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Contact

- All correspondence to Tiina Kanninen, tiina.kanninen@uta.fi

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About the Journal

The Finnish Journal of Ethnicity and Migration (FJEM) is devoted to the high quality study of ethnic relations and international migration. Published biannually by the Society for the Study of Ethnic Relations and International Migration (ETMU), this peer-reviewed, interdisciplinary, open-access journal provides a forum for discussion and the refinement of key ideas and concepts in the fields of ethnicity and international population movement. Although international in its scope of interests and range of contributors, the journal focuses particularly on research conducted in Finland and other Nordic countries. Opinions expressed in the FJEM articles are those of the authors and do not necessarily reflect the views of ETMU.

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Ursula Karl-Trummer, Sonja Novak-Zezula and Birgit Metzler

Managing a Paradox: Health Care for Undocumented Migrants in the EU

In 2008, The EU Project “Health Care in NowHereland” started to work on the issue of health care for undocumented migrants. Undocumented migrants gain increasing attention in the EU as a vulnerable group that is exposed to high health risks and challenges public health. National regulations often severely restrict access to health care for undocumented migrants. At the same time, right to health care has been recognized as human right by various international instruments ratified by European Countries (PICUM 2007a, Pace 2007). This opens a paradox for health care providers: if they give care, they may act against legal and financial regulations, but if they don’t give care they violate human rights and exclude the most vulnerable. This paradox cannot be resolved on a practice level but has to be managed in a way that violates neither human rights nor national regulations. In this research report, we present a conceptual model of health care provision for undocumented migrants as management of a paradox with different strategies on policy and practice level: “Functional Ignorance”, “Structural compensation” and “Informal solidarity.”

Definitions

The Glossary of Migration defines irregular migrant as “Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country’s admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation)” (IOM 2004: 34).

Other sources define undocumented migrants as: “foreign citizens present on the territory of a state, in violation of the regulations on entry and residence, having crossed the border illicitly or at an unauthorized point: those whose immigration/migration status is not regular, and can also include those who have overstayed their visa or work permit, those who are working in violation of some or all of the conditions attached to their immigration status: and failed asylum seek-

ers or immigrants who have no further right to appeal and have not left the country” (UWT 2008: 19). The CLANDESTINO Methodological Report¹ defines five groups of irregular migrants:

1. Illegal working EU-citizens
2. Persons with seemingly legal temporary residence status (e.g. “working tourists”)
3. Persons with forged papers, or persons who have assumed false identities with real papers (they may live a regular life unless the falsification is discovered)
4. Persons with pending immigration status (e.g. application for regularisation is pending and application papers prevent expulsion, third country nationals who have submitted an asylum claim, persons who have failed a request for status prolongation but still wait for a decision by the time that their limited residence permit runs out)
5. Persons who are without residence status in the country, but with knowledge and toleration of the authorities (toleration does not legalize or change the unlawful presence of the tolerated alien) (see Jandl et al. 2008: 6-7).

What becomes visible through these definitions is the heterogeneity of this group and also the difficulty to find a common terminology. The Platform for International Cooperation on Undocumented Migrants, PICUM, recommends the term “undocumented migrants”, as the use of the term “illegal” has a connotation with criminality (see PICUM 2007a). The authors follow this recommendation.

Numbers

Because of the nature of undocumented migration, exact numbers are missing and only estimates are available.² For Europe, these estimates vary between 1 – 4 % of the domestic population (OECD/SOPEMI 2007, Fernandes et al. 2007) or total numbers of 4.5 and 8 million, “with an estimated increase by 350 000 to 500000 per year” (European Commission 2007).

“Carriers”

Ways to become undocumented are defined as endogenous – with a legal entry into a country and a fall out of the legal status, for example by overstaying or not leaving when ordered – and exogenous, for example when crossing borders undetected (SOPEMI 1989). It is estimated that more than half of undocumented migrants are endogenous (Levinson 2005: 2).

Ongoing work on undocumented migration in Europe

Undocumented migration and its implications for health have become important issues in the discussion of European and national health policies. Several European projects approach this phenomenon from different angles, trying to improve the methodology of data collection, investigating policy approaches and examining ways to improve access to and quality of services for undocumented migrants. The EU-project ‘CLANDESTINO Undocumented Migration: Counting the Uncountable. Data and Trends across Europe’ provides an inventory of data and estimates on undocumented migrants (numbers and flows) in selected EU countries. The project’s aim is to improve knowledge, both in quantitative and in qualitative terms, of undocumented migration (ec.europa.eu/research/fp6/ssp/clandestino_en.htm, accessed 07.02.2009).

‘AMAC – Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities’ is a EU-project that reviews key health concerns of migrant populations in the context of social determinants of health. The project also serves as a platform for exchange for European projects concerned with migration and health (http://www.belgium.iom.int/page2.asp?Static_ID=10, accessed 07.02. 2009).

The ‘Averroès Network – Improving Access to Health Care for Asylum Seekers and Undocumented Migrants in the EU’ aims to improve the health status of undocumented migrants and asylum seekers by encouraging the elaboration and implementation of binding community regulations. For this purpose it created a NGO network covering 19 EU member states, which will carry out research, field surveys, and awareness-raising activities at national and EU levels (<http://www.mdm-international.org/spip.php?article103#>, accessed 07.02.2009).

The ‘COST Action IS0603 – Health and Social Care for Migrants and Ethnic Minorities in Europe HOME’ brings together an international group of experts to further the development of research and good practice concerning migrant health. In three working groups on social and policy factors, migrants’ state of health and its implications on health care for migrants and improvements in service delivery, the project consolidates and reviews work carried out so far, identifies blind spots and persistent problems and recommends ways forward to yield new insights into the causes of ill-health through a cross-national perspective (http://www.cost.esf.org/domains_actions/isch/Actions/HOME, accessed 07.02.2009).

These initiatives, together with recent studies concerned with issues of health and migration, name undocu-

mented migrants as an especially vulnerable group, whose insecure status leads to a higher health risk and at the same time, impeded access to health care services (Fernandes et al. 2007, Mladovsky 2007, Padilla & Pereira Miguel 2007). They ask for “greater transparency in countries’ approaches to responding to health and health care utilization inequalities experienced by this population, within the framework of human rights” (Mladovsky 2007: 5). It is pointed out that the lack of data not only stems from methodological and technical problems but is also a sign of a “policy dilemma,” as undocumented migrants play an important role in informal and flexible labour markets that despite all ideals are part of European economic reality (Schierup et al. 2006, in Mladovsky 2007).

Access to health care

A recent report from PICUM (2007b) gives insights into 11 European member states concerning regulations on access to health care for undocumented migrants. It is pointed out that access to health care for undocumented migrants in Europe depends on national competence; regulations are heterogeneous and sometimes confusing. There is a range of providing health care for undocumented migrants on a payment basis only (e.g. in Austria) to full access to health care (e.g. in Spain, Portugal). In some countries, like Germany, reporting regulations are in place, and health care providers are obliged to report encounters with undocumented migrants. Main access points are clinics established and run by NGOs and emergency care units. In general, NGOs take over an important role in providing health care and giving support to migrants in navigating through the system.

The report also points out that even when there is full access to health care, barriers arise due to lack of translators and cultural mediators, lack of information both within health care organisations as well as among undocumented migrants, uncertainties on the side of providers and fear and anxiety on the side of undocumented migrants. This is underlined by recent EU reviews that highlight the lack of knowledge about the health care system and mistrust of service providers as serious obstacles to access (Mladovsky 2007).

What these studies indicate is the combination of higher health risks due to hazardous living and working conditions and a worse access to health care for undocumented migrants. This threatens the health of this specific group as well as that of the rest of the population. Higher risks for public health associated with irregular migration arise mainly from transmissible diseases like tuberculosis and HIV/Aids, the control of which is additionally hindered (PICUM 2007b).

Health care in NowHereland: a European project on health care services for undocumented migrants

Among the recently started European initiatives mentioned above is the project ‘Health Care in NowHereland: Improving Services for Undocumented Migrants in the EU’.³ It focuses

on the necessary improvement of the level of knowledge on legal and financial frameworks, on the health status and health status determinants of this group of migrants, on ‘reasonable’ organisational behaviour in the given context and hence on sustainable and practical solutions within the EU-27. The running time of the project is January 2008 to February 2011. Findings are publicly available on the project website (www.nowhereland.info).

“Health Care in NowHereland” starts from the point of uncertainty that becomes evident in the literature: there is a “Nowhereland” within Europe, a land that is unknown, but at the same time part of a European present. As public awareness of undocumented migration increases, the lack of knowledge on this topic becomes accentuated. There is no research-based information on the extent of undocumented migration, on the specific health problems of undocumented migrants and their strategies to cope with health problems, and no shared experience of health care providers on how to cope with the situation. How does health care provision become possible in this NowHereland, who are the main stakeholders and what are the main challenges for policies, practices and people are central questions raised in this project.

The project has three general objectives on the levels of policy, practice and people:

1. To draw a European landscape of the different legal and financial frameworks within the 27 member states under which health care organisations, which are confronted with undocumented migrants, act.

2. To collect existing practices of health services in 17 EU member states⁴ and to identify models of good practice to support transfer and sustainability. These models are to be contextualised (that is, related to regulations and to clients’ needs).

3. To gain an overview of undocumented migrants’ health problems and of their strategies to get access to health care services in 17 EU member states.

The results and findings will be summarised and made available to a wider public in fact sheets on policies, practices and undocumented migrants’ needs and strategies.

In the course of the project, a database on European health-care practices will be compiled. Case studies on models of contextualised, good practice of health care for undocumented migrants will be assessed and described. When assessing these case studies, we will take into consideration policy frameworks as well as undocumented migrants’ needs and strategies. In this article, we describe the conceptual framework developed so far and exemplify it with our first empirical findings. We begin with a paradox on the policy level.

A paradox on the policy level

To begin our analysis we look at the policy level, where a particular contradiction becomes evident (see also Zanfrini & Kluth 2008): the dilemma between national regulations that control national borders and define citizenship and different entitlements to stay within a country on one hand, and the uni-

versal approach of human rights on the other. Access to health care is defined as a fundamental human right (Pace 2007) and thus as a right that does not depend on one’s legal status or financial capital. This definition should protect socio-economically disadvantaged and vulnerable groups (ECHR 1950). All EU member states do recognise this human right (see PICUM 2007a; Pace 2007). At the same time, national regulations restrict access to health care in different ways and guarantee access to certain basic services, for example emergency care, to different degrees.

This is a paradoxical situation for health care organisations and their personnel. They have to cope with contradictory demands: if they give care, they may act against legal and financial regulations, but if they don’t give care they violate human rights and exclude the most vulnerable. This paradox cannot be resolved on the practice level but has to be managed in a way that neither human rights nor national regulations are violated. To develop a concept of organisational and individual behaviour under such conditions, “management of paradox” seems to be appropriate. It is a concept that gained increasing attention within organisational theory (see Leybourne 2007; Simon 2007). Management of paradox is quite a common situation that emerges when contradictory goals are pursued. A common example is the car industry, where constructing cars follows at least two goals: to make them fast and to make them safe. One solution to handle this is to install two different organisational departments: the department for developing a technology of speed, and the department for developing a technology of safety. This strategy works by creating areas that are not stressed by paradoxical demands, so that the departments can concentrate on one goal at a time. To construct a car, the findings of these two departments have to be combined.

Unfortunately, for health care provision, the idea of constructing departments that follow state demands and others that follow a humanitarian approach seems to be more demanding. A person is not a car, and from a professional perspective of the Hippocratic Oath as well as from a policy perspective of human rights, the former of these has no right to exist, while from the state’s perspective, it is undocumented migration that should not exist.

So how is the management of paradox organised in the practice of health care for undocumented migrants? In this article, we begin to answer this question by describing NowHereland in Austria, the coordinating partner in the European project “Health Care in NowHereland”.

The NowHereland in Austria

Undocumented migrants in Austria

As for all European countries, only estimates on the number of undocumented migrants are available for Austria. These estimates range between 17.000 (Biffi 2002a and b; IOM 2005) and 100.000 people staying in the country without official entitlement (BMGF 2003). In recent debates, these estimates

have been criticized: “On the basis of the available evidence, no serious quantification of irregular migration in Austria is possible” (Kraler et al. 2008: 2).

Legal regulations

Health care provision in Austria is primarily regulated by the Federal Ministry of Health, Family and Youth (BMGFJ 2008). Nine federal states are responsible for the enactment and implementation of the legislation, as well as for the financing and provision of inpatient care (BMGF 2005). The main source for funding in the Austrian health care system are contributions to the social health insurance, which cover approximately half of the total health expenditure. The other half is financed through tax subsidies from federal governments, communities and private households, one quarter each (BMGF 2005; Hofmarcher & Rack 2006). In 2007 around 99% of the population was covered by the social health insurance (Hauptverband der österreichischen Sozialversicherungsträger 2008). This compulsory insurance under an obligatory scheme by law is financed through income-related contributions and is based on occupation. The insured are entitled to a broad spectrum of benefits within a legally defined framework. Coverage is extended to co-insured affiliates. For specific groups who are not covered by the compulsory insurance (e.g. marginal employed workers) the possibility of self-insurance is provided. Migrants who have a recognised status for humanitarian reasons like refugees and asylum seekers are entitled to health care and their services are covered by health insurance. Most of the registered persons without health insurance are unemployed without entitlement to benefits or asylum seekers who are not accepted into the federal care system (e.g. in case of leaving Austrian territory or being arrested or judged for a criminal offence). A study of the Federal Ministry of Health and Women (BMGF 2003) noted that in 2003 around 160.000 people⁵ aged 15 or older were living in Austria without any registered entitlement in case of illness.

If somebody without insurance makes use of the public health care system, in principle this works on a fee for service basis. In any case and despite the financial aspects, through the Austrian Federal Hospitals Act every hospital is committed to providing first aid in case of emergencies (KAKuG 2008). In cases where people are unable to pay for their treatment, or the identification of the patient is not possible, hospitals have to cover the expenses out of their own budget (IOM 2005).

Health care for undocumented migrants

There is no specific regulation for health care provision for undocumented migrants in the Austrian legislation. It can be said that on the regulatory level, undocumented migrants do not exist. In practice, undocumented migrants belong to the small group of people without health and social insurance, and with a high likelihood, are unable to pay expensive treatment costs.

In general, opportunities to receive medical treatment without being insured or able to pay for it directly are highly limited. The services offered mostly depend on sporadic agreements with doctors who offer medical treatment at a lower cost, or organisations that offer specific services (e.g. gynaecological examinations, child birth) free of charge. But there are also some established organisations that provide services for people that have fallen out of the health and social insurance system. Two main actors in the field of health care provision for this marginalised group can be distinguished: Hospitals and NGOs.

Hospitals

Access to hospitals is the least complicated option for undocumented migrants in the public health system in Austria. As there is no gatekeeper system like e.g. in the Netherlands, everybody can directly access the outpatient units at any time. As mentioned, in case of emergency providing treatment is mandatory. Starting from this obligation, a window of opportunity opens for undocumented migrants to get treatment beyond an actual case of emergency. E.g., medical professionals can ‘turn a blind eye’ by applying a wider definition of emergency, providing services knowing that they will not be paid and/or accepting false identities.

Some specific hospitals with a confessional background offer treatment free of charge for people without insurance. The most prominent example in Austria is the private order hospital of the Barmherzigen Brüder (“brothers of mercy”), founded in 1614, which has become one of the most important contact points for undocumented migrants in Vienna (PICUM 2007b; Karl-Trummer & Metzler 2007). Every year around 20.000–30.000 patients without insurance get treatment there, of which 1.000–5.000 are hospitalised. With the guiding principle of the so-called ‘new hospitality’, the hospital grants every patient the best possible nursing and medical care. There are no restrictions on service provision, and the whole range of outpatient and inpatient services is offered for undocumented migrants. The hospital is DRG-(Diagnosis-Related-Groups) funded by a provincial health fund and additionally financed by donations (www.barmherzige-brueder.at, accessed 21.01.2009). This organisation is both a public hospital and as such part of the regular health care system and at the same time, a NGO acting as a private welfare institution. This leads to the important role of NGOs in health care provision for undocumented migrants.

NGOs as intermediaries and as direct providers

A number of NGOs act as intermediaries providing guidance and practical assistance on accessing medical services. A prominent example in Austria is the “Verein Ute Bock” (www.fraubock.at, accessed 21.01.2009) or “Asyl in Not” (www.asyl-in-not.org, accessed 21.01.2009). The “Verein Ute Bock” offers accommodation, legal advice, consultation – including information about accessing health care, the pos-

sibility to name the address of the association for registration and a postal address, as well as education and training for asylum seekers and refugees. The initiative is based on volunteer work and financed through donations. “Asyl in Not” offers legal and social advice on various issues, including health insurance, in several languages.

Other NGOs provide direct medical care for people without insurance. The two largest organisations throughout Austria are AMBER-MED and the Marienambulanz (AMBER-MED 2008; Ambulatorium Caritas Marienambulanz 2008; Sprenger & Bruckner 2008).

AMBER-MED

Since 2004, AMBER-MED, a joint project of the refugee service of Diakonie Austria and the Austrian Red Cross has provided outpatient treatment, social counselling and medication for people without insurance coverage in Vienna. The services offered are free of charge and anonymous and include for example general medicine, gynaecological examinations, paediatric care and diabetes care. In 2007, 889 patients, the majority of whom were asylum seekers, refugees and homeless people, made use of AMBER-MEDs services, and the number of patients is increasing. The work of this organisation is made possible by volunteering doctors, nurses and interpreters – the team consists of 3 employees and 31 volunteers – as well as by the support of a large network of medical specialists and institutes. Until 2006, AMBER-MED was financed exclusively through donations. In 2007, the organisation started receiving subsidies from the Federal Ministry of Health and the Fund for Social Affairs in Vienna (Fonds Soziales Wien), and since 2008, also from the Vienna Health Insurance (Wiener Gebietskrankenkasse) (see AMBER-MED 2008, Diakonie Flüchtlingsdienst 2008).

Marienambulanz

Since 1999, the Marienambulanz in Graz, Styria, has provided primary health care for people without insurance coverage and for other marginalised groups. The organization responsible for Marienambulanz is the Caritas Austria. An outpatient department offers general medicine care as well as target group oriented care (e.g. diabetes, hypertension, psychiatric disorders). Furthermore, there is a mobile unit that visits different places in Graz once a week to provide medical and psycho-social care and counselling. The team consists of 5 employees and 31 voluntary workers who are covering a wide range of disciplines, cultural backgrounds and languages. In 2007, 7.954 documented contacts and 1.250 patients from 72 nations were treated and counselled in the outpatient department. About the half of the patients were without insurance coverage. The Marienambulanz co-operates closely with health authorities and institutions and has established itself in the health care system as an expert in the medical treatment of socially marginalised groups. It is financed by the Federal Ministry for Health, Family and

Youth, the “Land Steiermark – Gesundheitsfonds Steiermark und Sozialressort”, the Municipal Health Authority Graz and the Caritas. Since 2006, the ambulance has had a contract with the Styrian Health Insurance Company. In 2007, the Styrian Health Platform unanimously nominated the Marienambulanz as a measure that disburdens hospitals, which opened the possibility for further funding (Sprenger & Bruckner 2008; Marienambulanz 2008).

Management of paradox in practice

From these empirical examples central strategies for the management of the paradox can be identified on the level of policies as well as in organisational and individual behaviour. These are

1. functional ignorance and structural compensation as a policy strategy to neglect the demand of policy development and as an organisational strategy to open a paradox-free space for action
2. informal solidarity as an individual strategy to follow humanitarian values without violating state demands

Functional ignorance and making paradox-free space for action

In Austria there are no organisations which explicitly provide health care for undocumented migrants. Undocumented migrants are not mentioned as a target group, but they are included in the definition of socially disadvantaged and especially vulnerable people. For hospitals, the criterion for providing health care in the case of emergency is when the patient’s health is in serious danger. For NGOs, the criterion for providing health and social care is the status of (social) indigence. In both cases, organisations do not ask for information on the patients’ legal status, like residence permits or other documents. This ignorance of patients’ legal status opens a paradox-free space for action (Simon 2007), allowing medical personnel to act in accordance with the principles of human rights and professional ethics without getting into conflict with state demands.

This strategic ignorance of patients’ legal status can also be detected on the policy level. As shown in the example of AMBER-MED and the Marienambulanz, NGO services that prove to be successful in providing care to people that are excluded from the health and welfare system, are recognised as a relief. They provide a structural compensation for a health care system that does not offer services to undocumented migrants within mainstream health care structures. Delegating the challenge of health care provision for people without health insurance to private actors makes it possible for the public system to ignore the existence of undocumented migrants on a policy level. This seems to benefit these alternative health care providers, as their successful practice seems to be rewarded by increasing support from legal health care financiers. This is shown by the example of the Marienambulanz:

In its first years, the diocese of Graz Seckau was responsible for the Marienambulanz and the medical organisation was taken over from the non-profit association OMEGA. The organization established co-operation with volunteer medical specialists. Originally the ambulance was authorized just for 6 months to assess the demand for a low threshold medical service. Moreover, it relied on the goodwill of the medical association, the Municipal Health Authority and the federal state of Styria. The project has continued due to large and steadily growing demand, predominantly financed by Caritas and supported by the social services department of Graz, which was responsible for the payment of the outstanding hospital bills before the Marienambulanz was founded.

The proportion of public funding for the Marienambulanz has grown along with its success – a growing number of patients, its contributions to studies on marginalized groups, national and international media interest in the organization. In 2002 and 2003 the social department of Styria (Land Steiermark – Sozialressort) and the Municipal Health Authority were attracted as supporters and since 2005, the ambulance has received a subvention from the Federal Ministry of Health, Family and Youth. Since 2006 the service has had a contract with the Styrian Health Insurance Company. The service no longer depends on private donations, although it remains a private service.

Informal solidarity

On the level of individual behaviour, a successful strategy to cope with the paradox is “informal solidarity”. It can be observed within the mainstream services as well as in the NGO sector and informal private networks.

Professionals working in mainstream services in hospitals have some space for interpreting access regulations, for example in defining a case of emergency where giving treatment is mandatory or in accepting people whose entitlement to health insurance and ability to pay are unclear. This kind of informal solidarity is highly limited and each patient’s case needs to be considered individually, as the personnel cannot rely on supporting structures on organisational level. The most visible arena for informal solidarity is the paradox-free space provided by structural compensation, when health care professionals join NGOs as volunteers and give treatment to people who do not have access to regular services. As can be concluded from the high proportion of volunteers in NGOs, informal solidarity is important in enabling functional ignorance and structural compensation. Without the engagement of individual health care professionals, NGOs would not have the personnel necessary for providing services.

In both cases, this solidarity is informal and depends on the activities of individual people and a structural setting that promotes such activities. Such structures can exist in the hospital as long as the hospital administration accepts unpaid bills, or in NGOs that manage to attract donations and/or the goodwill of public financiers.

Concluding remarks

The project NoWhereLand has only begun to develop its central concepts. In the course of the project, empirical evidence from EU member states will be collected and used as the basis for further development. What has already become evident is that in many cases health care for undocumented migrants relies on private investments in a twofold way:

1. Health care provided within the welfare system, organised by established NGOs like Caritas and Diakonie, who provide structures and services that are not accessible in mainstream health care services.

2. Health care provided by individuals, e.g. health care professionals (medicals, nurses) who join structures provided by NGOs following a rationale of informal solidarity.

On the basis of the Austrian example it also can be concluded that these private investments help to keep up functional ignorance on policy level: As long as structural compensation works properly, there is no need for a reflection of policy approaches.

Bibliography

- AMBER-MED (2008) *Jahresbericht 2007*, Vienna: Diakonie Flüchtlingsdienst gem. GMBH.
- Ambulatorium Caritas Marienambulanz (2008) *Jahresbericht 2007*, Graz.
- Biffi, Gudrun (2002a) ‘Data Comparison: School Statistics and Resident Population According to Population Update and Microcensus’, in Gudrun Biffi (Coord.) *Integration of Foreigners and their Effects on the Labour Market in Austria*, Vienna: WIFO/Austrian Institute for Economic Research.
- Biffi, Gudrun (2002b) ‘Estimation on the Extent of the Informal Economy in Austria’, in Gudrun Biffi (Coord.) *Integration of Foreigners and their Effects on the Labour Market in Austria*, Vienna: WIFO/Austrian Institute for Economic Research.
- BMGF/Federal Ministry for Health and Women (eds.) (2003) *Quantitative und qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich. Studie des Europäischen Zentrums für Wohlfahrtspolitik und Sozialforschung im Auftrag des BMGF*, Endbericht, Vienna: BMGF.
- BMGF/ Federal Ministry for Health and Women (eds.) (2005) *Das Gesundheitswesen in Österreich*, Vienna: BMGF.
- BMGFJ/ Federal Ministry for Health, Family and Youth (eds.) (2008) *Krankenanstalten in Österreich/Hospitals in Austria*, Vienna: BMGFJ.
- Diakonie Flüchtlingsdienst (2008) *Jahresbericht 2007*, Vienna: Diakonie Flüchtlingsdienst gem. GMBH.
- ECHR/European Court of Human Rights (1950) *Convention for the Protection of Human Rights and Fundamental Freedoms*, Rome: Council of Europe.

- European Commission (2007) 'Towards a Comprehensive European Migration Policy: Cracking Down on Employment of Illegal Immigrants and Fostering Circular Migration and Mobility Partnerships', Press release, Brussels, 16 May. [<http://europa.eu/rapid/pressReleasesAction.do?reference=IP/07/678>] access date: 06.02.09.
- Fernandes, Ana et al. (eds.) (2007) *Challenges for Health in the Age of Migration. Health and Migration in the European Union*, Lisbon: Portuguese EU Council Presidency.
- Hauptverband der österreichischen Sozialversicherungsträger (eds.) (2008) *Handbuch der österreichischen Sozialversicherung 2008*, Vienna.
- Hofmarcher, Maria M. & Rack, Herta M. (2006) *Gesundheitssysteme im Wandel: Österreich*, Copenhagen: WHO Regional Office for Europe.
- IOM/International Organization for Migration (2004) *International Migration Law, Glossary on Migration*, Geneva: IOM
- IOM/International Organization for Migration (2005) 'Illegal Immigration in Austria. A Survey of Recent Austrian Migration Research', Austrian contribution to the European Research Study Project II: Illegally Resident Third Country Nationals in the EU Member States: State Approaches Towards Them and Their Profile and Social Situation, Vienna: IOM.
- Jandl, Michael et al. (2008) *CLANDESTINO – Undocumented Migration: Counting the Uncountable. Data and Trends Across Europe*, Report on Methodological Issues, Previously unreleased.
- KAKuG/Bundesgesetz über Krankenanstalten und Kuranstalten (2008) §§ 22-23 BGBl I/1957 idgF BGBl I 49/2008, Vienna: Austrian Federal Chancellery.
- Karl-Trummer, Ursula & Metzler, Birgit (2007) Internal working paper in the framework of consulting for the EU-project 'Access to Health Care for Undocumented Migrants', PICUM (Platform for International Cooperation on Undocumented Migrants).
- Kraler, Albert et al. (2008) 'CLANDESTINO Undocumented Migration: Counting the Uncountable. Data and Trend Across Europe, Country Report Austria', Country report prepared for the research project CLANDESTINO Undocumented Migration: Counting the Uncountable. Data and Trends Across Europe, funded under the 6th Framework Programme of the European Union.
- Levinson, Amanda (2005) *The Regularisation of Unauthorized Migrants: Literature Survey and Country Case Studies*, Oxford: Centre on Migration, Policy and Society, University of Oxford.
- Stephen A. Leybourne (2007): 'Improvisation within Management: Oxymoron, Paradox, or Legitimate Way of Achieving?', *International Journal of Management Concepts and Philosophy* 2 (3): 224–239.
- Mladovsky, Philipa (2007) 'Migration and Health in the EU', Research note for EC Directorate-General, Employment, Social Affairs and Equal Opportunities, Unit E1 – Social and Demographic Analysis. [http://ec.europa.eu/employment_social/spsi/docs/social_situation/rn_migration_health.pdf] access date: 06.02.09.
- OECD/SOPEMI (1989) *Continuous Reporting System on Migration*, Paris: OECD.
- OECD/SOPEMI (2007) *International Migration Outlook*, Paris: OECD.
- Pace, Paola (eds.) (2007) *International Migration Law. Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments*, Geneva: IOM.
- Padilla, Beatriz & José Pereira Miguel (2007) 'Health and Migration in the EU: Building a Shared Vision for Action', Background paper for the Portuguese EU Council Presidency 2007.
- PICUM/Platform for International Cooperation on Undocumented Migrants (2007a) *Undocumented Migrants Have Rights! An Overview of the International Human Rights Framework*, Brussels: PICUM.
- PICUM/Platform for International Cooperation on Undocumented Migrants (2007b) *Access to Health Care for Undocumented Migrants in Europe*, Brussels: PICUM.
- Simon, Fritz (2007) 'Paradoxienmanagement oder Genie und Wahnsinn der Organisation', *Revue für postheroisches Management* (1): 68–99.
- Sprenger, Martin & Bruckner, Cornelia B. (2008) *Ergebnisbericht Evaluation: Caritas Marienambulanz 2007–2008*, Graz: Caritas Marienambulanz.
- UWT/Undocumented Worker Transitions (2008) *Undocumented Migration Glossary. Work Package 5, EU Sixth Framework Programme Contract Number: 044272*, prepared by the Roskilde University and Working Lives Research Institute, with contributions from all project partners, September 2008.
- Zanfrini, Laura & Kluth, Winfried (2008) *Policies on Irregular Migrants. Volume I – Italy and Germany*, Strasbourg: Council of Europe Publishing.

Authors

Dr. Ursula Karl-Trummer

ursula.karl-trummer@donau-uni.ac.at

Dr. Sonja Novak-Zezula

sonja.novak-zezula@donau-uni.ac.at

Birgit Metzler, Bakk. phil.

birgit.metzler@donau-uni.ac.at

Danube-University Krems, Center for Health and Migration, Office Vienna, Schikanedergasse 12, PO 3, 1040 Vienna, Austria

Website: www.nowhereland.info

Notes

- 1 See the EU-project 'CLANDESTINO Undocumented Migration: Counting the Uncountable. Data and Trend Across Europe' (ec.europa.eu/research/fp6/ssp/clandestino_en.htm, accessed 21.01.2009).

- 2 For the difficulties of data collection and estimates see also the EU-project 'CLANDESTINO'.
- 3 Main coordinator: Center for Health and Migration, Danube-University Krems; Associate partners: Belgium: PICUM/Platform for International Cooperation on Undocumented Migrants, England: University of Brighton, Italy: AUSL di Reggio Emilia, Portugal: CIES/INSA, Sweden: University of Malmö, Scientific Consulting: Switzerland: University of Geneva; Collaborating partners: ICMPD/International Centre for Migration Policy Development, IOM/International Organization for Migration, HOPE/European Hospital and Healthcare Federation, University of Vienna/Institute for Nursing Sciences, WHO European Office for Integrated Health Care Services, United for Intercultural Action; 60 % are funded by DG Sanco, 40 % are financed by national funds of the project partner organisations.
- 4 The following member states will be included into the research project: Austria, Belgium, Czech Republic, Germany, France, Greece, Hungary, Ireland, Italy, Lithuania, Malta, The Netherlands, Portugal, Sweden, Spain, Slovenia, United Kingdom
- 5 The description of the concerned groups doesn't say if the data also covers an estimated number of undocumented migrants.