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ACCESS TO HEALTH CARE FOR VULNERABLE GROUPS IN THE EUROPEAN UNION in 2012

An overview of the condition of persons excluded from healthcare systems in the EU

Dental mobile unit in Greece

INTRODUCTION

> Médecins du monde (MdM) - Doctors of the World in Europe

Médecins du monde - Doctors of the World have been working in Europe since 1986. In total we run over 180 health programs in Belgium, Bulgaria, France, Germany, Greece, Netherlands, Portugal, Spain, Sweden, Switzerland, and the United Kingdom. Our aim is to help the people who are unable to access healthcare without assistance. We provide them with medical attention and document and assess their situation. We seek to increase knowledge, and raise awareness by describing and reporting on the condition of populations who have difficulties accessing healthcare.

MdM uses as a basis for our advocacy work the data we systematically collect, which includes information on the social determinants of health and the patients' state of health. Field work and data serve as the mainstay of the work we carry out with health professionals and institutions to obtain positive and long lasting changes in laws and practices.

Since 2004, Médecins du monde - Doctors of the World have expanded advocacy work to include the European Union and the Council of Europe. We have conducted two surveys[1] on access to healthcare for undocumented migrants based on individual interviews obtained when persons came to our health programs for social services and medical consultations. Between 2004 and 2008, while debates were underway on the EU Return Directive, we organized an advocacy campaign to seek protection for seriously ill migrants who were unable to access adequate healthcare in their country of origin.

In 2009, we also created the HUMA network and published two reports; one covered access to healthcare legislation in 11 EU member states and the second was on access to healthcare in Cyprus, Malta, Poland and Romania and was based on individual interviews with undocumented migrants and asylum seekers. We also drafted and circulated a petition among European health professionals that was signed by 147 health professional bodies[2] and was submitted to the European Parliament. In the petition health professionals declared that they will not deny treatment to patients on any basis.

> Our objectives

Médecins du monde - Doctors of the World head a Europe wide health advocacy project aimed at the enforcement of a fundamental human right: the right of enjoyment of the highest attainable standard of health.

Our goals include:

- to ensure that everyone living in the European Union benefits from equal access to health care coverage, especially for the most vulnerable segments of the population. This includes effective access to prevention, diagnosis and adequate healthcare;
- to obtain changes in European Union policies on measles, HIV, hepatitis and tuberculosis, all of which fall within the EU's mandate, in order to ensure access to treatment; and
- to provide healthcare and protection from deportation for seriously ill undocumented migrants in the EU, who cannot access adequate healthcare in their country of origin, because sending them back to a country where they will not receive adequate care leads to the serious deterioration of their health and, in certain circumstances, death.

> The situation today

In 2012, the consequences of the economic crisis on health and health-related issues are visible in the EU. In Greece access to hospitals is limited to the persons able to pay up-front hospital fee[3] for each medical procedure. More than ever, the European Union needs to ensure full health coverage to people who are already confronted with numerous vulnerability factors. The implementation of exclusion measures that target undocumented migrants, the Roma, drug users, the homeless, and sex workers has increased the likelihood that their health will deteriorate. In the European Union, financial barriers to healthcare, acts of discrimination, and frequent police harassment combined with the fear of being reported to the authorities and subsequently deported are leading an increasingly greater number of people to feel it is unsafe for them to seek medical attention. Consequently, they do not obtain primary health care, have no access to prevention programmes, or to treatment for chronic diseases; and this is true for children, pregnant women and adults in general.

Obtaining access to healthcare for destitute EU nationals living in an EU country other than their own has become an administrative nightmare. In most cases, they are unable to obtain healthcare aid and have to pay 100% of the costs. All they can do is hope for a hypothetical reimbursement from their home country's social security scheme – under the conditions that they find the right forms and provide all of the required documents. Non EU citizens with social security/national healthcare insurance coverage from one EU country who seek healthcare in another EU country face the same obstacles (i.e., a Moroccan woman with social security in Spain living in France). Because all of these barriers hinder timely access to treatment they lead to increased human and financial costs.

[1] European Observatory on Access to Healthcare, Chauvin P., Drouot N., Parizot I., Simonnot N., Tomasino A., published in 2007 and 2009
[2] http://www.medecinsdumonde.org.uk/campaign/humadeclarationfornondiscriminatoryaccesstohealthcare.asp
[3] Five euro fee for each medical act in hospital was one of the first austerity measures introduced in 2011

Many governments faced with the crisis have cut back on social and health spending despite the fact that the number of people in need of support and social protection is higher than before the crisis. In the long term, such budgetary restrictions are counterproductive. This has been highlighted by the World Health Organisation (WHO) in the Tallinn Charter recommendations which point to the fact that ensuring health is a key factor for economic development and wealth,[4]

"[…] Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High performing health systems contribute to economic development and wealth" […] "We, the member states commit ourselves to: promote shared values of solidarity, equity and participation through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups[…]."

Furthermore, the 2011 WHO Rio Political Declaration on Social Determinants of Health[5] clearly states,

"We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an ***'all for equity'*** *and* ***'health for all'*** *global action."*

The European Parliament has acknowledged that healthcare is not available to all. In its resolution[6] dated the 8th of March 2011, the European Parliament clearly stated that,

"[…] equitable access to healthcare is not secured, not only in practice but also in law, for undocumented migrants in many EU countries.[…]The European Parliament calls on Member States to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided equitable access to healthcare."

In the same way, the European Union Agency for Fundamental Rights (FRA) also stresses upon the fact that,

"As EU member states, faced with an ageing population and the repercussions of a global economic crisis, struggle to contain public health expenditure, the right to health for all - regardless of legal status - must remain a key concern".[8]

> Contents of the current paper

In this paper we present the **main findings drawn from data** collected daily in 2011 **in our health centers in Amsterdam, Brussels, London, Munich, and Nice.**

We also present our **key concerns: lack of access to antenatal care, to vaccinations, and to primary healthcare, all of which** are backed by patient interviews compiled in the 11 EU countries where we work.

And, we describe the condition of: **destitute EU nationals living in their own country; destitute EU nationals living in an EU country other than their own; seriously ill undocumented migrants who are not able to access healthcare in their country of origin; migrants in Greece,** specifically in the cities of Patras and Igoumenitsa, on whom we collected data during four months; **and asylum seekers** confronted with the impact of the Dublin II Regulation.

> Key figures

- **34% of patients seen at MdM centres perceived their state of health as poor or very poor despite the fact that the mean age of the group is 35.**
- **In cases where treatment was required, 46.2% received no treatment.**
- **Only 13.7% of patients who presented a condition which required treatment were migrants who knew of their disease before entering the EU.**
- **15% of patients seen in MdM centres in Amsterdam, Brussels, London, Munich and Nice were EU Citizens in 2011. However in Munich that figure rose to 57.9%.**
- **79% of pregnant women who were asked if they received antenatal care replied that they did not.**
- **Over 70% of the violence suffered by migrant patients in Greece occurred after their arrival in Greece.**

[4] June 2008: http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf
[5] October 2011: http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf
[6] In this resolution, the European Parliament stresses that, *"[…] health inequalities are not only the result of a host of economic, environmental and lifestyle-related factors, but also of problems relating to access to healthcare[…]"; furthermore, "[…]equitable access to healthcare is not secured, not only in practice but also in law, for undocumented migrants in many EU countries". The European Parliament calls on member states, […] to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided equitable access to healthcare […] to ensure all pregnant women and children, irrespective of their status, are entitled to and effectively benefit from social protection as defined in their national legislation".*
See: http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2011-0081&language=EN&ring=A7-2011-0032
[8] The Charter of Fundamental Rights of the European Union clearly stipulates in Article 35 which covers health care that, *"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".*
http://fra.europa.eu/fraWebsite/research/publications/publications_per_year/2011/pub_irregular-migrants-healthcare_en.htm

REPORT [9] ON DATA FROM FIVE CITIES IN EUROPE:
Amsterdam, Brussels, London, Munich, and Nice.

> Background

In 2006 and 2008, the Doctors of the World European Observatory [10] on access to healthcare conducted two surveys [11,12] that specifically looked at the condition of undocumented migrants in Europe. The surveys conducted in 2006 and 2008 were based on samples of MdM patients in various European countries. In the current paper the Observatory presents data on the living conditions of all of the patients, including undocumented migrants, seen in 2011 at MdM free clinics in five cities: **Amsterdam, Brussels, London, Munich, and Nice.** The current survey is based on information on social determinants and health data collected routinely in our clinics. The general objective of this report was to quantify and qualify the health and social experiences of the most vulnerable population groups seen in our centres in these 5 cities, the most underserved by national healthcare systems. We hope that this collection of quantitative testimony will inspire changes in healthcare systems so that they are guided by the principles of access and equity.

Breakdown of patients by site

	N	%
BE	149	3
DE	425	9
FR	2 712	56
NL	103	2
UK	1 449	30
Total	4 838	100

Amsterdam (The Netherlands= **NL), Brussels** (Belgium= **BE), London** (the United Kingdom= **UK), Munich** (Germany= **DE), Nice** (France= **FR)** [13]

> Statistics

Because of variation in population size in the 5 clinics and variation of missing value ratios from one centre to another and from one question to another, we chose to compute 4 estimates for every global figure (in most of cases, a proportion or a ratio): CAP (crude average proportion); WAP (weighted average proportion); MVCAP (missing values-corrected average proportion); MVWAP (the average proportion – corrected by the rate of missing values.

> Demographics

The majority of patients were male (56%), with the exception of Nice [14] where women accounted for 57.5% of the patient population and Munich where 53.9% patients were women. **The mean patient age was 35.4.** The age range was from 0 to 88. Age range was comparable among centres. A small proportion of the patients interviewed were under 18 years of age (CAP 9.3%). This figure was higher in Munich [15] (18.8%) and lower in Brussels (3.4%) and comparable to the overall mean for the remaining centres.

As is usually the case in MdM European network programmes, patient nationality varied considerably across the countries in the survey. Some of these differences may be due to the historical links that still exist between certain European countries and their former colonies.

Top five countries of origin (patient nationality) broken-down by centre

BE
- MOROCCO (56)
- ALGERIA (26)
- CAMEROON (10)
- DRC (8)
- GUINEA (4)

DE
- BULGARIA (159)
- RUMANIA (43)
- GERMANY (40)
- ETHIOPIA (19)
- AFGHANISTAN (12)

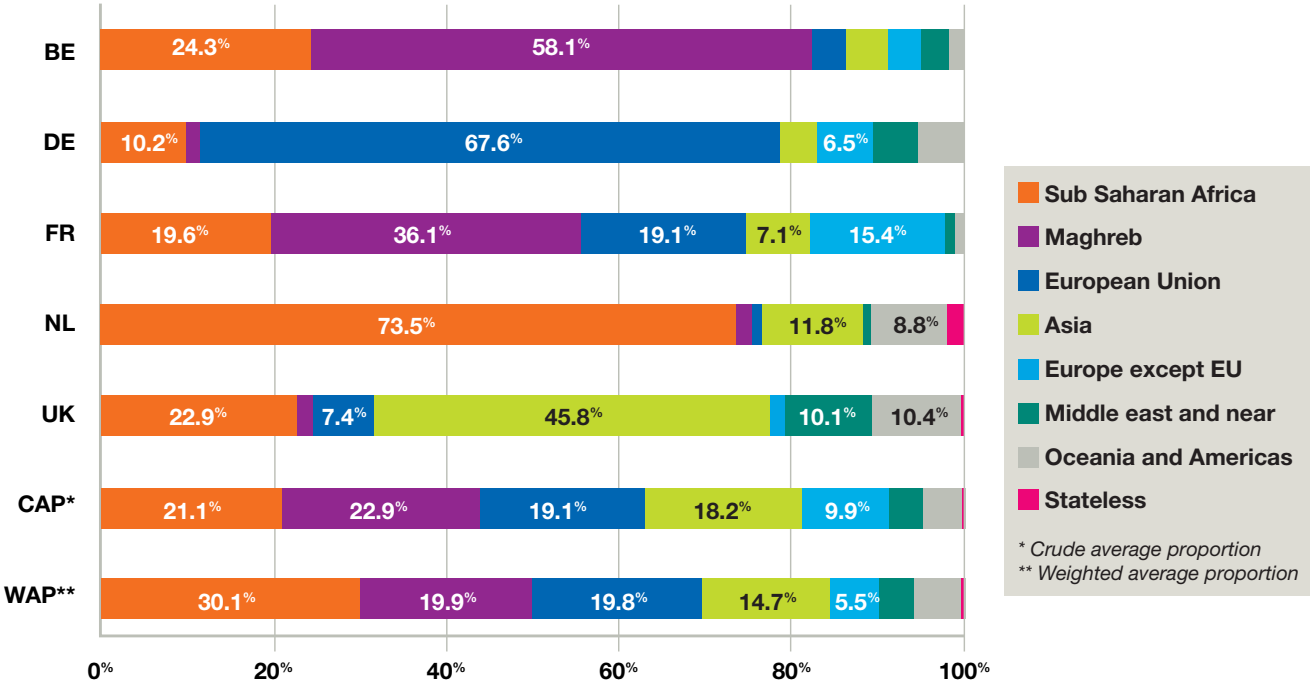
FR
- TUNISIA (530)
- ALGERIA (213)
- GREEN CAP (201)
- MOROCCO (197)
- RUMANIA (185)

NL
- NIGERIA (33)
- GHANA (28)
- SURINAM (4)
- INDONESIA (4)
- ETHIOPIA (3)
- PHILIPPINE (3)

UK
- BANGLADESH (185)
- INDIA (176)
- CHINA (104)
- UGANDA (96)
- BRAZIL (84)

[9] The complete report is available upon request
[10] The European Observatory was renamed International Observatory in 2011
[11] Chauvin P, Parizot I, Drouot N, Simonnot N, Tomasino A. European survey on undocumented migrants' access to health care. Paris, Médecins du Monde European Observatory on Access to Health Care, 2007, 100 p.
[12] Chauvin P, Parizot I, Simonnot N. Access to healthcare for the undocumented migrants in 11 European countries. Paris, Médecins du Monde European observatory on access to healthcare, 2009, 154 p. http://www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf
[13] In this current paper we use NL for Amsterdam, BE for Brussels, UK for London, DE for Munich and FR for Nice
[14] In France, Nice is one of MdM 20 free clinics which have their particularities in terms of the population seen. Read: http://www.medecinsdumonde.org/En-France/Observatoire-de-l-acces-aux-soins
[15] In Munich, a specific consultation was opened for children

Patient region of origin broken-down by site



For all sites, nationals [16] of the country where the centres are located were the least represented category of patients. A scant 0.7% of patients were Belgian nationals in Brussels, in London 0.4% of the patients were UK nationals. In Nice, nationals represented a higher proportion of the patients seen (4.4%) and that figure was much higher in Munich (9.7%). While none of patients in Amsterdam were Dutch. [17]

Half of the consultations (CAP 54%) required the services of **an interpreter;** that percentage was highest in the UK [18]. In most cases, an interpreter was made available. However, 14.3% of the consultations that required an interpreter took place without one. The high proportion of consultations that required an interpreter underscores the extent to which language can constitute an obstacle to proper access to healthcare and social services.

> Legal status

13.88% of patients were EU nationals. Over half of the EU nationals that came into MdM centres did not have authorization to live in the host country. A quarter of the EU nationals seen in MdM centres had been in the host country for less than 3 months and another quarter (less than 3% of the total patient population) were legal, long-term residents who benefitted from the same rights as the nationals of the host country. MdM centre in Munich had, by far, the highest proportion of patients who were EU nationals (17% were EU citizens < 3 months and 35% were EU citizens not allowed to stay).

Nearly two thirds (WAP=66%) of the patient population had no legal residency status in the host country:

- Over **half** of the patients (WAP 57%) **were undocumented migrants from non EU countries.** The proportion was higher than 75% in Brussels (78%) and Amsterdam (80%), [19] and far lower in Munich. (See below). In Nice and London, the number of undocumented migrants was comparable (58% and 57%, respectively).
- **9% were EU nationals who had lost their legal residency status** due to the lack of financial resources or of health insurance. This figure was highest in Munich where 35% of the patients were in this situation.

We can conclude that a crude average proportion of 19.5% [20] of the subjects (and a quarter of the total population when we apply the hypothesis that the missing values were also legal residents) were people who had legal, long term residency status in the host country.

[16] People with the citizenship of the site country
[17] Amsterdam's project is aimed at non European undocumented migrants
[18] The number of missing values is especially high in London. As the team told us, most of them concern people who do not need an interpreter, so the proportion of patients who needed an interpreter may be closer to 33%.
[19] The MdM support centre in Amsterdam specifically targets undocumented persons. The asylum seekers (10%) should have been registered in the category undocumented migrants as they were in extra procedure. But they received also a few other situations (3 patients with a valid residency permit, 3 with a tourist or short stay visa, etc... accounting for another 10% of the patients all together).
[20] With a weighted proportion a little lower (13% of subjects and approximately 17% of the total population, calculated by applying the hypothesis on missing values).

Among the non EU citizens, asylum seekers were the second largest sub-group, 10% (WAP) of patients and 13% (CAP) of the total non EU population. The number of asylum seekers was particularly high in London (14.9%, CI [21] 95% [13.2-16.9]), a major European megalopolis, and in Nice. We need to bear in mind that, since 2009, France has become the second host country of choice (second to the USA) among industrialized countries, for asylum seekers. [22]

When subjects were asked, "Have you ever requested asylum or do you plan to request asylum?" 22.8% (MVWAP) of subjects responded "yes". The highest proportions, by far, of asylum seekers were registered in London (49%) and Munich (41%). Half of all patients who responded "yes" (WAP 48%) had formally requested asylum and were awaiting a decision, 26% had been denied asylum, 19% had not yet submitted a request, 4% fell within the EU Dublin II Regulation - Eurodac system, [23] while only 3% had obtained the refugee status.

Finally, patients with a short stay or tourist visa accounted for approximately 4% of the total patient population under study. In London that figure rose to 8%. All the other administrative situations were quite exceptional, with very small numbers.

> Housing conditions

Housing conditions are particularly precarious for the population under study. Housing for **half of the population (50.8%) was either of a temporary or unstable nature.** The proportion of subjects who lack stable housing is particularly high and underscores the levels of social vulnerability specific to the population that comes into our centres.

The vast majority of patients live in a flat or house but 13% were sleeping rough (either in the street or in emergency or short-term shelters), while 5% were housed in middle-term accommodations (charity housing, hotels, etc.), 2.5% in squats (up to 7% in Amsterdam), and fewer in their place of work (0.6%) or in camps (0.4%). In Munich, Amsterdam and London where a specific question was asked, 17% to 40% of patients reported that their housing conditions were either affecting their own health and/or that of their children.

> Available emotional support

Subjects in Munich, Amsterdam and London were asked to generally describe the type of support (emotional and material) they could potentially receive. In Munich, the patients were only asked if they had some form of emotional support, as recommended by the MdM International Observatory. 21% (MVWAP) said they could rely on someone very often, 33% often, 30% occasionally, however, **16% stated that they had no social support at all.** In 2008, a similar proportion (17%) of the undocumented migrants interviewed by MdM in eleven European countries were in the same situation.

> Work and income

One quarter to one third of patients had a job. In Amsterdam and London, only a very small fraction declared that their income was sufficient to meet their daily living needs (this question was only asked in these 2 cities). In general, patients seen in MdM centres are far below poverty thresholds.

> Violence

Questions relative to violence were not asked in London and Brussels. At the other centres, the response rate was low for questions about violence and the issue is not always directly addressed during medical visits.

However, when the question was asked, it allowed patients to provide us with information on some of their experiences with violence. Acts of violence are frequent particularly against migrants and they can have physical and psychological consequences on the health of patients. Indeed, when interviewed on different forms of violence, **10% to 40% of the patients had experienced one form or another of violence.**

Among interviewed patients, **more than one third of men and women had lived in a country at war and one out five patients had been physically threatened or imprisoned, or tortured because of their beliefs.** Certain forms of violence were more frequently reported by women: psychological violence (32% of interviewed women), sexual assault (19%) and rape (19%), or confiscation of money or identity papers (13%).

Because certain forms of violence can require specific attention, patients, and recent immigrants who travel under rough conditions in particular, need to be systematically queried about episodes of violence. This should be the case for all refugees and asylum seekers. [24, 25]

[21] CI = confidence interval
[22] UNHCR. Asylum Levels and Trends in Industrialized Countries 2010. Geneva, UNHCR, Division of Programme Support and Management 2011, 40 p.
[23] For UNHCR Comments on Dublin II Regulation and Eurodac system, see: http://soderkoping.org.ua/page23538.html
[24] Toar M, O'Brien KK, Fahey T. Comparison of self-reported health & healthcare utilisation between asylum seekers and refugees: an observational study. BMC Public Health 2009;9: 214.
[25] Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. JAMA 2009; 302: 537-49.

Prevalence of violence by form of violence and gender (N= 145)

ACCESS TO HEALTHCARE

> Coverage of healthcare costs

An assessment of each patient's living conditions, needs and entitlements is systematically made during the first visit to the centres. These assessments have enabled us to detect marked differences across patient populations in centres that can be linked to the different health systems in each country [26].

- In Belgium and France, the vast majority of patients (94% and 83%, respectively) had no health insurance [27], on the day they came into the MdM clinics in Brussels and Nice. In Nice, 16% of patients were partially (8%) or fully (8%) covered by the national healthcare insurance system but came to MdM clinics because they could not afford out-of-pocket fees and/or were not yet entitled to the national health insurance for the destitue which provides 100% coverage. This was also due to the complexity of the national health insurance system in France. Certain patients are unaware of their rights or had been refused care despite the fact that they were entitled to it.
- In Munich, in the majority of cases (68% of patients), patients only had access to emergency care in hospitals. At the centre in Munich, which is the one with the highest proportion of EU citizens [28] among its patients, 8% of patients were covered by a health insurance or by the health insurance system of their country of origin.
- In the Netherlands, undocumented migrants are not entitled to national health insurance; however, health care providers can recover most of the costs incurred for health care provided to undocumented migrants, from a government fund created for that purpose. In London, 73% of patients were not registered with a GP even though in the context of the British National Health Service they are eligible to register (primary care consultations are free of charge while all other forms of care or medicines are not fully covered). 27% of patients were registered with the NHS and were fully covered. This is the case for legal immigrants and asylum seekers.

[26] Access to health care for undocumented migrants and asylum seekers in 10 European countries. Law and practice. Paris, Collantes S., HUMA Network, Médecins du Monde, 2009, 192 p.
[27] Persons who come to our centres in Brussels and Nice, and have health insurance are for the most part referred immediately to the mainstream healthcare system
[28] These EU citizens in Munich have very limited access to public or private insurance (they cannot afford it) and therefore to healthcare

Coverage of healthcare costs*

	BE	DE	FR	NL[29]	UK[30]	CAP**	WAP***
MV=	8 (5.37)	30 (7.06)	133 (4.90)	0 (0.00)	110 (7.59)		
No health coverage at all, patient incurs all expenses	133 (94.33)	45 (11.39)	2142 (83.06)	3 (2.91)	1 (0.07)	51.00	38.35
Access only in emergency room	2 (1.42)	269 (68.10)				5.95	13.90
Has medical coverage only for parts of costs		18 (4.56)	202 (7.83)	83 (80.58)		6.65	18.59
Access to GP but the patient must pay for part of the fees				12 (11.65)	1 (0.07)	0.29	2.35
Free access to GP					977 (72.96)	21.44	14.59
Full medical coverage, the patient cannot be charged	5 (3.55)	31 (7.85)	204 (7.91)	1 (0.97)	355 (26.51)	13.08	9.36
Chargeable for secondary care					5 (0.37)	0.11	0.07
Healthcare insurance coverage in another European country	1 (0.71)	32 (8.10)	31 (1.20)	4 (3.88)		1.49	2.78

* For the purposes of legibility null values appear as empty cells.
**Crude average proportion, ***Weighted average proportion

> Barriers to accessing healthcare

A high proportion of patients (WAP 75.3%) mentioned one problem in particular that they came across when trying to obtain healthcare over a period of twelve months. **Poor understanding or lack of knowledge of their rights and of the rules of the system** was the main problem patients cited in Nice (51%) and London (52%). It was rarely reported in Munich (<5%) and Amsterdam; perhaps because 43% of patients without legal residency in Munich have very few or no right to access the mainstream healthcare system. This may also explain why in the Netherlands and Germany patients frequently mentioned the **cost of medical consultation, or treatment** (11% and 18% of patients, respectively).

The second most frequently problem identified by patients was of an administrative nature: gathering of all the documents required to obtain healthcare. This was the case for 21% of patients (CAP), for 40 % of patients in London, and 30% of patients in Nice where access to existing rights for undocumented migrants and the severely ill has become increasingly difficult in recent years.

The third most frequently cited barrier, was language. Although, across centres there was a wide spread in the percentage of patients who cited language as a problem (0% to 20%). However, we mentioned before that, in practice, a much higher proportion of patients needed an interpreter at the time of their consultations in MdM centres (one third, see above).

Moreover, **30% to 40% of patients had not even tried to access health care services** over the 12-month period that preceded their visit. [31] It would be reasonable to assume that a proportion of these patients had little or no reason to seek care.

By contrast, the annual consultation rate for the general population in European OECD countries [32,33] is at least one contact with the healthcare system per year -with the exception of teenagers and young adults- (all reasons taken together -acute, chronic and/or preventive care). We can then assume that many of these patients did not attempt to seek health care services because they were profoundly convinced that they were not entitled to any form service or aid.

[29] In Amsterdam, the category "has medical coverage for a part of costs" and "has access to GP but must pay a part" are one in the same.
[30] In London, the categories "No health coverage at all, fully chargeable", ""Access to GP but must pay a part" , and "Chargeable for secondary care" should have fallen into Free access to GP" category.
[31] This question was not put to patients in Nice.
[32] Allonier C, Dourgnon P, Rochereau T. Enquête sur la santé et la protection sociale 2008. Paris, IRDES, 2010, 254 p.
[33] OECD Health Data, 2011.

Also noteworthy is the fact that 10% of the patients in Nice claimed that they had had a bad experience when trying to obtain medical attention. While at the centres in Munich and London approximately 20% of undocumented migrants stated that they did not seek care because they were afraid of being reported to the authorities or of being arrested [34].

> Denied access to healthcare

Actually, with only 47% and 35% of respondents in Brussels and Munich (this item was not collected in Nice [35] as such), only the British and Dutch data are exploitable. In Amsterdam, 29% of patients had been denied access to health care by a health professional the last 12-months; this was the case for 21% of the patients in London.

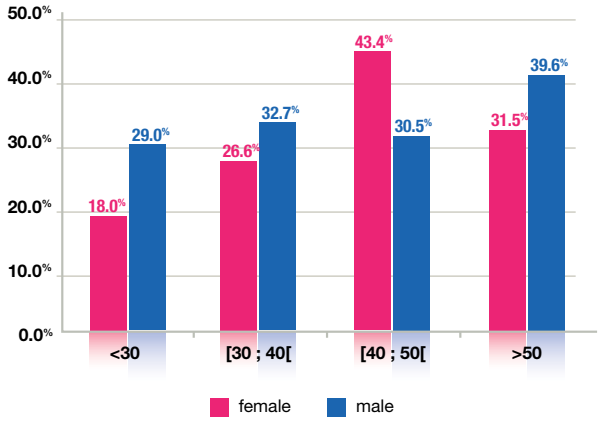
HEALTH CONDITIONS

> Perceived health status

One third (MVWAP 34%) **of people perceived themselves as being in poor or very poor health.** Among the general population in the European Union that figure stands at 9.7% [36].

In Amsterdam and Munich, 29% of people stated that they had poor or a very poor physical health and 33% stated that their mental health was poor or very poor.

Percentage of patients seen at MdM centres who perceive their health as poor or very poor, by gender and age



> Health problems

The most frequent categories of health problems observed were the ones usually seen in primary care: muscle-skeletal, gastro-intestinal, respiratory, dermatological, cardiovascular, and psycho-psychiatry. At MdM centres, **12.82% of the patients seen had psychological issues.** We need to keep in mind that most asylum seekers have lived through traumatizing events and that migrants are frequently faced with violence (see above).

> Chronic diseases and essential treatment

During medical visits, at least one chronic disease was reported for 20% of patients and at least one acute disease was reported for 20% of patients. There were large variations across centres: at least one chronic condition was reported for half of the patients in Brussels and Amsterdam, a quarter to one third for the patients in Munich and London, and one tenth for the patients in Nice [37].

According to physicians, half of the health problems reported required essential treatment. The rate was highest in Brussels (68% of conditions diagnosed) and lowest in London, 27%. **For conditions where treatment was deemed indispensable, 46.2% were not being treated at all,** and 53.8% were treated or were followed intermittently at the time they came to the MdM centre.

At the end of each visit with patients, physicians classified the case as “urgent”, “fairly urgent” or “not urgent”. **The majority of cases seen in MdM centres were classified as urgent** (WAP 20%) or fairly urgent (WAP 35%). 45% (WAP) of them were classified as ”not urgent”. Physicians deemed that 40% (WAP) of patients needed to be closely followed up.

Only a small minority (13.7%) of patients whom treatment was indispensable were migrants who knew of their disease before coming to Europe [38]. This figure is even lower than the one published in the 2008 European Observatory survey in which 15.7% of patients knew their disease before entering the host country. This dispels the myth that underpins the political discourse that paints a picture of foreigners migrating with the main purpose of obtaining medical treatment in Europe. As we pointed out in our previous survey report, [39] **the preconceived notion of massive immigration linked to persons seeking healthcare does not correspond to what we observed** in the population surveyed.

[34] In MdM previous European survey in 2008, 60% of the patients limited their movements or activities for fear of being arrested. see http://www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf
[35] In 2009, Nice made a specific survey on denial of healthcare: 18% of GPs and 48% of dentists did not want the persons with the specific health coverage for destitute persons (see MdM Report 2010 of Observatoire de l’accès aux soins en France, Drouot N., Fahet G.,Tomasino. A)
[36] National Health Interview Surveys (round 2004). Brussels, Eurostat, 2007.
[37] In 2011, medical doctors in Nice did not answer this question frequently.
[38] Our findings might suggest that the percentage of migrants who entered the EU with previous knowledge of their illness is even lower than what we observed given that the patients who come into our centres do so because they have some kind of health problem, which is not the case of all migrants.
[39] See: http://www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf

> Antenatal care

The interviews allowed establishing whether or not 278 women were pregnant (13.4% of the total number of patients). Among them, 129 were pregnant: 46.4% of the women interviewed and 6.2% of the total number of women (the assumption being that all the missing values correspond to women who are not pregnant).

In Amsterdam, London, Munich and Nice, in average, **79% of the respondents were not accessing antenatal care.** 95% of the women (or 59 out of a total of 62 pregnant women) did not receive antenatal care in London when it seemed lower in the three other cities (but with small or very small numbers [40]).

Also among the 64 pregnant women for whom the question had been asked, **50% received antenatal care only after the 12th week** of pregnancy.

> Vaccinations

Few doctors asked patients about vaccinations, consequently the number of missing values is high. Notwithstanding, it is worthwhile mentioning that **75% of the patients in Amsterdam and 71% of those in Nice said that they did not know where to go to get vaccinated.**

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[40] Respectively 61% in Munich (20/33) and 40% in Amsterdam (4/10). In Nice, medical doctors only noted 5 answers to antenatal care, not enough to be analyzed here.

Antenatal Care

➔ In 2011, 79% of pregnant women seen by MdM in Amsterdam, London, Munich and Nice had no access to antenatal care.

It is essential that antenatal care programmes that monitor women's health, as well as the health and development of the baby during pregnancy be made accessible to all pregnant women.

In Europe there are women who do not have access to antenatal care which detects, when provided, problems that can arise during pregnancy and birth, so that action can be taken to avoid or treat them.

Women who do not get adequate care run the risk that complications go undetected and will not be dealt with early enough which, in turn, increases the risk of serious consequences for both mother and baby. The work conducted globally to meet the UN Millennium Development Goals aims at lowering maternal and infant mortality, which are intrinsically linked to the provision of antenatal care.

The European Parliament has acknowledged that antenatal care is a priority. In its resolution [41] dated the 8th of March 2011, the European Parliament calls member States to promote public policies aimed at ensuring maternal care.

The Fundamental Rights Agency (FRA) pointed out in their opinion on antenatal, natal and post-natal care that,

"Article 24 of the Convention on the Rights of the Child and Article 12 (2) of the UN Convention on the Elimination of Discrimination Against Women call for the provision of ante- and post-natal healthcare services. However, healthcare entitlements for pregnant women and mothers vary across the EU. Women in an irregular situation should have access to the necessary primary and secondary healthcare service in case of delivery as well as to reproductive and maternal healthcare services at the same conditions as nationals. These should include primary and secondary ante- and post-natal care, such as the possibility to visit a gynecologist, access essential tests, family planning assistance or counseling." [42]

Patients' description of their situations

"I don't have health insurances. I am not health insured. I haven't seen a doctor during the first 8 months of the pregnancy. We are a poor family and since I am not health insured I must pay for every visit to a gynaecologist so I couldn't afford that. [...] I gave birth normally. On the second day my mother in law came to the hospital and saw me crying. I explained to her that the nurses were shouting and telling me that they won't let me leave the hospital [43] *until I pay my health insurances and they were threatening me that they will report me to the police."*

Ms A., age 20, Bulgarian citizen living in Nadezhda, the Roma neighbourhood in the city of Sliven, December 2011, Bulgaria.

"I met a Serb who lives here without papers and without money. I am expecting his child. I am so happy to still be able to get pregnant at my age. I was always told that I would not have children because of fibroids and cysts in my stomach. I have one friend here. She has a physician. I went with her. I had to pay 15 Euros for a consultation. I went to the hospital once because of severe abdominal pain and bleeding (I wasn't pregnant at the time), but there they immediately told me they couldn't help me, since I had no money and no papers.
Fortunately, I discovered Doctors of the World. Here I found help. The social worker told me that I could speak to the CPAS (social centre). But there, they refused to help me. It's up to my ex-husband to pay for everything, because when I applied for a visa, he signed a document certifying that he would pay for everything. But my husband isn't my husband any more. He lives in Morocco, how can he pay the physician and everything else?"

Ms B., age 40, Moroccan living in Belgium since 2009, Antwerp - December 2011.

[41] In this resolution, the European Parliament, *"[…] Calls on the Member States to promote public policies aimed at ensuring healthy life conditions for all infants, children and adolescents, including pre-conception care, maternal care and measures to support parents and, more particularly, pregnant and breast-feeding women, in order to ensure a healthy start to life for all newborns and avoid further health inequalities, thereby recognising the importance of investing in early child development and life course approaches; […] to ensure all pregnant women and children, irrespective of their status, are entitled to and effectively benefit from social protection as defined in their national legislation"*. See: http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2011-0081&language=EN&ring=A7-2011-0032

[42] http://fra.europa.eu/fraWebsite/research/publications/publications_per_year/pub-migrants-in-an-irregular-situation_en.htm
The Charter of Fundamental Rights of the European Union clearly stipulates in Article 35 which covers health care that, "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".

[43] All pregnant women have the right of free delivery at the hospitals in Bulgaria, regardless of their health insurance status but many Roma women living in the ghettos or in the villages don't know this.

Roma child looking at vaccination card issued by MdM in France

Vaccination

- **Over 70% of patients seen in 2011 in Amsterdam and Nice do not know where to go to be vaccinated.**
- **60% of patients and as much as 75% of Roma patients seen in France are not up to date on the main vaccinations.** [45]

In 1974 the WHO established its Expanded Programme on Immunization [46] to **ensure that all children in all countries benefited from life-saving vaccines.** In Europe, we are far from providing these life-saving vaccinations to all children, let alone globally.

The WHO [47] indicated that 40 of the 53 member states of the WHO European Region had reported 26,025 confirmed measles cases for the period January – July 2011. Children had not been vaccinated despite the fact that a highly effective, safe and relatively inexpensive vaccine has been available since the 1960s. Every case of measles is preventable and any death or disability from measles is unacceptable.

Throughout Europe, to a greater or lesser extent depending on national laws, there are children who have difficulties getting vaccinated, especially those who are part of the most vulnerable population groups. While some countries, such as the UK, provide vaccinations for children free of charge through the National Health Service, there are countries, such as Germany, where children have no health insurance and have limited or no access to the health services that provide vaccinations. Children living in difficult conditions are those who are most likely to suffer from the lack of vaccination. This is particularly true for a large number of Roma children and for the children of undocumented migrants. Vaccination campaigns for Roma in France have been stopped because the Roma are continuously displaced or deported. In its opinion on "Child healthcare" the FRA states,

"Children who have an irregular migration status continue to face legal and practical obstacles to accessing healthcare. In light of Article 24 of the Convention on the Rights of the Child, every child present on the territory of an EU Member State is entitled to the same healthcare services as nationals. This should also include immunizations, which are a major preventive healthcare measure. [48]"

Patients' description of their situations

"It was more than a year ago during the outbreak of measles. My wife Magdalena who was 16 had high temperature, nausea and unwillingness to eat. Pimples appeared on her face and all over her body. I took her to a doctor: she had measles. She was not the only one in the neighbourhood [49]. There were already many kids who got sick from measles, too. The doctor prescribed some pills. The same day it became worse. She started to wriggle and she had very high temperature. In the morning I took her to the hospital and ask them to hospitalize her. The doctors told me that there is no free space in the hospital. They gave an injection and said that she will get better and we should go home. But shortly after we got home she started shaking again with high temperature. Shortly after, my wife died. I don't understand why she was not hospitalized. It was visible that she was in very bad condition. It seems they don't care much about us since we are Roma. It is like they want to get rid of us."

Mr. A. age 18, Roma, citizen of Bulgaria, living in Nadezhda, the Roma neighbourhood in the city of Sliven. December 2011, Bulgaria.

"When I started going to school here it was very difficult. I had to go and see an official doctor from the school, he asked me for my vaccination but we didn't have any vaccination cards. When we left Rumania, we could not take everything with us and my mother doesn't know if I am vaccinated. The school told us that I need vaccination for measles, polio, diphtheria and tetanus, but they did not tell us where to get them without health insurance. I was looking forward to go to school and I was afraid that I would not be able to go. The doctor at the MdM clinic told me after a blood test that it was good that I came here as I wasn't vaccinated at all. So I and my sister got all the vaccinations at the MdM clinic and I started going to school."

Ms S., age 8, from Rumania, living in Germany for the last 3 years. January 2012

[45] Report 2010 Observatoire de l'accès aux soins en France, Drouot N., Fahet G., Tomasino A. http://www.medecinsdumonde.org/En-France/Observatoire-de-l-acces-aux-soins

[46] World Health Assembly resolution WHA27.57

[47] http://www.who.int/csr/don/2011_10_07/en/rvaccineethicsandpolicy.wordpress.com/2011/10/10/who-measles-outbreaks-in-european-african-regions-and-in-americas/ Global Alert and Response (GAR)

[48] http://fra.europa.eu/fraWebsite/research/publications/publications_per_year/pub-migrants-in-an-irregular-situation_en.htm

[49] Almost all of the children with measles have vaccination cards that indicate that they have been vaccinated. More than 4,000 Roma children were infected in the region of Sliven alone between 2009 and 2010 because of fraudulent practices that include claiming expenses for vaccinations that have not been provided and other problems within the health care system. For citizens under the age of 18, Bulgarian law provides free vaccinations.

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Primary health care

- **In 2011, 30 to 40% of people seen by MdM in Amsterdam, Brussels, London, Munich and Nice had not even tried to access healthcare services in the 12 previous months**
- **In 2011, 46.2% of the patients seen at MdM centres who had pathologies that required treatment were under no form of treatment.**
- **According to physicians, 55% of the cases seen in MdM clinics in 2011 were urgent but the majority of patients had no access to the mainstream health care system.**

Primary health care is provided by a general practitioner and is defined as the provision of first-contact care, person-focused, and ongoing care that meets the health-related needs of people. It has been proven that accessible primary health care improves health in general and also improves the efficiency of the overall health care system (by avoiding the overuse of the hospital emergency, for example). Lack of access to healthcare, for whatever reason, be it administrative, financial, or cultural could lead to a major breakdown in the continuity of care and prevention.

It is essential to facilitate access to primary health care for population groups that present many risk factors, the most vulnerable groups are those that are most at risk.

A more proactive approach is needed to remove the barriers to the access to a general practitioner in every EU member state. [50]

Description of a patient's situation

"Ms C. gets an indication for Cataract surgery at the hospital. She has to get a referral of a general practitioner but she does not have a GP. MdM starts looking for a GP in the deprived city area where C lives. GPs are not compensated for the extra workload that follows from the social deprivation of their patients. Six GP practices are located in this area; neither of them is willing to accept C. as their patient. Two practices announce that they do not want to have the extra work of getting their money through the fund made available by the Dutch government to healthcare professionals, to cover medical costs of undocumented migrants who cannot pay. A third practice expresses that they had negative experiences with 'this kind of people' in the past. A fourth practice only accepts patients who can hand over a valid ID. A fifth practice announces that they only accept undocumented patients if they can pay in cash in advance of their appointment. The 6th and last practice refers us to go back to the other practices in the area, because they have a duty of care, and they were asked first..."

Ms.C, age 76, from Morocco, lives in the Netherlands. December 2011.

Personal perspective of Project: London volunteer GP

"I am a general practitioner and work, when time permits, as a clinical volunteer at Project: London, a health advocacy programme set up by Doctors of the World UK in the East End of London. Here I treat those who cannot access primary care. These include those accepted or refused by the asylum system and undocumented migrants. The stories are varied and at times harrowing. A couple have been refused asylum. Local gangs threatened the husband's life life and they cannot go back home. The pregnant wife is in the third trimester. A depressed young woman fled the house where she had been enslaved since she was 14. A teenager with severe post-traumatic stress disorder has difficulties controlling his anger and is at risk of harming himself or others (he has already made a serious suicide attempt). A woman in her forties has rheumatic heart disease and is breathless with heart failure. These individuals are all in clinical need yet have been unable to access primary healthcare in the UK. The British Medical Association reminds doctors that there is no requirement to determine someone's immigration status to access primary care services. The General Medical Council's Good Medical Practice requires that doctors do not discriminate unfairly, but provide care and treatment to meet the clinical needs of all patients. The Royal College of General Practitioners (RCGP) endorses this: "Based on the principle that General Practitioners have a duty of care to all people seeking healthcare, the RCGP believes that GPs should not be expected to police access to healthcare and turn people away when they are at their most vulnerable. Receptionists and practice managers are exhorted to reject individuals who do not present a range of documents such as utility bills and passports - not easy if you are homeless or someone else holds your passport. These impositions carry no valid legal or ethical authority, but some may believe they do. This does not augur well for the vulnerable and dispossessed in need of humane clinical care"

Dr. Paquita De Zulueta, volunteer at Project: London. June 2011.

[50] Reports from the FRA, Médecins du monde/Doctors of the World (with Huma network's reports too), Picum etc are tools which should be used

Roma in Sliven, Bulgaria

An increasing number of hurdles for destitute EU citizens living in their own country

➔ **Between 2010 and 2011, the number of Greek citizens, this includes Greek Roma, coming into MdM policlinics in Greece doubled.**

Recently, the Doctors of the World International Network has had to deal with a sharp increase in the number of patients seen in MdM health programmes in what for the time being is two countries: Greece and Portugal. [51]

In Greece, at the time this paper was written, unemployment stood at 21 percent and was rising. According to Eurostat, in 2010, 27.7 % of the Greek population was considered at risk for poverty or social exclusion (3,031,000 persons -the highest number of inhabitants in this category among EU member states). [52]

Childhood poverty is also rising, 19.7% of children in Greece live in households unable to afford at least 3 out of 9 basic items. [53] That figure stands at 17.4% for all of the EU.

Austerity measures are having a serious impact on Greek society. New forms of social exclusion have emerged as an increasing number of people are left without jobs or with very low salaries. The rise in the number of socially excluded persons has increased and this has led to growing demand for all forms of social services and aid. Moreover, public welfare institutions are shrinking rapidly and invariably people have to rely increasingly on NGOs for assistance.

The Greek government has significantly reduced public spending on health [54] and has increased the cost of accessing health care services. As of October 2010, all public hospitals have instituted an up-front five euro fee for services. This has resulted in a greater number of people being excluded from the services provided by the national health care system quite simply because they cannot afford to pay.

In MdM policlinics in Greece, the percentage of Greek citizens seeking medical assistance more than doubled in 2011. One alarming fact is that many patients are retired elderly citizens whose pensions have been substantially reduced because of the austerity measures implemented by the government in recent years.

Patients' description of their situations

"I live in an apartment with my husband and 4 children. Our power supply will be cut soon, since we have no money to pay the new taxes. Therefore my family will have to survive through the winter with no heating. We have an extremely low income that is not enough to support a 7 member family. Finally, in due time, we will have no power supply and therefore the living conditions will become even worse.I am pregnant on my 5th child but until now, I haven't seen a gynaecologist. Given that both I and my husband are unemployed and we have no social benefits, I cannot access the public health system. My children haven't been immunized."
Ms. D., age 32, Greek woman living in Greece. November 2011.

"I was nine month pregnant. One night I felt that my "waters" broke. We don't have a car or a phone and taxi drivers are not willing to come to our neighbourhood, so my husband went to our neighbours to ask them to call the ambulance. He told the ambulance that I was giving birth. Meanwhile I went to the toilet because of "my waters" and I didn't want my 2 children to see me like that. As I was waiting in the toilet my birth pangs began. My mother in law came to me. The ambulance was still not coming. My husband went to the neighbours for a second time to call them. He called them saying "please come quickly, my wife is delivering". I was crying in the toilet and I couldn't move. My mother in law called other women, soon all neighbours around woke up and came and suddenly I delivered. The neighbour called Kalin- he is working as a health mediator. So Kalin called the ambulance again telling them that he is working in "Doctors of the World" and then in 10 minutes the ambulance came and took me to the hospital with my baby – born in the toilet. Very often such cases happen here. The "ambulance" is not willing to go to our neighbourhood."
Ms. T. 27 years old, Bulgarian, living in Nadezhda, a Roma neighbourhood in the city of Sliven. December 2011.

[51] This type of situation is starting also in Spain and France as our teams report now
[52] Eurostat website, tables of income and living conditions. Available at: http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do?tab=table&plugin=1&pcode=t2020_50&language=en. Last update: 23/02/2012.
[53] Matsaganis, M. (2010). Child poverty and child wellbeing in the European Union – Policy overview and policy impact analysis. A case study: Greece
[54] Kentikelenis, A., Karanikolos, M., Papanicolas, I., Basu, S., McKee and Stuckler, D., (2011). "Health effects of financial crisis: omens of a Greek tragedy". The Lancet, Early Online Publication, 10 October 2011

France, 2010

Destitute EU citizens living in another EU country have no access to healthcare!

➔ **In 2011, 15% of patients seen at MdM centres in Amsterdam, Brussels, London, Munich, and Nice were EU nationals. In Germany, 57.9% were EU nationals** [55]

EU nationals who do not have adequate financial resources or health insurance lost their right to reside in an EU country other than their own in 2004 with the advent of the European Directive on the right of citizens of the Union and their family members to move and reside freely. [56] Article 7 of the directive, states clearly,

"All Union citizens shall have the right of residence on the territory of another Member State for a period of longer than three months if they […) have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State during their period of residence and have comprehensive sickness insurance cover in the host Member State."

They find themselves in the same situation as undocumented migrants from outside the EU. Belgium and France have expanded their system of medical coverage for undocumented migrants to include EU nationals without residency status. But not all countries have followed suit. We have observed a constant rise in the number of EU citizens seen in our centres. Obtaining health care coverage is particularly difficult for them, even in the countries where there is entitlement. The same rules also affect the citizens of non EU countries who have legal residency in one European country and move to another EU country (e.g., a Moroccan family living in Spain who chooses to move to France).

Patients' description of their situations

"I have been working in Germany for the last 23 years. In the last few years the situation in Bulgaria has gotten worse, so I took my family with me to Munich. I was mostly working on building sites here in Germany but I never managed to get proper health insurance because the boss never registered my work with the local authority. Two years ago I had a heart attack and was rushed to the hospital here in Munich. They treated my condition but as I didn't have any insurance I was released from the hospital quickly and we got a bill from the hospital. I regularly need to take medication to keep my heart working, but the list of drugs is long and I don't have the money to afford it. The doctors told me that they can't help me and that I have to get insurance. But at the welfare department they said I can't have insurance! When we have some money left I buy some of the medication at the central station without prescription, but I have never taken any medication for my heart condition regularly. Also I have never had a follow up consultation with a doctor since I left the hospital. I am scared that my heart will fail again."
Mr. I, age 64 Bulgarian, Turkish minority. December 2011.

"F. is 26 years old, and she has lived in Spain for several years. She has worked continuously as a maid with different families practically since she arrived in our country. However, she never managed to have any of the families that she worked with enrol her in the Social Security System as a maid.
On October 2011, when she came to MdM, she was clearly affected emotionally and was having a very difficult time. She has been unemployed for the past several months as a result of the worsening economic crisis, though she has continued to actively look for work as a maid. Her employment situation has become somewhat more complicated seeing that less than a year ago she had a little girl, which has further limited her opportunities for entering the job market. F. owed 8 months of rent. She was in a situation of obvious social exclusion, subsisting on food provided by a religious institution.
Due to a health problem, she needed to see her family doctor. She was told that her health coverage had expired in July of 2011, and that they were not able to renew it due to being a citizen of the EU, and that they would only agree to maintain health coverage for her baby. When she presented her problem at MdM, we prepared a detailed report for the Health District. By the end of October 2011, all of the documentation was sent. 20 days later, we still had no answer. In early December, F. even filled out the documentation once again to try to obtain health coverage, but the centre's only response was that "they would call her in the event that an affirmative answer is received with regard to her petition". Subsequently, she asked the health centre once again, but the response was the same. By the end of December 2011, MdM once again requested further information on this case but to date we have not received any response.
Meanwhile, F.'s situation has not improved, she still needs to see a doctor, and six months after the expiration of her provisional health coverage she continues to be denied the right to health care and is not able to access the public health system."
F., age 26, Romanian living in Spain. Malaga, January 2012.

[55] People from countries that have recently joined the EU do not enjoy the right of free movement as workers in Germany
[56] Directive 2004/38/CE dated 29 April 2004. http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:229:0035:0048:en:pdf

Protecting and providing health care for seriously ill foreigners

- **Only 13.7% of patients in Amsterdam, Brussels, London and Munich knew their disease before coming to Europe.**
- **In France, between 2005 and 2009 there was no observed increases in the number of seriously ill foreigners requesting residency for health care purposes. Despite legislation that was enacted fourteen years ago and was clearly favourable to seriously ill foreigners, the number of persons who benefit from the law has not skyrocketed and remains under 30,000; most of them suffer from chronic diseases.**

Undocumented migrants who suffer from pathologies that require treatment and need regular medical follow up may come from countries where their access to adequate care is not effective. This is why certain European countries have decided to enact legislation and implement regulations to protect seriously ill foreigners from deportation. They are provided with a permit to remain in the country and thus avoid the obvious consequences that the lack of treatment would have on their health: physical and emotional suffering, physical disability, or even death. One such example is France [57] where since 1998 the lives of many seriously ill foreigners have been saved. France has set the example for the EU; moreover, their model did not lead to a sudden influx of foreigners.

Deportation to a country where access to adequate healthcare is impossible leads to the serious deterioration of health and sometimes death and goes against the European Convention on Human Rights, *"No one shall be subjected to torture or to inhuman or degrading treatment or punishment".*

A personal perspective – Eduardo's story

"Eduardo arrived in Spain in 2006 with big plans, his debts (he mortgaged his family home to obtain the money he needed to arrive), his commitments, and problems, but also with his health issues.

He was working for five months in the fields of Granada where he didn't get paid. After that, he searched for a new opportunity in Seville, where he ended up living on the streets and even suffering assaults. In this period of time, his state of mind suffered considerably because several months had passed without him being able to send money back to his country and his debts were considerable. In 2007, he went to Malaga to try his luck.

In May 2008 he was attended by the health care unit of Médicos del Mundo in Malaga. He never attended the appointment with the psychologist. He was later admitted to Emergencies after attempting suicide. On the 13th of July, he was raped and was once again admitted to Emergencies. This badly affected him. He reported his attacker but later decided not to press charges because of fear as an undocumented migrant.

He tried again to take his own life. After his admission to hospital, he began to follow a treatment and found a shelter where his situation was somewhat stabilised. He went once to MdM psychologist. However, he followed his treatment well and expressed his desire to carry on, and find a way out of his situation. He was considering abandoning Spain and going back to his country but he wanted to return with his head held high, after stabilising his health and earning some money to pay his return ticket and the debts incurred back home.

Two days after that appointment, Eduardo had an incident in the municipal shelter. He wasn't taking his medication correctly and he was quite unstable. It was in this condition that he started arguing and confronted police officers. As a consequence of this, he was arrested and accused of undermining police authority. They gave him a choice between a prison sentence and deportation, with entry to Spain prohibited for a period of 10 years. He was taken to the Immigration Detention Centre.

A few days later, he tried to commit suicide again. Some of his fellow inmates rescued him. After this incident, he was closely monitored by the Centre staff awaiting his expulsion. The thought of returning in this way and being locked up considerably affected him. In the meantime, the Asociación de Amigos de Bolivia tried to help him out by raising the money necessary to pay off his debts. An attempt was made to find psychiatric treatment for him that would be sufficient for two months, with the aim of being able to stabilise his situation in Bolivia and find some healthcare resources there for him.

On the 1st of October 2008, the social worker from the Immigration Detention Centre called MdM to find a psychologist for Eduardo in Bolivia. But clearly no organisation was in a position to guarantee Eduardo the healthcare he required in Bolivia. In fact, given his delicate mental state, it was logical to provide care here, immediately, and prior to his deportation.

Eduardo Medina Flores was deported in the early hours of the 15th of October.

No one had been informed: his family in Bolivia could not go and collect him at the airport when he arrived. His medication also failed to arrive, as did his luggage. This is how his hasty and rushed deportation was handled. All the efforts to prepare therapy so that he could stabilise his situation in his country were put to waste. Later on, this Association was informed by Eduardo's family that he had been admitted to the Hospital in a critical condition

On the 4th of December Eduardo Medina Flores died. The cause of death was severe anaemia and malnutrition. Since he'd arrived in Spain, he had hardly eaten. This was probably linked to his poor mental health and lack of adequate care."
Eduardo's Story by Gabriel Ruiz Enciso and Antonio Calderón - Asociación Amigos de Bolivia

[57] Unfortunately the law was changed for the worse in 2011. See campaigns and reports of Observatoire du droit à la santé des étrangers: http://www.odse.eu.org/

GREECE: MIGRANTS IN PATRAS AND IGOUMENITSA

In December 2010, Doctors of the World Greece set up two mobile units to help migrants access healthcare in Patras and Igoumenitsa, harbour towns located on the western coast of Greece. In this section we present findings based on routine data collected over a period of four months (April – July) in 2011.[58]

> Demographics

A total of 1,656 persons came into the mobile units. All of them were male. All, with the exception of three, were homeless. And, the vast majority (92%) needed an interpreter at the time of their consultation. The mean age of beneficiaries was 24, and the age range was 13 to 74. The average length of stay in Greece was 15.2 months.

Almost half (45%) of the beneficiaries were from Near or Middle East, 36% were from North Africa, 19% from Sub-Saharan Africa, 17.5% from Europe and very few from other parts of the world. The main countries of origin (nationalities) were, in decreasing order: Afghanistan (n=530), Algeria (n=234), Morocco (n=195), Sudan (n=152), Eritrea (n=58), the numbers were smaller for Tunisia, Somalia, Palestine, and Iraq (half of the migrants from Iraq were Kurds).

> Administrative status

Almost all of the patients were undocumented migrants (94%). 12.6% had requested or planned to request asylum.

> Violence

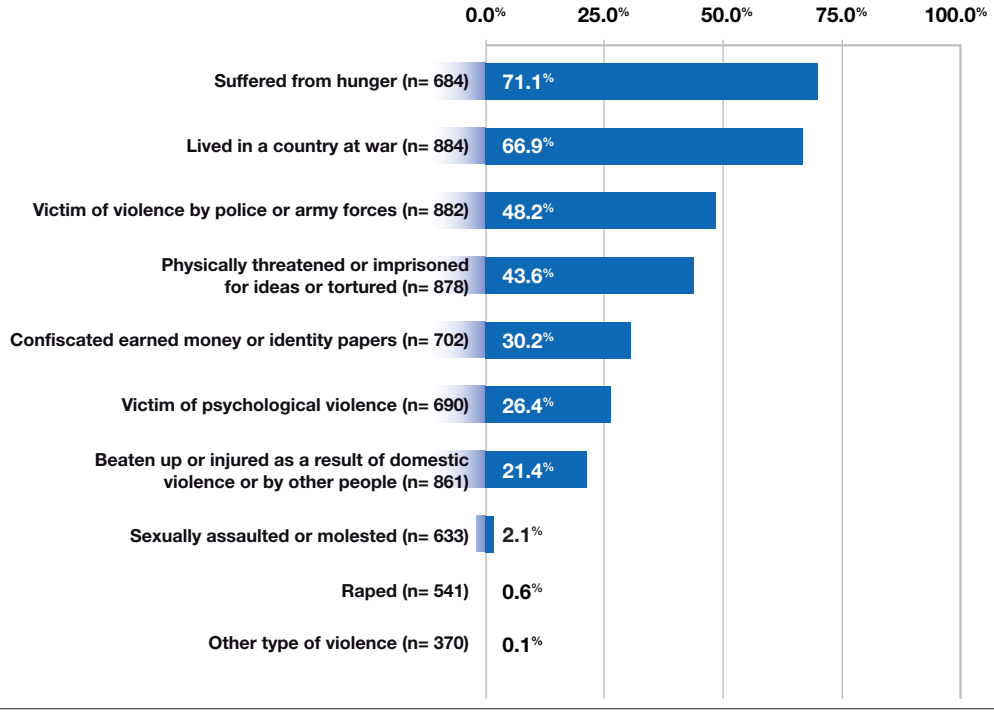
53% of patient population on the mobile units were queried about any possible past experience with violence. Particularly striking is that most of the violence[59] the migrants have been confronted with took place after their arrival in Greece. We asked patients what forms of violence they had suffered from and where it occurred: before leaving their country, during the migration or after their arrival in Greece.

The table below is a breakdown of information obtained during the course of interviews with patients.

Proportion of patients who suffered from acts of violence in Greece:

- Physical threats, or prison : 74.3% in Greece
- Violence by police or army: 79.7% in Greece
- Beaten up or injured: 82.2% in Greece
- Sexually assaulted or molested: for 6 out of 11 answers: in Greece
- Rape: for 3 out of 4 answers: in Greece
- Psychological violence: 32.5% before leaving and 64% in Greece
- Confiscation of money or identity papers: 11% before and during; 78% in Greece
- Suffering from hunger: 92% in Greece

Prevalence of violence broken down by form of violence



[58] The complete report is available upon request
[59] War related acts of violence took place either in the country of origin or during migration.

> Vaccinations

The mobile units in Greece reported data on vaccinations for 60% [60] of the patients (n=967). Despite these 40% of missing values, we observed – among the respondents – that for most of the vaccines, at best a quarter of people had been vaccinated (4% were certain they had been vaccinated and 20% believed they had been vaccinated). 38% were certain that they had never been vaccinated. In the case of the BCG vaccine, 17% of the patients had been surely vaccinated.

> HVC, HVB, HIV and TB screening

Half of the patients were asked about diseases for which they may have been screened. Of these patients, 12.3% reported being tested for HVC, 12,5% for HVB, 13,1% for HIV, and 11,2% for tuberculosis. The results of approximately one hundred tests were reported for each infection. We observed a declared **4.8% prevalence of positive HBV tests,** a 1% prevalence of positive HVC tests and a 0.9% prevalence of positive HIV tests.

> Symptoms and diagnosis

Patients seen at the mobile units had, unlike what is usually observed in primary care for the general population, a high frequency of skin problems (19% of the total number of patients) and, at a lower extent, a higher frequency of neurological problems (7%). These higher frequencies may be related to the characteristics of the population seen at the 2 mobile units (male, young, and homeless). In contrast, psychological problems appear to have been under-reported by patients and physicians, a prevalence of 1,3% seems very low, compared to what is to be expected with this type of population. All diagnoses related to injuries or accidents accounted for 4.4% of total diagnoses and for 3.7% of patients.

Patras

[60] The Greek mobile units reported more information on vaccination than the centres in 5 cities (see above)

Burning one's hand to avoid fingerprints…

Impact of EU Dublin II Regulation

In accordance with the Dublin II Regulation [61], an asylum application is to be examined by only one EU Member State. Member States have to assess which Member State is responsible for examining an asylum application lodged on their territory on the basis of objective and hierarchical criteria.

Any Member State may decide to examine an asylum application, even if such examination is not its responsibility under the criteria of Dublin II Regulation. When a State considers that the request for asylum should be examined by another Member State, it has a period of three months to ask that the Member State take back the asylum seeker. Readmission is implicitly granted after a period of two months [62].The State not responsible for the application has a period of six months to complete the transfer of the applicant. This means that the asylum seeker can stay 11 months in a country without knowing whether or not he will be able to stay there.

The main consequences of the Dublin II Regulation are that potential asylum seekers are no longer free to choose which country they will petition for asylum and they are exposed to more instability and are thus more vulnerable [63]. Situations vary from country to country. In certain countries asylum seekers who fall under the Dublin II Regulation may be eligible for a temporary waiting allowance, the right to work, immediate access to health coverage, and even housing, while in others they may be entitled to very little or nothing at all!

Without stable housing it is very difficult or impossible for children to attend school regularly.

The state of uncertainty and instability in which live people who fall under the Dublin II Regulation is such that it is difficult for them to recover from past trauma.

When, through family connections or some source of support and despite everything they manage to settle down still, usually integration begins (learning the language of the host country, going to school, etc.). But something can occur that tears everything apart and exacerbates their vulnerability.

Description of patients' situations

"The MdM Grand Littoral Immigrants Programme first saw R. on 15 March 2011 on the mobile clinic. We talk while he waits his turn at the foot of the ambulance; the discussion will pick up again next week. He explains that he has already spent time in England but was sent back to Italy six months earlier, as part of the Dublin II procedure, when he applied for asylum. Depressed and living in very precarious conditions, he started taking drugs (crack, heroin) to escape the everyday reality, he says. His family learned about it and has severed all contact with him. He explains that drug use is a taboo in his culture and that he is a disgrace to his family. He says that now he can't go back to Syria because he would be under a death threat there (honour killing)."
R., 21 years old, Syrian Kurd. August 2011.

"A couple and their three children (ages 3, 6 and 13) left Chechnya fleeing persecution. Their emigration path crosses through Poland. Once they arrived in France, they wanted to settle down in Nice where they have relatives who have requested political asylum. The Prefecture of Nice refuses to register their asylum application and makes a request that Poland take them back. They obtain administrative approval for housing but no accommodations are offered because they are not seen as seeking asylum in France.

The family was forced to separate to avoid living on the street. The eldest child is housed by a classmate. The 6-year-old is housed by the family (five people living in a single furnished hotel room).The mother and the youngest child stay with friends and the father has to find a new place to sleep everyday. All these accommodations are obviously stop-gap solutions that can disappear overnight.

To see their school-age children, the parents have to travel several hours a day by public transport.
Already affected by the situation experienced in their homeland, the family is no longer united and lives in a state of major psychological and material instability. One can easily imagine the consequences of this type of situation on the mental health of all the members of this family".
MdM clinic in Nice. February 2012.

[61] From a total of 219.557 asylum applications recorded in EURODAC in 2008, 38.445 applications were 'multiple asylum applications'
[62] http://europa.eu/legislation_summaries/justice_freedom_security/free_movement_of_persons_asylum_immigration/l33153_en.htm
[63] See UNHCR comments: http://soderkoping.org.ua/page23538.html

WHAT THE DOCTORS OF THE WORLD INTERNATIONAL NETWORK IS SEEKING

Doctors of the World - Médecins du monde (MdM) head a EU wide project to promote health.

We want to work together with European Union Members of Parliament, EU Institutions, WHO Europe, Council of Europe, organisations of health-care professionals, coalitions and grassroots organizations working with persons living with HIV, AIDS and hepatitis, undocumented migrants and similar groups.

By working together we will be able to achieve the tangible application of a fundamental human right: the enjoyment of the highest attainable standard of health.

Doctors of the World international network have one overarching objective:

> To have national public health systems built on solidarity, equality and equity, open to everyone living in all EU Member States; rather than systems based on a profit rationale

Solidarity between those who are well and those who are ill, between rich and poor.

Equality of care is inherent to equality in access to all services.

Equity individuals contribute in accordance with their means and access health care in accordance with their needs.

We feel it is unacceptable for anyone to be excluded from access to preventative health care measures and treatment because of their administrative or immigration status or their ability to pay.

All studies have shown that instituting user-fees does not make persons behave more responsibly when it comes to health expenses, quite simply because they are not themselves the prescribers of care. A system whereby part of the cost is incurred by the patient merely deteriorates access to health care for the poorest and most vulnerable members of our society. It leads people to give up treatment and significantly delay seeking care. In the long run denying healthcare costs more than providing free access.

Niger and Sierra Leone, two of the poorest countries in the world, try to promote free access to healthcare for pregnant women and children under 5 years. Why should it be acceptable in the European Union, one of the world's richest regions, to have pregnant women excluded from antenatal care and to not provide all children the protection afforded by vaccination?

Healthcare professionals find discrimination in access to healthcare unacceptable. It goes against their professional code of ethics which states that,

"[…]every person is entitled, without discrimination, to appropriate medical care[…]and physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them" [64].

This is the reason why the main entities that represent health professionals signed the European declaration on access to health care without discrimination [65] that calls for, inter alia, that health professionals be able to determine, in all circumstances, the type and level of care that patients need, using as sole basis their clinical judgment, without regard to the patients' status. Moreover, in cases where individuals are unable to pay, healthcare should be paid for by public funds. Health professionals call for the removal of any and all institutional impediments that prevent them from providing health care to vulnerable groups, this includes undocumented migrants.

There is a very clear and strong correlation between an individual's income and his or her health. Poverty leads to poor health. [66] On a larger scale, studies have demonstrated that the greater the inequality in a society the poorer their health.

Poor health is the leading cause of poverty. It can quickly tip people into poverty, especially those on the lower rungs of the socioeconomic ladder who lack health insurance or substantial savings to cover out-of-pocket health care costs. The financial repercussions of unexpected and serious health problems keep poor people immersed in poverty. Because medical bills can be exorbitant, they quickly deplete any financial resources they may have set aside. [67]

[64] World Medical Assembly Declaration on the Rights of the Patient, Preamble.
[65] http://www.medecinsdumonde.org.uk/resources/news.asp?yy=2011&id=2931
[66] Joseph Rowntree Foundation- Research on Long term ill-health, poverty and ethnicity in Canada p.3 http://www.jrf.org.uk/sites/files/jrf/1995-health-ethnicity-poverty.pdf
[67] http://ifpriforum.wordpress.com/2009/12/15/sick-and-tired/

For all of these reasons, the health policy of **each EU member state should have as its main objectives guaranteeing access to quality health care for everyone living in an EU country and the reduction of social inequalities in health.**

Public health policy can only be effective if it includes everyone living within its geographical area, and should not exclude any segments of the most vulnerable population groups, who are already the most difficult to reach. This rationale should also underpin vaccination policies and policies targeting the prevention and treatment of infectious diseases.

> Promote a coherent EU public health policy for the prevention and treatment of infectious diseases

The current measles pandemic, which has spread right across Europe since 2010, is hitting hard marginalised unvaccinated populations. There is still no access to vaccination for a large proportion of children living in the EU, either because they are the children of undocumented migrants, asylum seekers, or Roma or because they live in countries where there is no policy for systematic and free vaccination.

- We therefore, encourage the EU to provide free access and make vaccinations a priority for all vulnerable sections of the population in the European Union.
- In the case of HIV and hepatitis B and C there are European programmes that do target the at risk groups within the general population, including those that are most difficult to reach. Today, however, these programmes are limited to prevention. Numerous national and EU studies conducted on access to HIV screening have shown that **when access to treatment is not guaranteed, people do not get themselves screened.** Our own research (in 2006 and 2008 [68]) demonstrated that the countries where the lowest number of persons is screened for HIV are the two countries where HIV treatment for undocumented migrants is either not required by law and/or not free: the United Kingdom and Sweden. Furthermore **it is now widely recognised that providing antiretroviral therapy has considerable benefit both for treatment and prevention.**
- Certain population groups that present many vulnerability factors such as the homeless, persons without a residence permit, and the Roma are frequently excluded from or left on the wayside of campaigns for risk prevention, screening and treatment.

We call on the European Union to guarantee that everyone living in the EU is included in prevention, screening and treatment programmes. We expound the need for EU policies that converge programs for HIV and Hepatitis, given that these pathologies are frequently co-morbidities.

> We call for more protective measures for seriously-ill migrants who cannot access adequate health care in their country of origin

During the debate on the Return Directive (2004-2008), the MEPs voted for measures aimed at protecting seriously ill migrants from deportation. But the EU Council voted against the amendment. We want to re-introduce the amendment [69] which reads as follows:

"Member States shall grant a person suffering from a serious illness an autonomous residence permit or another authorisation conferring a right to stay so as to have adequate access to healthcare, unless it can be proved that the person in question can receive appropriate treatment and medical care in his/her country of origin."

The Doctors of the World International Network urge the European Union to develop means to protect seriously ill migrants from being deported to countries where they will not be able to access healthcare. Protecting these individuals and granting them access to adequate care will avoid the serious deterioration of their health and possibly death.

Doctors of the World, in alliance with health care professionals working in Europe, and with NGO health platforms call for an inclusive public health policy. In the EU, access to preventive measures and health care, the reduction of social inequalities, and taking into account the social determinants of health must serve as guiding principles for the drafting of health policy if everyone is to effectively enjoy one of the fundamental rights of human beings: the right to health.

[68] Reports of the European Observatory on access to healthcare for undocumented migrants, Médecins du Monde, see http://www.mdm-international.org/spip.php?article362

[69] Doctors of the World International Network and Naga Association (http://www.naga.it/) had written it.

> When everything goes wrong...

Patient's description of her situation

"My problems started in Iran when I got pregnant. I was not married. In my country this is a crime, and a serious offense to the family. My son was born without any rights. He didn't receive citizenship. He basically didn't exist in my country, he was stateless. Nobody was interested in helping me and the baby. My son's father was a violent man; he had experienced bad things in Afghanistan. I was afraid, and decided to take my son and leave. In 2004, we left the country, and crossed the border to Turkey. From there we went to Greece. In 2006, we arrived in Italy. All the time we just depended on each other, and were always afraid. My son got mature very fast. In Italy I applied for political asylum, it took time but we eventually got accepted. All these years I hadn't been able to talk to anybody about my feelings of sadness and my fears. The only one around was my son. I didn't have the chance to see a doctor or a psychologist.

After we got accepted, we were looking for a place to stay. I met a few men, who said they could look after me. The offered me and my son a place to sleep and some food. At first we were relieved, but then I realized that something was wrong. They were doing criminal business; later on, I understood they were mafia. They became violent to me, and threatened our lives. They said that if I left, they would look for me, find me and kill me. We were so afraid, I couldn't think clearly but we managed to leave.

From a friend I had known in Italy, I got this contact of an Iranian man in Munich. Three months ago, I arrived here in Munich. Since then, this man has looked after me. I didn't trust him so easily after everything that had happened. But we didn't have a choice, there was no place to go. I am afraid to go on the streets, because the mafia might find us. I never feel safe enough to sleep. My son cannot count the countries he has lived in anymore. Now he is again replaced to another school as we moved again. He cries very often, I think it would be good for him if we got some rest.

The doctor I saw at the clinic gave me some tablets and said that I am depressed and have anxiety issues, and that it would be necessary for me to talk to someone about my feelings regularly. I therefore met the psychologist that the clinic has called for me, and I told my story. She said that my mental condition is serious, that I am traumatized and that my condition will worsen if I go back to Italy. But me and my son will be deported to Italy as my residence permit from Italy is not recognized in Germany. I am therefore obliged to stay in Italy and speak to the authorities there about my problems. But they can't protect me from the men that are looking for me in Italy and I don't have anyone that I trust there. I will not be able to speak to a psychologist regularly in Italy as the waiting lists are long, and my son and me will constantly be afraid. I don't understand why I will be forced to stay in a country where people are threatening me and my son and where I will get worse, I don't feel stable enough to go back. Whether I live in Iran or Italy doesn't make a difference to me now, I have no chance to be happy in either of those countries.

The counselors are now trying to get my status recognized in Germany as I am too afraid to live in Italy. I hope that I will be able to stay in Munich, so that my son will be able to go to the same school for a few years."

Ms. Y., age 33, Iranian woman living in Germany. December 2011.

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Christmas tree made of cans of milk in Athens, to be distributed to destitute patients by MdM Greece. December 2011

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