



Migrants and Healthcare

Social and Economic Approaches

ASEF Public Health Network
Joint Research on Health and Migration in Asia and Europe

Migrants and Healthcare

Social and Economic Approaches

ASEF Public Health Network

Joint Research on Health and Migration in Asia and Europe

Migrants and Healthcare

Social and Economic Approaches

ASEF Public Health Network

Joint Research on Health and Migration in Asia and Europe

Authors

Ursula TRUMMER, Sonja NOVAK-ZEZULA
Centre for Health and Migration, Austria

Kai Hong PHUA
Lee Kuan Yew School of Public Policy, National University of Singapore

Sian GRIFFITHS, Roger CHUNG, Huso YI
JC School of Public Health and Primary Care, Chinese University of Hong Kong

Editor

Kidjie Ian C. SAGUIN

ISBN: 978-981-09-2274-0

The views expressed in this document can under no circumstances be attributed as the view or opinions of the Asia-Europe Foundation (ASEF) and its sponsor.

The Asia-Europe Foundation (ASEF) promotes understanding, strengthens relationships and facilitates cooperation among the people, institutions and organisations of Asia and Europe. ASEF enhances dialogue, enables exchanges and encourages collaboration across the thematic areas of culture, economy, education, governance, public health and sustainable development.

ASEF is a not-for-profit intergovernmental organisation located in Singapore. Founded in 1997, it is the only institution of the Asia-Europe Meeting (ASEM).

Together with about 700 partner organisations ASEF has run more than 650 projects, mainly conferences, seminars and workshops. Over 17,000 Asians and Europeans have actively participated in its activities and it has reached much wider audiences through its networks, web-portals, publications, exhibitions and lectures.

For more information, please visit www.asef.org

Table of Contents

LIST OF FIGURES	II
LIST OF TABLES	II
ACKNOWLEDGEMENTS	III
EXECUTIVE SUMMARY	IV
I. INTRODUCTION	1
II. RESEARCH METHODS	3
POLICY ANALYSIS	3
STAKEHOLDER ANALYSIS	4
CASE STUDY	4
CALCULATION OF COST	5
METHODOLOGICAL CHALLENGES AND LIMITATIONS	6
III. ASIA	8
A. HONG KONG	9
Migration Context: Mainland Chinese Migrants and Migrant Workers	9
Policy Review: Provision of Health and Medical Services	13
Stakeholder Analysis	19
Case Studies and Calculation of Costs	22
Discussion of Case Studies	32
B. SINGAPORE	34
Migration Context: Labour Policy in Singapore	34
Policy Review: Inclusion and Exclusion of Migrant Workers	40
Stakeholder Analysis	47
Case studies and Calculation of Cost	54
C. CONCLUSION	58
IV. EUROPE	61
Policy Stakeholders at the EU Level	64
A. AUSTRIA	67
Migration Context: Demographic and Political Drivers	67
Policy Review: Functional Ignorance	70
Stakeholder Analysis	72
Case Studies: Acute Injury and Communicable Disease	75
B. ITALY	79
Migration Context: Demographic and Political Drivers	79
Policy Review: A State of Partial Acceptance	79
Stakeholder Analysis	81
Case Study: Communicable Disease	84
C. CONCLUSION	85
V. COMPARISON OF ASIA AND EUROPE	86
VI. POLICY RECOMMENDATIONS	89
A. HONG KONG AND SINGAPORE	89
B. AUSTRIA AND ITALY	91
VII. CONCLUSION	93
REFERENCE LIST	95
GLOSSARY	105
APPENDIX 1: TECHNICAL STEPS FOR THE CONDUCT OF THE DELPHI	110
APPENDIX 2: ECONOMIC COST OF WORK INJURIES AND HEALTH – A SINGAPORE MODEL ..	115
APPENDIX 3: THE ECONOMIC CASE – SOCIAL COSTS OF MIGRANT HEALTH	117

List of Figures

Figure 1: Births to non-eligible mothers vs. local mothers in Hong Kong, 2000-2010	18
Figure 2: Projection of Foreign Manpower Demand for Healthcare Sector, Construction Workers and Foreign Domestic Workers.....	35
Figure 3: Asian population in Austria, 2002-2012.....	68
Figure 4: Asian migration to/from Austria, 2011	69
Figure 5: Asylum applications and decisions, 2001-2011	70
Figure 6: Countries of origin of patients, 2011	73
Figure 7: Countries of origin of patients, total, insured and uninsured, 2011	74
Figure 8: Countries of origin of patients, 2012	83

List of Tables

Table 1: Annual Number of Migrants from Major Southeast Asian Countries in Hong Kong (2002-2007).....	10
Table 2: Migrant Status Types	10
Table 3: Growth rates of employment in Singapore, 2006-2011	34
Table 4: Singapore Work Pass Framework	38
Table 5: Updated Work Injury Compensation Limits.....	43
Table 6: Public hospital daily charges for Singapore citizens, permanent residents and others.....	45
Table 7: Stakeholder analysis related to health of migrant workers	60
Table 8: Austrian population by Country of birth and citizenship (2012).....	67
Table 9: Austrian population, 2012.....	67

Acknowledgements

The Asia-Europe Foundation (ASEF) would like to express its sincere gratitude to the following individuals and organisations who conducted and contributed to the research and the publication of this report.

Dr Ursula TRUMMER (Center for Health and Migration, Vienna) was co-principal Investigator of this research.

Dr Sonja NOVAK-ZEZULA (Center for Health and Migration, Vienna) was responsible for sections on migration context and stakeholder analysis for Austria and Italy, for data collection in Austria as well as the analysis of data for the European cases.

Dr Daniela CARRILLO (Health and Welfare Unit, Ismu Foundation, Milan), Dr Gianfranco COSTANZO (National Institute for Health, Migration and Poverty (NIHMP), Rome) and Prof. Margherita GIANNONI (Dipartimento di Economia Finanza e Statistica, Università degli Studi di Perugia, Perugia), supported data collection and policy analysis for Italy.

The Health Care Center for the Foreign Families (CSFS), a dedicated service run by the Health Authority of Reggio Emilia, and the Caritas – Surgery “Querce di Mamre” (NGO) hosted site visits of researchers and provided data on real life cases in Italy.

Dr Stefan DINGES (Institute for Ethics and Law in Medicine at the Medical University Vienna and the University Vienna), Dr Klaus KAPUY (Austrian Economic Chambers), Livia MUTSCH (Neunerhaus), Prof. August ÖSTERLE (Institute for Social Policy, Vienna University of Economics and Business), Dr Gerhard POLAK (Going International), Anna RENNER (Gesundheit Österreich GesmbH), Dr Martin SPRENGER (Head of the Postgraduate Public Health Program, Medical University of Graz), Dr Ingrid ZECHMEISTER-KOSS (Ludwig Boltzmann Institute for Health Technology Assessment), supported conceptual development and policy analysis for Austria.

The Marienambulanz Graz, and Amber Med Vienna, both NGOs that provide health care services for vulnerable groups, hosted site visits of researchers and provided data on real life cases in Austria.

A number of individuals contributed to study on Austria and Italy by giving their opinion in the Delphi, participating in the workshops, giving advice as experts and providing data for our analyses.

Prof. Kai Hong PHUA (Lee Kuan Yew School of Public Policy, National University of Singapore) was co-principal investigator of this research.

As research associates who conducted literature review and research data collection and drafting of reports, Rachel HUI was responsible for sections on data and labour laws in Singapore. Marie NODZENSKI was responsible for sections on regional migration data and health governance.

As research assistants who conducted field work, interviews and translation, Nicole BACOLOD coordinated field work and interviews and conducted data collection on voluntary organizations, stakeholder analysis and translation in Tagalog. Sam Moses Paul JOHNRAJ conducted field interviews, data collection and translation in Tamil. Farhan Obaid AHMED conducted field interviews, data collection and translation in Bengali.

All participating voluntary organisations and individuals in Singapore provided invaluable inputs and assistance throughout the project.

Prof. Sian GRIFFITHS (JC School of Public Health and Primary Care, Chinese University of Hong Kong) initiated the collaboration and conceptualised the study with other international collaborators in the project. She also contributed to writing up of the report. Prof. Roger CHUNG and Prof. Huso YI (JC School of Public Health and Primary Care, Chinese University of Hong Kong) designed the study methods and led data collection, analysis, interpretations and writing up of the report.

Executive Summary

A growing interest on the intersection between migration and healthcare emanates from humanitarian and economic issues pertaining to the lack of access of migrants to healthcare. Despite making access to healthcare a basic human right in the European Union (EU), approaches of each member states to include migrants into the healthcare system significantly varies. In Asia, particularly for Asian economic tigers, countries are concerned over whether exclusion of migrant workers from healthcare will generate social costs and negative externalities that can be detrimental to their continued growth. Despite this interest, little is known about the implications of excluding migrants and migrant workers from the healthcare system. This comparative study seeks to contribute knowledge on this neglected area of research by estimating the cost related to different levels of exclusion of migrants to different healthcare systems across Asia and Europe.

For the Asian component of the study, Hong Kong and Singapore serve as cases to illustrate the challenges faced by economies with huge migrant worker population. Austria and Italy were chosen to illustrate the varied approaches of governments to providing healthcare to migrants in the EU. The study offers a unique perspective into the issue as it comprehensively examined the nature and extent of exclusion using different layers of analysis. In each of the country-case, a policy analysis was conducted to examine the causes and manifestations of the healthcare exclusion. Stakeholders were also identified and analysed in terms of their interest and power to influence the inclusiveness of the healthcare system. Micro-cases of exclusion were documented to provide a qualitative basis for computing costs using an innovative cost analysis framework. The study is an initial attempt of computing for the cost of exclusion, results of which are not meant to be generalizable.

The different country studies revealed that a host of factors influence how exclusion happens. As evidenced by the experience of Hong Kong and Singapore, most of the challenges related to migrants' access to healthcare come from the highly restrictive immigration policies in place. The policies do not seem to respond to the structural features of high irregularity and the temporary nature of migration in the region. In Hong Kong for example, while all migrants are eligible for public hospital services, anyone with undocumented status who availed of such services faces possible deportation. A similar problem confronts sex workers.

The Singaporean government enforces a highly regulated regime on foreign labourers, which has resulted to making employment of migrant workers very costly. In some cases, the costs have been passed to the workers. Poor enforcement of regulations exacerbated the fact that

foreigners are no longer eligible for subsidised medical care. As in the case of Hong Kong, migrant workers in Singapore have been discouraged to seek timely medical treatment due to its high cost.

The European cases exemplified how the system has been designed, delivered and utilised form an integral part of determining the inclusion or exclusion of migrants. In Italy's regime of "partial acceptance", migrants are provided with access to healthcare after going through some administrative procedures to verify eligibility. Despite this openness to migrants, the quality of service delivery constrains their ability to fully utilise the services. Barriers related to language, culture, financial means and low awareness level were observed in the micro-cases.

A similar issue is observed in Austria where the services by healthcare organisations are not differentiated according to the special needs of migrants. Given the diverse composition of the migrant population, translation and interpretation services should be provided at all times. Due to this, there seems to be a high incidence of delayed treatment of diseases, which implies that such system of exclusion is actually costlier than inclusion.

The study also revealed that provision of healthcare services by non-government organisations (NGOs) for excluded migrants and migrant workers is common among all country cases. By looking at the current capacity of NGOs, it becomes interesting to determine how the continued importance of migration and increasing migration flow would challenge the current structure of healthcare provision.

Based on these policy gaps and challenges in service provision, policy recommendations centre around recognising exclusion of migrants in healthcare as a social and economic problem that needs to be addressed. In Asia, the research teams suggested to reinforce the regulatory regime by establishing an independent statutory body for receiving and managing patient grievances and ensuring enforcement of laws preventing unlawful termination of contracts by employers and agencies. Additionally, healthcare service provision can be enhanced by installing interpretation services in public hospitals, especially for Hong Kong whose official language is Chinese.

In Europe, Italy's partial acceptance of migrants into the healthcare system can be used as a model as it institutionalises access to healthcare even for irregular migrants. This means that acknowledging all types of migrants as a part of the population is an integral part of ensuring access of migrants to the healthcare system. The research findings also point to the importance of generating data on migrants and exchange of information between EU member states. Data on the pull factors are particularly important to obtain given that this study showed that black labour market appear to be a strong driver of irregular migration in Europe.

This comparative study also recommends governments to work closely with NGOs given their central role in providing medical services to migrants both in Europe and in Asia. While this study is only a preliminary attempt at measuring costs of exclusion of migrants, it is hoped that it will spark policy discussions and further research on the intersection between migration and healthcare systems.

I. Introduction

Universal access to healthcare is not only seen as a basic human need and right, but also as a crucial factor for economic growth and social security. Globalised labour markets demand a healthy and productive workforce. How the issues of health and migration, especially labour migration, interact and influence each other gained eminence in recent policy debates particularly in Europe and Asia.

In the European Union (EU), all member states declared access to healthcare as a human right. Yet, there remains to be considerable variation of national policies concerning the access of migrants to healthcare, especially, those residing without a regular status within the EU.

While regular migrants are widely integrated into welfare regimes, national regulations about access to healthcare for undocumented migrants are much more restrictive. Those defined as “undocumented” or “irregular migrants”¹ form a specifically vulnerable group excluded from welfare state benefits despite forming a considerable workforce in black labour markets.

Undocumented migrants are therefore a group of specific interest in this comparative study. They are widely excluded from healthcare provision, but are in high need of healthcare support for various reasons. They face extreme physical and mental stresses in their work and living conditions, which increases the overall risk of contracting communicable diseases and related social problems. In a majority of countries, they are not being monitored and do not have access to social and preventive services.

It is often argued that this situation leads to “humanitarian costs” to society as it violates the human right to health. However, such restrictions have been justified as necessary since it insulates the healthcare system from incurring costs from treating people who do not contribute into welfare systems. Additionally, open access irrespective of migrant status and/or financial contributions may attract more undocumented migration.

There has been a growing recognition of undocumented migration as a regional reality: “there will always be a number of irregular migrants present in Europe, regardless of the policies adopted by governments to prevent their entry or to return them speedily.”² It becomes evident

¹ Communications from European bodies, e.g. European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU, 2010/2089(INI) use both terms synonymously. This report follows this practice.

² European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU, 2010/2089(INI)

that the implication of exclusion from regular care is not limited to humanitarian costs, but also includes unnecessary economic costs due to inefficient postponed treatment processes resulting in “forced emergencies”. The evidence base on these issues so far is poor.

While this is the case in Europe, a stronger economic case to capture social and humanitarian costs as indirect costs exists based on enlightened self-interests as well as communitarian externalities, and not just based on individual human rights. In comparative studies, the research framework will have to consider different contexts and value systems.

The traditional European emphasis on human rights and legislation may not sit comfortably with Asian economic tigers such as Singapore and Hong Kong. A more acceptable starting point is to extend the standard economic approach to value costs and benefits to include direct, indirect and social costs (including ethical, humanitarian and intangibles) from both demand and supply sides.

Understandably, the data on costs is more difficult to gather and thus, necessitates estimation and extrapolation of the costs based on micro sample cases. If a holistic societal perspective is taken, governments whether of source or host countries, can appreciate the benefit of protecting workers’ health and safety with stronger legislation and supporting services for all stakeholders.

This comparative study aims to create a preliminary knowledge base to analyse the costs of excluding undocumented migrants in Europe and migrant workers in Asia from healthcare. Ideally, it would not be difficult if information were available to estimate the size of the problem in all migrant populations, whether documented or undocumented. However, even regular migrant workers could be excluded from basic services provided under the law, as emphasised in the Asian parts of the study. The European project part concentrates on undocumented migrants as a population group that in most countries is systematically excluded from regular healthcare.

The study aims to examine policies in the selected jurisdictions related to migrants’ and migrant workers’ health to describe the nature of exclusion. Stakeholders are mapped to establish key actors that have an interest and can influence the state of exclusion and healthcare service provision. Micro-cases are then used to estimate for the costs of exclusion.

This report is prepared by the research teams from the Center for Health and Migration, Austria (C-HM), the Lee Kuan Yew School of Public Policy, National University of Singapore (NUS) and the Jockey Club School of Public Health and Primary Care, Chinese University of Hong Kong (CUHK), for the research project of the Asia-Europe Foundation (ASEF) entitled: “ASEF Public Health Network – Joint Research on Health and Migration in Asia and Europe”.

II. Research Methods

To compare Asian and European experiences and perspectives on this issue poses a specific challenge. Differences in migration histories and policies, labour market regulations, rural to urban and transnational migration, concepts of the welfare state have to be taken into consideration. This requires different starting points in doing the research within the Asian and European contexts.

In relation to this challenge, the research group adopted a mixed method approach which allowed the study to be sensitive to specific variations concerning data sources, research frameworks and target groups chosen for the survey. Furthermore, the mixed method approach allowed research processes to integrate the different methodological expertise of various disciplines involved, ranging from economics to sociology and anthropology. The research is comprised of policy analysis, stakeholder analysis, and “real life” case studies using economic models to calculate costs.

Policy Analysis

The comparative study aims to create an analysis on the nature and magnitude of the costs of exclusion of documented and undocumented migrants from healthcare. The objective of the comparative policy analysis is to examine various components of exclusion and inclusion of population groups from/into healthcare.

Secondary analysis of locally available state-of-the-art data sources was conducted. Identified gaps were filled with additional desk research. For the Asian comparative study, policy expert interviews were also conducted.

Specific to the Hong Kong study, thematic analysis was conducted to identify key themes focusing on difficulties in access to healthcare among migrants and to identify main policy gaps. Analyses involved both inductive processes (generating theories from the data collected) and deductive processes (using the data to support existing theories). From the five in-depth case interviews and the two focus group discussions with the stakeholders/experts, various important policy gaps are highlighted, which negatively affect health and medical provisions to migrants in Hong Kong.

For the European part, the comparative policy review focuses on access to healthcare for undocumented migrants. Austria and Italy were chosen because the countries represent two different approaches in healthcare financing and providing access to healthcare for undocumented migrants. In addition to the secondary review, an expert knowledge-based evaluation of relevant European policies was also undertaken. It involved the collection of expert opinions using Delphi and expert interviews and meetings.

A Delphi was established within the European Research Network COST Action IS1103 Adapting European health systems to diversity (ADAPT) as an internet survey with initial contact and invitation by email and several follow-ups. As the results of the first round showed a high degree of homogeneity, no additional rounds were taken. The internet surveys were conducted from 12 February to 7 May 2013. A total of 117 experts in various categories (health professions, research, management, administration) participated in the Delphi. Out of the 117 respondents, 75 came from Austria and 42 from Italy.

Expert meetings took place once in Vienna, and the other expert meeting was conducted at the London School of Economics in the framework of the COST ADAPT on 2 February 2013.

Individual expert interviews were held with policy, research and practice stakeholders from public health, medicine, medical insurance, hospital and primary care management, health technology assessment, social policy, medical ethics, human rights, non-governmental organisations, and governmental organisations.

Stakeholder Analysis

A stakeholder analysis was conducted, aiming to elicit the various perspectives of different interest groups. For the Asian comparative study, stakeholder interviews were conducted with selected stakeholders at the policy, administrative and service levels in order to triangulate different views and interests.

For the European comparative study, interviews covered stakeholders from different fields (public health, medicine, medical insurance, hospital and primary care management, health technology assessment, social policy, medical ethics, human rights, non-governmental organisations (NGOs) and governmental organisations). Stakeholder analysis was used to provide examples of the main features of service provision. For the Austrian study, two NGOs who are among the largest ones and are situated in the two major rural areas of Austria were selected to serve as examples of the main features of service provision: “Amber-Med” and “Marienambulanz”.

Case Study

The case studies hope to capture treatment processes as well as contextual factors like lifestyle issues, individual perceptions, the influence of the labour market, and other issues that on ground of the available evidence could not be taken into account so far. It is meant to trace individual life events of undocumented migrants to better elucidate the extent and nature of exclusion in healthcare provision.

In the Singapore study, narratives were extracted from face-to-face interviews of selected migrant workers with health issues to serve as case studies and social and related costs were elicited. The interview used a structure questionnaire in the interviewees' native languages (Tamil, Bengali, Tagalog and Bahasa).

For the Hong Kong case studies, the research team reached out to NGOs, churches and missions with strong ties to migrant community to recruit individual cases. Five individual cases from the three main migrant groups of Foreign Domestic Workers, South Asian Migrants and Mainland Chinese Migrants were surveyed.

For the collection of real life cases in Austria and Italy, site visits to organisations providing healthcare for undocumented migrants were conducted. Two service providers who had been identified as models of good practice in the European comparative study on "Healthcare in NowHereland"³ were visited. Real life cases were collected from different countries, and with different health issues based on the narratives of service providers and – where available – from patient records.

The analysis focused on three components: 1) life circumstances (labour, housing, relationships); 2) diagnosed disease and related health problems, stratified along the main public health themes-communicable/non-communicable disease, acute/chronic disease, and prevention; and 3) treatment processes and related costs. It turned out that information is seldom available for all three components. Taken into account this restriction, still those real life cases can serve as a robust basis for further economic modelling and evaluation.

Calculation of cost

The cost calculation aims to provide a rough estimate of indirect and direct economic and social costs of exclusion.

For the Asian study, the research employed an innovative approach of analysing the indirect costs of exclusion (as opportunity costs to society) in addition to direct costs of treatment. The calculation of the costs aims to provide knowledge-based evaluation of these policies on two dimensions: economic and social costs. Social costs are defined as all direct and indirect costs concerning violations of human rights and breach of professional values of healthcare professions (societal level), and individual harm that is done to people and could be avoided by better or timely treatment of health problems (individual level). Economic costs are defined as all direct and indirect treatment costs as well as productivity loss that could be avoided with timely treatment and/or preventive measures as provided in routine care. This qualitative evaluation serves as a robust knowledge base to develop recommendations for further health policy studies. Social issues and related costs were valued using estimates from available data such as occupational safety and health statistics.

³ Karl-Trummer, Ursula; Novak-Zezula, Sonja (2010): Health Care for Undocumented Migrants. Fact Sheet Practices <http://c-hm.com/chm/>.

A generalised costing framework can be used to calculate the economic and social costs due to a typical case of injury or disease among the sample of cases over a timeframe. The calculation would not only include the direct costs of medical and other health-related expenditure due to the injury or illness, but also the indirect costs of loss productivity that are computed from their average wage costs over the duration of their illness or disability.

For the European component of the study, additional considerations apply. As can be discerned from the cases, a very substantial part of the social costs would be intangible and cannot be computed in monetary terms. The migrant workers face not only much pain and suffering from their injuries and non-injury health problems, but also mental stress and anxiety as they go through the tedious processes of settling claims for workmen’s compensation or negotiating the bureaucratic maze. These can translate into much transaction or administrative costs if productive time is used up, or if there are related costs incurred by other parties such as NGOs and other voluntary contributions involved.

Summary of Costing Methodology and Analysis

Type of cases	Indirect Costs	Direct Costs	Intangible Costs	Total
Injury	<ul style="list-style-type: none"> Loss of productivity = No. of months without work X average monthly salary 	<ul style="list-style-type: none"> Medical (Hospital and doctor’s fees, medicines, aids, rehabilitation, etc.) 	<ul style="list-style-type: none"> Pain and suffering Stigma 	
Non-injury	<ul style="list-style-type: none"> Transaction costs Administrative costs Community/ voluntary contributions 	<ul style="list-style-type: none"> Housing Transport Food Miscellaneous 	<ul style="list-style-type: none"> Stress and anxiety Discrimination 	

Sample: >2000 cases over 2-year period from Jun 2010-May 2012; 1300 injury cases
 Average monthly salary for Indian / Bangladeshi / Sri Lankan foreign workers on Work Permit in construction and shipyard manual jobs: SGD 450-600

Methodological challenges and limitations

For the European part of the project, expert opinions on existing policies were collected, using different formats like a Delphi, workshops, and single interviews. The results do not claim to be generalisable, as the aim was not to do a systematic evaluation but to collect qualitative opinions on the issues raised in the policy analysis and stakeholder analysis.

Specific challenges are acknowledged that pose some limitations on the results.

- Due to issues of data protection and the protection of their vulnerable clients, healthcare providers are uncertain whether to share data on diagnostic and treatment steps concerning individual patients. Data collection therefore is challenging, even if data is available, and needs a sensitive and trustful relationship between researchers and practitioners.

- Available real life cases are not complete. In most cases, they only give sporadic information on treatment processes and especially living conditions. Concrete information of treatment costs and expenditures for living are accordingly incomplete and have to be supplemented by estimates.
- Cost parameters to be fed into the economic model were deducted from official sources (such as salary, pricing of drugs, and healthcare fees in the mainstream primary system) where possible. In case no official sources are available, estimations were made on basis of best available knowledge, especially expert knowledge of NGO staff members.
- Concerning data on wages and expenditures like housing costs, average numbers are not applicable for undocumented migrants. Wages on the black labour market can be supposed to be much lower than average wages. Concerning housing/lodging costs, it is known from qualitative interviews that undocumented pay higher rents than regular migrants. Actual wages and housing costs had to be estimated on basis of expert knowledge.

Some of the obstacles to the economic evaluation of the cost of exclusion identified by experts include:

- Health interventions for undocumented migrants in most countries are not monitored systematically. Even if there are data available on specific interventions, treatment processes are difficult to trace over time. The modelling of an appropriate and applicable treatment process therefore is of high complexity.
- Available European and national guidelines on treatment processes, such as for diabetes treatment, maternity care etc. do not refer to treatment procedures established in reality, but describe an ideal high-level treatment process. Therefore such guidelines are of limited use as a referential pathway.
- In every diagnostic or treatment step in a hypothetical treatment process, several options for further treatment from no to high risk scenarios open up what cannot be all included in an economic model.
- Undocumented migrants appear and disappear in the healthcare system; information is sporadic and highly selective. The modelling of a general (non) treatment process, therefore, is of high complexity.
- Economic calculation has a blind eye on those kinds of costs, which cannot be expressed in terms of money, as for example individual suffering, and other kinds of individual emotions.

Nonetheless, this attempt for comparative study will contribute to ignite discussion on economic analysis of migration and health.

III. Asia

As Asian countries have pragmatic market-based economies, it is prudent to justify the losses of productivity by taking into account the social costs and the negative spill over effects of migrants' ill health have on the economy. Several inefficiencies may exist in current systems – non-payment of medical treatment, long periods of waiting for settlements, transaction costs and loss of productivity – all these are costs that are not accounted for. Ultimately, employers are the ones who profit most from the cheap labour costs of migrant workers. Hence, they should logically be the ones to bear the brunt of related costs and not the whole of society.

On the other hand, there are also positive externalities if workers are well cared for and treated fairly in the labour market. A healthy worker is a more productive one. Moreover, in instances where accidents and injuries occur, lessening the 'limbo' period ensures that workers who can no longer work are sent home wherein their families care for them after receiving the necessary and appropriate treatment. Less waiting time means less cost for all involved in the extra administration, such as NGOs and other parties involved in the transactions.

With these considerations in mind, the study focuses on developed cities in country-sites that consist of different jurisdictions – Hong Kong SAR and Singapore (Hong Kong with an open market and policy framework but facing domestic constraints vis-à-vis China, and Singapore with an open market framework but restrictive policies relative to the region).

Hong Kong Special Administrative Region (SAR) of China has reverted to Chinese rule since 1997, from former colonial British administration. Under "One Country, Two Systems", which is the constitutional principle formulated by Deng Xiaoping, the former Leader of the People's Republic of China, the Hong Kong Special Administrative Region would retain its own political system, legal, economic and financial affairs, while there would remain to be only one China. This would be the case for 50 years after the return of Hong Kong to Mainland China. With the "One Country, Two Systems" policy in place, migration issues present new health challenges. Many Hong Kong-owned labour-intensive industries are operating in neighbouring Shenzhen, which draws migrants

from all over China. The health needs of migrants and their families have been studied⁴, but little is known of undocumented migrants both in Shenzhen and in Hong Kong SAR.

Singapore offers an interesting case study of a labour-scarce economy that has undergone rapid expansion recently, but with heavy dependence on migrant labour. Due to tight law enforcement, undocumented migration is rare, but there are many anecdotal accounts of occasional abuse and infringement of migrant workers' rights and denial of access to healthcare. While little is known of undocumented migrants except during such emergencies, the high costs of healthcare and the user-fee system of the public medical system would create entry barriers for all migrant workers. Thus, a comprehensive economic analysis of the health sector could be more complete with better estimates of the direct and indirect social costs for both documented and undocumented migrant work forces.

A. Hong Kong

Migration Context: Mainland Chinese Migrants and Migrant Workers

In the 19th and 20th century, Hong Kong's population was boosted by the arrival of hundreds of thousands of migrants from China. From 1945-1950, 1.5 million Chinese flooded south to Hong Kong to escape the Chinese Civil War. Following the Chinese Communist Revolution in 1949, over one million Mainland refugees sought shelter in Hong Kong. Subsequently, from 1965-1975, many Northern Vietnamese refugees fled to Hong Kong in fear of persecution during the Vietnam War.

The subsequent years of rapid economic growth and briefly relaxed border control gave rise to the immigration (both regular and irregular) of some 500,000 Chinese.⁵ Economic growth increased the employment of millions of workers in the neighbouring Chinese province of Guangdong as well as migrant workers from around the world. By 1969, the government sanctioned immigration of domestic helpers and the flow of migrant workers from South East Asia has been steadily increasing ever since.

Migrant Profiles

Since the return of Hong Kong to China in 1997, the Basic Law allows rights of abode to Chinese citizens in Hong Kong in two ways. The first pathway to citizenship for Mainland Chinese is through the One-way Permit (OWP), where Mainland Chinese can reunite with relatives in Hong Kong. The second is to be born on Hong Kong soil, which has led many Mainland mothers to travel to Hong Kong to give birth. Such a phenomenon has created various healthcare and economic challenges for the Hong Kong system.

⁴ Mou J, Cheng J, Zhang D, Jiang H, Lin L, Griffiths SM. Health care utilisation amongst Shenzhen migrant workers: does being insured make a difference? *BMC Health Serv Res*. 2009 Nov 21;9:214.

Mou J, Griffiths SM, Fong HF, Hu Q, Xie X, He Y, Ma H, Cheng J. Seroprevalence of rubella in female migrant factory workers in Shenzhen, China. *Vaccine*. 2010 Nov 23;28(50):7844-51. Epub 2010 29 October 2009.

Mou Jin; Cheng Jinquan; Griffiths Sian Meryl; Wong Yeung Shan Samuel; Hillier Sheila And Zhang Dan. "Internal Migration and Depressive Symptoms among Migrant Factory Workers in Shenzhen, China". *Journal of Community Psychology*, 39(2):212-230. 2011.03.

Gao Y, Li LP, Kim JH, Congdon N, Lau J, Griffiths S. The impact of parental migration on health status and health behaviours among left behind adolescent school children in China. *BMC Public Health*. 2010 Feb 3;10:56.

Wong, W. C., Holroyd, E., Chan, E. Y., Griffiths, S., & Bingham, A. (2008). One country, two systems": Sociopolitical implications for female migrant sex workers in Hong Kong. *BMC Int health hum Rights*, 8, 13.

⁵ Tsang, S. (2007). *A Modern History of Hong Kong: 1841-1997*. IB Tauris.

Mainland Chinese constitute the majority of Hong Kong's immigrant population. Between July 1, 1997 and the end of 2011, 189,900 certificate of entitlement holders entered Hong Kong from the mainland. In 2011, 43,400 Mainlanders joined their families in Hong Kong under the 'One-way Permit Scheme', which imposes a daily quota of 150.⁶

According to the World Health Organization, Hong Kong has a population with one of the highest proportions of migrants.⁷ In 2009, 39% of the Hong Kong population is foreign-born most of which are from Mainland China with non-Chinese foreign-born accounting for 5% of the population.⁸ These populations in Hong Kong are predominantly Southeast Asian particularly, Filipino, Indonesian, and South Asian.

Table 1: Annual Number of Migrants from Major Southeast Asian Countries in Hong Kong (2002-2007)

Year	The Philippines	Indonesia	Thailand	Others	Total
2002	148,400	78,100	6,700	3,900	237,100
2003	126,600	81,000	5,500	3,800	216,900
2004	119,700	90,000	4,900	3,800	218,400
2005	118,000	96,900	4,500	3,800	223,200
2006	120,800	104,100	4,300	3,600	232,800
2007	123,500	114,400	4,100	3,500	245,500

Source: Hong Kong Labour Department

Table 2: Migrant Status Types

Type	Status
Mainland Migrants	One-way permit holders: daily quota of 150; wait 7 years for permanent residency (N= 43,400 in 2011) Cross border births by Mainland mothers (N=38,882 in 2010)
Labour Migrants (unskilled)	Foreign domestic workers: mainly from the Philippines, Indonesia (7,150per year on average from 2003-07) Other labour workers: mainly from India, Pakistan
Labour Migrants (skilled/ professionals)	Quality migrant scheme: highly-skilled persons from Mainland and overseas. (N=2,094 since June 2006 till 2011) Capital Investment Entrant Scheme: required to invest not less than SGD 10 mil (N=13,111 in 2011) Non-Local Professionals (N=320,000 in 2011)
Irregular Migrants	Mainland: 1,631 undocumented immigrants in 2011 Vietnamese: 291 arrested in 2011 South Asians: Mainly from Pakistan, Bangladesh, Nepal, Sri Lanka and India Others: minimal
Other Groups	Returnees Dependents Non-Local Students

Source: Hong Kong Labour Department

⁶ HK Community Legal Information Center (CLIC) and HK Legco (LC Paper No. CB(2)1979/08-09(02)

⁷ Census and Statistics Department, Government of the Hong Kong Special Administrative Region. (1981). Hong Kong 1981 Population Census. Hong Kong: Government Printers; 1981.

⁸ United Nations. (2009). International Migration 2009. Retrieved from http://www.un.org/esa/population/publications/2009Migration_Chart/ittmig_wallchart09.pdf

The migrant worker population in Hong Kong has been increasing. In 2010, there were 284,901 foreign domestic workers (FDWs), which constitute 4% of the entire population. 48% of these FDWs were from the Philippines, 49.4% from Indonesia, and 1.3% from Thailand⁹. FDWs are the highest proportion of migrant ethnic minorities in Hong Kong, accounting for almost two-thirds of the city's non-Chinese population. Indonesian domestic workers tend to be younger than their Filipino counterparts and on average, have less years of education. Filipino domestic workers are typically older, better educated (many are college graduates), informed of their rights, and proficient in English. An overwhelming majority of domestic workers from both countries are women. Other nationalities particularly Pakistani and Nepalese migrants work as clerks, service workers, and in sales. Indian migrants are usually employed in managerial and professional sectors.

Since May 2006, the minimum wage level of FDWs is set at the level of HKD 3,400 per month. There is a large income disparity between migrant workers in Hong Kong with FDWs receiving the lowest monthly earnings:

- Indonesian (HKD 3,320)
- Filipino (HKD 3,370)
- Thai (HKD 4,000)
- Nepalese (HKD 8,000)
- Indian (HKD 15,000)¹⁰
- Korean (HKD 25,000)
- Japanese (HKD 30,000)
- White (HKD 45,000)

There are an estimated 10,000 irregular immigrants in Hong Kong, with 2,400 (about 25%) coming from Pakistan and Viet Nam who come as asylum seekers.¹¹ Most of the irregular immigrants come from Mainland China. A report by The Hong Kong Immigration Department reported 2,479 arrests of Mainland Chinese migrants in 2012.¹² Offenders risk prosecution and face a maximum fine of HKD 50,000 and up to 2-3 years imprisonment if convicted. Using fake or forged identity may result in a penalty of up to HKD 100,000 and 10 years' imprisonment.

Among those prosecuted for unlawful employment, many work in the sex industry. In 2012, 1,588 women working as sex workers were arrested and deported on the grounds of 'illegal immigration'.¹³ There are also many irregular workers in the construction sector who come to Hong Kong using a visitor's visa. However, official numbers are lower as they may not be systematically prosecuted.

⁹ Bhabha, J., Leader, P. S., Ruggie, M., Ignacio, E., & Mejia, Y. (2008). Managing labour migration: The case of the Filipino and Indonesian domestic helper market in Hong Kong.

¹⁰ Bhabha et. al (2008).

¹¹ Hong Kong Special Administrative Region Government. (2013). Retrieved from <http://www.gov.hk/en/about/about/hk/factsheets/docs/immigration.pdf>

¹² Lowe, A. (2012). *Hong Kong Immigration Officials Busted Illegal Immigrant Workers* | *International Immigration News*. Retrieved from <http://news.visato.com/hong-kong/hong-kong-immigration-officials-busted-illegal-immigrant-workers/20120811/>

¹³ United States Department of State (2012). 2012 Trafficking in Persons Report – Hong Kong. Retrieved from: <http://www.refworld.org/cgi-bin/texis/vtx/rwmain?page=country&category=&publisher=&type=&coi=HKG&rid=&docid=4fe30cc3c&skip=0>

According to the Hong Kong Government, the usual firms employing irregular migrants are construction sites, used electrical appliances recycling plants, auto spare parts recycling parts, warehouses, electronic spare parts recycling depots, restaurants, and foreign exchange shops.¹⁴

There is no reliable data on the number of migrant sex workers in Hong Kong. Hong Kong is primarily a transit territory for irregular migrants, some of whom become trafficked for sexual exploitation and forced labour in their destination country.¹⁵ According to UNHCR, human traffic victims originate mainly from Mainland China, Philippines, Indonesia, Thailand, Vietnam, Nepal, Cambodia, and Southeast Asia generally.

Health Status of Migrants and Migrant Workers

Migration and its impact on the psychological well-being of migrants is increasingly becoming a research focus. The literature shows that depressive symptoms are the most prominent factor in reducing immigrants' quality of life (QOL). Many new Mainland immigrants who reported lower levels of social support were more likely to report a high level of depressive symptoms.¹⁶ A strong social support network and optimism are the two important factors that enhance the QOL for immigrants.¹⁷ New immigrants to Hong Kong from Mainland China are at risk of experiencing depressive symptoms; therefore, prevention measures, particularly strengthening their social support, should be considered by policy makers. Besides mental health issues, studies have revealed that Chinese immigrants face serious difficulties in adjusting their lifestyles in Hong Kong.¹⁸ Some challenges include unacceptable housing conditions, unemployment, low income, discrimination, social isolation, lower social and economic status, and lack of access to basic services.

Despite entitlements to universal coverage and that nearly half of children immunised in Hong Kong Maternal and Healthcare Centres (MCHC) are migrant children, health inequalities are likely for migrant children in Hong Kong. A study of Hong Kong's immunisation database shows¹⁹:

1. Migrant children - visiting children especially - are more likely to receive immunisations later than local children.
2. They are significantly less likely to be up-to-date with immunisations at 3 months and 12 months.
3. There are information gaps in the Hong Kong database.

The health status of migrant workers appears to be influenced by human rights abuses, gaps in health knowledge, and limited access to healthcare information. As regards to human rights, a survey of Filipino domestic helpers undertaken by the Asian Migrant Centre in 2001 has

¹⁴ Hong Kong Special Administrative Region Government. (2012) *19 arrested during anti-illegal worker operation in New Territories North* Retrieved from <http://www.info.gov.hk/gia/general/201207/31/P201207310369.htm>

¹⁵ United States Department of State (2012).

¹⁶ Wong, W. K., Chou, K. L., & Chow, N. W. (2012). Correlates of quality of life in new migrants to Hong Kong from Mainland China. *Social indicators research*, 107(2), 373-391.

¹⁷ Chou, K. L. (2009). Pre-migration planning and depression among new migrants to Hong Kong: The moderating role of social support. *Journal of Affective Disorders*, 114(1), 85-93.

¹⁸ Home Affairs Department and Immigration Department 2004, 2009; HKISS 1997; Mo et al. 2006; Lai 1997; Wong 2008; Chow and Ho 1996

¹⁹ Fong H. 2011. Policy implications of migration for the immunization of Chinese children in Hong Kong. The Chinese University of Hong Kong. [PhD Thesis]

documented cases of abuse to include underpayment (27%), lack of time-off (22%), verbal abuse (19%), physical abuse (25%) and sexual abuse (4%), suggesting that this is a vulnerable population sub-group.²⁰ Another more updated 2013 survey conducted by Hong Kong-based Mission for Migrant Workers found that 58% of domestic workers faced verbal abuse, 18% faced physical abuse and 6% faced sexual abuse.²¹

Studies show that knowledge regarding HIV/AIDS and its route of transmission is inadequate amongst female migrant workers in Hong Kong. The needs of female migrant workers are not met by the HIV prevention and care activities in Hong Kong. From survey data, 70% of the foreign domestic workers being interviewed reported feeling discriminated against in Hong Kong while 42% felt discriminated against in hospitals.²² There is therefore a need for more culturally acceptable and affordable mass screening programmes that should be provided.

Female migrant sex workers in Hong Kong are extremely vulnerable to abuse and ill health.²³ Stigma in Hong Kong against migrants and sex workers contributes to their poor health and emotional well-being. Their undocumented status prevents them from adopting health-seeking behaviours such as actively checking for sexually transmitted infections (STIs), or seeking protection from crimes committed against them. As non-residents of Hong Kong, they are charged a high fee when accessing health services, which means many do not seek medical assistance when treatment is needed.

Policy Review: Provision of Health and Medical Services

In Hong Kong, public healthcare services are available to all and are provided on a fee-for-service basis. The residence status of individuals living in Hong Kong determines entitlement to subsidised healthcare. OWP holders and other non-permanent residents, who are holders of Hong Kong Identity Card, are considered Eligible Persons (EP) and therefore qualified for subsidised rates.²⁴ The EPs are: (a) holders of the Hong Kong Identity Card; or (b) children who are Hong Kong residents and under 11 years of age; or (c) other persons approved by the Chief Executive, Hospital Authority.²⁵ Foreign domestic workers are eligible for heavily subsidised public healthcare services. For irregular migrants, public healthcare services are provided only when there is an urgent need, and the patients will be reported to the police.

Policy Gaps and Issues in Health and Medical Provisions

Based on the thematic analysis, the following policy gaps in health and medical provisions were identified: lack of enforcement against errant employers, unregulated employment agencies, and non-eligibility of government subsidised public health services for non-Hong Kong ID holders/over-stayers.

²⁰ Asian Migrant Centre. (2001) *Underpayment: Research on Indonesian Domestic Workers in HK*

²¹ McBride M (2014). Indonesian migrant workers in Hong Kong exploited and forgotten. Ethics in Action. Asian Human Rights Commission

²² Bandyopadhyay, M., & Thomas, J. (2002). Women migrant workers' vulnerability to HIV infection in Hong Kong. *AIDS care*, 14(4), 509-521.

²³ Wong, W. C., Holroyd, E., Chan, E. Y., Griffiths, S., & Bingham, A. (2008).

²⁴ Wong, D. (2003). *Eligibility of Immigrants for Health Care Services*. Retrieved from <http://www.legco.gov.hk/yr03-04/english/sec/library/0304rp01e.pdf>

²⁵ Hong Kong SAR Hospital Authority (n.d.) Fees and Charges Retrieved from: http://www.ha.org.hk/haho/ho/cs/v3/serviceguide_feenchg-en.htm

Lack of enforcement against errant employers

Existing legislations to protect migrant workers are poorly enforced as can be seen from the exploitation of labour laws by employers, the widespread practice of subcontracting and unlawful termination of migrant workers. Some employers exploit loopholes in the labour legislation so that workers cannot be entitled to all the benefits guaranteed under the Employment Ordinance. While all employees are entitled to basic protection under the Ordinance, only employees who are employed continuously by the same employer for four weeks or more, with at least 18 hours of work each week (the so-called “4118” labour legislation) are entitled to additional benefits such as rest days, paid annual leave, sickness allowance, severance payment, long service payment.²⁶ For instance, workers who work for four days but with only 17.5 hours per week are not regarded as employed under a continuous contract. Migrant workers are particularly vulnerable to this employer malpractice. Although many work practically full time, the details in their work contract have been arranged in a way where they are designated as part time workers, which deny them health benefits. No regulatory body has been created to enforce labour legislation effectively.

In Hong Kong, many migrants work in construction and labour-intensive industries where the practice of sub-contracting is very common. With the practice of multiple sub-contracting, the respective legal responsibilities of the various but simultaneous employers towards their employees become very complex. Thus, it becomes questionable whether labour legislation is followed strictly in every sub-contract. Similarly, according to the Employees’ Compensation Ordinance (ECO), an employer is only liable to pay compensation for injuries sustained by employees due to accidents during the course of employment.²⁷ Self-employed or subcontractors are liable for any costs for injury and are recommended to have their own workers compensation policy.²⁸ Section 24 of the Ordinance states that, if an employee of a subcontractor is injured at work the principal contractor can be liable for any compensation claim in the event of the subcontractor defaulting. Afterwards, the principal contractor can even take action to recover any payment liable from the subcontractor.²⁹

Another key issue raised was the situation of unlawfully terminated migrant workers. A representative working with a local NGO serving pregnant migrant women expressed, “this issue of no access to healthcare is really a big issue to former domestic helpers who are terminated unlawfully.” She mentioned that domestic workers have only two weeks to find a new employer once they are terminated. During this time, their rights and access to healthcare become extremely limited. The most frequent cases of unlawful termination occur when domestic workers become pregnant. Although it is illegal to terminate domestic workers because of pregnancy, there is little enforcement of this legal provision according to their experiences.

²⁶ Hong Kong SAR Labour Department. (n.d.). *Chapter 1 - Application of Employment Ordinance*. Retrieved from <http://www.labour.gov.hk/eng/public/wcp/ConciseGuide/O1.pdf>

²⁷ Hong Kong SAR Labour Department - Labour Legislation. (n.d.). Retrieved from <http://www.labour.gov.hk/eng/legislat/content1.htm>

²⁸ Hong Kong SAR Labour Department. (n.d.). *Know Your Identity and Rights*. Retrieved from <http://www.labour.gov.hk/eng/public/wcp/SelfEmployedPerson.pdf>

²⁹ Hong Kong SAR Labour Department. (2012). *A Concise Guide to the Employees’ Compensation Ordinance*. Retrieved from <http://www.labour.gov.hk/eng/public/ecd/pco360.pdf>

Unregulated employment agencies

Once migrant workers arrive in Hong Kong, agencies take advantage of gaps in the international employment framework:

“First, they will be told to sign before the contract starts. “You will not be pregnant”. They force them to take like the contraception, the injection. That is the medical check-up, they say.”

“But agencies are the ones doing illegal arrangements for employers, like exploiting their situation, making them sign. You know when they sign, they think it is a big deal, so even though you are signing something that is not part of the contract, and you honour this. But they don’t realise that it’s illegal, invalid because it’s not covered in the contract.”

Employment agencies serve as the first point of contact, particularly for domestic workers providing training and employment referrals at the migrant’s country of origin and remain the main source of information for migrants after arrival in Hong Kong. The focus group revealed that many agencies take advantage of migrants’ trust and often misinform them about their rights, and mislead migrants during times of crisis.

Since agencies make money by charging a fee from either migrants or employers, they are motivated to funnel as many new migrants through the system as possible without regard to terminated workers. The problem can be seen as a market failure. Agencies operate purely out of self-interest and are unfettered by government can result in inefficiencies and negative externalities. Externalities can be financial and social, such as the social exclusion of migrants and unaccounted costs to government when migrants encounter ill health without insurance or legal status.

Legal status and limited access to healthcare

The migrants’ legal status limits their access to healthcare. This is particularly the case for non-Hong Kong ID holders, over-stayers, non-permanent residents, and migrant children. As noted earlier, resident status determines healthcare costs. Generally, hospital visits are set at a flat rate of around HKD 100, which includes consultation and medication but individuals who do not hold identity cards are not eligible for this subsidised rate: *“[People] with two-way permit do not have [the identity card]. They cost HKD 580 per visit in public hospital.”*

One main issue is that many migrants from Mainland China cross the border for work on a daily basis. They obtain two-way permits (TWP) which vary in length of stay (from a few days to three months). These migrants often work full time and stay in Hong Kong longer than they do back home but legislation has barred them from enjoying subsidised health services.

Before 2003, holding a visitor’s pass or a two-way permit sufficed to benefit from subsidised public services including healthcare. Policies implemented in 2003 on requirements for identity cards has increased healthcare costs for a number of individuals which has led to lower utilisation of services.

Since TWP holders are not eligible to receive healthcare services from public clinics and hospitals, they need to pay the full cost for all the public health services except attending tuberculosis and chest clinics, which are free of charge to the TWP holder and other visitors.³⁰

³⁰ Wong, D. (2003). *Eligibility of Immigrants for Health Care Services*.

Even though when they become the OWP holders, they still need to pay the medical expenses owned in holding the TWP. From 2002 to 2006, there were “37,000 Non Eligible People (NEPs) defaulting on payment of fees”, accounting to HKD 223 million.³¹

Similarly, also excluded are ex-foreign domestic helpers who cannot find work with another household within the two-week grace period in between employment. Many of these foreign domestic workers then become over-stayers in Hong Kong, and their rights and access to healthcare become very limited during this period. Their only resource is to apply for international humanitarian aid organisations in Hong Kong. This becomes a risk for migrants and their child if they are pregnant.

Children born to domestic workers often face difficulty in establishing their legal status in Hong Kong. Even if migrant women are still under contract, their children do not necessarily enjoy the same legal status as their parents. There is a lack of a clear policy or guidelines in Hong Kong to establish migrant children’s identity in Hong Kong and provision for public health services are lacking. Because of the complex legal system in healthcare that often eludes migrant parents, these children have lower rates of vaccination and regular check-ups.

Constraints to availability, accessibility, acceptability of healthcare services

The language used in the public health system in Hong Kong is primarily Cantonese. Although Mandarin and English are also official languages in Hong Kong,³² they will only be used in the public health system when the patients are not comfortable speaking in Cantonese. In Hong Kong, unlike other developed countries, many migrants of ethnic minorities do not integrate well into the local society and do not speak the local language well.³³ As discussed in the two focus groups, non-fluency in Cantonese caused frustration and discouragement among Mainland Chinese migrants, and even fear and confusion among other non-Chinese migrants, to seek for healthcare services in the public health system. In other words, Hong Kong, albeit being one of the most developed areas in the world, does not necessarily have a migrant-friendly healthcare system.

There is currently no central interpreter service provided for public hospitals and other public service agencies in Hong Kong. The government uses freelance court interpreters for the police and immigration departments; however, these interpreters are rarely used by hospital services or social services. When they are, they may not have adequate training for medical interpretation.³⁴

At hospitals, translation services are available through the request of medical staff or if patients request a referral from social workers. Migrants mostly rely on interpreter services through NGOs. According to the Hong Kong Council of Social Services, there are 11 major NGOs providing interpreter services in Hong Kong.³⁵ However, there is no accreditation

³¹ Hong Kong SAR Audit Commission. (2007). Report No. 47 of the Director of Audit — Chapter 5 Hospital Authority: Management of outstanding medical fees. Retrieved from: http://www.aud.gov.hk/pdf_e/e47ch05_sum.pdf

³² GovHK (n.d.) Hong Kong: The facts. Retrieved from: <http://www.gov.hk/en/about/abouthk/facts.htm>

³³ Hong Kong Human Rights Commission, Society for Community Organization and Asylum Seekers’ and Refugees’ Voice (2008). Interpreter services at hospitals for ethnic minorities. Retrieved from: <http://www.legco.gov.hk/yr06-07/english/bc/bc52/papers/bc520416cb2-1600-2-e.pdf>

³⁴ Hong Kong Human Rights Commission, Society for Community Organization and Asylum Seekers’ and Refugees’ Voice (2008).

³⁵ The Hong Kong Council of Social Service (2005). Retrieved from: www.hkcss.org.hk/fs/er/.../EM_Interpret%20Proposal20050831.doc

or testing procedure to ensure the quality of translation services. In this context, health information needs to be made available, for example, in both written and oral Filipino, the national language of the Philippines.³⁶

Another recurring issue was the inability of healthcare services to meet the special needs of migrants. Many migrants work in sectors, which have irregular hours. One participant in focus group pointed to the case of domestic workers who only have Sundays off. Because of the limited free time these migrant workers have, services needed should be open on Sundays for instance. Besides flexibility issues in clinic schedules, it was reported that migrant sex workers do not feel comfortable going to public clinics. As a result, NGOs provide health services for them confidentially and without judgment.

Discrimination due to race, migrant or socio-economic status is cited as one of the major barriers faced by migrants in Hong Kong's public health system. Hong Kong has enacted the anti-discrimination law, known as the Race Discrimination Ordinance (RDO) in July 2008, under which it is unlawful to discriminate, harass or vilify a person on the ground of his/her race in various areas including the provision of goods, facilities or services.³⁷ While migrants of different races are protected by the RDO, it is questionable how informed they are about the protection they are entitled to under Hong Kong's law. Since migrants in Hong Kong tend to be lower skilled workers or unemployed with lower education attainment, it is not surprising that they are not well aware of their legal rights and protection, especially when they did not grow up in Hong Kong.

There is a lack of education effort from the government in Hong Kong to inform migrants of their health rights.³⁸ Some NGOs currently take up the role of actively informing the migrants in Hong Kong; however, the number of migrants these NGOs can reach is limited. A closer collaboration between the government and the NGOs may help.

There are three major complaint mechanisms against discriminatory practices in healthcare. First, the Medical Council of Hong Kong was established in accordance to the Medical Registration Ordinance and was given the legal powers to "assure and promote quality in the medical profession in order to protect patients, foster ethical conduct, and develop and maintain high professional standards."³⁹ Second, Public Complaints Committee of the Hospital Authority has been in place with the aim of "providing a proper consideration of complaints from users of hospital services, or of members of the public, in relation to hospital services."⁴⁰ However, the Committee has no statutory status and therefore does not have direct power to investigate the cases. Last, the Department of Health under the Government Food and Health Bureau also provides outpatient services and monitors the private hospitals. However, since

³⁶ Holroyd, E. A., Taylor-Pilliaie, R. E., & Twinn, S. F. (2003). Investigating Hong Kong's Filipino domestic workers' healthcare behavior, knowledge, beliefs and attitudes towards cervical cancer and cervical screening. *Women & health*, 38(1), 69-82.

³⁷ Hong Kong Legal Information Institute (2008). CAP 602 Race Discrimination Ordinance. Retrieved from: <http://www.hkliv.hk/eng/hk/legis/ord/602/>

³⁸ Holroyd, E. A., Molassiotis, A., & Taylor-Pilliaie, R. E. (2001). Filipino domestic workers in Hong Kong: health related behaviors, health locus of control and social support. *Women & health*, 33(1-2), 181-205

³⁹ The Medical Council of Hong Kong (n.d.) Retrieved from: <http://www.mchk.org.hk/>

⁴⁰ Hong Kong SAR Department of Justice (1997). Hospital Authority Ordinance (Cap 113). Retrieved from: http://www.legislation.gov.hk/blis_pdf.nsf/6799165D2FEE3FA94825755E0033E532/6D14349D9F44AB37482575EE003D8C4C?OpenDocument&bt=0

the Department of Health handles complaints against services provided by the Department itself but not by another independent investigation body, the fairness of the complaint mechanism is highly questionable.⁴¹

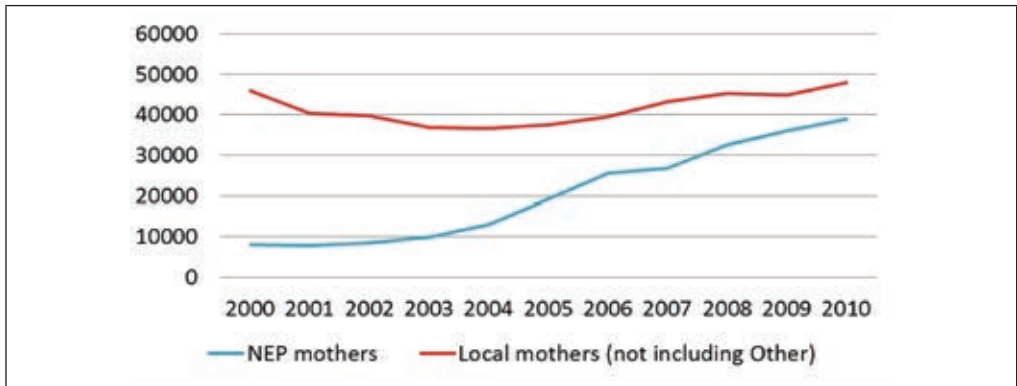
Although there are complaint mechanisms in place in Hong Kong, the public still has difficulty finding the right channel to make their voices heard in the system. Moreover, it has been known that discrimination against ethnic minority and the Mainland Chinese (especially due to the ever-growing identity crisis of the local Hong Kong population since 1997's handover of sovereignty) has been prevalent. This calls for the establishment of a regulatory body with statutory power to prevent discrimination from happening within the public healthcare system.

In addition, there is little incentive for migrants to go through the legal system. In lower court, duty lawyers are provided through an independent organisation funded by the government and managed by the Hong Kong Bar Association while in higher courts, the Legal Aid department offers legal representation and assistance in civil proceedings.⁴² NGOs for migrants/ migrant communities also provide legal support services through pro bono lawyers but the services are very limited and the number of lawyers interested in migrant rights is low. One participant explained that the legal system is often set up in a way that forces migrants to give up on their case. "They will try to drag the case out for 1 or 2 years." Domestic workers often have to wait for a long time with no support for their living and healthcare needs. When they are terminated while pregnant, domestic workers are left with little chance of finding new employment. Legal action does not ensure that they will find future employment.

Cross-border migrants' impact on health system

With increasing numbers of Mainland mothers giving birth in Hong Kong, the healthcare system is overloaded. Costs of obstetrics and gynaecology services have increased but hospitals have a hard time coping with an increasing number of patients. In addition to the financial costs, the government needs to prioritise long-term policy planning for the health provisions of local Hong Kong residents.

Figure 1: Births to non-eligible (NEP) mothers vs. local mothers in Hong Kong, 2000-2010



Source: Fong (2011)

⁴¹ YM Chu (2006). Quality of Care and Patient Redress: A Patient Perspective. In: Leung GM, Bacon-Shone J, eds. *Hong Kong's health system: reflections, perspectives and visions*. Hong Kong: Hong Kong University Press; 271-290.

⁴² The Duty Service Lawyer (n.d.) Frequently Asked Questions. Retrieved from: <http://www.dutylawyer.org.hk/en/faq.asp>

Stakeholder Analysis

The major stakeholders with significant interest in migrant's workers and their inclusion/exclusion in healthcare include several state and non-state actors.

Hong Kong Government

It is perceived that the government's interest is primarily to meet labour needs through recruitment of migrant workers while providing them with few legal rights to discourage long-term integration into society. The incentives and benefits such as promotion, pension and leave provided to attract and keep high-skilled migrant workers are not offered to low-skilled migrants. Although basic healthcare services are provided for migrant workers with valid contracts, utilisation of these services remains low due to the high turnover of migrants, the lack of legal protection and other barriers mentioned in the earlier section of this report that prevent access to services.

Two ministries in Hong Kong implement policies that may affect the health of migrants: Immigration Department and Labour Department.

Immigration Department

The Immigration Department has a strict position of keeping migrants from getting legal recognition even in extenuating circumstances. As mentioned in an earlier section on unlawfully terminated migrants, some migrants overstay their work visas due to a variety of reasons such as looking for further employment or to take legal action against their employers. During this time, the Immigration Department issues them recognisance papers, which do not provide legal entitlements to healthcare services.

Labour Department

The Labour Department has a relatively weak influence on migrant issues compared to the Immigration Department. Although there are measures in place to protect and inform migrants about their rights, there is a gap in ensuring these measures are carried out effectively. Furthermore, employment agencies often undermine the work of the Labour Department. The Labour Department lacks financial and human resources to better regulate agencies and has not been able to establish systematic collaboration with them.

Employment Agencies

The employment agency is the major hub through which government, employers and migrants operate. As mentioned above, since employment agencies make profits through fee from either migrants or employers, they may have vested interest in funnelling as many new domestic helpers through the system as possible. Therefore, agencies often being the only or main contact points of the foreign domestic helpers, they form a stronger sense of trust with their agencies while agencies are motivated to keep the migrants uninformed about their rights.

Employers

Employers' main interest is to maintain competitiveness and productivity and consequently to keep labour costs as low as possible. It has been observed that despite official support for migrants' rights to healthcare, employers may refuse to employ domestic workers who are ill or pregnant. When these situations arise, most employers will eventually (unlawfully) terminate the contract and the responsibility and costs are passed on to government or taxpayers. Employers may exploit loopholes in labour legislation, which prevent migrant workers from receiving welfare and medical benefits. The Labour Department provides information on employment law for employers but recommendations or legal obligations seem to be ignored without much consequence.

Migrant Workers

Regular and documented migrant workers in Hong Kong benefit from subsidised healthcare. However, various migrants are unaware of their rights and entitlements. This could cause delays in treatment (and rising emergency costs) as well as loss of productivity. The reliance on employment for migrants (who usually support families back home through remittances) has led numerous migrants to hide medical conditions from employers as a result of a fear of losing their employment.

Even for migrants who are eligible for subsidised health services, their low wages are often only sufficient for their daily living expenses. Acute or chronic illnesses can mean high out of pocket costs for them. Finally, while in-principle access exists, migrant workers face many access barriers to health services. It has further been noted that the healthcare system does not provide services that take into account the specific needs of migrants.

NGOs and International Organisations

Local NGOs and international organisations have filled the policy gaps by providing financial, legal and healthcare services and support to migrants. When migrants develop acute conditions and go to hospitals for emergency care, these bills eventually are paid by tax payers and international organisations but it is felt that the government should bear some more responsibility and clarify legislation for the well-being of this community. When migrants over-stay (due to unlawful termination of contract) in Hong Kong, international agencies, such as International Social Service (ISS), intervene via asylum seeking cases, providing housing allowance, and financing healthcare. Yet, the financial resource allocation capacity of ISS is limited in providing necessary support for migrants.

NGOs play a fundamental role in supporting migrants and in providing a range of services. There are approximately 20-30 organisations working on migrant workers-related issues in Hong Kong. The Hong Kong SAR government has been tolerant of civil activism aimed at helping migrant workers, and tolerant even of contentious advocacy for their labour rights. The British colonial administration established labour laws that were inclusive of migrant workers and provided institutional channels for redressing their rights. Migrants can bring labour dispute claims to court where a judge gives decisions. Because of its relative political

openness, since the 1980s Hong Kong SAR has been a site of vibrant and well-organised migrant worker activism, particularly by Filipino women, staging very visible demonstrations on a regular basis.⁴³

Migrant workers in Hong Kong are not organised and have difficulties doing so because of the high labour turnover and a lack of a strong network to connect to each other. NGOs work to bring migrants together and advocate on their behalf, like many other migrant community organisations. Migrant workers may also turn to international organisations for support, particularly when they over-stay their visas or while their cases are being reviewed, with both situations leaving them resource-less and with no subsidised access to healthcare. Most migrants can receive support from ISS after filing a torture case report to the United Nations.

International Social Service (ISS) Hong Kong Branch

ISS is an international non-governmental organisation to facilitate communication between social services that assist individuals and families who have personal and/or social problems that require inter-country cooperation. It was established in Hong Kong in 1958 as headquarters delegation, and was formally recognised as a Branch (Hong Kong Branch) by the International Council of ISS in 1973.

Inner City Ministries (ICM)

ICM is a Christian mission that serves the poor and marginalised in Hong Kong. The organisation seeks to provide spiritual, physical and emotional support to the South Asian ethnic minority in Hong Kong, specifically the Nepalese population. The Nepalese are one of the poorest groups in Hong Kong who are severely marginalised by high unemployment, discrimination and the inherited disempowerment that comes from widespread socio-economic deprivation.⁴⁴

Action for Reach Out (AFRO)

AFRO provides services and support to female sex workers in Hong Kong. Their services include outreach visits, peer education, a drop-in centre, and a hotline, referrals for health or legal consultation and social services. AFRO also actively promotes health and rights education. AFRO promotes public education aiming to facilitate communication and mutual understanding between sex workers and the public. They aim to eliminate prejudices and misunderstanding, and to arouse concern and support to sex workers. They are also engaged in research and advocacy.⁴⁵

New Women Arrivals Leagues (NWAL)

NWAL helps migrant women and children of migrant families who are new to Hong Kong to adjust to life in the city by providing monthly support-group meetings and a telephone hotline for counselling and services, engaging women through training programmes, providing support on women's issues, and policy advocacy, and supporting children with educational services, including an after-school tutoring programme.

⁴³ Yamanaka, K., & Piper, N. (2005). *Feminized migration in East and Southeast Asia: Policies, actions and empowerment* (Vol. 11). Geneva: UNRISD.

⁴⁴ Inner City Ministries (2010). Home. Retrieved from: <http://www.innecityministries.org/>

⁴⁵ Action for Reach Out (2007). Home. Retrieved from: <http://www.afro.org.hk/EN/>

New Home Association

The New Home Association aims to provide one-stop professional social services to new migrants in Hong Kong. Their services begin before migrants leave their country of origin and continue after they settle in Hong Kong. Before new migrants land in Hong Kong, their social workers will evaluate their case and tailor-make services to cater to their specific needs. They also provide consulting, counselling and training programmes to help migrants gain invaluable insights into their new community. After they arrive in Hong Kong, social workers will continue to provide personal consulting services and offer activities that will help them improve their work skills, develop family lives and get involved in the community. The association also provides funds to assist migrant families in grave financial circumstances and offers scholarships to students from Mainland China to realise their potential.⁴⁶

Pathfinders

Pathfinders serves migrant women and their children. The organisation helps migrants understand their rights and help work out long-term plans for their family, which can involve guiding them through their return home, changing their visa status so they can legally remain in Hong Kong or choosing adoption for their child. The organisation removes mothers and children from immediate danger, and provides them with access to critical services and support networks. Pathfinders provides skills training programmes so that mothers can make long-term, sustainable plans for themselves and their children.⁴⁷

Christian Action

Christian Action is a registered charitable organisation based in Hong Kong. Their mission is to serve those who are poor, disadvantaged, marginalised, displaced or abandoned regardless of their age, gender, nationality and religion. The organisation has several divisions working on different humanitarian projects in Hong Kong and China. One of their programmes involves casework and skill training for refugees, foreign domestic workers, and migrants from Mainland China.⁴⁸

Mission for Migrant Workers

The Mission for Migrant Workers is a registered charitable organisation dedicated to deliver responsive services (such as legal and employment assistance, crisis management, education and empowerment, skill training, and advocacy) to Asian migrants. The organisation is the longest existing independent service provider for migrants in Hong Kong and Asia. It is an outreach programme of the St. John's Cathedral.⁴⁹

Case Studies and Calculation of Costs

Case HK1: Foreign Domestic Worker with Tumour

S is a 27-year old female from Indonesia. She came to Hong Kong in 2011 to work as a domestic helper. She broke her contract with her employer after 3 months and overstayed her work visa. She is currently living in Hong Kong with 'recognition papers'. Under recognition

⁴⁶ New Home Association (2014). Service Centres. Retrieved from: <http://www.nha.org.hk/rSeverIndex.aspx?clid=124&lan=2>

⁴⁷ Pathfinders (2012). Home. Retrieved from: <http://www.pathfinders.org.hk/public/>

⁴⁸ Christian Action (2014). Home. <http://www.christian-action.org.hk/>

⁴⁹ Mission for Migrant Workers (2013). Home. Retrieved from: <http://www.migrants.net/>

papers, she is allowed to reside in Hong Kong but does not enjoy any legal rights while her case is being reviewed. She currently has a tumour that requires surgery but her legal status limits her access to affordable health services.

Not long after starting her job in 2011, she discovered a lump behind her ear. She did not seek medical attention initially and thought it was a minor infection. It started growing bigger and after one month, she went to see the doctor. She had two consultations, which cost HKD 200 respectively. Although she was entitled to health insurance from her employer, she did not know about her rights to health coverage and paid for her consultations out of pocket. The doctor diagnosed the growth as a tumour and recommended her to surgically remove it.

“And then the doctor said you must take [it] off but that time I also not understand the situation in here and just I live like this and slowly, slowly it get bigger, bigger, bigger.”

Since she was unfamiliar with her healthcare entitlements, she decided to defer medical treatment. She also hid the growth from her employer because she was afraid her health condition would affect her employment.

After working for three months, she ended her contract with her employer because she had financial trouble at home (i.e., Indonesia) and wanted to find other employment with higher pay. Because she needed more money, she tried to get extra work outside of her domestic contract, which she did not know was illegal. Her friend was the one to suggest to her about getting work outside of her contract. She trusted her friend to arrange work for her but she was deceived and ended up losing her money and Hong Kong ID.

“I lost everything when I left my employer. My friend lied to me. I met her during my holiday and she told me if you want good salary...talking like this. At that time, I had problem at my home country with my husband. After I left employer, they cheated with me. But I did not know also that work outside is illegal. But my friend told me to come outside from employer and she want to bring me to work in the restaurant. Because she said the restaurant is very big salary. When I met her, she ask me to work in garden in Jordan and she said one by one, I bring you back your property. Yes, they take my property – my money, my mobile, they take all.”

After she left her employer, she could not find another employer. Since she stayed in Hong Kong after the two-week grace period without a new contract, her legal status in Hong Kong became invalid. During the two weeks before her visa expired, she tried to find her friend and look for a new employer. She sought help from her agency. Her agency charged her monthly agency fees, which include training and employment referral services; however, she was denied employment support services.

“Because my salary is HKD 3570 and then every month I only get the HKD 570. The HKD 3000 must pay the agency. We cannot pay in Indonesia so after we have job, we must pay agency this for 7 months.” “I also don’t know why they do not open the door for me. Then after I become overstay, like that.”

After she overstayed her visa, she met her boyfriend who helped her during the difficult time. She decided to surrender herself to the Immigration Department and served two months in the detention centre (Castel Peak Bay Immigration Centre, CIC). After her sentence, she was released and given ‘recognisance papers’ allowing her to stay in Hong Kong until her case is reviewed. After her times in CIC, she reunited with her boyfriend and they had a child together. He helped her with visiting hospital for her pregnancy as well as her tumour.

As a ‘recognisance paper’ holder, she has very limited rights and access to healthcare. She cannot work and does not qualify for subsidised rates at hospitals. The only way for her to get medical care is through NGOs and the United Nations’ (UN) ISS, an international non-governmental organisation that assist individuals and families with personal or social problems whose solution requires inter-country cooperation.

During the time her case was reviewed, medical costs and other living expenses were provided and her child delivery costs were covered by ISS. However, she currently is unable proceed with her surgery for her tumour because her case as a holder of recognisance paper has been closed. She also cannot get waivers for her child’s immunisation and health checks.

“But this one, this quote, they said I need to make deposit of HKD 33,000 before I can do surgery but I cannot. Right now, it is difficult for me because my case is all finished so if I want to see the doctor now I must ask like this one, Pathfinder. Like for the baby. Baby need to use the welfare but now my torture claim is closed and so I cannot use the welfare. I cannot work so all day nothing to do.”

Economic Costs: Tumour (two months)

Item	Rate	Amount (in HKD)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wage	-	-	-
<i>Total (Indirect cost)</i>		-	
<i>B. Medical expenses (Direct cost)</i>			
Doctor’s appointments	Varies	2,380	ISS
Medical procedure (child birth)		7,590	ISS
Hospitalisation fee (child birth)		33,000	ISS
<i>Total (Direct cost)</i>		42,970	
<i>C. Other costs</i>			
Agent Fees	HKD 3,000 per month	6,000	S
Budget for food	HKD 1,000	2,000	S
<i>Total (Other cost)</i>		8,000	

Summary of Costs: Direct costs – HKD 42,970; Other costs – HKD 8,000

Summary of Social Issues: Financial problems at home, unawareness of rights, fear of termination, overstay, child immunisation, NGOs providing health services.

Case HK2: Foreign Domestic Worker with Gallbladder Stones

H is a 34-year-old female from Indonesia who came to Hong Kong in 2002 to work as a domestic helper. After working for five years, her employer terminated her. She overstayed her work visa and was eventually apprehended by Immigration. Just like Case S, she was given 'recognisance papers' allowing her to live in Hong Kong with no legal rights and very limited access to healthcare. She currently has gallbladder stones, which give her abdominal pain and can be fatal if not treated. Due to her residency status, she cannot work to save up for her surgery nor qualify for any subsidised rates or medical waivers from local or international social services.

While she was working as a domestic helper, she frequently had stomach pain but ignored it. She eventually went to the doctor and was prescribed medicine for her symptoms. She did not know she was developing gallbladder stones. She was given medication for pain. After the termination of her contract after working for five years, she only had two weeks to find another employer. She was unable to find a new employer and stayed in Hong Kong after her work visa expired. Since overstaying, she moved in with her long-time boyfriend who helped her. Not long after, she was caught by the Immigration Department. After she was released from the Immigration detention centre, she resumed her relationship with her boyfriend and had a child together. Her boyfriend was an asylum seeker and encouraged her to also apply for international aid. Over time, her stomach pain became worse. In early 2012, she was admitted to the Accident and Emergency (A&E) service and stayed in the hospital for one night due to intense pain in her abdomen. It was during this hospital visit that she was officially diagnosed with gallbladder stones.

"Yes, I try to ask very well, of course the time they tell me about operation but not tell me what sickness and why I must going to operation. They say, not yet, but if you feel painful, you must take operation to remove. I eat food and it gives me pain, if hungry also pain. Only eat enough so that my stomach is not hungry. Every four or five hours I will eat again.

Although she knew that it was important for her to receive surgery, she was worried how her surgery would affect her daughter.

"Now, how I feel is, everything is very difficult. Sometimes I am scare when I'm going to hospital I cannot breast (feed) her. She cannot eat anything. Even now, I try, starting to eat cereal, but she does not like. Just small (feeding motion) but she is like (make spitting noise)."

On the other hand, after leaving her home country, she started having difficulty staying in contact with her family. She eventually lost contact with them. By the time her contract was terminated, she felt that she no longer had a home to return to. She applied for her case in the ISS to stay in Hong Kong.

After overstaying her visa, it became difficult for her to access medical services. Her legal status did not allow her to work or receive subsidised rates at public hospitals. In order to receive medical care, she relied on ISS. Although she was able to receive medical waivers for some of her medical visits, she often had trouble understanding the procedures she needed to take to follow up on her illness. She found that different hospitals operate differently in terms of medical fees.

“At other hospital, I can get free payment. But this one I cannot. They say I must pay. No, this other hospital is different. That’s why I don’t understand why this hospital cannot help me. Prince Margaret, Queen Elizabeth still can help me to payment free. I have one [appointment] next month. I think if we can change to another hospital is better. If I go check up again then we have problem again about pay money. No, if immigration still valid then they will pay. But they will call immigration and have the paper to approve. They will say ok or not. If the paper is valid. If invalid, they will not pay. Only this hospital they tell me they cannot help me. So when I ask the hospital they say I can’t have torture claim in UN. Maybe in this hospital like that but other, Princess Margaret, they contact immigration and they say my immigration is valid and welfare will help me to pay. Even I don’t understand. They said that my daughter has no case. How she has no case? She follows me and how I cannot pay for my baby. Maybe I can change hospital but if I do, they ask me why, it so far. When you go to hospital finished see the doctor, you go to apply for, and will make it free but my case is finished in UN, so that why cannot have waiver.”

She did not have many close friends to help her. She knew some people who would offer her odd jobs so she could make some money. She currently goes to an NGO in Hong Kong that helps domestic workers with children. The centre provides toys and educational materials for kids. They also offer seminars, health services and case management.

She explained that she does not have enough for basic living expenses. Her medical expenses were paid for by ISS but the fee waivers were inconsistent. Since she cannot legally engage in any work, she cannot afford her medical expenses.

“How we can pay? Of course, we cannot have any job so we live like that. So what we have to pay? How we pay? We have no job. Only ISS (International Social Service) help. If ISS help to pay, all will going ISS. We just say how are we going to pay? We have no job and it’s also very expensive. I went to check and expensive also. That time they say 90,000 [for child delivery] and for us with immigration papers we said that welfare will pay. And then the bill contact when we stay at hospital, welfare will pay for the bill.”

Economic Costs: Gall Bladder Stone

Item	Rate	Amount (in HKD)	Source
A. Loss in Productivity (Indirect cost)			
Unpaid wage	-	-	-
<i>Total (Indirect cost)</i>		-	
B. Medical expenses (Direct cost)			
Doctor's consultation and medicines		656	ISS
Medical procedure (child birth)		90,000	ISS
Hospitalisation fee (gall stones)		7,150	ISS
Surgery for gall stones		33,000	Pending
<i>Total (Direct cost)</i>		130,806	

Summary of Costs: Direct cost – HKD 130,806

Summary of Social Issues: Limited healthcare access due to legal status, financial hardship

Case HK3: Construction Worker with Spinal Injury

P is a 34 year-old female from Nepal. She has lived in Hong Kong for 16 years and is a permanent resident. She is a single mother and worked in construction industry. During her last job in 2004, she was involved in an accident that fractured her spine. Since the injury, she can no longer work and suffers from back pain and limited mobility during her day-to-day life. Her company has denied her compensation. She feels that the Hong Kong institutions have systematically mistreated her.

While she was working at a construction site in 2004, she fell from a ladder from ten feet. Her colleague at the time did not secure the ladder while she was fixing a light bulb. After her fall, she was taken to the hospital where she felt the staffs were insensitive towards her.

“That time...that much pain. When I go to hospital, that time, the nurse in X-ray room, the nurse was behaving not well. The nurse said, “Get up and walk and sit at X-ray table!” (Pause) I was hurt, I can’t move. Not even a little...I feel very bad.”

After being examined, the doctor prescribed pain medication and told her to rest and she could recover in a few months.

“And then after that, doctor saw the X-ray and the doctor told me that I have no problem in my back, no problem, and then you can recover 3-4 months, it’s just some muscle pain.”

After taking three months off, she did not make a full recovery. She still felt pain in her back. She ended up taking one year paid leave. During this year, she sought medical attention for her back pain. Her medical costs were compensated by the Disability Allowance, a monthly allowance provided by Hong Kong Government Social Welfare Department to permanent residents who are severely disabled.

"I had an appointment in the hospital also. So many places I do treatments...pain clinic, ONT, outpatient or something, physical therapy...but even all the treatments, it didn't work. Still, my body was not normal."

The original X-ray she received in Hong Kong showed no injuries on her spine and doctors said that her condition was a result of normal deterioration from old age. She suspected that there was something wrong and decided to get a second opinion. She decided to get a full X-ray done in India. She felt her treatment in India was be more honest and fair compared to that in Hong Kong. The cost for flying to India and her second X-ray were paid out of pocket.

"I just do a MRI, because in India, make it fair you know, because I do it first time in Hong Kong they told me is no problem, is degeneration, and then I was not satisfied so I went to India and do a MRI. Because in India they got a fair, you know. It's very high cost because I had to go to Nepal, you know by plane is very expensive. 40,000 Nepalese, 40,000 from India to Delhi, and then again 40,000 from Delphi to Chennai. In Chennai is where I do this one. So 80,000, just to go from Nepal. From Hong Kong to Nepal is different...Hong Kong was around 4 or 5 thousand, around. Yea for two-way."

Her X-ray results from India showed that she had a fracture in her L1 vertebrae and no signs of degeneration. She brought her X-ray results back to Hong Kong but still was not given any treatment by HK doctors that could improve her condition.

Subsequent to her back injury, she had very limited mobility, which resulted in a second injury. While she was walking down some stairs, she fell and injured her foot. She was taken to the hospital and referred to a specialist. Although her condition was urgent, her appointment was for one year later. Her foot injury did not heal properly and she now limps when she walks. When she is on her feet for a long time, her foot would become swollen and she would need bed rest for a month to recover.

"Yes, and why the hospital give me appointment for 1 year later? The hospital said it was urgent (points to red stamp "URGENT" on the top of referral form) that means urgent is 1 year?"

After her injury, her company gave her 12 months paid leave. After 12 months, the construction project was finished and she did not have a work contract any more. She was then led to sign a blank statement that was later filled with incorrect information. This document was later used in court. Her company's Occupational Safety procedures were questionable.

“After the accident, for construction site, we have to write a statement, that time, the safety officer told me, sign in a blank paper, and they will write the correct statement. I write the statement, and the safety officer told me, “Not like that, I write correct and you just sign it.” I just sign a blank paper and gave to safety officer. But, (exhales) cheat me. He didn’t write the correct information.”

She took legal actions to receive lost future wages. Legal Aid Department of Hong Kong provides low income individuals in Hong Kong with legal consultation and representation. She was able to have court costs and legal fees waived through Legal Aid Department. However, her lawyers cancelled her legal aid claiming that her paid leave amount was correct and she could return to work. She did not have a lawyer on her hearing date. She lost her case and did not receive any compensation.

Throughout her medical treatment, she claimed that doctors and staff treated her unkindly, and felt that she was not given proper treatment and care due to her status as belonging to the ethnic minority in Hong Kong. Her misdiagnosis and lack of legal representation has led her to distrust the Hong Kong society.

“The nurse told me “You are liar! Doctor didn’t write you have fracture, you are liar.” The nurse told me like that. Everywhere I did not get proper treatment. So until now, I was suffering pain... and then, judge, even them... they didn’t do or good.”

Since her accident in 2004, she has suffered back pain and has not been able to perform daily tasks such as cooking and cleaning. Her mobility is severely limited and she can rarely leave her house. Her quality of life is diminished and she can no longer work.

“You know, for so many years I suffer from doctor make the fake report and wrong decision. Because of his one wrong decision, my whole life was damaged.”

She claimed that she became depressed after her injury and was unable to care for her child. She sent her son to Nepal to be cared for by relatives.

“Not only me, but my baby also. If I have money then of course I can afford a person to take care him and him go to school.”

She currently relies on welfare for her living expenses. The allowances are barely enough for her family and whenever she goes to the Social Welfare Department, she feels embarrassed and hopeless.

“But how many years I go to welfare and then beg and tell my story and like a beggar, it’s very hard.”

Economic Costs: Spinal Injury

Item	Rate	Amount (in HKD)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wage	-	-	-
<i>Total (Indirect cost)</i>		-	
<i>B. Medical expenses (Direct cost)</i>			
Hospital admission/doctor visit/medicine		200	P
MRI (Hong Kong)		2,500	P
MRI (India)		2,500	P
<i>Total (Direct cost)</i>		5,200	P
<i>C. Other costs</i>			
Travel expense to India		12,000	
Travel expense of son to Nepal		5,000	
<i>Total (Other cost)</i>		17,000	

Summary of Costs: Direct costs – HKD 5,200; Other cost – 17,000

Summary of Social Issues: Distrust, Medical malpractice, Discrimination, Quality of life, Depression, Disability, Workers compensation, Child's Health

Case HK4: Metal Worker/Food Service Worker with Eye Injury

K is a 34 year-old male for Mainland China. He came to Hong Kong as a One Way Permit holder to reunite with his family. During his work at a service depot, collecting spare metal parts, he injured his left eye. He received surgery and could not work for one year. His employer did not pay for his medical expenses or provide any workers compensation. While he was not working, he was not eligible for any social security allowances because he had not resided in Hong Kong for at least seven years. He is currently working at a restaurant and waiting for the hearing date of his case.

While he was dismantling old game machines and collecting spare parts at work, some metal scrap popped out and hit his left eye. His employer took him to the hospital and he was transferred three times before he was admitted for surgery. He was hospitalised for three days. Afterwards he was unable to work for one year.

"[It affects me] economically cause I can't work. When I was hurt, at that time, my left eye was blind. I can't see thing. Even now, my left eye is still not well, astigmatism. It won't be as good as my eye before, though my left eye is recovering."

The accident occurred on his second day of work. Initially, his employer took him to the hospital. When the employer found out that he needed surgery, he started to deny him as an employee. The employer ignored him and did not cover his medical expenses.

“At the very beginning, he thought it did not matter...not a problem. He was there when I was transferred to a hospital. When he knew that I needed to do surgery and the situation was serious, he denied. I can’t tell you which day or when did he quit my treatment.”

“I called him, but when he picked up phone, he became fierce...and hang up my phone. So, on the 2nd day, I called the police. I was hurt on April 23rd, and I was hospitalised on 24th and my employer ignored me so that I called the police. The Labour Department began to take care of my case, and I also sent letters to my old employer, and called him many times, he just ignored...no reply...”

After he was discharged from the hospital, he was introduced to Legal Aid. Legal Aid is now helping him on his case against his employer. He wants to be compensated for his medical expenses as well as the lost wages from being unable to work.

“[Paid] all by myself...cause my employer denied that he was my employer once I was hurt...he claimed that I was the self-employed...I just finished the medical assessment this month in Prince of Wales Hospital (PWH), on May 8th...and we will go through the legal action to sue the employer... Yes, he should take the responsibility...It was industrial injury... I think he should pay all my cost...If he loses the case, he will pay a lot to me...”

Although he was not eligible for Comprehensive Social Security Assistance (CSSA) due to the residency requirement, he was only able to receive some help from a labour NGO called The Hong Kong Federation of Trade Unions (HKFTU). Besides helping him with daily living expenses, the organisation recommended that he could take legal actions to recoup his medical expenses.

“Cause I am staying here for less than seven years...I have not work for almost one year... If you were a Hong Kong local, you could apply the CSSA. But we can’t as migrants... There was an agency in the hospital and they gave me HKD 2000. After I got hurt, I appealed to a lot of governmental departments. I have no subsidy...I asked how could I get some help since the family has no income then? They gave me some money through an agency of HKFTU in hospital, and told me to apply for Food Bank where I could get some free food weekly. They recommended me from one place to another. I even went to seek help from social workers, and they all told me that I had not been here for more than seven years, so I can’t access some treatment or help...only law could help me...”

Economic Costs: Eye Injury

Item	Rate	Amount (in HKD)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wage	-	-	-
<i>Total (Indirect cost)</i>		-	
<i>B. Medical expenses (Direct cost)</i>			
Treatment cost		1,394	
Drug charge		80	
Hospitalisation fee		400	
Operation fee		1,100	
<i>Total (Direct cost)</i>		2,974	

Summary of Costs: Direct cost – HKD 2,974

Summary of Social Issues: Workers Compensation, Legal Status, and Eligibility for Welfare

Discussion of Case Studies

As illustrated by Case 1, migrant workers lack the understanding of that they had legal rights about the health benefits covered in her contract and that it was illegal to work outside of the employment contract. The recognisance paper given to the female domestic helper after overstaying entitled her to be treated in public hospitals in Hong Kong. However, since residency status is a requirement to be covered by the Medical Fee Wavier Mechanism in the public healthcare system, she has to pay out of her own pocket approximately HKD 49,970 for the medical cost and other costs. She also paid HKD 6,000 known as the pending surgery fee if she is later accepted to undergo surgery. Losing her residency status meant that the local government could not help. Only NGOs provided support when the UN reviewed her case. As a result, when her case under the UN was closed, she was still not able to work legally with recognisance paper. In addition, she also faced challenges about the cost of her child's immunisation as well as other future costs in raising a child in Hong Kong.

Similar to Case 1, Case 2 also exemplifies the lack of awareness of legal rights among migrant workers particularly female ex-foreign domestic workers. The lack of awareness about her legal rights and fear of being fired by employees if they found out about her illness are possible explanations for seeing doctor when the first sign of symptoms appear. Even submitting herself in the health system, she found difficulties in understanding the procedure about her treatment and following up on her illness. It is reasonable to infer that the language barrier, including understanding the medical languages as well as the possibility that nurses and other staff may not be fluent in English in the public healthcare system in Hong Kong, could be an important hindering factor to her being treated properly within the health system in Hong Kong. Moreover, in this case, she paid HKD 130,806 in total for childbirth, agent fee and gallstone hospitalisation. If she were to undergo surgery in the future, she still needs to find ways to pay

for the medical fees. Since she is holding recognisance paper, she is not allowed to legally work in Hong Kong, which results in no income for her and her family to raise her new-born child.

As reflected by both cases, the lack of awareness about legal rights to health coverage during the time of employment for foreign domestic workers can delay medical treatment, preventable suffering, loss of productivity, and increased health costs when a condition becomes chronic or acute.

It is recommended that foreign domestic worker agencies offer workshops aiming to increase awareness regarding legal rights of foreign domestic workers who newly arrived in Hong Kong. Furthermore, this case also highlights the issue that these foreign domestic workers can easily become overstayers once their contract is terminated, because the two-week grace period for them to find another job as domestic worker is short, and some of them may have already lost contact with their family in the home country. It is recommended to review the length of the grace period for these foreign domestic workers to find another job in Hong Kong.

In Case 3, due to lack of legal knowledge, the construction worker signed a blank paper by her employer, which led to her losing the lawsuit. Compared with the previous two cases, she is already a Hong Kong permanent resident, which allows her to apply for social allowance from Social Welfare Department to support her daily life. However, due to her injury, she could barely work and take care of her son, who eventually was sent back to Nepal. In suspicion that she might be misdiagnosed or mistreated within the Hong Kong healthcare system, she fled to India for a second opinion and found a different diagnosis for her condition. While we cannot be sure whether the differences in doctors' diagnoses between Hong Kong and India were due to actual misdiagnoses in Hong Kong, perceived obstacles to accessing healthcare among the ethnic minority population still exist despite their permanent residency status. In other words, residency status of migrants does not necessary guarantee a life without discriminations and abundance of social capital (in this case, legal representation).

Therefore, from Case 3, we can see the importance of raising the awareness of possible discrimination against ethnic minority within the healthcare and legal systems in Hong Kong.

As in Case 4, OWP holder migrants from Mainland China would likely face financial difficulties if they have no income. One major reason is that they were not eligible to apply for CSSA from Social Welfare Department due to their residency status. However, this policy has already been changed with effect on 17 December 2013, from when the CSSA applicants need to only satisfy the one-year residence requirement.

Moreover, Case 4 again reflects the importance of legal awareness among the migrants' populations, without which he would not be able to fight for compensation for his medical expense and his lost wages.

B. Singapore

Migration Context: Labour Policy in Singapore

Singapore's reliance on foreign manpower can be traced back to when rapid economic growth led by exports in the late 1960s and 1970s transformed its high unemployment economy of an earlier decade into a labour-short, full-employment economy by the late 1970s. The size of Singapore's small domestic population could not have supported its rapid economic expansion.⁵⁰ The table below charts the changes in Singapore's foreign and local workforce from 2006 to 2011 across major sectors:⁵¹

Table 3: Growth rates of employment in Singapore, 2006-2011

		2006	2007	2008	2009	2010	2011	Employment level as at Dec 2011	Ratio (%)
Manufacturing	Local ⁵²	11.0	7.3	-4.6	-9.5	-0.1	-2.8	255.5	48.8
	Foreign	30.6	42.0	24.1	-34.3	-0.7	6.1	268.0	51.2
Construction	Local	5.3	4.4	5.2	4.3	-0.4	2.4	110.2	27.4
	Foreign	15.2	36.0	58.9	19.7	3.8	19.6	292.5	72.6
Services	Local	73.7	77.2	63.1	48.2	56.3	37.5	1,645.5	72.2
	Foreign	39.0	65.9	73.4	10.4	56.2	58.6	633.3	27.8
Overall	Local	90.9	90.4	64.7	41.8	56.2	37.9	2,030.6	62.9
	Foreign	85.1	144.5	156.9	-4.2	59.7	84.8	1,197.9	37.1
	Total	176.0	234.9	221.6	37.6	115.9	122.6	3,228.5	-

Source: Ministry of Manpower, Labour Report 2011; Note: Data may not add up due to rounding

The growth of Singapore's foreign workforce resulted from government policies to attract and rely on foreign manpower at both the high and low ends of the labour spectrum to overcome the limits of local human capital.⁵³ As shown in the Table 3, the growth rate of Singapore's foreign workforce across different sectors peaked over 2007 and 2008, and the government liberalisation of its immigration policy was justified at the time as a move to assist companies tide over the recession in Singapore during the global financial crisis by allowing them to bring in cheaper labour. However, it was an influx of "foreign talent" (more highly skilled foreigners) into Singapore during this period that bred public discontent towards the government's "open door policy". It was seen to cause the rise in costs of living, particularly for housing; overcrowding; increasing competition for jobs and education; and increasing pressure on public goods and services; as well as social problems engendered by underlying tensions between locals and foreigners. Consequently, immigration and the government's foreign labour policy

⁵⁰ Hui, W. T. (2002). Foreign manpower policy in Singapore. Koh, Lim, Hui, Rao, Chng (eds) *Singapore Economy in the 21st Century: Issues and Strategies*, McGraw Hill.

⁵¹ Adapted from Lee, K., McGuinness, C., & Kawakami, T. (2011). *Research on Occupational Safety and Health for Migrant Workers in Five Asia-Pacific Countries: Australia, Republic of Korea, Malaysia, Singapore and Thailand*. ILO.

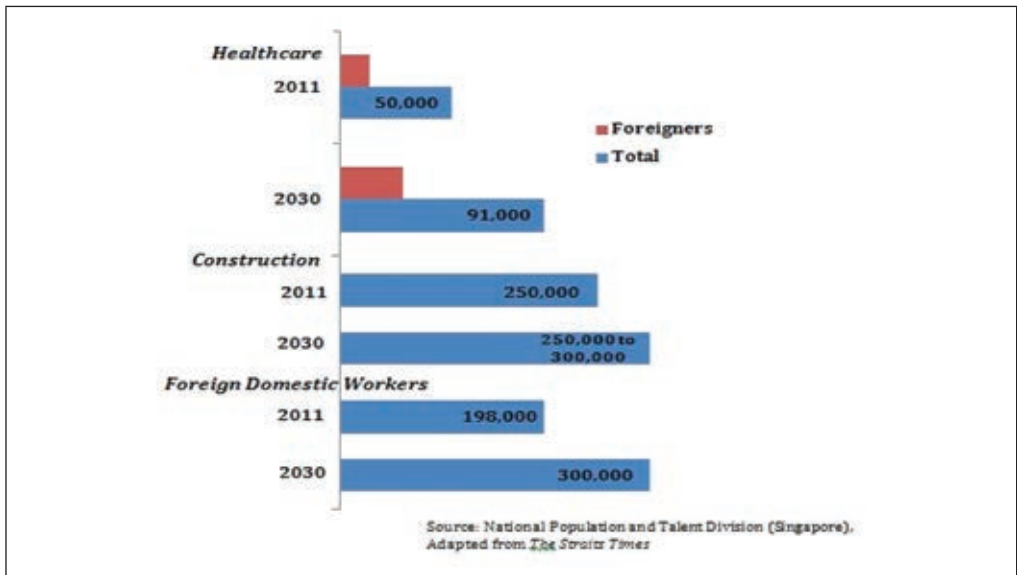
⁵² "Local" workers refer to both Singapore citizens and permanent residents in the workforce. Foreigners on various work passes are considered the "non-resident" workforce.

⁵³ Yeoh, B. S., & Lin, W. (2012). Rapid growth in Singapore's immigrant population brings policy challenges. *Migration Information Source*.

emerged as a hot topic during the 2011 General Election.⁵⁴ These political factors and changing economic conditions resulting from the global financial crisis put pressure on the Singapore government to scale back on its liberal immigration policies of the past.

The government has since tightened its foreign labour policy through a number of policy measures such as raising foreign worker levies for Work Permit and S pass holders, tightening levy tiers, imposing stricter criteria for higher educational qualifications and increasing the qualifying salaries for S Pass and Employment Pass holders. In the last two years, it has also introduced various schemes attempting to incentivise firms to increase their productivity through investments in technology. However, some observers have been concerned about the impact of this policy on investment and economic growth. Multinational companies and local small and medium businesses alike have voiced their concern over recent moves by the government to tighten the tap of foreign manpower.⁵⁵ Facing a shortage of manpower and pressure from tightened foreign worker quotas, businesses have urged the government to provide more clarity on its foreign manpower policies as they have significantly affected business operations. Some have warned of an exodus of companies relocating out of Singapore to where costs are cheaper and labour more plentiful. However, the Singapore government's position is that while foreign workers remain valuable to the Singapore workforce, there will be a "no U-turn" policy in restructuring the economy and weaning businesses off an "overdependence" on foreign labour, encouraging companies to raise productivity for more sustainable growth instead.

Figure 2: Projection of Foreign Manpower Demand for Healthcare Sector, Construction Workers and Foreign Domestic Workers



⁵⁴ See Report on Institute of Policy Studies Post-Election Forum 2011, 8 July 2011. Retrieved from: http://www.spp.nus.edu.sg/ips/docs/events/post-election/PEF_2011_report.pdf

⁵⁵ Saifulbahri Ismail (2011) "MNCs wants more clarity on foreign worker policy", TODAY, 12 November 2011.

Projection of Foreign Manpower Demand in 2030

While policy-makers have voiced their commitment to tightening Singapore's foreign labour policy, the National Population and Talent Division in November 2012 published their projections of the foreign manpower demand expected in the healthcare, domestic care, and built environment sectors in the future. By 2030, Singapore may need a projected total of 150,000 more foreign workers in these sectors, taking into account efforts to increase productivity, raise the skills of existing staff and to attract more residents to working in these sectors.⁵⁶

Of a projected 91,000 healthcare workers in 2030, 28,000 are projected to be foreigners, compared to the 13,000 foreign healthcare workers out of 50,000 in 2011. As FDWs continue to be relied on to provide care-giving support for families with elderly and children, particularly to allow seniors to age in a familiar living environment with their families and to allow Singaporean women to remain in the workforce, demand for FDWs could rise from 198,000 in 2011 to 300,000 FDWs by 2030. The construction workload is expected to increase by about 50% more than the current level due to the government's efforts to ramp up infrastructure development, such as the expansion of Singapore's rail network, launch of more housing projects, and the provision of more social and educational facilities as well as nursing homes and hospitals catering to its ageing population. Demand for foreign construction workers is expected to increase from 250,000 in 2011 to about 280,000 in the next few years, and within the range of 250,000 to 300,000 by 2030, depending on the extent of productivity improvements in the construction sector.

Labour Policies Governing Migrant Labour in Singapore

Since the 1980s, the government's policy of controlling immigration and allocating the inflow of foreign workers to sectors in which they are most needed has depended primarily on two key instruments: sector-specific "dependency ceilings" limiting the proportion of foreign staff in a company, and a monthly foreign worker levy imposed on employers for each foreign worker hired on a Work Permit or an S Pass. The dependency ceiling for the construction sector is currently seven foreign workers to each local full-time worker while the ratio for the marine sector is five foreign workers to one local full-time worker.⁵⁷

Foreign worker levies for workers hired on Work Permits or S Passes are paid to the government each month in addition to the workers' monthly salary. Levy amounts are determined by workers' qualifications. Moreover, for companies in the manufacturing and services sectors, the levy per worker increases with the proportion of foreign workers in their workforce. The quantum of the levy has been increased gradually for all sectors in response to the increasing demand for foreign labour. In an attempt to tighten the inflow of foreign workers and encourage employers to turn to less labour-intensive methods of production and operation, the government has committed to raising foreign worker levies every 6 months between July 2011 and July 2013. The current levy for construction workers is between SGD 250 – SGD 500 (USD 204 – USD 408) per worker per month, while the current levy for FDWs is SGD 295

⁵⁶ More details are available in the report "Projection of Foreign Manpower Demand for Healthcare Sector, Construction Workers and Foreign Domestic Workers", an Occasional Paper released by the National Population and Talent Division, Prime Minister's Office, November 2012.

⁵⁷ Ministry of Manpower (n.d.a). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/foreign-worker-levies/Pages/levies-quotas-for-hiring-foreign-workers.aspx>, accessed 18 November 2012.

(USD 241) per month.⁵⁸ However, levy concessions are available for families demonstrating a specific need for FDWs because of young children, aged family members, or family members with special needs.

The dependency ceiling and the foreign worker levies have remained the two instruments with which the government has regulated worker inflow in line with changes in domestic labour market conditions.⁵⁹ In the case of Work Permit holders (except for Malaysians), the imposition of a SGD 5,000 (USD 4,077) security bond payable by employers to the government also seeks to ensure that the workers do not seek to permanently settle in Singapore and must be repatriated when their contracts terminate. The security bond is also forfeited if any conditions of the Work Permit are violated (for instance if an FDW becomes pregnant).

Recent Amendments to Employment of Foreign Manpower Act (EFMA)

In November 2012, the Ministry of Manpower (MOM) implemented several changes to EFMA, aimed at enhancing the government's ability to "ensure the integrity of Singapore's work pass framework", and ensure that errant companies are deterred from exploiting foreign workers and denying Singaporeans jobs by circumventing existing regulations. In the face of tighter policies on the hiring and retention of foreign workers, errant employers were found to circumvent work pass regulation using several methods such as declaring higher salaries than paid to their foreign workers, illegally passing on the cost of the foreign worker levy and insurance premiums to them, and hiring "phantom" local workers to meet the required local to foreigner staff ratios. Exploitative syndicates were also profiting from setting up sham businesses to illegally import and supply foreign workers, devising increasingly complex schemes of evading the MOM's enforcement approaches.⁶⁰

Amendments to the EFMA have thus been introduced to expedite enforcement action taken against different contraventions by errant employers, workers and syndicates. They include a substantial increase in penalties for kickbacks and a "presumption clause" under which money taken from foreign workers are considered kickbacks unless an employer can prove that they are lawful salary deductions.⁶¹

⁵⁸ Ministry of Manpower (n.d.a).

⁵⁹ Prema-Chandra Athukorala and Chris Manning (2000). "Hong Kong and Singapore: City-States Shaped by Migrants". *Structural Change and International Migration in East Asia: Adjusting to Labour Scarcity*. Oxford University Press.

⁶⁰ There has been some limited recent media coverage on exploitative industry practices such as the extraction of illegal fees and kickbacks from workers. See for example, Radha Basu, "Bosses exploit foreign workers", *The Straits Times*, 12 August 2012 and Candice Neo & Radha Basu, "Complaints of vague clauses and illegal penalties", *The Straits Times*, 10 June 2012

⁶¹ More details available at the Ministry of Manpower website. Retrieved from: <http://www.mom.gov.sg/foreign-manpower/amendments-to-the-efma/Pages/default.aspx>, accessed 18 November 2012

Types of Migrant Workers

Documented Migrant Workers

In June 2012, Singapore's total population was 5.31 million including 1.49 million non-residents.⁶² Singapore's total foreign workforce makes up close to 40% of the total workforce and consists of workers under three types of work passes: Employment Pass, S Pass and Work Permit. The conditions of each pass are detailed below:

Table 4: Singapore Work Pass Framework⁶³

Type of Work Pass	Eligibility
Employment Pass	Fixed monthly salary of more than SGD 3,000 (USD 2,446). Possess acceptable degrees, professional qualifications or specialist skills. The Ministry of Manpower (MOM) evaluates each application and qualification on its merits.
S Pass	For mid-level skilled foreigners who earn a fixed monthly salary of at least SGD 2,000 (USD 1,631). S Pass applicants will be assessed on a points system, taking into account multiple criteria including salary, education qualifications, skills, job type and work experience.
Work Permit	For low-skilled or semi-skilled foreigners who earn a monthly salary of not more than SGD 2,000 (USD 1,631). The duration of a Work Permit is generally two years, subject to the validity of the worker's passport, the banker's/insurance guarantee, and the worker's employment period, whichever is shorter. The worker is only allowed to work for the employer within the specified occupation.

Source: Ministry of Manpower

Singapore's 931,200 Work Permit holders comprise 75% of the total foreign workforce, and this study focuses on them – as low-wage migrant workers in low or semi-skilled manual jobs such as the 277,600 employed in construction. It also includes 208,400 women employed as live-in foreign domestic workers (FDWs), colloquially referred to as “maids”.⁶⁴

Work Permit holders excluding foreign domestic workers (FDWs) comprise almost half of Singapore's non-resident population, at 46%, FDWs make up 13%, Employment Pass holders 12%, S Pass holders 9%, students 6%, and the dependents of citizens, PRs and work pass holders 15%.⁶⁵

Migrant workers who come to Singapore under a Work Permit are employed in low-wage jobs shunned by Singaporeans, thus they help to bridge the gap between the high demand for workers needed to fill labour-intensive jobs and a limited supply of local labour. In the public discourse, they are referred to as “foreign workers”, which distinguishes them from more highly skilled foreigners in Singapore's workforce, who are referred to as “foreign talent”.

⁶² Source: Singapore Department of Statistics, Ministry of Manpower

⁶³ More details available at Ministry of Manpower website. Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/Pages/default.aspx> on 18 November 2012.

⁶⁴ Source: Singapore Department of Statistics, Ministry of Manpower

⁶⁵ Source: Singapore Department of Statistics, Ministry of Manpower

Typically, “foreign workers” are employed in construction, low-skilled manufacturing, shipyard and marine industries, and service sector jobs including domestic work, healthcare, retail, entertainment and hospitality. Countries of origin of workers are mainly Malaysia, People’s Republic of China, Bangladesh, India, Thailand and Myanmar. FDWs mainly come from Indonesia, the Philippines and Sri Lanka. Smaller numbers come from India, Myanmar, Bangladesh, Thailand, Nepal and Pakistan. Approximately one in five Singapore families hires a live-in FDW.⁶⁶

Permit holders are subject to the most restrictions compared to those on Employment or S Passes, with regard to their rights to family⁶⁷: They may not bring family members with them,⁶⁸ and must obtain approval by the MOM before marriage to a Singapore citizen or permanent resident, both during and after the validity period of their Work Permit. Female Work Permit holders are also not allowed to become pregnant and give birth in Singapore (unless already married to a citizen, with prior approval).⁶⁹

Undocumented Migrant Workers

Limited data is available on Singapore’s “undocumented migrant workers”, defined as those who have typically entered Singapore on a tourist visa, and then stayed on illegally to work. In 2009, 3,760 such “over-stayers” were arrested. This is a much lower figure than the 12,000 caught about two decades earlier.⁷⁰ Those found to have spent three or more months in Singapore illegally are deported.

⁶⁶ AsiaOne (2012) “Maids to get weekly rest days”. Retrieved from: <http://news.asiaone.com/News/Latest+News/Singapore/Story/A1Story20120305-331728.html>, on 18 November 2012

⁶⁷ Only Employment Pass holders and selected S Pass holders (those earning a minimum of SGD 2,800/USD 2283 monthly) are eligible for “Dependent’s passes”, issued to their spouses and children under the age of 21, entitling them to come to live in Singapore with the work pass holder. Further details of discrimination and human rights violations faced by non-citizens particularly low-wage migrant workers, undocumented migrants, asylum seekers and foreign spouses can be found in the ‘Joint Submission by members of Solidarity for Migrant Workers for the 11th Session of the Universal Periodic Review’, May 2011, a report submitted by a coalition of NGOs promoting rights of the migrant community in Singapore through research, welfare services and advocacy.

⁶⁸ Ministry of Manpower (n.d.b). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/dependant-pass/before-you-apply/Pages/default.aspx>, accessed 18 November 2012

⁶⁹ Ministry of Manpower (2012) ‘Employment of Foreign Manpower (Work Passes) Regulations 2012’: Fourth Schedule, Conditions and regulatory conditions of work permit, Part V: Conduct. Retrieved from: <http://www.mom.gov.sg/Documents/services-forms/passes/WPSPassConditions.pdf>, on 18 November 2012

⁷⁰ Teh Joo Lin, “Broken dreams, tough life for overstayers”, *The Straits Times*, 2 August 2010

Policy Review: Inclusion and Exclusion of Migrant Workers

Migrant Workers' Inclusion in the Healthcare System and Labour Protection

Medical examination⁷¹

A Work Permit is only issued if the foreign worker in question passes a mandatory medical examination by a registered doctor within fourteen days of arrival in Singapore. Screening is done for four types of infectious diseases – tuberculosis (TB), HIV, syphilis and malaria – which are of concern to public health. The worker must also be deemed fit to work at the point of the examination. A foreign worker is repatriated if he/she is unable to pass the medical examination, or has been diagnosed with either active pulmonary TB and/or HIV. Employers are able to obtain the results of the medical examination directly from the doctor, without their workers' consent.

Foreign domestic workers are additionally required to go for a six-monthly medical examination to screen for infectious diseases and pregnancies. Pregnancy would be a legitimate reason for termination of work and immediate repatriation.⁷² A 2010 report found that at least 100 FDWs were sent home every year due to pregnancy, although it was not known how many terminated their pregnancies to avoid repatriation and loss of work.⁷³

Mandatory Medical Insurance and Personal Accident Insurance⁷⁴

Employers are required to purchase and maintain a minimum medical insurance coverage of SGD 15,000 (USD 12,231) per year for each Work Permit holder for inpatient care and day surgery, including hospital bills for conditions that may not be work-related. Employers are prohibited from passing on the costs of purchasing medical insurance to their worker. However, those who wish to arrange for medical treatment co-payment with their worker should ensure that: a) the co-payment amount is reasonable, forming not more than 10% of the Work Permit holder's monthly salary, and b) co-payment is stated explicitly in the Work Permit/ S Pass holder's employment contract or collective agreement, with the worker's consent.

In addition to mandatory medical insurance coverage of at least SGD 15,000 for FDWs, it is compulsory for their employers to take up a Personal Accident Insurance policy, with a minimum sum assured of SGD 40,000 (USD 32,616), for their FDWs before they are employed. Any compensation would be payable to her or her beneficiaries.

⁷¹ Ministry of Manpower (n.d.c). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fw/when-you-apply/Pages/medical-examination.aspx>

⁷² Ministry of Manpower (n.d.d) . Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fw/inform-mom/Pages/medical-examination.aspx>

⁷³ "Liew Hanqing, 100 pregnant maids sent home a year", The Straits Times, 29 Sep 2010

⁷⁴ Ministry of Manpower (n.d.e). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fw/before-you-apply/Pages/medical-insurance.aspx>

Ministry of Manpower (n.d.f). <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fw/before-you-apply/Pages/default.aspx>

Provisions for Well-Being and Medical Care of Foreign Workers⁷⁵

Employers are responsible for bearing the costs of their workers' "upkeep and maintenance" in Singapore, including the provision of medical treatment. In addition, they must bear any medical expenses incurred for medical examinations required by the MOM. Employers are expected to ensure that their workers are provided with adequate food, acceptable accommodation and safe working conditions.

Retrofitting of Transport Lorries to Protect Travelling Workers

It is common practice in Singapore for construction companies to ferry their workers to and from their worksites in the back of lorries. As a result an overturning of an open-deck lorry in 2010 and several other fatal accidents, tighter regulations on lorry safety were introduced in 2011 aimed at better protecting workers – all lorries used to ferry workers were required to be retrofitted with canopies and higher side railings. Lorry owners failing to comply could be fined SGD 1,000 (USD 815) or jailed for a maximum of three months. It was reported that the effect of these safety enhancements was a decline from 90 injuries and fatalities in the first half of 2010 to 50 in the first half of 2011.⁷⁶

However, some have noted that even with enhanced rules, the practice of ferrying workers in lorries continues to be unsafe. While most developed nations have banned the risky practice of "transporting humans like cargo" by ferrying workers on the back of lorries, an earlier transport workgroup organised by the MOM and the Land Transport Authority in 2010 had found that disallowing lorry transport of workers would raise transport costs significantly for many firms, and heavily impact those operating on narrow profit margins.⁷⁷

Exclusion of Migrant Workers

Legislative Exclusion of Foreign Domestic Workers

FDWs are excluded from the Employment Act, which specifies minimum rest days, hours of work, overtime entitlements, annual leave and medical leave. MOM has justified this exclusion based on the nature of domestic work in private households, making it impractical to regulate and enforce standard terms and conditions of work.⁷⁸ It would be legal for instance for a FDW to work every day of the year without a single day off.⁷⁹

In a recent reversal, the government introduced a mandatory weekly rest day for FDWs, effective in January 2013 for all new and renewed Work Permits. In his parliamentary speech, Minister of State for Manpower Tan Chuan-Jin said that this "basic labour right" would provide FDWs not simply physical rest, but also "an emotional and mental break from work". However, some have observed the potential limits of this new legislation, since employers are given the flexibility of compensating their FDWs with extra pay should they agree to forgo their weekly rest day, or replacing a rest day within the same month.⁸⁰

⁷⁵ More details available in the Employment of Foreign Manpower Act: Conditions and regulatory conditions of work permit. Retrieved from: <http://www.mom.gov.sg/Documents/services-forms/passes/WSPassConditions.pdf>

⁷⁶ Royston Sim (2011) "Fewer casualties with stiffer lorry ferrying rules", *The Straits Times*, 2 August 2011

⁷⁷ Radha Basu (2010) "Getting street smart on worker transport safety", *The Straits Times*, 30 June 2010

⁷⁸ Ministry of Manpower, "Employment Laws and Contracts". Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx>

⁷⁹ 'Joint Submission by members of Solidarity for Migrant Workers for the 11th Session of the Universal Periodic Review', May 2011, Point 32

⁸⁰ Ministry of Manpower website, "Well-being: Weekly Rest Day". Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx>

FDWs are also excluded from the Work Injury Compensation Act (WICA), which provides both local and foreign workers with compensation for workplace injuries and occupational illnesses.⁸¹ Although they are covered by mandatory medical and personal accident insurance, the extent of coverage and benefits are less favourable than those accruing to other low-skilled workers covered by WICA.⁸²

Vulnerability to Injuries and the Work Injury Compensation Act⁸³

While disaggregated data on workplace injuries for foreign workers is currently unavailable, incidents reported in the construction, marine and manufacturing sectors may disproportionately accrue to migrant workers compared to local workers since they constitute vast numbers in these sectors.⁸⁴ The construction industry appears to be the most accident-prone, being responsible for more than a third of workplace fatalities in 2011.

In recent years, falls from height and lapses in crane safety have been identified as two key contributors to fatalities, injuries and accidents. It was also noted that the costs to the construction sector for lapses in safety was the loss of man-days from workers injured on the job: 260,000 man-days were lost in 2009 due to injuries, 20% more than the 216,000 the year before. Migrant advocacy group Humanitarian Organisation for Migration Economics (HOME) noted that the link between work accidents and long working hours of construction workers must also be investigated, since it was common for many to work 12 or more consecutive hours, with some even working 24-hour shifts, making them vulnerable to safety lapses and accidents.⁸⁵

In this context, the Work Injury Compensation Act provides injured foreign workers with a low-cost, “no-fault” process by which they can settle their compensation claims, as an alternative to pursuing a civil suit against their employer or a negligent third party. Three compensation benefits can be claimed under WICA: a) medical leave wages, b) medical expenses, and c) lump sum compensation for permanent incapacity or death.

A worker is entitled to a WICA claim if he/she is injured in an accident or suffers a disease due to work. This includes any accidents “arising out of in the course employment”, such as if the worker slips and falls within the company’s premise or if he meets with a traffic accident while taking company transport to and fro the workplace. The worker does not need to engage a lawyer in order to file a claim.

Under WICA, the worker’s employer (or employer’s insurer) would be liable to pay the compensation regardless of who caused the accident or disease, even after the validity period of the worker’s work pass. Dependents of deceased workers are also eligible to claim Work Injury Compensation.

⁸¹ Ministry of Manpower, “Who is covered under the Work Injury Compensation Act?” Retrieved from: <http://www.mom.gov.sg/workplace-safety-health/work-injury-compensation/Pages/WICcovered.aspx>

⁸² As noted in the ‘Joint Submission by members of Solidarity for Migrant Workers for the 11th Session of the Universal Periodic Review’, May 2011, Point 31.

⁸³ Ministry of Manpower and Work Safety Health Council, *Work Injury Compensation: A Guide for Employers*, p. 6-7.

⁸⁴ See table on “Growth rates of Employment in Singapore, 2006 – 2011” on p.3

⁸⁵ Daryl Chin, “Safety issue in construction despite efforts”, *The Straits Times*, 3 July 2010

The alternative to a WICA claim would be for the worker to file a civil suit against the negligent party – either his employer or a third party – for damages under common law. However, he and his lawyer would need to prove that his injury was caused by their negligence.

While WICA compensation is subject to caps and computed based on a fixed formula taking into account the age, qualifications and severity of injuries sustained by the worker, under common law a worker must substantiate the amount of damages before the Courts that are not subject to caps.

As of 1 June 2012, the MOM increased WICA compensation limits as part of a regular review to account for changes in wages and healthcare costs as can be seen in Table 5.

Table 5: Updated Work Injury Compensation Limits

	Limits	Limit before 1 June 2012	Limit after 1 June 2012
Death	Minimum	SGD 47,000	SGD 57,000
	Maximum	SGD 140,000	SGD 170,000
Total Permanent Incapacity*	Minimum	SGD 60,000	SGD 73,000
	Maximum	SGD 180,000	SGD 218,000
Medical Expenses		Up to SGD 25,000 or 1 year from date of accident, whichever is reached first	Up to SGD 30,000 or 1 year from date of accident, whichever is reached first

Source: Ministry of Manpower

*Excludes additional 25% compensation paid to workers with total permanent incapacity to offset the cost of care for the injured worker.

Other Key Changes to Work Injury Compensation

Apart from the update to compensation limits, other key changes to WICA effective 1 June 2012 included the following:

- a) *Disallowing compensation for work-related fights:* except in certain scenarios such as where the worker was a victim and did not participate in the fight.
- b) *Expanding the scope of compensable diseases:* occupational disease resulting from exposure to excessive heat and diseases contracted due to work-related exposure to chemical or biological agents are now compensable, SARS and avian influenza removed.
- c) *Disallowing work-related exclusion clauses:* now prohibited for the purpose of WIC insurance, ensuring that insurers are liable for compensation even if work-related exclusions exist in the policy.
- d) *Clarifying the liability of employer's insurer to pay when there are multiple insurance policies:* to prevent disputes over liability among various insurers and expedite compensation paid to injured workers.
- e) *Clarifying the timeframe for filing a claim if one wishes to claim under WICA after having filed a common law claim earlier:* Injured workers have up to one year from their accident date to decide whether to file a claim under WICA, or switch to WICA after filing a common law claim.

Policy Gaps in Health and Medical Provisions⁸⁶

Foreign Workers Left Income-less during the WICA Claim Process

The Work Injury Compensation Claim Process can be a lengthy one for many workers, lasting from a few months to over two years.⁸⁷ The process of assessing permanent incapacity and a final compensation amount only commences after the injured worker's medical treatment is completed. The employer's ability to raise objections to the assessment of incapacity and compensation payable can protract the process further. Under WICA, workers are entitled to medical leave wages expected to tide them over the period of their medical leave.⁸⁸ However, in reality, injured workers who seek welfare services often report that they receive no legally mandated medical leave wages at all.⁸⁹

Seriously injured workers also routinely see their Work Permits cancelled by their employers so that they are not subject to the monthly foreign worker levy. Such workers are issued a "Special Pass" by the MOM to facilitate their legal stay in Singapore for the duration of their WICA compensation assessment. The injured worker may not seek employment under a Special Pass, even after his medical leave comes to an end. As a result, many foreign workers face difficulties surviving from day-to-day in the absence of any income, and resort to incurring debts or taking on illegal jobs for their daily expenses and medical treatment. This happens in spite of employers' responsibility over their foreign workers' "upkeep and maintenance", including the provision of food and medical treatment under the law.⁹⁰ Enforcement in this area has regrettably been weak.

A limited study in 2012 suggested that the mental health of foreign workers was negatively affected by the "limbo" caused by the lengthy process of waiting for WICA compensation.⁹¹ Many showed signs of clinical depression as they waited income-less for the conclusion of their cases, with the knowledge that their families depended on them for income. The study noted that depression and poor emotional well-being could also adversely affect the physical recovery of injured workers and their ability to deal with problems.

⁸⁶ NGOs assisting migrant workers have been instrumental in the research, particularly in identifying gaps in the provision of medical care for low wage migrant workers, and how the reality faced by workers requiring medical treatment diverge from how they are covered under the law.

⁸⁷ Migrant workers NGO TWC2 operates a daily food programme catering to destitute migrant workers out of work due to injuries and/or disputes with their employers. Of the injured workers who registered for meals in 2011, the median length of stay in the food programme – a proxy for the duration of the process for medical treatment and WICA assessment – was six or seven months, with a small number remaining around 18 months or more after their accident date. See Debbie Fordyce, "Injured workers' length of stay", TWC2 website. Retrieved from: <http://twc2.org.sg/2012/01/12/cuff-road-project-2011-injured-workers-length-of-stay/>

⁸⁸ Under WICA, foreign workers should receive full pay for working days covered by up to 60 days of hospitalisation leave or 14 days of outpatient MC days, and two-thirds of their pay afterwards, for up to a year, see Ministry of Manpower and Work Safety Health Council, *Work Injury Compensation: A Guide for Employers*, p.3

⁸⁹ See Alex Au, "Injured workers fall through upkeep gap", TWC2 website. Retrieved from: <http://twc2.org.sg/2012/01/08/injured-workers-fall-through-upkeep-gap>.

⁹⁰ See Employment of Foreign Manpower Act, Fourth Schedule, Part III, Clause 16: "The employer shall continue to be responsible for and bear the costs of the upkeep (including the provision of food and medical treatment) and maintenance of the foreign employee in Singapore who is awaiting resolution and payment of any statutory claims for salary arrears under the Employment Act, or work injury compensation under the Work Injury Compensation Act. The responsibility shall cease upon resolution and payment of the statutory claim or work injury compensation." Retrieved from: <http://www.mom.gov.sg/Documents/services-forms/passses/WPSPassConditions.pdf>

⁹¹ See Anita Mehay, "88% of migrant workers caught in 'limbo' show signs of clinical depression", TWC2. Retrieved from: <http://twc2.org.sg/2012/02/28/88-of-migrant-workers-caught-in-limbo-show-signs-of-clinical-depression/>

Dependence on Employer's Letter for Medical Treatment Force Foreign Workers to Bear Costs

Foreign workers depend on a 'Letter of Guarantee' (LOG) furnished by their employer in order to receive a waiver of upfront fees payable to clinics and hospitals at which they seek medical treatment. This document is required for every medical procedure or appointment needed by a worker. Although employers are responsible under the law for the costs of any necessary medical treatment – including hospital bills arising from medical conditions that may not be work-related – many shirk their responsibilities by refusing to provide the LOG, forcing workers to either forgo medical treatment or bear the cost on their own, often incurring mounting debts in the process. NGOs have also reported on the inefficiency, and administrative time and effort expended by those providing intervention on such workers' behalf to obtain these documents from their employers. This has resulted in the cancellation or postponement of medical appointments when workers are unable to obtain an LOG. In spite of public reminders by the MOM that employers are responsible for bearing the costs of their foreign workers' medical treatment,⁹² there has been no publicised enforcement to date against errant employers who fail to do so.

Medical Expenses over SGD 30,000: "No-man's Land"

Revised WICA compensation limits as of June 2012 raised the cap for employers' liability over injured workers' medical expenses to SGD 30,000 from SGD 25,000. Aiming to "maintain a fair balance between compensation for workers and the obligation placed on employers and insurers", the MOM justified the new limits for medical expenses as being able to fully cover more than 95% of claims where hospitalisation is required, while the one-year cap is adequate for most injuries that typically stabilise within a year of treatment.⁹³ While the cap of SGD 30,000 would be sufficient to cover most workplace accidents, NGOs providing welfare services to migrant workers have found that accidents requiring lengthy hospitalisations and/or multiple operations result in a gap faced by severely injured workers whose medical expenses breach the ceiling.

Table 6: Public hospital daily charges for Singapore citizens, permanent residents and others

	A Single bed	B1 Four beds	B2 Six beds	C Open ward
Acute ward				
- Singapore Citizen	229.60	185.00	58.00	30.00
- Permanent Resident	229.60	206.51	102.00	68.00
- Others	229.60	235.61	203.30	177.62
Intensive care				
- Singapore Citizen	545.70	480.00	150.00	90.00
- Permanent Resident	545.70	528.58	257.00	202.00
- Others	545.70	545.70	545.70	545.70

Source: Compiled by TWC2⁹⁴

⁹² See letter to the press issued by the Ministry of Manpower in "Bosses must pay foreign workers' medical bills", *The Straits Times*, 23 March 2012

⁹³ Workers who cannot afford or wish not to bear the excess medical expenses above the SGD 30,000 limit can choose to pursue a common law case (as detailed in the section on 'Work Injury Compensation Act') and attempt to recover their full medical expenses. However, a court process would entail additional legal costs and a long process of waiting. Needy workers requiring urgent care may also apply to the hospital for financial assistance but this is on a case-by-case basis.

⁹⁴ See Debbie Fordyce, "Mind the gap, no system in place to help workers needing costly medical care", *Transient Workers Count Too (TWC2) website*, 20 October 2012. Retrieved from: <http://twc2.org.sg/2012/10/20/mind-the-gap-no-system-in-place-to-help-workers-needing-costly-medical-care/>

Since 2007, healthcare subsidies at public hospitals and healthcare institutions have been removed completely for all non-residents (non-Singapore citizens and non-PRs). This resulted in medical charges that do not distinguish between the financial means of medical tourists from abroad, highly remunerated Employment Pass holders, and low-wage foreign workers. The table above shows how as “Others”, migrant workers cared for in the cheapest ‘C’ class open ward face hospitalisation costs about six times that of Singapore citizens.

This accounts for why medical expenses for seriously injured workers can quickly breach the SGD 30,000 ceiling, as any additional medical charges and procedures are also unsubsidised. The responsibility towards any medical expenses exceeding SGD 30,000 now lies in a virtual “no man’s land”, relying on the selective goodwill rather than legal obligations of employers particularly since there is no medical emergency fund for foreign workers.

Foreign Workers’ Medical Problems – Who Pays?⁹⁵

Foreign workers recuperating from injuries may also sometimes face difficulties obtaining fair compensation under WICA for permanent incapacity suffered. Secondary medical conditions may not show symptoms that are apparent at first, but arise months after an accident, discovered only in the course of workers’ recovery from severe injuries. However, to determine if such secondary problems arose from the initial accident, medical tests are necessary.

A problem results when the employer refuses to pay for the tests in the absence of positive proof that the secondary problems are work accident-related. This presents a difficult situation for workers unable to pay for often costly medical tests on their own, without which the hospital cannot proceed to prove that the secondary problems arose from the accident.

Other Health Issues Identified by Joint Report Submitted to the Universal Periodic Review in May 2011⁹⁶

- *Lack of access to medical/health services:* Due to the removal of subsidised medical care for migrant workers since 2007, many are denied medical insurance/treatment by errant employers, contrary to official policy, and due to inconsistent enforcement. In the worst cases, workers seeking potentially costly medical treatment due to serious injury are repatriated by errant employers.
- *Living conditions:* Some workers are housed cramped, poorly equipped and ventilated and/or unhygienic living quarters and inadequate nutrition.
- *Long hours:* It is not uncommon for construction, marine and service sector workers to work 12–16 hours a day, breaching legislation on maximum hours of work, which depends on industry but generally should not go beyond 12 hours. Less demanding work is allowed as long as overtime compensation is paid
- *Psycho-social health of FDWs:* For HOME, an NGO providing shelter housing for FDW, well-being violations included inadequate food or accommodation (43%), psychological abuse (30%) and non-payment of salary (14%).

⁹⁵ This policy gap was raised in a letter to the press by migrant workers’ advocacy NGO TWC2: Debbie Fordyce, “Foreign workers’ medical dilemma”, *The Straits Times*, 25 October, 2012. Retrieved from: <http://twc2.org.sg/2012/10/25/letter-in-straits-times-foreign-workers-medical-dilemma/>

⁹⁶ ‘Joint Submission by members of Solidarity for Migrant Workers for the 11th Session of the Universal Periodic Review, May 2011

Stakeholder Analysis

This section provides a comprehensive list of stakeholders relevant for the Singapore analysis. A discussion for each stakeholder is given to provide in-depth analysis. Identified through referrals and visits to major voluntary organisations providing social and health-related services and government agencies, stakeholders were interviewed in order to understand their support for and/or apprehension of the existing policies pertaining to the health of migrant workers.

The following organisations were selected as recognised services providing medical clinics, financial aid, legal assistance, shelters and meal programmes to migrant workers:

- 1) Centre for Migrant Workers (CMW)
- 2) HealthServe
- 3) Humanitarian Organization for Migrant Economics (HOME)
- 4) Transient Workers Count Too (TWC2)

The government agencies interviewed for this report were:

- 1) Ministry of Manpower
- 2) Ministry of Health

The analysis is both based on a literature review of local migration and health studies and news articles, and was undertaken with the status quo in mind.

Government Agencies

Ministry of Manpower

The Ministry of Manpower is the primary ministry of the Government of Singapore that directs the formulation and implementation of policies related to manpower (both foreign and local) in Singapore. Its mission is: “To develop a productive workforce and progressive workplaces, for Singaporeans to have better jobs and a secure retirement.⁹⁷” However, given the manpower shortage in Singapore, they understand that Singapore needs foreign workers in order to sustain its economy.

In 2012, there has been an increase in the projected amount of foreign labour force by the National Population and Talent Division under the Prime Minister’s Office⁹⁸. Hence, there is a need for the ministry to balance the interests of all stakeholders including the employers, the Singapore public, and the workers. On one hand, it is its task to attract the foreign workers to come to Singapore by providing them incentives to choose Singapore over other countries. On the other hand, it needs to ensure that policies regarding the safety and well-being of workers remain acceptable to the employers who will in the end bear the costs under the current framework. Moreover, it is also their task to ensure that costs are not passed on to the Singaporean public through unpaid medical bills, unproductive labour, and inefficient

⁹⁷ Ministry of Manpower Website. *Mission* - Ministry of Manpower. Retrieved from: <http://www.mom.gov.sg/aboutus/Pages/vision-mission-values.aspx> on 27 June 2013.

⁹⁸ More details are available in the report “Projection of Foreign Manpower Demand for Healthcare Sector, Construction Workers and Foreign Domestic Workers”, an Occasional Paper released by the National Population and Talent Division, Prime Minister’s Office, November 2012.

services. In recent years, the Singaporean government has been feeling the pressure from the populace due to what is perceived as overly migrant-friendly policies. However, those who show opposition to such policies are seen as “xenophobic”.⁹⁹

Ministry of Health

The principal mandate of the Ministry of Health is to oversee the health of the Singaporean population. Policies related to the health of migrants, such as repatriation, are made to ensure that any disease or infection does not spread to the rest of the populace. Higher medical costs for foreigners are reflective of the market price because they are not covered under government’s subsidy for Singaporean citizens but should be under the responsibility of employers via medical insurance.

Employers

Employers, as owners of business firms, generally seek to maintain competitiveness and productivity to earn as much profit as they can. Hence, it is in their interest that wages are low, regardless of nationality. Indeed, the demand of employers for workers is elastic. Despite the foreign worker levy and other policies put in place to encourage the hire of Singaporeans over foreign workers, companies still prefer to hire the latter because their wages remain lower than Singaporeans. Hence, recent government efforts to curb the influx of foreign workers in Singapore have already negatively affected employers.¹⁰⁰

As discussed earlier, minimum safeguards for the well-being of migrant workers, including medical tests, medical insurance, and injury compensation are provided under existing laws. Yet, also under the law, migrant workers are the sole responsibility of their employers. In the official blogpost of the Ministry of Manpower (MOM), the Minister said that employers must not only look at the wages “without caring for workers welfare and well-being” because it is not in accordance with Singapore’s values. He further said that “good management matters” and that “by taking care of workers, they would be more productive and committed”.

However, there have been instances of perceived discrimination against migrant workers by employers and reported violation of MOM’s reminder “that taking care of workers for them to be more productive and committed”. In 2012, about 180 Chinese bus drivers protested against their employer SMRT due to pay differences with their Malaysian colleagues and poor living conditions in their dormitory¹⁰¹; 5 were charged in court and jailed for instigating the strike and 29 others were deported back to China¹⁰² since the strike was considered to be illegal.

⁹⁹ AsiaOne Online. *Population White Paper Debate: Who’s Xenophobic?* Retrieved from <http://www.asiaone.com/News/Latest%2BNews/Singapore/Story/A1Story20130221-403658.html> on 27 June 2013

¹⁰⁰ Ghosh, Phalash (2013) Singapore Seeks To Cut Quota On Foreign Workers Amid Worries Over Immigration, Rising Labor Costs. *International Business Times*. Retrieved from: <http://www.ibtimes.com/singapore-seeks-cut-quota-foreign-workers-amid-worries-over-immigration-rising-labor-costs-1103229> on 27 June 2013.

¹⁰¹ Sim, Royston (2012) SMRT bus drivers say they are unhappy with pay, living conditions, *Straits Times*. Retrieved from: <http://www.straitstimes.com/breaking-news/singapore/story/smrt-bus-drivers-say-they-are-unhappy-pay-living-conditions-20121126> on 26 December 2012.

¹⁰² Almenoar, Maria (2012)/ Four SMRT bus drivers from China charged with instigating strike granted bail, *Straits Times*. Retrieved from <http://www.straitstimes.com/the-big-story/smrt-bus-driver-dispute/story/four-smrt-bus-drivers-china-charged-instigating-strike-g> on 26 December 2012.

Although a big case such as this gets reported in the media, it is barely the tip of the iceberg. Indeed, since firms would generally want to lessen costs incurred, very rarely do they go beyond the limits of medical insurance and they often withhold the letter of guarantee. Anything that incurs additional cost – even in terms of food and housing – employers would tend to avoid. Hence, when foreign workers cause too much trouble, including high medical fees due to accidents in the work place, the usual recourse is repatriation for their migrant workers. To them, it is easier and cheaper to hire a new worker than to maintain an older one who is considered less productive. This situation is possible due to the supply surplus of cheap foreign labour. Furthermore, the Singaporean government has provided employers with the ‘ease of doing business’ and as a corollary, becomes lenient in enforcement of regulations.

Migrant Workers

Migrant workers are the most affected among the stakeholders but they have the least voice, power and resources. They are considered as substitutable goods since there is a huge supply of labour abroad. Yet, even if the Singapore immigration policies ensure that they remain transient workers, they continue to be an important factor in keeping Singapore a vibrant economy. The Singaporean government has already projected an increase in demand for migrant workers in the coming years.¹⁰³ However, a concurrent decrease in supply may also occur as the economies of the current sending countries pick up and Singapore also faces competition with other receiving countries.¹⁰⁴ Employers in Singapore can thus substitute with other sources of cheaper labour, or trade-off with higher prices for the increased wage costs.

Usually unaware of their rights in their new environment, migrant workers are at the mercy of their employers, as revealed by the face-to-face interviews. Most of them come to Singapore in search of a better future and are often the breadwinners of their respective families at home. Remittances sent home monthly serve as a huge incentive to work abroad. However, there is loss of productivity if they encounter any sickness or incapacity while working. They would have otherwise been earning about SGD 20/day and not incurring short-run costs for the firm. If the injury is serious, they may even be unable to work even after they go back to their home country.

Non-Government Organisations

The role of volunteer organisations, such as HOME and Transit Workers Count Too, remains highly important as foreign workers are without constituency and representation in Singapore. The NGOs are the ones who look after their welfare, serving free meals and offering shelter for those who have problems with their employers. They also serve as the voice of migrant workers, often providing assistance regarding bureaucratic procedures. The lack in clear

¹⁰³ More details are available in the report “Projection of Foreign Manpower Demand for Healthcare Sector, Construction Workers and Foreign Domestic Workers”, an Occasional Paper released by the National Population and Talent Division, Prime Minister’s Office, November 2012.

¹⁰⁴ A publication of the International Organization for Migration in 2009, Prospects for Outward Migration Flows: China and Southeast Asia (ILO Asian Regional Programme on Governance of Labour Migration Working Paper No.24.), authored by Geoffrey Ducanes and Manolo Abella examined the various factors that are likely to influence the flows of migration in the Asian region. It finds that while current migration trends are likely to continue in the short-run, changing demographics, economic, and socio-political factors can shape it in the long run http://www.ilo.org/wcmsp5/groups/public/-asia/-ro-bangkok/documents/publication/wcms_105095.pdf

leadership with regard to this matter has caused several non-governmental institutions to occupy the vacuum. Although not a direct stakeholder, they are an important part of the equation because they often are very vocal with their displeasure with government policies.

The Humanitarian Organization for Migration Economics (HOME)

The Humanitarian Organization for Migration Economics or simply known as HOME, is a highly-recognised NGO working for the needs of migrant workers in Singapore. In 2004, it was registered as a society under the Societies Act. It became a member of NCSS and was registered as a charity under the Charities Act of Singapore in 2005. Also in the same year, it was given an Institute of Public Character (IPC) status. It was awarded the Asia Pacific Public Service Award in 2010 by the Asia 21 Society.

Committed to upholding the dignity of persons, HOME provides direct assistance to foreign workers who are victims of unfair labour practices and exploitative treatment from their employers. It has three helpdesks scattered around the island, specifically targeting different sectors of the foreign workers populace. These help desks provide a variety of services including paralegal counselling, conflict resolution, befriending and learning activities. The helpdesk for men primarily reaches out to the construction workers. Majority of the NGO's work is in assisting the workers in reporting offences and violations by errant employers to the relevant authorities. A shelter is provided for those who have run away and/or have been threatened with repatriation. The women's helpdesk primarily reaches out to the sex workers by providing free health consultation and medical check-ups. HOME's FDW volunteers, the ROSES, conduct public awareness campaigns by giving out "gift packs" consisting of condoms, women's health planner and safe sex reminders. Pro bono lawyers, meanwhile, provide paralegal assistance at the legal helpdesk. It also has a 24-hour helpline service which can be reached via call or SMS, which is especially useful for FDWs who reside in their employer's homes and unable to travel to the helpdesks.

With funding support from the Deutsche Bank Foundation, HOME was able to start HOME Campus at the ISS International premises. Catered mostly to FDWs, it offers vocational courses like dressmaking, cosmetology, care-giving, and cooking are offered to help increase their skills. Simple language course in Mandarin and English and basic computer skills are also offered.

HOME is also active on the advocacy front, ensuring that existing laws are enforced to uphold the dignity and rights of workers wherever they come from is central to its mission. Hence, it seeks to serve as the voice for the disadvantaged foreign workers in Singapore; where possible, it serves as mediator in meetings and/or negotiations between workers, their employers and other relevant parties such as agents or MOM officials. More recently, in 2011, HOME created the Human Trafficking Resource Centre to help the Inter-Agency Taskforce on Trafficking in Persons initiated by the Ministry of Home Affairs (MHA) and the MOM. It sought to analyse the link between human trafficking and migrant domestic labour in Singapore.

Transient Workers Count Too (TWC2)

Transient Workers Count Too (TWC2) recognises the contributions of migrant workers to Singapore's society and is "dedicated to assisting these low-wage migrant workers when they are in difficulty." Motivated by a sense of fairness and humanity, they believe that "no worker should be subjected to inhumane or degrading treatment". TWC2 is a registered non-profit

organisation under the Societies Act and a registered charity under the National Council of Social Service (NCSS) and Internal Revenue Authority of Singapore (IRAS). It relies solely on donations.

TWC2's main activity is the Cuff Road Project, a food programme that serves breakfast and dinner during weekdays and lunch during weekends in different restaurants in Little India. Volunteers are present and are tasked to inform foreign workers of their rights and provide advice related to their cases. Most of the cases they get are South Asian men working in the construction industry. Based on personal stories shared by foreign workers, they gather that these workers often suffer unconscionable exploitation in the hands of their employers. Data gathered from the Cuff Road Project shows that foreign workers are commonly exploited through the following:

- Having to pay high agency fees to secure a job in Singapore
- Low wages which are further reduced through illegal deductions
- Unpaid salaries
- Long working hours/no day off
- Doing dangerous work, leading to injuries
- Employers refusing to bear the cost of medical treatment
- Poor accommodation
- Threat of repatriation to the workers' home countries when they are in dispute with their employers over one or more of the above, without employers settling claims

There are 200-300 people who attend the feeding programme daily. Most of those who attend the food programme are in some kind of dispute with their employer and have no means of feeding themselves (accommodations are another story as TWC2 does not have a shelter). Because of the specific profile of the people who attend the programme, TWC2 is able to know the loopholes in Singapore's policies towards foreign workers very well. With this knowledge as advantage, it is able to do a lot of credible advocacy work such as social media campaigns, public talks, and outreach to schools.

The feeding programme serves as the first step in the work that TWC2 does for the migrant workers who seek their help. The service provided afterwards is divided into three types: information and referral, intervention, and case management. Information and referral is the most basic type of service where foreign workers would inquire, usually by phone, about their options given a challenging situation with their employer. Sometimes it is easily resolved when such inquiries are referred to other agencies that would be of more help. Intervention happens when the situation of the worker demands more attention than a brief phone conversation. They are signed up to the Cuff Road Food Program for monitoring purposes and TWC2 represents the welfare of the foreign worker in negotiations with the MOM, employers, police and/or hospital on their behalf. Case management happens when the situation proves to be extremely complicated. A social worker works on the case and ensures that "all options are explored" and the case is not "lost in the bureaucracy". The last two services are dependent of gravity of case and availability of resources. Monetary assistance through the CAREfund is provided in very special cases such as urgent and life-saving medical and surgical treatment.

HealthServe

Established in late 2006, HealthServe is a non-profit community development organisation that primarily provides medical services to foreign workers and needy Singaporeans. It does this through its three community clinics in Jurong, Geylang, and Little India. It is dedicated to serving the poor and disadvantaged in the three local communities where these clinics exist, regardless of their ethnicity, gender, religion and nationality. One of its aim is to foster genuine solidarity amongst the residents of the community by increasing opportunities for social engagement through different projects like the Local Youth Community Program. Since its launch with the opening of the first clinic in Geylang, its services has then branched out to providing legal and counselling advice and a food programme called the Geylang Food Project (GFP) for foreign workers.

HealthServe's major programme is the provision of affordable health services through their health clinics staffed by volunteers. General medical consultation and health check-ups are provided at a heavily subsidised price of SGD 5, inclusive basic consultation and medicine. Charges apply for other medical services such as STD checks, pregnancy tests, and HIV/AIDS testing, laboratory checks, vaccinations and travel immunisations, and pre-employment check-ups. However, as HealthServe is community-based, priority is given to the concerns of the locals. Meanwhile, the medical staff of the clinic, from the doctors, nurses, counsellors, to the clinic assistants, are all also from the same community. There were 50 rotating volunteer medical staff in 2011.¹⁰⁵

Since 2009, HealthServe has serviced almost 200 foreign workers with their work injury-related cases. Seeing that the WICA compensation claim takes months to resolve, other cases relating to the welfare of migrant workers were also initiated. Social community workers help foreign workers as they go back and forth the hospitals and a set of pro-bono lawyers give legal counselling. In the Jurong and Geylang clinics, foreign workers in WICA limbo can avail of free volunteer-taught English and computer classes. In Geylang, the GFP provides free lunch and dinner for Chinese workers who are also in WICA limbo. A Helpdesk was also set up to assist workers with injury and employment issues.

Migrant Workers' Centre (MWC)

In an effort to better understand the plight of Singapore's foreign workers, MWC was set-up in 2009 by the National Trades Union Congress (NTUC) and the Singapore National Employers' Federation (SNEF). According to its official website, its mission is to "champion fair employment practices and the well-being of migrant workers in Singapore". Through the MWC, foreign workers are able to join a trade union with a minimum membership fee of SGD 117 per annum. It pursues three main thrusts: 1) promoting equitable employment practices; 2) promoting social integration through the provision of social support networks and structures; and 3) providing interim humanitarian assistance and aid for distressed migrant workers.

MWC helps migrant workers by providing humanitarian assistance, advice as well as recreational and social activities for them. According to the Chairman of the Migrant Workers' Centre, Mr. Yeo Guat Kwang, more than 4,500 different cases have been handled by the MWC

¹⁰⁵ HealthServe Ltd (2012) Annual Report. Retrieved from: http://webboe.com/websysdocs/F8D_Annual_Report_2011.pdf on 3 January 2013.

since it started in April 2009. Of the 4,500 cases, over 10% of migrants facing such cases needed help with food and housing while they are in WICA limbo.¹⁰⁶ MWC provided for their subsistence, shelter, and other immediate needs.

Another important role it plays is representing migrant workers during negotiations with errant employers in seeking remedies against unfair labour practices.¹⁰⁷ For example, in December 11, 2012, 25 foreign workers, of Indian and Chinese nationality, stopped working in protest of their 4 months' worth of back pay at a construction site in Yishun.¹⁰⁸ In the negotiating table were officials from the Ministry of Manpower, MWC and the company, Sime Chong Construction. While MOM was there to ensure that Sime Chong did not breach any provisions of the Employment Act, MWC was there to ensure the well-being of the migrant workers concerned. The executive director of MWC, Edmund Ng, was quoted as saying, "We came here because we heard there were workers who might be in trouble, and we're here to help." During the night the dispute started, they provided accommodations for the migrant workers involved.

It also provides opportunities for social interaction among migrant workers. MWC opened a recreation centre for migrant worker, which was meant to serve as a "focal point for leisure and recreation". It is also used as a venue to help MWC "understand issues workers face", and encourages community building as they are integrated to the neighbourhood as night patrollers.¹⁰⁹ It also tries to facilitate social acceptance and integration through outreach activities, community engagement, advocacy and public education.

The Archdiocesan Commission for the Pastoral Care of Migrants and Itinerant People

The Archdiocesan Commission for the Pastoral Care of Migrants and Itinerant People (ACMI) is a Catholic non-profit organisation that works for the benefit of migrant workers and itinerants. It was commissioned as Diocesan Migrant Ministry in 1998 by the Roman Catholic Archbishop of Singapore to provide for the "pastoral needs" of all migrants and itinerants in Singapore without regard for their "race, language or religion". According to its website, its main objective is "to give migrants a sense of belonging and security through acts of compassion". To this day, it remains to provide legal and social services to all foreign workers, families of foreign workers, foreign students and transients.

In 2011, they have helped over 3,000 migrants with their specific issues or what they refer to as "casework" services. Casework services range from psycho-social counselling, "befriending network activities among other migrants, legal assistance with the help of the Catholic Lawyers Guild, providing shelter together with the Good Shepherd Centre, and financial aid where appropriate. Apart from providing social services, they also serve as a mediator between employers and their foreign workers. They negotiate with errant employers on behalf of foreign workers and employers also seek their help in dealing with difficult foreign employees. Through

¹⁰⁶ Channel News Asia (2012a) Migrant Workers' Centre welcomes amendments to Employment of Foreign Manpower Act, Channel News Asia. Retrieved from: <http://news.xin.msn.com/en/singapore/migrant-workers'-centre-welcomes-amendments-to-employment-of-foreign-manpower-act>

¹⁰⁷ Channel News Asia (2012b) Migrant Workers' Centre reminds employers of their roles, Channel News Asia. Retrieved from: <http://www.channelnewsasia.com/stories/singaporelocalnews/view/1243545/1/.html> on 26 December 2012

¹⁰⁸ Channel News Asia (2012c). Foreign workers in pay dispute at Yishun construction site, Channel News Asia. Retrieved from: <http://www.channelnewsasia.com/stories/singaporelocalnews/view/1243430/1/.html>

¹⁰⁹ Channel News Asia (2012d). Migrant workers' recreation centre opens at Penjuru, ChannelNewsAsia. Retrieved from: <http://www.channelnewsasia.com/stories/singaporelocalnews/print/1243075/1/.html> on 26 December 2012.

their casework programme, they gather data about the exploitation and the challenges that foreign workers have to face while in Singapore. They also network and work with embassies, government offices, such as MOM, and NGOs working with migrant groups.

ACMI reaches out to Singapore's foreign workers through their Bread Basket Program, a programme that they started in 2010. Every week, volunteers prepare "gift packs" or individual plastic bags consisting of rice, biscuits, juices and personal toiletries. These gift packs are then handed out to different dormitories every Sunday.

In 2001, ACMI opened the ACMI Training Centre where volunteer teachers and experts share their time, knowledge, and talents through different courses offered to FDWs. Courses offered are in the broad fields of beauty and wellness, baking, cooking, caregiving, computer literacy, dressmaking, language (English and Mandarin), hairdressing, and small business enterprise. Students are expected to make a payment of SGD 90 – SGD 100 per course availed.

Case studies and Calculation of Cost

Case SG1: Construction worker with head injury requiring a cranioplasty

M, a 22-year old Bangladeshi migrant worker, first came to Singapore in September 2010, through a SGD 5,400 worth of upfront agent fees his brother paid for by selling a fraction of their land. His first ever work experience was when he came to Singapore – in a construction site which earned him SGD 18/day with no overtime pay. In order to earn more money, he would do some odd jobs on the side. He went back to Bangladesh after a year after his construction contract expired.

In mid-September 2011, he came back to Singapore. He again did construction work, but this time he earned SGD 24/day. He worked every day so that he earn SGD 750-800/month. He can earn up to SGD 1,500/month if he works overtime, which he would often do (by simple computation, we can estimate his hourly rate to SGD 3/hour).

On 14 December 2011, he was in his construction site standing beside a construction lift when the automobile suddenly moved, causing the heavy equipment it was carrying to hit and throw him into the nearby wall. He was injured badly and was rushed to the Changi General Hospital.

He was unconscious for six days, causing the employer to call his family in Bangladesh to say that he died and that his deceased body would be sent home. Panicking, the mother called his uncle residing in Singapore to search for him in at the hospital. M's uncle rushed to the hospital where he was to spend a total of ten days recuperating at a C-class ward. M's uncle learnt that M was alive and that he had undergone an operation.

Due to the nature of his medical condition, M's bill reached SGD 33,885.45, which is more than the SGD 25,000 limit provided for by WICA. His employer paid for the total amount SGD 33,885.45 but would not spend a dollar more than necessary. Although there was a hole in his head, he was told to come back to work. Under the WICA, his employer is liable to provide for

medical leave wage. Moreover, he should have received full pay for working days covered by up to 60 days of hospitalisation leave or 14 days of outpatient MC days, and two-thirds of his pay afterwards, for up to a year.

M returned to work even if his wound was still fresh, and his health not yet fully recovered. In his first month, no salary was given to him. When he complained, his Work Permit was threatened to be cancelled. Fearing repatriation, he complained again only when his head started to hurt. He requested for the necessary treatment. This time he was not threatened to be sent home but was physically abused and locked up. With the help of a supervisor, he was able to run away. Unfortunately, his employer withdrew his LOG when he ran away. It was necessary so that upfront fees, such as SGD95 he had to pay the hospital to stitch his wound, would be waived.

Ever since he ran away from his physically abusive employer, he roamed the streets of Singapore sleeping in MRT stations and inconspicuous alleys before stumbling onto the TWC2. The NGO was kind enough to help him sue the employer and took care of him. On the 18th of September 2012, he experienced a small hemorrhage, which forced him to seek a doctor. The NGO gave him SGD 2,300 to have a CT-scan, which enabled him to finally have his cranioplasty. M did not pay for the second treatment; his employer refused to pay; TWC2 ensured that he was able to get his treatment. He is now back in his hometown, Kajipur, after his medical bill was settled by a Singaporean NGO.

Economic Costs: Head Injury (ten months)

	Rate	Amount (in SGD)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wages	SGD 1,500 per month	15,000	Not paid
<i>Total (Indirect cost)</i>		15,000	
<i>B. Medical expenses (Direct cost)</i>			
To open stitch		95	M
CT Scan and other test		2,300	TWC2
1 st operation		34,000	Employer
Weekly medicine for one month	SGD 20 per week	80	M
<i>Total (Direct cost)</i>		36,475	

Summary of Costs:

- Direct Cost of Medical Treatment – SGD 36,475 (excluding second operation)
- Indirect Cost of Lost Productivity – SGD 15,000 (10 months without work)

Summary of Social Issues:

- Hospital bill exceeded SGD 300 medical insurance coverage limit
- Discharged unfairly from employment, according to the provisions of the Work Injury Compensation Act

Case SG2: Lorry driver involved in traffic accident

On 3 July 2012, P, a 32-year-old Indian migrant worker, was driving the fateful lorry transporting 24 other construction workers to their work site. The lorry crashed with another lorry when it was nearing the construction site in Tanah Merah. The impact caused a 19 year old boy to fly out of the lorry and die on the spot. All the remaining passengers of the lorry were rushed to the Changi General Hospital. Five were under the intensive care unit and 15 others suffered serious injuries. Fortunately, the other lorry was empty, except for the driver.

After the accident, P and three of his co-workers no longer worked for the company who employed them. Among the four of them who remained in Singapore, one suffered a serious wrist injury, another underwent a liver operation due to internal bleeding, and two men fractured their ribs. All of them also suffered various injuries to the head, arms and shoulders. P still could not walk without his crutches three months after he left the company quarters. He had fifty stitches in his upper thigh, which was trapped inside the vehicle.

To add on, none of them had actually received any money since the accident. This money was “promised” but was to have followed the schedule of their regular work payments. Since coming to Singapore, they were only paid for their first month of work on the 10th day of the third month. This carried on despite the fact that under Work Permit regulations, employers are required to pay the salaries of foreign workers no later than seven days after the last day of the salary period. Injured, homesick and broke, the seriously injured co-workers were unhappy and wanted to go home. Having left the company without any compensation, they had no more money. Asked how they survive, P said, “We borrow money”.

Unable to walk, P relies on taxis to get to the hospital, making his financial situation even direr. He has up to three appointments at Changi Hospital each week, a return trip that costs him about SGD 30 dollars each time, or close to SGD 400 a month. This expense is on top of the hefty SGD 330 a month that he pays in rent for a small room with a bunk bed he shares with another worker.

There is a crucial, missing element to their story that ought to be known to any foreign worker involved in an accident. The lorry the injured men had been in was a company vehicle and they were on their way to work. By all accounts, they should be entitled to a lump sum compensation for permanent incapacity under WICA, a pay-out that is based on the effect of the injury on a worker’s present and future earnings. Given the severity of their injuries, they would probably have received a decent sum.

Most migrant workers who file what is colloquially known as a common law suit (against their employers) typically do so because they dispute the compensation as being unfair. But none of the men seemed aware that the WICA assessment should have been processed from the time they were admitted to the hospital for their injuries. In any case, going home and getting better with the help of traditional Indian medicine as soon as possible was P’s first priority.

Economic Costs: Traffic accident (Three months)

Item	Rate	Amount (in SGD)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wage	SGD 1,800 per month	5,400	Not paid
<i>Total (Indirect cost)</i>		5,400	
<i>B. Medical expenses (Direct cost)</i>			
Taxi fares	SGD 400 per month	1,200	P
Doctor's appointments	SGD 600 per month	1,800	P
Scans and operation		50,000	Employer
Medicines	SGD 300 per month	900	Employer
<i>Total (Direct cost)</i>		53,900	

Summary of Costs:

- Direct Cost of Medical Treatment – SGD 53,900 (3 months after accident)
- Indirect Cost of Lost Productivity – SGD 3,450 (3 months without work)

Summary of Social Issues:

- Hospital bill exceeded SGD 30,000 medical insurance coverage limit
- Unemployed with no compensation; Work Injury Compensation Act

Case SG3: Construction worker involved in a fight

B, a Bangladeshi migrant worker, has been in Singapore since 2008, working for a construction company the whole time. He has been earning close to SGD 1,150 per month as a signal operator.

On 23 August 2012, B was involved in an altercation with two other Bangladeshi migrant workers employed at the same company. On the day in question, a temporary supervisor asked him to lift cable wiring weighing around 60kg. B refused to do such heavy lifting as he argued that such work was not part of his job description. In response, the supervisor allegedly assaulted him with a spanner. He suffered injuries in his lower back, teeth and in his left eye as a result. The incident report filed with the police, a copy of which is in his possession, described the event as narrated.

Two months after the incident the physical injuries he had incurred during the assault were still visible on him and he explained that he was in no condition to return to work due to severe pain in his lower back. He could not bend down from his waist and also had trouble seeing through his left eye, which required him to wear dark glasses at all times. He had been undergoing medical treatment for some of his injuries.

His hospital bills amounted to SGD 15,000. Although he was supposed to receive workman's compensation and have a minimum medical coverage, he is yet to receive any compensation to cover his costs. So far some of the bills remain outstanding (a dental bill of approximately SGD 1,190 and a bill for tests/consultation of approximately SGD 70 of which he paid SGD 10

out of pocket). Some other medical treatment (MRI estimated at SGD 1,300 and treatment for his eye) are stalled until he is able to show a source of finance that will pay for it. He has been dealing only with an officer from the Ministry of Manpower, and had no contact with his employer or the insurance company with which he has a policy through his employer. In the meantime he had no income and was living at the shelter provided by HOME, eating meals at similar charity kitchens.

Ultimately, it turned out that the insurance company was unwilling to pay for B's medical costs, and only provided him SGD 200 a month to barely survive. The insurance company argued that the assault and battery is outside the scope of worker compensation (even if it happened inside the workplace) since starting June 2012 the WICA was amended to disallow the inclusion of work-related fights.

Economic Costs: Injuries from a fight (two months)

Item	Rate	Amount (in SGD)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wage	SGD 1,150 per month	2,300	
<i>Total (Indirect cost)</i>		2,300	
<i>B. Medical expenses (Direct cost)</i>			
Accumulated hospital bills		15,000	P
Dental bills		1,190	Outstanding
Test/consultation		70	Partly by B but still outstanding
<i>Total (Direct cost)</i>		16,260	

Summary of Costs:

- Direct Cost of Medical Treatment – SGD 16,260 (as of 23 months after accident excluding pending treatment/tests)
- Indirect Cost of Lost Productivity – SGD 2,300 (2 months without work)

Summary of Social Issues:

- Unemployed with little compensation; Work Injury Compensation Act

C. Conclusion

Foreign workers in both Hong Kong and Singapore face a similar situation. On the one hand, the government faces the challenge to balance the needs of workers with the needs of the employers. On the other hand, it has to make sure that employers are happy by providing avenues where the business firms are able to keep their costs low and profits high. Business firms have a tendency to absorb only the private costs. The high supply of foreign workers provides the gateway for employers to neglect employees' health and welfare. Rather than strive for more stringent safety and health practices, firms easily replace injured workers with new workers.

Moreover, the state also needs to respect the rights of foreign workers and perform its responsibilities to protect them. It can start by acknowledging that migrant workers, especially the victims of the policy gaps, are vulnerable and powerless. With the status quo, NGOs absorb the social costs of healthcare inefficiencies. There is no denying the trade-offs confronted by the stakeholders. However, finding a solution goes beyond simply enforcing current regulations and needs a more comprehensive policy framework that could plug the loopholes in policy. It is a nexus of policy issues requiring collaboration between all stakeholders.

In Singapore, balancing sustaining economic development and managing domestic politics about foreign workers has proven complicated. As mentioned, the 2011 General Elections has put the issue of migrant workers at the core of public discourse and awareness. With the election results as a signal of souring relations with the public, the ruling People's Action Party had to address issues related soaring prices, especially in housing, and rising unemployment due to competition perceived to be brought upon by migrant workers while keeping the economy afloat as blue-collared jobs are not being taken up by Singaporeans. Given this dilemma, Singapore remains competitive with lower labour costs for low-skilled foreign workers by keeping them transient residents. And thus, Singaporean laws and policies towards foreign workers continue to be weak in terms of enhancing employment benefits such as minimum wages and comprehensive protection.

Because of the transient nature of migrant workers, there currently exists a policy vacuum on preserving the health and well-being of foreign workers, which has caused several NGOs to fill in the gap. In Singapore, the importance of NGOs in ensuring the welfare of migrant workers are supported by NTUC Secretary-General Lim Swee Say saying that “legislations and mechanisms” already exist but that “the challenge lies in raising greater awareness of these sources of help” pertaining to NGOs, such as the NTUC-initiated Migrant Workers Union¹¹⁰.

In a blog post written by Singapore's Acting Manpower Minister Mr Tan Chuan-Jin released during International Migrants Day (December 18, 2012), he mentioned approaching NGOs as one of the legitimate channels for migrant workers to raise their employment grievances¹¹¹. He even acknowledged the special role that NGOs do in “referring cases to MOM”, and providing direct services to migrant workers such as resolving grievances and providing accommodations. However, the most important statement he made in the blog was “we can and will do more for [migrant] workers” as it shows the acknowledgement of certain shortcomings. In ensuring the welfare of foreign workers, a huge portion of the responsibility can only be provided for by the Singaporean government as NGOs have minimal resources and can henceforth only service a small fraction of the total number of migrant workers.

¹¹⁰ Migrant Worker's Centre (2012). NTUC spells out ways to tackle migrant workers's interests, MWC Centre's Latest News, http://www.mwc.org.sg/wps/portal/mwc/home/latestnews/latestnewsdetails?WCM_GLOBAL_CONTEXT=/content_library/ntuc/home/working+for+u/c6fe7c004dcf10da8eb0aec7b9d67807, accessed on 26 December 2012.

¹¹¹ Tan Chuan-Jin (2012). *Recognizing the Contributions of Foreign Workers*, The Manpower Blog, Ministry of Manpower. Retrieved from: <http://momsingapore.blogspot.sg/2012/12/recognising-contributions-of-foreign.html> on 26 December 2012.

Table 7: Stakeholder analysis related to health of migrant workers

Stakeholder	Motivations	Resources	Desired Outcome
Government agencies for labour	Ensure the welfare of the labour force; Proper implementation of government's policies toward migrant workers	Government support and resources	Strike a balance between the interests of several stakeholders; Ensure supply of low-wage labour
Employers	Cut costs of their firms by ensuring wage for labour remains as low as possible	Human resource and personnel departments	Low wages for labour; Flexible recruitment and dismissal terms of migrant workers; Avoid occupational hazards and ensure low medical costs
Migrant Workers	Earn as much money in for their families back home; Maintain their employment and health	Provide labour supply; Support work of non-government organisations	Work sufficiently to cover costs incurred and placement fees and be able to send money home to families; Avoid occupational hazards and have adequate medical treatment and injury compensation
Voluntary/Non-governmental organisations working for migrant workers	Act as the voice of marginalised communities and migrant workers	Public support, Voluntary resources and fund-raising	Fair treatment of migrant workers; Competition for limited charitable funds and media attention; Avenues for political opposition
Public healthcare providers	Primarily to ensure the health of citizens	Government support and resources	Healthy resident population; Health of migrants if there are negative externalities affecting local population

IV. Europe

The costs of healthcare are particularly considerable among European societies. It shows that health expenditures increased in both countries under study from 1995 to 2012. In Austria, the percentage of total health expenditures of the Gross Domestic Product (GDP) increased from 9.58% in 1995 to 11.47% in 2012, while in Italy from 7.06% to 9.17%.¹¹²

Three major economic reasons can explain such a growth of expenditures.¹¹³ First, the use of services and goods is rising. For the healthcare sector, this means an increase in physician and hospital visits as well as more prescriptions and purchases of drugs. The increase is mainly due to demographic changes such as falling fertility rates and a longer life expectancy, which increases the proportion of elderly people in society.¹¹⁴ The elderly more often suffer from chronic diseases and are therefore more likely to be in need of costly long-term care. Second, the increase in consumption of expensive goods and services compared to previous decades. This phenomenon can be rationalised by the rapid emergence of very expensive high-tech products (such as Magnetic Resonance Tomography / Magnet Resonance Imaging or other diagnostic technologies) in healthcare in recent years. Third, prices for healthcare services are rising faster than that for other goods and services.¹¹⁵

Consequently, avoidable costs and economic aspects in general are hot topics of discussion and high on the agenda of strategic development of healthcare systems and services.¹¹⁶

Modern healthcare approaches argue that healthcare should start with promotion and early prevention to tackle avoidable diseases from the onset. In this context, overtreatment or misguided provision of care may emerge as another issue on healthcare provision. This includes a prominent issue of misguided provision of care, which is avoidable or “forced” emergencies.¹¹⁷

¹¹² World Health Organization. (2014) Global Health Expenditure Databases. World Health Organization (WHO). Retrieved from <http://apps.who.int/nha/database/Home/Index/en>, on 04 August 2014

¹¹³ Folland, S., Goodman A.C., Stano M. (2010). The Economics of Health and Health Care. Sixth Edition. *Pearson International Edition*

¹¹⁴ Zweifel, P., Felder, S., Meiers, M. (1999). Ageing of Population and Health Care Expenditures: A Red Herring? *Health Economics* 8: 485-496

¹¹⁵ Folland et al., 2010

¹¹⁶ Brown, L., Thurecht, L., Nepal, B., (2012). The cost of Inaction on the Social Determinants of Health. Report no. 2/2012, June 4, 2012 CHA-NATSEM Second Report on Health Inequalities, *NATSEM, University of Canberra*

¹¹⁷ Caminal, J., Starfield, B., Sánchez, E., Casanova, C. and Morales, M. (2004). The role of primary care in ambulatory care sensitive conditions. *European Journal of Public Health*, 2004, 14: 3

Rizza, P., Bianco, A., Pavia, M. and Angelillo I.F. (2007). Preventable Hospitalization and access to primary health care in and areas of Southern Italy., *BMC Health Service Research*, 7:134.

Avoidable emergencies are widely discussed, especially in the US literature, pointing out that the number of avoidable emergencies is an important indicator of the efficiency and equity of a national healthcare system.¹¹⁸ Recent European studies on public health also propose that medical emergencies be avoided by a system of effective primary and preventive care.¹¹⁹ Caminal et al. (2004) suggested a European core list of prevalent ambulatory care sensitive conditions (ACSC) that are avoidable either by primary prevention, early diagnosis and treatment, or by good disease control and management. Avoiding emergencies, which in most cases lead to admission, implies avoiding costs and at the same time increasing public welfare.

Traditional health economic evaluation compares the costs or cost-effectiveness ratios of treatments because “policy concerns require that we frequently and systematically evaluate alternatives”.¹²⁰ Health economics focuses on costs that derive from health service provision or its savings. The starting point in this research endeavour is to question about costs derived from denying health service provision, including related types of direct, indirect and intangible costs that may not be usually captured.

Entitlements to healthcare are well-defined and ensured on level with national regulations for migrants residing in EU countries with regular status. However, migrants with an undocumented status – in what follows addressed as “irregular migrants” – are widely excluded from such regulations and consequently excluded from regular healthcare provision. This phenomenon happens despite ratification of the European Convention for the Protection of Human Rights and Fundamental Freedoms, adopted by the Council of Europe in 1950, “that has been interpreted as having a health dimension by the regional judicial accountability mechanism that is the European Court of Human Rights (ECHR)” by all European member states of access to healthcare as subject to human rights regulations.¹²¹ While recent policy debates acknowledge them as a specifically vulnerable group that needs more attention in European public health systems¹²², a majority of European countries still restrict access to healthcare for undocumented migrants to emergency care the point where healthcare provision is the most expensive. Austria and Italy then becomes good samples for comparative study on the cost of exclusion.

¹¹⁸ Pappas G., Hadden, W.C., Kozak, L.J. and Fisher, J.F. (1997). Potentially Avoidable Hospitalizations: Inequality in Rates between US Socioeconomic Groups. *American Journal of Public Health*, 1997, 87:5 Kruzikas, D.T., Jiang, H.J., Remus, D., Barrett, M.L., Coffey, R.M., and Andrews, R. (2000). Preventable Hospitalization: A Window into Primary and Preventive Care. *Agency for Healthcare Research and Quality*, 2004. HCUP Fact Book No. 5; AHRQ Publication No. 04-0056.

Russo, C. A., Jiang, H. J. and Barrett, M. (2007). Trends in Potentially Preventable Hospitalizations among Adults and Children, 1997-2004., HCUP Statistical Brief # 36, August 2006, *Agency for Healthcare Research and Quality, Rockville, MD*

¹¹⁹ Caminal et al., 2004; Rizza et al., 2007

¹²⁰ Folland et al., 2010; p.86.

¹²¹ Pace, P (2007). International Migration Law No 12-. Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments. *International Organisation for Migration, Geneva* http://publications.iom.int/bookstore/free/IML_12_EN.pdf [access date 04.08.2014]

¹²² European Parliament resolution of 8 March 2011, 2010/2089(INI)

One of the richest European countries, Austria is an important migrant-receiving country in the middle of Europe, which started when the economy boomed in the 1960s. In 2011, the share of the migrant population in Austria was 18.9%, most of whom are in Vienna where migrants comprise 38.8% of the capital city's population. Within the last decade, the share of the documented population with Asian migration background has nearly doubled. In Austria, the issue of undocumented migration is not high in the agenda of public debates. Access to healthcare of undocumented migrants is officially only possible in cases of emergency.¹²³

Italy has a large population of undocumented Asian migrants who work in the textile and agriculture industries. Through a system of registration of undocumented migrants with a health card called *Straniero Temporaneamente Presente* (STP), high quality data on the use of the healthcare system is available. Italy is one of the few European countries that allow partial access to the healthcare system for undocumented migrants.

Before looking at country-specific policy regimes, recent debates on European policy level and within the health and migration experts are the essential starting point for a comprehensive review of policies affective the inclusion or exclusion of migrants in healthcare. Three important arguments frame the debate on the issue of healthcare for undocumented migrants in Europe, namely: humanitarian, equity and economic.

Under the humanitarian argument, health is considered as a fundamental component of human rights. Ratified by all European member states, the Charter of Fundamental Rights of the European Union (EC 2000/C 364/01) state that: “everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices.” The Council of Europe (CoE) also names access to emergency care as minimum standard to ensure the fundamental rights to healthcare (Art.13.2 CoE 1509, 2006). But this standard has just recently come into discussion in another thematic domain: the Equity debate.

The European Commission names “An equitable distribution of health as part of overall social and economic development” a priority goal.¹²⁴ It is further outlined that:

“Particular attention needs to be given to the needs of people in poverty, disadvantaged migrant and ethnic minority groups, people with disabilities, elderly people or children living in poverty. For some groups, the issue of health inequality including reduced access to adequate health care, can be qualified as one which involves their fundamental rights.”¹²⁵

¹²³ Karl-Trummer, Metzler, Novak-Zezula 2009.

¹²⁴ European Commission (2009), p. 5

¹²⁵ European Commission (2009), p. 8

In similar vein, a recent report by the WHO Europe points out that “there is substantial evidence of inequities on both the state of health of these [migrant] groups and the accessibility and quality of health services available to them.”¹²⁶ In its resolution in 8 March 2011 on reducing health inequalities in the EU, the European Parliament explicitly names irregular migrants as a vulnerable group that has to be considered within the equity debate. It “Calls on the Member States to ensure that the most *vulnerable groups, including undocumented migrants*, are entitled to and are provided with equitable access to healthcare” (10/2089 (INI)).

In terms of economic consideration, discussions revolve around whether exclusion is costlier than inclusion, or, in other terms, whether there are quantifiable “costs of inaction.”¹²⁷ Given the steadily rising costs of healthcare provision and the scale of the healthcare sector, the understanding of the economics of health, which “...studies the allocation of resources to and within the health economy”¹²⁸ becomes very important.

Policy Stakeholders at the EU Level

European policies concerning irregular migration involve several agencies and organisations, and several reports are elaborating this issue in more detail.¹²⁹ This paragraph intends to give a brief overview of the main bodies that are concerned with irregular migration policies inside the European Commission.

To begin with, it can be stated that the central approach towards migration is a control-oriented one, resulting in very limited access for irregular migrants to rights when compared to legally residing migrant populations. This control-oriented approach gets visibility in the 2009 Stockholm Programme¹³⁰, which is the third programme of its kind for the states of the European Union as part of the wider Area of Freedom, Security and Justice for 2010-2014. It focuses on the rights of ‘citizens’ and ‘legally residing’. Concerning irregular migrants, the focus lies on combating irregular migration and improving cooperation among member states to on the return of irregular migrants. Still, it can be stated that “efforts are being made at the institutional level of the EU to develop policy approaches around access to rights and social inclusion”¹³¹ also for irregular migrants.

¹²⁶ WHO (2010), p. v

¹²⁷ Brown, Thurecht, Nepal 2012

Dahrouge, S., Devlin, R.A., Hogg, B., Russell, G., Coyle, D., Fergusson, D. (2012). The Economic Impact of Improvements in Primary Healthcare Performance PHC. *Canadian Health Services Research Foundation – CHSRF, Ottawa*

¹²⁸ Folland et al, 2010, p.24

¹²⁹ Carrera, Sergio; Parkin, Joanna (2011) Protecting and Delivering Fundamental Rights of Irregular Migrants at Local and Regional Levels in the European Union. Centre for European Policy Studies, (CEPS) <http://cor.europa.eu/en/documentation/studies/Documents/protecting-fundamental-rights-irregular-migrants.pdf>, access date: 04.08.2014

Vogel, D., Cyrus, N. (2008): Irregular Migration in Europe ? Doubts about the Effectiveness of Control Strategies, focus Migration Policy Brief No 9

¹³⁰ European Council (2010). *The Stockholm Programme — An open and secure Europe serving and protecting citizens*. Official Journal of the European Union. Retrieved from: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:115:0001:0038:en:PDF>, on 08 August 2014

¹³¹ Carrera, Sergio; Parkin, Joanna (2011) p. 6

Within the European Commission, several Directorates approach the issue of irregular migration. A working paper from the Centre for European Policy Studies (CEPS) names three main stakeholders among the Directorates-General: DG Home Affairs, DG Employment, Social Affairs and Equal Opportunities, and DG Health and Consumers.¹³²

DG Home Affairs takes a clear standpoint against irregular migration and formulates four main targets, namely to stop those who organise irregular immigration, to sanction those who hire irregular labour force, to improve external border controls, and finally to ensure a humane and effective Return and readmission policy. Access to health or other forms of social protection are not tackled in this arena.¹³³

DG Employment, Social Affairs and Equal Opportunities concentrate on issues of labour migration, social inclusion and coordination of the EU's anti-poverty agenda. Irregular migrations are addressed as a highly vulnerable and disadvantaged group. One of the first European wide studies on access to healthcare for irregular migrants, "Access to healthcare for undocumented migrants in the European Union" conducted by the Platform for International Cooperation on Undocumented Migrants (PICUM)¹³⁴ was co-funded by DG Employment within the framework of the Community Action Programme to Combat Social Exclusion.¹³⁵

DG Health and Consumers (SANCO)¹³⁶ is, among others, responsible for public health issues, and has traditionally considered migrants as a target group of public health policies. Irregular migrants are named as a group of high vulnerability. Several European projects on access to healthcare for irregular migrants in EU member states have been co-funded by DG SANCO. A background paper commissioned by the International Organization for Migration (IOM) in a framework of a DG SANCO project on social determinants on health in 2009 lists several such projects that worked on a better evidence base on access to healthcare for irregular migrants.¹³⁷

During the Portuguese presidency of the EU in 2007, the conference on "Health and migration on the EU: Better health for all in an inclusive society" was organised with the support of DG SANCO. In the framework of this event, the issue of irregular migrants and their access to healthcare was a major issue.

¹³² Merlino, Massimo; Parkin, Joanna (n.d.) Irregular Migration in Europe: EU policies and the Fundamental Rights Gap. Centre for European Policy Studies (CEPS). Retrieved from: http://migration.etuc.org/en/docs_en/1%20Irregular%20Migration%20in%20Europe_%20EU%20policies%20and%20the%20Fundamental%20Rights%20Gap.pdf on 29 July 2014

¹³³ European Commission (2014a). Irregular Immigration. European Commission Home Affairs. Retrieved from http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/immigration/irregular-immigration/index_en.htm on 29 July 2014

¹³⁴ Platform for International Cooperation on Undocumented Migrants (2014a). Home. Retrieved from: <http://picum.org/en> on 8 August 2014

¹³⁵ Platform for International Cooperation on Undocumented Migrants (2014b). Healthcare. Retrieved from: http://ec.europa.eu/health/index_en.htm on 8 August 2014

¹³⁶ European Commission (2014b). Public Health. European Commission Home Affairs. http://ec.europa.eu/health/index_en.htm acc.08.08.2014

¹³⁷ Karl-Trummer, Ursula; Metzler, Birgit; Novak-Zezula, Sonja (2009): Health Care for Undocumented Migrants in the EU: Concepts and Cases. Background Paper developed within the framework of the IOM project "Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities". Brussels: IOM

Beside the named Directorates, the European Union Agency for Fundamental Rights (FRA) is one of the EU's decentralised agencies set up to provide expert advice to the institutions of the EU and the Member States.¹³⁸ The agency aims to ensure that the fundamental rights of people living in the EU are protected, including irregular migrants.

In October 2011, the Agency launched a Report on Migrants in an irregular situation and their access to healthcare in 10 European Union Member States. In the foreword to the report, it is stated that:

“European healthcare systems are struggling to balance the conflicting considerations of costs and public health concerns. Due to the economic crisis and an ageing population, European countries are faced with the need to contain public expenditure in health. In this process, the right to health for all, irrespective of legal status, should always remain a key concern”.¹³⁹

¹³⁸ European Union Agency for Human Rights (2014). About the FRA. European Union Agency for Human Rights. Retrieved from: <http://fra.europa.eu/en/about-fra> on 29 July 2014

¹³⁹ European Commission Agency for Human Rights. (2011). Migrants in an irregular situation: access to healthcare in 10 European Union Member States. Retrieved from http://fra.europa.eu/sites/default/files/fra_uploads/1925-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf on 8 August 2012

A. Austria

Migration Context: Demographic and Political Drivers

Since 1995, Austria is member of the European Union (EU), with common borders with Germany, the Czech Republic, Slovakia, Hungary, Slovenia, Italy, Switzerland and Liechtenstein. All of these are, as Austria, Schengen countries. The Schengen rules require countries to eliminate internal border controls while simultaneously strengthen external border controls with non-Schengen states. Under the Schengen agreement, transiting from one country to another without border control is possible.

Austria has no borders with Non-EU countries, except to Switzerland, who joined the Schengen agreements and is therefore committed to joint border control.

Demographic Background

In 2012, Austria has a total population of 8.4 million, 11% of which are foreigners. Majority of the foreigners (6.8% of total population) are non-EU nationals.

Table 8: Austrian population by Country of birth and citizenship (2012)

Country of Birth	Total	Citizenship		Percentage	Citizenship	
		Austrian	Non-Austrian		Austrian	Non-Austrian
Austria	7,094,012	6,949,643	144,369	84%	82.3%	1.7%
Foreign country	1,349,006	522,834	826,172	16%	6.2%	9.8%
Total	8,443,018	7,472,477	970,541	100%	88.5%	11.5%

Source: Statistik Austria (2012)

Table 9: Austrian population, 2012

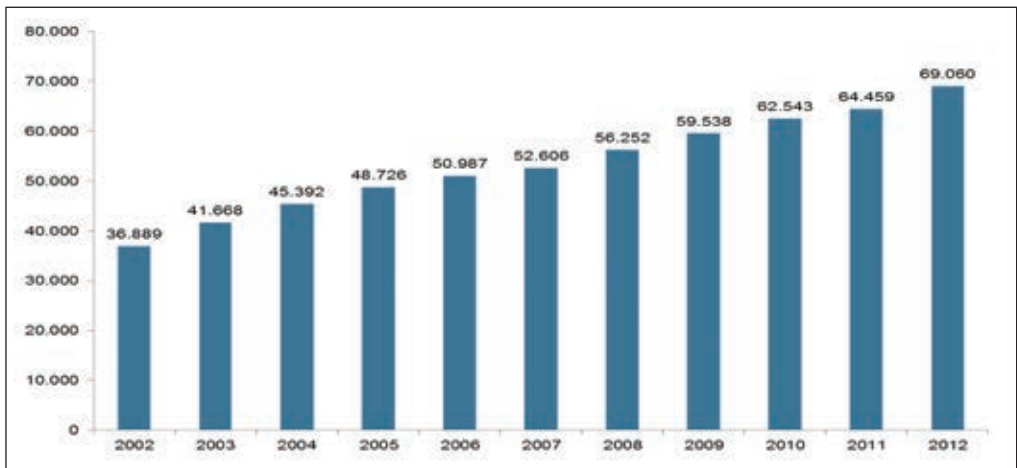
Citizenship	2012
Total	8,443,018
Austrian	7,472,477
Non-Austrian	970,541
Foreign Population Rate	11.5%
EU, EWR, Switzerland	399,254
EU countries till 1995 (EU-14)	212,297
Germany	153,491
Accession countries (2004; EU-10)	116,755
Accession countries (2007; EU-2)	61,412
Switzerland, EWR	8,790
Third countries	571,287

Citizenship	2012
Europe	444,291
Former Yugoslavia (excl. Slovenia)	296,377
Turkey	114,011
Other European countries	33,903
Africa	23,179
America	18,925
Northern America	9,261
Latin America	9,664
Asia	69,060
Oceania	1,469
Unknown, unclear or stateless	14,363

Source: Statistik Austria (2013)

The largest migrant groups come from former Yugoslavia (excluding Slovenia), Germany and Turkey. Asian migrants are the largest group coming from another continent other than Europe. The number of Asian migrants in Austria has doubled within the last decade.

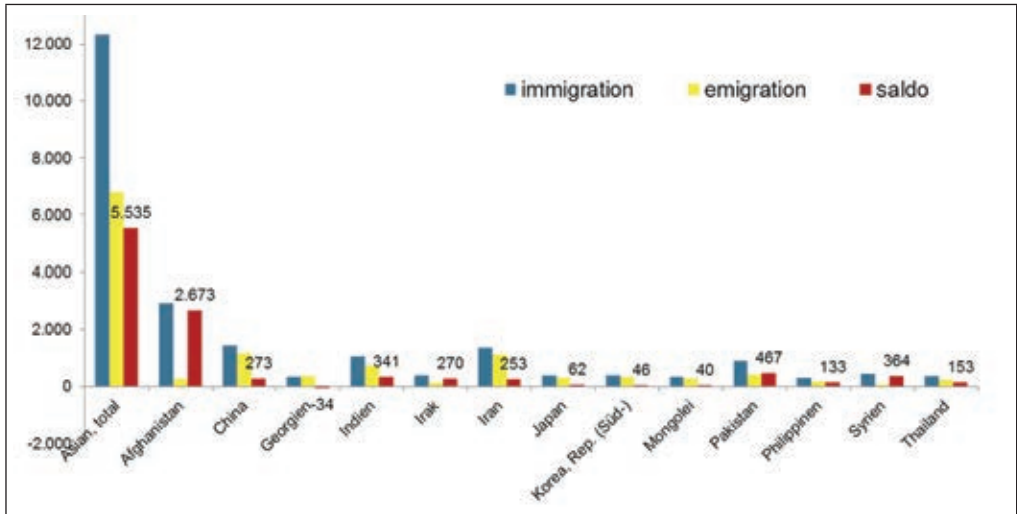
Figure 3: Asian population in Austria, 2002-2012



Source: Statistik Austria (2012)

The following figure shows the countries of origin of Asians migrating to and from Austria.

Figure 4: Asian migration to/from Austria, 2011



Source: Statistik Austria (2011)

Historical and Political Background

After World War II, the demand for labour increased due to the economic boom. Austria began to recruit guest workers from Turkey based bilateral agreement on labour recruitment in 1964) and from Yugoslavia in 1966. These guest workers were recruited as temporary workers, but most permanently settled together with their families. In 1973, almost 230,000 guest workers lived in Austria (178,000 of them from Yugoslavia). Due to the global economic crisis in the early 1970s and the early 1980s, the demand for guest workers decreased, and the Aliens Employment Act from 1975 restricted access to the labour market. By doing so, the law also has an impact on residency, as employment/income is the most important reason to get a permanent residence permit. In 1985, the employment level of Yugoslavian and Turkish guest workers was only half the level of 1973. When economy recovered, many guest workers returned to Austria. At this time, recruitment of guest workers had already stopped, and family reunification and individual labour migration became more important.¹⁴⁰

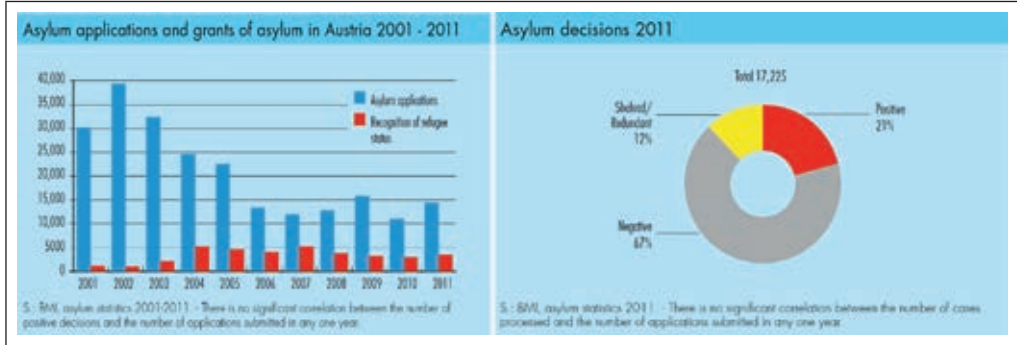
During the Cold War, Austria has been an important receiving country for refugees due to its geographical position with borders at the Iron Curtain. Main groups of refugees were the Hungarians in 1956/57, the Czechs in 1968. After several years of low refugee influx, the number of asylum seekers increased after the collapse of the communist system in Eastern Europe in 1987-1991. According to UNHCR, more than 2 million refugees have come to Austria since 1945, about 700,000 have staid.¹⁴¹

¹⁴⁰ andl, M., Kraler, A., (2003): Austria: A Country of Immigration? Retrieved from: <http://www.migrationinformation.org/Profiles/display.cfm?ID=105> on 14 February 2013

¹⁴¹ United Nations High Commission for Refugees (n.d.) Flüchtlingsland Österreich. UNHCR website. Retrieved from: <http://www.unhcr.at/unhcr/in-oesterreich/fluechtlingsland-oesterreich.html> on 30 July 2014

The increase of applications for asylum is connected to a decrease of the acceptance. At the end of the 1990s, two trends were observed: the increase in refugees from non-European countries; and increase in accepted refugees staying in the country. After the Kosovo conflict in 1998/99, Austria accepted 5,000 refugees; nevertheless, the rate of accepted refugees did not increase in this time.¹⁴² In 2011, 14,416 asylum applications were made in Austria. 11,553 applications were rejected, which is a share of 67% of applications decided in 2011.¹⁴³

Figure 5: Asylum applications and decisions, 2001-2011



Source: Statistik Austria (2012)

On level of legal regulations, the asylum law from 1992 to 2011 now became increasingly restrictive. Since 2011, new regulations in the Austrian migration law are in place. Instead of the contingent regulation, a system is implemented, which should make immigration easier for well-educated people who fulfil a number of preconditions (“Rot-Weiß-Rot-Card”).

Policy Review: Functional Ignorance

Legal Framework and Regulations on Access to Healthcare

Healthcare provision in Austria primarily is a public task, which is regulated by social law. Main legislative competencies are given to the Federal Ministry of Health. Nine federal states are responsible for the enactment and implementation of legislation, as well as for financing and provision of inpatient care¹⁴⁴. Main funding sources of the Austrian healthcare system are contributions to the social health insurance, which are financing 52.4% of the total health expenditure. More than twenty per cent are financed by taxes, 16.8% by private households, 5.5% by private health insurance and 1.4% by non-profit organisations and enterprises.¹⁴⁵

¹⁴² Demokratiezentrum (n.d.) Asylpolitik in Österreich im europäischen Kontext. Retrieved from: <http://www.demokratiezentrum.org/wissen/timelines/asylpolitik-in-oesterreich.html> on 4 August 2014

Demokratiezentrum (n.d.) Asyl in Österreich. Retrieved from: <http://www.demokratiezentrum.org/wissen/wissensstationen/asyl-in-oesterreich.html> on 4 August 2014

¹⁴³ BM.I Bundesministerium für Inneres (2011). Asylstatistik. Retrieved from: http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/2011/Asylstatistik_2011.pdf on 4 August 2014

¹⁴⁴ BMGF/Federal Ministry for Health and Women (2005). Das Gesundheitswesen in Österreich, *BMGF Vienna*

Hofmarcher, Maria M. & Rack, Herta M. (2006). Gesundheitssysteme im Wandel: Österreich. *WHO Regional Office for Europe, Copenhagen*

¹⁴⁵ Hofmarcher, Maria M. (2013). Das Österreichische Gesundheitssystem. Akteure, Daten, Analysen. *Medizinische Wissenschaftliche Verlagsgesellschaft, Berlin*

The compulsory insurance under an obligatory scheme by law is financed by 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. Specific groups who are not covered by the compulsory insurance such as marginally-employed workers can pay for their own insurance.

Access to Healthcare for Regular Migrants

When integrated into work and the insurance schemes, regular migrants have equal rights as nationals and should be treated equally. Work can be defined as the main inclusive factor. Specific regulations are in place for migrants who have a recognised status for humanitarian reasons like refugees and asylum seekers. They are entitled to get basic healthcare within a restricted area.

Studies show that migrants are at higher risk to get insufficient/inappropriate treatment due to lack of capability to adequately treat patients with diverse ethno-cultural background or low level of difference-sensitivity of healthcare organisations, For instance, the implementation of interpreting services is far from being comprehensive.

Access to healthcare for undocumented migrants

No Austrian legislation contains a specific regulation for healthcare provision for undocumented migrants. In effect, undocumented migrants do not exist on the regulatory level. This situation becomes ironic because undocumented migrants belong to a small group of people without health and social insurance, and in most cases are unable to pay expensive treatment costs. Official statistics name an insurance coverage of 99.9% in 2011¹⁴⁶, which do not include people without a documented residing status.¹⁴⁷

If somebody without insurance needs medical treatment, he or she has to pay out of pocket. One exception is emergency care, which is regulated through the Austrian Federal Hospitals Act. The “KAKuG/Bundesgesetz über Krankenanstalten und Kuranstalten StF: BGBl. Nr. 1/1957, Fassung 2012, §22 and § 23” says that people whose physical or mental condition requires immediate hospital treatment or otherwise that would lead to life-threatening situations or to danger of severe damage to health, must not be rejected and essential medical first aid must not be denied in public hospitals. This includes women in labour. In case people are unable to pay and/or identification of the patient is not possible, hospitals have to cover the expenses out of their own budget.¹⁴⁸ Additionally, there are specific regulations concerning patients with infectious tuberculosis: §2 of the Tuberkulosegesetz StF: BGBl. Nr. 127/1968 (Law on tuberculosis) says that persons with infectious tuberculosis are obliged to undergo medical treatment, over the length of time of the condition. Doctors and hospitals are required to report patients with tuberculosis and such patients who do not comply with continuous medical treatment to the local authorities. If patients cannot be convinced to

¹⁴⁶ Hofmarcher, M. (2013)

¹⁴⁷ Fuchs, M., Schmied, G., Oberzaucher, N. (2003). Quantitative und Qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich. *Bundesministerium für Gesundheit und Frauen, Wien*

¹⁴⁸ 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'. *IOM Vienna*

comply, they are retained at the hospital. These regulations reveal only access to medical treatment for undocumented migrants in Austria besides the care paid out-of-pocket, is limited to emergency or infectious disease considered as a severe public health threat.¹⁴⁹

Stakeholder Analysis

Public Authorities

Federal Ministry for Interior

The Federal Ministry for Interior concerning immigration is responsible for the asylum system and for police enforcement of legislation related to foreigners, the issuance of documents for foreigners and the granting of rights of entry, including arresting and deporting irregular migrants.¹⁵⁰

Federal Ministry of Health

The Federal Ministry of Health is the highest authority on national level as far as the health agenda is concerned. The ministry develops legislative proposals. It acts as regulatory authority for the social health insurance and for the professional organisations and monitors compliance with laws regarding healthcare.¹⁵¹

Acknowledging the importance of Health in all policies, the federal health commission and the Austrian Council of Ministers approved 10 health targets at federal level in 2012. One of these health targets is to “promote fair and equal opportunities in health, irrespective of gender, socio-economic group, ethnic origin and age.”¹⁵²

Provinces

Federal provinces and municipalities are responsible for implementation, organisation and controlling of the public health system. Austria consists of nine provinces, so there are nine regional health funds performing tasks for higher-level planning, control and financing of the healthcare system.

As outlined earlier, Austria’s policy framework on public health at federal and province level suffers from “functional ignorance”, where no official policies and legislative structures are in place to address the issue of healthcare provision for undocumented migrants.¹⁵³ In this situation, NGOs become important actors and stakeholders when it comes to health care provision, as they compensate the lack of structural frameworks in the regular healthcare system.

¹⁴⁹ Trummer, U., Novak-Zezula, S. (2013): Costs of Exclusion. Pros and Cons of Health Care for Irregular Migrants. In: *Going international*, March 2013

¹⁵⁰ BM.I Bundesministerium für Inneres. (n.d.) Aufgabenbereiche des Innenressorts. Retrieved from: http://www.bmi.gv.at/cms/bmi_service/start.aspx#t_aufgaben on 4 August 2014

¹⁵¹ Hofmarcher (2013)

¹⁵² Ministry of Health (2013) Rahmen-Gesundheitsziele. Retrieved from: <http://www.gesundheitsziele-oesterreich.at/>, on 4 August 2014

¹⁵³ Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit (2009): Managing a Paradox: Health Care for Undocumented Migrants in the EU. In: *Finnish Journal of Ethnicity and Migration*; 4, 2; p. 53-60., http://c-hm.com/NHC_FJEM_2_2009.pdf

This became visible in the framework of several projects funded by the European Commission that made first inventories of service providers and legal frameworks.¹⁵⁴ One outcome of these projects is a European Database on practices of healthcare provision for undocumented migrants. For Austria, it lists nine NGOs, two of which were also involved also in this study and will be described in more detail.¹⁵⁵

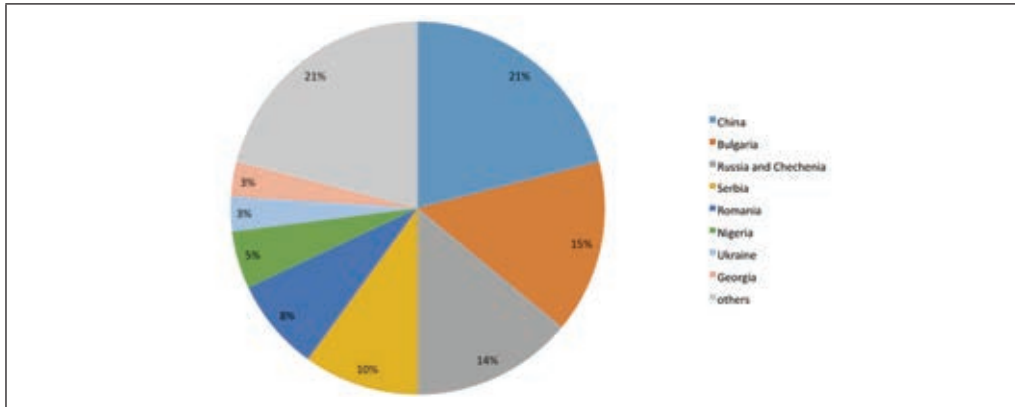
Amber-Med¹⁵⁶

Founded in 2004, Amber-Med is a joint project of the refugee service of Diakonie Austria, a social association of the Austrian protestant churches, and the Austrian Red Cross, the largest humanitarian non-profit organisation in Austria. It provides low-threshold, free of charge outpatient healthcare to uninsured patients in Vienna.

Services include outpatient general medical care, gynaecology, paediatrics, neurology and psychiatry. Social counselling, psychotherapy and psychological support and a drug deposit are also provided. Interpreters for Chinese, Bulgarian and Russian are appointed for defined opening hours, while interpreters for English, French, Bosnian/Croatian/Serbian, Farsi, Arabian, Romanian, Polish, Armenian and Kurdish languages are available on demand.

The main patient groups are asylum seekers and migrants. In 2011, 816 patients accessed Amber-Med, in total, 2,987 consultations are documented. Patients come from 68 nations. The largest group are Chinese (21%).

Figure 6: Countries of origin of patients, 2011



Source: Amber-Med (2011)

Disease patterns show diabetes and high blood pressure as the most frequent health problems, followed by gynaecological problems/maternity care, mental health problems and musculoskeletal disorders.

¹⁵⁴ Huma, Picum, NHC

¹⁵⁵ Karl-Trummer, U., Novak-Zezula, S. (2010). Health Care for Undocumented Migrants. Fact Sheet Practices. *Center for Health and Migration. Austria*. Retrieved from: http://c-hm.com/NHL_practice_rz_EN-1.pdf on 4 August 2014

¹⁵⁶ Amber-Med. 2011: Jahresbericht 2011

The team consists of five employed staff members, supported by a considerable staff of volunteers, including doctors, organisation assistants, interpreters covering six languages and 13 psychologists. Additionally, a network of medical specialists, laboratories and radio diagnostic centres, hospitals, and enterprises from pharmaceutical industries and for medical aids, is in place.

The annual budget is more or less equally raised from public subsidies from the Federal Ministry of Health, the Fund for Social Affairs in Vienna (Fonds Soziales Wien) and from the Vienna Health Insurance Company (Wiener Gebietskrankenkasse) and other contributions from civil society through voluntary work, donations and sponsorships.

Healthcare services provided in 2011 by volunteer doctors are stated to equal EUR 106,859 (USD 140,125) in total. This calculation is based on fixed rates that doctors can allocate from health insurance for insured patients' treatment.

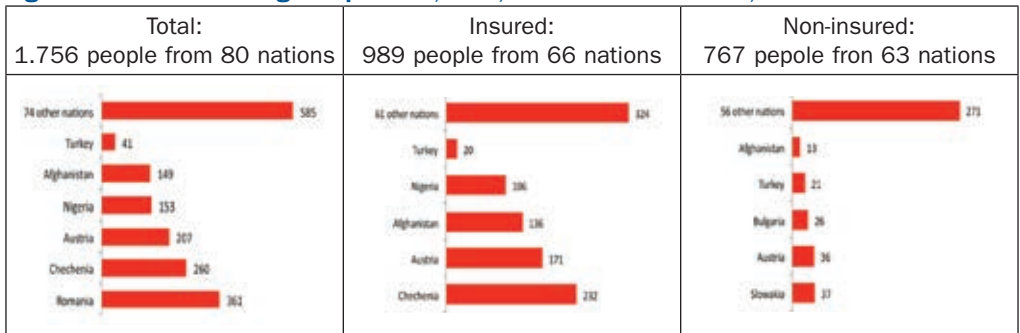
The drug deposit programme of the Austrian Red Cross in 2011 provided Amber-Med patients with medicine for free with a total value of EUR 37,850 (USD 49,632.50).¹⁵⁷

Marienambulanz¹⁵⁸

Founded in 1999, the Caritas Marienambulanz in Graz, Styria, provides primary healthcare for marginalised groups and patients without insurance coverage.

In 2011, six employed staff members were responsible for organisation and medical coordination. Medical professionals worked 1881 hours on a voluntary basis (doctors: 865 hours, medical assistants, 788 hours, others (interpreters, evaluation, pharmacy, massage, physio-therapy) 228 hours). Services include general medicine (6,277 consultations), gynaecology (381 consultations), diabetes (495 consultations), hypertonia (498 consultations), and psychiatry (883 consultations), which makes a total of 8,534 consultations. 1,756 patients from 80 nations were treated in 2011; the largest patient groups are Romanians, Chechens, and Austrians. Among uninsured patients, the majority are Romanians.

Figure 7: Countries of origin of patients, total, insured and uninsured, 2011



Source: Caritas, Ambulatorium Caritas Marienambulanz (2011)

¹⁵⁷ AmberMed (2011): Jahresbericht 2011

¹⁵⁸ Caritas, Ambulatorium Caritas Marienambulanz (2011): Jahresbericht/Annual Report 2011

Marienambulanz cooperates with different non-profit associations, the University Graz, the Federal government of Styria, the Styrian Health Insurance Company, medical institutes, hospitals and pharmacies and about 25 medical specialists.

The service is financed by the “Gesundheitsfonds”, the healthcare fund of the Land Steiermark, the Styrian Health Insurance Company, the Social Security Office and the Health Office of Graz, and the Federal Ministry for Health. In addition, services are financed through sponsorships, donations and voluntary work.

Case Studies: Acute Injury and Communicable Disease

Case AT1: Acute Injury

S is a 24-year-old undocumented male migrant from Pakistan, living in Vienna. S came to an NGO which provided him with healthcare on 16 January 2012 because of a blister from burns on his right forefinger. S has opened the blister in an attempt of self-treatment under poor hygienic conditions. The forefinger was highly inflamed. He was provided with the antibiotics, an analgesic and anti-inflammatory drug as well as new bandage. He was advised to come to the NGO again the following week.

The following encounter was on 25 January. The patient reported severe pain, which has been lasting for three days. At this time, he had stopped taking the antibiotics as he suffered from diarrhoea. He was provided with Dalacin 300mg, a different antibiotics, he was advised to make chamomile-baths for the finger.

On 29 February, he reported that diarrhoea had not stopped but number of stools in a day had decreased. The doctor provided him with drugs to balance the intestinal flora, which should be taken for three days. No further consultation was documented. As regular codes for medical treatment are included in patient records and costs of medicines are standardised in Austria, real medical costs can be included into the economic model. Costs of the medical treatment¹⁵⁹ of the inflamed finger and the antibiotics-caused diarrhoea are USD 132.

The patient record gives no information on the patient's life circumstances. Therefore, for further economic evaluation, assumptions had to be made based on expert knowledge from social workers at the NGO concerning:

- Monthly income: the recorded number on income is based on information on minimum gross salaries in defined economic branches for specific occupations, in this case for a kitchen help in gastronomy.
- Costs for monthly expenditures: costs for lodging, and food including miscellaneous expenses

¹⁵⁹ Costs of medical consultations, treatments, and medicine were calculated on the basis of contracts between primary care givers and insurance funds as well as on basis of officially regulated costs for medicine.

Based on a fictitious monthly income of USD 1,616, for the time before the injury S is supposed to spend USD 650 on his everyday life and to send remittances of USD 649. After the injury, costs for monthly expenditures have to be raised by S, although he is not able to continue working.

Following the assumption that S is not able to continue working as kitchen help in a restaurant due to his wound and antibiotics-caused diarrhoea, two months without work were estimated. Based on this, loss of economic productivity was calculated by multiplying months without work by monthly salary.

Integrating the numbers resulting so far into the economic model, the total makes social and medical costs amounting to USD 4,187.

What would the costs have been for a timely treatment? According to medical advice, a blister from burns can be treated with a disinfectant Betaisodona gel, which could have been applied directly after the injury, and which should prevent further inflammation. The costs for this gel are EUR 2.69 or USD 3.66. If the consultation costs for a visit at a general practitioner of EUR 11.11 are added, this makes a total of EUR 13.80 (USD 18.75).

The patient did not have the opportunity to consult a general practitioner and to buy the medication, so he tried to fix it by himself until he turned to the NGO at a later stage and with a worse condition. The cost for the medical treatment at that time was EUR 101. More recently, the costs has changed wherein for every Euro that has not been spent in an appropriate stage, EUR 7.30 have to be spent for delayed treatment.

What could have happened if he did not have the opportunity to turn to the NGO? In a worst case scenario, he could end with a sepsis. This would be his entrance ticket to the regular system, as this would be a case of emergency, with considerably higher costs related to hospital intensive care treatment.

Concerning the loss of productivity, costs of EUR 2,420 could have been avoided by early intervention with costs of EUR 13.80.

Economic Costs: Acute Injury (two months)

	Rate	Amount (in EUR)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wages	EUR 1,210 per month	2,420	(Fictitious)
GP/nurse/administrative staff of NGO		126	NGO
Overhead		30	NGO
<i>Total (Indirect cost)</i>		2,576	
<i>B. Medical expenses (Direct cost)</i>			
Medical treatment		54	NGO
Medicines		47	NGO
<i>Total (Direct cost)</i>		101	
<i>c. Other costs</i>			
Public transport		13	Self
Food		200	Self
Lodging		200	Self
Miscellaneous		100	Self
<i>Total (Other cost)</i>		513	

Summary of Costs: Direct Cost of Medical Treatment – EUR 101; Indirect Cost – EUR 2,576; Other costs – EUR 513

Summary of Social Issues: Misinformation about possibility to buy disinfectant gel at the pharmacy without prescription, exploitation at the work place, unnecessary pain and worsening condition, loss of income,

Case AT2: Communicable disease

R is a 45-year-old male Mexican, living in Vienna as undocumented migrant. He has good German language skills. He lives in an asylum centre run by the Caritas. Staff there advised him to go to the NGO for healthcare.

When he first came to the NGO on 8 August 2012, he reported to suffer from pain in his throat when eating, as well as night sweat.

Concerning former medical treatment back in Mexico, only verbal information from the patient is available: he says that a doctor in Mexico prescribed an antifungal drug (no information on health problems and time of treatment documented); after taking these drugs, his condition got worse. A laboratory test showed a bacterial infection, but antibiotics did not take effect.

The doctor at the NGO exams the patient and observes a reddened throat, reddened and enlarged palatine tonsils, and reddened root of tongue and inner lower lip. A swab of the oral flora didn't show any results. Stomatitis is diagnosed. The patient is referred to an ear, nose and throat specialist at the NGO the following day. No encounter with this specialist is documented.

Due to the stomatitis and his poor general health status, in the course of the next encounter on 5 September R, is referred to laboratory for a blood test. This test includes screenings on HIV, TB and lues/syphilis on a regular basis.

At the next encounter on 20 September, the patient is informed about the results of his blood test: The lues/syphilis screening was positive as well as the HIV test. The patient has not expected the lues and HIV diagnoses; he totally shocked and very confused. The doctor explains the diagnosis in detail and in a long talk, the next steps of treatment are discussed. The patient is provided with Xylocain Gel 2%, an anaesthetic for the mucous membrane and advised to approach the public STD ambulance of the municipality the next day. After September 20th, no further consultation is documented in 2012.

Medical costs for medical treatment, laboratory test and medicines so far are EUR 137¹⁶⁰ or USD 186.

There is no further documentation and information available for this case. It is not known whether he went to the municipal STD ambulatory as advised and whether he got further treatment there.

Economic Costs: Communicable disease

	Rate	Amount (in EUR)	Source
<i>A. Loss in Productivity (Indirect cost)</i>			
Unpaid wages	-	-	
<i>Total (Indirect cost)</i>			
<i>B. Medical expenses (Direct cost)</i>			
Medical treatment		90	NGO
Laboratory test		34	NGO
Medicines		13	NGO
<i>Total (Direct cost)</i>		137	

Summary of Costs: Direct Cost of Medical Treatment – EUR 137

Summary of Social Issues: Shock, desperation and depression after being diagnosed, uncontrolled risk of passing the disease to other people

¹⁶⁰ Medical treatment: EUR 90; laboratory test: EUR 34; medicines: EUR 13.

B. Italy

Migration Context: Demographic and Political Drivers

Italy was founding member of the European Economic Community (EEC) in 1957, which became the European Union (EU) in 1993. It shares common borders with France, Switzerland, Austria, and Slovenia, which are Schengen countries. This makes movement between borders much easier.

Demographic Background

Italy's total population is 60,820,764 in 2012. Foreigners comprise 7.5% of the total population, majority of which are non-EU nationals.¹⁶¹ The net migration for 2011 is +380,085 people, equivalent to a net migration rate of +3.2.¹⁶² The foreign population resident in Italy mainly comes from Europe, followed by Asians. The largest migrant groups are from Romania, Albania, Morocco followed by China, Ukraine and the Philippines.

Historical and Political Background

Until the end of the 1970s, Italy was a country of mass emigration. Only since then, immigration to Italy has become a relevant phenomenon. Since the fall of the Berlin Wall in 1989 and with the enlargement of the EU in 2004 and 2007, migrants are especially from the former socialist countries of Eastern Europe (Romanians, Albanians, Ukrainians and Polish). Traditionally, immigrants from North Africa, esp. Morocco, Egypt and Tunisia, hold a large share of migrants, even increasing with the Arab Spring since 2010/11. A growing influx from Asia, especially China and the Philippines can also be observed. Only 13% of the immigrants live in the south of Italy, while 87% live in the richer northern and central parts.

Policy Review: A State of Partial Acceptance

Legal Framework and Regulations on Access to Healthcare

The Italian National Health Service (Servizio Sanitario Nazionale) was established in 1978 and introduced universal coverage to all citizens with the aim to guarantee "equal access to uniform levels of healthcare, irrespective of income or geographical location" to everyone.¹⁶³

The responsibility for healthcare is organised on national, regional and local level. The state is in charge of defining and equally supplying the basic benefit package (Livelli Essenziali di Assistenza – LEA) and responsible to ensure the general objectives and principles of the

¹⁶¹ Eurostat (n.d.) Bevölkerung am 1. Januar. Retrieved from: <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=de&pcode=tps00001&plugin=1> on 19 November 2012

¹⁶² Eurostat (n.d.)

¹⁶³ Rico, A., Cetani, T. (Ed.) (2001): Health Care Systems in Transition. Italy. European Observatory on Health Care Systems.

national healthcare system are achieved. The task at the regional level is the organisation and administration of the healthcare system through regional health departments, while the local health authorities have the responsibility for healthcare service delivery.¹⁶⁴

The system is financed by regional and general taxation. In addition, local health units receive co-payments of patients through a system of prescription fees – so-called “tickets”. Private healthcare services and over-the-counter drugs have to be paid out-of-pocket. In 2004, around 15% of the population had complementary private health insurance.¹⁶⁵

Access to healthcare for irregular migrants

In Italy, accessing universal care (primary, secondary and hospitalisation) requires registration at the city council and the possession of a “Personal Healthcare Card” for everybody living in the country, including irregular migrants.¹⁶⁶

Since 1998, all migrants without a regular permit of stay have the right to urgent or primary hospital and outpatient treatment in case of sickness or accidents as well as for preventive treatment. Due to the Italian legislation on “Healthcare for foreign nationals who are not registered with the National Healthcare System” (Legislative Decree no.286 dated 25 July 1998 Art. 35), access is specifically guaranteed to the following services:

1. prenatal and maternity care;
2. healthcare for minors;
3. vaccinations;
4. preventive medicine programmes;
5. prevention, diagnosis and treatment of infectious diseases.

Additionally, there are three categories of irregular patients, who are covered by law and can be also treated besides emergency cases:

1. minors up to 18 years;
2. pregnant women up to six months after birth: as soon as the pregnancy of an irregular female migrant is confirmed, she is entitled to get access to the family planning clinic of the national healthcare service, which is located in each ASL (Azienda di Sanità Locale or Local Health Authority) where assistance is for free;
3. patients diagnosed with infectious diseases.

To access public health and medical care services, irregular migrants need to obtain the so-called regional “STP-Code” (Straniero Temporaneamente Presente - foreign national temporarily present). Irregular migrants may get the STP-code from a hospital administration or the ASL any time and free of charge. It is valid for six months and can be renewed.¹⁶⁷ This code is

¹⁶⁴ Große-Tebbe, S. & Figueras, J. (ed.) (2004). Snapshots of Health Systems. The state of affairs in 16 countries in summer 2004. *WHO Regional Office for Europe, Copenhagen*. Retrieved from: http://modelpolicies.thepraxisproject.org/files/model_policies/p44.pdf on 4 August 2014

Donatini, A. et al. (2001). Health Care Systems in Transition: Italy, *WHO Regional Office for Europe, Copenhagen*. Retrieved from: <http://www.euro.who.int/document/e73096.pdf> 29 July 2014

¹⁶⁵ Große-Tebbe & Figueras (2004:41f)

¹⁶⁶ Björngren Cuadra, C. (2010). Policies on Health Care for Undocumented Migrants in EU27. Country Report Sweden. *MIM/Health and Society, Malmö University*. Retrieved from: <http://files.nowhereland.info/692.pdf> on 29 July 2014

¹⁶⁷ see also PICUM 2007b

anonymous and consists of an STP-number, an ISTAT code (Italian National Statistics Institute) relating to the public health authority that issued it first, and the public health service where treatment is provided and a progressive number assigned at the date of issue. Regarding the provision of medical treatment, the code is used for accounting procedures, for compensation purposes and for the prescription of drugs. The code identifies the patient for all healthcare services he or she is entitled to receive and is recognised throughout Italy (Italian Presidential Decree no. 394 dated 31 August 1999 Art. 43). The STP does not entitle the irregular migrant to turn to a General Practitioner. If a GP is needed, irregular migrants can go to dedicated services or NGOs, where general medical care is provided.

If irregular migrants do not possess sufficient economic means for the medical treatment, they can apply for the “status of indigence” (Dichiarazione di Indigenza), which is certified by a self-declaration. This usually happens at the time when the regional STP-code is assigned. The self-declaration document is also valid for six months and permits irregular migrants to receive medical treatment free of charge in the framework of the above-mentioned services.

The Ministry of Interior covers costs incurred from urgent or primary hospital treatment, even for a continuous period. For refunding, the hospital in question informs the ASL. The hospital then gets reimbursement from the Ministry of Interior. For this, the anonymous STP-code, the diagnosis, the type of treatment and the reimbursement amount have to be provided. The payment of the special services (such as prenatal and maternity care, healthcare for minors, vaccinations, preventive medicine programmes, prevention, diagnosis and treatment of infectious diseases) follows a similar procedure and is covered by the National Healthcare Fund.¹⁶⁸

However, irregular migrants have to pay out-of-pocket contributions to expenses of specific services, e.g. dental care, on equal terms with Italian citizens. Such costs are not reimbursed.

Stakeholder Analysis

As outlined in the policy review, Italy follows a policy of partial acceptance of undocumented migrants providing them with some entitlements to access.¹⁶⁹ This entails that by law, certain responsibility for service provision also lies with the public health authorities, which are organised on a regional level. Therefore, the main providers of health services are public health authorities, which is complemented by NGOs that offer a range of services that in practice are made available for undocumented migrants.

Ministry of Labour, Social Services and Health

On national level, the ministry is responsible for healthcare planning and financing, framework regulation, and monitoring and has the general governance of the National Institutes for Scientific research.¹⁷⁰

¹⁶⁸ see also Italian Presidential Decree no. 394 dated 31st August 1999 Art. 43; PICUM 2007b

¹⁶⁹ Karl-Trummer, Ursula; Metzler, Birgit; Novak-Zezula, Sonja (2009): Health Care for Undocumented Migrants in the EU: Concepts and Cases. Background Paper developed within the framework of the IOM project “Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities”. Brussels: IOM.

¹⁷⁰ Lo Scalzo, Alessandra, Donatini, Andrea, Orzella, Letizia, Cicchetti, Americo, Profili, Silvia, Maresso, Anna (2009). Health System Review. *Health Systems in Transition* 11(6)1-216

Regions

Twenty regional governments, through their regional health departments, are responsible for ensuring the delivery of healthcare through a network of local health enterprises, so called *Aziende sanitarie locali* (ASLs) and public and private accredited hospitals on local level.¹⁷¹

It must be pointed out that, while the basic legal framework for access to and provision of healthcare is the same across Italy, different regions can implement these regulations in their own ways. Therefore, this analysis cannot cover all of Italy but has to concentrate on a specific region.

The following section gives an overview of services for undocumented migrants implemented in the City of Reggio Emilia, Region Emilia Romagna. Reggio Emilia is a region that belongs to the economically rich parts of Italy and has a long left-wing political tradition. It has been identified as a model of good practice in European projects on healthcare provision for undocumented migrants.¹⁷²

Reggio Emilia provides an example of the co-operation of stakeholders from the public health and NGO arena. Two main actors provide healthcare for undocumented migrants – “Centro per la salute della famiglia straniera” as a public health service, and “Querce di Mamre”, being an NGO.

Centro per la salute della famiglia straniera (“Centre for the health of foreign family”)

The healthcare centre *Centro per la salute della famiglia straniera* provides outpatient care, and medical treatment for undocumented migrants and for foreign nationals not registered in the National Health System. It is located within the jurisdiction of the Local Health Authority of Reggio Emilia and works closely with the Caritas Surgery “*Querce di Mamre*”. The centre employs healthcare professionals (general practitioners, midwives, paediatricians, gynaecologists, and nursing staff) and social workers. Services provided include gynaecological examinations and counselling, prenatal care, paediatric care and Tuberculosis (TBC) surgery. Services for specific target groups are offered on a project basis. In the framework of such projects, psychosocial support and healthcare for prostitutes and *Badanti* – elderly Eastern European women working irregularly as caregivers in private households – is offered. To facilitate communication and interaction, cultural mediators for Chinese, Arabic, Albanian, Russian, Indo-Pakistani and Nigerian are available.

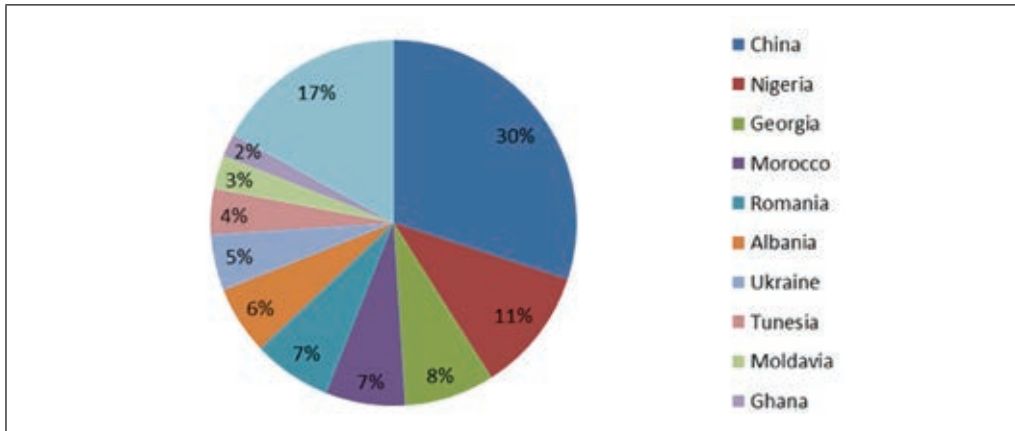
The healthcare centre keeps precise statistics on its patients made possible through the STP code. The statistical database is shared with the Caritas surgery *Querce di Mamre* (see section below), which enables both services to make appointments for patients in the respective centre. Both organisations, Caritas and the Centre for health of the foreign family, also provide shared information material for patients.

In 2011, the centre offered a total of 9,302 patient consultations with 2,842 patients. The largest communities represented are Chinese (30%), Eastern European (29%) and North African (24%).

¹⁷¹ Lo Scalzo, Alessandra, Donatini, Andrea, Orzella, Letizia, Cicchetti, Americo, Profili, Silvia, Maresso, Anna (2009).

¹⁷² Lo Scalzo, Alessandra, Donatini, Andrea, Orzella, Letizia, Cicchetti, Americo, Profili, Silvia, Maresso, Anna (2009).

Figure 8: Countries of origin of patients, 2012



Source: Centro per la salute della famiglia straniera, Dipartimento cure primarie Reggio Emilia (2012)

In urgent cases, the centre refers undocumented migrants to the emergency unit of the hospital and calls the responsible doctor at the hospital in advance. For special services (e.g. blood screening) the patients have to go to the regional healthcare service¹⁷³.

Continuity of care is an important factor of these services, especially during pregnancy. Staff members therefore try to ensure all appointments and steps through pregnancy in advance to assure the continuity of care. Through legislation, pregnant undocumented women are on equal terms with Italian women concerning healthcare. They can access the general healthcare system and do not need to go to the territorial healthcare service. Nevertheless, it is reported that most pregnant women prefer to receive treatment at the dedicated centre due to the trustful relationship and the continuous availability of a cultural mediator in these centres¹⁷⁴.

Caritas Surgery “Querce di Mamre”¹⁷⁵

Querce di Mamre is an outpatient clinic run by the Caritas in cooperation with the Local Health Authority of Reggio Emilia (AUSL). The AUSL provides the NGO with pharmaceuticals, dental materials, and covers costs for cultural mediators. Costs for electricity, heating, cleaning and waste disposal are also covered by the AUSL. The premises have five rooms for different medical consultations from practically all specialisations. It is well equipped with various instruments like ultrasound, electrocardiograph and has a well-stocked pharmacy. It is supported by a network of several medical specialists of different kinds that offer assistance directly at their private sites.

¹⁷³ see also Manghi 2005, AUSL di Reggio Emilia 2008b, Regione Emilia Romana 2008, Karl-Trummer & Metzler 2008

¹⁷⁴ Karl-Trummer, U. & Metzler, B. (2008). Internal protocol from site visits on health care organisations in Reggio Emilia, Italy, conducted in the framework of a COST STSM (Short Term Scientific Mission), 15.11.-20.11.2008

¹⁷⁵ Caritas Reggiana (n.d.) Ambulatorio. Retrieved from: <http://www.caritasreggiana.it/index.php?tipo=sezione&id=00012&idpadre=00002#articolo> on 7 August 2014

The team of *Querce di Mamre* consists of about 80 volunteering doctors (GPs and specialists) and 12 volunteering nurses. The large number of staff makes it possible to cover nearly all medical fields: general medicine, internal medicine, general surgery, obstetrics and gynaecology, paediatrics, otorhinolaryngology, ophthalmology, psychiatry, and dental care. Additionally there are two chemists, a psychologist and five informatics assistants. Communication and information services is supported by mediators and written information material.

The centre targets undocumented migrants and people with a declared status of indigence. To get services for free, patients need to declare the status of indigence immediately before they access the healthcare service in the so-called “listening centre” (*Centro d’Ascolto*). In the last five years, there was a steady increase of numbers of total visits from 437 in 2003 to 1,411 in 2008. More than half of the patients are aged between 20 and 40. In 2008, Chinese (approx. 20%), Moroccan (approx. 16%) and Moldovan (approx. 12%) comprise the three largest ethnic groups of patients.¹⁷⁶

Case Study: Communicable Disease

Case IT: Communicable Disease

X is a transgender prostitute working in Reggio Emilia, Italy. He is one of 33 transgender patients¹⁷⁷ of the municipal dedicated service, which provides outpatient care and medical treatment for undocumented migrants and for foreign nationals without registration in the National Health System service. More than half of them are diagnosed with lues.

In the course of an encounter, he is diagnosed with lues. X is provided with a penicillin therapy and advised to stay abstentious for the time of therapy, which is six days. Costs for penicillin for a six-day lues treatment in Italy are EUR 144, or USD 196.

As even smallest injuries of the mucous membrane provide a high risk for transmitting lues, the probability of spreading the disease while having sexual intercourse is extremely high. In addition, it is reported that sexual intercourses with transgender prostitutes often include practices of violence, which alters the risk of transmission.

According to staff members at the service, transgender prostitutes serve between five and eight male clients a day, most of them living in heterosexual partnerships. Non-treatment of a sex worker carrying lues who serves a minimum of five clients a day entails possible transmission of the disease to at least 35 men in a week. This very moderate model does not include any risks related to further transmission from infected clients to their partners/spouses etc..

¹⁷⁶ Pisi, R. (2008). Ambulatorio Caritas “Querce di Mamre”, Presentation at the conference ‘Qualità dei servizi sanitari in un contesto pluriculturale’, 09.10.-10.10.2008 Reggio Emilia, Italy. Retrieved from: http://www.OLD.ausl.re.it/HPH/Frontend/Home/DocumentViewer.aspx?document_id=344 on 4 August 2014

Caritas Diocesana di Reggio Emilia (2008). Retrieved from: <http://www.caritasreggiana.it/?sez=00011> on 29 July 2014
AUSL di Reggio Emilia (2008a). Odontoiatria Sociale. *Progetto AUSL e CARITAS di Reggio Emilia per cure urgenti ed essenziali a Stranieri Temporaneamente Presenti, Reggio Emilia*, 9-10 ottobre 2008. http://195.62.185.232/ausl/re/phocadownload/HPH_CHANNEL_377/c.5%20bianchi.pdf [access date: 04.08.2014]

¹⁷⁷ At the time of the researcher’s site visit in January 2013

Still, even with this moderate view, only one week of no treatment rises treatment costs with a factor 35, instead of EUR 144 for treatment of the undocumented sex worker, costs of medication for infected clients amounting EUR 5,040 or USD 6,858 arise. This does not include costs of medical consultations of the 35 infected clients.

Summary of Costs: Direct Cost of Medical Treatment – EUR 144

C. Conclusion

Looking at European policies, it has to be acknowledged that public health systems are not sufficiently able or willing to include undocumented migrants into mainstream healthcare services. Excluding tendencies can be observed at the practice level despite humanitarian and equity related arguments. NGOs therefore take over an important role when it comes to service provision. This has been criticised as a form of “charity” which helps to sustain a situation where public health bodies declare themselves as irresponsible¹⁷⁸.

Indeed, the analysis of cost calculations shows that NGOs play a crucial role in mobilising resources. Besides raising funds from donations, they work with volunteers who donate their work time, which can also be translated into an economic value. Eight NGOs in Austria do mobilise 337 volunteer hours per week. If a working hour is counted as equivalent to EUR 42 (which is the average rate for a medical doctor in 2009 according to the Austrian Court of Audit), this equals to a contribution of EUR 14,154 per week and EUR 736,008 per year. In other words, NGOs help public health systems save a considerable amount of money, not only by preventing expensive “last-minute” interventions and/or reducing risks of spreading infectious diseases, but also by fostering volunteer work from healthcare professionals.

¹⁷⁸ Gottlieb, N., Filc, D., Davidovitch, N. (2012): Medical humanitarianism, human rights and political advocacy: The case of the Israeli Open Clinic. *Social Science & Medicine*, Volume 74, Issue 6, pp. 839-845.

Verbal communication by the director of an NGO providing basic and dental health care for homeless people in Vienna, conducted on 8.120.2013

V. Comparison of Asia and Europe

Some of the major challenges identified in selected Asian countries are linked to regulations, which tend to be inadequate given the growing number of migrants in the region and the increasing reliance on foreign labour in the case of major receiving countries. Restrictive immigration policies are preventing the settlement of migrant workers and offer very little protection to migrants. This results in a large flow of irregular migrants (estimates of 1.5 to 2 million irregular migrants) in the region. Both the lack of institutional structures to deal with migration flows and the temporary nature of migration have impact on the health of migrant workers. Psychosocial health problems are raised consistently as one of the most prominent concerns among migrants. This reflects the importance of living and working conditions in the labour-intensive industries of Asia and impact on the health status of migrants.

In Hong Kong, undocumented migrants are eligible to use public healthcare services if there is an urgent need, but they will need to be reported to the Hong Kong police or authorities. Thus, some refuse to seek healthcare services for urgent cases. There are also migrant sex workers whose illegal status prevents them from actively seeking health treatment for STDs, or seeking protection from crimes committed against them. With Chinese migrant adults, depressive symptoms are the most prominent factor that affects the quality of life.

In Singapore, despite the existing legislations and tighter regulations to protect migrant health, these are not diligently practiced by employers. The removal of subsidised medical care for foreigners since 2007 has considerably raised the cost of treatment for migrant workers. While employers are responsible for providing insurance, many denied medical insurance and treatment to their migrant workers. This constrains workers to bear the costs themselves or to forgo and postpone treatments. In the worst cases, errant employers repatriate workers seeking costly medical treatment due to serious injury.

Documented migrants in Europe are provided with in-principle rights to access healthcare services. Countries like Italy have established policies targeting the needs of migrants. The challenge, however, is in the migrants' utilisation of available services, which points out to the need to improve access to healthcare services.

The issues of access to healthcare are common among the countries. In Europe, language and culture are identified to be the main barriers. Other challenges that constrains access to healthcare include: legal and financial barriers (especially for undocumented migrants),

communication barriers, migrants' low level of knowledge on health services, including lack of information on how to access them, and healthcare providers' low level of competence on understanding migrants' needs.

In Austria, equal rights and treatment is guaranteed for migrants who are legally employed and registered through insurance schemes. In practice, however, migrants are at a higher risk of getting insufficient or inappropriate treatment, mainly because of a low level of sensitivity to diversity in healthcare organisations. It can be attributed to cultural sensitivity, which is still a marginal issue in the Austrian healthcare system. For example, there is no implementation on the broader mainstreaming of translation or interpretation services in healthcare institutions. Without interpretation services, regular migrants also have high risks to be subjects of treatment errors due to miscommunications.

Legal and financial barriers to healthcare apply more to the undocumented migrants. Services can only be available when paid out of their own pockets. Undocumented migrants in Europe are denied access to healthcare until their condition becomes an urgent matter of concern, except for those in European countries that provide partial to full access to healthcare. Cost has been the main argument for exclusion policy, but considering its implications on several dimensions (economic, humanitarian, and social costs), the cost of exclusion may actually be higher than the costs of inclusion.

The most obvious implication would be the high cost of emergency services and the fact that undocumented migrants who are delaying treatment due to legal and financial barriers may constitute a higher health risk for the host population (e.g. infectious diseases). Exclusion also undermines human rights regulations and equity policies (humanitarian cost), and inequity in health weakens communities (social cost).

The economic crisis in Europe is also creating challenges to the health policies and interventions for migrants. Budget cuts have forced healthcare providers to adjust their resources (e.g. decreasing number of cultural mediators who play a key role in improving migrants' access to utilisation of healthcare). Some countries used to have a universal healthcare system that covered all health needs of the population, but the laws have changed after the economic crisis. Those who do not pay taxes will have poor access to healthcare. In addition, because of job losses, the number of irregular migrants is increasing, at least in the case of Italy where the number of permits not renewed was higher than the number of new permits released. This has increased the number of irregular migrants to half a million¹⁷⁹.

A comparison between Asia and Europe thus highlights considerable differences as well as similarities. Similarities can be seen in the growing importance of migration flows to ensure economic growth but also sustainability of existing systems of financing public healthcare systems through taxes and insurance payments. When it comes to service provision for vulnerable migrant groups, a remarkable similarity can be seen in the role of NGOs, especially faith-based organisations from established religions whether Buddhist, Hindu, Muslim

¹⁷⁹ Data based on the presentation during the 2nd ASEF Research Exchange Workshop of Dr Antonio Chiarenza of the WHO HPH Task Force on Migrant-Friendly and Culturally Competent Healthcare. Retrieved from the ASEF website at http://www.asef.org/images/docs/Session%201_3_Antonio%20Chiarenza_Case%20of%20Italy.pdf

or Christian. In the Asian as well as the European cases, it could be shown that a parallel structure of health and social care provision organised and implemented by NGOs and based on cooperation with volunteers plays a crucial role.

Another similarity becomes evident in the lack of robust evidence on costs of inclusion and exclusion of vulnerable migrant groups into healthcare. This can be seen as a confirmation that studies of this kind are urgently needed to foster evidence-based policy development. On the level of policy discussion and implementation, a traditional divide exists between the emphasis on human rights in welfare services of long-term developed Europe versus commercialism and need to compete on lower wage costs in rapidly developing Asia. The key policy question remains whether there will be future convergence with the reversal of economic growth and affluence in Asia versus economic slowdown and rising welfare costs in Europe, providing stronger justification for migrant health services based on the economic case (see Appendix 3: The Economic Case – Social Costs of Migrant Health).

VI. Policy Recommendations

A. Hong Kong and Singapore

In the light of the many common labour issues and stakeholders' interests relating to foreign workers in Hong Kong and Singapore, the following broad policy recommendations are proposed:

Establish a statutory body for patient grievances

As mentioned in the policy gap analysis, the current mechanisms to address grievances in the healthcare system are highly fragmented. Migrants, who have little experience with the local healthcare system, often find the process for remediation difficult. Therefore, there needs to be a more integrated agency for patient grievances with the following characteristics:

- There should be a **central integrated system for complaints**. The various channels through which patients can file their complaints are complex and have varying jurisdiction and powers. In Hong Kong, the “three complaint mechanisms” (referring to the Department of Health, Public Complaints committee of HA and the Medical Council of Hong Kong) each are responsible for only a part of the complaints process.¹⁸⁰ To ensure that patients can have a simple and straightforward process of filing complaints, there should be one statutory body that acts as a “one-stop-shop” for all compliant procedures.
- The mechanism for patient grievances must be an **independent statutory body**. The current complaint systems may not work in the interests of foreign workers as patients. Having an independent agency would avoid issues of conflicting interests.
- The complaints mechanism should have **direct investigative powers** to examine the relevant parties involved.
- The independent complaints mechanism should help obtain the necessary information that patients need for their case and **provide assistance and support** (whether legal representation or procedural services) to help foreign workers and patients navigate the complaint process.

¹⁸⁰ Leung GM, Bacon-Shone J, eds. *Hong Kong's health system: reflections, perspectives and visions*. Hong Kong: Hong Kong University Press; 288.

Establish public interpreter services in public hospitals

The lack of proper translation services in public hospitals poses a barrier to many migrants. In Hong Kong, according to the Race Discrimination Bill, there is no stipulation that it is illegal to deny services based on language.¹⁸¹ A system of interpreter services for public hospitals should be implemented to aid smoother communication between patients and hospital staff. Patients should not be denied their rights to proper medical treatment due to language problems. This gap in service should also not be left to voluntary community organisations. Thus, the following were recommendations by the Hong Kong Human Rights Commission submitted to the Hong Kong Bills Committee¹⁸²:

- Include language as a ground of discrimination and cancel the exemptions on language as mentioned in clause 58 of the proposed Race Discrimination Bill.
- Mainstream the use of interpreters in government departments. Information about the services, particularly those that concern migrants, should be provided in different languages.
- Set up an examination for medical interpreters to ensure their qualification and maintain high service standards.
- Actively hire ethnic minorities in the public sector in order to utilise their skills and talents. Integrating ethnic minority staff in the medical sector would be beneficial to ethnic minority patients.

Stronger law enforcement against errant employers and agencies

The regulatory bodies, Labour Department in Hong Kong and Ministry of Manpower in Singapore, should devote more resources for stronger enforcement to ensure that employers do not unlawfully terminate employment contracts or use part-time contracts to deny benefits to full-time workers. Enforcement agencies must regulate employment agencies more effectively and collaborate with them to inform migrant workers about their rights and entitlements.

Closer collaboration between NGOs and government

In light of the crucial role played by NGOs in delivering services to migrant workers, collaboration between government agencies and NGOs will be helpful in assessing the specific needs of migrant workers both in Hong Kong and Singapore, and in evaluating the economic and social costs of inappropriate or lack of access to mainstream healthcare services.

¹⁸¹ Hong Kong Human Rights Monitor (n.d.) Race Discrimination Bill. Retrieved from: http://www.hkhrm.org.hk/racial%20discrimination/database/eng/RaceDiscriminationBill_e.pdf on 31 August 2014

¹⁸² Hong Kong Human Rights Commission, Society for Community Organization and Asylum Seekers' and Refugees' Voice (2008).

B. Austria and Italy

When comparing the different approaches of “functional ignorance” as a main policy element in Austria and “partial acceptance” in Italy on level of practice implications, it becomes apparent that functional ignorance has a more informal nature of measures taken as well as the lack of reliable information on numbers of irregular migrants and their health needs. This implies also the lack of a solid basis to protect the legally residing population from risks emerging from infectious diseases.

In contrast, “partial acceptance” allows implementing administrative instruments to monitor the presence of irregular migrants and their health status and needs. Furthermore, it builds the basis to establish sustainable partnerships between public health institutions and non-governmental organisations for healthcare provision. This allows implementing stable structures to ensure access to healthcare for irregular migrants that go beyond emergency care and thus fosters access to fundamental rights.

Based on the insights gained in this project and the valuable work in previous projects on the situation of irregular migrants in the EU, the following recommendations can be formulated.

Acknowledge irregular migrants as part of a European population

As is reflected already in different communications from the European Commission, national policies should react and discuss how to ensure fundamental rights for irregular migrants in their territories. Evidence from several projects shows that all EU member states are affected by irregular migration and therefore would benefit from a better knowledge base on the issue.

Enable exchange of experiences in the framework of different policy approaches

A comparative view on policies in EU member states shows that there are different policy approaches in place, ranging from full access to healthcare to full exclusion from healthcare. What are the pros and cons of these different approaches and what are lessons to be learned from them? What are consequences on level of practices? The comparative view on Austria and Italy reveals the benefit of having implemented an administrative instrument to monitor health of irregular migrants and occurrence of diseases among them. The Austrian case of an irregular Mexican male, infected with lues and HIV shows the disadvantages of “functional ignorance”. The system cannot say precisely what happened after the last communication and if this man did get treated. In contrast, the Italian case shows that with the assigned status of the *Straniero Temporaneamente Presente*, the case of a man infected with lues gets traceable and treated for the benefit of an overall population.

Enable exchange of experiences on a practice level

Previous projects as well as this one have demonstrated that there are different practices of healthcare provision for irregular migrants in place, both within as well as in parallel to the regular public health systems. Exchange of experiences can foster joint development of practices that respond to demands of fundamental rights as well as to cost-effectiveness of interventions.

Foster closer collaboration between NGOs and government

As in the recommendations from the Asian part of the study, close collaboration between NGOs and government can be recommended from the findings for Europe. Both for Austria and Italy it shows that NGOs play a crucial role in service delivery for irregular migrants. Irregular migrants often do not dare to show up in the regular system and rely on services where they do not fear to get visible for state authorities. Furthermore, the Italian case shows that a stable partnership between governmental services and NGOs can successfully establish a high level support at low economic costs.

Continue the development of economic analysis of healthcare provision for irregular migrants

The attempts made in this project to develop elements for an economic analysis of healthcare have to be continued. It could be shown on case level that treatment costs rise considerably with time of treatment delay. Further steps should include an analysis that can generate results that are more generalizable.

Obtain better evidence on black labour market as driver/pull factor for irregular migration to Europe

The real life cases collected in this study show the close connection of irregular migration and black labour markets. They also reveal the difficult working conditions and the lack of protection at the workplace. Factors related to work have a high impact on the health of irregular migrants. Getting better knowledge about this area will also help to understand health issues of irregular migrants.

VII. Conclusion

Like the different starting points for this comparative research, Asian and European countries have a lot to learn from each other in understanding the nature and complexities of specific migrant populations and their health needs within the different contexts of the countries concerned. Despite the compelling case for social inclusion of universal health coverage on moral and public health grounds, the concept has not gained acceptance in many countries. Migrants and migrant workers are still struggling for basic protection and adequate workmen's compensation. Employers who are able to deny or reduce their liability for work-related diseases and injuries aggravate their situation. The cynical view would be that some governments and profit-driven business sector might see the costly regulatory environment of migrant safety and health in other nations as a distinct competitive economic disadvantage to be avoided at all costs. After all, "cheap labour" is what makes competitive countries attractive to foreign manufacturing plants.

However, the real lesson may be that the potential and full economic benefits of investing in migrant workers' health, of reduced sickness absenteeism and work disability, and of increased productivity to the economy, have not been clearly understood or demonstrated. The role of social costing and economic evaluation in these situations would be to buttress the moral and ethical arguments for migrant health services, and to illuminate the trade-offs and compromises that must inevitably be made in order that "net welfare loss" is minimised as a whole.

The various case studies presented in this study show the benefits of migrant health services. Challenges are abound in getting hard evidence to justify investing in its provision and expansion, given that every dollar spent on migrant health and safety means less money all around for alternative uses by citizens and non-migrants. However, the measurement and evaluation of the health and economic impact of policy interventions remain relevant because decision-makers understand and respond to evidence and money. Future investments in supporting more of such comparative trans-disciplinary studies to unravel the true costs of migrant health should facilitate better-informed, evidence-informed policy-making.

Thus, the economic arguments should supplement moral suasion. While most migrant health and safety initiatives in industrialised countries have come about despite the lack of economic arguments in the past, this is no longer tenable with rising health and labour costs. However, valid forms of economic evaluation to present the social cost-benefit equation would have to be reconciled with ethical and moral arguments reflecting deeply held societal values in

persuading more enlightened governments and firms to invest *a priori* in comprehensive or essential health services for migrants and their families. Ultimately, the formulation of policies concerning migrant health must be both economically and ethically sound.

This comparative study is a preliminary and modest attempt to advance the objectives of understanding the cost of exclusion of health services for migrants and the issues involved. It is achieved by mixed methods and different approaches in selecting empirical case studies, contextualising individual narratives to the related issues of exclusion within specific jurisdictions and systems. By valuing and extrapolating these social and economic costs (both direct and indirect) and relating the full range of costs towards a comparative policy review and stakeholder analysis, relevant policy lessons can be drawn to offer recommendations for greater inclusion of migrant populations to the healthcare systems of Asia and Europe.

Reference List

Action for Reach Out (2007). Home. Retrieved from: <http://www.afro.org.hk/EN/> on 31 August 2014.

Almenoar, Maria (2012). Four SMRT bus drivers from China charged with instigating strike granted bail. Straits Times. Retrieved from <http://www.straitstimes.com/the-big-story/smart-bus-driver-dispute/story/four-smrt-bus-drivers-china-charged-instigating-strike-g> on 26 December 2012.

AsiaOne (2012) "Maids to get weekly rest days". Retrieved from: <http://news.asiaone.com/News/Latest+News/Singapore/Story/A1Story20120305-331728.html>, on 18 November 2012.

AsiaOne Online (2013). *Population White Paper Debate: Who's Xenophobic?* Retrieved from <http://www.asiaone.com/News/Latest%2BNews/Singapore/Story/A1Story20130221-403658.html> on 27 June 2013.

Asian Migrant Centre. (2001) *Underpayment: Research on Indonesian Domestic Workers in HK*.

AUSL di Reggio Emilia (2008a). Odontoiatria Sociale. *Progetto AUSL e CARITAS di Reggio Emilia per cure urgenti ed essenziali a Stranieri Temporaneamente Presenti, Reggio Emilia, 9-10 ottobre 2008*. Retrieved from: http://195.62.185.232/auslre/phocadownload/HPH_CHANNEL_377/c.5%20bianchi.pdf on 4 August 2014.

Austrian Ministry of Health (2013) *Rahmen-Gesundheitsziele*. Retrieved from: <http://www.gesundheitsziele-oesterreich.at/> on 4 August 2014.

Bandyopadhyay, M., & Thomas, J. (2002). Women migrant workers' vulnerability to HIV infection in Hong Kong. *AIDS care*, 14(4), 509-521.

Bhabha, J., Leader, P S., Ruggie, M., Ignacio, E., & Mejia, Y. (2008). Managing labour migration: The case of the Filipino and Indonesian domestic helper market in Hong Kong.

Björngren Cuadra, C. (2010). Policies on Health Care for Undocumented Migrants in EU27. Country Report Sweden. *MIM/Health and Society, Malmö University* Retrieved from: <http://files.nowhereland.info/692.pdf> on 29 July 2014

BMGF/Federal Ministry for Health and Women (2005). Das Gesundheitswesen in Österreich, *BMGF Vienna*.

BM.I Bundesministerium für Inneres (2011). Asylstatistik. Retrieved from: http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/2011/Asylstatistik_2011.pdf on 4 August 2014.

BM.I Bundesministerium für Inneres. (n.d.) Aufgabenbereiche des Innenressorts. Retrieved from: http://www.bmi.gv.at/cms/bmi_service/start.aspx#t_aufgaben on 4 August 2014.

Brown, L., Thurecht, L., Nepal, B., (2012). The cost of Inaction on the Social Determinants of Health. Report no. 2/2012, June 4, 2012 CHA-NATSEM Second Report on Health Inequalities, *NATSEM, University of Canberra*.

Caminal, J., Starfield, B., Sánchez, E., Casanova, C. and Morales, M. (2004). The role of primary care in ambulatory care sensitive conditions. *European Journal of Public Health*, 2004, 14: 3.

Caritas, Ambulatorium Caritas Marienambulanz (2011). Jahresbericht/Annual Report 2011.

Caritas Diocesana di Reggio Emilia (2008). Retrieved from: <http://www.caritasreggiana.it/?sez=00011> on 29 July 2014.

Caritas Reggiana (n.d.) Ambulatorio. Retrieved from: <http://www.caritasreggiana.it/index.php?tipo=sezione&id=00012&idpadre=00002#articolo> on 7 August 2014.

Carrera, Sergio; Parkin, Joanna (2011) Protecting and Delivering Fundamental Rights of Irregular Migrants at Local and Regional Levels in the European Union. Centre for European Policy Studies, (CEPS). Retrieved from: <http://cor.europa.eu/en/documentation/studies/Documents/protecting-fundamental-rights-irregular-migrants.pdf> on 4 August 2014.

Census and Statistics Department, Government of the Hong Kong Special Administrative Region. (1981). Hong Kong 1981 Population Census. Hong Kong: Government Printers; 1981.

Centro per la salute della famiglia straniera, Dipartimento cure primarie Reggio Emilia (2012): *Attività 2011*.

Channel News Asia (2012a). Migrant Workers' Centre welcomes amendments to Employment of Foreign Manpower Act, Channel News Asia. Retrieved from: <http://news.xin.msn.com/en/singapore/migrant-workers'-centre-welcomes-amendments-to-employment-of-foreign-manpower-act>.

_____ (2012b). Migrant Workers' Centre reminds employers of their roles, Channel News Asia. Retrieved from: <http://www.channelnewsasia.com/stories/singaporelocalnews/view/1243545/1/.html> on 26 December 2012.

_____ (2012c). Foreign workers in pay dispute at Yishun construction site, Channel News Asia. Retrieved from: <http://www.channelnewsasia.com/stories/singaporelocalnews/view/1243430/1/.html>.

_____ (2012d). Migrant workers' recreation centre opens at Penjuru, ChannelNewsAsia. Retrieved from: <http://www.channelnewsasia.com/stories/singaporelocalnews/print/1243075/1/.html> on 26 Dec 2012.

Chou, K. L. (2009). Pre-migration planning and depression among new migrants to Hong Kong: The moderating role of social support. *Journal of Affective Disorders*, 114(1), 85-93.

Christian Action (2014). Home. <http://www.christian-action.org.hk/> on 31 August 2014.

Dahrouge, S., Devlin, R.A., Hogg, B., Russell, G., Coyle, D., Fergusson, D. (2012). The Economic Impact of Improvements in Primary Healthcare Performance PHC. *Canadian Health Services Research Foundation – CHSRF, Ottawa*.

Daryl Chin (2010) "Safety issue in construction despite efforts", The Straits Times, 3 July 2010.

Demokratiezentrum (n.d.) Asylpolitik in Österreich im europäischen Kontext. Retrieved from: <http://www.demokratiezentrum.org/wissen/timelines/asylpolitik-in-oesterreich.html> on 04 August 2014.

Demokratiezentrum (n.d.) Asyl in Österreich. Retrieved from: <http://www.demokratiezentrum.org/wissen/wissensstationen/asyl-in-oesterreich.html> on 4 August 2014.

Donatini, A. et al. (2001). Health Care Systems in Transition: Italy, *WHO Regional Office for Europe, Copenhagen*. Retrieved from: <http://www.euro.who.int/document/e73096.pdf> on 29 July 2014.

European Commission (2014a). Irregular Immigration. European Commission Home Affairs. Retrieved from http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/immigration/irregular-immigration/index_en.htm on 29 July 2014.

European Commission (2014b). Public Health. European Commission Home Affairs. Retrieved from: http://ec.europa.eu/health/index_en.htm on 8 August 2014

European Commission Agency for Human Rights. (2011). Migrants in an irregular situation: access to healthcare in 10 European Union Member States. Retrieved from http://fra.europa.eu/sites/default/files/fra_uploads/1925-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf on 8 August 2012.

European Council (2010). *The Stockholm Programme — An open and secure Europe serving and protecting citizens*. Official Journal of the European Union. Retrieved from: <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:C:2010:115:FULL&from=EN> on 8 August 2014.

European Union Agency for Human Rights (2014). About the FRA. European Union Agency for Human Rights. Retrieved from: <http://fra.europa.eu/en/about-fra> on 29 July 2014.

Eurostat (n.d.) Bevölkerung am 1. Januar. Retrieved from: <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=de&pcode=tps00001&plugin=1> on 19 November 2012.

Folland, S., Goodman A.C., Stano M. (2010). *The Economics of Health and Health Care. Sixth Edition. Pearson International Edition.*

Fong H. 2011. Policy implications of migration for the immunization of Chinese children in Hong Kong. The Chinese University of Hong Kong. [PhD Thesis].

Fuchs, M., Schmied, G., Oberzaucher, N. (2003). Quantitative und Qualitative Erfassung und Analyse der nicht-krankenversicherten Personen in Österreich. *Bundesministerium für Gesundheit und Frauen, Wien.*

Gao Y, Li LP, Kim JH, Congdon N, Lau J, Griffiths S. The impact of parental migration on health status and health behaviours among left behind adolescent school children in China. *BMC Public Health.* 2010 Feb 3;10:56.

Ghosh, Phalash (2013) Singapore Seeks To Cut Quota On Foreign Workers Amid Worries Over Immigration, Rising Labor Costs. *International Business Times.* Retrieved from: <http://www.ibtimes.com/singapore-seeks-cut-quota-foreign-workers-amid-worries-over-immigration-rising-labor-costs-1103229> on 27 June 2013.

Gottlieb, N., Filc, D., Davidovitch, N. (2012): Medical humanitarianism, human rights and political advocacy: The case of the Israeli Open Clinic. *Social Science & Medicine, Volume 74, Issue 6, pp. 839-845.*

GovHK (n.d.) Hong Kong: The facts. Retrieved from: <http://www.gov.hk/en/about/abouthk/facts.htm> on 31 August 2014.

WHO Regional Office for Europe, Copenhagen. Retrieved from: http://modelpolicies.thep Praxisproject.org/files/model_policies/p44.pdf on 4 August 2014.

HealthServe Ltd (2012) Annual Report. Retrieved from: http://webboe.com/websysdocs/F8D_Annual_Report_2011.pdf on 3 January 2013.

Holroyd, E. A., Molassiotis, A., & Taylor-Pilliae, R. E. (2001). Filipino domestic workers in Hong Kong: health related behaviors, health locus of control and social support. *Women & health, 33(1-2), 181-205.*

Holroyd, E. A., Taylor-Pilliae, R. E., & Twinn, S. F. (2003). Investigating Hong Kong's Filipino domestic workers' healthcare behavior, knowledge, beliefs and attitudes towards cervical cancer and cervical screening. *Women & health, 38(1), 69-82.*

Hong Kong Human Rights Commission, Society for Community Organization and Asylum Seekers' and Refugees' Voice (2008). Interpreter services at hospitals for ethnic minorities. Retrieved from: <http://www.legco.gov.hk/yr06-07/english/bc/bc52/papers/bc520416cb2-1600-2-e.pdf> on 31 August 2014.

Hong Kong Human Rights Monitor (n.d.) Race Discrimination Bill. Retrieved from: http://www.hkhrm.org.hk/racial%20discrimination/database/eng/RaceDiscriminationBill_e.pdf on 31 August 2014.

Hong Kong Special Administrative Region Government. (2012) *19 arrested during anti-illegal worker operation in New Territories North*. Retrieved from <http://www.info.gov.hk/gia/general/201207/31/P201207310369.htm> on 31 August 2014.

Hong Kong Special Administrative Region Government. (2013). Retrieved from <http://www.gov.hk/en/about/abouthk/factsheets/docs/immigration.pdf>.

Hong Kong SAR Audit Commission. (2007). Report No. 47 of the Director of Audit — Chapter 5 Hospital Authority: Management of outstanding medical fees. Retrieved from: http://www.aud.gov.hk/pdf_e/e47ch05_sum.pdf on 31 August 2014.

Hong Kong SAR Department of Justice (1997). Hospital Authority Ordinance (Cap 113). Retrieved from: http://www.legislation.gov.hk/blis_pdf.nsf/6799165D2FEE3FA94825755E0033E532/6D14349D9F44AB37482575EE003D8C4C?OpenDocument&bt=0 on 31 August 2014.

Hong Kong SAR Hospital Authority (n.d.) Fees and Charges Retrieved from: http://www.ha.org.hk/haho/ho/cs/v3/serviceguide_feenchg-en.htm on 31 August 2014.

Hong Kong SAR Labour Department. (n.d.). *Chapter 1 - Application of Employment Ordinance*. Retrieved from <http://www.labour.gov.hk/eng/public/wcp/ConciseGuide/01.pdf> on 31 August 2014.

_____ (n.d.). *Know Your Identity and Rights*. Retrieved from <http://www.labour.gov.hk/eng/public/wcp/SelfEmployedPerson.pdf> on 31 August 2014.

_____ (2012). *A Concise Guide to the Employees' Compensation Ordinance*. Retrieved from <http://www.labour.gov.hk/eng/public/ecd/pco360.pdf> on 31 August 2014.

Hofmarcher, Maria M. & Rack, Herta M. (2006). *Gesundheitssysteme im Wandel: Österreich. WHO Regional Office for Europe, Copenhagen*.

Hofmarcher, Maria M. (2013). *Das Österreichische Gesundheitssystem. Akteure, Daten, Analysen. Medizinisch Wissenschaftliche Verlagsgesellschaft, Berlin*.

Hong Kong Legal Information Institute (2008). CAP 602 Race Discrimination Ordinance. Retrieved from: <http://www.hklii.hk/eng/hk/legis/ord/602/> on 31 August 2014.

Hong Kong SAR Labour Department - Labour Legislation. (n.d.). Retrieved from <http://www.labour.gov.hk/eng/legislat/content1.htm> on 31 August 2014.

Hui, W. T. (2002). Foreign manpower policy in Singapore. *Koh, Lim, Hui, Rao, Chng (eds) Singapore Economy in the 21st Century: Issues and Strategies, McGraw Hill*.

Inner City Ministries (2010). Home. Retrieved from: <http://www.innercityministries.org/> on 31 August 2014.

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'*. IOM Vienna.

Jandl, M., Kraler, A., (2003): Austria: A Country of Immigration? Retrieved from: <http://www.migrationinformation.org/Profiles/display.cfm?ID=105> on 14 February 2013.

Leung GM, Bacon-Shone J, eds. *Hong Kong's health system: reflections, perspectives and visions*. Hong Kong: Hong Kong University Press; 288.

Lo Scalzo, Alessandra, Donatini, Andrea, Orzella, Letizia, Cicchetti, Americo, Profili, Silvia, Maresso, Anna (2009). Health System Review. *Health Systems in Transition* 11(6)1-21.

Karl-Trummer, Ursula; Metzler, Birgit; Novak-Zezula, Sonja (2009): Health Care for Undocumented Migrants in the EU: Concepts and Cases. Background Paper developed within the framework of the IOM project "Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities". Brussels: IOM.

Karl-Trummer, Ursula; Novak-Zezula, Sonja (2010): Health Care for Undocumented Migrants. Fact Sheet Practices <http://c-hm.com/chm/>.

Karl-Trummer, Ursula; Novak-Zezula, Sonja; Metzler, Birgit (2009): Managing a Paradox: Health Care for Undocumented Migrants in the EU. In: Finnish Journal of Ethnicity and Migration; 4, 2; p. 53-60., http://c-hm.com/NHC_FJEM_2_2009.pdf.

Karl-Trummer, U., Novak-Zezula, S. (2010). Health Care for Undocumented Migrants. Fact Sheet Practices. *Center for Health and Migration. Vienna*. Retrieved from: http://c-hm.com/NHL_practice_rz_EN-1.pdf on 04 August 2014.

Karl-Trummer, Ursula; Metzler, Birgit; Novak-Zezula, Sonja (2009): Health Care for Undocumented Migrants in the EU: Concepts and Cases. Background Paper developed within the framework of the IOM project "Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities". Brussels: IOM.

Karl-Trummer, U. & Metzler, B. (2008). Internal protocol from site visits on health care organisations in Reggio Emilia, Italy, conducted in the framework of a COST STSM (Short Term Scientific Mission), 15.11.-20.11.2008.

Liew Hanqing (2010) 100 pregnant maids sent home a year", *The Straits Times*, 29 Sep 2010.

Lowe, A. (2012). *Hong Kong Immigration Officials Busted Illegal Immigrant Workers | International Immigration News*. Retrieved from <http://news.visato.com/hong-kong/hong-kong-immigration-officials-busted-illegal-immigrant-workers/20120811/>.

McBride M (2014). Indonesian migrant workers in Hong Kong exploited and forgotten. Ethics in Action. Asian Human Rights Commission.

Merlino, Massimo; Parkin, Joanna (n.d.), Irregular Migration in Europe: EU policies and the Fundamental Rights Gap. Centre for European Policy Studies (CEPS). Retrieved from: http://migration.etuc.org/en/docs_en/1%20Irregular%20Migration%20in%20Europe_%20EU%20policies%20and%20the%20Fundamental%20Rights%20Gap.pdf on 29 July 2014.

Migrant Worker's Centre (2012). NTUC spells out ways to tackle migrant workers's interests, MWC Centre's Latest News, http://www.mwc.org.sg/wps/portal/mwc/home/latestnews/latestnewsdetails?WCM_GLOBAL_CONTEXT=/content_library/ntuc/home/working+for+u/c6fe7c004dcf10da8eb0aec7b9d67807, accessed on 26 December 2012.

Mission for Migrant Workers (2013). Home. Retrieved from: <http://www.migrants.net/> on 31 August 2014.

Mou J, Cheng J, Zhang D, Jiang H, Lin L, Griffiths SM. Health care utilisation amongst Shenzhen migrant workers: does being insured make a difference? *BMC Health Serv Res*. 2009 Nov 21;9:214.

Mou J, Griffiths SM, Fong HF, Hu Q, Xie X, He Y, Ma H, Cheng J. Seroprevalence of rubella in female migrant factory workers in Shenzhen, China. *Vaccine*. 2010 Nov 23;28(50):7844-51. Epub 2010 October 29.

Mou Jin, Cheng Jinquan, Griffiths Sian Meryl, Wong Yeung Shan Samuel, Hillier Sheila and Zhang Dan. "Internal Migration and Depressive Symptoms among Migrant Factory Workers in Shenzhen, China". *Journal of Community Psychology*, 39(2):212-230. 2011.03.

New Home Association (2014). Service Centres. Retrieved from: <http://www.nha.org.hk/rSeverIndex.aspx?clid=124&lan=2> on 31 August 2014.

Pace, P. (2007). International Migration Law No 12-. Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments. *International Organisation for Migration, Geneva*. Retrieved from: http://publications.iom.int/bookstore/free/IML_12_EN.pdf on 4 August 2014.

Pappas G., Hadden, W.C., Kozak, L.J. and Fisher, J.F. (1997). Potentially Avoidable Hospitalizations: Inequality in Rates between US Socioeconomic Groups. *American Journal of Public Health*, 1997, 87:5 Kruzikas, D.T., Jiang, H.J., Remus, D., Barrett, M.L., Coffey, R.M., and Andrews, R. (2000). Preventable Hospitalization: A Window into Primary and Preventive Care. *Agency for Healthcare Research and Quality*, 2004. HCUP Fact Book No. 5; AHRQ Publication No. 04-0056.

Pathfinders (2012). Home. Retrieved from: <http://www.pathfinders.org.hk/public/> on 31 August 2014.

Platform for International Cooperation on Undocumented Migrants (2014a). Home. Retrieved from: <http://picum.org/en> on 8 August 2014.

_____ (2014b). Healthcare. Retrieved from: <http://picum.org/en/our-work/health-care/> on 8 August 2014.

Pisi, R. (2008). Ambulatorio Caritas "Querce di Mamre", Presentation at the conference 'Qualità dei servizi sanitari in un contesto pluriculturale', 09.10.-10.10.2008 Reggio Emilia, Italy. Retrieved from: http://wwwold.ausl.re.it/HPH/Frontend/Home/DocumentViewer.aspx?document_id=344 on 4 August 2014.

Prema-Chandra Athukorala and Chris Manning (2000). "Hong Kong and Singapore: City-States Shaped by Migrants". *Structural Change and International Migration in East Asia: Adjusting to Labour Scarcity*. Oxford University Press.

Radha Basu (2010) "Getting street smart on worker transport safety", *The Straits Times*, 30 June 2010.

Rizza, P, Bianco, A., Pavia, M. and Angelillo I.F. (2007). Preventable Hospitalization and access to primary health care in and areas of Southern Italy., *BMC Health Service Research*, 7:134.

Royston Sim (2011) "Fewer casualties with stiffer lorry ferrying rules", *The Straits Times*, 2 August 2011.

Saifulbahri Ismail (2011) "MNCs wants more clarity on foreign worker policy", *TODAY*, 12 November 2011.

Sim, Royston (2012) SMRT bus drivers say they are unhappy with pay, living conditions, *Straits Times*. Retrieved from: <http://www.straitstimes.com/breaking-news/singapore/story/smrt-bus-drivers-say-they-are-unhappy-pay-living-conditions-20121126> on 26 December 2012.

Singapore Ministry of Manpower (n.d.a) Retrieved from: <http://www.mom.gov.sg/foreign-manpower/foreign-worker-levies/Pages/levies-quotas-for-hiring-foreign-workers.aspx> on 18 November 2012.

_____ (n.d.b). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/dependant-pass/before-you-apply/Pages/default.aspx> on 18 November 2012.

_____ (n.d.c). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fw/when-you-apply/Pages/medical-examination.aspx>.

_____ (n.d.d). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/inform-mom/Pages/medical-examination.aspx>.

_____ (n.d.e). Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fw/before-you-apply/Pages/medical-insurance.aspx>.

_____ (n.d.f) Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx>.

_____ (n.d.g) "Employment Laws and Contracts". Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx>.

_____ (n.d.h) "Well-being: Weekly Rest Day". Retrieved from: <http://www.mom.gov.sg/foreign-manpower/passes-visas/work-permit-fdw/before-you-apply/Pages/default.aspx>.

_____ (n.d.i) "Who is covered under the Work Injury Compensation Act?" Retrieved from: <http://www.mom.gov.sg/workplace-safety-health/work-injury-compensation/Pages/WICcovered.aspx>.

_____ (n.d.) *Mission* - Ministry of Manpower. Retrieved from: <http://www.mom.gov.sg/aboutus/Pages/vision-mission-values.aspx> on 27 June 2013.

_____ (2012). 'Employment of Foreign Manpower (Work Passes) Regulations 2012': Fourth Schedule, Conditions and regulatory conditions of work permit, Part V: Conduct. Retrieved from: <http://www.mom.gov.sg/Documents/services-forms/passes/WPSPassConditions.pdf>, on 18 November 2012.

Rico, A., Cetani, T. (Ed.) (2001): *Health Care Systems in Transition*. Italy. European Observatory on Health Care Systems.

Russo, C. A., Jiang, H. J. and Barrett, M. (2007). Trends in Potentially Preventable Hospitalizations among Adults and Children, 1997-2004., HCUP Statistical Brief # 36, August 2006, *Agency for Healthcare Research and Quality, Rockville, MD*.

Singapore Ministry of Manpower and Work Safety Health Council, *Work Injury Compensation: A Guide for Employers*, p. 6-7.

United Nations. (2009). *International Migration 2009*. Retrieved from http://www.un.org/esa/population/publications/2009Migration_Chart/ittmig_wallchart09.pdf.

United Nations High Commission for Refugees (n.d.) *Flüchtlingsland Österreich*. UNHCR website. Retrieved from: <http://www.unhcr.at/unhcr/in-oesterreich/fluechtlingsland-oesterreich.html> on 30 July 2014.

United States Department of State (2012). *2012 Trafficking in Persons Report – Hong Kong*. Retrieved from: <http://www.refworld.org/cgi-bin/texis/vtx/rwmain?page=country&category=&publisher=&type=&coi=HKG&rid=&docid=4fe30cc3c&skip=0>.

Tan Chuan-Jin (2012). *Recognizing the Contributions of Foreign Workers*, The Manpower Blog, Ministry of Manpower. Retrieved from: <http://momsingapore.blogspot.sg/2012/12/recognising-contributions-of-foreign.html> on 26 December 2012.

Teh Joo Lin, "Broken dreams, tough life for overstayers", *The Straits Times*, 2 August 2010.

The Duty Service Lawyer (n.d.) *Frequently Asked Questions*. Retrieved from: <http://www.dutylawyer.org.hk/en/faq.asp>.

The Hong Kong Council of Social Service (2005). Retrieved from: www.hkcss.org.hk/fs/er/.../EM_Interpret%20Proposal20050831.doc.

The Medical Council of Hong Kong (n.d.) Retrieved from: <http://www.mchk.org.hk/>.

Trummer, U., Novak-Zezula, S. (2013): *Costs of Exclusion. Pros and Cons of Health Care for Irregular Migrants*. In: *Going international*, March 2013.

Tsang, S. (2007). *A Modern History of Hong Kong: 1841-1997*. IB Tauris.

Vogel, D., Cyrus, N. (2008): *Irregular Migration in Europe? Doubts about the Effectiveness of Control Strategies*, focus Migration Policy Brief No 9.

Wong, D. (2003). *Eligibility of Immigrants for Health Care Services*. Retrieved from <http://www.legco.gov.hk/yr03-04/english/sec/library/0304rp01e.pdf>.

Wong, W. C., Holroyd, E., Chan, E. Y., Griffiths, S., & Bingham, A. (2008). One country, two systems": Sociopolitical implications for female migrant sex workers in Hong Kong. *BMC Int health hum Rights*, 8, 13.

Wong, W. K., Chou, K. L., & Chow, N. W. (2012). Correlates of quality of life in new migrants to Hong Kong from Mainland China. *Social indicators research*, 107(2), 373-391.

World Health Organization. (2014) Global Health Expenditure Databases. World Health Organization (WHO). Retrieved from <http://apps.who.int/nha/database/Home/Index/en>, on 04 August 2014.

Yamanaka, K., & Piper, N. (2005). *Feminized migration in East and Southeast Asia: Policies, actions and empowerment* (Vol. 11). Geneva: UNRISD.

Yeoh, B. S., & Lin, W. (2012). Rapid growth in Singapore's immigrant population brings policy challenges. *Migration Information Source*.

YM Chu (2006). Quality of Care and Patient Redress: A Patient Perspective. In: Leung GM, Bacon-Shone J, eds. *Hong Kong's health system: reflections, perspectives and visions*. Hong Kong: Hong Kong University Press; 271-290.

Zweifel, P, Felder, S., Meiers, M. (1999). Ageing of Population and Health Care Expenditures: A Red Herring? *Health Economics* 8: 485-496.

Glossary

In this report, terms are used according to the glossary in the Report on the 2nd Research Exchange Workshop and Public Briefing: Bringing the Migrant Health Discourse into Policy, Asia-Europe Foundation (ASEF) Public Health Network (28-29 November 2012, Makati City, Philippines).

Capacity building

Building capacity of governments and civil society by increasing their knowledge and enhancing their skills. Capacity building can take the form of substantive direct project design and implementation with a partner government, training opportunities, or in other circumstances facilitation of a bilateral or multilateral agenda for dialogue development put in place by concerned authorities. In all cases, capacity building aims to build towards generally acceptable benchmarks of management practices.

Country of destination

The country that is a destination for migratory flows (regular or irregular).

Country of origin

The country that is a source of migratory flows (regular or irregular).

Cultural competency¹⁸³

Cultural competency is a set of academic and interpersonal skills that allow individuals to increase their understanding, sensitivity, appreciation, and responsiveness to cultural differences and the interactions resulting from them. The particulars of acquiring cultural competency vary among different groups, and they involve an ongoing relational process tending to inclusion and trust-building.

Documented migrant

A migrant who entered a country lawfully and remains in the country in accordance with his or her admission criteria.

¹⁸³ University of California Berkeley (2011) "Glossary of Terms". Available at <http://diversity.berkeley.edu/glossary-terms>

Economic migrant

A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. This term is often loosely used to distinguish from refugees fleeing persecution, and is also similarly used to refer to persons attempting to enter a country without legal permission and/or by using asylum procedures without *bona fide* cause. It may equally be applied to persons leaving their country of origin for the purpose of employment.

Emigrant

A person undertaking an emigration (the act of departing or exiting from one state with a view to settling in another)

Exhausted Migrant Effect¹⁸⁴

Long-term residence in a host country leads to health deterioration among some immigrant groups as a result of poor living and working conditions.

Happy (Im)Migrant Effect¹⁸⁵

“Happy (Im)Migrant Effect” is a construct, in which there is reluctance to assert healthcare rights. Patients appear “happy” and satisfied, despite problems with their hospital care. Explanatory factors for the construct include extreme powerlessness related to being unable to communicate, a positive comparison of healthcare in the new country compared with the old, patriotism for the new country, cultural norms that proscribe acceptance, politeness or social desirability, self-denigration for not having learnt the language and, for a few, a fear of reprisals if they spoke out in complaint.

Health

According to the preamble of the World Health Organization Constitution (1946), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Healthy (Im)Migrant Effect¹⁸⁶

“Healthy (Im)Migrant Effect” (HIE) or “Healthy Migrant” effect refers to the alleged health advantage of immigrants; recent immigrants tend to be in better health than the native-born population and immigrants who have lived in the country for a long time.

Immigrant

A person undertaking an immigration (a process by which non-nationals move into a country for the purpose of settlement)

¹⁸⁴ Based on Ingleby D, Chimienti M, Hatziprokopiou P, et al. The role of health in integration. In: Fonseca ML, Malheiros J, eds. *Social integration and mobility: education, housing and health*. IMISCOE Cluster B5 State of the art report, Estudos para o Planeamento Regional e Urbano N 67

¹⁸⁵ Based on Garrett PW., et al. “The Happy Migrant Effect”: perceptions of negative experiences of healthcare by patients with little or no English: a qualitative study across seven language groups. *Quality and Safety Health Care*. 2008 Apr;17(2):101-3. Retrieved from: <http://www.ncbi.nlm.nih.gov/pubmed/18385402> on 3 June 2013

¹⁸⁶ Based on Domnich, A. et al. (2012) The “healthy immigrant” effect: does it exist in Europe today?, *Italian Journal of Public Health*, 9 (3), e7532-2-2-7532-7. Retrieved from: <http://ijphjournal.it/article/viewFile/7532/6791> on 3 June 2013.

Integration

While the term is used and understood differently in different countries and contexts, “integration” can be defined as the process by which migrants become accepted into society, both as individuals and as groups. It generally refers to a two-way process of adaptation by migrants and host societies, while the particular requirements for acceptance by a host society vary from country to country. Integration does not necessarily imply permanent settlement. It does, however, imply consideration of the rights and obligations of migrants and host societies, of access to kinds of services and the labour market, and of identification and respect for a core set of values that bind migrants and host communities in a common purpose. Local integration is one of the three durable solutions to address the plight of refugees. It may also be applied to victims of trafficking and unaccompanied children.

Internal migration

A movement of people from one area of a country to another area of the same country for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (e.g. rural to urban migration).

Irregular migrant

A person who, owing to unauthorised entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or receiving country. The definition covers *inter alia* those persons who have entered a transit or receiving country lawfully but have stayed for a longer period than authorised or subsequently taken up unauthorised employment (also called clandestine/undocumented migrant or migrant in an irregular situation). The term “irregular” is preferable to “illegal” because the latter carries a criminal connotation and is seen as denying migrants’ humanity.

Irregular migration

Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is entry, stay or work in a country without the necessary authorisation or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term “illegal migration” to cases of smuggling of migrants and trafficking in persons.

Labour migration

Movement of persons from one State to another, or within their own country of residence, for the purpose of employment. Labour migration is addressed by most States in their migration laws. In addition, some States take an active role in regulating outward labour migration and seeking opportunities for their nationals abroad.

Less/low skilled and semi-skilled migrant worker

There is no internationally agreed definition of a less or low skilled and semi-skilled migrant worker. In broad terms, a semi-skilled worker is considered to be a person who requires a degree of training or familiarisation with the job before being able to operate at maximum/optimal efficiency, although this training is not of the length or intensity required for designation

as a skilled (or craft) worker, being measured in weeks or days rather than years, nor is it normally at the tertiary level. Many so-called “manual workers” (e.g. production, construction workers) should therefore be classified as semi-skilled. A less or low-skilled worker, on the other hand, is considered to be a person who has received less training than a semiskilled worker or, having not received any training, has still acquired his or her competence on the job.

Migrant worker

A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national

Migration

The movement of a person, or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification.

Multiculturalism

Integration approach that recognises, manages and maximises the benefits of cultural diversity. Migrants remain distinguishable from the majority population through their language, culture and social behaviour without jeopardising national identity.

Permanent residence

The right, granted by the authorities of a host state to a non-national, to live and work therein on a permanent (unlimited or indefinite) basis.

Push-pull factors

Migration is often analysed in terms of the “push-pull model”, which looks at the push factors, which drive people to leave their country (such as economic, social, or political problems) and the pull factors attracting them to the country of destination.

Receiving country

Country of destination or a third country. In the case of return or repatriation, also the country of origin. Country that has accepted to receive a certain number of refugees and migrants on a yearly basis by presidential, ministerial or parliamentary decision.

Regular migration

Migration that occurs through recognised, authorised channels.

Reintegration

Re-inclusion or re-incorporation of a person into a group or a process, e.g. of a migrant into the society of his or her country of origin or habitual residence.

Rural-urban migrants

Internal migrants who move from rural to urban areas, often in response to poverty, low agricultural incomes, low productivity, population growth, shortages, fragmentation and inequitable distribution of land, environmental degradation, and the relative lack of economic opportunities in rural areas.

Sending country

A country from which people leave to settle abroad permanently or temporarily.

Transnationalism

The process whereby people establish and maintain socio-cultural connections across geopolitical borders.

Undocumented migrant

A non-national who enters or stays in a country without the appropriate documentation. This includes, among others: a person (a) who has no legal documentation to enter a country but manages to enter clandestinely, (b) who enters or stays using fraudulent documentation, (c) who, after entering using legal documentation, has stayed beyond the time authorised or otherwise violated the terms of entry and remained without authorisation.

Appendix 1: Technical Steps for the Conduct of the Delphi

On the basis of a workshop and first stakeholder interviews, five questions for the Delphi were designed and translated into the respective languages. Respective question addressed the dimension of equity, public health, economic costs, human rights, and medical ethics.

Delphi questions

Which statements do you agree more with?

- Healthcare for irregular migrants is unfair.
- Excluding irregular migrants from healthcare is unfair.
- Exclusion of irregular migrants from healthcare jeopardises public health.
- Care provision for irregular migrants jeopardises healthcare budgets.
- Restriction to emergency care helps to save money.
- Restriction to emergency care causes higher costs than access to basic care.
- Restriction to emergency violates human rights.
- Restriction to emergency is in line with human rights.
- Restriction to emergency violates medical ethics.
- Restriction to emergency is in line with medical ethics.

Translated versions were established as an internet survey with initial contact and invitation by email and several follow ups.

For dissemination to Austrian expert groups, the Centre for Health and Migration, Vienna, approached partner organisations in Austria and several networks.

1. Austrian Society of Sociology, Section of Medical Sociology, Austria (12.02.2013)
2. Advisory board and expert panel of project commissioned by ASEF (14.02.2013)
3. Austrian Going International Community Newsletter (21.03.2013)
4. Management of the KAV (“Krankenanstaltenverbund”), the main Austrian Hospital Trust (07.05.2013)

The following networks in Italy were approached (indicated dates refer to the initial contact, which was followed by at least three follow up rounds).

5. Network of Global Health in Italy (04.04.2013)
6. Italian Society of Migration Medicine (04.04.2012)
7. National Institute for Health, Migration and Poverty (NIHMP, Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà (INMP) (29.04.2013)

For dissemination to Italian experts, three distinguished national experts distributed an information text on the project and the link to the Italian survey to Italian expert networks.

A total of 117 experts in various categories (health professions, research, management, administration) participated in the Delphi (n=117; AT: n= 75, IT: n=42).

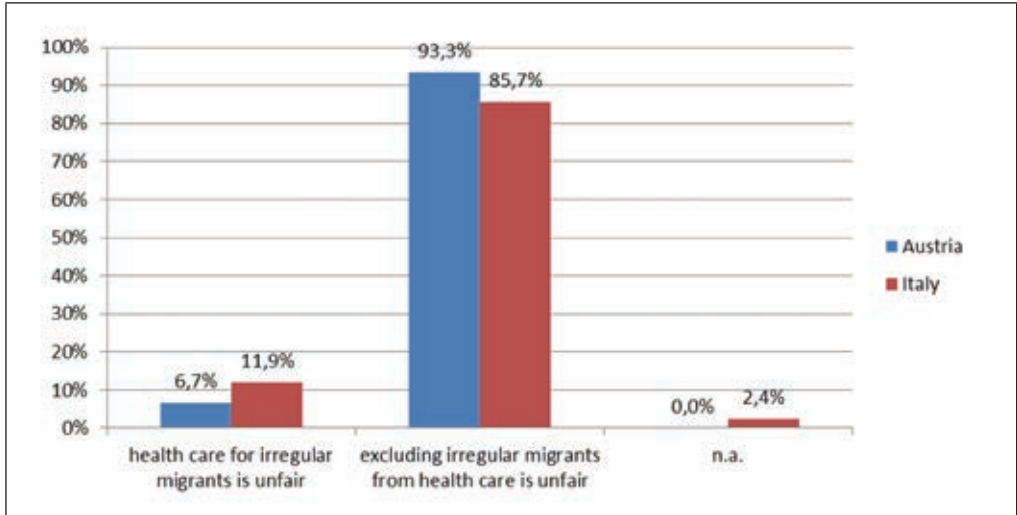
To further evaluate and discuss the findings, preliminary results were presented at two expert meetings:

COST Action IS1103, Adapting European health systems to diversity (ADAPT):
Strategic planning meeting for sub-project 6 /Economic arguments,
Meeting hosted by the London School of Economics
2 February 2013

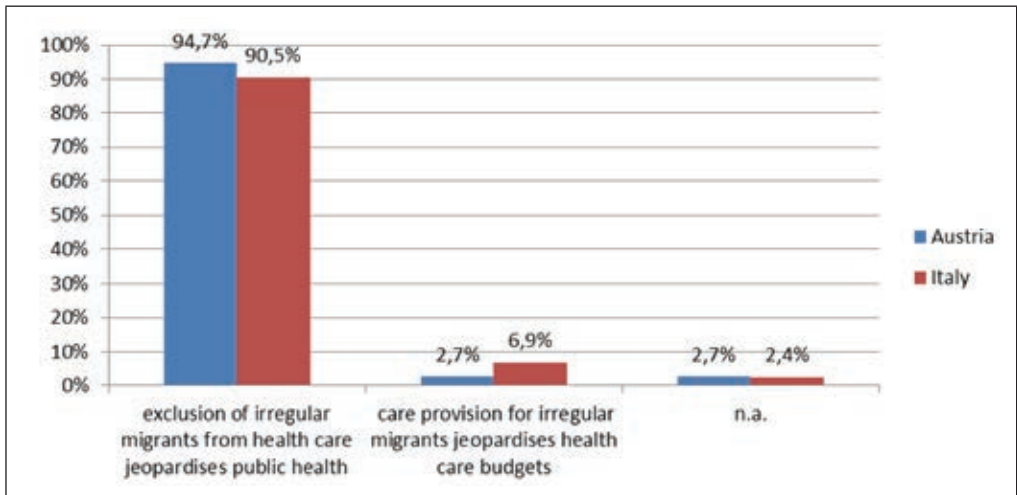
2nd Workshop “Bio-Ethics in Austria”
Institut für Ethik und Recht in der Medizin, University Vienna
Spitalgasse 2-4, Hof
25-26 April 2013

The following charts show these results in detail. As the results of the first round showed a high degree of homogeneity, no additional rounds were taken.

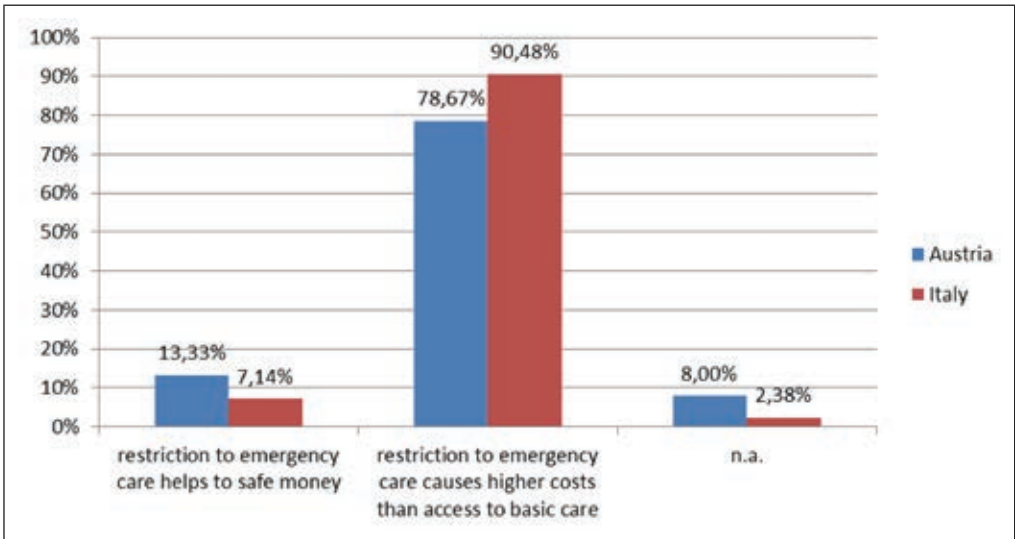
The equity dimension: Excluding irregular migrants from healthcare is unfair.



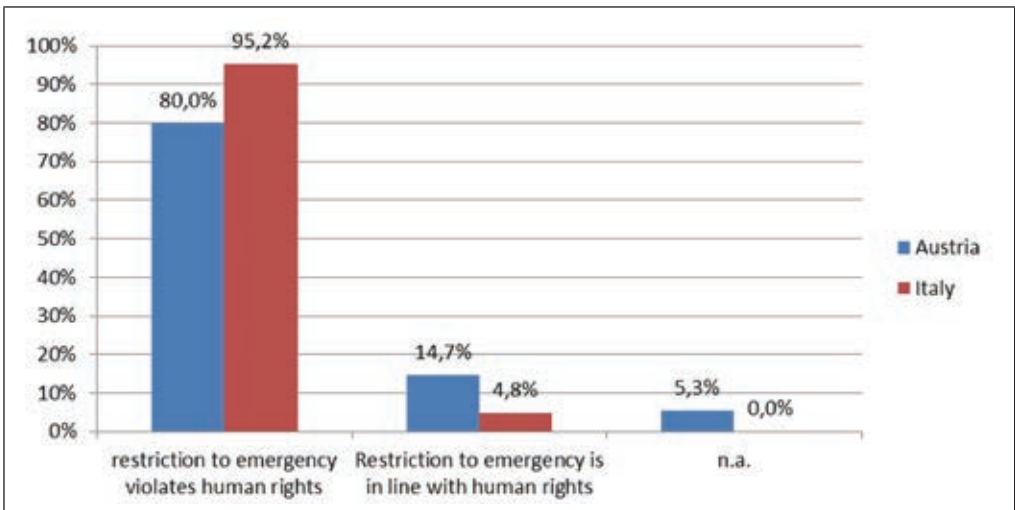
The public health dimension: Healthcare seems to be more jeopardised from exclusion than from inclusion.



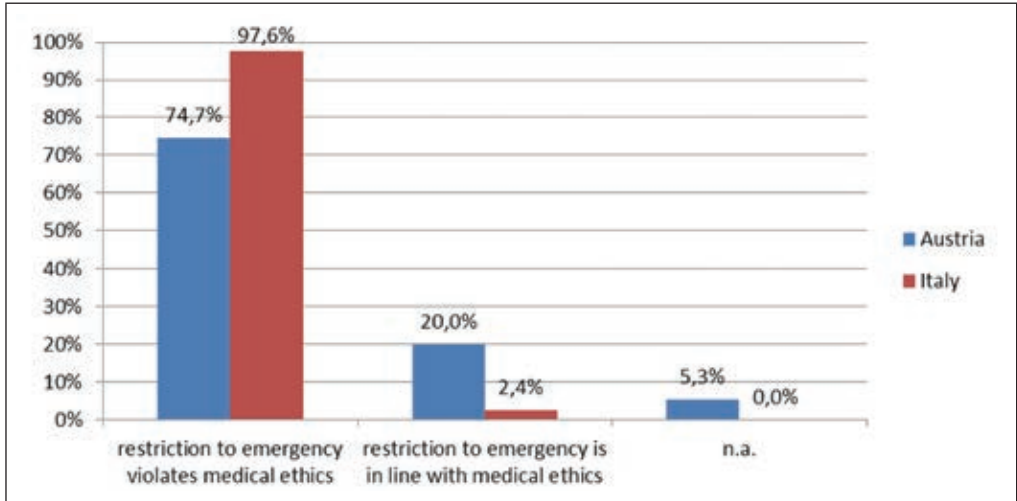
The cost dimension: Concerning economic arguments, restriction to emergency care is not seen as a cost saving policy.



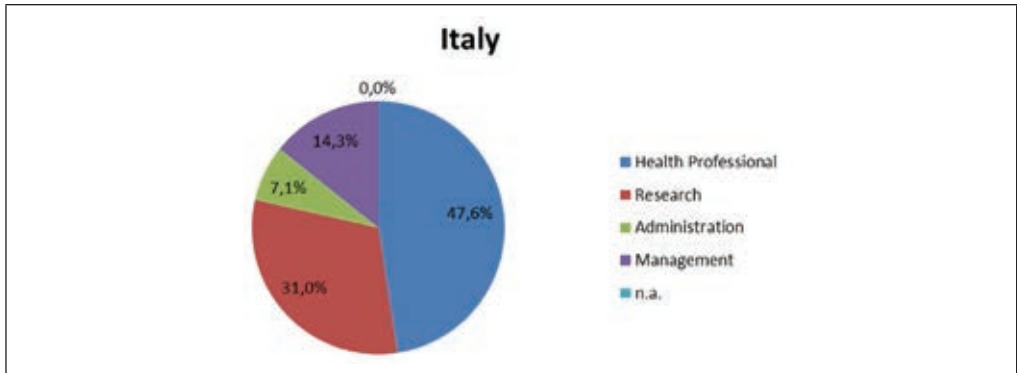
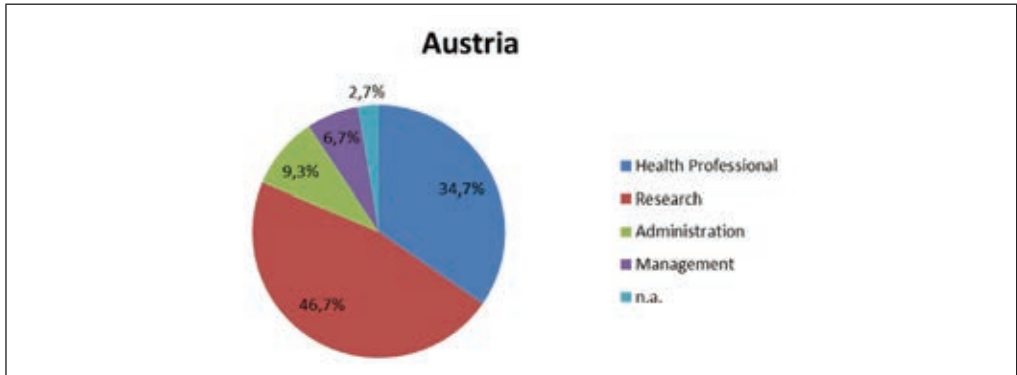
The human rights dimension: Restriction to emergency care is mostly seen as violation of the human rights to healthcare.



The dimension of professional ethics: Austrian experts are less critical towards restrictions than Italian experts.



Participants in the Delphi



Appendix 2: Economic Cost of Work Injuries and Health – A Singapore Model

The Workplace Safety and Health (WSH) Institute in Singapore has conducted a study to better understand the economic impact of workplace safety and health injuries and ill health on employers, employees and the community for 2011. The results highlight the importance of WSH not only for companies, but also for Singapore as a whole, thus providing additional impetus to reduce work injuries and ill health.

International studies

The International Labour Organization (ILO) estimated that about 2.3 million workers die from work-related accidents and diseases worldwide every year. It further estimated that 4% of annual global GDP or USD 2.8 trillion, would be lost due to the direct and indirect costs of such accidents and diseases. Other researchers have also reported that about 5% of the burden of *all* diseases and injuries in established market economies could be attributed to work. In the United States, Leigh estimated that the national cost of work-related injuries and diseases in USA amounted to USD 250 billion (1.8% GDP). Safe Work Australia estimated that the costs of work-related injuries and illnesses for Australia were AUD 57.5 billion or 5.9% GDP for financial year (FY) 2005–06 and AUD 60.6 billion (4.8% GDP) for FY 2008–09.

Singapore's model for economic costing of work injuries and ill health

The WSH Institute reviewed the methodologies and cost models from different countries to develop a working model for Singapore. The study methodology was adapted from similar studies done by other countries. Like Australia, the model only measures human cost and does not take into account the cost of property damage, and human pain and suffering. The analysis is based on cost incurred after an incident had occurred. The expected future cost of new cases in the reference year is used as proxy for on-going cost of cases from previous years.

In this model, the Institute determined the cost of work-related injuries and ill health that would be borne by employers, workers and the community (see Figure 1). Cost items linked to staff turnover, training of replacement workers, loss of worker output, insurance premium and legal cost incurred were computed as costs borne by employers. The costs borne by workers included loss of future earnings, additional expenses for medical treatment and rehabilitation, beyond that covered by compensation under the Work Injury Compensation Act. Cost items like social pay-outs, cost of incident investigation, workplace inspection and promotion activities by the Ministry of Manpower (MOM) and WSH Council, loss of human capital for fatal cases, and medical subsidies were considered as costs borne by community.

Key findings and observations from the study

Excluding lifetime costs, the cost for work injuries and ill health sustained for 2011 is estimated to cost **SGD 2.62 billion, with employers bearing 88.2%** of cost, employees 9.5% and the community 2.3%. If lifetime cost is included, i.e., net loss of future earnings and loss of human capital, the total cost of work injuries and ill health is estimated to be **SGD 10.45 billion**. The costs borne by different economic agents were estimated to be: SGD 2.31 billion (22.1%) by employers; SGD 5.28 billion (50.5%) by workers, and SGD 2.87 billion (27.4%) by the community. The results provide deeper insights into the potential costs of work-related injuries and ill health in Singapore. As this computation breaks the cost down into individual cost items (see Figure 1), it provides the evidence for the relevant stakeholders to identify and prioritise potential levers to reduce the cost of poor WSH practices in Singapore. The WSH Institute will produce a study report soon. It will also continue to refine this WSH economic cost model for Singapore, so that the individual cost items and the overall GDP equivalent attributable to work-related injuries and ill health can be more accurately computed. The next study will be conducted in two to three years' time.

Estimating the social costs of migrant health

Since the migrant workforce consists of about 40% of the working population in Singapore, it is estimated that the proportional costs of **migrant workers' health are SGD 104.8 million**, and if lifetime cost is included, **total lifetime cost of migrant workers health is about SGD 4.18 billion**. The proportion of costs is estimated to be borne at **SGD 2.11 billion by workers**, SGD 942 million by employers, and SGD 1.15 billion by the community respectively.

Total economic cost of work injuries and ill health

Employers

- Staff turnover costs
- Training costs
- Loss of worker output
- Insurance premiums
- Legal costs

Workers

- Net loss of future earnings i.e. future earnings minus compensation (lifetime cost)
- Additional costs of medical treatment and rehabilitation

Community

- Social pay-outs
- Investigation/ Inspection activities
- WSH promotion activities
- Loss of human capital (lifetime cost)
- Medical subsidies

Appendix 3: The Economic Case – Social Costs of Migrant Health

Simply making the case for spending more money for migrant health and calling for some intervention or other on the basis of human rights and social justice is not enough. We live in a world of competing demands for limited resources. Prudence dictates that, although a healthier migrant population will almost certainly mean increased productivity and although a safer living and work environment will surely result in fewer injuries and diseases, one must still weigh the economic benefits against the social costs and seek the most cost-effective way of achieving the same end. Under the current economic conditions of belt-tightening, cost-conscious governments and funding agencies around the world are increasingly turning to economic evaluation as a tool to guide rational choices and improve efficiency. In economic evaluation, both costs and outcomes are analysed, and alternative strategies are compared. The key questions to ask are “Is it worth doing?” and “Is it the best way of achieving the desired results?”

Cost-benefit analyses

Cost-benefit analyses are currently the best known and most frequently used tool in health settings. In its simplest form, the costs and benefits of a particular policy or programme are measured in terms of their equivalent monetary value. When benefits outweigh the costs, it is worth doing. In other words, cost-benefit analyses seek to measure the economic efficiency of a proposed policy or project. In the estimation of the benefits, a monetary value is usually apportioned to the avoided consequences (eg, costs of healthcare, rehabilitation or compensation). The analysis must also take into consideration the fact that costs and benefits may be generated over a period of time, the costs and benefits often occurring in different time periods. Because total costs or benefits years later are not directly comparable with their value today, financial discounting (ie, expressing all future costs and benefits in their present value equivalent) is applied in the analyses.

Thus, the net social value = $(B_t - C_t) / (1 + n)^t$,
where B = sum of all consequences, C = sum of all costs, t = discount over time, and n = discount rate.

The effects on productivity and reduced sickness absence can also be quantified and reflected as savings. More sophisticated forms of cost-benefit analyses would factor other intangible benefits into the equation (e.g., providing migrants with primary healthcare may prevent larger future costs in emergency or acute care later). When all else is equal, it would be logical to

choose the option to obtain the greatest benefit at least cost (productive efficiency). However, because not all else is always equal, there should be an attempt to track the distribution of costs and benefits among various segments of society, including the migrant population (eg, how the benefits are distributed by age, gender, income, race, location, and time) to ascertain whether imbalances between benefits and costs are present for those segments of the population which are most vulnerable (allocative efficiency).

Cost-effectiveness analyses

The cost-effectiveness analysis is a technique for comparing the cost and effectiveness of two or more alternatives. In its most common form, a new strategy is compared with current practice in the calculation of the cost-effectiveness (CE) ratio:

CE ratio = (Cost new strategy – Cost current practice) / (Effect new strategy – Effect current practice).

Note that cost-effectiveness analyses measure health benefits not in monetary units, but in natural units such as life years saved or gained or improvements in functional status (e.g., units of blood pressure or reduced) and that the cost-effectiveness ratio is actually the ratio of marginal cost to marginal effectiveness. One might think of the resulting number as the “price” of the additional outcome purchased by switching from current practices of non-provision or limited provision of migrant health services to new strategies of providing more effective health services. If the price is low enough, the new strategy is considered “cost-effective”. In general, one strategy is considered more cost-effective than another if it is: (i) less costly and at least as effective; and (ii) more effective and more costly, but the additional benefit is considered worth the extra cost. However, because costs and benefits are measured in non-comparable units, their ratio can only provide a measure of the relative efficiency of the alternative interventions. Cost-effectiveness analyses do not, for instance, enable us to evaluate the relative efficiency of interventions that provide more benefit at greater cost or less benefit at lower cost. Another limitation is their inability to compare interventions with differing natural effects (e.g. an intervention aimed at increasing life years gained cannot be directly compared with another aimed at improving physical functioning). Cost-effectiveness analyses therefore cannot directly address allocative efficiency, for migrant health versus other population health.

Cost-utility analyses

Cost-utility analyses are a variant of cost-effectiveness analyses, in which the outcomes of the intervention are translated into a measure that includes both morbidity and mortality dimensions, for example, using a utility-based measure such as quality-adjusted life years (QALY). The impacts of competing interventions are expressed in terms of costs per QALY. An intervention is deemed efficient, relative to an alternative, if it results in higher or equal benefits at lower cost. The use of a single measure of both qualitative (morbidity) and quantitative (mortality) health benefit enables diverse healthcare interventions to be compared. Hence, cost-utility analyses can address both productive efficiency and allocative efficiency, as in comparing outcomes for migrant health versus other programmes.

Limitations of the economic approach

A major limitation of all economic evaluations is that their validity depends on the validity of the assumptions made. For instance, while cost-benefit analyses attempt to quantify benefits or costs in terms of their monetary value, such quantification is not always possible or easy. How does one measure, for instance, the pain and suffering of victims who are migrants, and their loved ones in economic terms? The difficulty or impossibility of compensating for the loss of life or limb and the migrant's full potential reflects the inadequacy of trying to attach a value or worth to health in monetary units.

For this reason, sensitivity analysis is often required to show how the results will change with different analytical choices and with variations in the uncertain levels of key costs and benefits. Moreover, the improvement in migrant health and safety is more than a technical issue of costs. Decisions based on cost-benefit analyses, for example, may fail to consider all of society's objectives, including important social and ethical values.

Strengths of the economic approach

On the other hand, the strength of the economic approach lies precisely in its practical perspective because it offers the clarity needed for advocacy. Perhaps even more importantly, monetary value is what most politicians and key government officials understand and will respond to. Economic evaluation provides them with the justification needed for resource allocation decisions. Many a new initiative for migrant health, conceived in purely qualitative terms, would have had a better chance of gaining approval if the negative health or economic impacts had been quantified and shown to cost more than their prevention – since refusal of endorsement would then appear irrational. The process is admittedly technical, and there will inevitably be data and information gaps. However, it is often better to make the best estimates one can and present them along with a description of the uncertainties and caveats, than not to attempt an economic analysis at all.

In many countries, an assessment of economic impact has become one of the standard items of information required for the decision-making process when new health programmes and interventions are proposed. This is a positive development that renders the decision-making process more robust. Health and regulatory measures are no longer introduced in an *ad hoc* manner, reliant solely upon intuitive considerations. The trade-offs that have to be made when one course of action is chosen over another are made more transparent. And when each subcomponent of the proposed policy or programme is subjected to systematic scrutiny, important unforeseen or distributional consequences can be identified. There is also an increasing trend in the European Union and the United States to require a cost-benefit analysis before legislation on work safety and health is introduced. This requirement parallels the broader insistence of cost-conscious legislators and payers for evidence-based clinical practice, in response to runaway healthcare costs. After all, the introduction of legislative instruments, like the provision of healthcare, is not without costs and may even be counter-productive. How much of these costs represent waste, inappropriateness, and inefficiency? It is clearly consistent with society's implicit desire to find out.

Economic evaluation of existing measures concerning migrant health could be done at the programme level in many industrialised countries. However, the assessment of national migrant health systems at the macro-level has so far received limited attention. Ideally, there should be a standard format for conducting and presenting the results of economic evaluation. For example, there should be a core set of economic assumptions used in calculating benefits and costs like what is done for occupational health and safety programmes. The European Union is leading the way in developing a common methodology that would both improve the robustness of quantification processes and facilitate comparisons across countries. The Safety & Health & Performance & Enterprises (SHAPE) programme has produced relevant information on methodologies and is testing them for occupational safety and health cost-benefit analyses. The European Agency for Safety and Health at Work has also devised models for calculating the costs at company and national levels. In Singapore, the Work Safety and Health Institute has recently initiated such an economic cost study of work injuries and ill health for the first time, based on data for 2011 (see Appendix 1).

Towards a comprehensive cost-benefit analysis of migrant health care

The output of the economic analysis will be a cost-benefit analysis. That is the output of the model will compare the cost of providing access to healthcare in comparison to the potential cost savings associated with reduced negative health outcomes. The table below provide an illustration of the expected output from the economic analysis.

Output for migrant healthcare model

	Regular Resident	Irregular Migrant
Cost of intervention (access to healthcare)		
Healthcare cost of disease and related conditions		
<i>Hospital</i>		
<i>Outpatient</i>		
<i>Others (drugs, appliances, etc)</i>		
Total cost		
Cost savings		Total cost RR - Total cost IM

Other considerations

The economic model for healthcare of migrants will account for:

- **Total uninsured population:** legal migrants without adequate coverage and irregular migrants
- **Timing:** analysis of time when healthcare occurs and costs are incurred
- **Societal benefits:** benefits outside of healthcare cost
- **Sensitivity analysis:** analysis of the sensitivity ranges of key parameters

Total uncovered migrant population

The economic models outlined above are specifically focusing on estimating the value of providing access to healthcare for undocumented migrants compared to regularly covered migrants. The outputs of the analysis can be used to make a wider judgement on the value of providing healthcare to the uncovered in comparison to the uncovered. When using the model for the total uncovered population the following key factors need to be considered:

- **Differences in the provision of care for undocumented migrants compared to migrants without coverage.** The provision of healthcare for undocumented migrants is different from migrants without insurance.
- **Baseline health status.** When using the model to estimate the economic value of providing care for all uncovered, an assumption is made that the baseline health status of undocumented migrants is the same as migrants without coverage.

Timing of events

The economic models could be constructed on a cross-sectional basis over a fixed period or in the form of time series in longitudinal studies. Cost and benefits can be calculated or generated from avoiding disease-related conditions will be calculated per year. This will allow the models to consider the benefits in the short, medium and longer term.

This is particularly important when considering the length of stay for irregular migrants, as one particular category of uninsured, in any particular country. For example, if migrants only stay in a country for X years it can be expected that some of the long term costs associated with healthcare beyond X may not be incurred by the country healthcare sector as the migrant would have left by that time. Research around the length of stay of irregular migrants in the host country will not provide robust estimates in terms of number of years. The length of stay is associated with a number of factors such as:

- How easily irregular migrants can get a job in the host country
- Health and related services (or lack of) provided to irregular migrants in the destination country
- The overall economic conditions of the destination country.

Additional benefits

It is expected that avoiding conditions associated with preventable diseases can generate benefits beyond healthcare cost savings. For example, avoiding illness can have a significant impact on quality of life. Avoiding morbidity and disability can potentially lead to external benefits for migrants and their families. These wider benefits are excluded from the economic model due to the difficulty in measuring these outcomes. Focusing on robust estimates of healthcare costs would be the priority of any economic analysis. These additional but less intangible benefits could be included as narratives in individual case studies.

Sensitivity analysis

As with any economic analysis, parameters in the model are subject to uncertainty. It is recommended that one-way sensitivity analysis be undertaken to determine the impact of the uncertainty. One-way sensitivity analysis refers a process whereby key parameters within the model will be varied across a range of values to determine the impact on the final results. For example, the probability of receiving healthcare in the model can be changed from a value of 0 to 1 and the corresponding cost-savings for the model will be estimated for each change. The sensitivity analyses will be presented in a series of graphs. The selection of suitable parameters to be included within the sensitivity analysis will be based on accepted ranges from discussions with relevant sources.



This research project was made possible by the financial support of the Government of Japan.



ASIA-EUROPE FOUNDATION (ASEF)

31 Heng Mui Keng Terrace

Singapore 119595

T +65 6874 9700

F +65 6872 1135

E info@asef.org

www.asef.org