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Access to Health Care for Undocumented Migrant Children. European Regulations and Practices

Acceso a los servicios sanitarios para niños inmigrantes indocumentados. Reglamentos y prácticas europeas

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ABSTRACT: Health plays a prominent role in the Convention of the Rights of the Child. Article 24 explicitly states the “right of the child to the enjoyment of the highest attainable standard of health” where “States Parties shall strive to ensure that no child is deprived of his or her right of access” (UN/CRC 1989).

For children residing in Europe as undocumented migrants, this universal right to health in a majority of European Member States is overruled by national regulations that restrict access to health care to emergency care. Recent studies indicate that only 8 EU member states grant undocumented migrant children the same entitlements as national children. This puts health care professionals into a paradox situation: to save-guard ethical standards, they have to act against national regulations. Documentations on practices from first line healthcare providers show the high degree of vulnerability for undocumented children and underline the need of proper health care and ethically sound action.

RESUMEN: La salud juega un papel prominente en la Convención de Derechos del Niño. El artículo 24 defiende explícitamente “el derecho del niño al disfrute del más alto nivel posible de salud” donde “los Estados Partes se esforzarán por asegurar que ningún niño sea privado de su derecho al disfrute de esos servicios sanitarios” (UN/CRC 1989).

Para los niños residentes en Europa como inmigrantes indocumentados, este derecho universal a la salud está invalidado por las regulaciones nacionales que restringen el acceso a los servicios sanitarios sólo a los servicios de emergencia para inmigrantes indocumentados o irregulares. Estudios recientes indican que sólo 8 estados miembros de la UE garantizan los mismos derechos a los niños inmigrantes indocumentados que a los niños nacionales. Esto pone a los profesionales de la salud en una situación paradójica: para salvaguardar estándares éticos, tienen que actuar en contra de la legislación nacional. Los datos sobre las prácticas de los profesionales sanitarios en primera línea muestran, pues, el alto nivel de vulnerabilidad para los menores indocumentados así como la importancia de los servicios sanitarios para este grupo.

KEYWORDS: Health care, ethical standards, undocumented migrant children, legal regulations, practices, European countries, managing paradox, structural compensation, functional ignorance

PALABRAS-CLAVE: Atención sanitaria, niños inmigrantes indocumentados, normativas jurídicas, prácticas, países europeos, paradoja de la gestión, compensación estructural, ignorancia funcional

1. Introduction

To date, Europe is facing the challenge of a previously unknown flow of refugees with the number of refugees unparalleled in recent times. OECD is talking about an unprecedented humanitarian crisis “with an appalling and unacceptable human cost”. More than a million refugees and migrants arrived in the European Union in 2015 (IOM 2015). The growing influx of vulnerable populations poses many challenges to host countries, not least with regard to preparedness and resilience of health systems and access to health-care services.

Unaccompanied children are arriving in Europe in record numbers (IOM/ UNICEF 2015). In a communication from 11 Jan 2016, UNHCR reports that children make up one in four of refugees and migrants crossing the



Mediterranean since January 2015. Many travel without their parents or caretakers. In 2014, over 23,000 asylum applicants in the EU were considered unaccompanied and separated children – or 4 per cent of all asylum applicants, and 14 per cent of all child applicants (UNHCR 11/01/2016).

Along with registered migration flows, a considerable share of undocumented migration is taking place. In a media briefing dated 22 December 2015¹, IOM reported that over a million irregular migrants and refugees arrived in Europe in 2015, mostly from Syria, Africa and South Asia.

Given these developments, Europe is faced with the challenge to provide access to social services to especially vulnerable children: those with an undocumented status. Access to health care can be defined as of utmost importance, as health is a pre-requisite for living and participating in society.

Undocumented migrant children, in what follows referred to as UMC, are in this paper defined as children from third countries, who arrive and/or reside on the territory of an EU Member state without being registered by immigration authorities and without holding any kind of legal status. They may, but are not necessarily, travelling and living without their parents or another adult responsible for them like unaccompanied minors (EMN 2015).

It is important to acknowledge that not all children who enter EU Member States are applying for asylum; therefore not all are registered as asylum seekers and/or unaccompanied minors. As a recent report states “Many migrate to reunite with family members, work, or escape abusive family situations while others are victims of trafficking [...] As such, the asylum numbers only paint one part of the picture of unaccompanied child migration in the European Union (Levinson 2011).

This article aims to work on three questions concerning the access to health care and the health care need of UMC:

1. What legal frameworks are in place on international and national level in European countries that regulate access to health for UMC and how is the nexus to ethical standards?
2. What are the main health needs and problems of UMC as documented by first line healthcare providers?

3. How do health care providers deal with conflicting demands of national restrictive policies on one hand and fundamental rights and ethical standards on the other?

2. International and European frameworks concerning children's access to healthcare

EU Member States have ratified the United Nations Convention on the Rights of the Child, which establishes the best interests of the child as governing all major policies regarding the treatment of minors (UN 1989). Health plays a prominent role in the Convention. Article 24 explicitly states the 'right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health' where 'States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services'.

Similarly, several Council of Europe institutions have invited Member States to ensure universal access to healthcare. Its Committee of Ministers issued a recommendation on mobility, migration and access to health care in 2011 (Rec CM/Rec(2011)13), calling on Member States to put in place mechanisms to ensure that migrants' entitlement to health care is properly guaranteed irrespective of residence status. The Parliamentary Assembly of the Council of Europe (PACE) has adopted several resolutions calling on member states to provide equal access to health care services for undocumented migrants, including Equal access to health care (Parliamentary Assembly 2013) and Undocumented migrant children in an irregular situation: a real cause for concern, (Parliamentary Assembly 2011) which encourage member states to guarantee the right to health care.

The EU Fundamental Rights Agency (FRA) has stated in an opinion that "In light of Article 24 of the CRC, every child present on the territory of an EU Member State is entitled to the same healthcare services as nationals. This should also include immunisations, which are a major preventative healthcare measure" (FRA, 2011). Further the FRA recommends that immigration control practices should be de-linked from health care – there should be no requirement for information to be shared with immigration authorities and no apprehensions at or next to medical facilities (FRA 2013).

In 2015, the European Union Agency for Fundamental Rights together with the Council of Europe and the European Court of Human rights published the Handbook on European law relating to the rights of the child (FRA, 2015). In this handbook, regulations that define access to health care are summarised (ibid p137 and p149ff). References to UN and EU legal instruments are collected in this handbook and shall not be repeated here.

3. National regulations

In recent years, a number of projects on European level have surveyed legal regulations concerning access to health care for UMC. In 2009, the Medecins du Monde European Observatory published a report on *Access to Health care for undocumented migrants in 11 European countries* (Medecins du Monde 2009). In 2010, two EU-funded projects published reports on the matter: "Health Care in NowHereland" compiled data on 27 EU member states (Karl-Trummer et al 2010a). The HUMA NETWORK provided a comparative overview in 16 EU countries (HUMA 2010). The European Union Agency for Fundamental Rights published a report including 10 EU member states in 2011 (FRA 2011).

In 2015, the Centre on Migration, Policy, and Society (COMPAS), a Research Centre within the University of Oxford, published a study covering the 28 EU member states (Spencer et al 2015).

And yet, it is still difficult to draw a concise landscape of regulations on access to health care for UMC in EU member states, mainly for two reasons: i) an inconsistency of categories chosen to differentiate between different access models, and ii) inconsistencies in references to regulations of access. In what follows, both inconsistencies will be briefly outlined in order to make it possible to evaluate summarising conclusions.

Inconsistency of categories: The reports by FRA and Compas distinguish three forms of healthcare: emergency, primary and secondary (and beyond) and whether full payment is required. The NowHereland report also uses three categories, namely: no access except emergency, partial access, full access/same as nationals. When referring specifically to entitlements for children, the Compas report by uses the

following categories comparing the access to medical care for migrant children with irregular status: same as nationals, same as migrant children with legal status, same as adults with irregular status, additional rights if unaccompanied and/or known to the authorities/ tolerated status. The HUMA study distinguishes three different levels of discrimination in access to healthcare of different groups of children (unaccompanied [Asylum seeking] children, asylum seekers' children, unaccompanied [migrant] children, children of undocumented migrants) in comparison to national children.

Inconsistency in references: When juxtaposed, the reports give sometimes different or contradictory accounts of level of entitlements for irregular migrants in general and for children in particular. One of the reasons for this can be the fact that they were written in different time periods and the legislation in some countries has changed over time. Nonetheless, this cannot explain all observed discrepancies.

However, some interesting findings can be drawn from the reports:

Concerning countries where no additional or specific entitlements for children in comparison to adult irregular immigrants are in place, the reports are unanimous in regard to 6 countries, which are: Bulgaria, Finland, Hungary, Ireland, Latvia and Slovakia. These are also all 'no access except emergency' countries according to NowHereland report which means that also children have access only to emergency care and are excluded from any other forms of health care.

According to the newest reviewed report (Compas, 2015), 8 EU Member States grant irregular children the same entitlements as national children (regardless whether they are accompanied or not), these are: Estonia, France, Greece, Italy, Portugal, Romania, Spain and Sweden.

In case of the remaining countries, entitlements (according to at least some of the reviewed reports) in specific cases more comprehensive than for adults, like for example in cases when children are unaccompanied. According to Compas report in 5 EU Member States (Belgium, Croatia, France, Luxembourg and the UK) unaccompanied children are entitled to the same level of care as nationals of the country.

4. The nexus of international and national regulations to ethical standards: The impact of regulations on practices of providing health care to UMC

As the authors of this article are no law scientists, their viewpoint in this matter follows a common sense approach. That being said, we would like to point out the following paradox: while international regulations on fundamental rights clearly refer to ethical standards when discussing access to health care, national regulations often use other references, e.g. citizenship or insurance coverage. By doing so, they introduce a contradiction to the human right to health. Access to health care then is not granted for every human being, but only for those who hold an insurance or are registered citizens.

Even with its limitations concerning consistency and comparability, the overview on national regulations provided by the projects included in the analysis show that many EU Member States continue to have restrictive laws concerning access to healthcare for UMC.

What do such regulations mean for the actual practice of health care provision for UMC?

Here are some examples, collected by Médecins du Monde (MdM) – Doctors of the World, an international aid organisation that since 1980 provides medical care and aims to improve access to healthcare for people who face numerous vulnerability factors all over the world. (<https://doctorsoftheworld.org/>) Besides providing medical attention, MdM systematically collect data on the social determinants of health and the patients' state of health to raise awareness about the difficulties vulnerable populations face.

MdM runs over 171 health programmes across Europe: in Belgium, Bulgaria, France, Germany, Greece, Luxembourg, the Netherlands, Portugal, Romania, Spain, Sweden, Switzerland and the United Kingdom. Since 2015, MdM established a European Network on reducing Vulnerabilities in Health, with partners from 17 EU and 2 EFTA/EEA countries².

It seems that in practice, access to health care for UMCs is difficult in all European member states, even in those that on legislative level grant access to health care for UMCs.

For example in Spain, one of the 8 EU Member States that grant UMCs the same entitlements as national children, an individual health card is needed to get access to services. Nonetheless, the acquisition of an individual health card for the children

of undocumented migrants is not so easy, and public health centres are reported to sometimes not knowing how to deal with minors who don't have a health card and then are denied care and/or vaccination. (REDER, 2015).

In the UK, one of the 5 EU Member States where unaccompanied children are entitled to the same level of care as nationals of the country, being registered at a General Practitioner is the gate to healthcare. Doctors of the World team in the UK saw that children are only accepted in a GP practice if at least one of their parents is already registered. So many children of undocumented migrants stay with no access to prevention and care if their parents were not accepted in a GP practice, which occurs quite often for undocumented migrants. Maternity care for undocumented pregnant women is billed for the full course of care throughout pregnancy, which is around €7,000 without complications. Although NHS guidance states that maternity care is 'immediately necessary' care and must not be withheld because the woman is unable to pay, antenatal care is often denied to these women (Doctors of the World UK, 2015).

In Belgium and France, as well of the 5 EU Member States where unaccompanied children are entitled to the same level of care as nationals of the country, children need to obtain the specific health coverage designed for undocumented migrants before they are fully entitled, but administrative hurdles constitute a strong barrier before they really get it.

In Switzerland, if the parents do not pay the monthly health insurance premium for their children, they will have no health coverage and will not be allowed to attend schools without health coverage. According to the Nowhereland report (Karl-Trummer et al 2010b) the average total monthly cost of basic health insurance in 2009 was 262 CHF or 185 EUR.

5. Main health needs and problems of UMC

It appears that main health needs and problems of UMC can be associated with unstable living conditions, characterised by poor hygiene, housing and nutrition as well mental strain due to fear of being arrested and/or being separated from parents who get arrested, becoming a victim of violence and abuse.

In the most recent European survey by Doctors of the World (Chauvin et al 2015), 64.7% of patients were living in unstable or temporary accommodation and 29.5% declared their accommodation to be harmful to their health or that of their children. 9.7% were homeless. Furthermore, 91.3% of all the individuals seen were living below the poverty line.

One of the strong determinants of health for children of undocumented migrants is the fact that they live in constant fear of having their parents arrested and expelled.

Figures are also worrying for pregnant women: 55.3% were living in unstable or temporary accommodation. 89.2% lived below the poverty line while 81.1% did not have health coverage. More than 30% reported poor levels of moral support. This comes down to a very stressful environment in which to expect a child.

Another main issue is the lack of prevention care for children, best getting evident in vaccination rates.

In 2014, MdM launched an analysis of 29,400 consultations provided to 16,881 patients across 25 cities in eight European countries in 2013, focusing on antenatal care and childhood vaccinations (Chauvin et al 2014).

Among 285 pregnant women seen, 65.9% had had no access to antenatal care before coming to one of the MdM health centres and 42.8% received care too late. Two thirds of pregnant women and their unborn children seen by MdM were at risk.

Of the 1,703 children who attended one of the European centres, only half had been vaccinated against tetanus, hepatitis B, measles and pertussis (whooping cough). In some countries this rate was less than 30%, well below vaccination coverage rates for the general population of around 90%.

6. Ethics in practice: managing paradox

It is an ongoing debate whether undocumented migrants should be granted access to welfare schemes including health care, with a con-argument that those who violated national regulations on immigration should in return not benefit from national regulations on welfare support.

But even those authors who argue for exclusion of undocumented migrants from national welfare regimes make a clear distinction when it comes to children “children need to be given a better legal position than adults. This should also be reflected in the legal instruments, and a suggestion is that new regulations — both on a national and international level — to a larger extent grant children a more favoured position than adults” (Søvig, 2011).

Evidently, UMC are in need of health care, and ethical standards laid down in various international regulations clearly make provision of health care imperative.

This opens a paradox situation for health care organisations and their personnel. They have to cope with contradictory demands: if they give care, they may act against legal and financial regulations, if they don't give care they violate human rights and children rights and exclude the most vulnerable. This paradox cannot be resolved on a practice level but has to be managed somehow.

Management of paradox is not new – in organisational theory, it is defined as a quite common demand that emerges when contradictory goals are pursued. An example is given from the car industry, where constructing cars follows at least two contradictory goals: make them fast and make them safe. (Simon 2007)

From an ethical standpoint, there is no other option than providing care for UDC. This standpoint is based on international regulations. Still, when national law restricts access to health care, providing care means to act against such regulations.

So how is the management of paradox organised in practice of health care for undocumented migrant children?

It is characterised by two main strategies. These can be described as Functional Ignorance and Structural Compensation. (Karl-Trummer et al 2009)

The following case from Austria will illustrate these strategies. Austria was among the five main destination countries of refugee movement to EU in 2015

It was reported by a medical doctor who herself is working as a volunteer in an NGO two days per month where she provides medical service to those patients who either by national legislation or by practical obstacles are excluded from health care provision (Karl-Trummer, 2009).

To start with the legal framework, Austria belongs to the “No Access” countries, and there are no organisations in place which explicitly provide health care for undocumented migrants, no matter of what age. Health care provision is primarily a public task regulated by social law and financed as an insurance based system, with approximately half of the total health expenditure being financed by insurance contributions; the other half financed one quarter each through tax subsidies from federal governments, communities and private households (BMGF 2005).

While migrants with a recognised status for humanitarian reasons like refugees and asylum seekers are entitled to get health care, this is not the case for undocumented migrants, and there are no specific entitlements for UMC in place. The only official gateway to health care is emergency treatment, which by law must not be denied, but where costs can be charged.

The case reported starts on a public playground: An undocumented migrant child has an accident while playing and breaks its arm. The child is taken to a public hospital by an ambulance. At the public hospital, the administrative staff asking for papers and insurance cards realises that the child and its parents have no papers and no insurance. They ignore the fact that the children (and its parents) do not hold an insurance and do not have any other official papers and admit the child for treatment. The medical staffs interpret the medical condition as an emergency case (live threatening or causing severe and lasting damage if not treated immediately). This is needed to comply with Austrian regulations, where UMC have no access to health care, but treatment must not be denied in case of emergency.

The staffs ignore the irregular status in order to be able to act according to ethical and professional standards. This ignorance becomes functional to safeguard ethically sound action.

To put the example further: The child gets a plaster cast to fix the broken arm. It now needs an appointment to have the plaster cast removed. If access to health care were secured in national regulations, it would be easy to make such appointment at the hospital. But in this case, this is not possible. The emergency condition cannot be applied any more.

So staff members at the hospital advice the family to turn to an NGO. This NGO is established to provide health care to vulnerable groups who for various reasons cannot

access regular public health services. It is financed partly with public money, mostly with private donations. The NGO is well known among vulnerable communities.

The doctor, who in her professional life runs a General Practice, meets the child on premises of this NGO to remove the plaster cast. She reports "I got a phone call from colleagues from the hospital. They told me about the child – and I told them to send it to the NGO where it could get the proper treatment and follow up examination. They couldn't do any follow ups at the hospital"

The NGO provides the structure to compensate the lack of available treatment in the regular health care system. It is this structural compensation both on level of infrastructure – the NGO holds the premises – and personnel – doctors work at the NGO's premises on a voluntary basis – that allow the ethically sound practice of giving health care to the undocumented migrant child.

7. Discussion and Conclusions

Despite the ratification of the UN Convention of the Rights of the Child by all EU Member States and recommendations from a wide range of international and European institutions, numerous studies and NGO reports show that the universal right to health in a majority of European Member States is overruled by national regulations that restrict access to health care for undocumented migrant children to emergency care only, with often even emergency treatment available on an out of pocket payment basis only.

There is a clear gap between internationally granted rights and nationally defined possibilities to get access to those rights in practice. Even if national regulations allow partial or full access to health care for UMC, in practice access is made difficult due to uncertainties and fears both on side of undocumented migrants and their children and health care providers.

The contradictory nature of international and national legal regulations opens up a paradox situation for health care providers, who whatever they do, act in violation of one or the other legal framework.

Many points for further discussions emerge from this paradox. On level of practices, it is foremost the discussion about how to do it right; about choices between doing what is "good" in ethical terms or what is "correct" in legal terms. It is also a discussion on who are and should be stakeholders and actors of ethics in practice. Evidently, to date it is mainly NGOs that through structural compensation set up structures to provide health care for undocumented migrant children and act according ethical standards. NGOs provide structures where health and social care professionals work as volunteers in pursue of their ethical values. Just to give an example, the voluntary work contribution from 4 Austrian NGOs amounts 578,240 Euros per year (Trummer, Novak-Zezula 2014).

It remains an unanswered point for discussion whether NGOs should be institutionalised agents of human rights and by doing so, allow public health system to remain ignorant concerning the needs of the most vulnerable.

"A child is first, foremost and only, a child." This is the first sentence of the Council of Europe Parliamentary Assembly Recommendation on Undocumented migrant children in an irregular situation (2011). The paradox dissolves from the ethical standpoint. There is no other option than to provide health care to an undocumented migrant child.

European Member states should take action that also the last sentence of the Recommendation enters into reality, that "each undocumented child [to] have a health card or a medical file which may be used wherever they go".

The recent developments show very clearly that such action is needed on European and national level to grant the right to health for UMC not only as law in the book but also as law and action in practice.

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Notes

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2. <https://mdmeuroblog.wordpress.com/the-european-network/>.