

Access to health care for illegal immigrants in the EU: should we be concerned?

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Summary

The presence of illegal immigrants in EU countries is increasing despite considerable immigration policy efforts over the last years. EU Member States have responded by strengthening their fight against illegal immigration, with different multi-level measures that include the curtailment or denial of social security rights such as access to publicly funded health care. Although significant differences exist between Social Health Insurance and National Health Service countries with regard to legislative provisions, access to health care for illegal immigrants is generally limited to situations that are life threatening (emergencies) or pose a risk to the public health (i.e. infectious diseases). In practice, strong barriers to access exist even in those situations. Because health care needs of illegal immigrants are not being met, access to health care for this population should be an issue of utmost concern to both policy makers and the public. National legislations and implementation practices need to be upgraded in order to grant illegal immigrants effective access to health care, as mandated by Human Rights laws. That is feasible and not necessarily incompatible with current immigration policies.

'Nothing in this Declaration shall be interpreted as legitimizing the illegal entry into and presence in a State of any alien, nor shall any provision be interpreted as restricting the right of any State to promulgate laws and regulations concerning the entry of aliens and the terms and conditions of their stay or to establish differences between nationals and aliens. However, such laws and regulations shall not be incompatible with the international legal obligations of that State, including those in the field of human rights.'

Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live (Article 2.1) United Nations (1985)

1. Introduction

The fight against illegal immigration (IM) is currently a priority for all OECD countries. The last decades have witnessed a substantial tightening of national legislations, with subsequent increases in border control, identity checks, workplace inspections, and return migration. At the same time, international co-operation has been actively sought in order to increase the efficiency of these policies. Examples include Article 3 of the International Labour Organisation (ILO) Convention No. 143 *concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers* (1975) and the adoption of the United Nations Convention *against Transnational Organised Crime* and its two supplementing Protocols against trafficking and smuggling of migrants (2000).

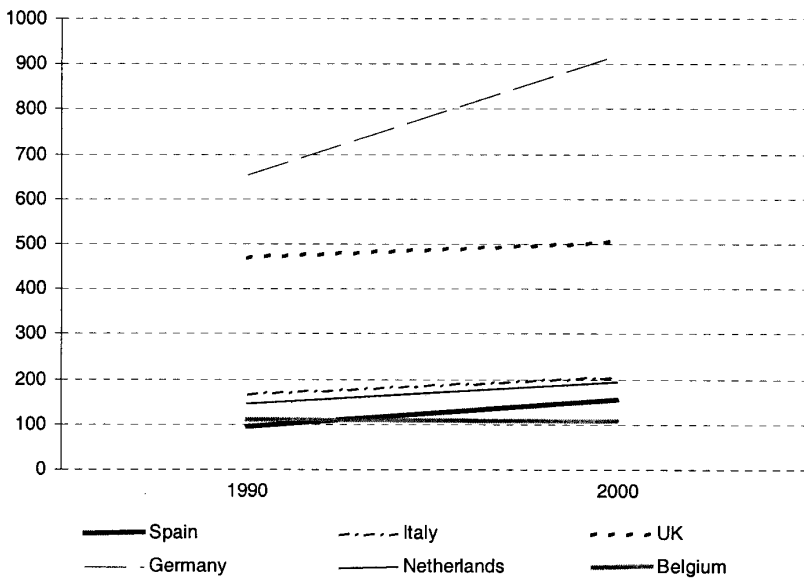
Member States of the European Union (EU) have preferentially channelled their co-operation through the distinctive EU political structures and policy pathways. With the entry into force of the Treaty of Amsterdam on 1 May 1999, the Council was empowered to adopt common measures concerning 'illegal immigration and illegal residence, including repatriation of illegal residents' (Article 63(3)(b) of the consolidated Treaty). Since then, EU policies and responses to IM have become ever tougher. Recent major policy developments include a Resolution *on the creation of an early warning system for the transmission of information on illegal immigration and facilitator networks* (1999), Directive 2001/40/EC *on the mutual recognition of decisions on the expulsion of third country nationals* (2001), a Proposal *for a comprehensive plan to combat illegal immigration and trafficking of human beings in the European Union* (2002) and Framework Decision 2002/946/JHA *on the strengthening of the penal framework to prevent the facilitation of unauthorised entry, transit and residence* (2002).

Despite all these efforts, IM into Europe has *persisted* both on an organised and a personal basis, underscoring 'the difficulties faced by host and sending countries in controlling migration flows',¹ which are partly due to the 'increasingly

porous nature of borders and the improved facility of travel'.² Statistical data on IM is unavailable, but indirect estimates can be made,³ and they are confirming public and political fears that IM into the EU is not only not being curbed, but also increasing.

According to ILO estimates, in 1991 there were 2.6 million illegal immigrants (IMs) living in Western Europe.^{4,5} For both the International Organization for Migration and the UN, this number was almost two million, but by 1998 it had already increased by one million.⁶ As Figure 1 shows, not all countries contributed equally to this upward trend, some of them being more 'preferred' destinations.

Figure 1. Number of IMs (thousands) in six EU countries (overall trend, 1990-2000). ILO calculation method⁷



Common and individual EU immigration policies are currently struggling to effectively tackle the issue of IM, but this paper does not attempt to provide answers as to why that is the case. Rather, it simply departs from the fact that, at least at present, IM is a *tangible social reality*, which necessarily spills over into non-immigration policy spheres. Specifically, the focus will be on a health policy-related situation, in which a *de facto* present IM interacts with a publicly funded health care system (i.e. in the event of an illness). This encounter is regarded as problematic because, as opposed to *asylum seekers* (immigrants whose

asylum applications are pending resolution) and *refugees* (successful asylum seekers under the 1951 United Nations Convention relating to the Status of Refugees), IMs do not enjoy any entitlement to public health care:

Table 1. Entitlement of IMs to publicly funded health care: a theoretical approach

Entry	Residence	Example	Work	Theoretical entitlement	
				TF-NHS: Citizenship/legal residence	SHIS: Contributions from a legal work [*]
I	I	Smuggled/trafficked person Entry with forged documents	I / IN	NO	NO
L	I	Overstayer Rejected asylum seeker	I / IN	NO	NO
I	L	Regularised illegal entrant	L	YES	YES
			I		NO

* Generally requires legal residence

I: illegal; L: legal; IN: inactive

TF-NHS: Tax-financed National Health Service; SHIS: Social Health Insurance System

Exceptions:

- *Unaccompanied illegal minors* may be automatically taken into the asylum procedure
- Detainees who receive *compulsory* medical treatment

This paper draws on library-based research and is structured as follows. The first section challenges the theoretical approach outlined in the chart above with various arguments justifying that IMs *should be entitled* to use publicly funded health care services. A legal study follows that will look at the current state of the art in six EU countries (three SHISs and three TF-NHSs, which are in fact two comparison clusters), and a last section will discuss whether those provisions are sufficient or not. Some room is finally left for conclusions.

2. Should IMs have access to publicly financed health care?

In EU countries, health care coverage of the *official* population has expanded very rapidly since the 1960s, according to the principle of universality. In the view of T. H. Marshall (1950), the endowment of this key social right was the furthest step in the consolidation of democracy, following successive recognitions of civil and political rights. Critical, however, was the fact that all those rights were

anchored to *citizenship*, which failed to anticipate future phenomena such as IM and the associated problem of an increasing number of persons ‘without rights’. More contemporarily, with the emergence of so-called *post-materialism*, a debate has been launched on the convenience of adding a ‘fourth phase’ to the Marshallian sequence, namely the detachment of rights from citizenship in favour of entitlements based on *the simple condition of human being*.

In effect, health care is regarded nowadays as a fundamental human right.⁸ However, when the focus is shifted from the literature onto the real health policy arena, the supremacy of *human rights of persons over social rights of citizens* becomes less evident. All EU Member States have recognised the right of *everyone* to the ‘highest attainable standard of physical and mental health’ and to receive medical care in the event of sickness or pregnancy – reading together Article 25 of the *Universal Declaration of Human Rights* (UN 1948), Article 5 of the *International Convention on the Elimination of All Forms of Racial Discrimination* (UN 1965), Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (UN 1966), Article 12 of the *Convention on the Elimination of All Forms of Discrimination against Women* (UN 1979) and Article 24 of the *Convention on the Rights of the Child* (UN 1989). However, the lack of implementation of standards, coupled with explicit disinterest in ratifying or acceding to new available instruments –most notably the *Convention on the Protection of the Rights of All Migrant Workers and Member of Their Families* (UN 1990)–symbolizes, in words of Taran, ‘a broader general resistance to recognition of application of human rights standards to migrants, particularly undocumented migrants’.⁹ Van Krieken also notes that this ‘virtual exclusion of illegals would appear to confirm that the present state of human rights focuses on citizens, and, rightly, tries to be accommodating to non-nationals, as long as they are lawfully present’.¹⁰

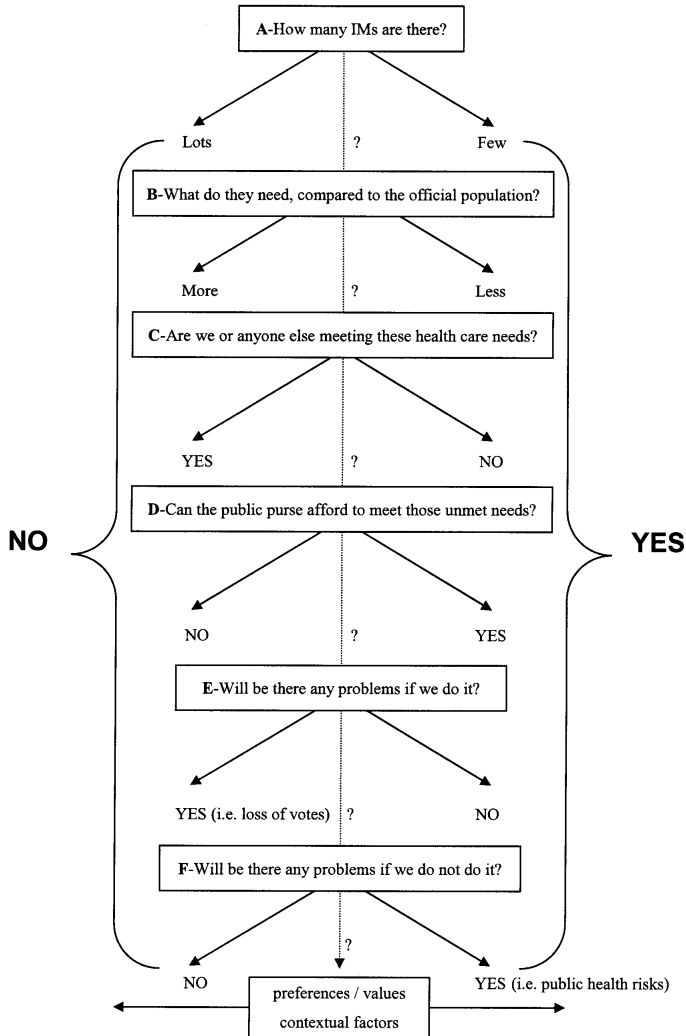
There is further confirmation of that. For instance, Article 1 of the *European Convention on Social and Medical Assistance* (Council of Europe 1953) and Article 13 of the *European Social Charter* (Council of Europe 1961) explicitly require nationals of a Contracting Party be *lawfully* present in the territory of another Contracting Party if they are to be entitled to medical assistance in equal terms with nationals. In addition, Article 8 of the *Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live* (UN 1985) states that only aliens *lawfully* residing in the territory of a State may enjoy the right to health protection and medical care. And although Article 35 of the *Charter of Fundamental Rights of the European Union* (EU 2000) recognizes ‘the right of everyone to access to preventive health care and the right to benefit from medical treatment’, the scope of this right (as defined in Article 52) could entail, as Peers warns, ‘certain restrictions based on nationality or migration status’.¹¹

Even voices from official bodies such as the Council of Europe have risen to denounce this unclear situation, acknowledging that IMs, ‘who are falling outside the scope of existing health and social services’, ‘represent a major problem in the area of health-care provision’ that ‘requires closer examination’.¹² In the face of that, the action of the European Commission has been just to remind Member States that, in effect, ‘illegal immigrants are protected by universal human rights standards and should enjoy some *basic* rights e.g. *emergency* healthcare and primary school education for their children’¹³ (italics not in the original).

It is clear that EU Member States are not willing to extend *full* health care coverage to IMs. Official explanations as to why that is the case have not been supplied but, as Vonk¹⁴ suggests, it is likely that ‘too generous’ social rights are being seen as a ‘pull factor’ for further IM, an undesired effect given the restrictive nature of current immigration policies. However, that assumption disregards empirical evidence showing that most IMs do not make a rational choice of their destination country after comparing the benefits of different welfare systems.^{15,16}

Is it possible for ‘Fortress Europe’ to be built in a ‘human rights-friendly’ way, that is, without having to impose *any health punishment* on those people who have found their way through its pores? In a serious attempt to answer this question, a policy-maker could consider the questions in Figure 2.

Figure 2. Should IMs be granted full access to publicly funded health care? A basic decision balance

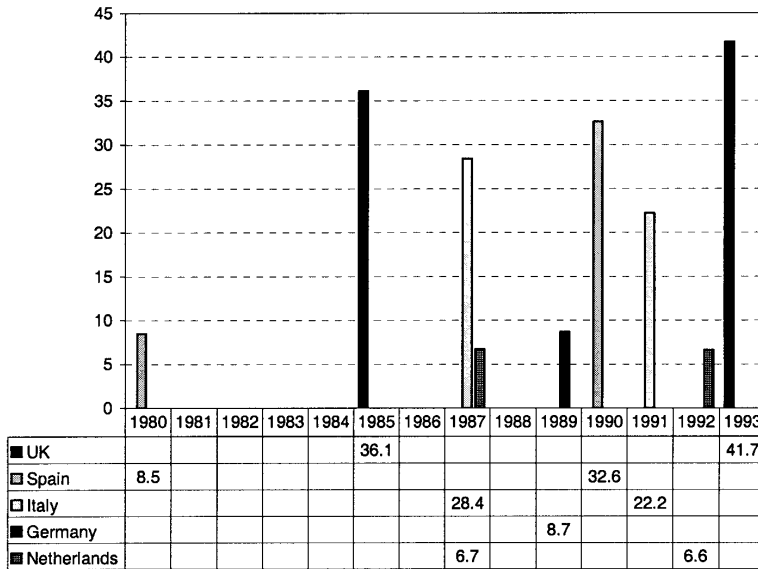


With respect to question C, non-for-profit organisations are significant providers (or purchasers) of health care for IMs in EU countries,¹⁷ but their relative importance *vis-à-vis* the public sector is thought to be minor. To an extent, both sectors might be *complementary*, the ‘more friendly’ NGOs being the preferred providers of ‘primary care’ and the public sector the ultimate recipient of those IMs who require sophisticated, costly interventions. An official acknowledgement of this important (and indeed convenient) role of NGOs could be implicit in Article 1(2) of the EU Council Decision *on the strengthening of the penal framework to prevent the facilitation of unauthorised entry, transit and residence* (2002), which, *exceptionally*, allows Member States ‘not to impose sanctions [...] where the aim of the behaviour is to provide humanitarian assistance to the person concerned’. In fact, this clause relieved the concerns of many voluntary organisations in the EU dealing with the health care of IMs, whose activities were feared to become ‘illegal’ under the Decision.

Question D on affordability is related to the need to contain public expenditure in health care, another imperative that has curtailed the entitlements of even the official population. Thus, every effort is constantly being made by every EU country to prevent collectively funded health care systems from being used by *free riders*, that is, people who, if allowed, would benefit from services at zero cost (i.e. without having paid taxes and/or social contributions). However, this concept does *not* entirely apply to IMs.

In fact, IMs are *indirect tax payers*, which could have significant entitlement implications in those cases where the public health care system receives a significant proportion of its funding from this kind of revenue. As Figure 3 shows, in the early 1990s the proportion of public health expenditure met by indirect taxes was as high as 22.2% in Italy, 32.6% in Spain and 41.7% in the UK, whereas in SHI countries that proportion was much smaller (regrettably, more recent figures are not available). The fact that indirect taxation systems are largely regressive makes IMs likely to be non-negligible contributors to some tax-financed health care budgets in the EU, even after allowing for the possibility that consumption patterns of IMs could be below average.

Figure 3. Proportion (%) of public health expenditure met by indirect taxes 5 EU countries, 1980-1993¹⁸



Moreover, from the point of view of the broader economy (which has indeed effects on the size and structure of health care budgets), these fiscal contributions must be added to other more 'intangible' contributions, the sum of which is unlikely to be offset by the sum of all public expenditures associated to IM (Table 2). On these grounds, the opinion of the House of Lords of the United Kingdom Parliament is that it could be the case that IM *increases the GDP of a nation*.¹⁹

Table 2. Framework for an economic cost-benefit analysis of IM

Costs	Benefits
<i>Direct</i> <ul style="list-style-type: none"> · Justice and home affairs (border control, police, prisons) · Health care · Social services 	<i>Direct</i> <ul style="list-style-type: none"> · Consumption of goods and services (indirect taxes)
<i>Indirect</i> <ul style="list-style-type: none"> · Unpaid direct tax and national insurance contributions · Unemployment among relatively highly paid low-skilled native workers 	<i>Indirect</i> <ul style="list-style-type: none"> · Informal economy · Job creation (economic activities targeted to IMs)

Economic effects aside, question E is concerned with the popularity of the decision to open public health care systems to IMs. Many citizens would welcome the initiative, but others would perceive it negatively, i.e. as an announcement of more ‘competition’ for already scarce health care resources (and subsequent effects on waiting times/lists, rationing practices, etc.). However, if no action is taken (question F), extra *work* and extra *costs* are likely to be generated that may offset anticipated savings (i.e. emergent treatment is more expensive than preventive/elective ones). Moreover, concern is often expressed as to whether untreated communicable diseases carried by IMs (i.e. tuberculosis, HIV/AIDS) might pose an unacceptable risk for the health of the host population. To that respect, the Council of Europe has expressed that ‘given the inevitable interdependence between the health of migrants and their host countries’ populations, this issue is of general concern and should be given high importance’.²⁰

3. Access to health care for IMs: legal provisions in six EU countries

The discussion above is followed here by a description of the legal provisions in six EU countries with respect to access to publicly funded health care for IMs. Three Social Health Insurance (SHI) systems (Belgium, Germany and the Netherlands) are considered against three tax-financed National Health Services (NHS) (United Kingdom, Spain and Italy), in order to see whether organisational and contextual factors and, most especially, the different provider payment methods correlate with different levels and/or forms of provision. In general, in SHI systems health care providers belong to private organizations and doctors are paid on a (reimbursed) fee-for-service basis, whereas in NHS countries health care providers

belong to the public sector and doctors are paid on a salary basis. Exceptions to this rule or other relevant special circumstances are possible and will be referred to as appropriate.

3.1 *Three Social Health Insurance systems*

Belgium

In Belgium, general practitioner (GP) and outpatient specialist fees have normally to be paid *in full* by patients, who are then retrospectively reimbursed by their mutualities at a rate that ranges from 60% to 92%. That does not apply to in-patient treatment (hospital stay), but patients are always required to pay a fixed *per diem*.²¹

In order to make such an ‘uninsured-unfriendly’ system comply with Article 23 of the Belgian Constitution, the Law of 8 July 1964 provided for the establishment of a tax-financed, universal emergency medical service, covering the call system, first aid, transport and admission to hospitals. According to Verbruggen,²² this system will help *everybody* in case of an emergency (life-threatening situation) without his or her insurance being checked first.

The Royal Decree of 12 December 1996 (*Arrêté royal relatif à l'aide médicale urgente octroyée par les centres publics d'aide sociale aux étrangers qui séjournent illégalement dans le Royaume*, entered into force on 10 January 1997) laid down that the costs of providing ‘urgent medical care’ to an IM can be reimbursed to the provider by the relevant Social Welfare Centre (OCMW/CPAS). Many kinds of care are reimbursable (ambulatory or inpatient, preventive or curative) as long as the provider issues (before or after the treatment) a document certifying its ‘urgent’ nature and the IM is found as unable to pay. Table 4a shows what ‘urgent medical care’ is considered to be in practice according to various authors. To dissipate any doubt, a recent amending Royal Decree of 13 January 2003 explicitly included the *continuous* treatment of infectious diseases that may jeopardise public health. Article 4 of the Royal Decree of 12 December 1996 guarantees that any information appearing on medical certificates will be treated confidentially and will not be used for any purpose other than repayment.

Germany

In Germany, statutorily insured patients do not have to pay in advance the fees of their providers. There is no cost sharing for GPs or specialists, and inpatient charges are relatively small. It is thus in the best interest of (private) providers

to ensure that a third party (sickness fund, private insurer) will pay for every treated patient. The requirement to produce evidence of health insurance at the point of service is strictly observed.

A&E treatment should be provided to *everyone* according to Article 323(c) of the 1998 Social Code (*Strafgesetzbuch*) penalising ‘omitted assistance’ (*Unterlassene Hilfeleistung*). To that end, Article 121 of the 1994 Federal Social Welfare Assistance Act (*Bundessozialhilfegesetz*) lies down the conditions under which providers can ask their Social Welfare Centre (*Sozialamt*) for reimbursement of the costs incurred.

Article 19 of the *Infektionsschutzgesetz* (Act to prevent and combat infectious diseases contracted by humans, passed in 2000) states that in case of communicable diseases (STDs and TB) with *immediate* risk for the public health, public health offices (*Gesundheitsämter*) and collaborating (publicly subsidised) private medical centres will diagnose and treat uninsured people anonymously and free of charge without engaging *a priori* in a ‘long’ means-testing procedure. However, as table 4a shows, that does not apply to HIV/AIDS treatment.

Apart from Article 203 of the *Strafgesetzbuch* (on medical professional secrecy), not one law in Germany protects IMs from being reported to the immigration authorities. Moreover, all *public* employees (i.e. *Sozialamt* employees and non-medical *Gesundheitsämter* staff) are obliged by Article 76 of the 1990 Aliens Act (*Ausländergesetz*) to denounce any IM encountered during the course of their work. In Germany, being an IM is considered as a *criminal* offence, and not only a simple breach of administrative rules.

The Netherlands

A distinctive feature of the Dutch health care system is the existence of a health insurance scheme for ‘exceptional medical expenses’ (AWBZ), which is compulsory for the entire population and is, perhaps, more accessible for IMs. The ‘sickness fund scheme’ (ZFW) is mandatory only for people earning less than a given income (64% of the population) and displays the same characteristics referred to in the German system. The remaining high-income earners are left to the private health insurance market.

The principle laid down by the 1998 Linkage Law (*Koppelingswet*) is embedded in section 10(1) of the current (2000) Aliens Act: ‘an alien who is not lawfully resident may not claim entitlement to benefits in kind, facilities and social security benefits issued by decision of an administrative authority.’ However, section 10(2) includes two important exceptions: ‘the provision of care that is medically necessary’ and ‘the prevention of situations that would jeopardize public health’. According to the Dutch *Ministerie van Volksgezondheid, Welzijn en Sport* that should include: a) prevention and treatment of life threatening situations or

situations of permanent loss of essential functions; b) diagnosis and treatment of communicable diseases (such as TB and HIV/AIDS); c) pregnancy and maternity care; d) preventive youth health, including the supply of vaccines to children in accordance to the national calendar and e) compulsory psychiatric treatment.

Reimbursement schemes are different for primary and secondary health care providers. Verbruggen²³ reports that hospitals have to pay the costs from their budgets, but can apply for a special yearly budget for unpaid bills (*Dubieuze Debiteuren*). 'First line' providers (GPs, midwives, pharmacists, dentists, physiotherapists, home carers) can apply for money from the 'Linkage Fund' (*Koppelingsfonds*). According to the Aliens Act, the safety of the procedure for the IM is guaranteed, but does not confer the right to lawful residence.

3.2 *Three tax-financed National Health Services*

United Kingdom

British GPs are mainly paid on a capitation basis, while NHS hospital doctors receive a salary. Since the general purchaser-provider split in 1990, considerable financial risk has been shifted to providers, giving powerful incentives for the development of entrepreneurial ('private') behaviours. However, the system still remains free at the point of service for people who are *ordinarily resident* in the country.

Non-ordinary residents (IMs among them) who require hospital treatment in England and Wales are subject to the provisions of the 1989 NHS (Charges to *Overseas Visitors*) Regulations, Statutory Instrument No. 306 (as amended). These regulations place a duty on NHS Trusts to establish (by means of interviews and requests for documentary evidence) the residential status of all patients. Where an NHS Trust identifies a person who is not ordinarily resident in the UK and is not otherwise exempt from charge, the regulations provide then for the making and recovery of a charge by the trust for most types of hospital treatment.

Overseas visitors will not be charged for the treatment received in a hospital A&E department, including an overnight admission for observation. Further inpatient or outpatient treatment may be charged for, except for a list of communicable diseases (Schedule 1 of the Regulations) or when a reciprocal international agreement applies (Schedule 2). Diagnosis and treatment of STDs at a hospital GUM clinic is also free of charge but, importantly, HIV treatment may be charged for as well as the remaining hospital services.

Charges to overseas visitors for primary care services are regulated by the 1992 NHS (General Medical Services) Regulations, Statutory Instrument No. 635 (as amended). According to them, *any* person, whether registered with a GP or not,

who requires treatment that is regarded by a GP as 'emergent or immediately necessary' must receive that treatment free of charge for a period of up to 14 days. GPs are otherwise free to include or not someone into their lists, needing neither party to request/produce documentary evidence of identity or migration status. GPs may offer/accept to provide non-NHS services at agreed fees.

Spain

A long and asymmetric process of transference of health care competences to the Autonomous Communities (ACs) has been recently concluded by Royal Decree No. 840 of 2 August 2002, establishing the disappearance of the National Health Institute (INSALUD) and its transformation into an managerial body (INGESA) responsible for the co-ordination and oversight of 15 'independent' health services (*Servicios Autonómicos de Salud*). Different practices and traditions exist between them that might have accessibility implications for IMs (i.e. purchaser-provider split in Catalonia). All systems are free at the point of service but, since 1991, NHS patients must produce evidence of their entitlement in the form of an individual health card (*Tarjeta Sanitaria Individual*, TSI).

IM is a relatively new phenomenon in Spain. The old Aliens Act (1985) did not make any reference to the health care rights of IMs; only Constitutional Law 1/1996 *on the legal protection for those under the legal age of majority* recognised the right of illegal minors to receive medical care. Otherwise, only hospital A&E departments and obstetrics units were *de facto* available to everyone, especially after some judicial rulings laid down the obligations of Spain following ratification of certain international human rights treaties.^{24,25}

It was not until the new immigration law was being drafted at the Parliament that the possibility to upgrade these provisions and incorporate them in the law was considered; indeed, it was encouraged by the results of an official study showing the minimal economic impact of doing so.²⁶ Thus, Organic Law No. 4 of 11 January 2000 *on the rights and liberties of foreigners in Spain and their social integration* came out with an innovative Article 12 on the right to health care, which has not been amended by subsequent Organic Law No. 8 of 22 December 2000. This article lays down that those IMs who register with their local census (*Padrón Municipal de Habitantes*) will be *fully* entitled to health care in the same conditions as Spaniards. Unregistered IMs will retain entitlement as long as they are minors under 18 or women during pregnancy, delivery and postpartum. To the rest, only urgent care will be provided in the event of severe illnesses or accidents (including corresponding follow-up until medical discharge). Surprisingly enough, no reference is made to unregistered IMs with communicable diseases.

It is worth noting that a certificate of local registration (*empadronamiento*) does not confer direct entitlement to health care, but it is necessary in order to

apply for a *means-tested* TSI, which is the final entitling document.²⁷ The safety of the procedure is guaranteed by Article 18 of the Law No. 7 of 2 April 1985 (*Ley Reguladora de las Bases del Régimen Local*, as amended by Law No.4 of 10 January 1996), which explicitly outlaws any exchange of information between local councils and the Ministry of Internal Affairs (MI) with respect to the legality of residence of foreigners (Table 3):

Table 3. Separation of competencies between local councils and the MI²⁸

	Local Council (Ayuntamiento)	Ministry of Internal Affairs (Ministerio del Interior)
Duty to register...	All residents in the municipality	All foreigners in Spain
Concerned with legal status?	NO	YES
Document issued	Certificate of local registration	Residence permit

Italy

Italy's health care system is a regionally based national health service that provides universal coverage free of charge at the point of service. The National Health Plan for 1998-2000 prescribed that it should be organised according to several principles, most notably those of *human dignity* (equal rights for everyone irrespective of personal or social characteristics), *health need* (everyone in need has a right to health care) and *solidarity with the most vulnerable people*.

Current legislative provisions concerning health care for IMs can be found in Article 35(3) of the Legislative Decree No. 286 of 25 July 1998, which is a single text that puts all prior existing provisions together, including those of the Decree No. 489 of 18 November 1995 and the 'Turco-Napolitano' Law (No. 40 of 6 March 1998). Provisions are detailed in Article 43 of the Decree of the President of the Republic No. 394 of 31 August 1999 and Health Ministry's *Circolare* No. 5 of 24 March 2000 (Section II-B). The new immigration law No. 189 of 30 July 2002 has not modified these provisions. In particular, IMs in Italy have the right to receive:

a) Urgent and essential primary and hospital care due to illness or accident, with guarantee of the principle of *continuity* of care (defining *urgent* care as that that can not be differed without putting into danger the life or the health of the person concerned, and *essential* care as those diagnostic and therapeutic interventions on conditions that are not dangerous in the immediate/short run, but that, if left untreated, will cause major harm for the health of the person or put his or

her life into risk, due to complications, chronification or worsening); b) pregnancy and maternity care; c) *full* health care for everyone under 18; d) vaccinations according to the rules and within the areas of intervention set by the regions; e) interventions of international prophylaxis; f) prophylaxis, diagnosis and treatment of infectious diseases, including the eradication of their focuses and g) prevention, treatment and rehabilitation of toxic dependencies.

In order to enjoy these rights, the IM has to fill in first an official form self-declaring that he or she lacks sufficient economic resources (*Dichiarazione di Indigenza*). Then, he or she is assigned an anonymous ID regional code (*Codice SPT: Straniero Temporaneamente Presente*), which is valid for six months and allows the IM to use the above-mentioned health care services in the same conditions as Italians. In turn, the concerned regional health authority (*Unità Sanitaria Locale*) will refund the provider the expenses incurred. Article 35(5) of the Legislative Decree No. 286 remarks that access to the health care system by an IM may not be reported to the authorities, except when it is compulsory (in the same cases as Italian citizens).

Table 4a – Access to health care for IMs in three SHI countries: summary of legal provisions

	Legal Framework	Reimbursed health care							Reimburser
		A&E	Pregnancy & maternity	TB	HIV/ AIDS	Primary	Mental ²⁹	Other	
B E L G I U M	Law of 8 July 1964	•							Social Welfare Centre (OCMW/CPAS)
	Royal Decree of 12 December 1996		• ³⁰		• ³¹	(*) ³²	X ³³		
	Royal Decree of 13 January 2003			•					
	Ministerial Decree of 30 January 1995 (as amended by M. D. of 18 October 2002)								
G E R M A N Y	Social code (StGB)	•							Social Welfare Centre (Sozialamt)
	Infectious Diseases Law (IfSG)			•	X ³⁴				
	Abortion Law – special cases (GHFSF)							•	
	Federal social assistance Law (BSHG)								
N E T H E R L.	Linkage Law (1998)								For hospitals: <i>Dubietuze Debiteuren</i> Rest of providers: <i>Koppelingsfonds</i>
	Aliens Law (2000), section 10 ³⁵	•	•	•	•	• ³⁶	X ³⁷		
	Health Insurance Act Exceptional Medical Expenses Act								

•: full access. X: no access. (*): access, with some exceptions. (X): no access, with some exceptions

4. Access to health care for IMs: the situation *in practice*

The legal provisions referred to for each country in the previous section may be considered as sufficient, insufficient or even excessive according to different views, and it is tempting to immediately engage in a debate on the advisability of maintaining, expanding or curtailing them, respectively. However, if a biased perspective is to be avoided, it is necessary to question beforehand whether IMs can actually enjoy the entitlements that all those laws are currently providing for (or in other words, whether those provisions can actually reach the IMs). Only after having reviewed the available evidence on that issue, and having put it together with the rest of the evidence already presented, this paper will present conclusions and a firm answer to the question posed in its title.

There is some evidence that IMs use public health care facilities significantly less than the rest of the population. Measuring utilisation rates of public health care resources by IMs is not an easy task, but it has been attempted by two studies that reached similar conclusions. The first one, authored by Torres and Sanz,⁴⁶ was undertaken in Madrid (Spain) in 1997 (note: before Law 4/2000 was passed), and reports that seeking public health care for the last episode of illness was significantly more frequent if immigrants had legal status, evidencing the existence of a ‘strong barrier to health care utilization for sick illegal immigrants’. The second study, by Reijneveld et al.,⁴⁷ is based on a nationwide survey among 1,148 Dutch GPs (conducted in 1997), and argues that, assuming a population of 100,000 illegal immigrants in the Netherlands and the fact that they represented 0.47% of all GP contacts, their GP contact rate would be, at most, about 70% of that of legal residents.

Regrettably, in neither of the above cases have updates been published that might take into account the more recent legal developments in those countries. Yet, more indirect evidence still confirms that even when IMs have the same level of entitlement as the rest of the population, several different barriers substantially impede access to health care. Table 5 provides an overview of such deterrents. Each one will be illustrated with appropriate evidence, beginning with the ‘supply-side’ factors.

Table 5. Factors impeding IMs from having effective access to public health care

Demand-side factors	Supply-side factors
Lack of information	
Fear	Ambiguous legal definition of entitlements
Lack of financial resources (co-payments)	Lack of implementation provisions
Complicated administrative procedures	
Lack of time	The duty to denounce
	Discrimination
Cultural issues, language problems	

4.1 Supply-side factors

A major problem in many countries is that health care managers and providers are unaware of the legislative developments concerning access to health care for IMs, a fact that obviously hinders the normal provision of those minimum services. Even when that information has been made available to first-line health care workers, problems remain when the entitlements are ambiguously or imprecisely defined, allowing excessive room for discretion in the implementation process (and creating, in turn, substantial horizontal inequities). That is certainly the case in both the Netherlands and Belgium, where whether a health care intervention is, respectively, regarded as urgent or medically necessary is, in practice, left entirely up to the health care provider.⁴⁸ Moreover, providers are often affected by the fact that the new legal provisions are being followed by inappropriate implementation measures and, critically, by insufficient funding. Clarke and Bröring⁴⁹ have reported the latter for Belgium and the Netherlands, along with Domingo et al.⁵⁰ for Spain. Another discouraging, frequently encountered obstacle, particularly in Germany, takes the form of complex, costly, time-consuming administrative reimbursement procedures, which all too often end up being declined. Non-public hospitals in Belgium are experiencing the same difficulties.⁵¹

The duty to denounce to the authorities the irregular situation of an immigrant is not applicable to doctors and paramedics, who are bound by professional secrecy. Yet, public officers and civil servants, even if working within health care services, are obliged, if the law so requires, to report the details of any IM encountered during the course of their work. Such a contradiction is distinctive of the German

case, and has been reported as one of the major factors undermining the access of IMs to health care in that country.⁵²

It is also worth remarking the enormous impact that certain negative attitudes of health workers towards IMs have in impeding, consciously or not, access to health care. That is especially relevant in the light of evidence that when health care professionals adopt positive and sustained ‘proactive’ roles towards IMs, restrictive legislations may not only be impossible to be enforced, but also end up being modified. Italy is an example of the latter, where, according to Zincone, ‘widened access to the public health service for undocumented immigrants is an example of the role played by local *contra legem* practice in transforming Italian legislation’.⁵³ The former (lack of enforcement) applies to the UK, where the relevant trade unions have always called on their members not to participate in the immigration checks that the 1989 regulations imposed on hospitals.⁵⁴ As a result, many IMs are *de facto* using the NHS for free. However, the response of UK legislators has not been as welcoming as in Italy, and three major policy developments have been put forward to put an end to this situation: first and foremost, the new Amendments to the 1989 Regulations (into force since 1st April 2004) and, more indirectly, the Health and Social Care (Community Health and Standards) Bill (2003) and David Blunkett’s National Identity Card scheme.

4.2 *Demand-side factors*

Of equal or more importance are those IM-related factors that limit or impede their access to public health care services, specifically the lack of information, which is certainly worse than in the supply side. For instance, a report by *Salute per Tutti* points out that in Italy ‘there seems to be no clear knowledge of the laws concerning the medical card for foreigners [...] and therefore of the possibility of using a general practitioner; this often acts as a strong deterrent to immigrants here illegally against using public health structures, as they fear that, in doing so, they will expose themselves to the risks connected to their legal status’.⁵⁵ Although many NGOs in the EU have been trying to fill in this information gap, the fact is that most IMs are still afraid of using public health care services. The consequences of that are self-evident and include high severity rates of disease when, in the end, IMs seek medical treatment in the public sector.⁵⁶

Yet, information availability is not the only limiting factor on the demand side. Other frequently (co-)existing situations such as illiteracy, language problems or lack of disposable time account for the fact that, even when they are aware of their rights, IMs often find it extremely difficult or almost impossible to complete the application process in order to obtain regular access to the health care. For instance, procedures in Belgium and Spain are far too long and complicated,^{57,58}

and have clearly disregarded the special socio-economic and cultural characteristics of IMs. Thus, a normalised legal situation in a given country may not have any real correlate, in spite of local stories of success by NGOs that try to ‘guide’ the IMs through intricate bureaucratic pathways.

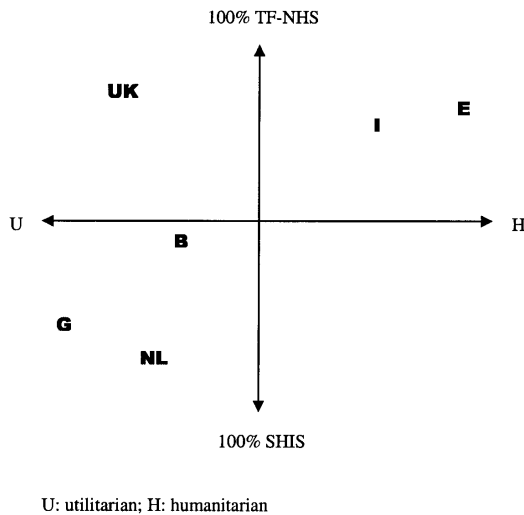
The impact of user charges and other costs of accessing publicly funded health care have also to be considered in the light of the inability to pay of so many IMs. This ‘post-access’ barrier to health care is applicable across-the-board, both in NHS and SHI countries. However, discriminatory practices against IMs continue to exist, i.e. with regard to the expensive antiretroviral (anti-HIV/AIDS) drugs in Germany and the UK, where IMs have inevitably to face a 100% co-payment.

5. Conclusions

Roughly speaking (and probably overestimating), IMs represent around 1% of the persons present in the EU. This proportion may be greater in big urban nuclei (where public health care facilities are also more concentrated). Although there are good reasons to think that the proportion may not decrease in the future, this paper strongly agrees with the assertion that ‘health care is not a *pull* factor, nor will the halt of health care *push* immigrants away’.⁵⁹

Ultimately, only host States are accountable for the consequences of the illegal presence of people within their borders. Among these consequences, the International Bill of Human Rights obliges all EU Member States to guarantee the right of IMs to *the highest attainable standard of health*, taking account of *all* its dimensions, namely *availability*, *accessibility* (non-discrimination, physical accessibility, affordability and information accessibility), *acceptability* and *quality*. This requirement *necessarily* demands *comprehensive* health care coverage of IMs (that is, the same as the official population). Among the six EU countries studied, only Spain has created the *legal* conditions for the fulfilment of this duty, followed in ‘generosity’ by Italy (another TF-NHS). This *humanitarian* (or human rights-based) approach contrasts with the more *utilitarian* (or negative externalities-based) approach seen in Germany and, to a lesser extent, the UK, which cover IMs insofar as that ‘protects’ (physically and psychologically) the health of the host population, being otherwise their legal provisions a simple account of the fact that doctors are (anyway) required by their professional code to treat anyone in acute emergencies. Belgium and the Netherlands would represent a ‘softened’ case of this utilitarian approach (Figure 4):

Figure 4. Legal provisions with regard to access to health care for IMs in 6 EU countries. A qualitative ranking



Without disregarding the impact of these legal provisions, it has been shown that access to health care for IMs is *in practice* conditioned by more factors. A critical one is the extent to which the supply of health care to an IM threatens the income of the provider (i.e. a doctor or a manager). In SHISs, providers are reluctant to treat uninsured people who appear unable to pay because, beyond the specific clauses in the law, any expense incurred will not be refunded. *Humanitarian behaviour* is thus perceived as synonymous to *loss of income*. Therefore, it is crucial for the ‘humanitarisation’ of SHISs that governments upgrade and improve the scope and function of the existent public reimbursement schemes, making them more attractive to providers. In NHSs, health care workers earn *the same* regardless of the legal status of the person treated, which allows for Human Rights ideals to flourish without being eclipsed by economic interests. The importance of that is illustrated by the UK, where utilitarian policies at the macro/meso-level have always been designed to curtail humanitarian practices at the micro-level, with scarce success (so far). In fact, the maxim ‘equal access to health care for *people* in equal need and free at the point of service’ is deeply rooted in the minds of the British NHS staff.

Action must be directed towards other practical barriers such as the lack of information, which is bilateral. It is important for policy makers to note that giving

publicity to 'generous' measures will not only *not* have any 'disastrous' consequences (either at home, creating a xenophobic and hostile environment, or abroad, acting as a pull factor for IM), but it will also contribute to an image of *fair play* (with the toughest immigration policies going hand in hand with the most exquisite respect for Human Rights). In that 'game', the state needs to play *in partnership* with the voluntary sector, which is a key actor willing to supply and/or purchase highly tailored medical services and act as a guiding bridge to the public health care system when appropriate. Indeed, the voluntary and the public sector must be viewed as *complementary*, rather than mutually excluding.

In view of the current restrictiveness of most legislation and taking account of the evidence about their poor penetrance, the issue of access to health care for IMs in the EU should be of *utmost concern* to all involved parties (policy makers, health care managers and practitioners, the general public and, of course, IMs themselves). Firstly, because IM is, and will continue to be in the foreseeable future, a tangible (*though not an overwhelming*) social reality. Secondly, because IMs are *in need* of health care interventions that may be denied in the public sector and not available elsewhere (i.e. ophthalmologic surgery, HIV/AIDS medications). Thirdly, because from a Human Rights perspective, the latter situation is just *inadmissible*. And fourthly, because the lack of effective access to certain health care resources (i.e. TB treatment) may *eventually* pose a risk to the broader public health in the host population.

Moreover, it is *feasible* for European health care systems to assume the burden of this extra 1% population without major changes having to be made to their funding or organisational arrangements; that has already been experienced in some TF-NHS countries where large-scale regularisation campaigns have been undertaken. However, because of various factors, most notably the fact that IMs demand significantly less of (and also are offered less from) the health care system than legally present people in the same conditions (due to fear, lack of perception of rights, etc.), the interaction *IMs – public health care system* is particularly *silent* and *cheap* (but unsatisfactory by the same rule of thumb). Finally, proceeding to stigmatise IMs with tedious means-testing practices on doubtful cost-containment grounds may be unfair and discriminatory, especially if it turns out that IMs are significant economic contributors to health care budgets. Further research is urgently needed to shed clearer light on all these topics.

Notes:

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