrimination faced by migrants, and commits to ensuring the full respect for human rights and humane treatment of refugees, internally displaced persons, and migrants, regardless of status, and promoting equitable and affordable access to health care and family planning for all, without discrimination.

The **WHO European Healthy Cities Network** consists of nearly 100 cities and towns from 30 countries concerned with health and sustainable development. The network launches priority themes every five years with a political declaration and accompanying strategic goals. Its overarching goals for Phase VI (2014-2018) are improving health for all and reducing health inequalities. The national meeting of Italian Health Cities Network in May 2016 in Palermo, Sicily, focused specifically on migration.

In November 2016, **UNESCO** (United Nations Educational, Scientific and Cultural Organisation), together with the Marianna V. Vardinoyannis Foundation and the European Coalition of Cities against Racism (ECCAR), convened a conference in Athens, Greece on the theme of "Welcoming Refugees: Promoting Inclusion and Protecting rights". The mayors and deputy mayors of Athens, Amaroussion, Lesvos, Piraeus and Thessaloniki gathered alongside political representatives from Albania and Cyprus as well as civil society actors to exchange good practices on ways to achieve greater inclusion and protection of rights. The conference also served as an occasion to launch a publication on enhancing effective urban governance in the age of migration, according to which "[g]overnment at all levels has obligations to ensure respect, protection and fulfilment of human rights for all migrants and refugees, irrespective of their status." The report provides a checklist for a "welcoming city governance agenda," which includes the provision of universal access to social services for all, without discrimination on any basis.

Sources:

- UNITAR, https://www.unitar.org/dcp/human-mobility-programme/facilitating-policy-dialogue
- Quito Local Agenda on Migration & Development (2015), https://www.unitar.org/dcp/sites/unitar.org.dcp/files/uploads/quito_outcome_document_en_0.pdf
- Barcelona Declaration (2014), http://www.bcn.cat/novaciutadania/pdf/ca/home/DeclaracioBcn.en.pdf
- New Urban Agenda, https://www2.habitat3.org/bitcache/97ced11dcecef85d41f74043195e5472836f6291?vid=588897&disposition=inline&op=view
- WHO European Healthy Cities Network, http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network
- UNESCO (2016), Cities Welcoming Refugees and Migrants: Enhancing Effective Urban Governance in an Age of Migration.

Is the right to health protected in Europe for everyone?

The right to health is a universal right that is not dependent on status of any kind. It is established in numerous international and regional human rights treaties, and in many national constitutions, as a universal right guaranteed to all.[5] The ratification of these instruments by all EU member states obliges them – at all levels of government - to ensure access to health care services for all without discrimination, regardless of residence status.

But the reality is very different. Laws, policies and practices in all EU member states deviate from these obligations to varying degrees.[6] Expert bodies that monitor states' compliance with international human rights treaties that protect the right to health have repeatedly expressed serious concerns about a range of both legal and practical barriers to obtaining health care, goods and services. These barriers impede and undermine the enjoyment of the right to health by people without status. Indeed, in the majority of EU member states, someone without papers is only entitled to access emergency health care, and in some, even this is liable to charging after care.[7] In others, additional health services are made available by law, but are not accessible in practice because of contradictory laws requiring public officials to report people without status to the immigration authorities, or because of financial, administrative or other practical barriers.[8]

What is the impact of exclusion from health systems?

The damaging effects of systematically limiting access to health systems for people who are undocumented begin with the individual, and ripple outward to affect the broader community. Most obviously, restricted access to health care means that people are unable to get assistance that allows them to adequately treat and manage existing conditions, to the detriment of their mental and physical health. Exclusion from health systems also means exclusion from basic information about risk factors, disease prevention and health promotion, as well as access to routine testing for pregnancy, communicable infections, and chronic conditions. It means no diagnosis or support for mental health conditions until they reach a crisis point; and no appropriate management and treatment of physical or cognitive disabilities. In some cases, it means the absence of pre- or post-natal care, and vaccines or routine pediatric follow-up during childhood.[9]

In turn, excluding a segment of the population from public health systems can have a negative impact on public health programs, and undermine efforts to improve infant and maternal mortality, to manage chronic conditions, and prevent and control the spread of communicable diseases. The European Centre for Disease Prevention and Control has recognised the particular obstacles faced by the undocumented in accessing HIV services, and urged states to take steps to address them.[10]

Providing health care primarily through emergency care departments in hospitals, frequently the only

5 See Universal Declaration of Human Rights (Article 25), International Covenant on Economic, Social and Cultural Rights (ICESCR), (Article 12); International Convention on the Elimination of All Forms of Racial Discrimination (Article 5), International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (Article 12); Convention on the Rights of the Child (CRC) (Article 24); the Charter of Fundamental rights of the European Union (Article 35), European Convention on Human Rights and Freedoms (Article 3, as interpreted by the European Court of Human Rights in the case of *Pretty v. UK*, where the court found that "*the suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment [...] for which the authorities can be held responsible.*") and the European Social Charter (Article 13). Recent case-law found that by employing a dynamic interpretation of the Charter, its rights cannot exclude undocumented migrants if their human dignity is found to be directly impacted. See for example International Federation of Human Rights League (FIDH) v France (Complaint no. 14/2003), Defence for Children International (DCI) v The Netherlands (Complaint no. 47/2008); Defence for Children International (DCI) v Belgium (Complaint no. 69/2011), Médecins du Monde – International v. France (Complaint No. 67/2011).

6 FRA (2015), Healthcare entitlements of migrants in an irregular situation in the EU-28.

7 FRA (2011) Fundamental rights of migrants in an irregular situation in the European Union, FRA (2012), Migrants in an irregular situation: Access to healthcare in 10 European Union Member States; see also FRA, Healthcare entitlements of migrants in an irregular situation in the EU-28, http://fra.europa.eu/en/theme/asylum-migration-borders/healthcare-entitlements.

8 See S. Spencer, V. Hughes (2015), Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe.

9 Médecins du Monde (2016), Legal Report on Access to Healthcare in 17 Countries.

10 ECDC (2013), Evidence Brief – Migration: Monitoring Implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 Progress Report.

WHAT IS "UNIVERSAL" HEALTH CARE?

National health systems vary greatly among EU member states, but all are recognised as being underpinned by the same values: universality, access to good quality care, equity and solidarity.

In November 2016, the Organisation for Economic Cooperation and Development (OECD) concluded, in a joint report with the European Commission looking at health systems across the EU, that "most EU countries have achieved universal (or near-universal) coverage of health care costs for a core set of services." This claim, based on an analysis of data gathered from member states, stands in stark contrast to evidence demonstrating that the majority of EU member states systematically exclude from their health systems people with irregular status. Limited data is available on the situation in practice for undocumented individuals; however, there is good evidence about their entitlements under national law, which are extremely limited. The conclusion that states have achieved "universal coverage", in spite of such evidence, therefore calls into question the meaning of "universal" in this context.

Who is captured within "universal" is not a matter of mere semantics or politics. Addressing inequities in health – that is, reducing disparities between the best and the worst off – is recognised as an important indicator of health system performance. This means that states that aspire to achieve more efficient, resilient and accessible health systems cannot afford to do so only for certain segments of their population; nor can they continue to ignore the financial burdens of exclusion, and of its enforcement. Indeed, in 2016, a group of health experts convened by the International Organisation for Migration (IOM) recommended that the "principle of universal and equitable health coverage should be applied to all persons residing de facto in a country, regardless of their legal status."

Sources:

- EC Communication (2014) http://ec.europa.eu/health//sites/health/files/healthcare/docs/com2014_215_final_en.pdf
- OECD (2016), http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2016_9789264265592-en
- WHO (2013), http://www.euro.who.int/__data/assets/pdf_file/0009/244836/Health-System-Performance-Comparison.pdf
- IOM (2016), Recommendation on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus.

place where people with irregular status can access care, is also extremely costly for health systems.[11] For women without status, for instance, undetected or untreated health conditions during pregnancy can mean complex interventions later on, if not identified during prenatal care. Laws that limit their entitlement to care, or deter health-seeking behaviour by imposing heavy financial costs, expose the woman and her child to unacceptable risk, and the health system to significant and avoidable costs.[12] A recent study financed by the European Commission demonstrates that timely treatment in a primary health care setting can save between 49 percent and 100 percent of direct medical costs (incurred by the patient and the health system) and non-medical costs (incurred by the patient or wider society as a result of disability and illness-causing health burden) for patients who would otherwise only be entitled to emergency care.[13]

There are also, undeniably, broader human and social costs reflected in the impact on families and communities, of an individual's inability to obtain adequate medical assistance,[14] as well as the well-

11 FRA (2015), Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation; Kayvan Bozorgmehr, Oliver Razum, "Effect of Restricting Access to Health Care on Health Expenditures among Asylum Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013.," 22 July 2015.

12 R. Feldman, "Maternity care for undocumented women: the impact of charging for care," *British Journal of Midwifery*, Jan 2016, 24:1.

13 Centre for Health and Migration, Summary of Findings (2016), Infographic on costs of exclusion from healthcare.

14 National Latina Institute for Reproductive Health (2013), Nuestra voz, nuestra salud, nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley.

recognised impact of ill-health on a person's ability to work.[15] Restrictive health policies also negatively affect health professionals, whose commitment to medical ethics is contradicted by requirements to sort their patients, based on complex immigration rules, into those who are and those who are not entitled to care.[16] In some cases, health professionals and other service providers have responded by mobilising to protest discriminatory rules,[17] and to provide basic health services to excluded populations, often working in difficult conditions.

SPOTLIGHT

Regional and City-Level Initiatives to Improve Access to Health Services for Undocumented People in North America

In the **United States,** the City of **San Francisco's** Department of Public Health operates a program called Healthy San Francisco that subsidises medical care for uninsured residents of the city. The program aims to make health care services available and affordable to uninsured San Francisco residents, regardless of immigration status.

Like other New York residents who lack health insurance, New Yorkers who are undocumented and uninsured rely on local safety-net health care systems. The New York City Health and Hospitals Corporation (HHC) is the nation's largest public hospital system and receives funding from the city. In 2014, **New York City** Mayor Bill de Blasio announced an initiative to create a city identification card for residents regardless of their residence status. Less than a year later he launched the largest municipal identification card program in the US (IDNYC). All New York City residents age 14 and older are able to sign up for IDNYC regardless of their immigration status, which enables them to access all city services. In April 2016, IDNYC partnered with NYC Health and Hospitals to allow IDNYC cards to serve as a registration card to help improve the patient experience by reducing registration wait times, streamlining the registration process and providing patients with an easy way to register at patient care locations within the health system.

According to the **Canada** Health Act, undocumented migrants are excluded from the public health service. Nonetheless, the province of **Ontario** provides funding to Community Health Centres (CHCs). CHCs are non-profit organisations that provide primary care services and health promotion programs for individuals, families and communities, regardless of their immigration status. In 2013 **Toronto**'s City Council introduced the Access T.O. program for undocumented Torontonians. The program aims to ensure that Torontonians, regardless of immigration status, have access to City services without fear of being asked for proof of status. The City of Toronto does not collect personal information unless there is a legislative or operational requirement to do so.

Sources:

- Official Website of the City of New York http://www1.nyc.gov/office-of-the-mayor/news/379-16/city-additional-benefits-idnyc-cardholders-new-integrations-nyc-health-
- Healthy San Francisco http://healthysanfrancisco.org/
- City of Toronto, "Access T.O.", http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=9dfc33501bac7410VgnVCM10000071d60f89RCRD

15 OECD (2016), Health at a Glance: Europe 2016.

16 See, for instance, World Medical Association (April 2016), Council Resolution on Refugees and Migrants; American Nurses Association (2010), "Nursing Beyond Borders: Access to Health Care for Documented and Undocumented Immigrants Living in the US," ANA Issue Brief; European Board and College of Obstetrics and Gynaecology (2014), "Standards of Care for Women's Health in Europe: Gynaecology Services."

17 See, e.g., in the UK, Docs not Cops, http://www.docsnotcops.co.uk/; in Italy, 8 January 2009, Corriere della Sera, "'Niente Cure Mediche ai Clandestini in Friuli' – E I Medici Insorgono"; in Canada, OHIP for All – Healthier Together, http://ohipforall.ca/.

How are cities responding?

Laws regulating the health system, including who has the right to access health services and under what conditions, are often established by the central, or national, government. Nonetheless, in many countries, governmental authorities at the more local level retain a degree a responsibility for health-related policy making.[18] In some European countries, regional governments and city councils have authority to legislate concerning or to organise the delivery of local social services, including health care, although they may be constrained by regulations on public finances. At the same time, they are also bound by international, regional and national human rights standards.

Unlike their national counterparts, municipalities are directly confronted with the day-to-day experiences of their residents and expected to meet their needs: "local governments, with their proximity to the city population, are most directly called on to meet human rights and public services obligations in the provision of adequate shelter, food, healthcare, education, water, and sanitation facilities [...]".[19]

There are numerous examples from across Europe – reflecting a global trend– of cities using their autonomy to adopt measures that facilitate access to health care for residents living with irregular status. The following chapters showcase some of these cases, providing a snapshot of initiatives from across Europe within different national contexts – namely Belgium, Finland, Germany, Italy, the Netherlands, Poland, Spain and Sweden – and their role as key partners in the effort to bring about – and advocate for – more inclusive health systems, from the bottom up.

18 See the Committee of the Regions for detailed information on the division of competences between national, regional and local authorities available at http://cor.europa.eu/en/documentation/studies/Documents/division_of_powers/division_of_powers.pdf.

19 UNESCO (2016), Cities Welcoming Refugees and Migrants: Enhancing Effective Urban Governance in an Age of Migration.

BELGIUM

What Authority Does the City Have to Act in the Area of Health Care?

Belgium is a federal state composed of three regions (made up of provinces and municipalities) and three (language) communities. Public health is a shared responsibility of the federal government and the communities, with the communities responsible for 'person–related matters', including preventative health policy and social assistance. Both the federal government and the communities have legislative powers in the area of health.

The municipalities are responsible for the administration of social welfare, including the verification of whether undocumented migrants have the right to access health care, following the national regulations on social welfare centres.

National Context

People who are undocumented – both adults and children - are ineligible for national health insurance in Belgium but can qualify for coverage under a separate scheme called Urgent Medical Assistance (*Aide medicale urgente* (AMU) / *Dringende Medische Hulpverlening* (DMH)).[20] Despite its name, the AMU/DMH framework explicitly provides coverage for preventative and curative care; indeed, all medical treatments covered by the basic national health insurance are covered. The reference to 'urgent' care can cause confusion for many doctors who feel that a patient should require care that is fairly urgent, but not life-threatening, to qualify for coverage. Coverage under the AMU/DMH is valid for up to three months. But in general, and in jurisprudence, it is known that Urgent Medical Assistance is much larger than emergency care.

Urgent Medical Assistance (AMU/DMH) is administered by local social welfare centres (*Centre Public d'Action Sociale* (CPAS)/*Openbaar Centrum voor Maatschappelijk Welzijn* (OCMW)).[21] To obtain AMU/DMH coverage, an undocumented person must register with the local CPAS/ OCMW, which then provides the patient with a document or a medical card permitting access to the required care once certain conditions have been met: namely, it must be verified that the patient lives irregularly and is 'destitute' (subsists on income below a certain threshold) in that municipality, and a medical certificate demonstrating medical need must be provided by a doctor.[22]

This administrative procedure creates numerous practical barriers for people who are undocumented, for whom it is often difficult to prove habitual residence because they are homeless or without stable accommodation. The standard practice to determine whether someone is destitute is a house visit by a social assistant, but if the person is staying with friends or family, their hosts often refuse the visit for fear of any potential negative consequences for providing accommodation of someone who is undocumented. The social investigation can take up to one month, as defined by law, and each

20 See Royal Decree of 12 December 1996 on state medical assistance.

21 See Organic law organizing the Social Welfare Centres of 8 July 1976.

22 The CPAS/OCMW has to make a decision in thirty days as to whether to agree on paying medical assistance.

CPAS/OCMW has the discretion to determine what constitutes adequate evidence of residence. Requiring medical certification of the urgency of the care as a condition for granting access the care also has the effect of delaying treatment and imposes the cost, unattainable by some, of the initial consultation.

In December 2015, the Belgium Health Care Knowledge Centre / *Federaal Kenniscentrum voor de Gezondheidszorg* / *Centre fédéral d'expertise des soins de santé* (KCE) published a report following up on earlier work by the National Institute for Health and Disability Insurance (INAMI-RIZIV) and Doctors of the World based on input from more than 300 stakeholders in the Belgian health and welfare sectors. The report concludes that the complexity of the existing system is problematic for all actors, leads to unpredictable access for undocumented migrants, cumbersome and costly administrative procedures for municipalities, difficulties for health professionals, and challenges in monitoring care and costs for public authorities. It recommends several reforms to the AMU/DMH to simplify and harmonise administrative procedures and to streamline access to health services and information. These include doing away with the requirement to obtain a medical certificate to quality for AMU/DMH, and bringing consistency to the criteria used by municipal bodies to determine financial eligibility.[23]

City-Level Responses

Each local social welfare centre (CPAS/ OCMW) can determine its own procedures relating to AMU/DMH. This means that the procedures are often complex and inconsistent across centres, as each CPAS/OCMW has its own 'urgent medical assistance certificate' for doctors to complete and different criteria to decide whether or not someone is entitled to the care, is destitute, and has his or her habitual residence on its municipality's territory.[24] The variation on local level exacerbates lack of awareness on the part of both health care providers and undocumented residents about how the AMU/DMH system works and for how long they have coverage.

At the same time, some municipalities have used their autonomy in this area to address the practical barriers erected by the national system to better facilitate health care for their undocumented residents.

- Rather than requiring certification every time a health service is needed, several CPAS/OCMW issue medical cards for longer periods.
- A growing number of CPAS/OCMW have established agreements with doctors, primary care, sexual and reproductive health care, and mental health care centres, to limit refusals of care due to lack of awareness of the AMU/DMH system.
- Several initiatives address the difficulties individuals face in obtaining the mandatory certification showing medical need, a precondition for coverage under AMU/DMH.

Municipality of Molenbeek (Brussels)

For a number of years, the CPAS/OCMW in Molenbeek, one of the 19 municipalities in the Brussels-Capital Region, has been arranging and paying for the first medical consultation, as soon as an undocumented person registers and requests medical assistance. The CPAS/OCMW settles the bill for the first consultation without requiring that the administrative conditions for AMU/DMH eligibility be met. This considerably reduces administrative barriers and allows much more rapid detection of serious illnesses.

Ghent

The CPAS/OCMW in Ghent provides a medical card to undocumented patients that is valid for three months, whether or not the person is ill at the time the medical card is requested. If it is not possible to provide an address, the applicant can rely on other types of evidence, such as declarations by organisations or testimony by locals to prove residence in the city.

23 KCE, Belgian Healthcare Knowledge Centre, https://kce.fgov.be/publication/report/what-health-care-for-undocumented-migrants-in-belgium#.WHjd41MrKUm

24 For more information, see MdM (2016), International Network 2016 Observatory Report: Access to Healthcare for People Facing Multiple Vulnerability in Health in 31 Cities in 12 Countries.

FINLAND

What Authority Does the City Have to Act in the Area of Health Care?

The central government, through the Ministry of Social Affairs and Health, has responsibility for planning, legislation and directing the implementation of social and health policy in Finland.[25]

Municipalities are charged with implementing social and health legislation. At the regional level, regional state administrative agencies direct and supervise municipal and private social welfare services, according to national legislation. These supervising bodies are responsible for licensing and registration of private social welfare service providers, and the processing of complaints.

National Context

According to the Constitution of Finland, "those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care."[26]

Finland has a residency-based centralized social security system, grounded in the notion of a "municipality of residence." Once a person has officially been registered with and thus assigned a municipality of residence, they can access a range of social services, including health care. Undocumented individuals do not have the right to a municipality of residence, because they do not fulfil the requirements as established in the Municipality of Residence Act, including a right of residence. Under the Finnish Health Care Act and the Act on Specialized Medical Care, undocumented migrants are therefore only entitled to care in urgent cases, defined under the Health Care Act as care where an "immediate intervention is required and where treatment cannot be postponed without risking the worsening of the condition or further injury."

As a result, outside of "urgent" cases, the full cost of the treatment can be charged to patients without proper residence status. In practice, this means a bill from several hundred euros (for an uncomplicated emergency room visit) up to thousands or tens of thousands of euros (for any hospital stay). Undocumented migrants also need to pay for all prescribed medication.

25 Ministry of Social Affairs and Health Finland, http://stm.fi/en/ministry/task-and-objectives

26 Constitution of Finland, Chapter 2, section 19, subsection 1.

The National Institute for Health and Welfare (*Terveyden ja hyvinvoinnin laitos,* or *THL*) published a report in 2014 that presented several recommendations on how to organise health care for undocumented migrants, which was followed by a Government Bill on the organisation of health care for undocumented migrants in 2014. The Bill, however, was dropped in 2015.

City-Level Responses

Helsinki

In response to the inequities created by restrictive national laws, representatives from several non-governmental organizations agreed to set up a network to offer and promote health care services for undocumented members of their community. In April 2011, the Global Clinic was established in Helsinki to provide basic health care for undocumented migrants, modelled on clinics operating in Sweden. The guiding principles of the Global Clinic include non-discrimination and anonymity. The clinic is operated mostly on a voluntary basis, with voluntary medics, nurses, midwives, psychologists and medical students offering primary health care services on a weekly basis. Patients are registered using pseudonyms so that service is provided anonymously. The Helsinki Deaconess Institute,[27] a public foundation that offers a range of services, provides the clinic with premises and equipment. Private donations are used to cover medicines and laboratory exams.

In 2013, the city council of Helsinki decided to offer health care for undocumented migrants residing in the city, in particular for children under 18 and for pregnant women. The city was the first in Finland to make a political commitment to improve the basic rights of undocumented migrants in Finland. Similar programs have since been initiated in Turku and Espoo. Implementation of the political decision took more than a year, and involved a significant push by individual health professionals and NGOs to inform health care professionals and administrators across the city of the new policy. The Global Clinic and the city of Helsinki partnered to create treatment protocols to accompany the new policy. Public health care services for undocumented migrants are now provided via public health care centres and hospitals. The Global Clinic offers services for those who cannot access public health services. The aim, however, is to direct people to use public services whenever possible.

27 Helsinki Deaconess Institute, https://www.hdl.fi/en/.

GERMANY

What Authority Does the City Have to Act in the Area of Health Care?

The Federal Republic of Germany has 16 federal states. Legislative competence is shared between the Federation and the federal states (*Länder*). Within the legal framework, federal states and municipalities have wide-ranging power with respect to the design of their health systems. This creates a great diversity in the implementation of health care, with a simultaneous attempt to apply uniform standards. Germany has a national health insurance system legislated at national level.

The ministries in each federal state are responsible for passing their own regulations, supervising subordinate authorities, and financing investment in the hospital sector. The federal states are subdivided into administrative districts and local authorities (towns, municipalities, counties), all of which have numerous competencies in the area of health, from health promotion to hospital planning.

National Context

In Germany, there are more than 100 statutory health insurance companies, and numerous private providers. Federal legislation regulates who is eligible for health insurance and who is not. It also regulates the scope of benefits under the statutory health insurance schemes and defines the minimum health care that must be financed by the social authorities if no health insurance is available.

According to the German Asylum Seekers Assistance Law,[28] people who are undocumented in Germany are, like asylum seekers, entitled to health care in the event of acute illness and pain, and to maternity care. They are, however, hindered in their ability to access the care they are entitled to because of the administrative procedures they must comply with for their care to be subsidised, which expose them to being reported to immigration authorities. Under the German Residence Act, all public bodies, except educational institutions, have a duty to notify the immigration or competent police authorities when they obtain information about someone who is without a valid residence permit.[29] This obligation is not imposed on health care providers or administrative staff within health care institutions, due to extended medical confidentiality.[30]

SPOTLIGHT
Medibüros and Medinetze

In response to a recognised need, a network of 32 voluntary *Medibüros* (Medical offices) and *Medinetze* (Medical networks) have developed across Germany that facilitate access to health care for undocumented migrants in their particular local or regional context. Several *Medibüros*, which are largely independent from each other in their operations, cooperate with their local and regional authorities to both meet the immediate medical needs of undocumented migrants, and to work towards a more sustainable solution that integrates the provision of health care for undocumented migrants into the public health service. Most of the offices provide a weekly consultation for undocumented migrants with health concerns, arrange appointments with doctors working free of charge and provide further information about ways to regularise a patient's status, where possible.

28 See Asylbewerberleistungsgesetz, § 1.5, § 4 and § 6.

29 See German Residence Act (Aufenthaltsgesetz), § 87.

30 See German Residence Act (Aufenthaltsgesetz), as amended by the General Administrative Provision of the Federal Department for the Interior, § 88.2 amending the German Residence Act, 2009 (Allgemeine Verwaltungsvorschrift des Bundesinnenministeriums zum Aufenthaltsgesetz).

Where care is provided by emergency hospital departments, the health care provider has to apply for reimbursement from the social welfare office (*Sozialämter*) following treatment. This extends medical confidentiality to the welfare office.[31] But any care provided outside hospital emergency departments must first be approved by the social welfare office. This includes services relating to acute illness and pain or maternity services, for which the undocumented patient must obtain a health insurance certificate from the social welfare office, if the care is to be covered. Hospitals are obliged to inform the welfare office of planned surgeries. In such cases, the welfare office has a duty to share undocumented patients' data with the relevant authorities, thus rendering undocumented migrants' entitlements to access non-emergency health care services meaningless.

These contradictory laws and regulations mean that undocumented migrants are, in practice, only able to access emergency treatment free of charge and are at risk of denunciation and deportation when accessing all other health services, due to the social welfare offices' duty to report undocumented migrants in non-emergency cases. As a result, many health care providers treat undocumented patients using their own resources to offer them the services they are entitled to under the German Asylum Seekers Assistance Law, and to uphold their professional ethical commitments.[32]

City-Level Responses

Recognising the difficulties faced in accessing health care by members of their communities who are undocumented, several cities in Germany are taking steps to make it possible for them to access health services, in cooperation with civil society, by setting up drop-in centres and providing specific services, such as vaccinations for children and services for pregnant women.

In addition, independent initiatives and voluntary welfare care providers have developed strategies to provide medical care to people without papers in a way that allays their fear of being deported. Many of these projects are funded by donations alone, while others receive support from state funds or municipal funds.

Frankfurt

In 2001, the Department of Health of the City of Frankfurt (*Gesundheitsamt der Stadt Frankfurt*) agreed to work with the organisation Maisha,[33] an African women's NGO in the city, to provide medical consultations and treatment for undocumented migrants. The initiative is also supported by the Women's Department and the Department of Multicultural Affairs and the Department of Social Care. The Health Department provides doctors, Social Care provides medicine and the Women's Department provides some financing for Maisha's work. Health care is provided anonymously to address migrants' fears of being denounced or otherwise detected because of accessing services. There are targeted services for women, including specific consultation times and information on sexual and reproductive health. The centre also provides social counselling, with the assistance of cultural mediators.

This initiative has become a benchmark of good practice in Germany, and several other major city administrations have implemented similar drop-in centres that have 'Humanitarian Consultation Hours' (*Humanitäre Sprechstunde*) providing medical consultations and basic treatment for undocumented migrants. The consultations are provided free of charge, and contributions towards medical treatment costs are arranged according to the patient's means. The centres work in partnership with networks of specialist doctors, to refer patients with more serious health concerns. The Frankfurt model remains unique in Germany as an example of a genuine partnership between city officials and civil society, permitting community-based, integrated care that builds trust in the city's migrant communities because they are active partners in the initiative.

31 See also Federal German Medical Association (2013) *Patientinnen und Patienten ohne legalen Aufenthaltsstatus in Krankenhaus und Praxis* (Patients without legal residence status in the hospital and the doctor's office), published jointly with Medibüro Berlin and Malteser Migranten Medizin, November 2013, available at: http://www.bundesaerztekammer.de/page.asp?his=0.6.37.8822.

32 See Statement of the Central Ethical Commission of the Federal German Medical Association (Zentrale Ethikkommission bei der Bundesärztekammer, ZEKO), May 2013, available at: http://www.aerzteblatt.de/download/files/2013/04/down49039045.pdf.

33 See http://www.maisha.org/

Kiel

The Health Authority of the City of Kiel cooperates with Medibüro Kiel by providing childhood immunisations and medical care for pregnant women. At the regional level, Medibüro Kiel was successful in getting the federal government of the state of Schleswig-Holstein to allocate 200,000 EUR every year since 2014 to support humanitarian projects that provide assistance to people in medical crises who are without insurance, providing a mechanism to fund undocumented migrants. However, the allocated funds can only be used to cover overhead expenses, such as salaries, rent and office material; they cannot be used to cover medicines or medical procedures, which means that, in practice, only a small fraction of the money set aside is actually used. The long term goal of Medibüro Kiel is the use of health insurance cards based on pseudonyms to allow undocumented migrants to see a doctor without fear that their data will be shared with governmental authorities.

Düsseldorf

In Düsseldorf, the refugee initiative STAY! (STAY! *Flüchtlingsinitiative*) offers consultations and information for migrants and refugees. Since 2008, STAY! together with MediNetz has been consulting and providing medical assistance to people without residence status.

Until 2014, this was on a purely voluntary basis. In December 2014, the Düsseldorf City Council agreed on the introduction of an anonymous health insurance certificate and the establishment of a clearing centre at STAY!/MediNetz for people without a residence permit. The city administration and STAY! developed a workable concept, and the Committee for Health and Social Affairs (*Ausschuss für Gesundheit und Soziales*) agreed on a three-year pilot project entitled "Care Concept for People without Papers with Acute Medical Needs in Düsseldorf" („*Versorgungskonzept für papierlose Menschen in akuten medizinischen Notlagen in Düsseldorf*"), which was launched on 1 July 2015. The allocation of two full-time social workers to STAY! and the establishment of a city fund of 100,000 EUR annually to provide health care services to undocumented patients were also approved.

To be eligible to receive medical help through the emergency fund (which covers medical assistance in accordance with the German Asylum Seekers Assistance Law (*Asylbewerberleistungsgesetz, AsylbLG*)), patients must be without a residence permit; have lived in Düsseldorf for at least six months; not be entitled to services through any other public health provider; and be unable to afford to pay for the necessary care. In addition to determining eligibility based on these criteria and providing direct health services to those who qualify, the clearing centre also provides information about possible ways that patients can regularise their status. Clients receive advice free of cost and are either treated during the volunteer consultations that take place twice per week, or are referred to practicing doctors or hospitals. The doctors bill according to the lowest rate of the German Scale of Medical fees (*GOÄ*) or German Scale of Fees for Dentists (*GOZ*), and the hospitals bill fees directly to STAY!, which is reimbursed through the emergency fund. Nonetheless, a substantial part of the work done by both practicing doctors and doctors taking part in the consultations is on a volunteer basis.

IN FOCUS

Sweden: Law Reform Ensures Broader Coverage But Also Uncertain Application

In Sweden, the central government holds exclusive legislative powers. Regions (*landstinget*) and municipalities cannot develop legislation. Nonetheless, they enjoy important taxing powers, and counties and regions are considered competent in the field of public health, including the organisation of health care and medical services. Municipalities hold mandatory administrative powers in the area of health protection.

Before 2013, undocumented migrants over 18 years of age were not mentioned in the Swedish law on Health and Medical Care for Asylum Seekers and Others of 2008, and so were only entitled to minimal health care – namely, emergency care only – and were required to pay the full costs for receiving that care (after treatment). As an example, a pregnant undocumented woman would have been expected to pay a fee of around 5,000 EUR to give birth in a public hospital.

In 2013, the Swedish Government introduced significant reforms to the health care system, enacting a law on health and medical care for certain foreigners living in Sweden without necessary permits, which entered into force on 1 July 2013. According to the 2013 law, undocumented adults are entitled to access acute care and health care '*that cannot be deferred*', including dental care, maternity care, contraceptive counselling, abortion, and related medicines, for a small charge (5 EUR) – the same level of care provided to asylum seekers. The law also grants access to health care to all undocumented children (including those that have not claimed asylum) on the same level as regularly-residing and Swedish children. The concept "care that cannot be deferred" is controversial, however, and places the responsibility to decide whether a person is entitled to health care on the individual health professional. The National Board of Health and Welfare has come to the conclusion that the concept is not consistent with science, medical ethics or human rights. The 2013 law stipulates that regions may offer undocumented migrants wider health coverage, up to the level of citizens. Currently, six regions do so: Sörmland, Västmanland, Östergötland, Västerbotten, Västernorrland and Gävleborg.

Swedish law therefore provides frameworks for the provision of subsidized health care for Swedish nationals, asylum-seekers and undocumented migrants from non-EU countries. Left out are nationals from other EU countries, documented and undocumented, who remain outside the scope of coverage. In December 2014, the National Board of Health and Welfare stated publicly that EU citizens should be considered undocumented for the purpose of their entitlement to health care, a position they reiterated in April 2015. In practice, however, they are required to pay for the full cost of care in most hospitals and health centres.

Sources:

- Statskontoret (2016), Vård Till Papperslösa: Slutrapport av uppdraget att följa upp lagem om vård till personer som vistas I Sverige utan tillstånd.
- Médecins du Monde (2016), Legal Report on Access to Healthcare in 17 Countries.

IN FOCUS

Italy: A Strong National Framework Supported by Regional Action

The Italian health care system has undergone a process of decentralisation since a constitutional amendment in 2001 conferred larger autonomy to the regions for organising health care services. The national government is responsible for adopting general health care legislation regarding essential levels of care and basic needs, establishing the general principles for the protection of health in the country. The regions have the power to issue concurrent legislation and regulations in the area of health, with the exception of the definition of fundamental principles, which is reserved to the central government.

The national law that regulates migration in Italy (National Immigration Law T.U. 286/98 (Legislative Decree No. 286/1998 *Testo unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero* (25 July 1998))) guarantees health care to all migrants, with or without regular status. By law, undocumented migrants are entitled to access urgent care (care that cannot be deferred without endangering the patient's life or damaging their health) and essential care (diagnostic and therapeutic health services related to non-dangerous illnesses in the immediate short term, but that could cause greater damage or put the patient's life at risk in the longer term). This care can be continuous and curative or preventive. Undocumented migrants in need of 'urgent' or 'essential' treatment receive health care until the whole treatment and rehabilitation period has been completed. However, they are not entitled to register with a General Practitioner (GP), which is a major barrier to accessing primary and secondary care in practice, as secondary care provided in hospitals requires referral. All care for children is included until the age of 14.

However, the situation varies greatly from region to region with some seeking to restrict access to health care through legal, administrative and practical barriers. In some regions, only care provided by an emergency department of a hospital is available. Across the country, undocumented children's entitlements to all care have been limited in practice as most regions, until recently, did not provide access to a paediatrician, limiting their access to continuous and specialist care. Prior to 2013, some regional governments in Italy surpassed the standards that have been established at the national level, by providing additional health services for all residents, regardless of status. For a number of years, the Regions of Puglia, Tuscany, and the Autonomous Province of Trento have made it possible for undocumented children to have access to a paediatrician. The Regions of Umbria and Puglia have also been providing access to a general practitioner for undocumented adults. In some regions, these extended rights for undocumented migrants have been established in regional laws.

Recognising that a number of workers in the agricultural sector in **Puglia** are undocumented, the regional government has enacted measures to ensure inclusive health care services, including through mobile clinics. In 2009, the regional government of Puglia introduced a law that grants undocumented migrants full access to health care services, as well as the right to choose a GP and a paediatrician for their children (Regional Law 32/2009). In February 2010, the Italian government challenged this provision in court as unconstitutional, claiming it was beyond the competencies of the Puglia region to grant access to health care for migrants, but the Constitutional Court ruled that the claim was inadmissible. In practice, some problems around implementation remain. Moreover, 2015 regional regulations have reduced access to health care for undocumented migrants.

In 2009, the regional government of **Tuscany** passed a law emphasising the human rights of all, regardless of status, and granting undocumented migrants equal access to health care and other forms of social assistance, such as access to homeless shelters and meals at municipal cafeterias (Regional Law29/2009). The constitutionality of this legislation was also challenged by the Italian government, on the basis that it surpassed the rights and liberties stipulated in the Italian Constitution and was discriminatory to Italian citizens. In this case, the Italian Constitutional Court again declared the Italian government's claim inadmissible and unfounded. Despite an inclusive legal framework, some problems around implementation in practice remain.

On 20 December 2012, in an effort to harmonise practice across regions, the **Italian State-Regions Permanent Conference** concluded an agreement for the implementation of good standards in access to health care for foreign nationals. According to the agreement, undocumented children have full access to health care through the national health insurance system, rather than through the separate administrative program for undocumented migrants, and are therefore assigned a paediatrician until the age of six, can continue to see a paediatrician or register with a General Practitioner (GP) until age 14, and can register with a GP thereafter, as is the case for national children. The agreement also reiterates that access to health care for undocumented migrants must not imply any duty to report residence status to public authorities. The State-Regions Permanent Conference agreement has been formally adopted by thirteen out of the 20 Italian regions and by the Autonomous Province of Trento. Another two regions – Emilia Romagna and Lombardy - have not formally adopted the agreement, but have agreed to provide undocumented children access to a paediatrician.

Sources:

- NAGA-Milan, SIMM (June 2016), The Current Italian Health Legislation for Irregular Migrants and Its Current Implementation at Regional Level.
- PICUM (2012), Building Strategies to Protect Children in an Irregular Migration Situation. Country Brief: Italy.

THE NETHERLANDS

What Authority Does the City Have to Act in the Area of Health Care?

In the Netherlands, the health system is highly centralised. The national government holds exclusive authority to legislate in the area of health care, and is responsible for organizing the delivery of health services and reimbursement of care under the national insurance scheme.

Regions and municipalities have no jurisdiction to legislate in the area of health care, and no role in the provision of services. They have discretion, however, to use their funds to support non-governmental organisations that provide assistance to under-served segments of the population by, among other things, facilitating access to certain services and to medicines.

National Context

Under Dutch law, the ability to obtain state health insurance is linked to authorised residence. As a result, people who are without regular status cannot insure themselves for health care costs.[34] According to law, they are entitled to care that is "medically necessary," which is all care that is considered "responsible and appropriate" by the health care professional,[35] the costs of which they are expected to pay themselves. Patients who cannot afford to pay may, however, have the costs of their care reimbursed by CAK (formerly *Zorginstituut Nederland*), provided that the care in question is within the package of services included under the National Basic Health Insurance, and that the health care institution has a contract with the CAK. CAK is a public body responsible for carrying out certain tasks in the area of health care, including the reimbursement of health care providers for the provision of health services to uninsurable migrants. Pharmacies and hospitals must also have a contract with the CAK to be eligible for reimbursement, except in the case of emergencies or maternity-related care. General practitioners (GPs) are exempt from this requirement.

The package of services covered under the National Basic Health Insurance is quite broad, especially for children, but does have some limitations. Costs related to dental care for adults, for instance, cannot be reimbursed, nor can most of the cost for physiotherapy. Pharmacies require a contribution of 5 EUR per prescription from the patient, which may be outside the reach of destitute patients, particularly those with chronic conditions requiring long-term treatment. Uninsured EU nationals are not covered by this system.

34 Article 5 paragraph 2 Exceptional Medical Expenses Act excludes people not lawfully resident from the AWBZ insurance (full text available at http://www.st-ab.nl/wetawbz.htm) and only those insured under AWBZ are able to access basic health insurance under the Health Insurance Act (full text available at http://www.st-ab.nl/wetzvworbz.htm). Note undocumented children are still legally able to access care normally regulated by the AWBZ Act (for example, if they require nursing in a specialist institution) when an assessment indicates that the care is needed.

35 Commissie Medische zorg voor (dreigend) uitgeprocedeerde asielzoekers en illegale vreemdelingen, "Arts en Vreemdeling," available at http://www.pharos.nl/documents/doc/webshop/arts_en_vreemdeling-rapport.pdf.

All children under the age of four years can access free vaccination. Undocumented children who are accompanied by their families or other caregivers have access to health care under the same conditions as undocumented adults.

In practice, it can be difficult for health professionals to determine if someone is eligible for reimbursement through CAK. Health professionals and hospitals therefore tend to rely heavily on local non-governmental organisations (NGOs) who support migrants to provide a note affirming that a particular patient qualifies. Undocumented migrants who have limited contact with support organisations face significant challenges in proving their eligibility, and may be turned away.

Complex and bureaucratic systems for reimbursement can also make doctors and hospitals reluctant to treat patients without proper status. GPs sometimes hesitate to provide care because they only receive 80 percent reimbursement of unpaid costs, or insist that the patient pay 20 percent of the costs of care upfront, which is not required by law. Some health care professionals and hospital staff are unaware of the rights of undocumented patients and their duties towards them, they are sometimes refused care to which they're entitled, both by GPs and at hospital reception desks because of lack of insurance or inability to pay. With the exception of emergencies, treatment in hospital requires a referral from a GP. Access for undocumented migrants is greatly facilitated when the referral is accompanied by a note from the GP that the patient is eligible for reimbursement under CAK.

Medical professionals have no duty to report patients without residence status to immigration authorities.[36]

City-Level Responses

Several municipalities in the Netherlands support local NGOs that provide assistance and services to undocumented migrants, particularly those whose asylum application has been rejected. In **Eindhoven**, **Amsterdam**, **Nijmegen** and **Utrecht**, city councils contribute to cover the costs of health services that fall outside the National Basic Health Insurance scheme, such as dental care and physiotherapy, and also cover the 5 EUR fee for pharmaceuticals that some patients are not able to afford. In some cases, local organisations facilitate access to dental services by connecting patients with dentists willing to serve them for a reduced fee.

36 Under Section 107 of the Immigration Act 2000 administrative bodies are required to provide information on foreigners to the IND if requested for the implementation of the Immigration Act. However, the Minister of Health, Welfare and Sport has clarified that health care providers and healthcare institutions have no role in the tracking and reporting of undocumented migrants (Answer, Parliamentary Question (*Kamervraag)* 840, 7.12.07; available online here http://ilegaalkind.nl/data/2007nr840.pdf).

POLAND

What Authority Does the City Have to Act in the Area of Health Care?

Responsibility for the health care system is shared between the central government and local municipalities. Poland has a national health insurance system legislated at the national level. The funding from the National Healthcare Fund is distributed to cover treatment by public and private health care institutions, such as hospitals and clinics. The funding of health care is distributed at the level of the province (*voivodship*) by the National Health Fund.

Each municipality (*gmina*) is responsible for meeting the health care needs of its residents and may, should the need arise, fund some of the medical treatment through its own budget. However, the majority of health care is provided through health care institutions set up by the municipality and funded by the National Health Fund.

National Context

According to the Polish Constitution, "Everyone shall have the right to have his health protected."[37] At the legislative level, the Act on Health Care Benefits Financed by Public Funds of 27 August 2004[38] specifies who is eligible for services under the national health care system, which is based on statutory health insurance.[39] Undocumented migrants are not included. What this means is that they only have a clear legal entitlement to emergency care – that is, "care that cannot be denied to any person in the event of immediate danger to life or health."[40]

In Poland, rescue teams operate in a separate system, managed at the province level, and funded directly from the central government's budget. These teams consist of 2-3 people performing medical rescue activities on people in immediate risk of loss of life outside the hospital. Emergency care provided by rescue teams is free of charge to everyone, but it is not clear whether such care is free of charge when provided in hospital departments, because there is no legislation that establishes who would bear the costs.[41] This means that undocumented patients may be liable to pay the full costs for emergency care in hospitals after treatment. Similarly, care

37 The constitution of the Republic of Poland 1997, Article 68(1), full text available at http://www.sejm.gov.pl/prawo/konst/angielski/kon1.htm.

38 Full text available at http://www.pup-olkusz.pl/dokumenty/ustawa_20040827.pdf.

39 Insurance is compulsory for most of the population, who pay income-based contributions (9% of salary or benefits). Others may take out insurance voluntarily. Anyone who is not insured may be refused health care unless there is an 'immediate threat to life or health'. Children and pregnant women who are citizens are also entitled to additional care regardless of insurance status. Certain care is always free of charge. Refugees and people with subsidiary protection status are entitled to statutory health insurance on the same basis as nationals, and asylum seekers and unaccompanied minors have access to free "health services" with costs covered by public funding by specific providers (see also Act of 13 June 2003 on Granting Protection to Foreigners, full text available at http://www.asylumlawdatabase.eu/sites/www.asylumlawdatabase.eu/files/aldfiles/en%20-%20granting%20protection%20to%20aliens%20within%20the%20territory%20of%20the%20Republic%20of%20Poland%20.pdf. For more information, see HUMA Network (2011) Access to Health Care and Living Conditions of Asylum Seekers and Undocumented Migrants in Cyprus, Malta, Poland and Romania, pp. 99-106.

40 *Ibid,* p. 101 citing various laws relating to the provision of health care.

41 *Ibid*, p. 101.

during labour and delivery cannot be denied, but undocumented women may have to pay the full costs. Exceptions exist regarding HIV screening and treatment, and the treatment of certain infectious diseases,[42] which everyone can access free of charge. [43] Undocumented children have access to health care under the same conditions as undocumented adults, except for medical and dental devices, as well as mandatory vaccinations, medical check-ups, and screening tests, which are free of charge while they are attending public school. [44] In practice, however, health care in schools is delivered by nurses, and not every school has its own nurses. In addition, schools cannot insure children without documents under the national insurance system, as they do other pupils, even though in theory they are eligible for services under the national health care system as long as they attend schools. And while the check-ups and screenings may be free of charge (when accessed), the treatment is often prohibitively expensive (especially specialist, dental or optometry care). This means that undocumented children do not receive continuous care.

For the most part, undocumented migrants avoid public health facilities and hospitals, unless it is an emergency. This is largely due to fear of being detected, the high costs involved (when the type of treatment is not free of charge), and the high rate of refusal because valid identity papers are often required for registration.[45] Uninsured patients admitted for emergency hospital treatment are often released as soon as possible to minimize the financial costs to the hospital, without due consideration for their condition and the possible health risks. Instead, they largely rely on self- and non-professional medical help, [46] or else access private clinics[47] where they can receive care without providing identification documents. Treatment and medication must still be paid for in full.[48]

City-Level Responses

Warsaw

Doctors of Hope, which began as a branch of Doctors of the World (*Médecins du Monde* or MdM), has been operating a health clinic in Warsaw for uninsured residents since 1991. In 2016, they had 25 doctors working on a pro bono basis, and provided services without discrimination to Polish nationals, EU citizens and nationals of non-EU countries in need, whatever their residence status. In 2015, they treated approximately 8,000 patients.

Since around 1996, Doctors of Hope have been receiving public funding for its work by successfully applying to public grants launched by the City of Warsaw with the aim of providing assistance to its homeless population. Every three years, they must make an application for a renewal of funding. Doctors of Hope is now the only such clinic in Warsaw, and one of only two in all of Poland. In 2016, 40 percent of Doctors of Hope's funding came from the City of Warsaw and the province (*voivodship*) and 40 percent came from private donations.

Doctors of Hope is actively engaged in advocacy towards government ministries and the city to improve access to public health services for all uninsured people, whatever their status. They cooperate closely with the Polish Ombudsman, and are a member of a civil society advisory body within the city council advising on issues of homelessness.

42 *Ibid*, p. 104-105 citing the Law on contagious diseases.

43 HIV treatment is unconditional, but only Post-Exposure Prophylaxis (PEP) is free of charge.

44 *Ibid*, p. 101 citing Articles 92 (1)(2) of the Law on education system of 7 September 1991 and Regulation of the Minister of Health on the organization of the prophylactic healthcare for children and youths of 28 August 2009.

45 *Ibid*, p. 125.

46 *Ibid*, p. 125.

47 There are also some outpatient clinics contracted by the National Health Fund to provide medical services on payment, without requiring identification documents (ibid, p. 131).

48 *Ibid*, pp. 126-127.

SPAIN

What Authority Does the City Have to Act in the Area of Health Care?

The central government is responsible for establishing basic conditions and general coordination of health matters. According to Spanish Constitutional Law, the autonomous regions (*Comunidades Autónomas*) have legislative and implementation powers in matters of health, hygiene and social services. Therefore, the autonomous regions develop legislation in the area of health and hygiene and provide health care services, at least to the basic standards provided by national law. In some regions, cities have a degree of authority over the management of sanitation, environmental health and public health.[49] The exclusion of undocumented migrants from the public health care system has caused discrepancies between the national government's policies and provision of health care in the autonomous regions across the country.

National Context

Until 1 September 2012, the right to access free public health care in Spain was guaranteed to both Spanish citizens and those habitually residing in the country, irrespective of their residence status, in accordance with international human right standards. But a reform of the health care system,[50] approved on 20 April 2012 and in force since 1 September 2012, significantly restructured the health care system by linking the right of access to health care services to the condition of being a Spanish citizen or of being registered with the Social Security department – a requirement that cannot be met by residents lacking a regular administrative status. The reform implies a significant breakdown of the universal health care model that had been implemented in Spain for over a decade, through the implementation of an insurance-based health care system that created multiple categories of eligible patients, and different procedures for each to access care, resulting in significant bureaucratic complexity. According to the reform, '*healthcare assistance in Spain, with charges to public funds, will be guaranteed to those who are duly insured*',[51] whereas it was previously sufficient to be registered in the municipal register (*padrón*) to be able to access the health care system.[52]

The national law now only entitles undocumented migrants to receive free treatment in emergencies, and during pregnancy, delivery and postpartum. Undocumented children are still granted the same right to health care as national children. Difficulties in accessing these services in practice have been reported.[53] The 2012 law also creates gaps for regularly residing individuals – including EU nationals and Spanish citizens – who are unemployed, ineligible for social security, and do not meet the financial threshold of eligibility, who are therefore not entitled to coverage.

49 S. Garcia-Armesto et al., Spain: Health System Review, *Health Systems in Transition*, Vol. 12 No. 4 (2010).

50 Royal Decree Act 16/2012 of 20 April 2012 on urgent measures to ensure the sustainability of the national healthcare system and improve the quality of its services.

51 Article 1 of the Royal Decree modifies the content of Article 3 of the Law of Cohesion and Quality of the Health Care System 16/2003, which provided that "*...all citizens and foreigners present in the country according to Article 12 of the Ley Orgánica 4/2000*" (i.e. those who are duly registered as residents in the local municipality) have a right of access to health care. According to the new provision, "*healthcare assistance in Spain, with charges to public funds, will be guaranteed to those who are duly insured*". See also Royal Decree 1192/2012 which establishes who is considered as insured or a beneficiary of the National Health System, by law.

52 In Spain, undocumented migrants can be registered in a municipal census (*padrón*), irrespective of their residence status.

53 Médicos del Mundo España has monitored cases of migrants being denied access to healthcare across the country as a consequence of the implementation of the Royal Decree 16/2012 on an ongoing basis. See Médicos del Mundo España (2014) Dos años de reforma sanitaria: más vidas humanas en riesgo.

The 2012 reform of the health care system prompted strong reactions among Spain's autonomous regions. The Basque Country was the first to react by taking measures to introduce universal coverage; and Catalonia passed legislation to overcome barriers for excluded groups in their region. Others introduced complementary measures to widen access to public health care, creating special programs that facilitate access to additional health care services than those provided under national law.

Two autonomous communities, Andalusia and Asturias, provide equal access to services for undocumented migrants and Spanish nationals. In 2015, the only autonomous region implementing the Royal Decree-Law in its entirety, Castilla-La Mancha, had a change in government which led, in March 2016, to the extension of health coverage to undocumented migrants through the introduction of a health card (*tarjeta para la atención sanitaria*). The card is valid for twelve months and permits access to health care within the region. All autonomous communities now therefore provide some degree of access to covered health care for people in an irregular situation.

While generally a positive development, this patchwork of varying regulations creates administrative confusion in practice, and inconsistency from one region to another in the services to which they are entitled, and the procedures by which they can access them.[54]

City-Level Responses

Madrid

The City Council of Madrid launched a campaign in December 2015 entitled *Madrid sí cuida* ("Madrid does look after you") to inform all undocumented residents that they have the right to access public health care services, regardless of their status. The campaign encourages everyone to register in a health centre and gives details about where to report or to seek help if they are improperly denied access to health care. The campaign comes as a response to the 2012 Royal Decree that deprived undocumented migrants of access to publicly subsidized health care. To counter the effects of this norm, the Autonomous Community of Madrid circulated an internal notice to all the city's health professionals, requiring them to provide assistance to all patients, regardless of their residence status. The *Madrid sí cuida* campaign aims to inform migrants of this change in policy at the community level and to let them know that they are not excluded from the public health system within the region.[55]

The City Council is also in the process of adopting a Human Rights Plan that will guide all the City Council's actions. Among other things, the Plan addresses the subject of guaranteeing access to health care for migrants, without discrimination of any kind.[56] In October 2016, Madrid's City Council approved the creation of a City ID card for undocumented patients, with the aim of ensuring their access to all public services offered by the city, particularly health care, education, social services and employment-seeking services. Anyone who is registered with the City and does not have a valid identification document can apply for the City ID card.[57]

54 Court challenges were filed by six autonomous regions contesting both the form and substance of the 2012 Royal Decree. The regional governments of Andalusia, Asturias, the Basque Country, the Canary Islands, Catalonia and Navarra claimed that the provisions of the Royal Decree trampled on the regions' power to legislate, and on fundamental rights established in the Spanish Constitution. In July 2016, the Constitutional Court ruled in favour of the national government, holding that the Royal Decree-Law was consistent with the Spanish Constitution, and that cutting back social rights was justified in times of economic crisis.

55 Madrid si cuida, https://si-cuida.madrid.es/.

56 Decide Madrid, Plan de Derechos Humanos, https://decide.madrid.es/derechos-humanos

57 El Mundo (2016), "El Ayuntamiento de la capital crea un 'DNI municipal' para inmigrantes 'sin papeles.'"

Barcelona

In 2015, the city of Barcelona launched an active registration policy that encourages all undocumented residents to register in the municipal register, known as padrón. Even residents who have difficulty demonstrating where they live, or who have no fixed addresses, are eligible to register. Registering enables all residents, whatever their status, to have access to all local services and to the public health system provided by the Catalán Region. A service of district advisors has been established to provide information and to facilitate access to the health card for all migrants, including undocumented residents and European Union nationals. A local committee has been set up to examine specific cases where individuals are inappropriately billed for care. Barcelona has created, and posted in the emergency rooms of all hospitals, posters informing the public that everyone has the right to free emergency room services, and that no one should be billed for care.

Barcelona's City Council launched in 2010 the Barcelona Anti Rumour Campaign (*Estratègia BCN Antirumors*). The Campaign is based on the assumption that the greatest obstacle to coexistence in a diverse society is ignorance of others' experiences and backgrounds. This ignorance can give rise to fear or rejection and be manifested in myths and false stereotypes, such as "migrants steal our jobs", "they don't pay taxes" or "they abuse the health care system". The Campaign aims to create tools and narratives to undo these stereotypes to promote a cohesive intercultural society, such as comic books, manuals and leaflets, as well as workshops for individuals, institutions and service providers in different neighbourhoods of Barcelona on issues such as multiculturalism.

Ajuntament de Barcelona

XARXA BCN antiRUMORS

Sources:
http://ajuntament.barcelona.cat/bcnacciointercultural/ca/blanca-rosita-barcelona

CONCLUSION AND RECOMMENDATIONS

With few exceptions, European countries severely curtail access to public health systems, based on residence status, in spite of evidence and growing consensus[58] that this is detrimental not only to the individual patient's health, but also to public health goals, to reducing health inequalities and the achievement of universal health care. It is also contrary to medical ethics and states' human rights obligations.

But different models are being implemented by a growing movement of cities and regional governments aware of how counterproductive it is to exclude a segment of their population from preventive and primary health care services. In countries across Europe governments at the local and regional levels are taking steps, often in cooperation with civil society, to increase the level of services available to the undocumented men, women and children in their localities, and tackle practical barriers to access.

Cities individually, and as part of global and regional networks, are taking a stand in favour of more inclusive approaches to service delivery, and a greater voice in national-level policy making on migration in recognition of their unique and important perspective by virtue of their proximity to the population. They are also pushing for a greater focus on integration over deterrence. Recognising the interplay between health status and broader social determinants, cities are advocating for improved access to health services, as well as to labour markets, education, housing and social support structures for all residents, whatever their status, to address the effects of poverty and social exclusion.[59]

Examples described here illustrate how cities have used a variety of strategies to improve access to health services, including **funding local clinics** in Helsinki and Warsaw; **partnering with local NGOs to provide integrated, community-based care** in Frankfurt; **easing administrative burdens** in Ghent; **campaigning to raise awareness of the right to health services** in Madrid; and **funding coverage for services denied under national plans** in Eindhoven, Amsterdam, Nijmegen and Utrecht.

These initiatives, while imperfect, represent a positive trend of cities' pragmatic and humane responses to the needs of their residents. But they are no substitute for reforms of national legislation that excludes individuals from basic health care because of their residence status. The successes and challenges of these initiatives provide a strong basis to improve policy and legislation at the national level, to ensure the appropriate financial and administrative environment for the delivery of quality and accessible services to their residents, without discrimination, and to increase consistency and efficiency of service provision across cities and regions.

Ensuring more equitable health systems requires political action and courage by those with the greatest proximity to the situation in practice, including NGOs, health professionals and administrators, and city authorities, in raising awareness about the harmful effects of existing national frameworks, and calling for more inclusive, evidence-based policies for the benefit of all.

58 International Organisation for Migration (2016), Recommendation on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus.

59 See Box *Spotlight: Cities Mobilising Globally*, above, at p. 9.

Lawmakers, at the national, regional and local levels

Reform legislation and policy that deny or limit access to health services on the basis of residence status.

Health care should be provided on the basis of need, and not tied to or conditioned upon residence status. Proactive steps are needed to remove administrative barriers to accessing services, including discriminatory refusal of treatment and requirements for documents that residents living in an irregular situation are unable to provide.

Clearly detach the provision of health care from immigration control.

In line with the European Commission against Racism and Intolerance (ECRI)'s guidelines on safeguarding irregularly present migrants from discrimination,[60] and recommendations by the European Union Fundamental Rights Agency (FRA),[61] governments and health care administrators should establish a 'firewall', a clear separation between the provision of health care services, on the one hand, and immigration enforcement mechanisms, on the other, to ensure protection of and respect for fundamental rights. This means they should not impose a duty on health care professionals, hospitals, health care administrators or public authorities to report undocumented patients to or otherwise share their information with immigration authorities; and should establish rules protecting patients' confidentiality, and ensuring that data gathered in the context of their medical care is used only for medical purposes and then only with their consent.

Implement proactive measures, in partnership with civil society, to improve access to health services for undocumented migrants in the region or locality.

Authorities at the city, county and regional levels should consult civil society in the development and implementation of locally relevant measures to improve access to health care for all residents in their communities. They should also inform themselves of the many examples of existing good practice, and where possible apply or adapt them to their local context, or innovate new models to suit local needs. To promote consistency in quality and practice, local and regional authorities are encouraged to work collaboratively, and also to advocate for appropriate reforms in the legal and financial framework at the national level to ensure adequate and consistent service provision for all, across localities and regions.

The European Union

Ensure that all EU efforts to promote and to measure health system performance in member states duly address health inequalities, and take into account evidence of the ability of the most marginalised, including people without residence or with insecure status, to access services.

Health care cannot be universal if health systems systematically exclude certain segments of the population; nor can health systems be efficient and effective if they push patients to rely on emergency services because they cannot access primary care. The EU should ensure that initiatives to promote and to measure member states' health systems take account of marginalised populations who face structural barriers to care, including based on residence status. This means ensuring that they are included in the design of such efforts, both in their substance and in their process, so that relevant actors (e.g., in civil society or academia) can provide the relevant input, given the dearth of information gathered on these groups by governments.

60 ECRI (2016), General Recommendation No. 16 on safeguarding irregularly present migrants from discrimination.

61 FRA (2012) Apprehension of migrants in an irregular situation – fundamental rights considerations http://fra.europa.eu/en/news/2012/fundamental-rights-considerations-apprehending-irregular-migrants.

Promote an evidence-based policy dialogue and exchange of good practices, and ensure coherence with health objectives in all EU policies relevant for undocumented migrants.

Inclusive and efficient health care provision for all, without discrimination based on migration or any other status, in all EU member states is an established goal of the EU, and can be facilitated by EU institutions in a variety of ways.

- The European Council has recognised the need for universal access to services on a number of occasions.[62] The European Council should provide a forum for the exchange of promising practices and evidence-based policy dialogue on the impact and modalities of developing universal health coverage, in particular measures to appropriately ensure the inclusion of undocumented persons and other uninsured groups.
- The European Commission should ensure that undocumented persons are explicitly addressed in the work of DG SANTE, and systematically assess and address the impact of policies across relevant sectors on the health of migrants, explicitly including those who are undocumented.[63] It should also take a clear position, firmly grounded in international and EU law, that access to health services must never be instrumentalised for the purposes of migration control.
- The European Commission should fund research on the nature and extent of systemic exclusion of people from health systems based on residence status, and its impact on individuals, families and health systems; as well as the impact of inclusive, non-discriminatory measures on individual and population health outcomes, as well as on health systems indicators.
- The European Parliament should build on adopted resolutions[64] to further promote access to public health systems for people without residence status by mainstreaming migrants' health concerns through the Parliament's legislative and non-legislative actions. The European Parliament can also make an important contribution to evidence-based policy dialogue by developing the evidence base on the impact of including and excluding undocumented migrants and other marginalised populations from health coverage, as well as promising practices.

62 Informal meeting of the EPSCO Council, Athens, 28-29 April 2014 (see the Greek Presidency of the Council of the European Union's press release 30 April 2014; The Vilnius Declaration: Call for Action. Sustainable Health Systems for Inclusive Growth, Lithuanian Presidency of the Council of the European Union, 20 November 2013; European Council Conclusions, on Equity and Health in All Policies: Solidarity in Health of 8 June 2010, European Council Conclusions on Common values and principles in European Union Health Systems of 22 June 2006.

63 The Treaty on the Functioning of the European Union stipulates that "A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities" (Article 168). This means that impacts on health must be considered and addressed in the development and implementation of EU policies in other areas.

64 European Parliament resolution on undocumented women migrants in the European Union of 4 February 2014; European Parliament resolution 'Impact of the crisis on access to care for vulnerable groups' of 4 July 2013l European Parliament Resolution on "Reducing health inequalities in the EU" of 8 March 2011.

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