

**PROMISING
LOCAL PRACTICES
FOR THE ENJOYMENT OF
THE RIGHT TO HEALTH
BY MIGRANTS**



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HUMAN RIGHTS**
Europe Regional Office

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FOREWORD



Urbanization is one of the most important global trends of the 21st century. More than half of the world's population lives in cities, a figure that is expected to rise to 60 per cent by 2030. As pressure mounts on housing and health services, disparities, marginalization and exclusion often intensify, endangering human rights and inter-group relations.

In daily and direct contact with people, authorities at the local level play a key role in upholding human rights and protecting individuals and groups in a situation of vulnerability.

In the Universal Declaration of Human Rights, States proclaimed that everyone has the right to a standard of living adequate for the health and well-being of him/her-self and of his/her family, including food, clothing, housing and medical care and necessary social services (article 25). Almost 70 years later, States recommitted to ensuring healthy lives and promote well-being for all at all ages in Goal 3 of the 2030 Sustainable Development Agenda.

In reality, however, some groups risk being left behind, including in Europe, the world's region with the highest ranking in the Human Development Index. Migrants in particular face barriers in accessing health services, whether due to restrictive legislation, prohibitive cost, a lack of knowledge or fear. Some local authorities and health practitioners, however, are taking action to protect the dignity of migrant children, women and men.

This study by the UN Human Rights Regional Office for Europe maps creative and innovative solutions in cities throughout Europe to protect the right to health for migrants and to prevent the challenges that arise when people are left without medical care. It is our hope that others - local and national authorities - will be inspired to follow their lead.

Birgit Van Hout

Regional Representative for Europe
UN Human Rights Office

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EXECUTIVE SUMMARY

International human rights law establishes the enjoyment of the right to health by all persons without discrimination.¹ In Europe, however, there are still certain obstacles preventing migrants from enjoying this right. Just like anyone, migrants' physical and mental well-being is placed at risk when they are deprived of access to health services.² This study maps some promising field research-based practices that facilitate access to health care and services for migrants (irregular and regular), as well as for other individuals and groups that fall through the cracks.

These practices are found in eleven European cities (Amsterdam, Barcelona, Bari, Dusseldorf, Eindhoven, Frankfurt, Ghent, Oslo, Trondheim, Utrecht, and Vienna), and in seven countries (Austria, Belgium, Germany, Italy, Norway, Spain, and the Netherlands). The study also highlights some practices found in other European cities (Geneva, Switzerland; London, United Kingdom; Madrid, Spain; Nijmegen, The Netherlands; and Reggio Emilia and Foggia, Italy), as well as in some regions in Italy, Spain, and Sweden.

Limiting migrants' health care access to only emergency care risks over-burdening emergency services and driving up States' health care expenditure. Providing health services beyond emergency care, however, has a positive impact on public health for all, since including the entire population in the health care system is in the best interest of the community as a whole. Research further suggests that addressing health problems early on, through preventive and primary care as opposed to eventual emergency interventions, lowers costs for the health care system.³

Irregular migrants are particularly at risk of finding themselves in vulnerable situations when it comes to accessing health care and services. The term "irregular migrant" or "migrant in an irregular situation" may refer to a person who crosses an international border without legal permission of entry or identity documents.⁴ It is also used for persons living in a country without legal authorisation, even if they have entered the country in accordance with the law or previously

possessed a residence permit. This publication will use the terms "migrants" in general for all types of migrants, as well as "irregular migrants" for those international migrants in an irregular situation, including undocumented and documented migrants and rejected asylum seekers.

National legislation or regulations that restrict health care only to emergency care constitute the greatest barrier for irregular migrants seeking to exercise and enjoy their right to health.⁵ Practical barriers that complicate or impede the enjoyment of the right to health include procedural requirements for accessing health care and services that irregular migrants cannot meet; medical or treatment fees; irregular migrants' fear of being reported to immigration authorities and deported, particularly in countries lacking "firewalls"⁶ between health services and immigration authorities; and shortcomings in the provision of information on entitlements to both migrants and health care providers.

Regional and municipal authorities ("local authorities") are first-line responders when it comes to fulfilling the needs of the local population and providing essential services. As authorities, they are bound by international and national human rights laws adopted by their countries.

Local authorities can ensure the continuity and quality of care beyond emergency care. For example, within its sphere of competence, the Italian Region of Puglia adopted regulations that allow irregular migrants to register with general medical practitioners. Some cities in Germany and Norway have established municipal health teams or medical centres to provide irregular migrants with treatments that they cannot access through the national system, or they have funded medical centres run by non-governmental organisations (NGOs).

Within their executive authority, other municipalities, such as the Belgian city of Ghent, have simplified administrative procedures to enable access to care for persons with limited

documentation or no fixed residence and to provide reimbursements to medical practitioners.

Local authorities have also made treatments affordable. The city of Dusseldorf, for example, set up a dedicated fund to cover the costs of care for irregular migrants not covered by national insurance plans. The city of Vienna financially supports NGOs that provide treatment to irregular migrants. Several Dutch municipalities also fund NGOs to cover the cost of medicine and treatments not reimbursed by national schemes.

To establish clear “firewalls” between healthcare and immigration authorities, some German cities, such as Frankfurt, have set up dedicated medical centres that irregular migrants can turn to anonymously. In Dusseldorf, local authorities have externalized consultations, referrals, and the reimbursement of treatments to municipally-funded NGOs that are not bound by the obligation to report on an individual’s migration status.

The city of Barcelona seeks to overcome the lack of awareness of migrants’ legal entitlements through targeted outreach of migrants by

local social services, as well as through training healthcare centres’ staff and coordinating with regional healthcare authorities to improve regulations and access.

The promising practices documented in this study show that regional and municipal authorities and other stakeholders have an important role to play in

- ensuring the continuity and quality of health care and services for migrants;
- overcoming administrative barriers (such as proof of habitual residence);
- ensuring that doctors do not refuse to treat patients on grounds of legal status;
- ensuring the affordability of health care and services for migrants;
- guaranteeing patient confidentiality through “firewalls” and addressing migrants’ fear of being reported to immigration authorities and/or being deported to their country of origin; and
- increasing migrants’ awareness of their human rights and entitlements.

Regional and municipal authorities and other stakeholders have an important role to play in

Ensuring the continuity and quality of health care and services for migrants



Overcoming administrative barriers (such as proof of habitual residence)



Ensuring that doctors do not refuse to treat patients on grounds of legal status



Ensuring the affordability of health care and services for migrants



Guaranteeing patient confidentiality through “firewalls” and addressing migrants’ fear of being reported to immigration authorities



Increasing migrants’ awareness of their human rights and entitlements



INTRODUCTION

The United Nations Human Rights Regional Office for Europe seeks to contribute to making the enjoyment of the right to health a reality without discrimination for all persons. This study sheds light on international human rights law related to the right to health for migrants and shares some promising practices that already exist at the local level. It also aims to stimulate a discussion among regional and municipal authorities, facilitate the sharing of practices, inspire other cities and regions, raise awareness among local authorities about international norms and standards related to the right to health, and enhance the capacity of local authorities and service providers to meet the health care needs of migrants.

The right to health is a universal human right anchored in the Universal Declaration of Human Rights, and is protected by the core international and regional human rights treaties,⁷ as well as by various policy instruments. Yet, in parts of Europe, migrants – particularly those in an irregular situation – face obstacles in accessing health care and services.⁸ Barriers include laws or administrative regulations restricting eligibility, high health care costs, lack of knowledge about entitlements or about the functioning of health care systems, and migrants' hesitation to approach public service providers out of fear of being reported to immigration authorities and deported to their countries of origin. These constraints negatively affect migrants' enjoyment of their right to health, as observed by international human rights mechanisms, such as the United Nations treaty bodies⁹ and the Universal Periodic Review.¹⁰

In 2018, the United Nations Human Rights Regional Office for Europe reviewed documentation from United Nations and European Union (EU) entities, academia, and civil society on access to health care for migrants in Europe with a view to mapping “promising practices”.¹¹ Following this desk review, some promising practices were identified, and field research was then conducted in eleven cities

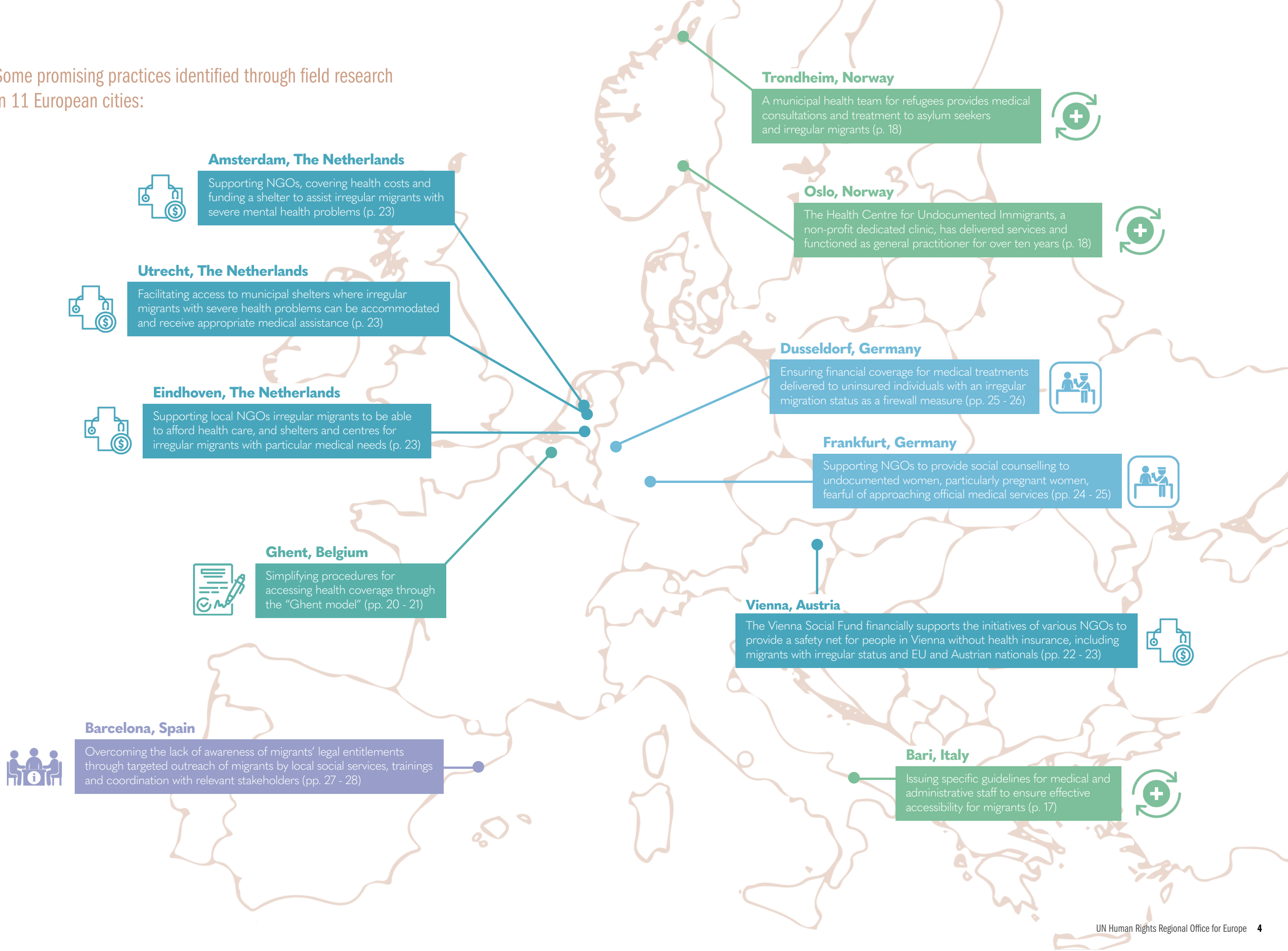
(Amsterdam, Barcelona, Bari, Dusseldorf, Eindhoven, Frankfurt, Ghent, Oslo, Trondheim, Utrecht, and Vienna), which are located in seven countries (Austria, Belgium, Germany, Italy, Norway, Spain, and the Netherlands).

The study also highlights some practices found in other European cities (Geneva, Switzerland; London, United Kingdom; Madrid, Spain; Nijmegen, The Netherlands; and Reggio Emilia and Foggia, Italy), and in some regions in Italy, Spain, and Sweden. The field research consisted of local visits to observe the practices identified in the eleven cities, and interviews, including with two elected officials, nineteen municipal employees, and twelve civil society representatives. The practices in these cities were selected based on the desk research, including a review of the findings of the European Union Agency for Fundamental Rights and the University of Oxford.¹²

Moreover, on 6 December 2018, the Regional Office for Europe organised a consultation in Brussels, Belgium on migration and the right to health, which benefitted from the participation of local authorities and service providers from several cities covered in the mapping, as well as specialists working in the areas of migration and the right to health from international and European organisations and civil society organisations.

For the purpose of this study, “promising practices” are understood here as local and creative solutions, often involving various stakeholders, which contribute towards the realisation of the right to health for migrants (in regular and irregular situations) in several European cities. Although a vast amount of desk and field research and numerous consultations were carried out for this study as described above, it must be noted that the United Nations Human Rights Office has not thoroughly evaluated or assessed the practices and their effectiveness.

Some promising practices identified through field research in 11 European cities:



CHAPTER I

Who is a migrant in an irregular situation?



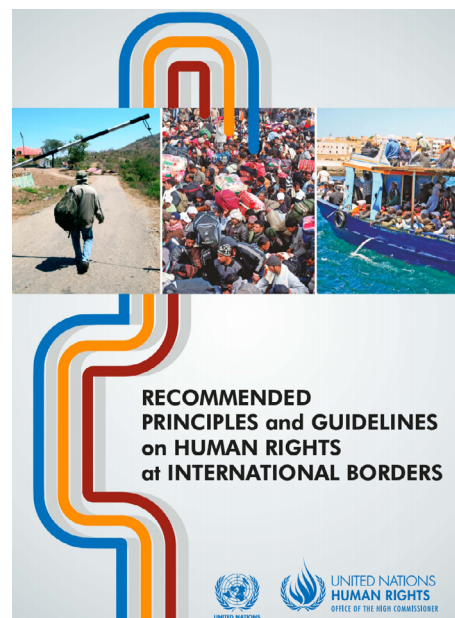
In line with the *Recommended Principles and Guidelines on Human Rights at International Borders*, the term international migrant “refers to any person who is outside a State of which he or she is a citizen or national, or, in the case of a stateless person, his or her State of birth or habitual residence,” and also “includes migrants who intend to move permanently or temporarily, and those who move in a regular or documented manner as well as migrants in irregular situations.”¹³ Various factors may lead to a migrant being or becoming irregular, and in practice, the term refers to people in a variety of situations.

A migrant is typically considered irregular when entering the host country without the required documentation or entry visa. The undocumented migrant, however, may change status after commencing an asylum claim or other immigration procedure. Children may inherit an irregular migration status from their parents. Persons who have overstayed a work, tourist, study, or residence permit are also considered irregular migrants. Rejected asylum seekers, whose removal orders have not yet been executed, are also frequently referred to as irregular migrants. In this study, the term irregular migrants covers all categories of migrants in an irregular situation.

In 2017, there were about 258 million international migrants worldwide (around 3.4% of the world’s population), out of which 124.8 million were women, 36.1 million were children and 25.4 million were registered refugees.¹⁴ As of 1 January 2018, there were about 22.3 million non-EU citizens living in the EU (about 4.4% of the EU population), most of which (76%) were living mainly in Germany (9.7 million), Italy (5.1 million), France (4.7 million), Spain (4.6 million), and the United Kingdom (6.3 million).¹⁵

However, there is no exact data on the number of irregular migrants in the EU, especially since gathering reliable data in changing contexts and conditions of irregularity can be difficult. The lack of data concerning marginalised populations is also often linked to patterns of exclusion and discrimination that only make these individuals even more invisible. The most recent data from 2009 demonstrated that there were an estimated 1.9 to 3.8 million irregular migrants in the EU,¹⁶ which is approximately 0.3% to 0.7% of the EU population.

Research suggests that the majority of irregular migrants have entered the country of destination legally and have subsequently fallen into a situation of irregularity.¹⁷ Indeed, many migrants experience fluidity between regular and irregular status; a person’s status can become regular after having been irregular, and vice versa. The World Health Organization (WHO) has also specified that there is “relatively little information about the health status of, and health policies for, refugees and migrants, in particular irregular migrants”, and that the available information “often does not distinguish between documented and irregular migrants.”¹⁸



Migrant workers are perhaps the largest group making up the international migrant population. Globally, the International Labour Office (ILO) has estimated that, in 2013, 150 million people (out of 232 million migrants) are migrant workers.¹⁹ The International Convention on the Protection of the Rights of Migrant Workers and Members of Their Families, which has not yet been ratified by Member States of the EU, indicates that migrant workers and members of their families are considered

- a. documented or in a regular situation if they are authorized to enter, to stay, and to engage in a remunerated activity in the State of employment pursuant to the law of that State and to international agreements to which that State is a party; or
- b. non-documented or in an irregular situation if they do not comply with certain conditions.²⁰

In 2017, the European Commission estimated that more than one million asylum seekers would become irregular following the rejection of their asylum applications.²¹ This poses challenges in terms of the right to health of those individuals who are reaching the end of the asylum process and those whose asylum was already rejected, since subsequently they are most likely to be excluded in practice from the official reception system.

In 2017, 36% of non-EU citizens who were ordered to leave the EU effectively did so.²² The non-return of the remaining 64% is due to a variety of factors. These include statelessness, a conflict situation in the country of origin, the refusal by the country of origin to allow the re-entry of its nationals, the absence of a return programme in the host country, or the physical or mental health of the migrant.²³

Migrants, both regular and irregular, may find themselves in a vulnerable situation due to either the conditions that compelled them to leave their country of origin or their experiences during the journey to Europe²⁴ or while residing in the EU host country. Grounds such as sex, ethnic origin, disability, age, or sexual orientation – or a combination of these characteristics – may also cause or aggravate vulnerability. Individuals specifically at risk due to a physical or psychological condition include, for example, pregnant or nursing women, persons in poor health, persons living with HIV, persons with disabilities, older persons, and children – including unaccompanied or separated children. An irregular migration status also tends to further exacerbate pre-existing vulnerability.²⁵

This study focuses on non-EU nationals in selected European countries, as identified by the desk review and mapping exercise conducted for this study. Under EU law, citizens of EU Member States and nationals of the Schengen Associated Countries residing in another EU country are not considered irregular migrants.²⁶ The situation of EU migrants is thus beyond the scope of this study, even if they may also face barriers to accessing health services and care. However, several initiatives documented in this study also address the health care needs of EU nationals without health insurance.

2017

258 million international migrants worldwide

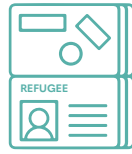
around **3.4%** of the world's population



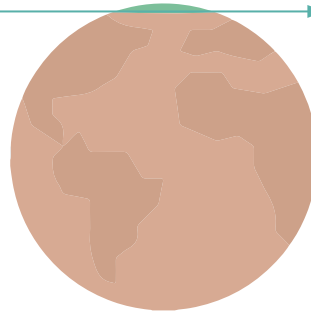
124.8 million were **women**



36.1 million were **children**



25.4 million were **registered refugees**



2018

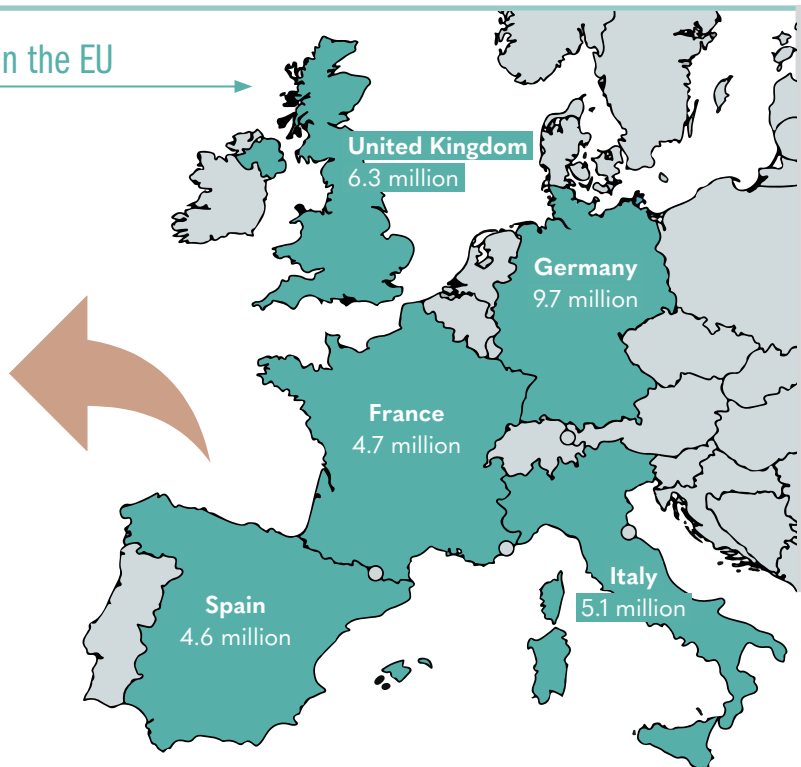
22.3 million non-EU citizens living in the EU

estimated **1.9 to 3.8 million irregular migrants in the EU***



approximately **0.3% to 0.7%** of the **EU population**

* According to most recent data from 2009

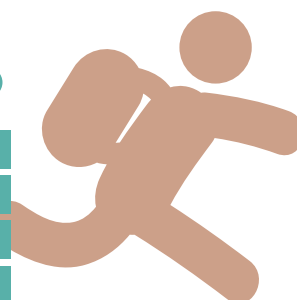


2017

The European Commission estimated that **more than one million asylum seekers** would become **irregular** following the **rejection of their asylum applications**

36%

of **non-EU citizens** who were ordered to leave the EU effectively did so



The **non-return** of the remaining

64%

is due to a **variety of factors**

CHAPTER II

The right to health and access by migrants



A. The right to health under international human rights law

The right to health is protected in several international and European treaties, declarations, and frameworks.²⁷ The 1966 International Covenant on Economic, Social and Cultural Rights – which was ratified by all EU Member States – recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health.

Article 12 of the Covenant is considered the most comprehensive provision on the right to health in international human rights law, complemented by the detailed General Comments adopted by the United Nations Committee on Economic, Social and Cultural Rights (CESCR)²⁸ that further clarify the content of the right to health. State parties to the Covenant must ensure that the right to health is respected, protected, and fulfilled.²⁹

Article 12, International Covenant on Economic, Social and Cultural Rights

- “1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
- The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - The improvement of all aspects of environmental and industrial hygiene;
 - The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

The CESCR has clarified that everyone under a State’s jurisdiction should enjoy the rights protected by the Covenant and makes explicit reference to asylum seekers, refugees, and irregular migrants.³⁰ This is based on the human rights principle of non-discrimination, which guarantees that the “Covenant rights apply to everyone, including non-nationals, such as refugees, asylum seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation.”³¹

The CESCR has also indicated that differential treatment on grounds of nationality or legal status is only permissible when it is in accordance with the law, pursues a legitimate aim, and remains proportionate to the aim pursued.³² Similarly, the United Nations Committee on the Elimination of Racial Discrimination³³ (CERD) has specified that States should ensure that immigration policies do not have the effect of discriminating against persons based on race, colour, descent, or national or ethnic origin.³⁴

In its *General comment No. 14*, the CESCR clarified States’ legal obligations to refrain from denying or limiting equal access to preventive, curative, and palliative health care services to migrants in an

irregular situation.³⁵ This translates into the provision of timely and appropriate health care; access to safe and potable water and adequate sanitation; an adequate supply of safe food, nutrition and housing; healthy occupational and environmental conditions; and access to health-related education and information, including on sexual and reproductive health.³⁶ Thus, the CESCR established and defined the core criteria of the right to health, indicating that all services, goods, and facilities must be **available, accessible, acceptable**, and of **good quality**.³⁷

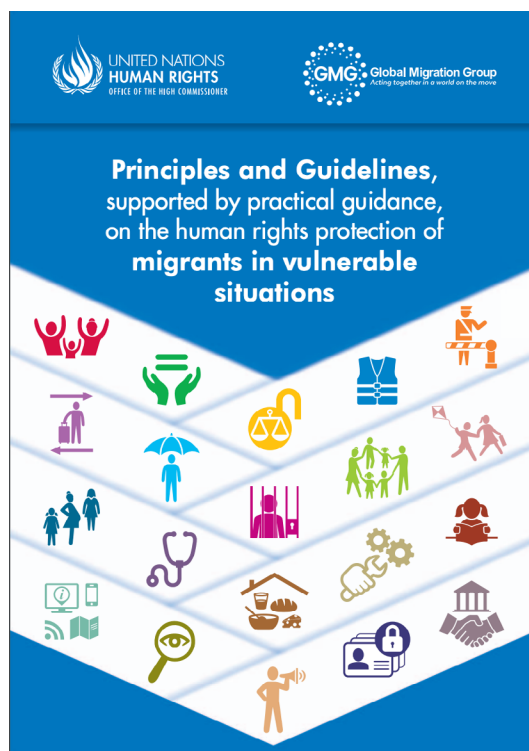
States must guarantee access to health facilities, goods, and services on a non-discriminatory basis. They have the duty to create the conditions necessary to ensure medical services and medical attention are available in the event of sickness through, for example, the provision of equal and timely access to basic preventive, curative, rehabilitative health services and education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries, and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.³⁸

It is worth mentioning that the right to social security is also a determining factor that influences how the right to health is enjoyed. For example, the right to social security encompasses the right to access and maintain benefits (whether in cash or in kind) without discrimination, and to secure protection in the event of, among other things, unaffordable health care. The CESCR has clarified that “non-nationals should be able to access non-contributory schemes for income support, affordable access to health care and family support,” and states that “refugees, stateless persons and asylum seekers, and other disadvantaged and marginalised individuals and groups, should enjoy equal treatment in access to non-contributory social security schemes, including reasonable access to health care and family support, consistent with international standards.”³⁹

Beyond this core normative framework, there are other relevant policy instruments that further elaborate on and protect the right to health for migrants, and also with a sustainable development approach. These include the 2007 Bratislava Declaration on Health, Human Rights and Migration; the 2016 Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region; the 2030 Agenda for Sustainable Development and Sustainable Development Goal 3; the 2018 Global Compact for Safe, Orderly and Regular Migration; the 2018 Global Compact on Refugees; and the WHO Global Action Plan “Promoting the health of refugees and migrants” (2019-2023).



Moreover, the *Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations* offer a more detailed description of what the right to health entails for migrants.⁴⁰ They give examples of the type of care and support that migrants may require and look into the specific and diversified needs of unaccompanied or separated children, pregnant and nursing women, older persons, persons with disabilities, and survivors of torture or trauma, among others. The care that migrants receive in health facilities should be gender-responsive, culturally and linguistically appropriate, as well as tailored to migrants' needs. For example, specific support must be provided to migrant women and girls who have experienced trauma, including sexual and gender-based violence, through specialized medical and psychosocial support, sexual and reproductive health services, goods, and information (Principle 11).



B. Irregular migrants' right to health care

In 2017, the CESCR noted that irregular migrants face specific obstacles to accessing health care and services, including the lack of required documentation or the fear of being reported and/or deported, particularly in countries where public officials have a duty to report irregular migrants. Therefore, the CESCR has called for establishing “firewalls”, which are “strict walls [that] should exist between health-care personnel and law enforcement authorities [...] in order to ensure that such situations do not result in migrants avoiding seeking and obtaining health care.”⁴¹

The CESCR further called on States to make adequate information available in the languages commonly spoken by migrants in the host country.⁴² Similarly, the CERD recommended that States remove obstacles that prevent the enjoyment of economic, social, and cultural rights by non-citizens, notably in the areas of education, housing, employment, and health.⁴³

What are firewalls?

The term “firewall” refers to a measure that States and non-State actors implement to separate immigration enforcement activities from public services, such as health care, so that irregular migrants are not discouraged from accessing essential services out of fear of being reported to authorities and/or deported to their country of origin. Firewalls are designed to ensure that immigration enforcement authorities are not able to access information regarding the legal status of individuals who seek assistance at medical facilities, schools, and social service institutions.⁴⁴



The *Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations* recommend that States establish binding and effective firewalls between public health service providers and immigration enforcement authorities and other security actors; make sure that firewalls are respected; and ensure that immigration authorities do not carry out enforcement operations in or near medical premises (Principle 12).

In 2016, the European Commission against Racism and Intolerance of the Council of Europe issued General Policy Recommendation No. 16 on safeguarding irregularly present migrants from discrimination. It calls for the creation of firewalls to prevent State and private sector actors from denying human rights to irregular migrants, and it prohibits the sharing of personal data or other information about persons suspected of irregular presence or work for purposes of immigration control and enforcement.⁴⁵ The Recommendation establishes that Member States should ensure that public or private bodies providing health care services are not subject to reporting duties for immigration control and enforcement purposes (Recommendation 11).

Furthermore, with the 2018 Global Compact for Safe, Orderly and Regular Migration,⁴⁶ States agreed to ensure that cooperation between service providers and immigration authorities does not exacerbate vulnerabilities of irregular migrants by compromising their safe access to basic services or unlawfully infringing upon their human rights to privacy, liberty, and security at places of basic service delivery.

A 2018 WHO consultative study found that some European countries have put in place “specific policies that protect irregular migrants from deportation when accessing health care in particular circumstances.” These include, for example, Luxembourg’s practice of providing access with proof of harm in the absence of care, France’s and the Netherlands’ temporary permit for health care in the case of pregnancy, and Italy’s national law that prohibits health services from reporting irregular migrants to officials (except under very restrictive conditions).⁴⁷

C. Legal restrictions to health care in the European Union

National health care systems vary from country to country, as do the entitlements to access and the scope of health care and services for migrants.⁴⁸ In a given country, the scope of care granted to migrants in irregular situations can vary between emergency, primary, and/or secondary care.⁴⁹ In 28 EU Member States, migrants – regardless of their legal status – are entitled to receive emergency health care, which differs in each country, and it may require payment in some instances.⁵⁰ However, some cases of migrants being denied emergency health care have been documented.⁵¹

A study found that, in 2015, irregular migrants, had access to

- emergency-only care in six Member States;⁵²
- emergency care and some specialist services, but no primary or secondary care, in twelve Member States;⁵³ and
- emergency care and some level of access to primary and secondary care in ten Member States.⁵⁴

In 2015, in eight EU Member States, children with irregular status had the same entitlements as child nationals, and in five EU Member States, children had the right to emergency health care only.⁵⁵ The EU's Fundamental Rights Agency (FRA) recommended that migrants in an irregular situation be entitled to "necessary" health care services, which should go beyond emergency care, including the possibility to see a general practitioner and receive necessary medicine.⁵⁶

At the level of the Council of Europe, Parliamentary Resolution no. 1509 (2006) on Human Rights of Irregular Migrants establishes that "emergency health care should be available to irregular migrants, and States should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly." Moreover, in cases of return processes, the European Directive 2008/115/EC establishes that EU Member States must ensure that emergency health care and essential treatment of illness are provided to third-country nationals during the period of voluntary departure and during periods for which removal has been postponed (Article 14.1.b).⁵⁷

Noteworthy are two studies carried out by the WHO in 2018,⁵⁸ which identified several practices and health system responses to large-scale migration in Europe. Some of these practices analysed by the WHO in these studies also give access to irregular migrants, for example, in France, Italy, and Spain:

Newly arrived migrants in **France** can receive information about access to the health care system in twenty-three different languages. Practitioners also receive training on how to provide quality services for migrants on an equal footing with nationals and how to protect their privacy. Asylum seekers have access to the universal free health insurance system (*Couverture Universelle Maladie Protection Complémentaire*), and low-income irregular migrants are covered by State Medical Aid (*Aide Médicale d'Etat*) under certain conditions. Groups and individuals in vulnerable situations, for example, pregnant women and people with infectious diseases, can be granted a temporary permit to access health care, while those falling outside the system can access emergency services and care.

In **Italy**, irregular migrants are entitled to access urgent and essential health care free of charge through an anonymous code. Children are included on their parents' code, and preventive care (maternity care and treatment for potentially dangerous diseases) is also included. Italy has also carried out promotion campaigns, provided interpreters and cultural mediators, and disseminated information at national and regional levels in different languages.

Under the Migrant-Friendly Hospital Project (2002-2005) in **Reggio Emilia, Italy**, several structural changes carried out in the health care sector were implemented to ensure that migrants have access to health care and services. The organisational approach of the *Azienda Unità Sanitaria Locale di Reggio Emilia* included a comprehensive process of change and adaptation of their services to respond to the needs of migrants and other groups and individuals in vulnerable situations. The law also specifically includes minors up to eighteen years of age, pregnant women up to six months after birth, and people diagnosed with infectious diseases. Under this scheme, access to health care for irregular migrants includes prenatal and maternity care; health care for minors; vaccinations; preventive medicine programmes; and prevention, diagnosis, and treatment of infectious diseases.

In **Barcelona, Spain**, although legislation generally safeguards access to health services for most regular and irregular residents, some NGOs run programmes that aim to improve and facilitate access to health services for irregular migrants. For example, the *Salud y Familia* Association ensures that migrants have access to a health card and conducts policy advocacy and coordination with service providers and the Government. It also runs a programme entitled “Mothers Between Two Cultures” in collaboration with the public hospitals of Cataluña, targeting migrant mothers with different cultural backgrounds who have children three years old or younger, in order to improve coverage and reduce needs in the area of maternal and child health. In addition, the “Assistance for At-Risk Maternity” programme provides some assistance for pregnant women to receive prenatal care and psychosocial support.

Is it lawful for States to legally restrict access to health care for migrants?

The progressive realisation of economic, social, and cultural rights, including the right to health, requires States to immediately take concrete, targeted, and deliberate measures towards realisation.⁵⁹ On the other hand, austerity measures that result in the retrogression of the realisation of rights are presumed to be unlawful, even when there is a reduction in social sector spending.⁶⁰ The United Nations Committee on Economic, Social and Cultural Rights has indicated that a lack of available resources cannot be considered an objective and reasonable justification for differential treatment, “unless every effort has been made to use all resources that are at the State party’s disposition in an effort to address and eliminate the discrimination, as a matter of priority.”⁶¹

The principle of non-discrimination is a core obligation that engages the immediate responsibility of the State. Thus, States have a special obligation to provide those with insufficient means with the necessary health insurance and health care facilities. They also have the obligation to prevent any discrimination on internationally prohibited grounds in providing health care and health services, especially with respect to the core obligations of the right to health,⁶² obligations which also pertain to and include migrants.

D. Practical barriers to health care and services

Being legally entitled to access health care and services does not guarantee access and enjoyment in practice. The WHO has pointed out that “even where entitlements are established for certain migrant groups and regulations permit access, further barriers may exist in terms of the organisation of health care, unawareness of entitlements by health care providers and beneficiaries, limitations of health staff expertise, linguistic and cultural barriers, and the wider governance of migration.”⁶³ Even where a formal entitlement to comprehensive health care exists, irregular migrants may encounter other obstacles, such as

- **Procedural or administrative requirements to access care.** Irregular migrants may be unable to meet requirements such as proof of residence, an official address, a social security number, or other documentation.⁶⁴
- **Financial burden of treatment.** In health insurance and tax-based health systems, a lack of documentation may prohibit irregular migrants from obtaining health insurance, thereby forcing patients to pay the full cost of medical treatments.⁶⁵
- **Migrants’ fear of being reported to immigration authorities when approaching public health facilities.** Such fear may be due to the absence of firewalls or may exist even in countries where national legislation guarantees the confidentiality of personal information. Regulations obliging public officials to report migrants, or the absence of firewalls, constitute a risk that care-seeking migrants will be reported to authorities and/or deported to their country of origin.⁶⁶
- **Lack of knowledge about legal entitlements.** Migrants may be unaware of their rights and might not seek the help of medical professionals. Health care staff (medical or administrative) may also lack knowledge of the legislation regulating access to care by irregular migrants, or how reimbursements for that care can be sought.⁶⁷
- **Lack of culturally-sensitive and non-discriminatory health care and services.** Health care and services must be culturally appropriate and respectful of medical ethics and the culture of individuals, minorities, peoples, and communities. It must also be sensitive to gender and life-cycle requirements.⁶⁸

CHAPTER III

Local authorities and the right to health



Local authorities are responsible for ensuring the respect, protection, and fulfilment of human rights at the local level.⁶⁹ They are bound by the prohibition of discrimination in the enjoyment of and access to rights, and they must therefore prevent, alleviate, or eliminate discrimination in practice.⁷⁰ They are also first-line responders to the social needs and concerns of the population. Cities and regions can play a role in health-related policy-making, and in some countries, they have legislative powers over health care and are responsible for delivering local services.⁷¹

Like national authorities, local authorities should not adopt regulations, policies, or practices that directly or indirectly deprive certain groups of people of access to local health care and services. Within their areas of competence, they should take positive steps to facilitate the fulfilment of everyone's rights, including irregular migrants' right to health, and to ensure that third parties do not violate people's right to health.

Local regulations, policies, or practices may appear neutral when they do not explicitly exclude irregular migrants from access to a service. However, they would still be considered discriminatory under international human rights law if they have the effect of making health care inaccessible.⁷² If, for example, accessing health services involves a local procedure that requires specific documentation, an insurance scheme, or a disproportionate fee that migrants in an irregular situation may not be able to provide, this would create barriers preventing them from accessing their right to health.

There are multiple benefits to ensuring access to health care beyond emergency-only care. Such access can have a positive impact both on migrants' physical and mental well-being and within the public health sphere, since including formerly excluded populations in the health care system is in the interest of the entire community.⁷³ Local authorities that participated in this study were also motivated by ethical and moral imperatives as well as by the desire to perceive their city as a place where human rights are protected and promoted for everyone.

In addition, evidence suggests that enabling access to preventive and primary care – beyond just emergency care – may lower the overall costs of the health care system.⁷⁴ Data shows that the cost of excluding irregular migrants from broad access to care can prove higher than the costs of including them. Facilitating early treatment and continuous care can produce savings and prevent the saturation of emergency rooms in local hospitals. On the other hand, if irregular migrants are prevented or discouraged from accessing preventive or early care, they are forced to delay medical treatment until emergency care becomes necessary, resulting in significantly higher costs for health providers and authorities.⁷⁵

A study by the EU argued that extending access to primary health care to irregular migrants could generate a 49% or greater potential cost-savings in direct medical and non-medical expenditures.⁷⁶ Providing access beyond emergency care can therefore have a positive impact on the public health system overall, since including the entire population in the health care system is in the interest of society from a human rights and financial perspective.

CHAPTER IV



Ensuring the continuity and quality of health care

Legal or administrative measures can restrict access to preventive care, as well as the continuity and quality of care. In some cases, irregular migrants are not entitled to or able to register with a general practitioner. In response, some local authorities have taken measures to overcome these barriers.⁷⁷ For example, local authorities with the relevant legislative competences in **Italy, Spain, and Sweden**⁷⁸ have adopted regulations further extending entitlements to health care within their local jurisdictions, such as allowing registration with general practitioners and paediatricians.

Authorities without such competences have adopted initiatives to allow continuity of care in other forms, such as creating medical teams or supporting NGOs to manage medical facilities that act as family doctors or provide medical services not offered by national health services (see local initiatives in **Trondheim** and **Oslo** below).

Florence – a medical centre to ensure the continuity of care and reduce health care costs

In 2011, the city of **Florence** and the Region of **Tuscany** (Italy), together with Caritas, established a medical centre to host and provide post-hospitalisation care for patients with an irregular migration status, and other marginalised individuals not registered with the national health service. This centre was created to ensure continuity of care to individuals who were not entitled to continued medical attention beyond emergency care, but also to avoid prolonged and costly stays in emergency rooms. The project aims “to ensure post-hospitalisation continuity of care, identify adequate socio-medical care, and reduce costs from improper hospitalisations.”⁷⁹

Regions broadening the entitlement to health care

In 2012, **Spain’s** national health care reform involved a transition from a universal health care system to an insurance-based system.⁸⁰ While the former universal system entitled irregular migrants to health care on an equal footing with nationals, under the insurance-based system, irregular migrants receive emergency care due to serious illness or accidents, as well as assistance during pregnancy, childbirth and postpartum. Moreover, children under the age of eighteen receive health care under the same conditions as Spaniards.⁸¹

In response to the reform, some Autonomous Communities in Spain – which have legislative competences in matters of health, hygiene, and social services⁸² – introduced regulations broadening irregular migrants’ access to care and, in some cases, re-establishing access to health care for irregular migrants on an equal footing with Spanish nationals (**Andalusia, Asturias**⁸³ and **Catalonia**).⁸⁴

In 2013, the Government of **Sweden** enacted a law on health and medical care for certain foreigners living in Sweden without the necessary permits.⁸⁵ The law grants all undocumented children access to health care on the same basis as regularly-residing and Swedish children. It also entitles undocumented adults to acute care and health care that cannot be deferred (dental care, maternity care, contraceptive counselling, abortion, and related medicines) for a fee of 5 EUR, which is the same case for asylum seekers. The law stipulates that Swedish regions can further broaden the level of care for irregular migrants, and thus, six regions offer undocumented migrants health coverage on an equal footing with citizens (**Sörmland, Västmanland, Östergötland, Västerbotten, Västernorrland** and **Gävleborg**).⁸⁶

In **Italy**, where regional authorities share legislative powers in the area of health with national authorities, a number of regions adopted legislation allowing the continuity of care beyond national standards. Some regional authorities allowed irregular migrants to register with local general practitioners (**Puglia**) and paediatricians, or extended other forms of entitlements (**Tuscany**). In 2012, the Italian Regions and the central government agreed to allow children of irregular migrants, after having turned fourteen years old, to register with a paediatrician or with a general practitioner.⁸⁷ Since then, thirteen regions and the autonomous province of **Trento** have formally implemented this provision of the agreement.

Puglia (Italy) – Regional legislation allowing registration with a general practitioner

In **Puglia**, a large number of migrants work informally in the agricultural sector. Thus, in 2009, the Region adopted a law to ensure the right to health care for irregular migrants.⁸⁸ The Constitutional Court pronounced the law's conformity with constitutional standards as it aims to advance the fundamental rights of the individuals concerned.⁸⁹ The law contributes to preventing the proliferation of medical conditions that would otherwise generate more health care system costs⁹⁰ and responds to the actions of local medical associations.⁹¹ The law also

- Grants irregular migrants primary and secondary care, including pharmaceutical assistance, mental health services, gynaecology, abortion, drug addiction treatment and prevention, and rehabilitative care.⁹²
- Allows irregular migrants to register with a general practitioner and a paediatrician, thereby granting equal treatment to irregular migrants and Italian nationals. The law also aims to provide proper care for chronic illnesses such as diabetes, asthma, hypertension, and rheumatic diseases, which are not fully treated in emergency rooms or outpatient clinics.⁹³ Irregular migrants can also register with a general practitioner when requesting the code that allows them to anonymously access medical services in Italy.⁹⁴
- Ensures that emergencies and infectious diseases are treated in the emergency rooms of local hospitals.
- Invites local health units ("ASL") in areas with high numbers of irregular migrants to establish dedicated outpatient clinics for irregular migrants.⁹⁵

The Region of Puglia,⁹⁶ local health units in **Foggia** and **Bari**,⁹⁷ for example, and local medical associations have further issued specific guidelines for medical and administrative staff to ensure effective accessibility.⁹⁸

Trondheim and Oslo (Norway) – providing a substitute for the general practitioner

In **Norway**, irregular migrants are only entitled to “emergency” and the “most necessary” care,⁹⁹ which, in principle, includes some primary and secondary care.¹⁰⁰ However, since Norway’s health care system requires enrolment with a national insurance provider, which irregular migrants usually do not have, they are, in practice, expected to bear the full cost of any medical care received, including emergency and primary care.¹⁰¹

Since medical facilities are required to provide emergency services without requiring guarantees of payment, hospitals must then bear the costs if an individual cannot pay.¹⁰² In addition, since irregular migrants are not entitled to register with general practitioners (*‘fastlege’*) – who are the entry point to most primary and secondary care in Norway – general practitioners can refuse to see these patients,¹⁰³ and hospital admission for non-emergency treatment requires a referral from a *fastlege*.¹⁰⁴

To address this problem, the municipality of **Trondheim** set up a “municipal health team for refugees” that provides medical consultations and treatment to asylum seekers and irregular migrants “with an asylum background”, including rejected asylum seekers and persons whose entitlement to protection has terminated.¹⁰⁵

The main components of this initiative include

- The team – which acts as a substitute for the general practitioner – serves about 110 individuals living in a refugee reception centre in the city, half of whom have had a final rejection of their asylum claims but could not be deported.¹⁰⁶ The health team also accepts patients with irregular status and an asylum background who live “under the radar” in the city.¹⁰⁷
- The team consists of twenty-six municipal employees, including a doctor, specialised nurses, psychiatrists, a midwife, a medical secretary, and administrative staff. Irregular migrants and asylum seekers are offered medical consultations with a family doctor, as well as vaccinations, assistance with pregnancy, paediatric care, and mental health care.
- Migrants can be referred to hospitals and receive psychosocial counselling and support. Additional mental health support is offered in the event of a final rejection of an asylum claim.¹⁰⁸
- Care is offered free of charge, and public transportation costs are reimbursed for those patients needing continuous support.

In **Oslo**, the Health Centre for Undocumented Immigrants has delivered services and functioned as “general practitioner” for about ten years. It is a non-profit dedicated clinic set up and managed by the Oslo Church City Mission together with the Red Cross. The centre provides free medical services to irregular migrants and EU nationals without health insurance, “based on medical needs”, including primary and secondary care.¹⁰⁹ The centre mostly relies on volunteer doctors and nurses, including specialists, mental health doctors, and dentists, and on the work of part-time employees, including one doctor, a midwife, and some coordinators.

Irregular migrants benefit from free access to vaccinations for children, prenatal care, and deliveries for pregnant women in municipal clinics. A diaconal private hospital also provides free services to the centre’s patients. The centre assists around 900 persons per year, mostly irregular migrants from Africa and Asia. Uninsured EU nationals account for about one-third of the patients.¹¹⁰ In 2017, the City of Oslo decided to contribute to the funding of the centre, which mainly relies on funds from the Oslo Church City Mission, the Red Cross, private donations, and financial support from the Norwegian Directorate for Health and Social Affairs for projects related to the promotion of HIV/AIDS testing.¹¹¹

Geneva (Switzerland) – providing access to health care for all in the city and the University Hospitals

The 2006 Geneva Law on Health aims to contribute to the promotion, protection, maintenance and restoration of health for individuals, groups, the entire population and animals, while respecting everyone's dignity, freedom and equality. Guided by the 2006 Law, the *Hôpitaux Universitaires de Genève* (HUG) provide health care and services to everyone regardless of their background, socio-economic status or affiliation with an insurance scheme.

As providers dedicated to public interest work, the HUG offer treatment to individuals in vulnerable situations due to factors such as their age or social, economic or legal status. Such individuals may include, for example, asylum seekers, irregular migrants, and persons deprived of their liberty. The majority of HUG patients and caregivers are foreigners; thus, professional interpreters are available free of charge in over fifty different languages. Moreover, in the city, the Mobile Outpatient Consultation Unit for Community Care (CAMSCO) facilitates access to preventive, curative and rehabilitative treatment for individuals in vulnerable situations, such as homeless people, irregular migrants, or people without health insurance.¹¹²

CHAPTER V

Simplifying procedures and requirements for accessing care



Official procedures for accessing care or obtaining insurance coverage may require documentation or conditions that irregular migrants are unable to provide or meet, such as a social security number, a valid residence permit, proof of residence, or a fixed address. Cumbersome reimbursement procedures may also be a challenge, not only for migrants, but also for health care providers who might be reluctant to accept patients with irregular status due to the difficulty or inability of being reimbursed.

Ghent (Belgium) – simplifying procedures for accessing health coverage

Since irregular migrants are not eligible for coverage under **Belgium’s** national health insurance, the *Aide médicale urgente* or *Dringende Medische Hulpverlening* (“AMU/DMH”), under Belgian law, covers medical costs for irregular migrants who cannot afford health care. This covers urgent care, such as all treatments covered by the basic national health insurance, including preventive and curative care, and primary and secondary care.¹¹³ Irregular migrants may also register with a general practitioner or paediatrician, and obtain coverage for dental care.¹¹⁴

Requirements for coverage under the AMU/DMH include, for example, proof that the person is habitually residing in Belgium with an irregular status, is a habitual resident in the municipality where they are requesting coverage, cannot afford to pay for health care, and does not have alternative insurance or social security coverage.¹¹⁵ The municipal public social service centre (“CPAS/OCMW”) must verify these conditions.¹¹⁶ In practice, however, these procedures have proven cumbersome and lead to unpredictable access to care for irregular migrants.¹¹⁷

In an effort to ensure the right to health care for irregular migrants, the municipality of Ghent promotes the use of a medical card by AMU/DMH beneficiaries. The national government created the medical card to facilitate access to medical care for irregular migrants. The three-month card can be requested from the CPAS/OCMW prior to seeing a doctor. The CPAS/OCMW can thus verify eligibility beforehand and release a medical card certifying the migrant’s coverage. The card acts as a measure to prevent doctors from refusing a patient.¹¹⁸

In cases where the individual does not have documentation proving destitution or habitual residence, the municipal officers accept alternative evidence and rely on validation by a network of trusted NGOs. The verification happens on average within an hour (or seven days if a home visit is exceptionally required).

The new procedure allows doctors to apply directly to the municipality for reimbursement (rather than to federal authorities). The municipality immediately reimburses local doctors, collects medical bills, and obtains a collective reimbursement from the federal government. This procedure has reduced the reimbursement time from six months to one week.¹¹⁹

For exceptional cases, when an irregular migrant needs to see a doctor for a medical emergency during the CPAS/OCMW closing hours, municipal officers have provided local hospitals and

doctors with special forms to collect patient information that is necessary for the CPAS/OCMW to verify eligibility and disburse payment.

In addition, municipal officers engage in outreach activities with local NGOs to explain the procedure. Similarly, the CPAS/OCMW organises regular meetings with local hospitals and doctors to inform them about the relevant procedures, make sure that irregular migrants are not refused care, and monitor the functioning of the system. Training sessions on “the Ghent model” have been organised for officers of other municipalities to encourage replication of the practice. On average, 950 beneficiaries of AMU/DMH request medical treatments in Ghent per month, and about thirty people per month requested new medical cards in 2018.¹²⁰

CHAPTER VI

Covering the costs of medical care provided to the uninsured



Whether it is in an insurance-based or a tax-based system, health care costs can be a barrier for anyone seeking to access their right to health. Irregular migrants may be unable to enrol in national health insurance schemes or may be required to pay full fees for treatment, despite being legally entitled to those treatments, including emergency services.¹²¹ Health providers may refuse care, for example, out of fear of not being reimbursed.¹²² According to FRA, at least eleven EU Member States require irregular migrants to pay for emergency care, despite their formal entitlement to receive such care.¹²³ A requirement to pay for the full cost of care can in practice nullify an entitlement.¹²⁴ Unaffordable costs for health care and services were an obstacle in most of the cities visited for this study, and almost all initiatives were designed to overcome this cost barrier.

It was observed – especially in countries with an insurance-based health care system – that irregular migrants fall through the cracks along with other “non-insurable” people, including mobile EU nationals and homeless people. Some local initiatives target all uninsured individuals (as in **Vienna, Frankfurt, and Oslo**), while others specifically target people with irregular immigration status only (such as in **Eindhoven, Dusseldorf, and Trondheim**).

Austria – supporting a safety net for uninsured people

The **Vienna** Social Fund financially supports the initiatives of various NGOs to provide a safety net for people in Vienna without health insurance, including migrants with irregular status and EU and Austrian nationals. It is rare for irregular migrants in Austria to obtain health insurance,¹²⁵ and rejected asylum seekers are only temporarily covered for basic care.¹²⁶ Uninsured migrants are expected to pay for all health care received, including emergency care; however, hospitals cannot refuse to provide emergency treatment due to the lack of insurance.¹²⁷

The Vienna Social Fund supports three initiatives for different target groups and offers complementary services in an effort to reach out to all the uninsured individuals in the city. These include

- **AmberMed:** an outpatient clinic managed by Diakonie Austria in cooperation with the Red Cross, offering medical consultations and treatment to uninsured individuals.
- **Neunerhaus:** an NGO-managed health centre offering care, including dental care, to homeless individuals (or people hosted in homeless shelters)¹²⁸ who may have health insurance, yet who are nevertheless prevented from accessing the mainstream health care system due to other barriers.
- **LouiseBus:** a mobile health unit managed by the local Caritas, which serves those in need in different areas of the city, providing basic medical assistance and consultations to homeless people and advises people with no insurance or no fixed home on how to obtain medical assistance in Vienna.¹²⁹

Irregular migrants, who are mostly uninsured, fall mainly within the target group of AmberMed, and about one-third of its patients are rejected asylum seekers and irregular migrants.¹³⁰ The clinic’s staff relies on a network of about eighty volunteer doctors, including specialists, who take turns in the outpatient clinic or who treat AmberMed’s referred patients free of charge.

The organisation also cooperates with private medical or pharmaceutical companies who provide blood services, X-rays, and some medicine *pro-bono*. Thus, AmberMed can offer almost any treatment that does not require hospitalisation – apart from dental care – including continuous care. The Refugee Department of the Vienna Social Fund provides about one-fourth of the organisation’s budget, while the rest is provided mostly by private donations, the Austrian Ministry of Health, and the Viennese public health insurance fund.¹³¹

Homeless irregular migrants may also visit Neunerhaus’ medical facilities, where about 5% to 10% of users have irregular immigration status.¹³² Neunerhaus has a modern clinic and a team of twenty-five workers, including specialist services and psychosocial counselling. The organisation is mostly funded by the Vienna Social Fund and the Viennese public health insurance fund.

The organisations can refer patients to each other in order to avoid double treatment and to offer complementary services. For example, only AmberMed provides insulin to patients with diabetes, while only Neunerhaus may provide dental care.¹³³

Dutch cities – providing financial support for non-covered treatments

Irregular migrants in the **Netherlands** cannot register with mainstream health insurance schemes since they do not have a social security number, and the ability to obtain health insurance is limited to migrants possessing regular residence.¹³⁴ Yet, Dutch law has established a public agency (“CAK”) mandated to reimburse health care providers, including doctors, hospitals, and pharmacies for “medically necessary” treatment and medicine provided to irregular migrants. Irregular migrants can access a relatively broad range of medical services, including the possibility to see general practitioners and access certain primary and secondary care.¹³⁵

However, certain treatments, including dental care, physiotherapy, or mental health care, are not covered, and irregular migrants are expected to pay a contribution for medicine (5 EUR per prescription). Since the early 2000s, the City of **Eindhoven**¹³⁶ has been funding a local NGO (Vluchtelingen in de Knel) to support destitute non-EU nationals with irregular status in affording the care that is not reimbursed by CAK. The organisation covers the costs of dental or mental health care, physiotherapy, eyeglasses, and transportation for people who need to travel outside the city to get health care elsewhere.

The organisation also ensures that local health care providers are familiar with the national scheme for reimbursements. In 2017, the organisation supported 228 persons approximately 2,000 times, spending slightly less than the annual budget provided by the municipality for this purpose (37,500 EUR).¹³⁷ **Amsterdam, Utrecht, and Nijmegen** have similar programs.

Certain municipalities, including Utrecht and Eindhoven, also provide funding for shelters for irregular migrants with particular medical needs. Eindhoven has a specific centre for individuals with serious medical conditions, while Utrecht facilitates access to municipal shelters for people whose medical condition requires “stable” accommodation, such as diabetic patients who need refrigerators for their medicine or people following a mental health care path. Utrecht and Amsterdam also contribute to funding a shelter in Amsterdam (*Medisch Opvangproject Ongedocumenteerden*) where irregular migrants with severe mental health problems can be accommodated and receive appropriate medical assistance.¹³⁸

CHAPTER VII

Addressing migrants' fear of being reported to immigration authorities



Irregular migrants' fear of being reported to immigration officials or being deported to their country of origin may discourage them from seeking health care in official medical facilities.¹³⁹ As a result, migrants who refrain from seeking timely medical help may develop chronic diseases or health conditions requiring emergency treatment, thereby placing their health, and, in the case of pregnant women, their unborn children's health at serious risk.¹⁴⁰ A health provider interviewed for this study reported that undocumented pregnant women in Frankfurt tend to delay seeking pre-natal care until the latest stage of their pregnancy, when the risk of deportation no longer exists.¹⁴¹ NGO workers in Dusseldorf have reported cases of migrants seeking medical help when it was too late to provide life-saving treatments.¹⁴²

For a variety of reasons, such as lack of information or fear, irregular migrants still refrain from approaching official medical facilities, even in countries where national legislation protecting medical confidentiality explicitly prevents the exchange of information between medical staff and immigration authorities.¹⁴³ In other cases, gaps in legislation regarding medical confidentiality can result in migrants being reported to law enforcement authorities.

The interviews conducted for this study revealed that legislation could still create confusion among practitioners, for example, in terms of what constitutes an "emergency", which can create uncertainty over when social welfare officers have the obligation to report a patient. As a result, municipal health and welfare authorities are uncertain about their obligations, and irregular migrants are hesitant to approach medical facilities, which in turn leads to essential treatment not being provided.¹⁴⁴

In such legislative contexts, local authorities can play a crucial role in implementing initiatives that establish a "firewall" that shields patients in an irregular situation from interacting with officials who are duty-bound to report irregular migrants. In **Germany**, several municipalities, in cooperation with NGOs, have established dedicated "drop-in" centres where irregular migrants can obtain medical consultations without the direct involvement of local social welfare employees.¹⁴⁵

Frankfurt am Main (Germany) - a dedicated drop-in centre

In 2001, the city of **Frankfurt** recognized the value of the work of a local NGO and decided to support *Maisha* (a local NGO) in providing social counselling to undocumented African women, particularly pregnant women, fearful of approaching official medical services. The City's Health Department, together with the Social Welfare Department and *Maisha* proposed "Humanitarian Consultation Hours" (*Humanitäre Sprechstunden*).

Following a decision of the local City Council, the centre was founded as a part of the City's Health Department, in partnership with *Maisha*, and began receiving funding from the Social Welfare Department. The main features of Frankfurt's Humanitarian Consultation Hours include

1. A municipal Health Department drop-in centre providing irregular migrants and other uninsured individuals with non-emergency health care services, including individual medical

consultations, basic treatments and medicine, paediatric check-ups, vaccinations, laboratory analyses, vision and hearing tests, sonograms and X-rays, testing and treatment for HIV/AIDS, and psychosocial support.¹⁴⁶ In 2017, the centre provided medical services to 613 uninsured adults 1,698 times, and to 182 children 486 times.¹⁴⁷

2. Medical services in the centre are offered anonymously and free of charge. The only details asked of patients are whether they have health insurance (in the affirmative case they would be referred elsewhere) and if they live in Frankfurt, since the service is reserved to persons living in the city, although no specific proof of residence is required.
3. For services not offered within the Humanitarian Consultation Hours, the centre has developed partnerships with external gynaecologists and other medical specialists to whom the migrants can be referred. The Health Department has secured agreements with certain doctors and local hospitals to offer their services to irregular migrants at reduced and fixed rates (to be paid by the migrants), for example, for deliveries of uninsured pregnant women.¹⁴⁸ The centre has also developed partnerships with local NGOs that offer medical services other than those offered by the city.¹⁴⁹

In almost twenty years of activity, Frankfurt's Humanitarian Consultation Hours has received several awards, including the City's Integration Award in 2002.¹⁵⁰ It has become a benchmark of good practice in Germany (known as the "Frankfurt model"), and has inspired several other major city administrations in the country to adopt similar initiatives.¹⁵¹

Düsseldorf (Germany) – outsourcing health care services to NGOs

In cooperation with a local NGO, the City Council of **Düsseldorf** adopted a pilot project for 2015-2018 to ensure financial coverage for medical treatments delivered to uninsured individuals with an irregular migration status, and to avoid the direct involvement of the local welfare office in reimbursements for those treatments.¹⁵² Thus, medical consultations, referrals, and reimbursements were outsourced to a municipally-funded NGO (*STAY! Düsseldorfer Flüchtlingsinitiative*), which – as a non-public actor – is not obliged to report under the German Residence Act. The organisation, known as "STAY!MediNetz", operates as a drop-in medical centre for irregular migrants.

The main components of Düsseldorf's initiative include

- A "clearing centre" ("*clearingstelle*") operated by the organisation's staff to verify eligibility and provide legal counselling on residence status. Individuals must be non-EU nationals without medical insurance in an irregular situation who have lived in Düsseldorf for at least six months.
- General medical consultations that are offered once a week at the NGO's facilities by volunteer doctors acting as general practitioners.
- A referral system to specialist private doctors, operated by the NGO, within a network of thirty to forty practitioners who have agreed to provide treatments to referred individuals at the lowest applicable rates according to the German scale of medical fees.¹⁵³ Migrants who visit the STAY!MediNetz facility are provided with a paper referral describing the necessary treatment. Upon referral, irregular migrants can obtain primary and secondary care, including gynaecological, dental, ophthalmological, orthopaedic, urological, surgical, and psychotherapeutic care.¹⁵⁴

- The municipality provides a yearly budget of 100,000 EUR to reimburse treatment costs. Following treatment, the doctors bill the organisation rather than the migrants or the municipal social welfare office. Doctors have agreed to apply minimal rates, thus generating savings of approximately 50% per treatment.¹⁵⁵ In the period between June 2015 and December 2016, this system generated savings of 20,557 EUR as compared to regular costs.¹⁵⁶ This fund can also be used to reimburse for treatments offered by local medical facilities to irregular migrants who were not referred by the organisation. The NGO has informed local hospitals that it reimburses for treatments provided to any patient without a regular residence permit, and it has distributed information to hospitals explaining that the NGO should be contacted instead of the social welfare office.
- Outreach activities are also carried out by the NGO with the migrant community to build migrants' awareness and trust in the service.¹⁵⁷

CHAPTER VIII

Informing migrants and health care providers about entitlements



If migrants are unaware of their entitlements to health care, they will have difficulty accessing care.¹⁵⁸ Even in countries that offer irregular migrants access to health care, migrants may still refrain from seeking medical assistance because they do not know their rights. Health care professionals may also refuse to provide care even if a legal entitlement exists, due to a lack of awareness. Narratives that aim to exclude irregular migrants from services can also cause misconceptions.¹⁵⁹

National and local authorities can offer guidance to relevant service providers regarding irregular migrants' entitlements.¹⁶⁰ This guidance can take various forms, including the distribution of circulars to local health providers,¹⁶¹ information campaigns targeting both health professionals and irregular migrants, outreach activities, counselling by NGOs,¹⁶² and training of professionals. For example, the Mayor of London, together with other organisations, published a leaflet explaining how migrants in an irregular situation may access primary care, considering that many do not register with a general practitioner despite an entitlement to do so.¹⁶³

Barcelona and Madrid (Spain) – addressing misinformation

Since the national health reform in 2012, several Autonomous Communities have adopted regulations to preserve irregular migrants' entitlements to health care. In addition, regional and municipal authorities have sought to raise awareness among both professionals and beneficiaries of the health care entitlements, and have intervened in individual cases where irregular migrants were improperly denied care or were asked to pay for it.

In 2015, the Autonomous Community of **Madrid** adopted an internal notice instructing local health professionals to provide assistance to all patients regardless of their migration status. The City Council of Madrid launched a public campaign entitled "*Madrid sí cuida*" ("Yes, Madrid cares!") to inform irregular migrants about their right to access public health care, regardless of their status. The city encouraged all migrants to register with a local health centre and provided information on how to seek help and report when care was denied.¹⁶⁴

The municipality of **Barcelona**, together with regional Catalan authorities, ensured that no one was improperly denied care due to misinformation¹⁶⁵ following the regional¹⁶⁶ health reform. Regional regulations enabled the granting of a medical card to irregular migrants who were registered in the municipal records in Catalonia for at least three months. In 2016, the Catalonia Health Service and the City of Barcelona created a special committee composed of regional and municipal authorities from the health and immigrant reception departments of Barcelona to monitor irregular migrants' access to health care in the city, to identify problems in implementing the regulation, and to discuss and assess individual cases. The special committee

- identified, along with local NGOs, cases of improper denial of care and worked to resolve these individual cases (including by mediating with local employees), assisted the individuals involved, and identified local health centres and hospitals in need of training;

- promoted a new regulation offering free assistance to migrants without a health card who had declared themselves unable to afford the health costs;
- prepared leaflets on the procedure for obtaining the medical card and about free emergency care and distributed them to health care professionals and health care users;
- began training public employees on relevant rules and procedures in the regional health centres (*Centros de Atención Primaria*) where medical cards are requested; and
- ensured that information reached professionals in local health centres and hospitals.

The municipality also has specialised services for migrants and refugees, such as reception and social work services for vulnerable populations, which help them sort out administrative barriers for registration and access to public services, including healthcare. As a result, municipal authorities reported that most irregular migrants in Barcelona are able to obtain a medical card and to access health care in the city.¹⁶⁷

CONCLUSION

International human rights law guarantees the right to health for all, including irregular migrants, and prohibits discrimination based on a person's migration status or nationality. In the EU and beyond, local authorities (at the regional and municipal levels) and other actors (such as service and health care providers and immediate responders to the needs of the population) have taken measures to overcome obstacles and alleviate or eliminate direct or indirect discrimination in the provision of services, including health care for migrants.

The field research carried out for this study also indicated that irregular migrants in poor health, or who are traumatised, are unlikely to leave or travel in the host country. Limiting the right to health of irregular migrants to only emergency care can drive up health care costs and overburden emergency services. Providing access beyond emergency care, however, can have a positive impact on the public health system, since the inclusion of the entire population in the health care system is in the interest of society as a whole. In Europe, certain local authorities have acted within their competence to provide effective access to health care and services for migrants at the local level.

The promising practices documented in this study show that regional and municipal authorities and other stakeholders can:

1. Ensure the continuity and quality of health care and services for migrants.

Within their sphere of competence, local authorities can adopt regulations that extend care locally, for example by allowing irregular migrants to register with general practitioners. Local authorities can also establish a medical centre or municipal health teams that provide care and treatment to irregular migrants who cannot be registered in the national system. Municipalities can further support shelters for irregular migrants who need to be (but cannot be) hospitalized or who have particular medical needs.

2. Overcome administrative barriers (such as proof of habitual residence) and ensure that doctors do not refuse to treat patients on grounds of legal status.

Within their competences, local authorities can simplify procedures, for example by issuing special medical cards or by making existing cards available to people with irregular migration status, limited documentation, or no fixed residence. They can also simplify procedures for reimbursing expenses incurred by local doctors or service providers.

3. Ensure the affordability of health care and services for migrants.

Local authorities can set up a special fund to cover the costs of care provided to irregular migrants who are not covered by national insurance schemes. The special fund can be supplemented by private donations. Alternatively, local authorities can support NGOs to provide treatments or to

reimburse medicine and treatment costs that are not reimbursed through national coverage. They may also allow doctors to claim reimbursements directly from the municipal authorities.

4. Guarantee patient confidentiality through “firewalls” and address migrants’ fear of being reported to immigration authorities and/or being deported to their country of origin.

Local authorities can adopt “firewall” measures that prevent interaction between patients in an irregular situation and officials who are duty-bound to report on migration status. Local authorities can establish dedicated centres that can be accessed anonymously and free of charge. Alternatively, consultations, referrals, and reimbursements can be provided by a municipally-funded NGO or other external actor not duty-bound to report on an individual's migration status.

5. Increase migrants’ awareness of their human rights and entitlements.

Local authorities can reach out to migrants, distribute leaflets, carry out public information campaigns, or fund local NGOs working with irregular migrants to inform them about their rights and entitlements, especially when legislation and regulations change. They can also engage with local hospitals and medical doctors, for instance by setting up a special committee to monitor access to health care for irregular migrants in the city, identify gaps and cases of improper denials of care, and deliver training or briefings at the municipal level.

The promising practices documented in this study show that regional and municipal authorities and other stakeholders can:

1

Ensure the continuity and quality of health care and services for migrants.



2

Overcome administrative barriers (such as proof of habitual residence) and ensure that doctors do not refuse to treat patients on grounds of legal status.



3

Ensure the affordability of health care and services for migrants.



4

Guarantee patient confidentiality through “firewalls” and address migrants’ fear of being reported to immigration authorities and/or being deported to their country of origin.



5

Increase migrants’ awareness of their human rights and entitlements.



ENDNOTES

1. OHCHR (2004), *The Economic, Social and Cultural Rights of Migrants in an Irregular Situation*. https://www.ohchr.org/Documents/Publications/HR-PUB-14-1_en.pdf
2. Ingleby D. and Petrova-Benedict R. (2016), *Recommendations on access to health services for migrants in an irregular situation: an expert consensus*, Brussels: IOM Regional Office Brussels. <https://eea.iom.int/publications/recommendations-access-health-services-migrants-irregular-situation-expert-consensus>
3. FRA (2015), *Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation*; Bozorgmehr K. and Razum O. (2015), *Effect of Restricting Access to Health Care on Health Expenditures among Asylum Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013*. See also UNGA (2010), *Report of the Special Rapporteur on the human rights of migrants*, (A/HRC/14/30); FRA (2011a), *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*, p.45. <https://fra.europa.eu/en/publication/2012/migrants-irregular-situation-access-healthcare-10-european-union-member-states>
4. OHCHR (2014), *op. cit.*, p.4.
5. Spencer S. & Hughes V. (2015), *Outside and in: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe*, Oxford: COMPAS. <https://www.compas.ox.ac.uk/2015/outside-and-in>
6. In the migration context, the term “firewalls” refers to measures that separate immigration enforcement activities from public services such as health care, labour law enforcement, and criminal justice. In the absence of firewalls, irregular migrants are likely to refrain from soliciting public services out of fear of deportation.
7. Universal Declaration of Human Rights (Article 25); International Covenant on Economic, Social and Cultural Rights (Article 12); International Convention on the Elimination of All Forms of Racial Discrimination (Article 5), International Convention on the Elimination of All Forms of Discrimination against Women (Article 12); Convention on the Rights of the Child (Article 24); International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (Article 28); Charter of Fundamental Rights of the European Union (Article 35); and the European Social Charter (Article 13).
8. Spencer S. & Hughes V. (2015), *op. cit.*; FRA (2011a), *op. cit.*; FRA (2011b), *Fundamental rights of migrants in an irregular situation in the European Union* <https://fra.europa.eu/en/publication/2012/fundamental-rights-migrants-irregular-situation-european-union>; Björngren-Cuadra C. (2012), *Policy towards Undocumented Migrants of the EU27*, in Biffl G. & Altenburg F. (Eds.), *Migration and Health in NowhereLand - Access of Undocumented Migrants to Work and Health Care in Europe*; Björngren Cuadra C. (2011), *Right of access to health care for undocumented migrants in EU: a comparative study of national policies*, in *European Journal of Public Health*, Vol. 22, Issue 2, pp.267-271; HUMA Network (2010), *Are Undocumented Migrants and Asylum Seekers Entitled to Access Health Care in the EU? A Comparative Overview in 16 Countries*; PICUM (2007), *Access to Health Care for Undocumented Migrants in Europe* http://picum.org/Documents/Publi/2007/Access_to_Health_Care_for_Undocumented_Migrants_in_Europe.pdf; PICUM (2017), *Cities of Rights: Ensuring Health Care for Undocumented Residents* https://picum.org/wp-content/uploads/2017/11/CityOfRights_Health_EN.pdf; Médecins du Monde (2016), *Legal report on access to healthcare in 17 countries* <https://mdmeuroblog.files.wordpress.com/2016/11/mdm-2016-legal-report-on-access-to-healthcare-in-17-countries-15112016.pdf>.
9. The international human rights treaty bodies are committees of independent experts that monitor progress in the implementation by States of the core international human rights treaties they have ratified.
10. For example, CESCR E/C.12/SWE/CO/6 Sweden paras. 20 and 32, E/C.12/GRC/CO/2 Greece para. 36, E/C.12/FIN/CO/6 Finland para. 27, E/C.12/CZE/CO/2 Czech Republic para. 15, E/C.12/AUT/CO/4 Austria para. 21; A/HRC/33/7 Greece para. 134.148; A/HRC/32/8 Belgium paras. 139.21 and 141.33.
11. FRA (2011a), *op. cit.*; FRA (2011b), *op. cit.*; Spencer S. & Hughes V. (2015), *op. cit.*; PICUM (2017), *op. cit.*; Delvino N. (2017), *European Cities and Migrants with Irregular Status: Municipal initiatives for the inclusion of irregular migrants in the provision of services*, Oxford: COMPAS <https://www.compas.ox.ac.uk/2017/european-cities-and-migrants-with-irregular-status/>. See also, the *City Initiative on Migrants with Irregular Status in Europe*, a working group of nine European cities facilitated by the Global Exchange on Migration and Diversity at the University of Oxford’s Centre on Migration, Policy and Society, which aims to, *inter alia*, build a body of evidence on practices of European cities in relation to migrants with irregular immigration status <https://www.compas.ox.ac.uk/project/city-initiative-on-irregular-migrants-in-europe-c-mise/>.
12. *Ibid.*

13. OHCHR (2014), *Recommended Principles and Guidelines on Human Rights at International Borders*, p.4. https://www.ohchr.org/Documents/Issues/Migration/OHCHR_Recommended_Principles_Guidelines.pdf
14. IOM (2018), *Global Migration Indicators*, p.9. https://publications.iom.int/system/files/pdf/global_migration_indicators_2018.pdf
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16. Clandestino (2009), *Size and development of irregular migration to the EU - Comparative Policy Brief - Size of Irregular Migration*. http://irregular-migration.net/fileadmin/irregular-migration/dateien/4.Background_Information/4.2.Policy_Briefs_EN/ComparativePolicyBrief_SizeOfIrregularMigration_Clandestino_Nov09_2.pdf
17. *Ibid.* See also: OHCHR (2014), *op. cit.*, pp.3-4.
18. WHO (2018a), *Health of refugees and migrants Regional situation analysis, practices, experiences, lessons learned and ways forward WHO European Region*, p.29. <https://www.who.int/migrants/publications/EURO-report.pdf?ua=1>
19. ILO (2015), *ILO global estimates on migrant workers, Results and methodology, Special focus on migrant domestic workers*, p.xi. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_436343.pdf
20. International Convention on the Rights of Migrant Workers and Members of their Family (Article 5).
21. According to the European Commission, around 2.6 million asylum applications were filed in 2015-2016 (European Commission (2017), *Communication from the Commission to the European Parliament and the Council on a more effective return policy in the European Union - A renewed action plan*).
22. European Commission (2018), *State of the Union Address 2018: A stronger and more effective European return policy* https://ec.europa.eu/commission/sites/beta-political/files/soteu2018-factsheet-returns-policy_en.pdf
23. European Migration Network (2016), *The Return of Rejected Asylum Seekers: Challenges and Good Practices* http://emn.ie/cat_publication_detail.jsp?clog=1&itemID=3006&t=6.
24. For example, the serious human rights violations and abuses experienced throughout the journey of migrants and refugees through Libya (OHCHR (2018), *Desperate and Dangerous: Report on the human rights situation of migrants and refugees in Libya*) <https://www.ohchr.org/Documents/Countries/LY/LibyaMigrationReport.pdf>.
25. For more information on the human rights protection of migrants in vulnerable situations, please see: Global Migration Group and OHCHR (2018), *Principles and Guidelines supported by practical guidance, on the human rights protection of migrants in vulnerable situations* <https://www.ohchr.org/Documents/Issues/Migration/PrinciplesAndGuidelines.pdf>
26. EU Directive 2004/38/EC.
27. Please refer to footnote 7 for the list of instruments that protect the right to health, and page 9 for the relevant policy frameworks.
28. This Committee is composed of 18 independent experts who monitor State Parties' implementation of the Covenant on Economic, Social and Cultural Rights. See more at: www.ohchr.org/EN/HRBodies/CESCR/pages/cescrindex.aspx
29. According to CESCR's General Comment No. 14, "the obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health," "the obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees," and "the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health."
30. CESCR (2017), *Duties of States towards refugees and migrants under the International Covenant on Economic, Social and Cultural Rights*, para.3. <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFE-ovLCuW1AVC1NkPsgUedPIF1vfPMJbFePxX56jVvNBwivepPdIEe4%2BUb4qsdJhuBDpCRSOwCXPjZ7VN7SXN0oRoXkZh-CuB9Z73iyU35LZveUjX0d7u>
31. CESCR (2009), General Comment No. 20, para.30. See also Article 2 UDHR; Article 2(2) ICESCR; Article 7 ICMW.
32. CESCR (2017), *Duties of States towards refugees and migrants under the International Covenant on Economic, Social and Cultural Rights*, para. 5. See also *Toussaint v. Canada*, CCPR/C/123/D/2348/2014, para. 11.8 "The [Human Rights] Committee considers that in the particular circumstances of the case where [...] the exclusion of the author from the IFHP care could result in the author's loss of life or the irreversible negative consequences for the author's health, the distinction drawn by the State party, for the purpose of admission to IFHP, between those having legal status in the country and those who have not been fully admitted to Canada, was not based on a reasonable and objective criteria, and therefore constituted discrimination under article 26."

- 33.** This Committee is the body of independent experts that monitors the implementation of the Convention on the Elimination of All Forms of Racial Discrimination by its State parties. See more at: www.ohchr.org/EN/HRBodies/CERD/Pages/CERDIndex.aspx
- 34.** CERD (2005), General recommendation No. 30, para.9.
- 35.** CESCR (2000), General Comment No. 14, para.34.
- 36.** *Ibid.*, para.11.
- 37.** *Ibid.*, para.12. *Availability* refers to States' obligation to ensure that functioning health care facilities and services and the underlying determinants of health are available in sufficient quantity. *Accessibility* includes affordability, which is particularly relevant for irregular migrants who cannot access national health insurance schemes. *Acceptability* requires all health facilities, goods, and services to be respectful of medical ethics and culturally appropriate. The principle of *quality* requires health facilities, goods, and services to be scientifically and medically appropriate and of good quality.
- 38.** *Ibid.*, paras.17 & 43.
- 39.** CESCR (2008), General Comment No. 19, paras.37-38.
- 40.** Global Migration Group and OHCHR (2018), *Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations*. These principles and guidelines provide guidance to State and other relevant stakeholders on implementing the international human rights framework concerning migrants who are in vulnerable situations.
- 41.** CESCR (2017), *op. cit.*, para.12.
- 42.** *Ibid.*
- 43.** CERD (2005), General Recommendation No. 30, para.29.
- 44.** Crépeau and Hastie (2015), *The case for 'firewall' protections for irregular migrants: safeguarding fundamental rights*, in *European Journal of Migration and Law*, vol. 17, Nos. 2-3, p.165.
- 45.** General Policy Recommendation No. 16 encourages Member States of the Council of Europe to "develop legislation, policy guidelines and other measures to prohibit public and private bodies from reporting to and sharing with immigration authorities the personal data of, or information about, migrants suspected of irregular presence for any purposes, other than in exceptional circumstances which are set out in law and subject to judicial review and a substantive appeal right" (Recommendation 12).
- 46.** The Global Compact for Safe, Orderly and Regular Migration is an international framework for cooperation on migration, which was adopted by UN member States on 10 December 2018 in Marrakech, Morocco, and endorsed by a majority of UN member States at the UN General Assembly on 19 December 2018 <https://www.iom.int/global-compact-migration>.
- 47.** WHO (2018a), *op. cit.*, pp.8-9 & 15-16.
- 48.** Spencer S. & Hughes V. (2015), *op. cit.*, pp.9-10.
- 49.** The CESCR indicated that "all persons, irrespective of their nationality, residency or immigration status, are entitled to primary and emergency medical care" (2008, General Comment No. 19, para.37). Emergency care can include life-saving measures and medical treatments that are necessary to prevent serious damage to a person's health (FRA, 2011b, p.74). As per primary and secondary care, the CESCR also specified that primary health care deals with "common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost," while "secondary health care is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes inpatient care at comparatively higher cost" (2000, General Comment No. 14, footnote 9).
- 50.** Spencer S. & Hughes V. (2015), *op. cit.*, p.11. Furthermore, FRA publishes an overview of national legislation regulating irregular migrants' entitlement to access emergency, primary, and secondary healthcare in the 28 EU Member States, available at <http://fra.europa.eu/en/theme/asylum-migration-borders/healthcare-entitlements>
- 51.** "The Jesuit Refugee Service reported that social services refused to reimburse hospitals for emergency treatments of irregular migrants. The German Caritas Association was concerned about cases where severely ill persons did not receive necessary health care and where access to health care was made dependent on the outcome of the asylum procedure" (FRA (2019), *Migration: Key Fundamental Rights Concerns Quarterly Bulletin (1-1-2019 – 31-3-2019)*, p.3).
- 52.** Bulgaria, Cyprus, Finland, Lithuania, Luxembourg, and Slovakia (Spencer S. & Hughes V. (2015), *op. cit.*, p.11).
- 53.** Austria, Croatia, Denmark, Estonia, Greece, Hungary, Latvia, Malta, Poland, Romania, Slovenia, and Spain (*ibid.*).

54. Belgium, Czech Republic, France, Germany, Ireland, Italy, Netherlands, Portugal, Sweden, and the United Kingdom (*ibid.*, p.12).
55. *Ibid.*, pp.29-37.
56. FRA (2011b), *op. cit.*, p.83.
57. Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally remaining third-country nationals.
58. WHO (2018a), *op. cit.*, pp.13, 15, 16 & 21; WHO (2018b), *Compendium of health system responses to large-scale migration in the WHO European Region*, pp.87-91.
59. CESCR (2000), General Comment No. 14, para.30.
60. *Ibid.*, para.32.
61. CESCR (2009), General Comment No. 20, para.13. This General Comment further specifies that “differential treatment based on prohibited grounds will be viewed as discriminatory unless the justification for differentiation is reasonable and objective. This will include an assessment as to whether the aim and effects of the measures or omissions are legitimate, compatible with the nature of the Covenant rights and solely for the purpose of promoting the general welfare in a democratic society.”
62. CESCR (2000), General Comment No. 14, para.19.
63. WHO (2018a), *op. cit.*, p.9.
64. OHCHR (2014), *op. cit.*, p.14.
65. Spencer S. & Hughes V. (2015), *op. cit.*
66. FRA (2011a), *op. cit.*
67. *Ibid.*
68. CESCR (2000), General Comment No. 14, para.12.
69. UNGA (2015), *Role of local government in the promotion and protection of human rights – Final report of the Human Rights Council Advisory Committee (A/HRC/30/49)*, para.21.
70. OHCHR (2014), *op.cit.*, pp.28-29.
71. PICUM (2017), *op. cit.*; Committee of the Regions of the EU (2012), *op. cit.*
72. CESCR (2000), General Comment No. 14, para.12.
73. Delvino N. (2017), *op. cit.*, pp.8-10.
74. Please refer to footnote number 3..
75. FRA (2011a), *op. cit.*, p.45. Also see, UNGA (2010), *Report of the Special Rapporteur on the human rights of migrants (A/HRC/14/30)*.
76. Centre for Health and Migration (2016), *Cost analysis of health care provision for irregular migrants and EU citizens without insurance* https://eea.iom.int/sites/default/files/publication/document/Cost_analysis_of_health_care_provision_for_irregular_migrants_and_EU_citizens_without_insurance.pdf.
77. See also the *Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations*, which recommend that States and stakeholders should, in conjunction with relevant actors, “develop strategies that will provide continuity of care for migrants who have long-term or chronic health needs. To this end, make every effort to ensure, inter alia, that mechanisms are in place to transfer medical records at all stages of migration and to wherever migrants are detained or relocated.” (Principle 12, Guideline 6)
78. PICUM (2017), *op. cit.*
79. Municipality of Florence (12 September 2011), *Marginali e immigrati irregolari, un progetto per garantire l’assistenza anche dopo l’ospedale*, [Press]. http://press.comune.fi.it/hcm/hcm58683-1_Marginali+e+immigrati+irregolari
80. Real Decreto-ley 16/2012 de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones (20 April 2012). <https://www.boe.es/buscar/act.php?id=BOE-A-2012-5403>
81. *Ibid.*
82. PICUM (2017), *op. cit.*, p.29. These communities were governed by different political parties than the party in power in the central government.
83. *Ibid.*

84. Interview with municipal officials (Barcelona – Interview 1).
85. Law 407/2013, Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act.
86. PICUM (2017), *op. cit.*, p.21.
87. Italian State-Region Conference (20 December 2012), *Accordo tra il Governo, le Regioni e le Province autonome di Trento e Bolzano sul documento recante "Indicazioni per la corretta applicazione della normativa per l'assistenza sanitaria alla popolazione straniera da parte delle Regioni e Province autonome"*. <http://www.regioni.it/sanita/2012/12/27/conferenza-stato-regioni-del-20-12-2012-accordo-tra-il-governo-le-regioni-e-le-province-autonome-di-trento-e-bolzano-sul-documento-recante-indicazioni-per-la-corretta-applicazione-della-normativa-p-281709/>
88. Interview with civil society representative (Puglia – Interview 1); also see Delvino N. & Spencer S. (2014), *Irregular Migrants in Italy: Law and Policy on Entitlements to Services*, Oxford:COMPAS, pp.24-25. http://www.compas.ox.ac.uk/wp-content/uploads/PR-2014-Irregular_Migrants_Italy.pdf
89. Italian Constitutional Court, Decision No. 299 of 2010; Delvino N. & Spencer S. (2014), *op. cit.*
90. Delvino N. & Spencer S. (2014), *op. cit.*, pp.24-25.
91. Interview with civil society representative (Puglia – Interview 1). Prior to the adoption of law, local family doctors had been providing services to irregular migrants, but only on a voluntary basis and in an informal and unstructured way. The local medical association of general medicine doctors had come to a formal agreement with regional authorities one year prior to the adoption of the law to permit the enrolment of irregular migrants with general practitioners.
92. Apulian Regional Law No. 32/2009, Article 10, para.5.
93. Interview with civil society representative (Puglia – Interview 1).
94. According to national law, irregular migrants with no financial resources can receive treatments for free by simply declaring a personal condition of destitution. General practitioners and paediatricians are given a flat fee by the state for the services they offer. Interviews with civil society representative and regional official (Puglia – Interview 1 & 2).
95. Apulian Regional Law No. 32/2009, Article 10, para. 8. For instance, the ASL of Foggia established a dedicated out-patient clinic in the proximity of agricultural fields with a high concentration of irregular migrant workers. Interview with regional official (Puglia – Interview 2).
96. *Deliberazione della Giunta Regionale n. 987 (21 May 2013)*, Bollettino Ufficiale della Regione Puglia - n. 83 del 19-06-2013 https://fimmg.bari.it/documenti/Z8856_1.pdf.
97. See ASL Bari (20 October 2014), *Linee guida per la corretta applicazione della normativa in materia di assistenza sanitaria per la tutela del diritto alla salute dei cittadini stranieri non comunitari e comunitari in Puglia*, Circular 184423/1. https://fimmg.bari.it/documenti/FV97M_1.pdf
98. Interview with civil society representative (Puglia – Interview 1).
99. Health care that cannot be postponed without imminent risk of death, permanent severe disability, serious injury or pain, and which requires treatments within three weeks; Regulation 1255 on the right to health care for people without permanent residency in Norway of 16 December 2011, implemented on 1 January 2012, §3-4-5. See Médecins du Monde (2016), *op. cit.*, pp.102-103.
100. Médecins du Monde (2016), *op. cit.*, pp.102-103.
101. *Ibid.*
102. Interview with NGO staff member (Oslo – Interview 1); Médecins du Monde (2016), *op. cit.*
103. Interviews and exchange with municipal official and NGO staff member (Oslo – Interviews 1 & 2).
104. Interview with NGO staff member (Oslo – Interview 1).
105. Interview with municipal health staff (Trondheim – Interview 2).
106. Interviews with municipal official and municipal health staff (Trondheim – Interviews 1 & 2).
107. Interview with municipal health staff (Trondheim – Interview 2).
108. Interview with municipal health staff (Trondheim – Interview 2).
109. Interview with NGO staff member (Oslo – Interview 1).
110. Interview with NGO staff member (Oslo – Interview 1).
111. Interviews and exchange with municipal official and NGO staff member (Oslo – Interviews 1 & 2).
112. For more information, please consult: www.hug-ge.ch/en/rapport-social-environnemental-2015/hug-provide-treatments-everyone

113. PICUM (2017), *op. cit.*, p.14.
114. Interview with municipal official (Ghent – Interview 1).
115. Interview with municipal official (Ghent – Interview 1).
116. *Centre Public d'Action Sociale or Openbaar Centrum voor Maatschappelijk Welzijn*.
117. For example, home visits may be required to prove the beneficiary's condition of destitution or habitual residence, which can be a challenge for individuals who do not have stable accommodation. Complex procedures may lead to uncertainty for medical doctors regarding whether they will be reimbursed for the treatment provided. See KCE, Belgian Health Care Knowledge Centre (2015), *Vers une réforme de l'accès aux soins de santé pour les personnes en séjour irrégulier*. Interview with municipal official (Ghent – Interview 1) <https://kce.fgov.be/fr/press-release/vers-une-r%C3%A9forme-de-l%E2%80%99acc%C3%A8s-aux-soins-de-sant%C3%A9-pour-les-personnes-en-s%C3%A9jour-irr%C3%A9gulier#.Vnf70PkrLmE>.
118. Before the adoption of the medical card, an irregular migrant would first see a doctor, and the latter subsequently had to apply for reimbursement, without certainty that the municipal authorities would verify the patient's eligibility and that reimbursement would be provided. Thus, doctors were reluctant to treat irregular migrants. Interview with municipal official (Ghent – Interview 1).
119. Interview with municipal official (Ghent – Interview 1).
120. Interview with municipal official (Ghent – Interview 1).
121. See Médecins du Monde – European Observatory on Access to Healthcare (2009), *Access to healthcare for undocumented migrants in 11 European countries* (2008 Survey Report).
122. FRA (2011a), *op. cit.*
123. FRA (2011b), *op. cit.*, p.75.
124. Spencer S. & Hughes V. (2015), *op. cit.*
125. Irregular migrants can only acquire health insurance coverage if they register at asylum centres or are in contact with immigration authorities (Article 2(6) §§2,4 of the BGBl Nr. 80/2004); see Spencer S. & Hughes V. (2015), *op. cit.*
126. Interview with municipal officials (Vienna – Interview 1).
127. Interview with NGO staff member (Vienna – Interview 2); also see Spencer S. & Hughes V. (2015), *op. cit.*
128. Irregular migrants cannot be hosted in Vienna's shelters, apart from the 'night shelters' during wintertime. Interview with NGO staff members (Vienna – Interview 3).
129. Interview with municipal officials (Vienna – Interview 1).
130. Other patients include uninsured EU nationals and regular migrants, as well as asylum seekers who have lost their insurance coverage and Austrian nationals (3-4%); interview with NGO staff member (Vienna – Interview 2).
131. Interview with NGO staff member (Vienna – Interview 2).
132. Interview with NGO staff members (Vienna – Interview 3).
133. Interview with NGO staff members (Vienna – Interview 3).
134. Article 5 para. 2 Exceptional Medical Expenses Act; see PICUM (2017), *op. cit.*
135. Interview with NGO staff member (Amsterdam – Interview 1).
136. PICUM (2017), *op. cit.*, p.25.
137. Interview with municipal official (Eindhoven – Interview 1).
138. Interview with municipal officials (Utrecht – Interview 1).
139. FRA (2011a), *op. cit.*, p.45.
140. *Ibidem*, p.46.
141. Interview with health staff and NGO staff member (Frankfurt – Interview 1).
142. Interview with NGO staff members (Dusseldorf – Interview 2).
143. FRA (2011a), *op. cit.*, pp.46-47.
144. Interview with municipal officials (Dusseldorf – Interview 1). See also Altenburg F. & Biffl G. (2012), *The Voices of Undocumented Migrants*, in Biffl G. & Altenburg F. (Eds.), *Migration and Health in NowhereLand - Access of Undocumented Migrants to Work and Health Care in Europe*, p.196.
145. FRA (2011a), *op. cit.*, p.36.

146. Tiarks-Jungk, Petra (presentation, 30 November 2017), *Healthcare for undocumented immigrants and persons without health insurance in Frankfurt am Main*, Germany.
147. Interview with health staff and NGO staff member (Frankfurt – Interview 1).
148. Six local obstetric clinics have thus agreed to charge a reduced and fixed amount of 700 EUR (instead of 1,500 EUR - 2,000 EUR) for deliveries, 100 EUR of which is provided by the City of Frankfurt and irregular migrant women are expected to pay the remaining 600 EUR.
149. Interview with health staff and NGO staff member (Frankfurt – Interview 1).
150. Maisha, *The Humanitarian Consultation Centre*, [brochure] http://www.socialplatform.org/wp-content/uploads/2017/03/cs5_the_humanitarian_health_consultation_centre.pdf.
151. PICUM (2017), *op. cit.*, p.19; see also FRA (2011a), *op. cit.*, p.36.
152. Interview with municipal officials (Dusseldorf – Interview 1).
153. Gebührenordnung für Ärzte (GOÄ).
154. Interview with municipal officials (Dusseldorf – Interview 1).
155. Interview with NGO staff members (Dusseldorf – Interview 2).
156. Interview with municipal officials (Dusseldorf – Interview 1).
157. Interview with NGO staff members (Dusseldorf – Interview 2).
158. FRA (2011a), *op. cit.*, pp.43-45.
159. FRA (2011a), *op. cit.*, p.47.
160. “Local authorities should organize, on a systematic basis, human rights training for their elected representatives and administrative staff, and the dissemination of relevant information among citizens about their rights. By promoting human rights, local authorities can help build a culture of human rights in the community” (UNGA (2015), *Role of local government in the promotion and protection of human rights – Final report of the Human Rights Council Advisory Committee*, para. 28.)
161. ASL Bari, (2014), *op. cit.*
162. Delvino N. (2017), *op. cit.*, p.24.
163. OHCHR (2014), *op.cit.*, p.45.
164. PICUM (2017), *op. cit.*, p.29.
165. Interview with municipal officials (Barcelona - Interview 1); also see PASUCAT (2014), *Dos anys des del canvi de model sanitari. Dos anys d'exclusió* <https://docs.google.com/file/d/0B2opi6SzyEKTXRxTWtLTjlxNmc/edit>.
166. Starting with *Instrucció 10/2012 del CatSalut*, of 30 August 2012; *Instrucció 8/2015 de la Generalitat de Catalunya*; *Resolució 30 Septembre 2016 sobre Assistència i Facturació en Urgències*.
167. Interview with municipal officials (Barcelona – Interview 1).



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