



Health for Undocumented Migrants  
and Asylum seekers

# ARE UNDOCUMENTED MIGRANTS AND ASYLUM SEEKERS ENTITLED TO ACCESS HEALTH CARE IN THE EU ?

A COMPARATIVE OVERVIEW IN 16 COUNTRIES



Stowarzyszenie  
Interwencji  
Prawnej



## About this publication

This report gathers together the executive summary of the HUMA publication “Access to health care for undocumented migrants and asylum seekers in 10 EU countries” (2009) and the results of a new piece of research undertaken in six more countries with the support of the HUMA partners. All together, this study concerns sixteen EU countries: Belgium, Cyprus, Czech Republic, France, Germany, Greece, Italy, Malta, the Netherlands, Poland, Portugal, Romania, Slovenia, Spain, Sweden and United Kingdom.

This publication will be available in 13 languages and is primarily addressed to individual professionals and organisations advocating for migrants’ rights and for the right to health as well as to national and EU policy makers.

Given the legal nature of this report, the data could be subject to continuous changes depending on legislative amendments in the different countries. In this regard, one should bear in mind that the information concerning Belgium, France, Germany, Italy, Malta, the Netherlands, Portugal, Spain, Sweden and United Kingdom is from September 2009. The data on Cyprus, the Czech Republic, Greece, Poland, Romania and Slovenia corresponds to September 2010.

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# INTRODUCTION

There are currently a significant number of undocumented migrants living in the EU. This population constitutes one of the most excluded social groups present in our territory. This marginalisation also has an impact in the health field. These migrants often do not access any health care. Not only do they face barriers that are common to the whole migrant population (e.g. lack of awareness and time, language and cultural barriers...) but they also support the consequences of their weak status and invisibility within society. Circumstances such as short entitlements and administrative conditions imposed, their permanent fear of being denounced, their lack of both information and the financial means to pay, make going to the doctor or a hospital the very last resort that they seek and only in the gravest situations.

The situation of asylum seekers regarding health care is also problematic, although in most countries this does not seem to be that critical given their authorised status. Nonetheless, their effective access to health care depends to a great extent on the legal entitlements recognised by the host country, the administrative conditions required and the existence of active policies seeking to improve access by this population to mainstream health facilities.

Another important difference between these two socially excluded groups concerns the EU response. Whilst there is an EU directive establishing the minimum reception standards for asylum seekers, including the minimum health care protection that Member States should guarantee to asylum seekers, there is no EU provision for undocumented migrants' right to health care or to other basic social needs. In the EU, the debate concerning undocumented migrants continues to be rooted in the fight against "illegal migration", and no debate has yet been open about the need to protect undocumented migrants' rights at EU level nor the ratification of the International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families. This instrument protects the rights of all migrants, irrespective of their administrative status, and has not been ratified yet by any EU Member State.

The direct consequence of this approach is that nothing prevents Member States from using health care as an instrument to serve migration control purposes rather than considering it as a right that they should protect in accordance with their international Human Rights obligations. Given the fact that each EU Member State has put in place its own system of regulating undocumented migrants' and asylum seekers' access to health care, the rights and administrative conditions imposed on these populations greatly differ from country to country.

The main objective of this publication is to give a general overview of the legal entitlements as regards access to health care for undocumented migrants and asylum seekers in each of the targeted countries. These results are presented country by country and through three comparative tables concerning, respectively, adult undocumented migrants, adult asylum seekers and children and pregnant women. The report also identifies the countries where there are legal mechanisms to protect seriously ill undocumented migrants from deportation, the policies as regards the duty to denounce and the criminalisation of assistance to undocumented migrants.

In short, this research provides evidence that the access to health care by undocumented migrants, and to a lesser extent by asylum seekers, is not guaranteed in the EU. The standards set by the main international treaties are far from being respected and member states instead of working on the “progressive realisation” of this right, are increasingly using it as a tool to discourage the entry of new migrants.

This restrictive tendency is occurring throughout Europe and it risks progressively endangering the effectiveness of general public health policies inasmuch as there is a part of the population living in Europe who remains excluded from the mainstream health system.

Based on the research conducted, the HUMA network proposes specific recommendations to the EU institutions as well as to the Member States in order to improve access to health care so as to avoid any discrimination on the basis of the administrative status.

## SITUATION PER COUNTRY

### **BELGIUM** (insurance-based system)

Asylum seekers are entitled to access practically all types of preventive and curative care. In regards to health coverage, there is not a significant discrimination compared to Belgian nationals. The situation is different if we consider the administrative steps to follow to access health care.

Besides emergency care, undocumented migrants can access free of charge the *Aide Médicale Urgente* («urgent medical assistance») entailing a large range of medical services with the only exception of some prosthesis, devices and some categories of medicines. To implement these entitlements, a parallel administrative system has been put in place with a number of complicated steps among which there is a spot investigation by the social services and the agreement of the doctor through a certificate defining the “urgent” character of the care requested. This system is highly bureaucratic and very differently implemented by the authorities in the various catchment areas.

Only a very few number of asylum seekers and undocumented migrants (namely unaccompanied children) can access health care on equal grounds as nationals in regards not only to coverage but also to administrative conditions.

### **CYPRUS** (combination of four different systems)

Contrary to the situation in the other studied countries, entitlements to access health care for authorised migrant workers in Cyprus vary according to their professional sector and can be rather minimal. For instance, women domestic workers must contribute 50% of the cost of their private medical insurance and are not even covered for gynaecological and delivery care.

Asylum seekers can access free of charge emergency care and necessary treatment only if living in a reception centre, receiving welfare benefits, demonstrating a proven lack of sufficient resources or belonging to a vulnerable group. The rest will have to pay the full cost of services. The term “necessary” is generally interpreted in a broad sense as to include primary and secondary care, medicines and treatment of serious infectious diseases such as HIV. According to the legislation, “vulnerable groups” include minors, persons with special needs, the elderly, pregnant women and victims of different types of violence and are also entitled to access free of charge “other care under any circumstances”.

There are no legal provisions referring to undocumented migrants’ entitlements to access health care in Cyprus. There are only some ministerial circulars stating that any person can access emergency care free of charge as long as he or she does not need hospitalisation. Besides this, the only care theoretically provided free of charge to undocumented migrants (adults and children) is the diagnosis and treatment of HIV and other infectious diseases.

## **CZECH REPUBLIC** (insurance-based system)

Asylum seekers are eligible for public health insurance and thus they are entitled to access the same types of preventive and curative care as Czech nationals. Although exempted from paying the insurance premium, anytime they seek health care they have to pay, as all other insured persons, the “regulation fee” which, despite being only 1.20 EUR, constitutes an obstacle for them to access health care. In fact, they are neither allowed to work in the Czech Republic during the first year nor to receive welfare money from public institutions. In addition, asylum seekers do not receive the common insurance card but only a paper certificate mostly unknown by the majority of health care professionals. This also hinders their access to health services.

This system also applies to all unaccompanied children, except for the payment of the “regulation fee” which is generally covered by the centre for minors where they are accommodated.

Undocumented migrants, including very vulnerable groups such as children or pregnant women, do not have access to any medical services free of charge in the Czech Republic. They have to pay the full cost of any kind of care with no exceptions. Nonetheless, if they cannot pay, they cannot be denied immediate care (which is mainly interpreted as care needed in life-threatening situations) and treatment of infectious diseases, including HIV. These types of services are accessible for them (the law obliges health care providers to treat all persons in need of emergency care or treatment for infectious diseases), but chargeable.

The only option they have is to take out private health insurance. There are mainly two kinds. The first one is relatively accessible for them but only covers “immediate care” and has almost no applicability in practice. The other type is wider but undocumented migrants hardly take it due to the lack of information, the need to be illness-free to buy it and the high cost and limited coverage.

Until very recently, the highly problematic issue of undocumented migrants’ access to health care had not been discussed in the Czech Republic at all. In addition, there does not exist any public local program or initiative addressing their health needs and the health services provided by civil society organisations are still very scarce.

## **FRANCE** (insurance-based system)

Asylum seekers are entitled to access health care on equal grounds as French nationals in regards to coverage and conditions. This also applies to unaccompanied children as long as they have the support of the social services.

Undocumented migrants can access health care free of charge (with minor exceptions) through a parallel administrative system called “Aide

*Médicale État*” (state medical assistance). However, to obtain the AME and enjoy these entitlements, they must comply with two conditions: residence in France for more than three months and be under a certain economic threshold. To comply with these conditions, they have to follow a number of administrative steps and sometimes even provide supplementary evidence. This all represents a significant obstacle to accessing health care effectively.

All other undocumented migrants can access emergency care, ante and post natal care, abortions and medical terminations of pregnancy as well as treatment of HIV, and other infectious diseases - such as tuberculosis free of charge.

A proposal for a new law (that could come into force in 2011) requests adult undocumented migrants to pay an annual contribution of 30 € to benefit from the AME. This would mean the end of free access to health care for undocumented migrants in France.

## **GERMANY** (insurance-based system)

Asylum seekers are significantly discriminated against in the German legislation during their first four years of residence in Germany. During this period, they are only entitled to access free of charge medical treatment in cases of “serious illness or acute pain” as well as “everything necessary for recovery, improvement or relief of illnesses and their consequences” (including, among others, ante/post natal care and HIV treatment). Only children have rather extended coverage.

The law recognises these same entitlements to undocumented migrants. However, this apparent parallelism between entitlements of asylum seekers residing for less than forty eight months and undocumented migrants is not reflected in daily practice given the obligation to denounce imposed by the German legislation on public administrative institutions, including the social welfare centres that have competences on health administration issues. Only very recently, the new implementing regulation (formally adopted by the German Parliament) has excluded these centres from the duty to denounce in cases where they are asked for reimbursement by health care providers in emergency situations.

This rigid framework has only been “broken” by few initiatives taken at local level intending to provide some health care to undocumented migrants and to this aim procuring their anonymity.

## **GREECE** (combination of a national health system and an insurance-based system)

Asylum seekers are entitled to access free of charge almost all types of medical care and medicines under the condition of lacking enough resources to pay (HIV treatment is however excluded). They can only ac-

cess these services in public health facilities unless they are employed. In the latter case, they will be eligible to become members of one of the compulsory insurance funds and therefore contribute and co-pay some services, as is the case for all insured persons. The legal framework regarding access to healthcare for asylum seekers has a rather small applicability in practice due to the incapability of the Greek government to acceptably manage asylum applications and implement minimum standards of protection for asylum seekers.

Undocumented migrants face very serious discrimination in Greece. The law prohibits (at the risk of penalty) public entities, including health centres or hospitals, to provide services to them. The only exceptions concern children or adults in need of emergency care until their health has stabilised. This entails that adult undocumented migrants are entitled neither to insurance coverage nor to any other health service free of charge. In practice, however, it seems that health care professionals tend to interpret this concept quite largely.

Given the succinct provisions, it is only possible to state that the law does not prohibit providing healthcare to children of undocumented migrants. In Greece, it is generally interpreted that all children have the right to access health care free of charge; however, effective access is extremely endangered since there are no clear regulations or guidelines seeking to fill the gap of information about health care entitlements and conditions. Unaccompanied children are better protected by law as far as they are mentioned by the legislation establishing the reception conditions for asylum seekers.

## **ITALY** (national health system)

Asylum seekers are entitled to access health care on equal grounds as Italian nationals in regards to coverage and conditions. This is also the rule for unaccompanied children.

Undocumented migrants have access to wide health coverage (specifically detailed and listed in the law) through a specific system called “STP – Temporarily Present Foreigners” consisting of a short-term but renewable anonymous code that is easily provided to all undocumented migrants. Although undocumented migrants are normally requested to pay a symbolic contribution to the system through the “ticket”, the major barrier is the lack of entitlement to have a family doctor, which also leads to many obstacles accessing specialists.

## **MALTA** (national health system)

The treatment that Maltese legislation gives to asylum seekers and undocumented migrants is not very different. This treatment is to a great extent explained by the absence of a legal framework that clearly diffe-



rentiates the groups of foreigners present in the territory and establishes their basic rights.

There is a law recognizing the right of asylum seekers to access “state medical care and services” (without any more specification). However, no Maltese legal provision refers to undocumented migrants’ access to health care. There is only a non-legally binding “policy document” establishing that all foreigners in detention are entitled to “free state medical care and services”. Although the interpretation of this term is usually quite large, practice shows that effective access to health care and medicines by these populations highly depend on discretionary decisions made at hospitals or on the scarce medical resources of detention centres and the willingness of their guardians.

In the cases where they are allowed to receive medical services, they access the mainstream system primarily showing their “police number” as a unique identification.

## **THE NETHERLANDS** (insurance-based system)

Asylum seekers are entitled to access free of charge all types of health care with very few exceptions. In regards to conditions, the system differs from Dutch nationals because asylum seekers cannot choose the insurance company but this difference does not have a major impact on the services received and the conditions applying. Undocumented migrants can only access care considered by doctors on a case by case basis as “medically necessary”. The rule is that they will have to pay for it unless it is proven they cannot pay. If this is the case, health care providers, hospitals and pharmacies will provide care or treatment and then ask for reimbursement to the specific public fund.

Although rather generously interpreted by law and particularly in practice (also including HIV treatment and ante-post natal care), this concept does not offer enough guarantees to effectively access health care because it makes access dependent on doctors’ discretionary appraisals. In addition, many health care providers are not so motivated to provide access since they can only receive maximum the 80% of the cost incurred.

## **POLAND** (insurance-based system)

Asylum seekers are not eligible for the statutory health insurance however they can still access free of charge “health services” in specific medical facilities. There is no formal interpretation of this provision but it is generally understood as comprising all health services available for the insured.

Undocumented migrants are very discriminated against in Poland to the extent that the only care they can access free of charge is that provided by rescue teams outside hospital in the case of emergency or for the treatment of infectious diseases that require mandatory treatment (inclu-

ding post-exposition anti-viral treatment). Given the obligation imposed on health care providers never to deny assistance in cases of immediate danger to life or health, undocumented migrants can be treated in the emergency units but they should bear the total cost.

Concerning children with no residence permit (whether they are accompanied or not), the only difference is that those children attending public schools receive free medical and dental prophylactics, including mandatory vaccination, medical check-ups and screening tests.

## **PORTUGAL** (national health system)

Asylum seekers are entitled to access health care on equal grounds as Portuguese nationals in regards to coverage and conditions. Extensive health coverage is provided by law to undocumented migrants as long as they can prove that they have been living in Portugal for more than ninety days. However, the need to provide this evidence often constitutes a critical barrier for them to exercise their entitlements. Access is organized through temporary registrations at health centres and is normally done each time they seek health assistance. For most services, patients must pay a moderating fee, unless they obtain a certificate of lack of resources.

Short-stay undocumented migrants are considered tourists and have reduced coverage that nonetheless includes HIV treatment and ante-post natal care, among others.

## **ROMANIA** (insurance-based system)

In theory, asylum seekers are eligible for the statutory health insurance if they are working or if they decide to take out the “facultative insurance”. Nonetheless, inability to pay the contributions means that they can only enjoy the rights recognised by the Asylum legislation. This legislation entitles them to access free of charge: primary care, emergency care and treatment of very serious chronic diseases that can cause an imminent danger to life (HIV is normally included). Moreover, it provides that those having “special needs” will have “adequate medical assistance”, however, the legislation does not give any more details. In addition to this, asylum seekers are also subject to the general legislation on health care and thus can also access free of charge treatment of potential epidemic diseases, ante and post natal care and family planning.

These general rules also apply to undocumented migrants as well as all other uninsured persons. In Romania, at least in theory, everybody is entitled to receive free care in the case of emergency, potential epidemic diseases, pregnancy or if they need family planning support. All other health care services are only provided on full payment basis. The only exception is the case of children under eighteen who, irrespective of legal status, are treated equally as national children.

Some undocumented migrants have “tolerated status” (authorisation to stay) due to the fact that they cannot be deported. Up to now, this status does not imply the recognition of any rights, however the authorities are currently considering the possibility of recognising their right to work and thus to being insured upon payment of the contributions.

## **SLOVENIA** (insurance-based system)

According to applicable legislation in Slovenia, asylum seekers and undocumented migrants have the same entitlements. They can access free of charge “emergency medical care and essential treatment”. Besides the services needed in very grave situations, ante and post natal care, family planning and assistance for abortion are also covered. Even though the law provides for a rather exhaustive definition of the concept “essential treatment”, it also establishes that this term will be interpreted by doctors on a case by case basis. In addition, vulnerable asylum seekers with special needs (including children, unaccompanied minors, pregnant women and victims of several types of violence) and exceptionally some other applicants have the right to “additional medical services” as defined by a special commission appointed by the Ministry of Internal Affairs.

Some undocumented migrants who cannot be expelled from Slovenia obtain the “tolerated status”. This is just an authorisation to stay (not a residence permit) mainly granted to rejected asylum seekers and persons leaving the detention centre. These persons are entitled to the same health care rights as asylum seekers and other undocumented migrants.

## **SPAIN** (national health system)

Asylum seekers and undocumented migrants are entitled to access health care on equal grounds as Spanish nationals in regards to coverage and conditions. The problem is that for undocumented migrants it is more complicated to comply with the administrative requirements, mainly the *empadronamiento* – local civil registration, because it implies having valid identity documentation and an address.

Children and pregnant women are exempted from any administrative requirement. At least four regions in Spain (out of seventeen) have adopted a more friendly approach consisting of providing a “health card” to all undocumented migrants without any kind of administrative conditions.

## **SWEDEN** (national health system)

In Sweden, asylum seekers and undocumented migrants are highly discriminated against by the legislation governing access to health care. The sole exceptions are children of asylum seekers, asylum seeking children and those children whose parents’ application for asylum failed. Asylum seeking adults are only entitled to access free of charge “care

that cannot be postponed”, ante and post natal care, family planning and abortion. They have to pay a patient contribution for some of these services.

Undocumented migrants have been totally invisible for the legislation. Only very recently, a law has formally referred to adult rejected asylum seekers only to leave them outside the categories of foreigners who have some access to the health system. Thus, undocumented migrants in Sweden, including children (other than children of rejected asylum seekers), pregnant women or persons in emergency situations or with serious infectious diseases do not have any access to health care free of charge and have great difficulties paying the high costs of the health services. Since there is not a formal prohibition to provide care to undocumented migrants, some county councils and public hospitals have adopted timid initiatives to provide some health care to this extremely marginalized social group.

## **UNITED KINGDOM** (national health system)

Asylum seekers are entitled to access health care on equal grounds as British nationals in regards to coverage and conditions. This is also the rule for unaccompanied children.

Undocumented migrants (adult and accompanied children) can only access free of charge primary care, emergency care, family planning, treatment of communicable diseases (except HIV) and in serious mental health cases. Since 2004, they have had to pay the full cost of any other hospital treatment or diagnosis including secondary care, inpatient care, ante/post natal care provided in hospitals, medicines and HIV treatment. Furthermore, they can be denied access to these services if they cannot advance payment as long as the treatment can wait until the patient returns to his/her country of origin.

An important obstacle for undocumented migrants arises from the fact that general practitioners in the United Kingdom have the discretionary power to include or not include patients in their NHS list and this is the gate to access the meager entitlements that the undocumented migrants have.

# OVERVIEW TABLES

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The tables seek to summarise the results contained in the different country profiles of the HUMA network publication, “Access to health care for undocumented migrants and asylum seekers in 10 EU countries” and those of the additional research in Cyprus, Czech Republic, Greece, Poland, Romania and Slovenia. They show the main features of each system and allow the comparison of them. However the overall complexity of each system can not be presented in this table. For a complete overview of undocumented migrants’ and asylum seekers’ entitlements as well as residence permits for medical reasons, it is advisable to read the correspondent country profile in the HUMA network reports.

Colour code


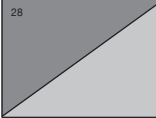
	ACCESS TO HEALTH CARE					ACCESS TO TREATMENT		
	Primary	Secondary (outpatient)	Hospitalisation (inpatient)	Emergency	Ante-post natal	Medicines	HIV	Other infectious diseases
BELGIUM	If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)	If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)	If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)		If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)	If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)	If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)	If entitled and obtain the AMU (thus i) spot investigation of address and lack of resources; and ii) "urgent" character)
CYPRUS <sup>2</sup>				If hospitalisation is not needed <sup>3</sup> .				
CZECH R.								
FRANCE	If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources)	If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources)	If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources)		If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources) <sup>7</sup>	If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources)	If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources) <sup>8</sup>	If entitled and obtain the AME (thus i) proved residence of more than three months; and ii) proved lack of enough resources) <sup>9</sup>
GERMANY	No access due to the existence of the duty to denounce undocumented migrants that completely override entitlements <sup>10</sup>							
GREECE	The law prohibits (at the risk of penalty) public entities, centres or hospitals, to provide these services to undocumented migrants.				The law prohibits (at the risk of penalty) public entities, centres or hospitals, to provide these services to undocumented migrants.			
ITALY <sup>11</sup>	However, they are not allowed to have a family doctor					12		
MALTA	No legal provisions, only a non legally-binding policy document applying to undocumented migrants and asylum seekers in detention centres <sup>13</sup>							

ACCESS TO HEALTH CARE						ACCESS TO TREATMENT		
	Primary	Secondary (outpatient)	Hospitalisation (inpatient)	Emergency	Ante-post natal	Medicines	HIV	Other infectious diseases
NETHERLANDS	If “medically necessary” and proved lack of resources to pay	If “medically necessary” and proved lack of resources to pay	If “medically necessary” and proved lack of resources to pay	If “medically necessary” and proved lack of resources to pay	If “medically necessary” (always considered in practice) and proved lack of resources to pay	If “medically necessary” and proved lack of resources to pay	If “medically necessary” (always considered in practice) and proved lack of resources to pay	If “medically necessary” (always considered in practice) and proved lack of resources to pay
POLAND				Only care provided by rescue teams outside hospitals <sup>14</sup> .			<sup>15</sup>	If included in list of diseases that require mandatory treatment.
PORTUGAL <sup>16</sup>	If proved residence for more than 90 days and proved lack of resources	If proved residence for more than 90 days and proved lack of resources	If proved residence for more than 90 days and proved lack of resources	If proved residence for more than 90 days and proved lack of resources		If proved residence for more than 90 days and proved lack of resources <sup>17</sup>		
ROMANIA								If potential epidemic disease.
SLOVENIA								If needed to prevent the spread of an infection that could lead to a septic state.
SPAIN <sup>18</sup>	If obtain «em-padronamiento» and thus the «health card».	If obtain «em-padronamiento» and thus the «health card».	If obtain «em-padronamiento» and thus the «health card».			If obtain «em-padronamiento» and thus the «health card».	If obtain «em-padronamiento» and thus the «health card».	If obtain «em-padronamiento» and thus the «health card».
SWEDEN				<sup>19</sup>				<sup>20</sup>
UK	If included in a NHS list by a general practitioner				<sup>21</sup>	If included in a NHS list by a general practitioner		If it is one of the 35 specified diseases and if included in a NHS list by a general practitioner <sup>22</sup>

according to applicable national legislation

Colour code

NO ACCESS	ACCESS FULL PAYMENT	ACCESS CO-PAID	ACCESS FREE OF CHARGE	NO LEGAL PROVISION
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	ACCESS TO HEALTH CARE					ACCESS TO TREATMENT		
	Primary	Secondary (outpatient)	Hospitalisation (inpatient)	Emergency	Ante-post natal	Medicines	HIV	Other infectious diseases
BELGIUM	If they request first the “ <i>réquisitoire</i> ” <sup>23</sup>	If they request first the “ <i>réquisitoire</i> ”	If they request first the “ <i>réquisitoire</i> ”		If they request first the “ <i>réquisitoire</i> ”	If they request first the “ <i>réquisitoire</i> ”	If they request first the “ <i>réquisitoire</i> ”	If they request first the “ <i>réquisitoire</i> ”
CYPRUS	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group. <sup>24</sup>	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.			If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.	If living in a reception centre, receiving welfare benefits, proved lack of sufficient resources or belonging to a vulnerable group.
CZECH R. <sup>25</sup>								
FRANCE <sup>26</sup>								
GERMANY	If residence above 48 months otherwise only if “illness or acute pain” and if get in advance the “ <i>Krankenschein</i> ”	If residence above 48 months otherwise only if “illness or acute pain” and if get in advance the “ <i>Krankenschein</i> ”	If residence above 48 months otherwise only if “illness or acute pain” and if get in advance the “ <i>Krankenschein</i> ”		If residence above 48 months otherwise if they get in advance the “ <i>Krankenschein</i> ”	If residence above 48 months otherwise if they get in advance the “ <i>Krankenschein</i> ” <sup>27</sup>	If residence above 48 months otherwise only if “illness or acute pain” and if get in advance the “ <i>Krankenschein</i> ”	If residence above 48 months otherwise only if “illness or acute pain” and if get in advance the “ <i>Krankenschein</i> ”
GREECE	If lack of resources.	If lack of resources.	If lack of resources.		If lack of resources.	If lack of resources.		
ITALY								
MALTA	One legal provision generally entitling them to “state medical care and services” and a non-legally binding policy document applying to asylum seekers and undocumented migrants in detention centres <sup>29</sup>							



	ACCESS TO HEALTH CARE					ACCESS TO TREATMENT		
	Primary	Secondary (outpatient)	Hospitalisation (inpatient)	Emergency	Ante-post natal	Medicines	HIV	Other infectious diseases
<b>NETHERLANDS</b>								
<b>POLAND</b>						30		
<b>PORTUGAL</b>						31		
<b>ROMANIA<sup>32</sup></b>								If the disease creates an imminent danger to life.
<b>SLOVENIA</b>								If needed to prevent the spread of an infection that could lead to a septic state.
<b>SPAIN<sup>33</sup></b>	If obtain “ <i>em-padronamiento</i> ” and thus the health card” <sup>34</sup>	If obtain “ <i>em-padronamiento</i> ” and thus the health card”	If obtain “ <i>em-padronamiento</i> ” and thus the health card”			If obtain “ <i>em-padronamiento</i> ” and thus the health card”	If obtain “ <i>em-padronamiento</i> ” and thus the health card”	If obtain “ <i>em-padronamiento</i> ” and thus the health card”
<b>SWEDEN</b>	If care “cannot be postponed”	If care “cannot be postponed”	If care “cannot be postponed”	If care “cannot be postponed”		If treatment “cannot be postponed”		If disease included in the list provided by law
<b>UK</b>	If included in a NHS list by a general practitioner.	If included in a NHS list by a general practitioner	If included in a NHS list by a general practitioner			If included in a NHS list by a general practitioner	If included in a NHS list by a general practitioner	If included in a NHS list by a general practitioner

## Access to health care for foreign children and pregnant women according to applicable national legislation

This table shows whether (asylum seeking or undocumented) children/pregnant women are discriminated against or not when compared to the comparable national population, according to the national applicable legislations. As a reminder, Article 24 of the International Convention on the Rights of the Child provides that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services”. Pregnant women are also protected by this Convention which stipulates that “States shall take measures to ensure pre-natal and post-natal healthcare for mothers”.

In none of the countries studied are undocumented pregnant women denied access to care at the time of delivery, since this is normally considered an emergency situation. Nonetheless, in some countries this care is chargeable. Monitoring of pregnancy is however inaccessible for them in those countries where they are not entitled to free pregnancy care as they cannot pay the full cost of these services.

Colour code

**HIGHLY DISCRIMINATED**

**DISCRIMINATED WHEN COMPARED TO NATIONAL CHILDREN (OR NATIONAL PREGNANT WOMEN) (ENTITLEMENTS AND/OR ADMINISTRATIVE CONDITIONS)**

**NOT DISCRIMINATED WHEN COMPARED TO NATIONAL CHILDREN (OR NATIONAL PREGNANT WOMEN)**

	CHILDREN				PREGNANT WOMEN	
	unaccompanied (Asylum seeking) children	asylum seekers' children	unaccompanied (migrant) children	children of undocumented migrants	asylum seeking	undocumented
BELGIUM		= entitlements ≠ conditions		= entitlements ≠ conditions	= entitlements ≠ conditions <sup>35</sup>	
CYPRUS		If own asylum application: = entitlements ≠ conditions  If not own asylum application: ≠ entitlements ≠ conditions	Access ONLY in case of emergency and infectious diseases otherwise ONLY on full payment basis.			Access ONLY in case of emergency and infectious diseases otherwise ONLY on full payment basis.
CZECH REP.		<sup>36</sup>		Access ONLY on full payment basis	<sup>37</sup>	Access ONLY on full payment basis
FRANCE				= entitlements ≠ conditions <sup>38</sup>		= entitlements ≠ conditions

	CHILDREN				PREGNANT WOMEN	
	unaccompanied (Asylum seeking) children	asylum seekers' children	unaccompanied (migrant) children	children of undocumented migrants	asylum seeking	undocumented
GERMANY	If residence > 48 months		= entitlements ≠ conditions		If residence > 48 months	= entitlements ≠ conditions
	If residence < 48 months: ≠ entitlements <sup>39</sup> ≠ conditions		The duty to denounce overrides entitlements.		If residence < 48 months: ≠ entitlements ≠ conditions	The duty to de-nounce overrides entitlements.
GREECE		= entitlements ≠ conditions	= entitlements ≠ conditions (No clear legal provisions)		= entitlements ≠ conditions	Access ONLY in case of emergency otherwise ONLY on full payment basis.
ITALY				= entitlements ≠ conditions		= entitlements ≠ conditions
MALTA			= entitlements ≠ conditions  There are NO legally binding norms.			= entitlements ≠ conditions  There are NO legally binding norms
NETHERLANDS			= entitlements ≠ conditions			≠ entitlements ≠ conditions
POLAND	= entitlements ≠ conditions		ONLY very limited access at school.		= entitlements ≠ conditions	Access ONLY on full payment basis.
PORTUGAL						
ROMANIA	= entitlements ≠ conditions		= entitlements ≠ conditions		= entitlements ≠ conditions	
SLOVENIA	≠ entitlements ≠ conditions		Access ONLY in case of emergency, otherwise ONLY on full payment basis.			
SPAIN <sup>40</sup>						
SWEDEN			Access ONLY if rejected asylum seeker, otherwise ONLY on full payment basis.			Access ONLY on full payment basis.
UK				= entitlements ≠ conditions		Access ONLY in case of emergency or assistance by midwives in the community, otherwise ONLY on full payment basis <sup>41</sup> .

## Protection from expulsion for medical reasons

In certain countries, there are legal mechanisms protecting seriously ill undocumented migrants (sometimes also asylum seekers) against expulsion. In most countries, these persons are granted specific residence permits (many times called “humanitarian” permits) but there also exists in some countries other types of legal mechanisms that make possible to temporarily stop deportation for medical reasons. The conditions and the rights attached to these permits greatly differ among countries although in most cases these permits are granted through administrative decisions which are in many cases rather discretionary.

**Code:** “X” means that there are legal provisions

	RESIDENCE PERMITS FOR MEDICAL (OR HUMANITARIAN) REASONS	OTHER LEGAL MECHANISMS TO AVOID EXPULSION OR REFUSAL-OF-ENTRY FOR MEDICAL REASONS
BELGIUM	X	
CYPRUS	X	
CZECH REPUBLIC	X	X
FRANCE	X	X
GERMANY	X	X
GREECE	X	
ITALY	X	
MALTA		X
THE NETHERLANDS	X	X
POLAND	X	
PORTUGAL	X	
ROMANIA		X
SLOVENIA		
SPAIN	X	X <sup>42</sup>
SWEDEN	X	
UNITED KINGDOM	X	

## THE DUTY TO DENOUNCE AND THE PENALISATION OF ASSISTANCE TO UNDOCUMENTED MIGRANTS

There are only very few countries in the EU whose legislations formally establish **the duty to denounce undocumented migrants** to the police or immigration authorities. Among the targeted countries, we find Germany and Romania.

In Romania, health care professionals are obliged to breach their duty of confidentiality when it is considered that they are facilitating the illegal stay of undocumented migrants “under any form”.

In Germany, the obligation to denounce is not directly imposed on doctors and nurses but on public administration entities, including the Social Welfare Centres. The existence of the duty to denounce in Germany has brought continuous critics from many institutions and organisations in Germany and throughout Europe. This could be behind the fact that Germany has recently softened the implementation of the legal provisions to the point to exclude the Social Welfare Centres from this duty when they are contacted by hospitals providing emergency care to undocumented migrants.

Certainly, this kind of practices has always provoked an enormous controversy among health care professionals, institutions and civil society organisations. In Italy, the firm reactions of many doctors and nurses also managed to stop an attempt to allow doctors to denounce undocumented migrants.

Besides legal considerations, it is important to note that in practice, cases are reported where health administrations and medical personnel spontaneously denounce undocumented migrants to the police despite the inexistence of laws obliging them to do so.

Similarly, there are still examples of legislation that criminalizes assistance to undocumented migrants residing in member states, even if this assistance is not given for financial gain. The most obvious example is the Greek legislation that formally prohibits (at the risk of penalty) public entities, including health centres or hospitals, to provide services to undocumented migrants. The only exceptions concern emergency situations or if the patient is a child. There was an attempt by the Swedish government to adopt similar provisions in 2008.

In France, a literal interpretation of the applicable provisions makes any person lending assistance in good faith a suspect, and several recent well-known cases have demonstrated that this situation is not merely theoretical. The German legislation also penalises assistance even if such assistance is not rendered for financial gain. The latest example comes from Spain which has recently included as a serious offence, the fact of housing an undocumented migrant (not living at his/her home) to allow the latter to be recorded in the local registry which is the gate to access certain basic social rights.

# RECOMMENDATIONS

The members of the HUMA network demand equitable<sup>43</sup> access to health care, treatment and prevention for all people living in Europe, without any discrimination on the basis of legal status or financial means.

## The HUMA network calls for:

- Effective and equitable access to health care and prevention for undocumented migrants and asylum seekers (access on equal grounds as nationals with the same medical needs and level of resources);
- The specific needs of vulnerable groups (pregnant women, children and victims of torture) to be addressed, including providing them immediate access to prevention and care.
- The protection of seriously ill undocumented migrants from expulsion by granting them a permit to stay when they are unable to receive effective access to treatment in their country of origin.
- The respect of medical confidentiality, an end to the duty to denounce undocumented migrants within the health system and an end to the penalisation of assistance to undocumented migrants.
- Effective access to health care for foreigners confined in detention centres and the monitoring of detention centres by independent bodies.

Based on the outcomes of the HUMA publications, the HUMA network and its members address specific **policy recommendations** to the European institutions as well as to competent national, regional and local authorities in the field of health and immigration. These recommendations are available at [www.huma-network.org](http://www.huma-network.org).

43. Equitable access to health services is commonly described as "equal access to treatment for those in equal medical need, irrespective of other characteristics, such as income", [European Union Public Health Information System \(EUPHIX\)](http://www.euphix.org/object_document/o5679n29797.html), Inequalities in health services access, [www.euphix.org/object\\_document/o5679n29797.html](http://www.euphix.org/object_document/o5679n29797.html).

# FOOTNOTES

1. The term "urgent" is interpreted very widely as to cover most of curative and preventive health care.
2. There are not specific laws regarding access to health care for undocumented migrants but only some general provisions and a Circular from the Ministry of Health stating that "the Regulations should be implemented so as to allow access to emergency care free of charge for any person as far as they do not need hospitalisation".
3. There are only ministerial circulars referring to this.
4. They however cannot be denied this care if they cannot pay.
5. Ibid.
6. Ibid.
7. Nonetheless, undocumented migrants who do not comply with these conditions can have free-of-charge access through the "*Permanences d'accès aux soins de santé*" (PASS) and in which are in place only in some hospitals or through emergency department.
8. Ibid.
9. Ibid.
10. In September 2009, the new implementing regulation (formally adopted by the German Parliament) has excluded the social welfare centres (competent on health administration issues) from the duty to denounce in cases where they are asked for reimbursement by health care providers in emergency situations.
11. The system is organized through an anonymous code flexibly provided to undocumented migrants ("STP code"). Note also that the copayment ("*ticket*") by undocumented migrants is very symbolic in Italy and sometimes they are exempted.
12. Access free of charge or co-paid depending on the category of medicines.
13. According to this policy document, undocumented migrants are entitled to "free state medical care and services".
14. Health care providers are obliged to provide care in cases of immediate danger to life or health but undocumented migrants bear the cost of the services received in the emergency units of hospitals.
15. They however have free access to post-exposition anti-viral treatment.
16. Note also that the copayment (moderating fee) to be done by asylum seekers and nationals is very symbolic in Portugal. Undocumented migrants are usually exempted if they get the certificate of precarious economic situation.
17. Access free of charge or co-paid depending on the category of medicine.
18. This information refers to the situation in the majority of Spanish regions. There are however some of them which have eliminated all administrative conditions to obtain the health card.
19. However, access cannot be denied because the law obliges to provide emergency care.
20. The general legislation on contagious diseases seems to be applied to everyone through the specialised clinics for sexually transmitted diseases.
21. They can however access some pregnancy care provided by midwives in the community. Even if delivery care is chargeable, it is always accessible.
22. Some treatment is however provided through designated sexual health clinics upon no conditions.
23. This condition only applies to asylum seekers who choose not to live in public reception centers.
24. Even if entitled to free-of-charge access, in practice, they pay 2 EUR as a nominal contribution with the exception of some medical services and some serious chronic diseases if necessary treatment.
25. As all other insured persons, asylum seekers have to pay the "regulation fee". Although this fee is rather small (1.20 EUR), it is quite difficult for asylum seekers to pay it given the fact that they are not allowed to receive welfare money or to work during the first year of stay.
26. They are usually entitled to the "complementary CMU" (as long as they are below a certain economic threshold) allowing them to access free of charge all care and treatments.
27. The asylum seekers who have been residing in Germany for less than four years and getting in advance the *Krakenschein*, they receive the medicines free of charge.
28. Access free of charge or co-paid depending on the category of medicines.
29. According to this policy document, asylum seekers are entitled to "free state medical care and services".
30. The copayment rate depends on the category of medicine. In practice, many medicines are provided for free in the reception centres.
31. Access free of charge or co-paid depending on the category of medicines.
32. Asylum seekers in Romania are also entitled to the social health insurance if they are working (one year after submitting the asylum application) or if they have signed the "facultative insurance agreement". This possibility has not been reflected in this table given its remote applicability in practice (difficulties to pay the contributions).
33. For asylum seekers, the condition of "empadronamiento" does not imply a major barrier to being in possession of official identification documents.
34. For asylum seekers getting the "empadronamiento" (registration in the municipal registry) is as easy as it is for nationals.
35. However, they can also receive preventive ante and post natal care free of charge under no conditions at the *Office de la Naissance et de l'Enfance*.
36. Even if the "regulation fee" is requested from all insured persons, for asylum seekers the payment of 1.20 EUR each time they seek health care poses a serious problem. See note 22.
37. Ibid.
38. Children of undocumented migrants directly get the AME. They do not need to comply with the conditions concerning the three-month residence and the lack of economic resources.
39. They have however more entitlements than adult asylum seekers living in Germany for less than 48 months.
40. To facilitate access to health care for all categories of foreign children and pregnant women, the Spanish law does not even require the condition of being registered in the local civil registry as it is required for all other users of the National Health System.
41. Pregnancy care provided in hospitals is always chargeable.
42. Only in case of risk during pregnancy.

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# THE HUMA NETWORK

The HUMA network's general objective is to promote access to health care on equal grounds as nationals for undocumented migrants and asylum seekers within the European Union.

It is an advocacy network active at national and European level and initiated by Médecins du Monde. It is currently composed of 16 NGOs in 16 European countries and a coordination team based in Paris, Brussels and Madrid.

The HUMA network members develop activities related to health and migration and, in particular, targeting undocumented migrants and asylum seekers; most of them provide these populations primary care. They also lead advocacy programs and campaigns at national and European level and contribute to the expertise and data collection of the network.

The different Médecins du Monde organisations in Europe take part in this network. Médecins du Monde France leads the whole project together with Médecins du Monde Spain and Médecins du Monde Belgium.

For more information about the project and its activities, see HUMA network website: [www.huma-network.org](http://www.huma-network.org)

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