





# Health Care for Undocumented Migrants in the EU: Concepts and Cases

International Organization for Migration (IOM)

## Background Paper

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## Executive Summary

Undocumented migrants are gaining increasing attention in the EU as a vulnerable group that is exposed to high health risks and at the same time challenges public health. Health of undocumented migrants is highly at risk due to difficult living and working conditions often characterised by uncertainty, exploitation and dependency. In general, undocumented migrants face considerable barriers in accessing services. In a state-control logic, national regulations often severely restrict access to health care for undocumented migrants. At the same time, the right to health care has been recognized as a human right by various international instruments ratified by European countries (PICUM 2007a; Pace 2007). This creates a paradox for health care providers: if they give care, they may act against legal and financial regulations; if they don't give care, they violate human rights and exclude the most vulnerable. This paradox cannot be resolved on a practice level but on the contrary should be managed in a regulated way in which neither human rights nor national regulations are violated.

The EU Project "Health Care in NowHereland" (co-funded by the EC DG SANCO, Jan. 2008 – Feb. 2011) works on the issue of improving health care services for undocumented migrants. Experts from research and practice identify and assess contextualised (for policy frameworks and clientele needs) models of good practice of health care for undocumented migrants. The project builds upon compilations of:

- policies in the EU 27 (national level)
- practices of health care for undocumented migrants (regional and local level, collected in a public database)
- experiences from NGOs and other advocacy groups from their work with undocumented migrants (from the European to the local level)

With its title, the project introduces the image of an invisible territory of Nowhereland that is part of the European present "here and now". How health care is organised in NowHereland, what are the policy frameworks influencing health care provision and who are the people that live and act in this NowHereland are central questions raised.

A conceptual model presented in this paper introduces the concept of health care provision for undocumented migrants as a management strategy of the above mentioned paradox with different forms on the policy and practice level: "Functional Ignorance", "Partial Acceptance", "Structural Compensation" and "Informal Solidarity". Study cases from Austria and Italy are used to illustrate the concept.



## Introduction

### 1. Inhabitants of NowHereland: Definitions

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

Other sources define undocumented migrants as *"foreign citizens present on the territory of a state, in violation of the regulations on entry and residence, having crossed the border illicitly or at an unauthorized point: those whose immigration/migration status is not regular, and can also include those who have overstayed their visa or work permit, those who are working in violation of some or all of the conditions attached to their immigration status, and failed asylum seekers or immigrants who have no further right to appeal and have not left the country."* (UWT, 2008: 19).

With regard to stocks of residents the CLANDESTINO project Methodological Report defines five groups of irregular status:

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

Reports on specific policies on irregular migrants in five Council of Europe member states (Armenia, Germany, Greece, Italy and the Russian Federation) draw the conclusion *"that the main cause of irregular migration may be over-restrictive procedures for regulated migration and a flexible, "tolerated" concealed labour economy"* (Zanfrini & Kluth, 2008: 22).

Ways to enter NowHereland and become undocumented are defined as endogenous – with a legal entry into a country and a fall out of the

legal status e.g. from overstaying or not leaving when ordered – and exogenous – e.g. when crossing borders undetected (SOPEMI 1989). It is estimated that more than half of undocumented migrants are endogenous (Levinson, 2005: 2).

There are also ways to get out of NowHereland, e.g. through regularisation programmes.

The REGINE study (further details below) defines regularisation as *"any state procedure by which third country nationals who are illegally residing, or who are otherwise in breach of national immigration rules, in their current country of residence are granted a legal status."* (Baldwin-Edwards & Kraler, 2009a: 7).

In the recent past the great majority of EU member states have already conducted regularisation measures. According to the REGINE report there are two distinct logics that regularisation follows: 1) a *"humanitarian and rights based logic"*, that addresses policy (e.g. failures in the asylum system) and where regularisation is often used as an alternative to removal; and 2) a *"non-humanitarian, regulatory and labour market oriented logic"* where regularisation is a mean to tackle irregular migration and the informal economy (Baldwin-Edwards & Kraler, 2009a; ICMPD, 2009). *"However, in the short term and in particular in countries with large irregular migrant stocks, regularisation is often a necessary and unavoidable option to address the presence of irregular migrants, which reforms of admission procedures [for legal migration] cannot directly address."* (ICMPD, 2009: 5).

Apap, de Bruycker and Schmitter (2000) distinguish in a report the following five types of regularisation:

1. Permanent or one-off: Permanent regularisations are programmes on an on-going basis and have no time limits. A successful application is often determined by the criterion of how long a migrant has been residing (illegally) in the country. One-off regularisations refer to programmes that occur one-time and are often restricted to a limited number of migrants.
2. Fait accompli or for protection: Fait accompli regularisations are often based on geographic or economic criteria and refer to migrants who have been residing in a country irregularly since a specific date. Protective regularisations mainly concern humanitarian, medical or family grounds.
3. Individual or collective: In the event of an individual regularisation authorities make their decision on the individual merit of the case. Collective regularisation refers to the regularisation of a larger number of migrants by using objective criteria.

4. Expedience or obligation: The degree to which a state is forced to regularise a certain number of migrants because of constitutional and national human rights laws or international law.
5. Organized or informal: This category refers to the degree a formalised regularisation procedure exists. Informal regularisations refer to cases where, due to lack of clear criteria, individual migrants request regularisation to immigration authorities.

In practice a regularisation programme is a combination of these categories rather than solely one of them (Apap et al. in Levinson, 2005: 4; Baldwin-Edwards & Kraler, 2009a: 19f)

It has to be kept in mind that *“Regularisation programmes are usually undertaken only when internal and external migration controls have failed. The OECD (2000) cites three reasons why countries are opposed to amnesties or general regularisation programmes, including: the possibility that they will attract more undocumented immigration; that not all immigrants in an irregular situation will be able to take advantage of the programme (not being able to “wipe the state clean”); and having to implicitly acknowledge that existing controls were ineffective. Thus, countries undertake regularisation programmes with reluctance, and usually in conjunction with other methods of combating undocumented migration. In addition to regularisation, Baker (1997) identifies two other primary methods countries use to control immigration: wholesale deportation, and efforts at the border and internally to interdict and discourage new flows.”* (Levinson, 2005: 5f).

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

## 2. Numbers and Estimates

It lies within the nature of undocumented migration that exact numbers are missing and only estimates are available. For Europe these estimates vary between 1–4 % of the domestic population (OECD/SOPEMI, 2007; Fernandes et al., 2007) or, according to estimates of the Hamburg Institute of International Economics (HWWI), total numbers of 2.8 to 6 million people without legal residence permit in the EU. This is significantly less than the published numbers from the European Commission in 2007 (ibid.) with an estimate between 4.5 and 8 million. Both estimates – of the European Commission and the HWWI – were calculated for 2005. Analyses of flow trends show that since then the amount of irregular migration has rather decreased than increased. The estimate of the HWWI relies on a database on irregular migration that was developed in the framework of the project

CLANDESTINO (further details below) which provides background information and quantitative data on the amount of irregular migration in twelve European countries<sup>1</sup> which represent altogether 83% of the regular EU population (CLANDESTINO, 2009; Vogel & Kovacheva, 2009).

## 3. Access to Health Care for Undocumented Migrants in EU Member States

A report from PICUM (PICUM, 2007b) gives insights into eleven EU Member States concerning regulations on access to health care for undocumented migrants. It is pointed out that as access to health care for undocumented migrants in Europe is a national competence; regulations are heterogeneous and sometimes confusing. Regulations range from provision of health care for undocumented migrants on a payment basis only (e.g. in Austria) to offering full access to health care (e.g. in Spain, Portugal). In some countries, like Germany, reporting regulations were until recently in place where health care providers were obliged to report undocumented migrants, while for example in Italy, until now, the legislation prohibited the health services any form of reporting undocumented migrants to the authorities, except in cases in which this became compulsory due to equal treatment applied to Italian citizens. Just recently this legislation came into discussion (MSF, 2009; PICUM, 2009c). In February 2009, the Italian Senate approved to modify the concerned legislation so that now health care personnel is free to report undocumented migrants who seek their services to the authorities (SIMM, 2009; Turone, 2009).

Main access points for undocumented migrants are emergency care units and clinics established and run by NGOs. In general, NGOs take over an important role in providing health care and giving support to navigate through the system.

The PICUM report also points out that even under conditions of full access, barriers exist due to a lack of translators and cultural mediators, a lack of information of both health care organisations and undocumented migrants, uncertainties on the side of providers and fear and anxiety on the side of undocumented migrants. This is underlined by recent EU reviews that highlight the lack of knowledge about the health care system and mistrust of service providers as serious obstacles to access care (Mladovsky, 2007). Health care professionals that were interviewed in the course of the PICUM project point at the problem of late – sometimes too late – access. *“Many undocumented migrants are uninformed about the possibility of receiving medical treatment and are continually very reluctant to seek health care in any venue, as they fear discovery. As Dr. Pichler from the Krankenhaus der Barmherzigen Brüder said, “Here in Austria, undocumented migrants only come to hospital when they are in an extreme situation. Some of them come only to die.”* (PICUM, 2007b: 18).





What becomes visible in these studies is the combination of higher health risks due to hazardous living and working conditions and a worse access to health care for undocumented migrants. This threatens the health of this specifically vulnerable group as well as that of the regular population. Higher risks for public health associated with irregular migration arise mainly from transmissible diseases of which control is additionally hindered. Tuberculosis and HIV/Aids are the most frequently named (PICUM, 2007b).

#### 4. Current European Initiatives Working on the Issue of Undocumented Migration

Undocumented migration and its implications for health have become an important issue in the discussion of European and national health policies. Recent studies concerned with issues of health and migration mention undocumented migrants as a especially vulnerable group, which due to an insecure status has a higher health risk and at the same time impeded access to health care services (Fernandes et al., 2007; Mladovsky, 2007; Padilla & Pereira Miguel, 2007). These studies ask for *“greater transparency in countries’ approaches to responding to health and health care utilization inequalities experienced by this population, within the framework of human rights.”* (Mladovsky, 2007: 5). It is pointed out that the lack of data not only stems from methodological and technical problems but also it is a sign of a “policy dilemma” as undocumented migrants play an important role in informal and flexible labour markets that despite all ideals are part of the European economic reality (Schierup et al., 2006, in Mladovsky, 2007).

Several European projects approach the issue from different angles, trying to improve the methodology of data collection, investigating policy approaches and examining ways to improve access to and quality of services for undocumented migrants. A short overview of some of these projects is listed in the following section:

The European level IOM project ‘AMAC – Assisting Migrants and Communities: Analysis of Social Determinants of Health and Health Inequalities’,<sup>2</sup> within the framework of which this paper has been elaborated, reviews key health concerns of migrant populations in the context of social determinants of health. This project also serves as a platform for exchange on European projects concerned with migration and health.

‘CLANDESTINO – Undocumented Migration: Counting the Uncountable. Data and Trends across Europe’<sup>3</sup> is a European level project, led by the Hellenic Foundation for European and Foreign Policy (ELIAMEP), that provides an inventory of data and estimates on undocumented migrants (stocks and flows) in selected EU countries. The project’s aim is to improve knowledge, both in quantitative and in qualitative terms, of the undocumented migration phenomenon and to build up

a reliable picture. A database on irregular migration which was built in the framework of the project is available at <http://irregular-migration.hwwi.net>.

The EU-project ‘REGINE – Regularisations in the European Union’<sup>4</sup> of the International Centre for Migration Policy Development (ICMPD) provides a detailed picture of regularisation practices related to third country nationals illegally residing in the EU 27 with a comparison of practices in Switzerland and the US. Besides the investigation on regularisation practices in the different countries, the project also examines the relationship of regularisation policies to the overall policy framework and the political position and views of different stakeholders..

The Médecins du Monde ‘Averroes Network – Improving access to health care for asylum seekers and undocumented migrants in the EU’<sup>5</sup> aims to improve the health status of undocumented migrants and asylum seekers in the EU by encouraging the elaboration and implementation of binding community regulations. For this purpose it created a NGO network covering 19 EU Member States, which carries out research, field surveys and awareness raising activities at national and EU levels.

The ‘COST Action IS0603 – Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME)’<sup>6</sup> brings together an international group of experts to further the development of research and good practice concerning migrant health. In three working groups on social and policy factors, migrant’s state of health and its determinants, and health care for migrants and improvements in service delivery, the action consolidates and reviews work carried out so far, identifies blind spots and persistent problems and recommends ways forward to yield new insights into the causes of ill-health through a cross-national perspective.

Among these European initiatives is the project ‘Health Care in NowHereland: Improving Services for Undocumented Migrants in the EU’.<sup>7</sup> It works on the improvement of knowledge about legal and financial frameworks governing health care, health status and health determinants of undocumented migrants, on ‘reasonable’ organisational behaviour in the given context and hence on sustainable and practical solutions within the EU-27. The running time of the project is January 2008 to February 2011. Findings are publicly available on the project website (<http://www.nowhereland.info>).

“Health Care in NowHereland” originated in the point of uncertainty that becomes evident in the literature: there is a “Nowhereland” within Europe, a land that is unknown, but at the same time part of a European present. Along with the increasing public attention the lack of knowledge on this topic becomes visible. There is no backed information on the extent of undocumented migration, on the specific

health problems of undocumented migrants and their strategies to cope with them, and no shared experience of health care providers on how to cope with the situation.

How health care provision is possible in this NowHereland, who are the main stakeholders and what are the main challenges for policies, practices and people concerned are central questions which are raised. The project has three general objectives on the levels of policy, practice and people:

1. To draw a European landscape of the different legal and financial frameworks within the 27 EU Member States.
2. To collect existing practices of health services in 17 EU member states<sup>8</sup> and to identify contextualised (related to regulations and to clients' needs) models of good practice to support transfer and sustainability.
3. To gain an overview in 17 EU Member States about relevant health problems undocumented migrants face and on their strategies to get access to health care services.

Results and findings will be summarised and made available to the wider public in fact sheets on policies, practices and on undocumented migrants' needs and strategies.

In the course of the project, a database will be made available to illustrate the European practice. Case studies on models of contextualised good practice of health care for undocumented migrants will be described and assessed, taking into consideration the policy frameworks as well as the identified undocumented migrant's needs and strategies.

In this paper, the conceptual framework developed so far is described and exemplified with the first empirical findings. It starts by outlining a paradox that exists on the policy level.



## Analysis

### 1. A Paradox Opened on the Policy Level

With the analysis starting on the policy level, one fact becomes evident and is pointed out already in previous studies (Zanfrini & Kluth, 2008): the dilemma between national regulations that control national borders and define citizenship and the different entitlements to stay within a country, on the one hand, and the universal approach of human rights, on the other hand.

Access to health care is defined as a fundamental human right (Pace, 2007) and thus as a right irrespective of legal status or financial capital. This should protect particular socio-economically disadvantaged and vulnerable groups from extreme disadvantages (ECHR, 1950). All EU Member States recognise this human right (PICUM, 2007a; Pace, 2007). At the same time, national regulations restrict it in different ways and to different degrees, e.g. to certain basic services, such as emergency care.

This opens a paradoxical situation for health care organisations and their personnel. They have to cope with contradictory demands: if they give care, they may act against legal and financial regulations; if they do not give care, they violate human rights and exclude the most vulnerable. This paradox cannot be resolved on a practice level but has to be managed in such a way that neither human rights nor national regulations are violated.

To develop a concept of organisational and individual behaviour under such conditions, the idea of “management of the paradox” seems to be appropriate. It is a concept that gained increasing attention within organisational theory (Simon, 2007; Leybourne, 2007). In this logic, management of a paradox is a quite common demand that emerges when contradictory goals are pursued. A common example is the car industry, where constructing cars follows at least two goals: make them fast and make them safe. One solution to handle this is to install two different organisational departments: the department for developing a technology of speed, and the department for developing a technology of safety. This follows the strategy to create areas that are not stressed by paradox demands, so that they can concentrate on one goal. To construct a car then, of course, among other things, the findings of these two departments have to be combined.

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

So how is the management of the paradox organised in the practice of health care for undocumented migrants? In this paper, we start by giving insight into the NowHereland in Austria, being the home of the coordinating partner; and Italy, being home to the responsible partner for collecting services for undocumented migrants in the 17 EU Member States.

### 2. NowHereland in Austria

#### Undocumented Migrants in Austria

As for all European countries, for Austria only estimates on numbers of undocumented migrants are available. These estimates point at numbers between 17.000 (Biffl, 2002a and b; IOM, 2005) and 100.000 people staying in the country without an official entitlement (BMGF, 2003). Recent debates criticise these numbers and clearly state that: *“On the basis of the available evidence, no serious quantification of irregular migration in Austria is possible.”* (Kraler et al., 2008: 2)

In Austria, the issue of undocumented migration is not high on the agenda of public debates, and relevant data and information is accordingly scarce. Reports state that there is no comprehensive policy approach to legalise or regularise irregular migrants. Procedures are based on selective and individual regulations, an explicit programme to regularise irregular staying migrants has never been implemented, (Kraler et al., 2008; Baldwin-Edwards & Kraler, 2009b).

There are a few options for undocumented migrants to turn from an illegal to a legal status that have been significantly reduced with the last amendment to the law in 2005. For example, before 2005 it was possible to receive a legal status through marriage with an Austrian citizen which constituted an important option. As now applications for family reunification have to be submitted from abroad it is no longer possible for irregular migrants to obtain a residence title this way (Kraler et al., 2008).

One possibility into legality is the asylum application as it is likely that a certain share of asylum applicants has been staying illegally in the country before the asylum claim was submitted (Kraler et al., 2008).

The main option to receive legal status is the granting of the status of humanitarian stay that was first introduced in 1997 and is awarded by the Federal Ministry of Interior. For illegally staying third country nationals this is the only way provided by the state to obtain a legal residence title (Kraler et al., 2008). The most important reason for granting a humanitarian residence title is non-refoulement. Other reasons are family reunification and facilitation of criminal prosecu-

tions particularly meant for victims of trafficking (Baldwin-Edwards & Kraler, 2009b). According to the IOM report on illegal immigration in Austria, humanitarian residence permits have also been granted for other reasons, e.g. to “long-term resident, paperless adolescents, who were brought into the country irregularly by their parents” or to “persons with severe health problems, who cannot receive adequate treatment in their country of origin (e.g. in cases of cancer, Aids or dialysis)” (IOM, 2005:37).

Over the last years there has been a significant decline in the number of persons who were granted humanitarian stay, from 1.500 in 2001 to 460 in 2007 (Kraler et al., 2008: 46). *“The current practice of awarding humanitarian stay is deficient in several regards: to date, no right to apply for this status exists and the status is awarded on the discretion of the responsible authorities; in addition, decisions are not judicially scrutinized, nor are there clear criteria for awarding the status or a strong right to humanitarian stay for particularly vulnerable groups.”* (Kraler et al., 2008: 57).

### Legal Regulations Concerning Health Care

Health care provision is primarily a public task in Austria, which is regulated by social law. Main legislative competencies are given to the Federal Ministry of Health, Family and Youth (BMGFJ, 2008). Nine federal states are responsible for enactment of the legislation and implementation, as well as for financing and provision of in-patient care (BMGF, 2005). The main funding source of the Austrian health care system are contributions to the social health insurance, through which approximately half of the total health expenditure is financed. The other half is financed one quarter each through tax subsidies from federal governments, communities and private households (BMGF, 2005; Hofmarcher & Rack, 2006).

In 2007, around 99% of the population was covered by the social health insurance (Hauptverband der österreichischen Sozialversicherungsträger, 2008). This compulsory insurance under an obligatory scheme by law is financed through income-related contributions and is based on occupation. The insured are entitled to a broad spectrum of benefits within a legally defined framework. Coverage is extended to co-insured affiliates. For specific groups who are not covered by the compulsory insurance (e.g. marginal employed workers) the possibility of a self-insurance is provided. Migrants who have a recognised status for humanitarian reasons like refugees and asylum seekers are entitled to obtain health care and their services are covered by health insurance. Registered persons without health insurance mostly comprise unemployed people without entitlement to benefits or asylum-seekers who are not accepted into the federal care system (e.g. in case of leaving Austrian territory or being arrested or judged for a criminal offence). A study of the Federal Ministry of Health and Women (BMGF, 2003) noted that in 2003 around 160.000 people<sup>9</sup> aged 15 or older

were living in Austria without any registered entitlement in case of illness.

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

### Access to Health Care for Undocumented Migrants

The Austrian legislation does not comprise a specific regulation for health care provision for undocumented migrants. It can be said that on a regulatory level, undocumented migrants do not exist. In practice, undocumented migrants belong to a small group of people without health and social insurance, who very likely are unable to pay expensive treatment costs.

In general, opportunities to receive medical treatment without being insured or able to pay directly are highly limited. Offered services mostly depend on sporadic agreements with doctors who offer medical treatment at lower-cost, or organisations who offer specific services (e.g. gynaecological examinations, child birth) free of charge. But there are also some established organisations that provide services for people that have fallen out of the health and social insurance system (PICUM, 2007b).

### Services Providing Health Care for Undocumented Migrants in Austria

Two main actors in the field of health care provision for this marginalised group can be distinguished: Hospitals and NGOs.

#### Hospitals

Hospitals are the lowest threshold provider of the public health system in Austria. As there is no gatekeeper system like e.g. in the Netherlands, everybody can directly access the outpatient units at any time.

As mentioned, in case of emergency providing treatment is mandatory. This obligation opens a window of opportunity for undocumented migrants to obtain treatment beyond an actual case of emergency. For example, health professionals can ‘turn a blind eye’ by applying a wider definition of emergency, providing services knowing that they will not be paid and/or accepting false identities. Professionals also mention the possibility that if cases are “interesting”, people receive treatment with the argument of scientific and/or educational benefits (Karl-Trummer & Metzler, 2007).



Some specific hospitals with a confessional background offer treatment free of charge for people without insurance. The most prominent example in Austria is the private order hospital of the Barmherzigen Brüder ("brothers of mercy"), founded in 1614, which has become one of the most important contact points for undocumented migrants in Vienna (PICUM, 2007b; Karl-Trummer & Metzler, 2007). Every year around 20.000–30.000 patients without insurance get treatment there, of which 1.000–5.000 are hospitalised. With the guiding principle of the so-called 'new hospitality', the hospital imposed itself to grant every patient the best possible nursing and medical care. There are no restrictions on service provision, the whole range of outpatient and inpatient services is also offered for undocumented migrants. The hospital is DRG (Diagnosis-Related-Groups), funded by the provincial health fund and additionally financed by donations ([www.barmherzige-brueder.at](http://www.barmherzige-brueder.at), accessed 21.01.2009).

This organisation is both a public hospital, and as such part of the regular health care system, and at the same time an NGO acting as a private welfare institution.

This leads to the important role of NGOs for health care provision for undocumented migrants.

### **NGOs as Intermediaries and as Direct Providers**

There is a number of NGOs that act as intermediaries which provide guidance and practical assistance on how to access medical services.

A prominent example in Austria is the "Verein Ute Bock"<sup>10</sup> or "Asyl in Not"<sup>9</sup>. The "Verein Ute Bock" offers accommodation, legal advice, consultation –e.g. concerning access to health care–, the possibility to name the address of the association for registration as own's postal address, as well as education and training for asylum-seekers and refugees. The initiative is based on volunteer work and financed through donations. "Asyl in Not" offers legal and social advice including on health insurance issues in several languages.

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

### **AMBER-MED**

Since 2004, AMBER-MED, a joint project of the refugee service of Diakonie Austria and the Austrian Red Cross, provides outpatient treatment, social counselling and medication for people without insurance coverage in Vienna. The services offered are free of charge and anonymous and include among others general medicine, gynaecological examinations, paediatric care and diabetes care. In 2007, 889

patients, the majority asylum-seekers, refugees and homeless people, made use of AMBER-MEDs services – the trend is increasing. The existence of this organisation has mainly been made possible due to the volunteering of doctors, nurses and interpreters –the team consists of 3 employees and 31 volunteers– as well as through the support of a large network of medical specialists and institutes. Until 2006, AMBER-MED had been financed exclusively through donations. In 2007, the organisation received for the first time subsidies from the Federal Ministry of Health and the Fund for Social Affairs in Vienna (Fonds Soziales Wien); and since 2008, also from the Vienna Health Insurance (Wiener Gebietskrankenkasse) (AMBER-MED, 2008, Diakonie Flüchtlingsdienst, 2008).

### **Marienambulanz**

Since 1999, the Marienambulanz in Graz, Styria, provides primary health care for people without insurance coverage and for other marginalised groups. The responsible body is Caritas Austria. An outpatient department offers general medicine care as well as target group oriented care (e.g. diabetes, hypertension, psychiatric disorders). A mobile unit visits different places in the city once a week to provide medical and psycho-social care and counselling. The team consists of 5 employees and 31 voluntary workers who cover among them a wide range of disciplines, cultural backgrounds and languages. In 2007, there were 7.954 documented contacts and 1.250 patients from 72 nations were treated and counselled in the outpatient department. About half of the patients was without insurance coverage. The Marienambulanz is in close co-operation with health authorities and institutions and established itself in the health care system as an expert institution for medical treatment of socially marginalised groups. Financing is supplied by the Federal Ministry for Health, Family and Youth, the "Land Steiermark – Gesundheitsfonds Steiermark und Sozialressort", the Municipal Health Authority of Graz and Caritas. Since 2006, the service has a contract with the Styrian Health Insurance Company. In 2007, the Styrian Health Platform as the responsible public body 'nominated' the Marienambulanz unanimously as a measure that disburdens hospitals, which opened the possibility for further funding (Sprenger & Bruckner, 2008; Marienambulanz, 2008).

## **3. NowHereland in Italy**

### **Undocumented Migrants in Italy**

From a historical perspective, Italy represents a traditional source country of emigration that has become a receiving country "*with little experience of managing the high number of incoming flows*" (Zanfrini & Kluth, 2008: 13). Documented immigrants currently represent a 5.7% of the total population and "*contribute for about 70% of the growth of the population residing in Italy, and their babies born in Italy are about one tenth of the newborns*" (Fasani, 2008: 9).



According to estimates, a high proportion of the regular immigrant population currently residing in Italy passed from an undocumented status to a legal one. This was enabled by five mass-regularisation laws that came into force in 1986, 1990, 1995, 1998 and 2002 and which have jointly regularised almost 1.5 million irregular migrants who were already residing in the country. Nearly 700.000 of them obtained their legal status through the regularisation in 2002 (Fasani, 2008:13; Zanfrini & Kluth, 2008: 30).

It is suggested that Italy is a prominent receiving country for undocumented migration especially for economic reasons: "Italy attracts illegal immigration more than other countries due to the importance of its informal economy, which enables a flexible expansion of private care and domestic services as well as a proliferation of small enterprises where unregistered labour can more easily be hidden" (Zincone, 2001: 1). *"There is a widespread consensus among experts and commentators that the lack of adequate possibilities of legally accessing the Italian labour market (...) has played a major role in increasing undocumented stocks and flows."* (Fasani, 2008: 16)

According to the CLANDESTINO country report, the latest estimates on the stock of undocumented migrants in Italy amount up to approximately 541.000 in 2005, 650.000 in 2006 and 349.000 in 2007 (Fasani, 2008:31). The decline in the estimates from 2007 is mainly explained due to the effect of the so-called "flow-decree" in 2006, a quota system established by the government every year to manage the legal inflows of migrant workers. The "flow-decree" allows employees to apply for hiring immigrant workers until the quota number is filled. It does not allow applications for immigrant workers who are already residing in the country. *"... if they [undocumented migrants] find a job and an employer who wants to legalize their situation and working contract, they wait for the 'flow decree', apply for a place (in recent years, applications have to be submitted to any post office and with the last decree (2007) one could apply through internet: the application can be made by the migrants on behalf of their employers), and, finally, if the application is accepted, they move back to their origin countries and then return to Italy, entering officially and pretending not to have been in Italy before. Basically, migrants undergo an indeterminate probation period as undocumented ones and, if the working relationship consolidates, they may obtain the legal status and emerge from the underground economy."* (Fasani, 2008: 37)

In 2007, the Italian Ministry of the Interior published estimates on the main types of undocumented migration. According to these, the majority of the group of undocumented workers are over-stayers (60-75%). Another significant part entered Italy at the Northern borders by avoiding the border controls and at international ports and airports. Only a small proportion is landing along the Southern shores (Fasani, 2008: 13).

With respect to the undocumented migrants' country of origin, it is reported that in 2005 the largest group (more than half) were from Eastern European countries (Albania, Romania, Ukraine and Poland), nearly one sixth was from Northern Africa (mainly from Morocco and Tunisia), around one tenth were from Asia and Oceania, Sub-Saharan Africa and Latin America (ISMU estimates, Fasani, 2008: 50f). A comparison between documented and undocumented migrants shows that there are no big differences concerning the composition of nationality.

## Legal Regulations Concerning Health Care

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 health care, irrespective of income or geographical location" to everyone. This universal system replaced an insurance based system that had been set up after the Second World War. The aim of the 1978 reform was to implement a fully tax-based public health care system with only marginal private contributions (Donatini et.al., 2001:14f). Although universal coverage has been realized, health care and health expenditure between the regions show great differences, with a clear north-south divide.

The responsibility for health care is organised on the national, regional and local level. The state is in charge of defining the basic benefit package (Livelli Essenziali di Assistenza – LEA) which must be supplied equally throughout the country and has to ensure the general objectives and principles of the national health care system. The task at regional level is the organisation and administration of the health care system through regional health departments where the local health authorities have the responsibility for the health care service delivery (Große-Tebbe & Figueras, 2004: 41; Donatini et.al., 2001:19).

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 – the so-called "tickets". Private health care services and over-the-counter drugs also have to be paid out-of-pocket. In 2004, around 15% of the population had complementary private health insurance (Große-Tebbe & Figueras, 2004: 41f).

## Access to Health Care for Undocumented Migrants

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



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

Additionally, there are three categories of undocumented patients which are covered by law and can be also treated besides emergency/urgency: minors up to 18 years, pregnant women up to 6 months after birth and patients with diagnosed infectious diseases.<sup>12</sup>

According to the regional law *“Immigrant women shall be treated on equal terms to Italian women and shall enjoy social safeguard pursuant to the legislation on women clinics, promoting and supporting health and social services sensitive to cultural differences. The safeguard of minors under the age of eighteen is also guaranteed, in conformity with the principles established by the Convention on the Rights of Child, held in New York on 20th November 1989 and ratified with law no. 176 of 27th May 1991.”*<sup>13</sup>

As soon as the pregnancy of an undocumented woman is attested, she is entitled to get access to the family planning clinic of the national health-care service, which is located in each ASL (Azienda di Sanità Locale, Local Health Authority) and where assistance is for free.

The Italian legislation prohibits the health services any form of reporting to the competent authorities the presence of undocumented migrants, except cases in which reporting is compulsory, due to equal treatment applied to Italian citizens (e.g. serious injuries as a result of a criminal offence, reporting in case of infectious or diffusive diseases). In such cases, the healthcare facilities must record the personal data provided by the patient, even if ID documents are not available (Ministerial Circular no.5 dated 24th March 2000: Applicative provisions of Legislative Decree no. 286; Pace, 2007:23f; PICUM, 2007b: 51ff). This regulation safeguarding the undocumented from detection, however, is under discussion (MSF, 2009; PICUM, 2009c) and was changed in February 2009 (SIMM, 2009; Turone, 2009).

To access to public health and medical care services, undocumented migrants need to obtain the so-called regional “STP-Code” (Straniero Temporaneamente Presente, foreign national temporarily present). Undocumented migrants may get the STP-code from a hospital administration or the ASL any time and free of charge. It is valid for 6 months and can be renewed (PICUM, 2007b). This code is anonymous and consists of an STP-number, an ISTAT code (Italian National Statistics Institute) relating to the public health authority that first issued it, 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 health care services he or she is entitled to and is recognised throughout Italy

(Italian Presidential Decree no. 394 dated 31st August 1999, Art. 43). The STP doesn’t entitle the undocumented migrant to turn to a general practitioner. Instead, if a GP is needed, undocumented migrants go to dedicated services or NGOs, where general medical care is provided.

If undocumented 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 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 undocumented migrants to receive medical treatment free of charge in the framework of the abovementioned services. However, undocumented migrants have to pay the out-of-pocket contributions to the expense on equal terms with Italian citizens. Costs incurred from urgent or primary hospital treatment, even for a continued period, are covered by the Ministry of Interior. For refunding, the hospital in question informs the ASL which 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 financing of the special services (prenatal and maternity care, health care 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 (Italian Presidential Decree no. 394 dated 31st August 1999, Art. 43; PICUM, 2007b).

### Services Providing Health Care for Undocumented Migrants in Italy – The Example of Reggio Emilia

The following section gives an overview of services for undocumented migrants implemented in Reggio Emilia, Region Emilia Romagna. Reggio Emilia is a region that belongs to the “rich parts” of Italy and has a long left-wing oriented political tradition.

It is important to point out that, while the basic logic of access and provision of health care all over Italy is almost the same, regions are dealing with this common logic in different ways. This might be due to the richness of a region but also because of its political orientation.

PICUM states that there are remarkable differences in implementing the law – between regions as well as within regional health care centres and hospitals. They conclude that access to health care seems less guaranteed in areas with less immigrant population or with just low pressure of NGOs and state that the degree of awareness and information about access to public health care services for undocumented migrants varies among the relevant actors in the different cities and regions (PICUM, 2007b: 53ff).

Information on policies and practices concerning health care for undocumented migrants was gathered in the framework of a Short Term Scientific Mission funded by the COST Initiative<sup>14</sup>. As stated, health care and health expenditure in Italy show great differences between regions.

Findings on the regional level therefore cannot be generalised for other regions.

In Reggio Emilia, three main actors providing health care for undocumented migrants could be identified, two of them public and one private:

1. Hospitals, accessible in cases of emergency and/or urgency;
2. The so called “dedicated services”, tailored services for undocumented migrants, networking with NGOs;
3. NGOs as specific services for the poor.

These main actors are described in the following section through three health care organisations which were visited in the framework of the Short Term Scientific Mission.

#### ***Hospital: City Hospital Santa Maria Nuova***

As in Austria, emergency units in hospitals are the lowest threshold provider. In Reggio Emilia, the emergency unit at the City Hospital Santa Maria Nuova offers health care provision for undocumented migrants in case of emergency and/or urgency. Main cases of treatment are related to workplace accidents, violence and trauma.

The Hospital also serves as a contact point for other health care providers that give services to undocumented migrants. The hospital provides undocumented migrants with leaflets and information about these services.

As the legislation foresees that in case of pregnancy undocumented women shall be treated on equal terms to Italian women, undocumented women also have access to the gynaecological department. In the hospital there is no monitoring of undocumented migrants. For the gynaecological department it is estimated that within the whole group of migrant patients, about 30% of the total, around 5% are undocumented (Karl-Trummer & Metzler, 2008). The department provides cultural mediators for Arabic and Chinese.

#### ***Dedicated Service: Centro per la salute della famiglia straniera***

The Centre for the Health of the Foreign Family (Centro per la salute della famiglia straniera) is providing outpatient care and medical treatment for undocumented migrants and for foreign nationals without registration in the National Health System. It is the responsible body within the Local Health Authority of Reggio Emilia and has close cooperation with Caritas. The centre employs health care professionals (general practitioner, midwife, paediatrician, gynaecologist and nursing staff) and social workers who are available twice a month. The provided services include gynaecological examinations and counselling, prenatal care, paediatric

care and one time per month a TBC surgery. Services for specific target groups are offered on a project basis. In the framework of such projects, psychosocial support and health care for prostitutes and “Badanti” –elderly 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 working at the centre.

The health care centre keeps precise statistics on its patients. This is made possible through the STP code. The statistical database is shared with the Caritas surgery “Querce di Mamre” (see section below) which among other enables both services to make appointments for patients in the respective centre. Both organisations also provide shared information material for patients.

According to the patient statistics of 2007, the centre had a total of 3.189 patients. 53,7 % of these were there for the first time. The largest communities represented are Asian (33,9%), Eastern European (33,2%) and North African (21,6%). In cases of urgency, the centre refers undocumented migrants to the emergency unit of the hospital and calls the responsible doctor there in advance. For special services (e.g. blood screening) the patients have to go to the territorial health care service (Manghi, 2005; AUSL di Reggio Emilia, 2008b; Regione Emilia Romana, 2008; Karl-Trummer & Metzler, 2008).

Continuity of care is an important factor of these services, especially during pregnancy. Staff members therefore try to fix 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 health care. They can access the general health care system and do not need to go to the dedicated service. Nevertheless it is reported that most pregnant women prefer to receive treatment at the dedicated centre. Reasons for this are the trustful relationship and the continuous availability of a cultural mediator (Karl-Trummer & Metzler, 2008).

#### ***NGO: Caritas Surgery “Querce di Mamre”***

Querce di Mamre is an outpatient clinic run by 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 NGO has two surgeries for general medicine, one gynaecological surgery, a dental surgery and a surgery with tools and drugs for emergency use. 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 surgeries that offer assistance directly at their private sites.

The team of Querce di Mamre consists of 60 volunteering doctors (GPs





and specialists) and 15 volunteering nurses. The large number of staff makes it possible to cover nearly all medical fields; among other, general medicine, internal medicine, general surgery, obstetrics and gynaecology, paediatrics, otorhinolaryngology, ophthalmology, psychiatry, and dental care. Additionally there are two chemists, one psychologist and five IT assistants. Communication and information is supported by mediators and written information material.

The target group of the centre is undocumented migrants without access to the NHS 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 health care service in the so-called "listening centre" (Centro d'Ascolto) which is in the same block of buildings. In the last five years there was a steady increase of numbers of total visits from 437 in 2003 to 1411 in 2008. More than half of the patients are aged between 20 and 40. In 2008 the 3 largest groups were represented by Chinese (approx. 20%), Morocco (approx. 16%) and Moldova (approx. 12%) (Pisi, 2008; Caritas Diocesana di Reggio Emilia, 2008; AUSL di Reggio Emilia, 2008a).

## Conclusions

### 1. Strategies to Manage the Paradox in Practice

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

1. Functional ignorance as a policy strategy to neglect the demand for policy development with structural compensation as an organisational strategy to open a paradox-free room for action;
2. Partial acceptance as a policy strategy to turn an intangible phenomenon into an administrable (and statistically ascertained) one;
3. Informal solidarity as an individual strategy to follow humanitarian values without violating state-control-demands.

#### Functional Ignorance and Structural Compensation Opening Paradox-Free Rooms for Action

Functional ignorance seems to be an important strategy for Austrian policies and practices. In Austria, there are no organisations which explicitly provide health care for undocumented migrants. Undocumented migrants are not mentioned as target group, but get integrated into a definition of socially disadvantaged and especially vulnerable people. For hospitals, the criterion for provision of health care is the case of emergency when health is in serious danger. For NGOs the criterion for provision of health and social care is the status of (social) indigence. In both cases, organisations do not ask for information on legal status like residence permits or other documents. This ignorance concerning the legal residence permit opens a paradox-free room for action (Simon, 2007), that allows acting in accordance with the principles of human rights and professional ethics without getting into conflict with state-control demands.

This functional ignorance for provision of health care and safeguarding of human rights gets also visible on the policy level. As shown in the Austrian example of AMBER-MED and the Marienambulanz, NGO services that prove to be successful in providing care to people that are excluded from the health and welfare system are recognised as relief. They provide structural compensation for a health care system that does not offer services accessible for undocumented migrants within mainstream health care structures.

Delegating the challenge of health care provision for somebody without entitlements to private actors makes it possible for the public system to ignore the existence of undocumented migrants on a policy level. This seems to have a high benefit for the health care system as, along with its success, it gets increasingly supported by legal health

care finances. This is shown by the example of the Marienambulanz.

In its first years, the diocese Graz Seckau was the responsible body of the Marienambulanz and the medical organisation was taken over from the non-profit association OMEGA. First, cooperation with medical specialists were established, who provided their work on a voluntary basis. Originally the ambulance was authorized just for six months to assess the demand for a low threshold medical service. Moreover, its existence was reliant on the good will of the medical association, the Municipal Health Authority and the federal state Styria. The project continued due to the large and steadily growing demand, predominantly financed by Caritas and supported by the municipal social services department, which was responsible for the payment of the outstanding hospital bills before the Marienambulanz was founded.

The more successful the Marienambulanz became –growing numbers of patients, contributions to studies on marginalized groups, national and international media interest on their work– the larger became the shares of public funding. In 2002 and 2003, the social department of Styria (Land Steiermark – Sozialressort) and the Municipal Health Authority could be counted among supporters and, since 2005, the service receives also financial support from the Federal Ministry of Health, Family and Youth. Since 2006, the service has a contract with the Styrian Health Insurance Company. In 2007, the Styrian Health Platform as the responsible public body ‘nominated’ the Marienambulanz unanimously as a measure that disburdens hospitals. This nomination opened the possibility for further funding (Sprenger & Bruckner, 2008, Marienambulanz, 2008). That means that the service is no more dependent on private donations, but remains a private service.

#### Partial Acceptance through Assignment of a Specific Status

The Italian case shows, in contrast to Austria, a strategy of partial acceptance of undocumented migrants. Regulations are in place, and there is a system established that allows the organisation and provision of health care services. Through the STP, course and history of diseases can be recorded, routes of undocumented migrants within the country can be reconstructed (given the case that an undocumented migrant accesses services in different parts of Italy); it can be retraced if an infection, e.g. with TB, was caught in Italy or abroad.

The assignment of a specific status facilitates the organisation of service provision. On the policy level this also can be seen as a strategy to



turn an intangible phenomenon into an administrable (and statistically ascertained) one.

Despite differences on the level of official acceptance e.g. lack of a specific status and non existence of dedicated services in Austria, Italy and Austria have one thing in common: both seem to rely on private actors that provide structural compensation. Besides the dedicated services, the Caritas Centre as an NGO plays a vital role in health care provision for undocumented migrants. As the Marienambulanz in Austria, it provides structural compensation for and is to a considerable extend funded by the regional public health authority. Another similarity is that it includes undocumented migrants into service provision not because of their status of being undocumented but of their status of being poor. This has to be proven with the declaration of indigence, which is a precondition for getting treatment at the centre.

### Informal Solidarity as Individual Strategy to Pursue Humanitarian Values

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

Professionals in mainstream services in hospitals have a small margin to interpret access regulations, e.g. in defining a case of emergency where giving treatment is mandatory or in accepting people where entitlements and ability to pay are unclear. This kind of informal solidarity is highly limited and has to be decided on a case per case basis as it cannot rely on supporting structures at the organisational level.

The most visible and supported way of informal solidarity is to use the paradox-free room that is provided by structural compensation. This is the case when health care professionals join NGOs as volunteers and give treatment to people who do not have the chance to access regular services.

As it can be concluded from the high proportion of volunteers in NGOs, informal solidarity is important to enable functional ignorance and structural compensation. It is most likely that without the engagement of individual health care professionals, NGOs would not have the personnel necessary to provide services.

In both cases, this solidarity is informal and likewise depends on the activities of individual people as well as on a structural setting that promotes such activities. In the hospital as long as the hospital administration accepts unpaid bills; in NGO structures as long as these structures can be maintained through donations and/or the good-will of public financial bodies.

## 2. Questions for Reflection and Discussion

As stated, the process of concept development in the framework of the NowHereland project is still at the beginning. In the course of the project, empirical evidence from EU Member States will be collected and used as a basis for further development. In 2010/2011, evidence on policy contexts, practice models and good practice examples will be available. What becomes visible already in these first attempts is that in many cases health care for undocumented migrants relies on private investments in a two-fold way:

1. Within the welfare system, organised by established NGOs like Caritas and Diakonie, who provide structures and services that are not accessible in mainstream health care services;
2. From individuals e.g. health care professionals (medical staff, nurses) who join structures provided by NGOs to act in a rationale of informal solidarity.

It also becomes visible that (undocumented) migration is tackled by different stakeholders and from different perspectives, which results in different regulations that are sometimes contradictory. This is underlined as needing future development in other research reports:

*“Migration has to be tackled by a multi-dimensional approach, based on respect for human rights. Strict and security-oriented measures entail very restricted access to minimum rights, and so parallel structures (such as informal networks and NGOs) develop a less than perfect replacement for the lack of governmental responsibility. When these structures are not sufficiently well developed, the lack of access to basic services can result in serious problems of social exclusion and marginalisation that exacerbate the problems caused by migrant’s illegal or clandestine status.” (Zanfrini & Kluth, 2008: 22).*

The Austrian as well as the Italian example show that “parallel structures” of NGOs and private investments take over a decisive part of health care provision for undocumented migrants both under conditions of ignorance (Austria) and partial acceptance (Italy). This raises the question to what extent those parallel structures help to keep up functional ignorance on the policy level. It may also be argued that it has always been private welfare organisations that showed responsibility for the most vulnerable and marginalised groups.

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## Footnotes

- <sup>1</sup> Austria, the Czech Republic, France, Germany, Greece, Hungary, Italy, the Netherlands, Poland, Slovakia, Spain, and the UK.
- <sup>2</sup> (<http://www.migrant-health-europe.org>)
- <sup>3</sup> ([http://ec.europa.eu/research/fp6/ssp/clandestino\\_en.htm](http://ec.europa.eu/research/fp6/ssp/clandestino_en.htm), accessed 27.02.2009)
- <sup>4</sup> (<http://research.icmpd.org/1184.html#c2309#>, accessed 27.02.2009)
- <sup>5</sup> (<http://www.mdm-international.org/spip.php?article103#>, accessed 07.02.2009)
- <sup>6</sup> ([http://www.cost.esf.org/domains\\_actions/isch/Actions/HOME](http://www.cost.esf.org/domains_actions/isch/Actions/HOME), accessed 07.02.2009)
- <sup>7</sup> Main coordinator: Centre for Health and Migration, Danube-University Krems; Associate partners: Belgium: PICUM/Platform for International Co-operation on Undocumented Migrants, England: University of Brighton, Italy: AUSL di Reggio Emilia, Portugal: CIES/INSA, Sweden: University of Malmö; Scientific Consulting: Switzerland: University of Geneva; Collaborating partners: ICMPD/International Centre for Migration Policy Development, IOM/International Organization for Migration, HOPE/European Hospital and Healthcare Federation, University of Vienna/Institute for Nursing Sciences, WHO European Office for Integrated Health Care Services, United for Intercultural Action; 60 % of the project is funded by DG SANCO, 40% is financed by national funds of the project partner organisations.
- <sup>8</sup> The following EU Member States will be included into the research on practice and people level: Austria, Belgium, Czech Republic, Germany, France, Greece, Hungary, Ireland, Italy, Lithuania, Malta, the Netherlands, Portugal, Sweden, Spain, Slovenia, and the United Kingdom.
- <sup>9</sup> The description of the concerned groups does not specify if the data also cover an estimated number of undocumented migrants.
- <sup>10</sup> ([www.fraubock.at](http://www.fraubock.at), accessed 21.01.2009)
- <sup>11</sup> ([www.asyl-in-not.org](http://www.asyl-in-not.org), accessed 21.01.2009)
- <sup>12</sup> This refers to Article 19, Paragraph 2, Letters a) and b) of the National Law.
- <sup>13</sup> According to the National Law: Unified text of the provisions regarding immigration control and the norms on the condition of foreign nationals. Legislative Decree no. 286 dated 25th July 1998, Article 35, Paragraph 3:
- a) the social safeguard of pregnancies and the maternity condition, on equal terms to treatment to Italian women, pursuant to laws no. 405 of 29th July 1975 and no. 194 of 22nd May 1978 and the Decree by the Minister of Health of 6th March 1995 published on the Official Gazette no. 87 of 13th April 1995, and on equal terms of treatment to Italian citizens;
  - b) the safeguard of the minor's health in compliance with the Convention on the Rights of the Child dated 20th November 1989, ratified and enforced pursuant to law no. 176 of 27th May 1991;
  - c) vaccinations according to the applicable legislation and within the ambit of community prevention campaigns promoted by the Regional Authorities.
- <sup>14</sup> 'COST Action IS0603 – Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME) The authors would like to thank again the COST initiative for this opportunity.





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