Access to healthcare of excluded people in 14 cities of 7 European countries

Pierre Chauvin, Nathalie Simonnot

MÉDECINS DU MONDE 世界医生组织 DOCTORS OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO Γιατροί
του Κόσμου DOKTERS VAN DE WERELD MÉDICOS DO MUNDO MÉDICOS DEL MUNDO 世界の医療団 ÄRZTE DER WELT दुनिया के
डॉक्टर MÉDECINS DU MONDE 世界医生组织 DOCTORS OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO
Γιατροί του Κόσμου DOKTERS VAN DE WERELD MÉDICOS DO MUNDO MÉDICOS DEL MUNDO 世界の医療団 ÄRZTE DER WELT
Argentina | Belgium | Canada | France | Germany | Greece | Japan | Netherlands | Portugal | Spain | Sweden | Switzerland |
United Kingdom | United States of America

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Final report on social and medical data collected in 2012

Photo: Alfredo Matilla

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Key figures

- Data was collected in 2012 in 14 cities (7 countries) through direct interviews with 8,412 persons (19,302 contacts including 10,968 medical consultations; 11,921 diagnoses).
- 54.0% were male
- Median age was 34 years; 8.2% were 18 years old or less, and 7.7% were over 60 years old (27.7% in Perama-Greece)
- 25.1% were EU citizens among whom 9.4% were nationals (up to 88.0% in Perama-Greece)
- 55.1% of the EU citizens were not permitted to reside in the host country, 20.8% were in the host country for less than 3 months, 17.9% were permitted to reside after 3 months stay
- 61.0% of all MdM service users were not permitted to reside in the host country (between 22.3% in Greece and 89.7% in Amsterdam)
- Of the reasons given for migration, personal health reasons represented 1.6%, escaping from war 5.8% and economic survival 42.8%.
- 49.2% had unstable or temporary housing
- One third of the patients said that their housing was affecting their health or their children's health (56.9% in Greece)
- 52.3% of the patients had a low emotional support, including 14.2% who could never rely on anybody
- 23.9% had a job but the vast majority declared that their income was not sufficient for basic needs (over 70% in Greece and Spain)
- 6.8% of the patients were asked about their personal experience of violence
    - 40% of the respondents had lived in a country at war; 1/5 had been physically threatened, imprisoned or tortured because of their ideas; 1/5 had been victim of violence from the police or army forces; 40% had been beaten up; 22% had been confronted with psychological violence; 8% had been sexually assaulted and 5% raped.
    - 26.6% of the respondents reported having suffered of violent acts after their arrival in the host country
- 80.7% had no possibility to access care without paying full costs on the day we met them
- 76.9% reported at least one barrier in accessing health care. The 2 most cited barriers were a lack of knowledge of one's own rights or understanding of the health system (21.2%), and administrative problems (19.9%)
    - Expensive cost of consultation, treatment or deposit constituted 20% of the barriers cited by nationals or EU citizens
    - Fears of being reported or arrested constituted 6.6% of the barriers cited by undocumented migrants
- About 40% of the patients needed an interpreter. MdM managed mostly to get one as only 7% to 13% of the consultations in need were made without an interpreter
- 65.9% of the migrants with precarious administrative status declared that they limited their activities and movements due to the fear of being arrested
- One patient in five reported having been denied access to care by a healthcare provider in the last 12 months (up to 61.9% in Spain)

- 11.3% of the patients belonging to ethnic minorities in Greece, 8.5% in Spain and 6.9% in Amsterdam had been confronted with racism in a healthcare structure in the last 12 months
- 35.8% of the patients had given up seeking healthcare in the last 12 months
- 65.6% of the patients consulted MdM for medical reasons, 32.4% came for administrative, legal or psychosocial issues
- 25.8% of the patients had a bad or very bad perceived health status
    - 28.0% declared a bad or very bad mental health. Mental health was particularly damaged in Greece where this proportion was 50.8%
    - Altogether 66.7% of MdM service users declared a low perceived health status (i.e. very bad, bad or fair), which is much higher than what is observed in immigrants over 50 years old in Europe (37.8%) even though they are much younger in MdM programmes (median age = 34 years)
- Hypertension, diabetes, back symptoms, teeth or gum problems, abdominal pain, pregnancy, upper respiratory infection, depression and anxiety, and cough were the 10 most frequent diagnoses (among the total number of 11921 diagnoses reported by the doctors)
- Half of the medical consultations were for urgent (18%) or fairly urgent (32%) cases
- Chronic diseases concerned 61.4% of all the diagnoses made; 51.6% of the patients seen by a doctor had at least one chronic disease
    - Medical doctors considered that 62.5% of their consultants needed a "necessary" treatment and 23.3% a "precautionary" one
    - 75.9% of all the diagnoses made during the medical consultations required a "necessary" treatment
    - 54.6% of the patients had at least one health problem which required a necessary treatment and was not being dealt with or treated at all at the time of the consultation
    - 10.5% of the migrants had a chronic disease that they knew of before migrating
- 5.9% of the women seen by MdM were pregnant.
    - When interviewed about their access to care, 59.3% of the pregnant respondent did not have access to antenatal care when we met them, and
    - 46.7% did not receive care timely (i.e. after the 12th week of pregnancy)
- Around 10% of the children were surely not vaccinated for tetanus, HBV and MMR; another 10 to 17% had an unknown vaccination status
- 14% of adults were surely not vaccinated against tetanus and 19.4% against HBV; another 28.4% and 33.6% had unknown vaccination status respectively
- 60.0% of all patients did not know where to go to get vaccination

Introduction

Faced with the economic crisis, many governments have cut back on social and health spending despite the fact that the number of people in need of support and social protection is higher than ever. In the long term, such budgetary restrictions are counterproductive. This has been highlighted by the World Health Organisation (WHO) in the Tallinn Charter recommendations which point to the fact that ensuring health is a key factor for economic development and wealth,[1] *"[…] Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High performing health systems contribute to economic development and wealth" […] "We, the member states commit ourselves to: promote shared values of solidarity, equity and participation through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups[…]."*

Furthermore, the 2011 WHO Rio Political Declaration on Social Determinants of Health[2] clearly states, "*We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an '**all for equity'** and '**health for all'** global action."*

The European Parliament has acknowledged that healthcare is not available to all. In its resolution[3] dated the 8th of March 2011, the European Parliament clearly stated that, *"[…] equitable access to healthcare is not secured, not only in practice but also in law, for undocumented migrants in many EU countries. […] The European Parliament calls on Member States to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided equitable access to healthcare."*

In the same way, the European Union Agency for Fundamental Rights (FRA)[4] also stresses upon the fact that, *"As EU member states, faced with an ageing population and the repercussions of a global economic crisis, struggle to contain public health expenditure, the right to health for all - regardless of legal status - must remain a key concern".*[5]

Soaring unemployment rates[6], rising child poverty, people losing their homes because of insolvency every month… The social welfare systems in Europe are quaking under the strain. Whereas most European countries have in recent years been host countries for immigrants, an increasing number of

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1 June 2008: http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf

2 October 2011: http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf

3 In this resolution, the European Parliament stresses that, *"[…] health inequalities are not only the result of a host of economic, environmental and lifestyle-related factors, but also of problems relating to access to healthcare[…]"; furthermore, "[…]equitable access to healthcare is not secured, not only in practice but also in law, for undocumented migrants in many EU countries". The European Parliament calls on member states, […] to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided equitable access to healthcare[…] to assess the feasibility to support healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined by their national legislation; […] to ensure all pregnant women and children, irrespective of their status, are entitled to and effectively benefit from social protection as defined in their national legislation".* See: http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2011-0081&language=EN&ring=A7-2011-0032
The Charter of Fundamental Rights of the European Union clearly stipulates in the Article 35 (which covers health care) that "*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".*

5 http://fra.europa.eu/fraWebsite/research/publications/publications_per_year/2011/pub_irregular-migrants-healthcare_en.htm

6 According to the latest Eurostat figures, the highest increases in unemployment were registered in Greece (18.9% to 26.0% between September 2011 and September 2012), Cyprus (9.5% to 14.0%), Spain (23.0% to 26.6%) and Portugal (14.1% to 16.3%). In November 2012, the youth unemployment rate (under 25 years old) was 23.7% in the EU-27. In Greece 57.6% of young people are out of work (September 2012), while in Spain the figure is 56.5%. See http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Unemployment_statistics#Recent_developments_in_unemployment_at_a_European_and_Member_State_level

European citizens are now pushed to economic migration, both within Europe and beyond. The crisis has generated austerity measures that have had a deep impact on all social safety nets, including healthcare provision, in an unprecedented way.

In its 2012 report[7] "Health policy responses to the financial crisis in Europe", the WHO classified the global financial crisis that began in 2007 as a health system shock or "an unexpected occurrence originating outside the health system that has a large negative effect on the availability of health system resources or a large positive effect on the demand for health services". The WHO further warned that "cuts to public spending on health made in response to an economic shock typically come at a time when health systems may require more, not fewer, resources – for example, to address the adverse health effects of unemployment". Measures such as reducing the scope of essential services covered, reducing population coverage, increasing user charges for services and reducing the number of health providers were specifically identified as policy tools that undermine health system goals.

Nevertheless, many Member States have raised the share of out-of-pocket expenditure for patients. As a consequence, people delay or even abandon seeking healthcare. According to a report published by the OECD in 2011, the most common reason mentioned in Greece and Portugal for self-reported unmet needs is the cost[8]. According to the OECD, 25% of the Portuguese population still reports unmet needs for dental care. In 2012, 36% of the people who came to MdM clinics had given up seeking healthcare at least once.

The Spanish Government reduced spending on health and education by €7 billion in 2012. In its memorandum signed with the Greek government, the Troika[9] specified that public health expenditure should not exceed 6% of gross domestic product[10] (versus 10.6% in 2009[11]).

In theory, Greece's universal public healthcare system entitles insured people on a very low income to visit general practitioners free of charge and to get medicine for free but a lot of people do not get the necessary "welfare card" allowing them not to pay upfront, mainly because of the complexity of administrative procedures in Greece. Since October 2010, all public hospitals impose a €5 entrance fee and further examinations also have to be paid for – a measure that excludes many people. Many hospitals in Greece lack staff, basic equipment and supplies. Pharmacies often lack supplies and demand that customers pay cash upfront, as the state owes them a lot of money. According to Greek journal Kathimerini, these debts were as high as €250 million at one point last year[12].

As vaccinations now have to be paid for, many children do not get any, which not only puts their health at risk but also prohibits them from accessing school. In the MdM polyclinics in Greece[13] – which deliver healthcare to the most vulnerable – nearly half of the patients are now Greek citizens (up to 88% at one of them). Many of them have passed retirement age (at the same polyclinic up to 28% are over 60 years old). Their pensions have been cut almost in half due to the austerity measures. There is no doubt that the efficiency of Greece's healthcare system could be greatly improved. However, current austerity measures imposed by the Troika seem more likely to exacerbate the general collapse of the health system instead of preventing it.

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7 See www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

8 OECD. Unmet health care needs. In: *Health at a glance 2011: OECD indicators*. Paris, OECD, pp. 130-131, available at http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2011/unmet-health-care-needs_health_glance-2011-52-en

9 Name given since the beginning of the crisis to the working group of the European Commission, European Central Bank and International Monetary Fund.

10 See Government of Greece (2012), *Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding*.

11 See *OECD Health Data 2012*, www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm

12 See www.ekathimerini.com/4dcgi/_w_articles_wsite1_1_22/05/2012_443402

13 MdM Greece runs five polyclinics; four of them have been collecting data since the end of September 2012.

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

People confronted with numerous vulnerability factors were already facing major health inequalities before the economic and financial crisis hit Europe. Earlier MdM surveys indicated that financial inaccessibility of care for patients led to unmet needs that vastly surpassed the average level of unmet needs of the population of any EU Member State. For instance, in 2011 the MdM France medical teams[14] found that in a sample of 1,547 patients, 38% should have been treated earlier.

These figures confirm those from an earlier comparative survey across 11 EU countries (2008) that showed that 25% of the MdM patient population received treatment late (this number rose to 33% for patients with chronic health conditions, such as diabetes and hypertension).

Before the crisis, people confronted with numerous vulnerability factors already reported their perceived state of health to be up to three times poorer than that of the average population across Europe[15.] **Now the MdM teams in Greece and Portugal are faced with patients who have to choose between eating and buying their medicines.**

Due to the budgetary cuts, vulnerable groups are now even less likely to receive the necessary attention from healthcare providers, although the number of people facing precarious living conditions is increasing. For instance, in Greece, the legal entitlement to healthcare for the few asylum seekers who manage to formally apply for asylum is far from guaranteed. Undocumented migrants only have access to emergency treatment, but due to the enormous strain on the Greek health system, even this is often not possible anymore.

In 2012, the Spanish government excluded adult undocumented migrants (including the chronically and severely ill) from public healthcare, thereby ignoring the direct and indirect economic benefits of health promotion and prevention for the most vulnerable populations.

In Portugal, the lack of information about the new regulations reduces access to healthcare. For example, homeless people who have not declared their income have no way to prove they have a right to be exempted from the usual co-payment.

On top of all this, many NGOs taking care of the health needs of vulnerable people are also facing important budget cuts, both from private donors and from the State. Several MdM associations that partially depend on government subsidies are finding it hard to cope. For instance, MdM Portugal has had to close eight domestic programmes because of lack of funding from the State. MdM Spain has had to considerably reduce the number of contracted staff and has also had to close quite a few programmes.

We hope that this report will shed a new light on the situation of the persons who, in Europe in 2012, could not access healthcare professionals in the mainstream system. We hope that this report will help to bring changes in the laws and practices which deny one of the fundamental human rights, the right to health.

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[14] See http://www.medecinsdumonde.org/Publications/Les-Rapports/En-France/Observatoire-de-l-acces-aux-soins-de-la-mission-France

[15] Baert K, De Norre B. *Perception of health and access to healthcare in the EU-25 in 2007*. Brussels, Eurostat (Statistics in focus), 2009, no 24.

Methods

In 2006 and 2008, the Doctors of the World European Observatory[16] on access to healthcare conducted two surveys that specifically looked at the condition of undocumented migrants in Europe.[17,18] These past surveys were based on samples of MdM patients in various European countries. Three years later, in 2012, the Observatory has presented data on the living conditions of *all* of the patients, including undocumented migrants, seen in 2011 at MdM free clinics in 5 European cities: Amsterdam, Brussels, London, Munich, and Nice[19]. It was then the first analysis ever made by the Observatory that was based on information on living conditions and health data collected *routinely* (and not only among subsamples of patients) in our clinics.

One year later, we are pleased to present in this document the analysis and main results observed on data collected in 14 cities located in 7 European countries: Brussels and Antwerp in Belgium, Nice in France, Munich in Germany, Athens, Perama, Patras and Thessaloniki in Greece, Amsterdam in the Netherlands, Alicante, Tenerife, Valencia and Zaragoza in Spain, and London in the United Kingdom.[20] Progressively, the coverage of such a routine collection of social and medical data among the vulnerable people who are consulting MdM in our clinics all over Europe has been increasing, and so is the quantitative value of our results and the scope of the testimony of this Observatory.

First and foremost, all the participating sites and the 8412 patients who answered our questions deserve to be thanked for their efforts.

Each patient who consulted MdM in 2012 was systematically interviewed, using one or the other of the 3 questionnaires implemented (social form, medical initial form, re-consultation form).

Belgium, France, Greece and UK are the countries with the highest numbers of patients reported in this survey; Nice and London (and at a lesser extent Brussels) gave the highest number of people in the final surveyed population.

In Greece, data only started being collected end of September 2012. So the figures only count for 3 months activity.

In Spain, a specific survey was organised for over a month (mid-November to end of December) in order to collect at least 100 patient files.

All along this report we shall use in the tables and figures:

- BE (Belgium) for Antwerp and Brussels
- DE (Germany - Deutschland) for Munich
- EL (Greece – Ellada) for Athens, Perama, Patras, Thessaloniki
- ES (Spain – España) for Alicante, Tenerife, Valencia and Zaragoza
- FR (France) for Nice
- NL (the Netherlands) for Amsterdam
- UK (United Kingdom) for London

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16 The European Observatory was renamed International Network Observatory in 2011

17 Chauvin P, Parizot I, Drouot N, Simonnot N, Tomasino A. *European survey on undocumented migrants' access to health care*. Paris, Médecins du Monde European Observatory on Access to Health Care, 2007, 100 p.

18 Chauvin P, Parizot I, Simonnot N. *Access to healthcare for the undocumented migrants in 11 European countries*. Paris, Médecins du Monde European Observatory on Access to Health Care, 2009, 154 p.

19 Chauvin P, Simonnot N. *Access to health care for vulnerable groups in the European Union in 2012*. Paris, Médecins du Monde International Network Observatory on Access to Health Care, 2012, 23 p.

20 In the rest of the document, countries will be cited by alphabetic order of their official code, according to the European recommendations (*Interinstitutional Style Guide*, EU, Rev. 14 / 1.3.2012). The readers must constantly keep in mind that data are from some cities only in each country (between 1 and 4 cities per country).

The present report is based on the description of 8412 patients, 19302 contacts (including 10968 medical consultations) and 11921 diagnoses reported by voluntary doctors.

Statistical results are illustrated with some patients' stories based on verbatim collected by MdM teams.

Table 1. Breakdown of patients by countries

	No	%	Survey period	
BE (2 cities)	2.027	24.1%	02/01/2012	31/12/2012
DE (1 city)	439	5.2%	09/01/2012	19/12/2012
EL (4 cities)	1.505	17.9%	24/09/2012	28/12/2012
ES (4 cities)	103	1.2%	15/11/2012	28/12/2012
FR (1 city)	2.600	30.9%	01/01/2012	31/12/2012
NL (1 city)	177	2.1%	23/01/2012	13/12/2012
UK (1 city)	1.561	18.6%	14/03/2012	31/12/2012
Total (14 cities)	**8.412**	**100.0%**		

Statistics

Because of the variation in population size of the 14 clinics and the difference in missing value ratios from one centre to another and from one question to another, we chose to compute three estimates for each global figure (mostly proportions or ratios):

- CAP (*crude average proportion*), i.e. without any correction;
- WAP (*weighted average proportion*) is the mean proportion, i.e. the global proportion if all the countries had contributed for the same number of patients;
- MVWAP (*missing-values-corrected weighted average proportion*) is further corrected by taking into account the rate of missing values in every site for the question analysed.

In the following text, we will give one or the other indicator, depending of the distribution of respondents and missing values.

Statistical tests have been also performed to compare some proportions. Classically, we used Chi-square test or Fisher's exact test when the numbers were low. All the tests have been performed on crude data, using SAS Software (v. 9.2, SAS Institute Inc., Cary, NC, USA).

Demographics and countries of origin

The majority of patients were male (54%), with the exception of Munich and the Spanish clinics where women accounted for the majority of the consulting population. A similar sex ratio was also observed in Munich[21] with the 2011 data.

Table 2. Gender distribution by site

	BE (n=2027)	DE (n=439)	EL (n=1505)	ES (n=103)	FR (n=2600)	NL (n=177)	UK (n=1561)	Total (n=8412)	MVWAP*
MV	0.59	1.82	0.40	1.94	0.08	2.26	5.12	1.36	
Female	32.26	56.38	47.23	57.43	42.38	42.20	45.78	47.07	46.03
Male	67.74	43.62	52.77	42.57	57.62	57.80	54.22	64.18	53.97
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	

*MV=missing values, *Missing values-corrected weighted average proportion*

The mean age of the population was 35.7 years (median = 34) and 50% of the population were between 26 and 46 years old (range = [0-93]). In Greece, we observed that a quarter of the patients seen in Perama (27.7%) were over 60 years old, whereas in the other three cities in Greece this was not the case.

Figure 1. Age distribution of the population by country (interquartile, median and mean)

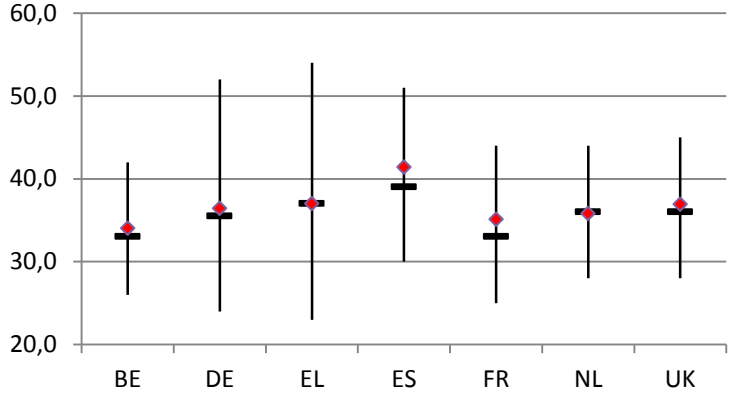
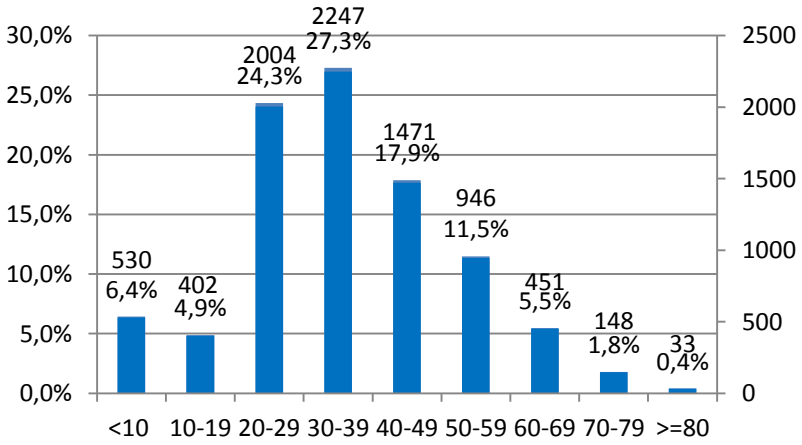


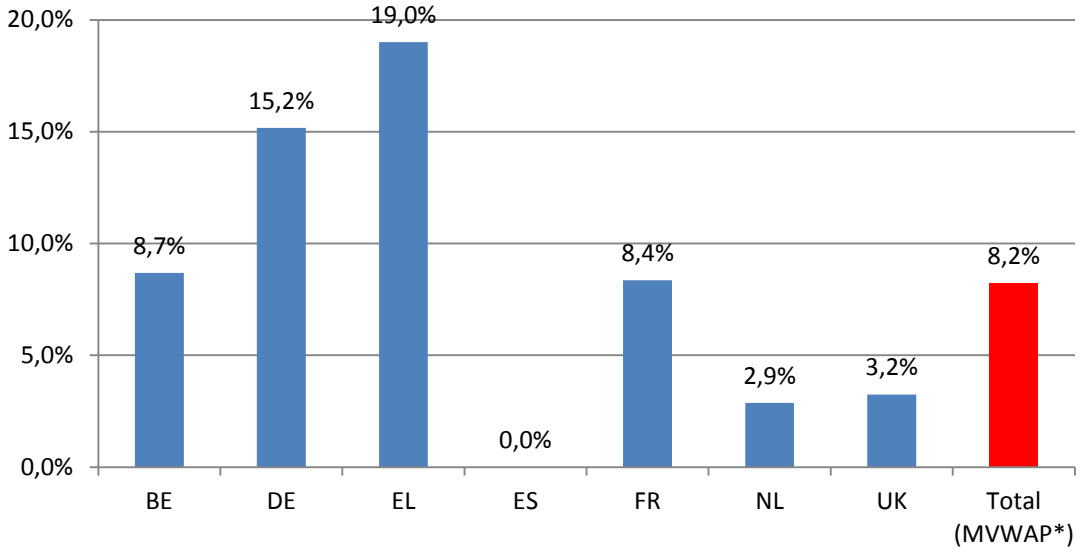
Figure 2. Distribution of the population by age group (in years)



[21] A gynaecological consultation takes place in Munich.

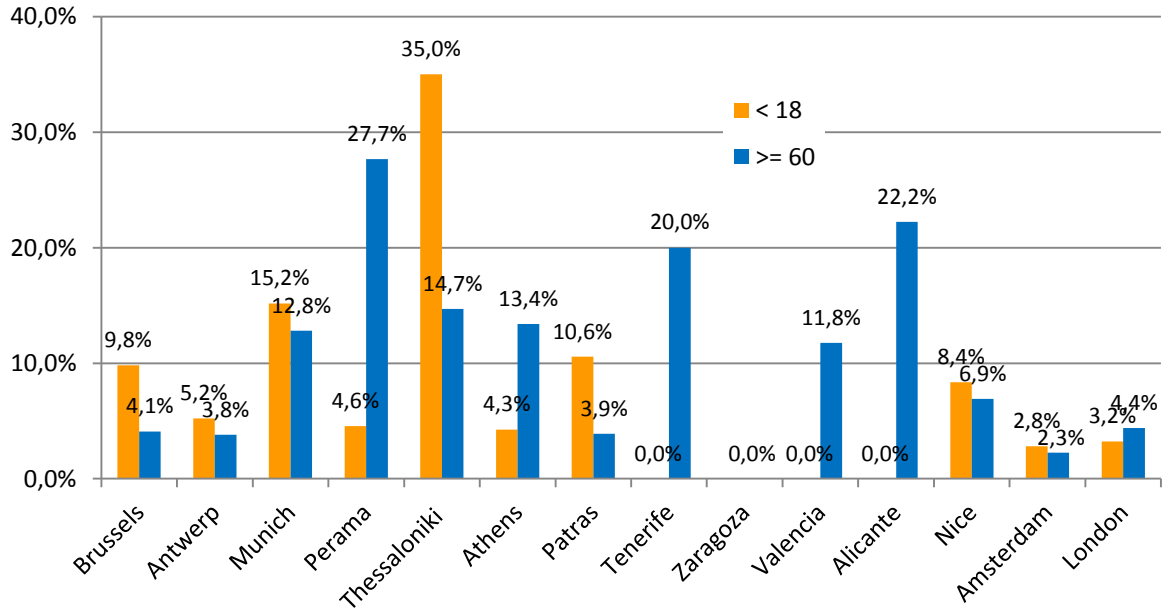
A small proportion of the patients interviewed were under 18 years of age (8%). This figure was much higher in Greece (19%), especially in Thessaloniki where minors represented 35% of the patients seen. The figure was 15% in Munich where paediatric consultations take place. Only the Spanish clinics did not see any minors at all. This can be explained by the fact that the Spanish health reform does not exclude minors from healthcare (although in practice, some do get excluded) and the fact that the survey in Spain lasted only six weeks.

Figure 3. Proportion of minor patients by country (under 18 years old)



**Missing values-corrected weighted average proportion*

Figure 4. Proportion of minors and elderly by city

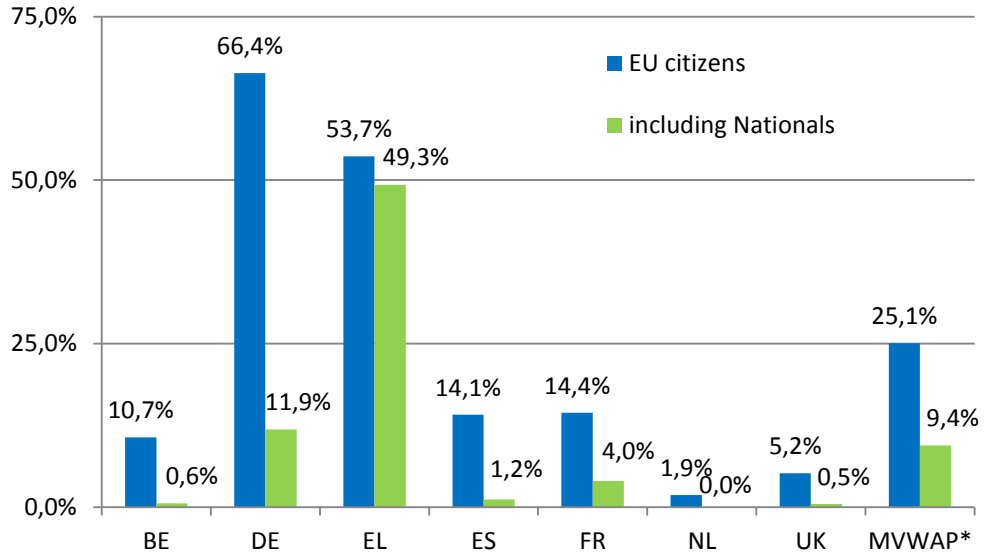


The origins of the patients varied considerably between countries:

- **In Munich, 66.4% of the patients were EU citizens, as were 53.6% in Greece** (including Germans and Greeks, see below). In contrast, EU citizens were extremely rare in Amsterdam (<2%) and in London (5.4%), whereas they accounted for 10 to 15% of patients in Belgium and Spain and 18% in Nice.

- **It is particularly noteworthy that approximately half (49.3%) of the patients seen in the four Greek clinics in 2012 were Greek nationals**. Up to 88.0% of patients in Perama, 52.1% in Thessaloniki, 11.8% in Athens and 5.8% in Patras were Greek. The high rate of Greek nationals seeking healthcare from humanitarian NGOs is a dramatic consequence of the severe crisis which has hit Greece over the last two years. It is unique among the clinics that participated in the data collection: in the other countries, this proportion was less than 5% (except in Munich where 12% of patients were nationals) and was almost zero in Amsterdam, Antwerp, Brussels and London.

Figure 5. Proportions of EU citizens, including nationals, by country



***Missing values-corrected weighted average proportion*

As is usually the case in MdM International Network domestic programmes, **the patients' nationality varied considerably across the countries**. Some of these differences may be due to the historical links that still exist between some European countries and their former colonies (e.g. 36% of the patients in Nice were from Maghreb countries and 45% of the patients in Spain were from Latin America). In Amsterdam, 60.5% of the patients were from Sub-Saharan African countries like Ghana (they also represented the majority of patients in 2011). These historical links provide much more of an explanation for the migration process than the welfare systems (which the migrants know nothing about).

Migrant patients had lived in the host country where they were interviewed for a median length of 32 months (interquartile = [11-73]). This figure was shorter in Belgium and Munich (median <= 20 months), and the longest one in the Greek centres (median=96 months, i.e. 8 years); in all the other centres, it varied between 4 and 5 years. It was also a little – but significantly - longer in men (median=31 months) than in women (26 months, $p<0.0001$). In average, people from Asia had lived in the country of interview for the longest period of time when Europeans (both from EU or outside EU) had arrived more recently.

Figure 6. Length of stay in the host country (median and interquartile, in months)

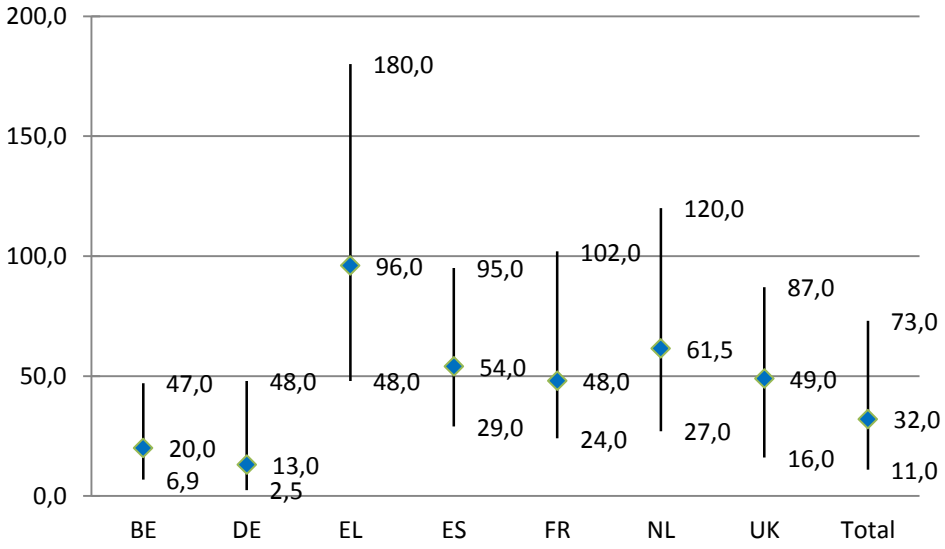


Figure 7. Length of stay in the host country by geographical origin (median and interquartile, in months)

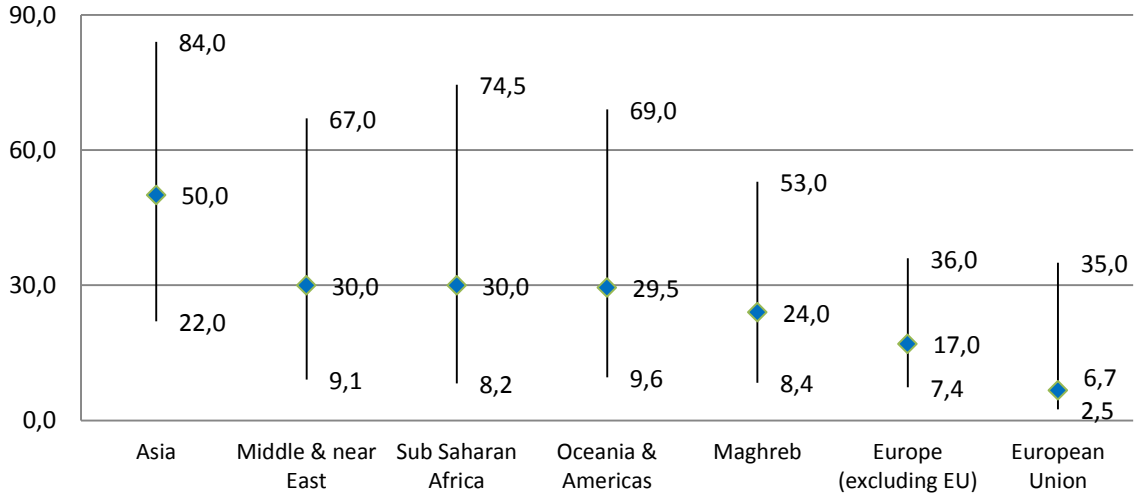
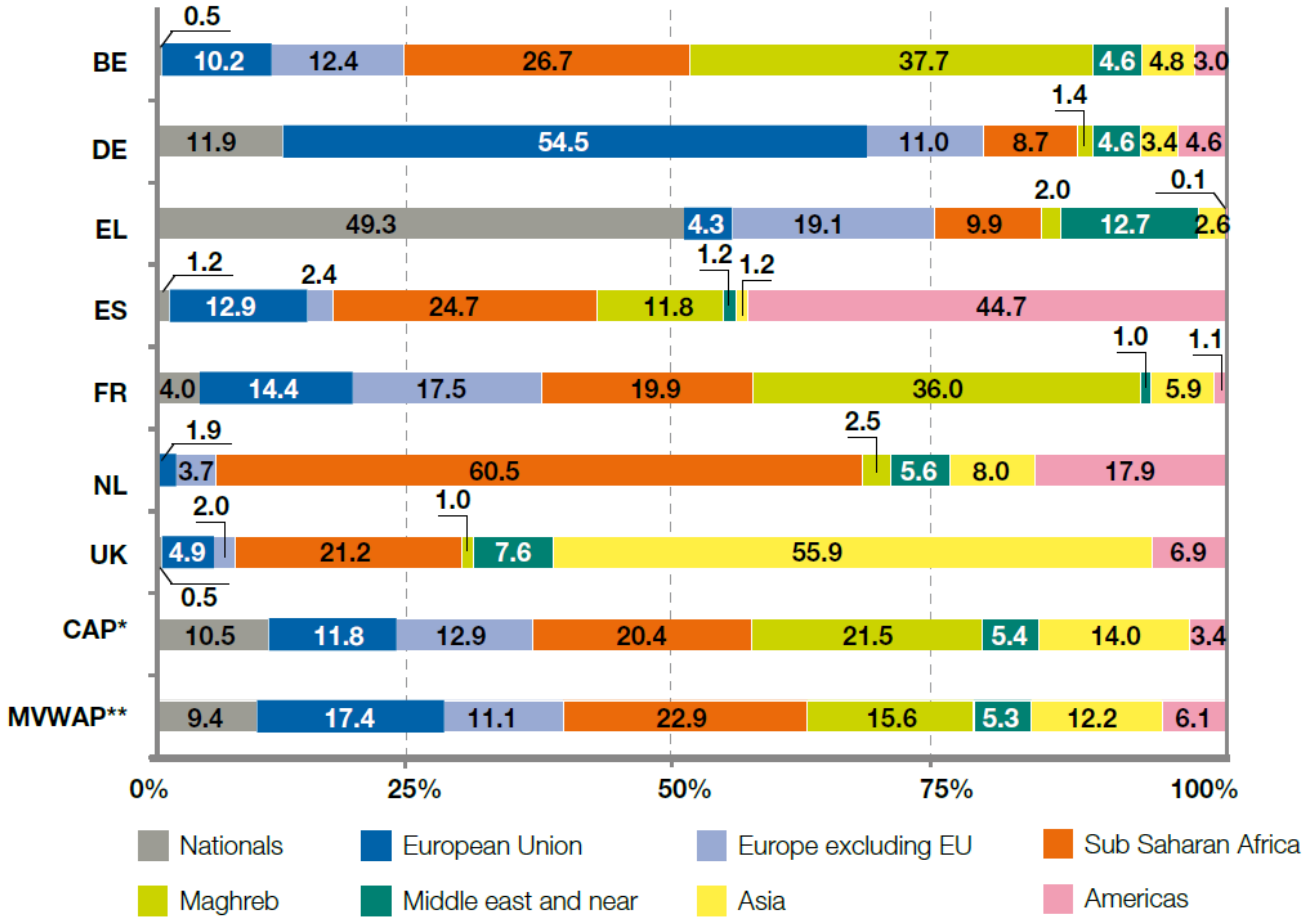


Figure 8. Patient place of origin by country



**Crude average proportion, **Missing values-corrected weighted average proportion*

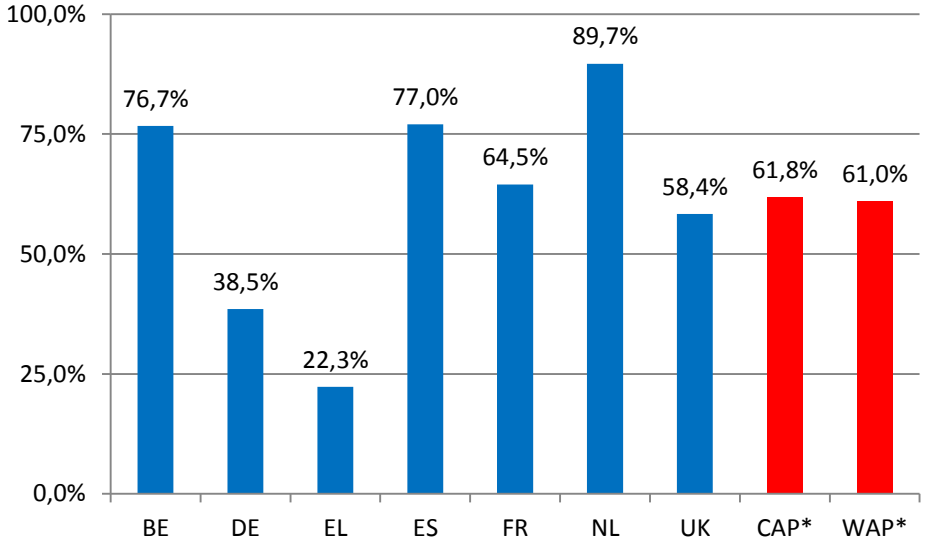
Table 3. Top 10 nationalities by country

BE	DE	EL	ES	FR	NL	UK
MOROCCO (541)	BULGARIA (153)	GREECE (683)	GUINEA (8)	TUNISIA (505)	NIGERIA (38)	BANGLADESH (260)
ALGERIA (152)	GERMANY (52)	ALBANIA (146)	MOROCCO (8)	MOROCCO (207)	GHANA (36)	CHINA (171)
GUINEA (110)	RUMANIA (43)	AFGHANISTAN (129)	ARGENTINA (7)	CAP VERT (206)	SURINAM (12)	INDIA (142)
CAMEROON (96)	ETHIOPIA (14)	GEORGIA (68)	RUMANIA (7)	ALGERIA (200)	BRAZIL (10)	PHILIPPINES (139)
RUMANIA (80)	POLAND (9)	NIGERIA (54)	COLOMBIA (6)	RUSSIA CHECHNYA (187)	EGYPT (6)	UGANDA (121)
CONGO (60)	SPAIN (9)	BULGARIA (41)	NIGERIA (5)	RUMANIA (179)	UGANDA (6)	BRAZIL (67)
ARMENIA (44)	NIGERIA (8)	BANGLADESH (26)	DOMINICAN REP (5)	PHILIPPINES (124)	TURKEY (4)	VIETNAM (55)
BULGARIA (44)	TURKEY (6)	ARMENIA (24)	NICARAGUA (4)	FRANCE (103)	SIERRA LEONE (4)	NIGERIA (53)
SENEGAL (43)	SERBIA (6)	SUDAN (24)	VENEZUELA (4)	COMORES (86)		PAKISTAN (46)
NIGERIA (40)	AFGHANISTAN (6)	SYRIA (18)		ITALIE (32)		AFGHANISTAN (36)

Legal status

Almost two thirds (WAP=61.0%) of the population were not permitted to reside in the host country; the same proportion as observed in 2011. This proportion differed considerably, depending on the country surveyed: it ranged between 22.3% in Greece and 89.7% in Amsterdam[22], whereas London and Nice were close to the global average.

Figure 9. Proportion of patients who were not permitted to reside in the host country



**Crude average proportion, **Weighted average proportion*

Two sub-groups of people were not permitted to reside:

- **Half of the patients (WAP=49.6%) were undocumented migrants from a non-EU country**. This proportion was even higher in Brussels and Antwerp (72.3%), Amsterdam (89.1%) and London (57.1%), but was notably low in Munich (8.5%). It should be noted that none of the patients in Perama were undocumented, but 74% were undocumented in Patras where MdM had run a specific mobile unit for migrants in 2011[23].

- **11.4% of patients were EU citizens who had lost their legal residency status due to lack of financial resources and/or health insurance**. This situation was particularly common in Munich, where 30% of the patients were in this situation, but also in Spain (35.0%). In Spain, this might be a consequence of the combined effect of the financial crisis (and the subsequent dramatic increase in unemployment that affects immigrants first) and the new law, which came into force in September 2012, stopping undocumented migrants from accessing healthcare, whether they are EU citizens or third-country nationals.

[22] The MdM support centre in Amsterdam specifically targets undocumented migrants.

[23] Chauvin P, Simonnot N. *Access to healthcare for vulnerable groups in the European Union in 2012*. Paris, Médecins du Monde International Network Observatory on Access to Health Care, 2012, p. 23.

Table 4. Legal status by country (%)

	BE	DE	EL	ES	FR	NL	UK	CAP*	WAP**
Missing values	5.03	6.61	54.42	2.91	3.08	1.69	6.15	13.46	
Residence permit not applicable (e.g. national, child)	0.57	13.41	53.79	4.00	9.88	0.00	0.34	9.52	11.71
Has a valid residency permit (all types except asylum seekers)	4.00	7.80	10.06	7.00	8.17	0.57	1.37	5.66	5.57
Can stay: has adequate "official" means and health insurance[1]	2.13	8.05	2.04	4.00	1.75	1.15	1.84	2.27	2.99
Asylum seeker	9.97	1.95	9.04	1.00	11.03	5.75	20.68	11.73	8.49
Tourist / short-stay visa	2.81	10.49	0.29	3.00	2.18	1.15	7.24	3.64	3.88
Does not require a residence permit: staying for < 3 months	3.27	15.37	1.02	3.00	2.46	0.00	1.71	3.06	3.83
Specific situations giving a right to stay	-	0.73	-	0.00	0.00	0.57	3.21	0.70	0.90
Student visa	0.16	2.44	-	0.00	-	0.00	0.68	0.32	0.66
Work visa	0.00	0.98	-	1.00	-	0.00	0.61	0.19	0.52
Humanitarian protection / discretionary leave	-	0.24	0.29	0.00	-	0.00	0.07	0.05	0.12
Not permitted to reside: has stayed > 3 months & no resources or no health insurance[1]	4.47	30.00	0.73	35.00	7.70	0.57	1.30	6.36	11.40
Undocumented	72.26	8.54	21.57	42.00	56.83	89.08	57.06	55.48	49.62
Unable to define status	0.36	0.00	1.17	0.00	0.00	1.15	3.89	1.02	0.94
TOTAL	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

[1] *In the host country or in the country of origin*
**Crude average proportion, **Weighted average proportion*

Among the EU citizens seen in the MdM centres (n=878), 55% were not permitted to reside in the host country, due to their lack of resources or health insurance after three months of residence. The other 21% had been in the host country for less than three months and did not need any authorisation; 18% were permitted to reside in the host country.

Table 5. Legal status of the EU citizens (excluding nationals) by country (%)

	BE (n=188)	DE (n=215)	EL (n=29)	ES (n=11)	FR (n=368)	NL (n=3)	UK (n=64)	CAP* (n=878)
Not permitted to reside: has stayed > 3 months & no resources / no health insurance[1]	61.70	56.28	48.28	45.45	57.88	33.33	21.88	55.12
Doesn't require a residency permit: here for less than 3 months	18.09	28.37	13.79	18.18	16.03	0.00	35.94	20.84
Can stay: has adequate 'official' means and health insurance[1]	17.56	15.35	37.93	36.36	13.04	66.67	40.63	17.88
Residency permit not applicable (children)	0.53	0.00	0.00	0.00	13.04	0.00	0.00	5.58
Unable to define status	2.13	0.00	0.00	0.00	0.00	0.00	1.56	0.57
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

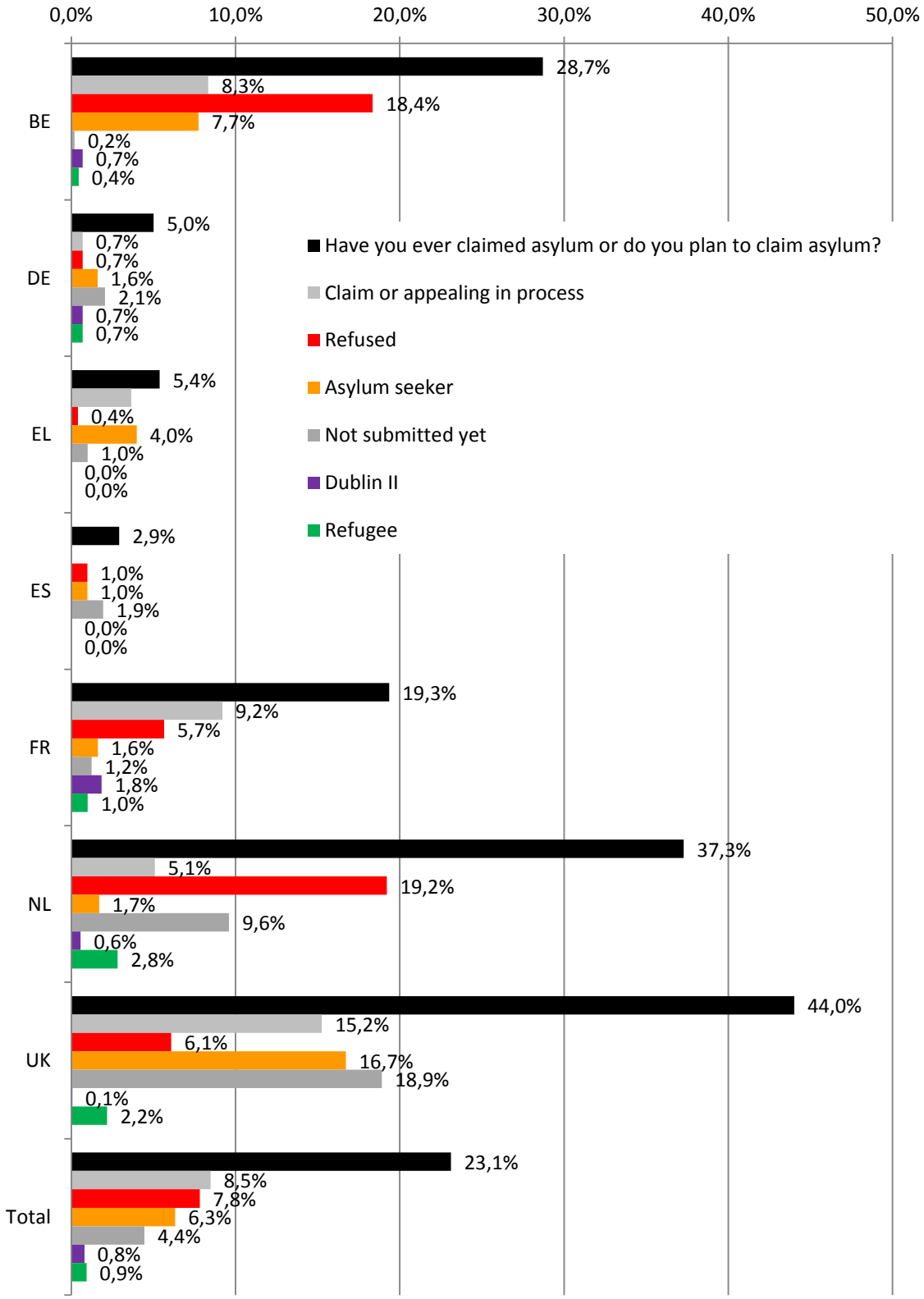
[1] *In the host country or in the country of origin*
**Crude average proportion*

Altogether, a crude proportion of 23.1% of the patients had ever requested asylum or planned to do so. Their numbers were particularly high in Amsterdam (37.3%) and London (44.0%), lower in Brussels and Antwerp (28.7%) and Nice (19.3%), and rare in Greece (5.4%), Munich (5.0%) and Spain (2.9%).

Among these, overall (MVWAP), 27.9% had formally requested asylum and were awaiting a decision, 31.9% had been denied asylum, 30.7% had not yet submitted a request, 4.3% fell within the EU Dublin II Regulation - Eurodac system[24], and **only 5.3% had been granted refugee status**.

[24] For UNHCR Comments on the Dublin II Regulation and Eurodac system, see http://soderkoping.org.ua/page23538.html

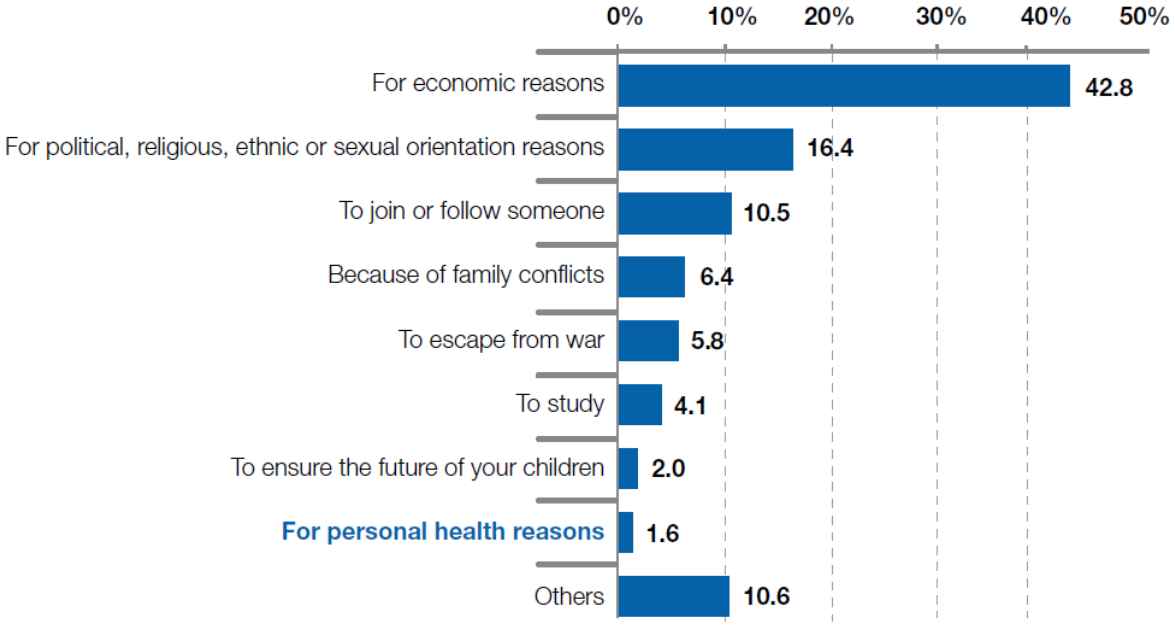
Figure 10. Different situations of asylum seekers by country (in % of total migrant population)



Reasons for migration

In all the countries except Belgium and France, the migrants were asked about their reasons for migration. Multiple answers were possible. **By far the most frequently cited reasons were economic** (42.8% + 2.0% to ensure the future of their children), political (overall 16.4%), familial (either to escape it, 6.4%, or to join someone, 10.5%) or to leave a country at war (5.8%). **Health reasons were extremely rare (1.6%)**, even less frequent than in the 2011 results (2.2%).

Figure 11. Reasons for migration declared by undocumented migrants



Crude average proportions

Usually, the fact of not being able to survive in one's country of origin is the first reason given for migration, especially among migrants in Spain. Political reasons were most frequently cited in London, where the number of asylum seekers was also high (in the London clinic sexual orientation is commonly cited, especially by homosexuals (women) from Uganda, a factor which is also illustrated by the figure for "family conflicts").

Once again our surveys reveal one of the highest scores for "personal health reasons" (although it still remains very low) in one of the countries where access to healthcare is most difficult: Germany!

Homophobia: a reason for migration

This year at the MdM UK clinic, 60 individuals (3.6% of the patients) reported leaving their country because of their sexual orientation. An increase of 2.4% was observed in comparison with last year. The vast majority of these patients came from Uganda (85%) and 60% were women. As many as **98% of their asylum claims were refused on first application** (as compared to 78% of all asylum claims refused on first application)[25]. The asylum interview itself is a highly traumatic experience for these men and women. They are often not accustomed to discussing their intimate sexual experiences openly with strangers and interviewers ask very intrusive questions.

[25] UK Lesbian and Gay Immigration Group. *Failing the grade – Home Office initial decisions on lesbian and gay claims for asylum*. London, UKLGIG, 2010, 16 p.

Many end up spending significant periods in detention centres where the staff and other detainees often hold homophobic attitudes. As a result of their experiences, both in their country of origin and in the UK, many of these individuals are amongst the most vulnerable groups seen at the clinic and form a significant proportion of the user group for our Close Follow-Up emotional support programme.

Patient story

Sarah, 27, has lived in the UK for more than three years. Her neighbours in Uganda reported her to the police after seeing her with her girlfriend: the two of them were arrested and tortured. As soon as she was freed, Sarah fled to the UK to stay with her sister. She never discovered what happened to her girlfriend.

"My sister told my mother in Uganda that I was a lesbian and she has refused to speak to me since."

For two years, Sarah rarely left the house. "I was terrified all the time. I thought maybe someone would look at me and see that I was a lesbian and arrest me. My sister didn't really approve of my sexuality so I didn't feel I could talk to her. I didn't claim asylum because I was so scared. I knew that if it went wrong, I would be sent home and killed. I was drinking too much because I couldn't sleep and I felt so depressed".

MdM Project London referred Sarah to the Refugee Therapy Centre in North London. She chose to attend a group session rather than individual sessions and reports that, "It is really helping. It's a chance to talk with people who are also victims of torture. It helps me know I'm not alone, that I'm not the only one".

Sarah spoke to her MdM clinic Close Follow-Up volunteer, Clare, regularly on the phone for five to six months: "Being phoned was really great. I often felt so alone in the evenings when my sister's kids were in bed but when I spoke to Clare I felt OK. It helped me build the confidence I needed to claim asylum. When I went for the asylum interview, Clare just told me to be natural and I did. I am so happy that they believed my story." Clare wrote a letter of support for her asylum claim outlining how Sarah had become involved in Doctors of the World. Finally, Sarah was granted full refugee status in June 2012.

"I would like to study nursing, maybe mental health nursing. There used to be so much pressure on me, I thought about all the 'what ifs' and imagined what it would be like if I were forced to go back. It was such a relief to learn that I could stay here. Just knowing I'm not going back tomorrow and that I am somewhere safe for as long as I want to be."

MdM UK – London - October 2012

Table 6. Reasons for migration by country (among all migrants)

	DE (n=390)	EL (n=336)	ES (n=114)	NL (n=147)	UK (n=1681)	CAP*	WAP**
For economic reasons, to earn a living	60.24	55.08	76.00	48.41	43.13	42.77	50.10
For political, religious, ethnic or sexual orienta-tion reasons	4.75	1.85	13.00	19.05	26.21	16.38	11.22
To join or follow someone	23.44	10.46	9.00	14.29	9.64	10.46	11.76
Because of family conflict(s)	2.37	7.08	3.00	7.14	8.81	6.37	5.04
To escape from war	5.34	16.31	3.00	8.73	4.79	5.77	6.92
To study	3.86	2.46	1.00	5.56	5.55	4.09	3.22
To ensure the future of your children	2.08	6.15	0.00	2.38	1.53	1.95	2.22
For personal health reasons	3.86	1.23	5.00	1.59	1.32	1.61	2.28
Others	9.79	2.77	4.00	9.52	15.60	10.61	7.24

*Crude average proportion, **Weighted average proportion

Living conditions

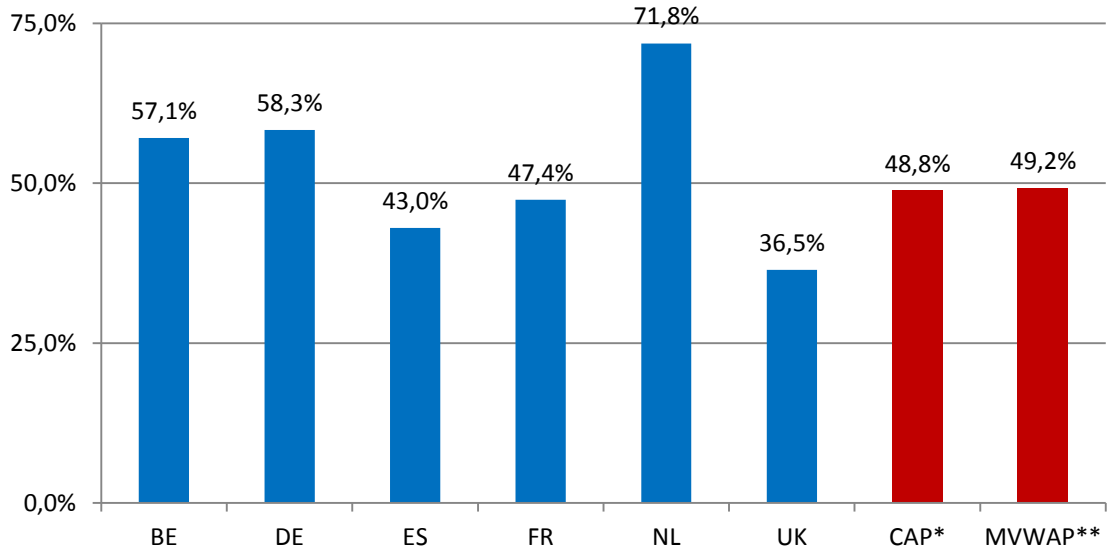
Housing conditions

Housing conditions are **unstable / temporary for half of the patients** (MVWAP=49.2%).

The highest rate was recorded in the Netherlands (71.8%), whereas there was not much difference between the patients in the other countries. This means that half of the people who went to an MdM clinic carried the heavy weight on their shoulders of not knowing for sure where they would sleep that night. This hinders people in undertaking any preventive measures in relation to their health. Unstable housing makes it more difficult to take medication in a regular way, implement the doctor's dietary advice, enjoy regular sleep, etc. Obviously, not having a place to call "home" also has a significant impact on adults' and children's mental health and capacity to deal with daily problems.

9% of those interviewed were sleeping rough (either on the street or in emergency or short-term shelters), while 7.5% were housed in medium-term accommodation (charity housing, hotels, etc.), 1.6% in squats and a few at their workplace (0.9%) or in camps (<0.1%). Only London seems to offer relatively better housing conditions.

Figure 12. Proportion of people housed in temporary/unstable accommodation



**Crude average proportion, **Missing values-corrected weighted average proportion*

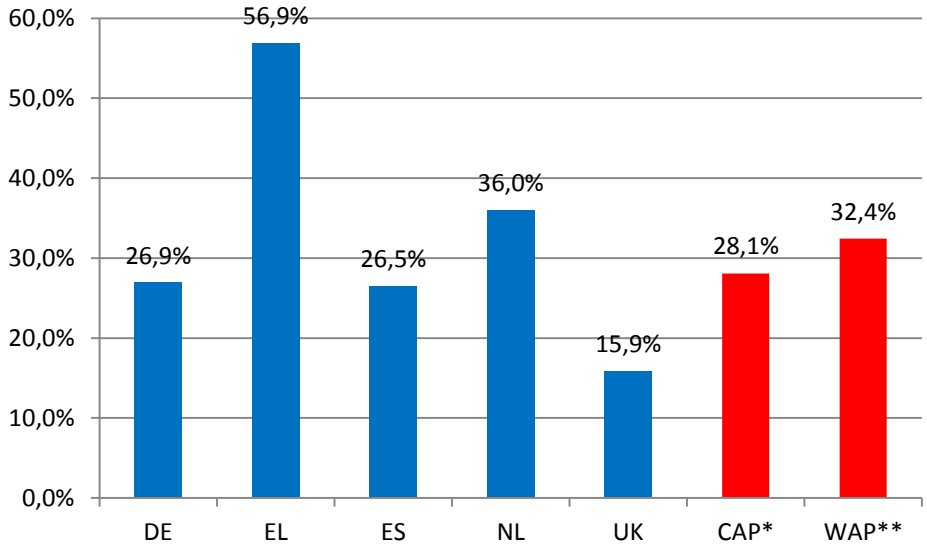
Table 7. Distribution of housing conditions by site

	BE	DE	ES	FR	NL	UK	CAP*	MVWAP**
Flat or house	79.07	81.64	77.45	80.29	78.00	93.81	82.01	81.04
NGO / hotel (>15 days)	2.50	8.19	14.71	7.42	11.33	1.65	4.94	7.54
Street /emergency (<15 days)	19.03	9.43	0.98	11.06	10.00	2.96	11.36	8.79
Squat	2.04	0.00	3.92	1.18	0.00	0.89	1.32	1.64
Working place	0.31	0.25	2.94	0.00	0.67	0.69	0.32	0.90
Camp	0.05	0.50	0.00	0.04	0.00	0.00	0.06	0.09
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

**Crude average proportion, **Missing values-corrected weighted average proportion*

One third of patients felt that their housing conditions were affecting their health or their children's health. This proportion was highest in Greece where a majority of people expressed such an opinion (56.9%): 87.7% in Patras, 70.3% in Thessaloniki, 44.4% in Perama and 41.8% in Athens. These poor housing conditions can be partly explained by the new housing taxes which must be paid together with electricity bills (the electricity is cut off if the bill is not paid). The data in Greece were collected in autumn 2012, by which time heating was already a necessity.

Figure 13. Proportion of people who reported that their housing conditions were affecting their health



**Crude average proportion, **Weighted average proportion*

Available emotional support

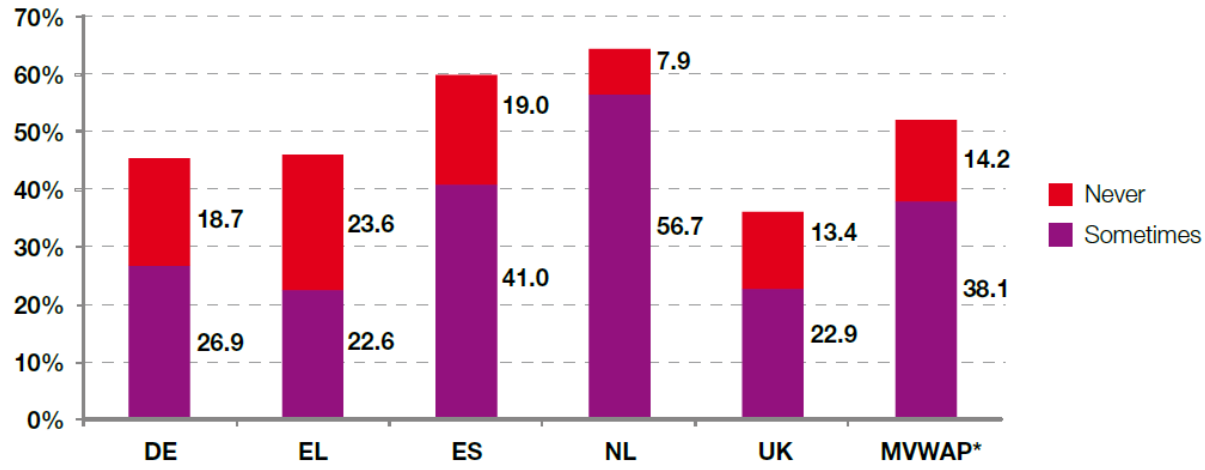
52.3% of people had a low level of emotional support, including 14.2% who were completely without support (especially in Greece). This level of isolation is similar to that observed in our previous surveys. People seemed to be more frequently isolated in Amsterdam (56.7% of people reported having emotional support only sometimes and 7.9% said they never did) and also at the Spanish centres (41% and 19% respectively).

Table 8. Available emotional support by country

	DE	EL	ES	NL	UK	CAP*	WAP**	MVWAP***
MV	33.03	61.46	2.91	28.25	11.85			
Very Frequently	12.59	21.21	14.00	7.87	26.53	22.16	16.44	16.08
Frequently	41.84	32.59	26.00	27.56	37.21	35.73	33.04	31.67
Sometimes	26.87	22.59	41.00	56.69	22.89	25.76	34.01	38.09
Never	18.71	23.62	19.00	7.87	13.37	16.35	16.51	14.16
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Crude average proportion, **Weighted average proportion*Missing values-corrected weighted average proportion*

Figure 14. Proportion of people with a low level of emotional support

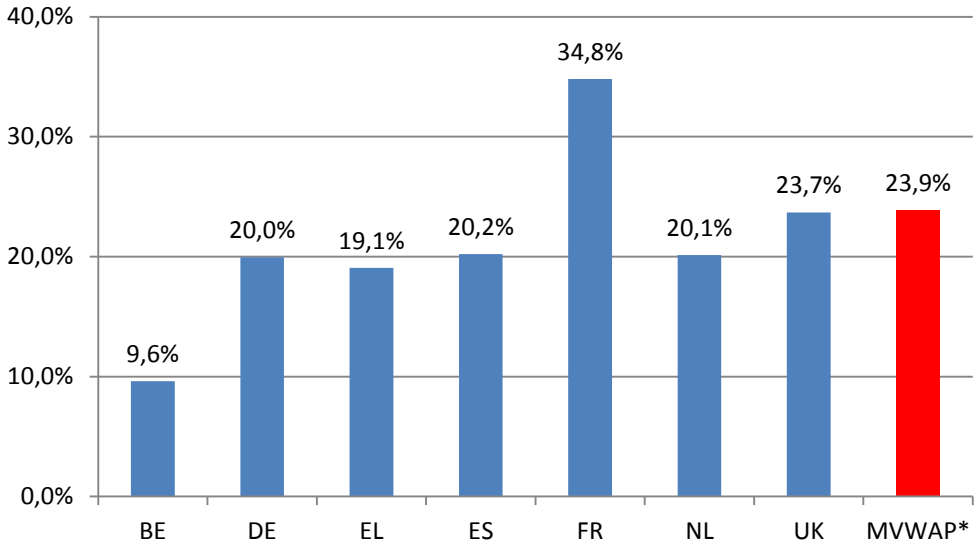


**Missing values-corrected weighted average proportion*

Work and income

Only a quarter of the patients declared that they had a job or an activity to earn a living. This proportion was the highest in Nice (34.8%). It was closer to 20% in the other countries. Nice is situated in a rich area of France with many opportunities to work in the domestic service sector (gardens, homes). **Among those who declared that they were working, a vast majority in Greece (79.5%) and in Spain (73.7%) indicated that their income was not sufficient to pay for their basic needs**. This was also the case for 40.9% of working people in Amsterdam, but more rarely observed in London (13.6%).[26]

Figure 15. Proportion of people with a job by country



** Missing values-corrected weighted average proportion*

[26] The question was not asked in Belgium, France and Germany.

Patient story

"During my last five years in Bulgaria I was working for the food industry in a packaging factory. I was responsible for the coordination of the production process. At the time, I had a good life and could go and see a doctor. I lost my job there when the company went bankrupt four years ago. I decided to go to Spain to look for a job there. My family is large and needs money. I am a grandfather. For a while I worked in greenhouses picking tomatoes. Then the crisis started in Spain and I lost my job again. I returned to Bulgaria where I had an accident which caused a hip fracture. I was operated in hospital. But at the time I had lost my insurance and I had to pay the whole bill myself."

"In Bulgaria, I couldn't find any work in the food industry. So I left the country to go to Berlin where I worked in a kebab restaurant. I was able to earn my living there but it was not a good business. After I had paid for my rent, as I only earned €3 per hour, I still didn't have any health insurance. Then I decided to move to Munich. Here I do something different every week. I've worked for the maintenance of graveyards, but here also I am paid only €4 an hour instead of the promised €8. My boss refuses to answer his phone. A few months ago I had a chance to get a real contract with health insurance when I started to work as a furniture maker in a hotel. But I lost my chance when one of my colleagues (from East Germany), who didn't like foreigners like me, started to talk badly about me."

MdM Germany – Munich – December 2012

Violence

Questions relating to violence were only asked by some of the volunteer doctors. The results presented here are based on the answers of the 396 to 576 patients interviewed about these experiences (depending on the questions asked). Questions about violence were not asked in London and Brussels[27] and, at the other centres, this issue could not always be addressed during the medical consultations.

Yet, **it is noteworthy to remind that most of the studies have shown the great acceptability (and medical usefulness) of systematic questions about violence in primary care**. It is now widely known that women accept very well (or even plea for) any form of systematic screening for domestic violence[28]. Actually, most of the barriers to such a screening are much more related with the doctors' personal discomfort with this issue, their lack of knowledge, and their time constraints than with women's discomfort, emotional distress, or concerns[29].

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[27] Both teams made this choice: in London this was because they cannot refer the patients who need psychological help; in Brussels the decision was made by the team to let only psychologists talk about experiences of violence.

[28] Richardson J, Feder G. Domestic violence: a hidden problem for general practice. *Br J Gen Pract* 1996; 46: 239-42.
Bradley F, Smith M, Long J, O'Dowd T. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *BMJ* 2002; 324: 271.
Lebas J, Morvant C, Chauvin P. Les conséquences des violences conjugales sur la santé des femmes et leur prise en charge en médecine de premier recours. *Bull Acad Natl Med* 2002; 186: 949-59.
Chen PH, Rovi S, Washington J, et al. Randomized comparison of 3 methods to screen for domestic violence in family practice. *Ann Fam Med* 2007; 5: 430-5.
Garcia-Esteve L, Torres A, Navarro P, Ascaso C, Imaz ML, Herreras Z, Valdés M. Validación y comparación de cuatro instrumentos para la detección de la violencia de pareja en el ámbito sanitario. *Med Clin (Barc)* 2011; 137: 390-7
Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Ann Intern Med* 2012; 156: 796-808.

[29] Sprague S, Madden K, Simunovic N, Godin K, Pham NK, Bhandari M, Goslings JC. Barriers to screening for intimate partner violence. *Women Health* 2012; 52: 587-605.

Regarding other forms of violence among migrants, refuges and/or asylum seekers[30], their prevalence varies greatly within the patients populations or care settings studied (between 5% and 35% among refugees, according to a pretty old reference[31]).

Primary healthcare professionals should play an important role in the identification of the consequences of violence. This applies not only to the well-described post-traumatic stress disorder (PTSD), but also to more unspecific symptoms[32]. **Indeed, knowing the sub-acute and chronic signs and symptoms of violence enables physicians to diagnose and treat (often obscure) symptoms with a much clearer understanding**[33].

Let's insist also on the fact that psychiatric disorder or psychological distress may be present years after the initial violence experience (for example, a study on mental health among Guatemalan refugees in Mexico 20 years after the conflict showed that 12% had a PTSD, 54% anxiety symptoms and 39% a depression![34]).

Almost 40% of the patients who spoke out about violence in MdM clinics had lived in a country at war; one fifth had been physically threatened, imprisoned or tortured because of their ideas. One fifth had been victims of violence by the police or the armed forces. Civil or domestic violence were also frequently reported: **almost 40% of people had been beaten up or injured as a result of domestic violence or by other people**, 22% had been victims of psychological violence, 8% had had money they had earned or identity papers confiscated, 8% had been sexually assaulted or molested and 5% had been raped. Generally speaking, men are even more reluctant than women to speak out about sexual violence they have experienced.

As expected, the types of violence experienced were different according to gender. Men have lived in a country at war more frequently than women (44.3% versus 27.3%). Men also have suffered from hunger more frequently than women (40.9% versus 21.1%), have been victim of political (28.7% versus 8.3%) or police/army (27.1% versus 11.4%) violence.

Patient story

Dorian is 26 years old and comes from Burkina Faso. He fled his country 10 years ago. His father used to beat him regularly. He once hit him so hard that Dorian fell to the ground unconscious. One day his mother tried to stop his father, grabbed a gun, and shot him dead. The police came to the house and arrested Dorian's mother and took her away. In a single day, Dorian lost both his parents. He fled the country and ended up in Europe. After five years of sleeping rough he arrived in the Netherlands. He applied for asylum but with no success. His asylum appeal was refused three times. He is now sleeping rough in Amsterdam.

MdM Netherlands – Amsterdam – February 2012

30 Toar M, O'Brien KK, Fahey T. Comparison of self-reported health & healthcare utilisation between asylum seekers and refugees: an observational study. *BMC Public Health* 2009; 9: 214.

31 Baker R. Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. *In*: Basoglu M, ed. *Torture and its consequences*. Cambridge, Cambridge University Press, 1992, pp. 83-106.

32 Loutan L, Berens de Haan D, Subilia L. La santé des demandeurs d'asile : du dépistage des maladies transmissibles à celui des séquelles post-traumatiques. *Bull Soc Pathol Exotique* 1997; 90: 233-7.
Vannotti M, Bodenmann P. Migration et violence. *Med Hyg* 2003; 61: 2034-8.

33 Weinstein HM, Dnasky L, Lacopino V. Torture and war trauma survivors in primary care practice. *West J Med* 1996; 165: 112-8.

34 Sabin M, Lopes Cardozo B, Nackrud L, Kaiser R, Varese L. Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. *JAMA* 2003; 290: 635.42.
Thomas SL, Thomas SDM. Displacement and health. *Br Med Bull* 2004; 69: 115-27.

Figure 16. Prevalence of violence by type

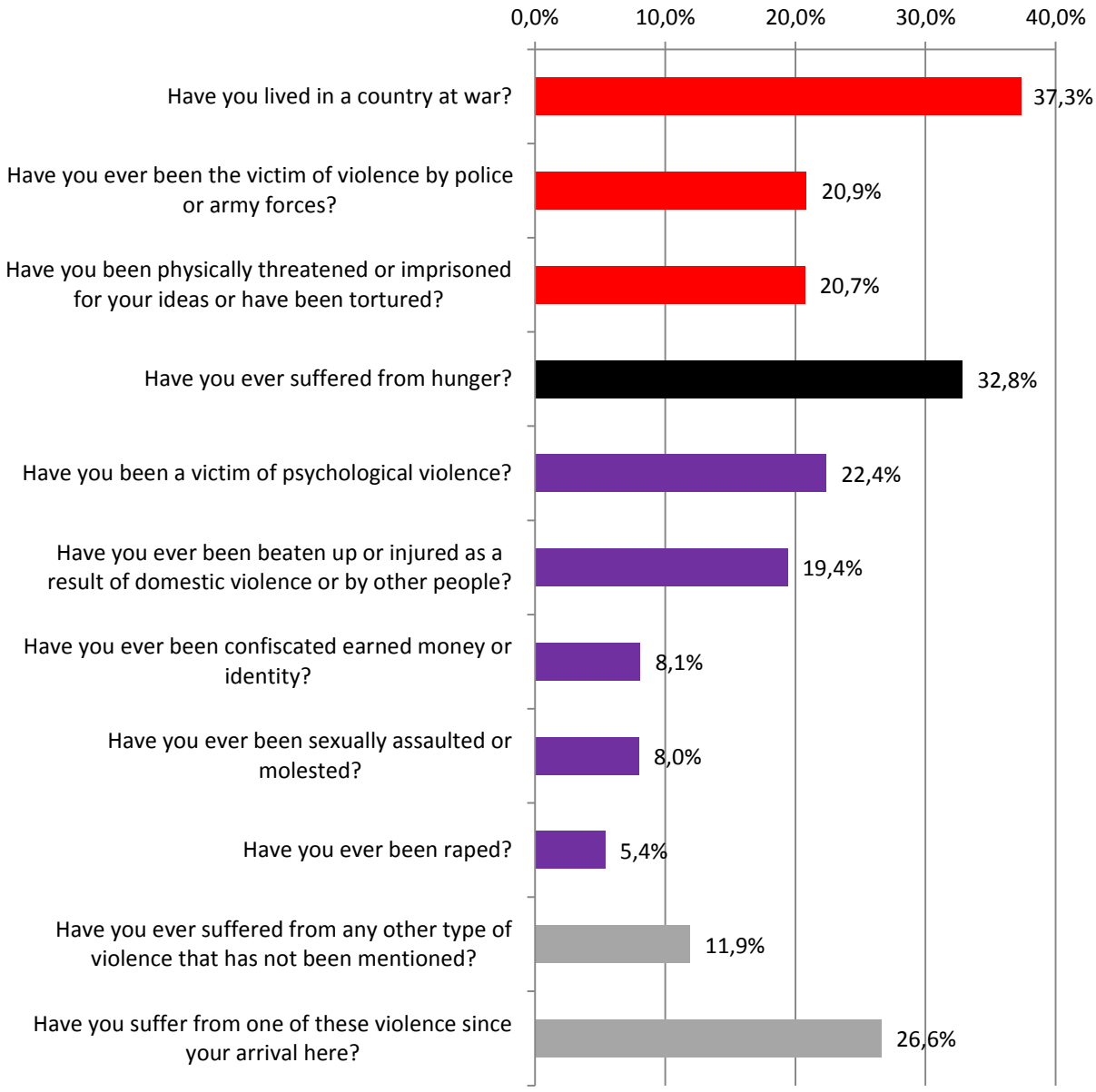
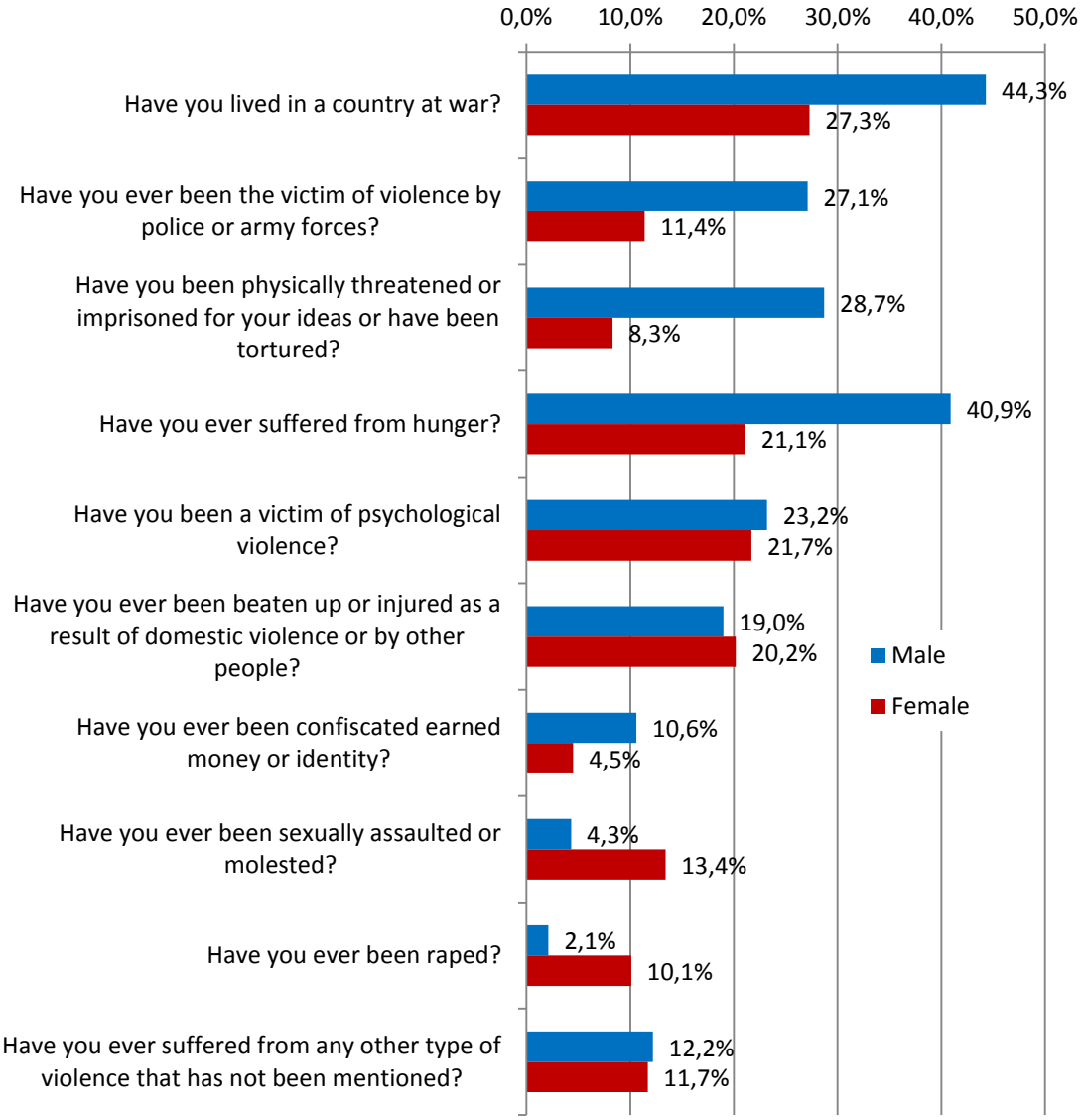


Figure 17. Prevalence of violence by type and gender



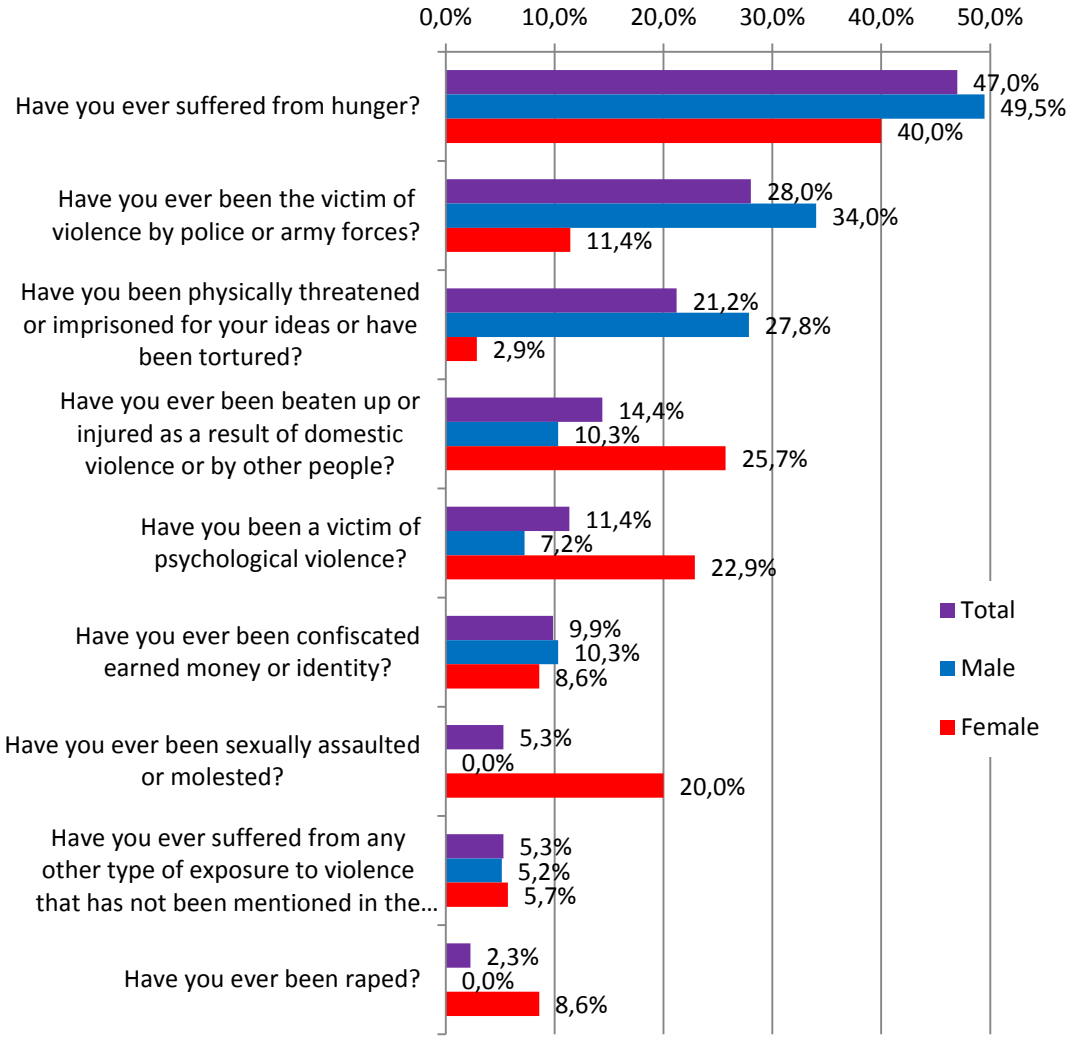
A quarter (26.6%) of the people interviewed reported that they have suffered from violence since their arrival in the host country. Among these, the most frequently cited violence was suffering from hunger (49.5% of men and 40.0% of women). Having been a victim of violence on the part of the police or armed forces was also not exceptional (34.0% and 11.4%) and neither was having been physically threatened for their ideas (27.8% of men). Physical violence (including domestic violence), psychological or sexual violence were cited by 20 to 25% of the women who declared they had been victims of violence in the host country.

Patient story

Fatima is 29 years old and from Tunisia. She lives in Athens. Last October she was attacked at night by a group of six men, as she was returning home with a friend. They were approached in a threatening way with a pit-bull dog and asked about their nationality. Four men attacked her while another one attacked her friend. The last one just watched what was happening, holding the dog. Although there were quite a few people passing by who witnessed the scene, nobody intervened to help and stop the attack. Fatima was severely injured. She mentioned that the men were dressed in black with clear gold signs and white crosses – members of Golden Dawn, the Greek neo-Nazi party.

MdM Greece – Athens – October 2012

Figure 18. Distribution of the types of violence since the arrival in the host country, by type and gender (among people declaring at least one type of violence since arrival*)



**n=97 men and 35 women*
Lecture: hunger was cited by 49.5% of the men who have declared at least one type of violence since arrival in the host country.

Our results show that **migrants are particularly exposed to acts of violence, even once they have arrived in Europe, especially women**. Violence has inevitable physical and psychological consequences on health[35]. Indeed, among MdM service users, perceived health status is almost always poorer among victims of violence than among other patients. Of course, the numbers are quite small and statistical significance is missing (with the notable exception of patients who declared that they had been victim of psychological violence, who were at higher and significant risk of being in bad or very bad mental health: RR=1.5, p=0.02).

[35] Carta MG, Bernal M, Hardoy MC, Haro-Abad JM. Migration and mental health in Europe. *Clin Pract Epidemiol Mental Health* 2005; 1: 13.

Access to healthcare

Coverage of healthcare costs

An assessment of each patient's level of coverage of healthcare costs was systematically made during the first visit to each centre. This data was available for more than 90% of the population, except in Greece where 61.5% of values were missing for this question.

These assessments enabled us to detect marked differences across patient populations in centres, which can be linked to the different health systems in their respective countries[36], even if the absence of any health coverage was by far the most frequent situation for the patients on the day they came to the MdM clinics (CAP=80.7%).

Table 9. Coverage of healthcare costs by country

	BE (n=1874)	DE (n=421)	EL (n=579)	ES (n=100)	FR (n=2319)	NL (n=172)	UK (n=1481)	CAP* (n=6946)
No health coverage at all, fully chargeable (or no GP in UK)	89.86	52.26	77.55	75.00	81.8	5.23	89.60	80.65
Full medical coverage, not chargeable	6.56	7.13	15.37	1.00	7.07	2.32	0.07	5.87
Medical coverage only for parts of costs	0.21	-	6.74	1.00	7.59	92.44	0	5.40
Insured in another Euro-pean country	1.39	13.54	0.35	0.00	3.54	0	0	2.38
Free access to GP	-	-	-	0.00	-	0	10.34	2.18
Access only in emergency room	-	24.47	-	48.00	-	0	0	2.15
Access on case-by-case basis	1.97	2.61	-	1.00	-	0	0	0.70
Accessing secondary care & no access to GP yet	-	-	-	0.00	-	0	3.17	0.67

** Crude average proportion*

[36] A full update on legislations in each of the countries is available on request. A chapter (containing a short version of this update) is included in "Access to healthcare in Europe in times of crisis and rising xenophobia". See www.mdm-international.org

- **In Belgium and France, the vast majority of patients (90% and 82%, respectively) had no health insurance[37] on the day they came into the MdM clinics** in Antwerp, Brussels and Nice. In Nice, 15% of patients were partially (8%) or fully (7%) covered by the national healthcare insurance system. People with full health coverage came to MdM clinics in order to see the social worker, a psychologist and a dentist (no real access to dental prosthesis in the mainstream health system), but also to see a medical doctor. Even though legally and financially they could access one in the mainstream system, it sometimes takes time to convince them to leave our clinic, to trust new people, to believe they will be well received, with no discrimination due to their specific health coverage. In both countries, a small number of patients were insured in another European country.

- In Spain, the vast majority of patients (97.0%) had no health coverage at all. **In Spain the four cities where data was collected applied the new Royal Decree (passed in April 2012, it came into force in September 2012) stopping undocumented migrants from accessing healthcare**, unless they pay a fee of €59.20 per month if they are under 65 years old and €155.40 per month if they are over 65[38]. Only three patients had medical coverage (full coverage, partial coverage or on a case-by-case basis). For 48% of the patients, the teams declared that they could only access accident and emergency departments (which is actually the case for all of them except the three mentioned above).

- **In London, 89.6% of the patients had access to care only with specific free healthcare providers** (this is a situation which we compared with people in other EU countries who have no health coverage at all: it means that they were not registered with a GP and could not access care until they did register). 10.3% had access to a GP without being charged (as is usual in the National Health Service). 0.07% had access to secondary care and were registered at a GP practice but came for help with other issues. 3.17% had access to secondary care (usually through the accident and emergency department, since secondary care is only accessible by GP referral), even though they had not yet registered with a GP.[39]

- **In Munich, 76.7% of patients (52.26%+24.47%) had no health coverage at all. This means that they could only access care in an accident and emergency department**, even though for some of them, as undocumented migrants, they have the right to care on the same basis as asylum seekers. However, in reality, it does not work because of the fact that all civil servants have a reporting obligation to the immigration authorities (and migrants consequently fear arrest). 13.5% were insured in another European country (Munich is the location with the highest proportion of EU citizens among its patients). 7.1% were insured but had private or student insurance which does not reimburse some costs (treatments that are not considered urgent or dental care), or had debts with their insurance and therefore only had access to emergency care, or could not pay the necessary co-payment for glasses or dental care. 2.6% had access to care on a case-by-case basis, mainly asylum seekers trying to get the "right" papers in order to consult a medical doctor.

- In the Netherlands, 92.4% of patients could not obtain insurance as they were undocumented migrants from outside the EU, but the costs of healthcare (80% for GP consultation to 100% for midwives) can be reimbursed to the health provider if the patient cannot pay. 5.2% could not obtain this coverage because they were uninsured EU citizens or non-EU nationals with a residency permit in another EU country (but without valid health insurance in the Netherlands) and 2.3% were insured in the Netherlands or elsewhere in the EU.

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[37] The people who come to any of our centres, but especially in Athens, Brussels and Nice (because of the amount of people coming each day), and do have an effective health coverage are for the most part referred immediately to the mainstream healthcare system.

[38] In practice, migrants who have declared that they want to pay these insurance fees have stated that it is impossible to do so because there is no clear process to pay these sums to the public administrations.

[39] More than one answer was given in a significant number of cases in London and Spain only. In the other countries, this question was considered as a single-answer one.

- In Greece, even though this question was not always answered, we noted that 78% of the patients were not covered at all: either they had no right to health coverage or they had not been able to pay the insurance fees.

It should be noted that, in all the countries surveyed, if patients are insured in another EU country (whether they are EU citizens or not), they are faced with a real problem because, even at state hospitals, in the majority of countries, patients often have to pay upfront. They then need to submit the proof of payment to the health insurance provider in the country where they are insured and might subsequently be reimbursed.

Once fully implemented (at the end of October 2013), a new Directive (2011/24/EU) on cross-border healthcare will guarantee patients reimbursement that is at least equivalent to the price of the service that would have been performed in their home country. However, the Directive does not specify how healthcare providers might directly bill insurance companies in the patient's home country. In practice, reimbursement protocols are very different from one country to another. Consequently, **the Directive does not protect those patients who cannot afford the upfront fees**. On a national level, some countries such as France have taken the initiative to put in place a system where insurance companies are (at least in theory) billed directly, which is definitely a good practice.

Barriers to accessing healthcare

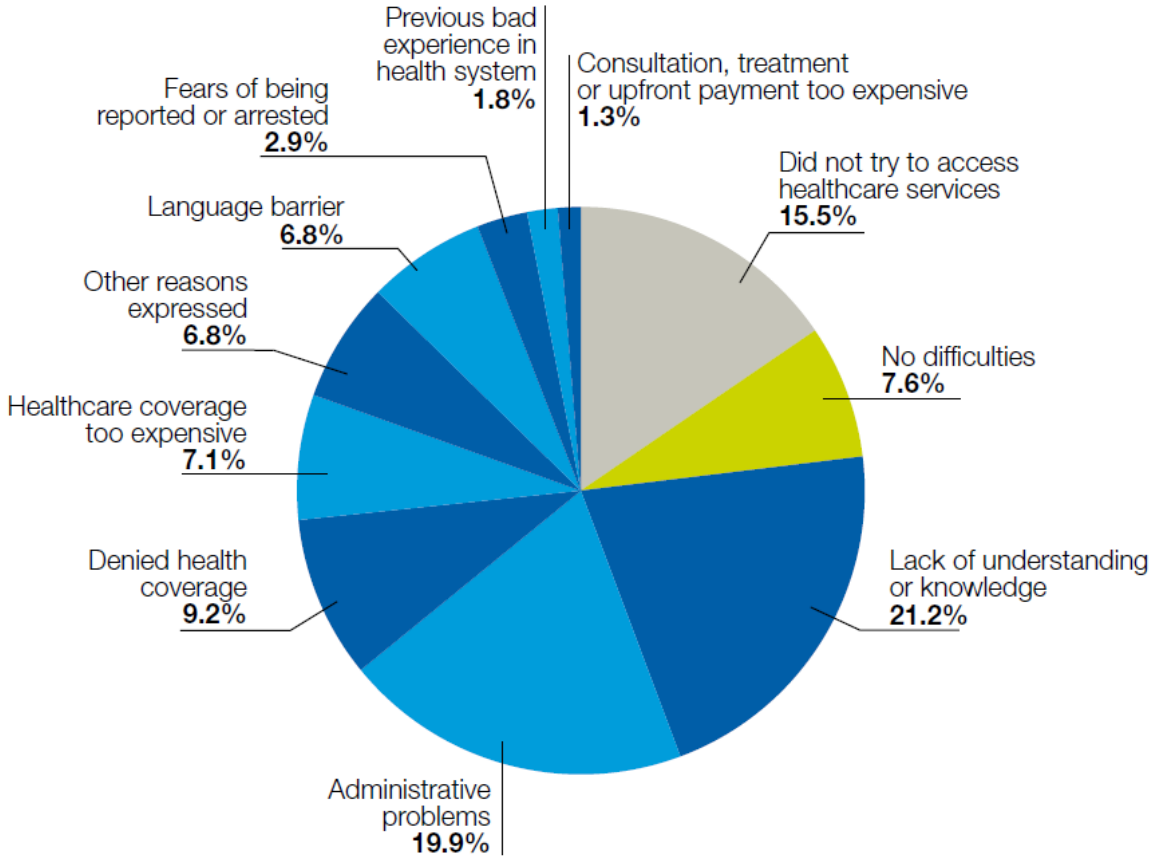
Among the patients surveyed, **only 7.6% of people declared that they had not experienced any difficulty in accessing healthcare.** 15.5% said that they had not tried to access healthcare: some might have had no need or reason for seeking healthcare but others could have interiorised barriers to accessing healthcare so strongly that they did not even try to access healthcare, even though they needed to[40].

This means that the other **76.9% of the total population reported at least one barrier in accessing healthcare**. **The two most frequently cited barriers were, as in our previous survey, a lack of knowledge or understanding of their rights and administrative problems** (including difficulties in gathering all the documentation needed to obtain any form of rights or healthcare coverage).

Since the first studies by the MdM International Network's Observatory in 2006, nothing seems to have changed regarding these two issues: a majority of the patients are still frequently ignorant of their rights and/or get lost in the bureaucratic procedures of their host country. **These results clearly contradict the commonly held view that migrants come to Europe in order to benefit from social services.**

[40] It may explain why 14% of the nationals were in that situation, versus 22% of the EU migrants and 23% of the non-EU, undocumented migrants (see Figure 20).

Figure 19. Distribution of barriers in accessing healthcare (total population, MVWAP*)



**Missing values-corrected weighted average proportion*

Actually, the main obstacles and barriers cited varied a lot according to the country. Some of the differences may be due to the legal and administrative background or the organisation of health care for the underserved and/or the undocumented but others may also be due to the different populations who consulted in the centres (in terms of origin, time of immigration, etc.).

- In Belgium, a lack of understanding or knowledge was cited by a third of the patients when a quarter of them also declared that the consultations, treatments or deposits were too expensive. It is also in this country (as well as in Munich and in London) that the proportion of patients who did not try (or even try?) to access health care previously was the highest (40.6%).

- In Munich, the costs of health care coverage (29.4%) and the costs of consultations, treatments or deposits (30.5%) were often declared as too expensive. Language barriers were also quite often cited (by 16.4% of respondents).

- In Greece, figures were somehow different: 28.3% of people declared that they had no difficulties and the barrier the most frequently cited was the costs of consultations, treatments or deposits. All the other reasons were also cited, but at a much lower frequency (approx. 10% of the consultants also cited a barrier language, and/or administrative problems, and/or having denied from health care coverage).

- In Spain, a past experience of having been denied access to health care coverage is, by far, the most frequently cited barrier by 43.8% of the patients. This is surely due to the recent changes in

the law limiting access to health care for undocumented migrants. A third had (also or separately) administrative problems to obtain any form of health coverage.

- In Nice, very few people declared that they had not tried to access health care, which could be the sign of a certain trust in the healthcare system there. It is also in Nice that the patients quote most frequently (42.9% of the patients) the lack of knowledge or understanding about their rights and the health care system. That confirms the complexity of the procedures that are opposed to vulnerable people (and especially undocumented people) when they try to access their rights that are theoretically accessible in France. In our previous survey in 2011, this lack of knowledge was already most frequently cited in Nice (and in London also, see below).

- In Amsterdam, we observed the highest proportion of people who declared to have no difficulty in accessing health care (41% of the respondents). This might be related to the fact that many of the patients are offered to get help from MdM team with a registration in a regular GP practice. This way, they obtain a better access to healthcare further on. With the exception of administrative problems (cited by 13.0% of the patients), no other barrier was cited by more than 10% of the people.

- In London, a centre with the highest proportion of people who had not tried to access to health care either because they did not need it or because they knew they could not access without having registered with a GP, lack of knowledge and administrative problems were both the most frequent barriers (55.9% and 42.0% respectively, which is even higher than in France), but also – quite surprisingly – some language barriers (23.5%) and, at a significant higher frequency than in all the other countries or cities, the fear of being reported or arrested (19.5%).

Table 9. Frequency of difficulties and barriers in accessing health care by country

	BE	DE	EL	ES	FR	NL	UK	CAP*	MVWAP**
Did not try to access healthcare services	40,6%	40,4%	25,8%	20,8%	3,4%	30,9%	43,5%	16,3%	15,5%
No difficulties	13,7%	20,9%	28,3%	8,3%	2,6%	41,4%	4,4%	6,3%	7,6%
Lack of understanding or knowledge	33,3%	26,8%	5,9%	2,1%	42,9%	8,0%	55,9%	24,6%	21,2%
Administrative problems	14,1%	13,3%	10,1%	33,3%	28,0%	13,0%	42,0%	16,4%	19,9%
Was denied health coverage	10,9%	5,1%	10,3%	43,8%	0,0%	4,9%	14,5%	4,8%	9,2%
Healthcare coverage too expensive	0,7%	29,4%	3,3%	17,7%	6,0%	3,7%	2,5%	3,4%	7,1%
Language barrier	1,8%	16,4%	9,4%	1,0%	18,3%	0,6%	23,5%	9,2%	6,8%
Fears of being reported or arrested	0,3%	4,0%	4,4%	3,1%	0,7%	2,5%	19,5%	3,4%	2,9%
Previous bad experience within the health system	0,7%	3,1%	4,5%	4,2%	5,6%	0,6%	1,9%	2,2%	1,8%
Consultation, treatment or deposit too expensive	23,6%	30,5%	26,0%	8,3%	0,0%	8,0%	3,4%	6,6%	1,3%
Other reasons expressed	6,7%	9,0%	5,2%	8,3%	18,3%	2,5%	4,7%	6,9%	6,8%

Also, the main obstacles and barriers cited varied a lot according to the subgroup of population considered, when comparing between nationals, EU citizens and undocumented (non EU) migrants:

- Undocumented migrants declared twice less frequently the absence of barrier in accessing healthcare in the last 12 months (6.5% versus 13.5% of EU citizens and 14.9% of nationals, $p<0.01$).

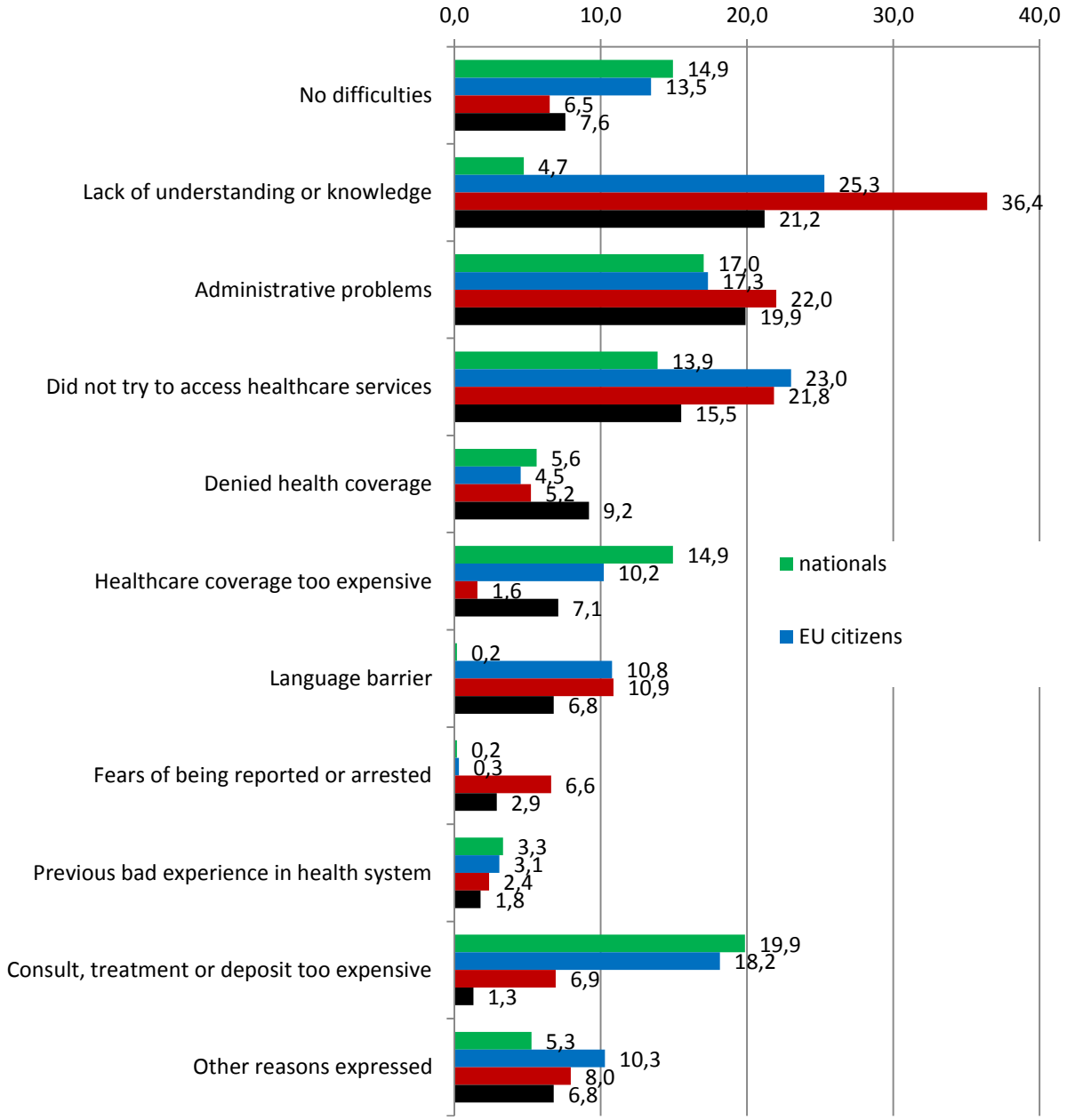
- Unsurprisingly, they were also those with the highest prevalence of lack of understanding (36.4%) and administrative problems (22.0%).

- On the opposite, both nationals and EU citizens cited the too expensive cost of consultations, treatments or deposits twice more than the undocumented (around 19% versus 6.9%, respectively). Concerning the costs of healthcare coverage, undocumented migrants cannot get any in most countries.

- Language barriers were cited by 11% of EU citizens and 11% of undocumented, non EU, migrants as well.

- Fears of being reported or arrested constituted 6.6% of the barriers cited by undocumented migrants.

Figure 20. Distribution of barriers in accessing healthcare in different subgroups of population



Language barriers

About **40% of the patients required the services of an interpreter.** This proportion was higher in London (53%) and in Munich (62% – or 48.5% if one considers that the missing values (MV) correspond to people without any need of an interpreter). Doctors of the World teams usually managed to find an interpreter[41], as only 7 to 13% of consultations were made without an interpreter (if needed). In Amsterdam, the rate of consultations without an interpreter (32.8%) has increased a lot since last year, maybe as a consequence of the State's austerity measures which mean interpreters are no longer provided in the Netherlands for medical or mental health consultations. The high proportion of consultations that required an interpreter underscores the extent to which language can constitute an obstacle to proper access to healthcare and social services.

Table 10. Proportion of consultations needing an interpreter by country

	BE	DE	EL	ES	FR	NL	UK	CAP*	MVWAP**
MV	6.27	13.21	35.55	1.94	5.69	1.69	5.12		
No need	68.95	38.32	64.02	78.22	58.65	64.37	46.86	58.99	61.05
Present	22.89	53.54	24.12	8.91	37.64	2.87	32.28	30.67	23.03
By phone	1.68	0.00	0.00	0.00	0.33	0.00	13.84	3.28	3.01
No	6.47	8.14	11.86	12.87	3.38	32.76	7.02	7.05	12.92
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

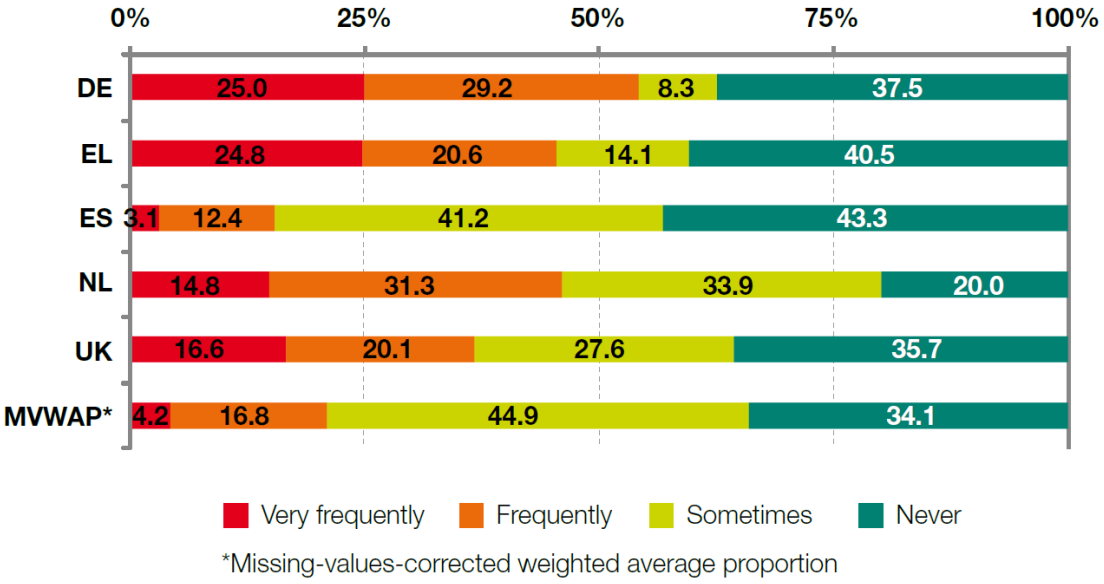
**Crude average proportion, **Missing values-corrected weighted average proportion*

Limited mobility due to the fear of being arrested

At all the locations, except in Antwerp, Brussels and Nice, patients who were not permitted to reside in the host country were asked if they currently limited their activities and movements due to their fear of being arrested. Altogether, **two thirds (65.9%) of this group reported that this was the case**: either very frequently (4.2%), frequently (16.8%) or sometimes (44.9%). It seems that such fears were more often reported in Amsterdam, if all levels of frequency are added together, but similar or higher levels of frequency were (also) observed in Munich and Greece. In Patras, for example, 87.5% of the migrants limit their activities and movements.

[41] Interpreters are either professionals, members of the MdM team or people the patients brought with them to interpret.

Figure 21. Frequency of the limitations to activities or movements due to the fear of being arrested among undocumented migrants in different countries



Patient story

*"*I avoid many places like the shopping centre because if the policemen see me, they will put me in detention. They told me so, and they did it nine times before. I do not fight or do any criminal things. Just seeing my face is enough for them to put me into detention. (…) I also fear where I sleep. There are many men there. They smoke, drink alcohol, and stay up late. I am worried the neighbours will call the police. Then they would put me in detention again. The situation of being without rights because you have no documents causes brain damage."

Dorian, MdM Netherlands – Amsterdam – February 2012

It should be recalled that, according to the Fundamental Rights Agency, *"EU Member States should disconnect healthcare from immigration control policies and should not impose a duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration"*[42].

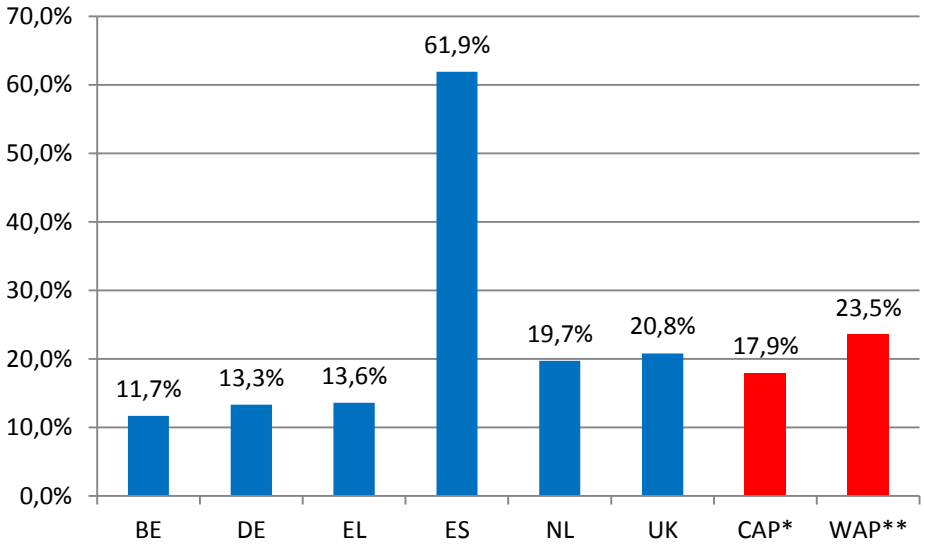
Denial of access to healthcare

Altogether, approximately **one patient in five reported that they had been denied access to healthcare** in the last 12 months[43]. It is in Spain that this prevalence was the highest (62% of patients reported such an experience) and this is probably due to the change introduced by the new restrictive law. In Amsterdam and London, 20% of patients had experienced this. The frequency was slightly lower in the other countries.

[42] European Agency for Fundamental Rights. *Apprehension of migrants in an irregular situation – fundamental rights considerations*. Vienna, FRA, 2012.

[43] This question was not asked in Nice.

Figure 22. Prevalence of denial of access to healthcare in the last 12 months



**Crude average proportion, **Weighted average proportion*

Racism in health structures

Concerning the experiences of racism[44] when attending health care structures (a question not asked in Belgium and in Nice), the response rate varied a lot between countries. Actually, it is highly probable that this question was asked preferably to patients belonging to a "visible" minority. Indeed, the rates of missing values are much higher in the total population than in a sub-group constituted by African, Maghrebi, Middle-Eastern, Asian or American people in all the survey sites except in Amsterdam (a sub-group that we will name (A) below).

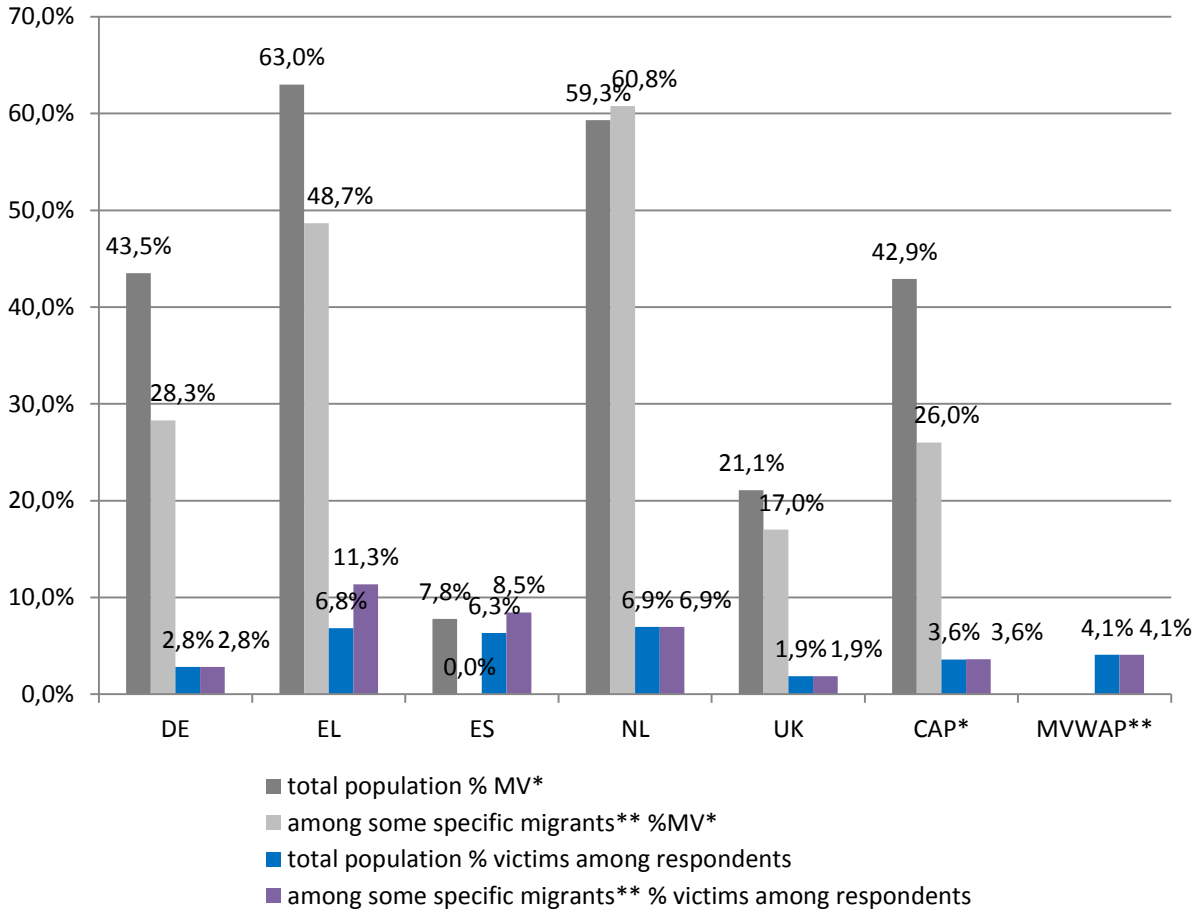
Theoretically, this question of denominator should be harmonized in future surveys because this absence of any denominator leads to different estimates of the proportion of victims of racism. Either the question must be asked to everyone – which is impossible in its present formulation[45] - or it may be preceded by a filter question (e.g. "Does this patient belong to a visible minority?"). These solutions cannot be easily implemented in MdM centres.

Actually, in 2012, because the total numbers were low in Spain and Greece and because the prevalence of racism was the same among respondents in the total population and in the sub-group (A) above mentioned, both CAP and MVWAP are similar in the two populations but it could have been different.

[44] The question about racism was: *"In the past year have you personally been a victim of racism (colour or ethnic origin) by a healthcare provider?"* It was not asked in Nice or Belgium.

[45] This is one of the benefits of a more complete way of asking about discriminations in their various dimensions (e.g. gender, social status and ethnic origin): such a wide question is, then, suitable for everyone.

Figure 23. Proportion of missing values and frequency of racism faced by the respondents: in the total population and in a subgroup of migrants

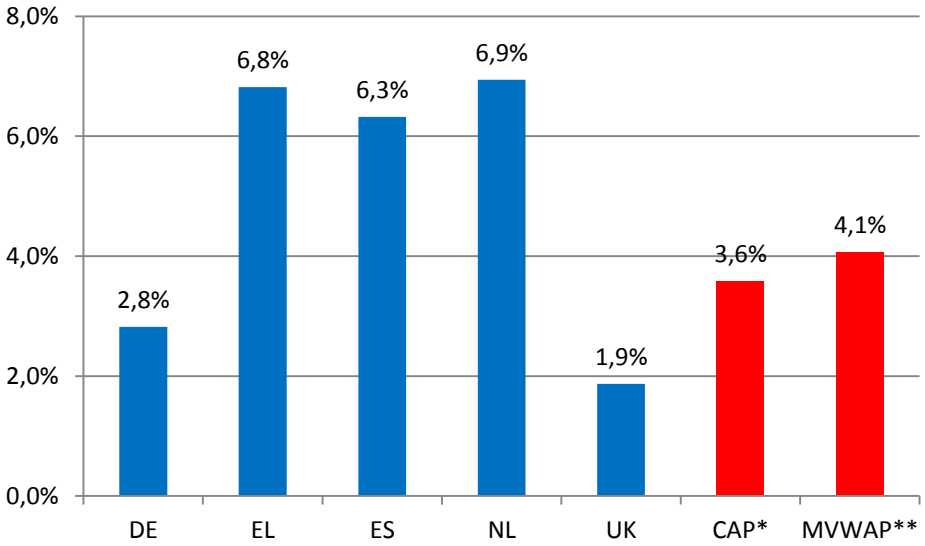


**Missing values, **Migrants from Sub Saharan Africa, Maghreb, Middle-east, Asia or America*

Experiences of racism in healthcare structures over the last 12 months were least frequently reported in London (1.9% of patients). This might be due to the high rate of ethnic diversity within the NHS health providers. The proportions were higher (but for a smaller number of reports) in Greece, Spain and Amsterdam, with frequencies between 6% and 7%.

If only migrants from Africa, the Middle East and Central and South America are considered, 11% of patients had faced racism in Greece and 8.5% in Spain. It should be recalled that the two previous surveys from 2006 and 2008, focussing only on undocumented migrants, showed that the prevalence of reported racism when attending healthcare facilities was the highest in Southern European countries (which are countries of more recent immigration).

Figure 24. Prevalence of racism in a health care structure in the last 12 months (% of respondents)



**Crude average proportion, **Missing value weighted average proportion*

Giving-up seeking health care

Between 22% and 36% of patients reported that they had given up seeking medical care or treatment for themselves in the last 12 months (depending on the estimate chosen: CAP or MVWAP). This proportion was notably high in Spain (52%) and in Munich (42%). %) but we must mention the high level of missing data: unfortunately, this question was not asked to 55% of the patients in Belgium, 25% in Munich, 62% in Greece, 58% in Nice, 18% in Amsterdam and 16% in London. In Spain, the response rate was very high (95%)[46].

We already saw in the previous surveys that patients stop seeking healthcare when they believe it will be too difficult to access. Since the survey was conducted in four cities in Spain where the law had recently stopped access to care for undocumented migrants, the patients probably gave up seeking care. The same goes for Germany, where uninsured people know that they have to pay the full costs.

Although the indicator is not exactly the same, it is interesting to compare these numbers with the mere 6.4% of the EU-25[47] population who declared in 2007 that there had been at least one time during the last 12 months when they needed a medical examination or a treatment but did not receive it. The two main reasons given for this were because it was too expensive or because they gave up seeking healthcare[48]. In France in 2008, 15.4% of the adult population reported adopting such a position for financial reasons. Within this there was a strong and significant social gradient: immigrants, destitute and uninsured people were the most represented[49].

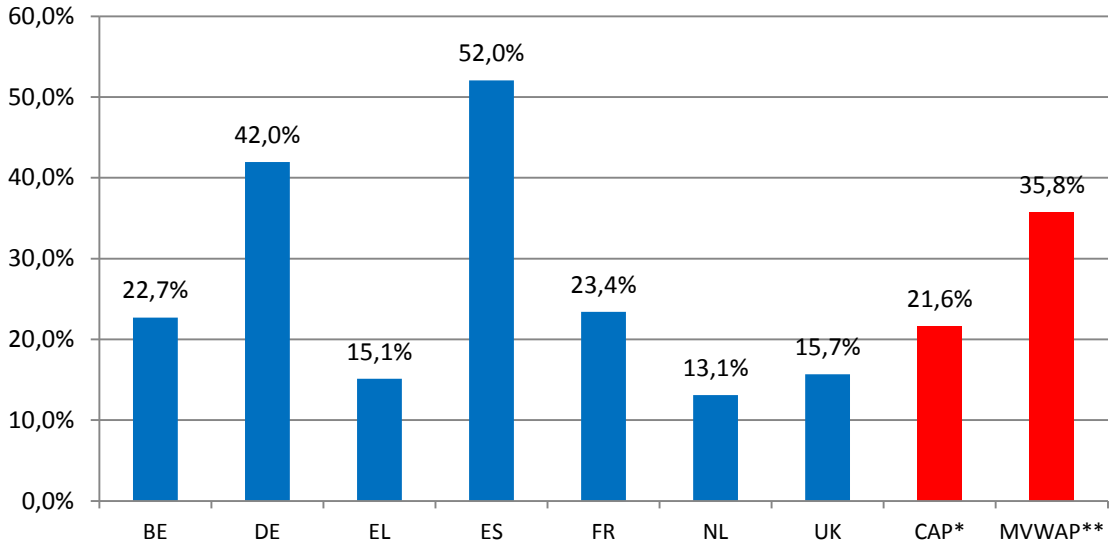
[46] The high rate in Spain is explained also by the fact that Médicos del Mundo teams made a specific survey during 6 weeks in order to participate to the International Network's Observatory. All other teams in Europe collect routine data.

[47] 25 European Union Member States (before Bulgaria and Romania joined the EU).

[48] Baert K, De Norre B. *Perception of health and access to healthcare in the EU-25 in 2007*. Brussels, Eurostat (Statistics in focus), 2009, no. 24.

[49] Renahy E, Vallée J, Parizot I, Chauvin P. Le renoncement aux soins pour raisons financières dans l'agglomération parisienne : déterminants sociaux et évolution entre 2005 et 2010 dans la cohorte SIRS *In*: Boisguerin B., ed. *Le renoncement aux soins*. Paris, DREES (Coll. Etudes et Statistiques), 2012, pp. 41-66.

Figure 25. Frequency of giving up seeking health care over the last 12 months by country



**Crude average proportion, **Missing value weighted average proportion*

Health conditions

In average, each patient had consulted an MdM clinic 1.77 times during the time of the survey, with a median at 1 consultation/person and a maximum number that could rise above 30 in Antwerp, Brussels or Munich, and above 20 in Nice.

Table 12. Frequencies of consultation per patient, by country

	BE	DE	EL	ES	FR	NL	UK	Total
Mean	2.22	2.26	1.15	1.01	2.07	1	1.27	1.77
Min	1	1	1	1	1	1	1	1
1st quartile	1	1	1	1	1	1	1	1
Median	1	1	1	1	1	1	1	1
3rd quartile	2	2	1	1	2	1	1	2
Max	33	31	3	2	21	1	8	33

Reasons for consulting MdM clinics

People attend MdM health centres for many reasons, not only for medical care, but also for social care, psychosocial issues, help with administrative procedures or legal affairs, etc. Overall, **these non-medical reasons concerned one third of the consultations** (MVWAP=32.4%) and were particularly frequent in Belgium (63.5%) and in London (83.7%). Administrative and legal issues include trying to get access to a general practitioner in the mainstream health system[50]. This explains why the figure is so high in Brussels and London. In Greece, they were less frequent (10%); this may be related to the fact that the majority of the patients seen there have no possibility to access the mainstream health system, including the destitute Greek citizens.

[50] In Amsterdam medical reasons was coded instead of administrative ones when the reason was to find a GP. That explains the high level of answers "for medical care" in Amsterdam even though no direct medical help is provided in the MdM referral clinic.

Overall, medical care was sought at two thirds of the consultations (MVWAP=65.6%) and at over 80% of them at most sites, except in London (where they represented only half of the consultations) and, to a lesser extent, in Greece and Nice.

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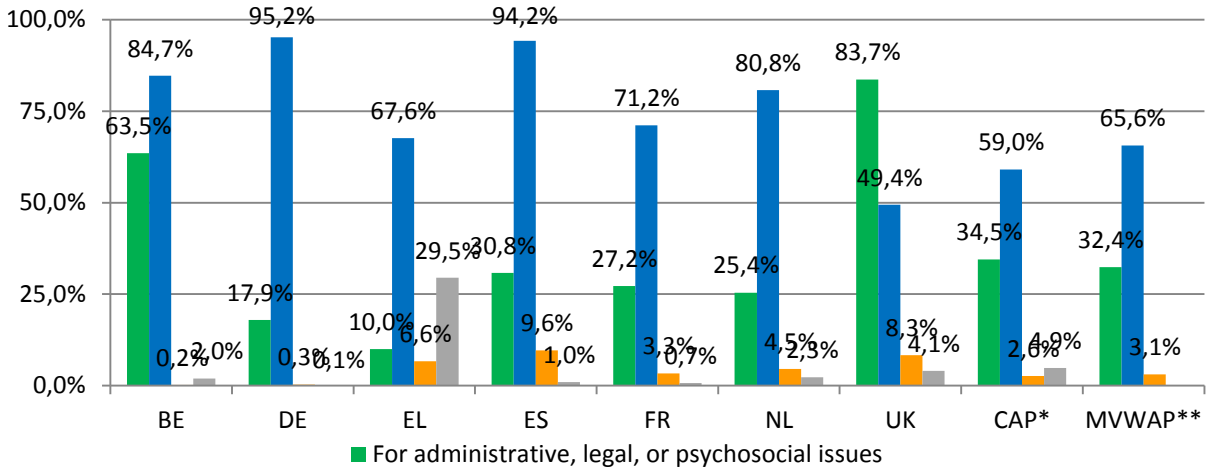
Figure 26. Reasons for consulting MdM clinics



Crude average proportion,Missing values-corrected weighted average proportion*

Perceived health status

Self-perceived health status is a common, internationally used, individual indicator of subjective general perception of health. In a population-based approach (not individually), it has been shown that it is a strong, independent and reliable predictor of morbidity, healthcare utilisation, mortality[51], and health needs[52].

Generally speaking[53], migration may have various consequences on (perceived) health status, depending on several factors: background in the country of origin (including cultural habits), events and living conditions during the migration process, socioeconomic factors in the host country, and selection process such as the (transitory) 'healthy migrant effect'[54].

A quarter (MVWAP=25.8%) **of the patients perceived themselves as being in poor or very poor health**. **As a reminder, this figure was 10.0% for the general population of the European Union** in the European Statistics of Income and Living Conditions (EU-SILC) survey in 2007[55]. In all the countries surveyed, the general health status of the patients seen by MdM is worse than that of the general population. **Of course, it is to be expected that MdM service users would be in poor health, since two thirds of people were attending our clinics for medical care**, inducing a selection bias by definition. **But since the surveyed population is also younger** than the general population[56], these differences are valid and need to be underlined.

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51 Kaplan GA, Goldberg DE, Everson SA, Cohen RD, Salonen R, Tuomilehto J, Salonen J. Perceived health status and morbidity and mortality: evidence from the Kuopio ischaemic heart disease risk factor study. *Int J Epidemiol* 1996; 25: 259-65.

52 Stronks K, Ravelli A, Reijneveld S. Immigrants in the Netherlands: Equal access for equal needs?' *J Epidemiol Community Health* 2001; 55: 701–7.

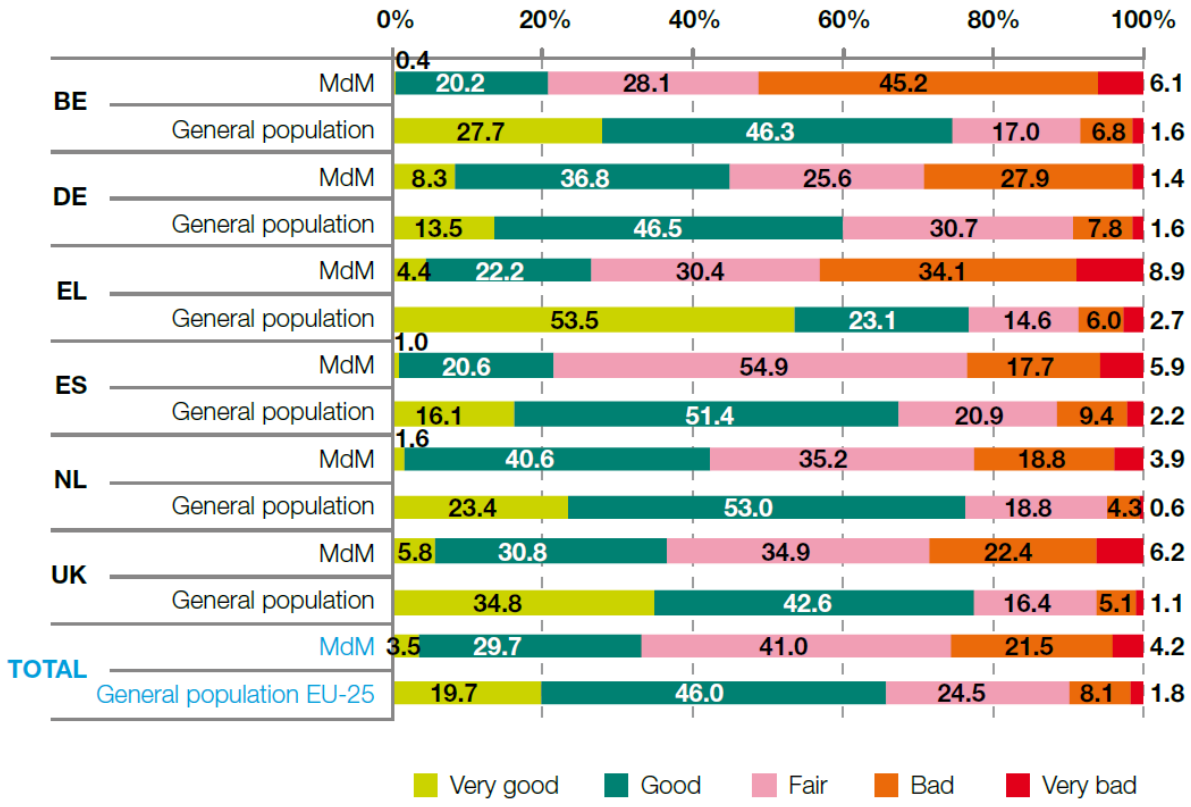
53 Nielsen SS, Krasnik A. Poorer self-perceived health amon migrants and ethnic minorities versus the majority population in Europe: a systematic review. *Int J Public Health* 2010; 55: 357-71.

54 Thomas SL, Thomas SD. Displacement and health. *Br Med Bull* 2004; 69: 115-27.

55 Baert K, De Norre B. *Perception of health and access to healthcare in the EU-25 in 2007*, Brussels, Eurostat (Statistics in focus), 2009, no. 24.

56 Of the MdM patients, only 5.2% of people were aged 65 or over, versus 16.2% in the EU as a whole.

Figure 27. Perceived general health status of respondents by country, compared with those of the general population (source: EU-SILC survey, Eurostat, 2007)



Mental health seemed slightly worse than physical health (respective proportions of bad or very bad mental health status: 28.0% and 21.2%, $p<0.001$[57]). **Mental health seemed particularly badly affected in Greece** where 50.8% of patients had a bad or very bad perceived mental health (versus 24.2% in Spain, 33.5% in Munich and 34.4% in Amsterdam). This may be linked with the economic crisis, since some Greek surveys have shown a recent and dramatic increase in suicidality in this difficult context[58].

In contrast, **at the Spanish locations physical health was more often perceived as bad or very bad** (41.8%, versus 27.8% in Greece and 22.2% in Amsterdam).

[57] Statistical test on crude data.

[58] Madianos M, Economou M, Alexiou T, Stefanis C. Depression and economic hardship across Greece in 2008 and 2009: two cross-sectional surveys nationwide. *Soc Psychiatry PsychiatrEpidemiol* 2011; 46: 943-52.
Economou M, Madianos M, Theleritis C, Peppou LE, Stefanis CN. Increased suicidality amid economic crisis in Greece. *Lancet* 2011; 378: 1459.
Fountoulakis KN, Grammatikopoulos IA, Koupidis SA, Siamouli M, Theodorakis PN. Health and the financial crisis in Greece. *Lancet* 2012; 379: 1001-2.

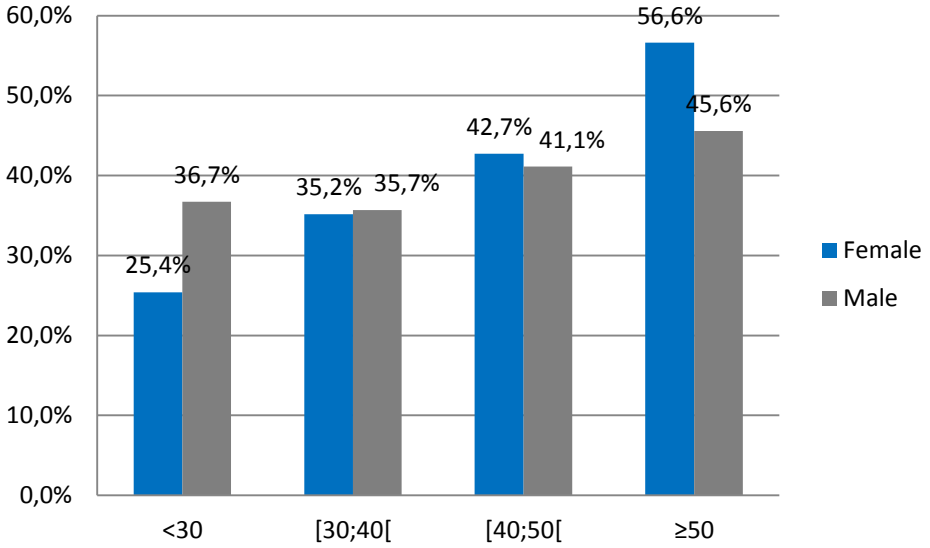
Figure 28. Perceived general, physical and mental health status in the total population

MVWAP (all sites except Nice; in Belgium and in London: general health only)

Altogether, 66.7% of the patient population reported a low self-perceived health status (i.e. neither good nor very good). This is dramatically higher than what was observed among immigrants in representative samples of the population aged 50 and over in 11 European countries in 2004/2005 through the Survey of Health, Aging and Retirement (SHARE), even though the MdM service users are notably younger (median age is 34 years). According to SHARE, on average 37.8% of immigrants aged 50 had a low self-perceived health status[59].

As expected, the general perceived health status has been getting worse with age. This trend was particularly notable among women: 43% of women aged 40-50 years old declared a bad or very bad health status. Among men, this trend was less obvious: in the two younger age groups (up to 40 years old), 37% of them already declared a poor health status (similar observations have been made in our previous surveys in 2008 and 2010).

Figure 29. Proportions of patients with a bad or very bad perceived health status, by gender and age



[59] Solé-Auro A, Crimmins E. Health of immigrants in European countries. *Int Migr Rev* 2008; 42: 861-76.

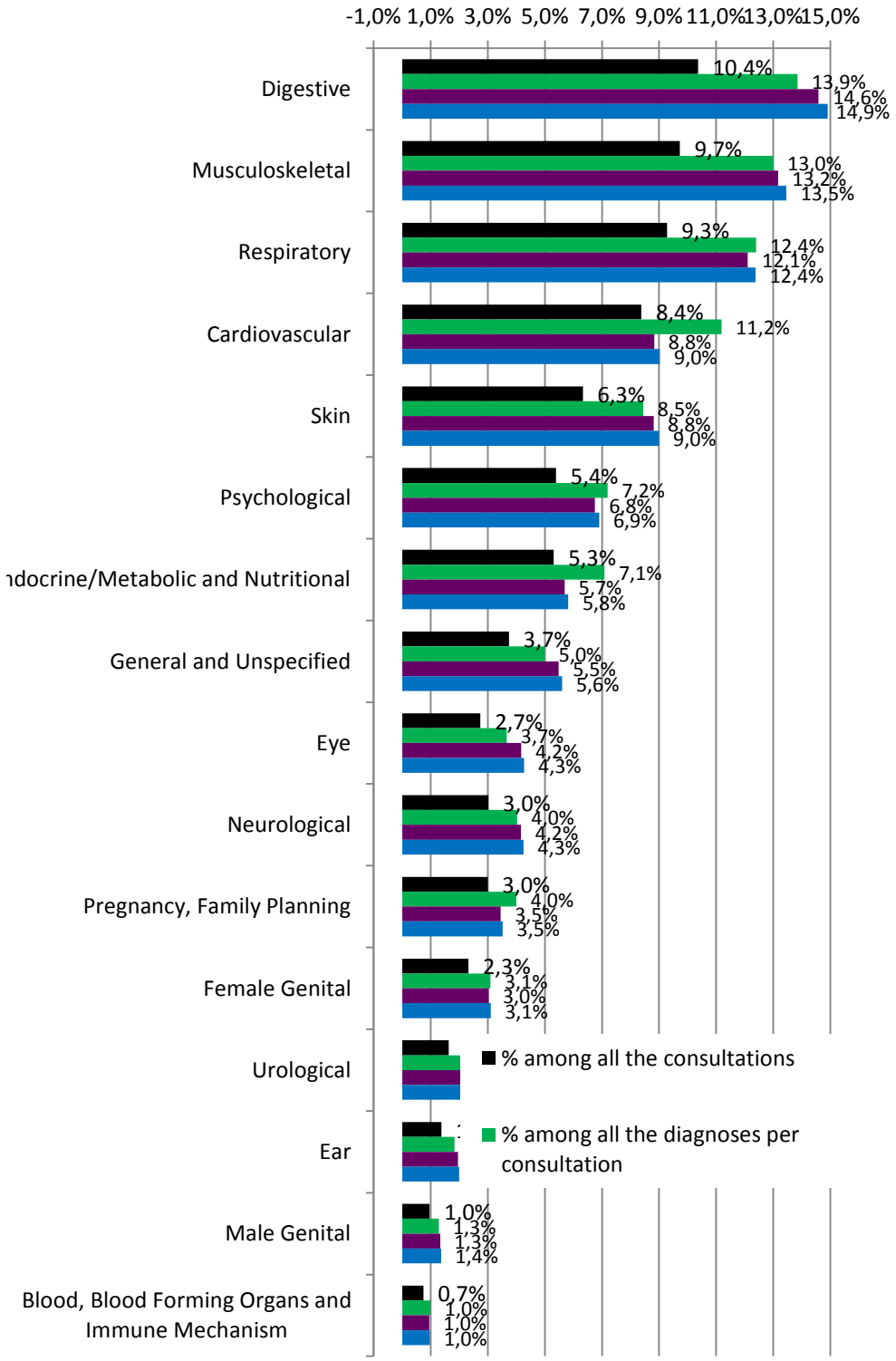
Health problems

The most frequent categories of health problems observed were those usually seen in primary care: digestive, musculo-skeletal, respiratory, cardiovascular, dermatological and psychological and psychiatric. When looking at the detailed diagnosis, we observed that hypertension, diabetes, back symptoms, teeth or gum problems, abdominal pain, pregnancy, upper respiratory infection, depression and anxiety, and cough were the 10 most frequent diagnoses (among the total number of 11,921 diagnoses reported by the doctors). This means that the care activities of MdM clinics are typically those of primary care centres, although some serious diseases were also reported, happily with a much lower frequency (e.g. cancers, HIV or tuberculosis).

Table 11. Frequency of some diagnoses (in % of all the 11921 diagnoses reported by the doctors)

15 most frequent diagnoses	
Hypertension	7,80%
Diabetes	4,75%
Low back/back symptoms	3,55%
Teeth/gum disease	3,18%
Abdominal pain	2,88%
Pregnancy	2,62%
Upper respiratory infection	2,43%
Depression	1,91%
Anxiety	1,84%
Cough	1,36%
Headache	1,29%
Acute bronchitis	1,17%
Asthma	1,08%
Knee symptom	1,06%
Viral hepatitis	0,89%
Frequencies of some selected diagnoses	
STI	0,50%
Cancer	0,36%
HIV	0,23%
Tuberculosis	0,08%

Figure 30. Frequencies of health problems reported by the doctors



Lecture of the different proportions, respectively:

- *Among all the consultations, 10.4% concerned a digestive problem (total > 100% since different problems could be declared for a given consultation);*
- *Among all the different diagnoses declared in all the consultations, 13.9% concerned a digestive problem (it is the simple frequency of all the problems cited, all consultations together);*
- *Among all the consultants, 14.6% of one or the other of their consultation concerned a digestive problem (total > 100% since different problems could affect a given patient, but a problem is counted only once, whatever the number of his/her consultations for the same problem);*
- *Among all the different diagnoses declared by all the patients at least once, 14.9% concerned a digestive problem (it is the simple frequency of all the problems cited, all patients together)*

Chronic diseases and essential treatments

During medical visits, **at least one chronic disease was reported for 52% of the patients** seen by a doctor (and at least one acute disease was reported for 42% of the patients). There were large variations across centres and one could distinguish 3 groups of clinics: at least one chronic condition was reported

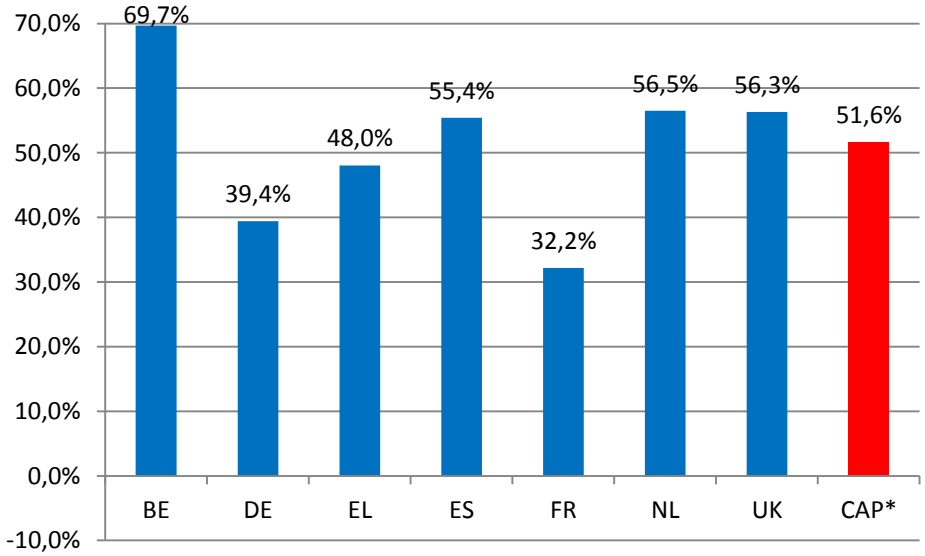
1) for 70% of the patients in the Belgium sites;

2) for approx. half of the consultants in Greece, Spain, Amsterdam and London;

3) for 30% to 40% of the consultants in Munich and Nice.

Altogether, **chronic diseases represented 61.4% of all diagnoses made during the medical consultations,** while the remaining diagnoses concerned an acute disease in 33.4% of cases and were impossible to categorise by doctors[60] in 5.2% of cases.

Figure 31. Proportion of consultants with a chronic disease by country



**Crude average proportion*

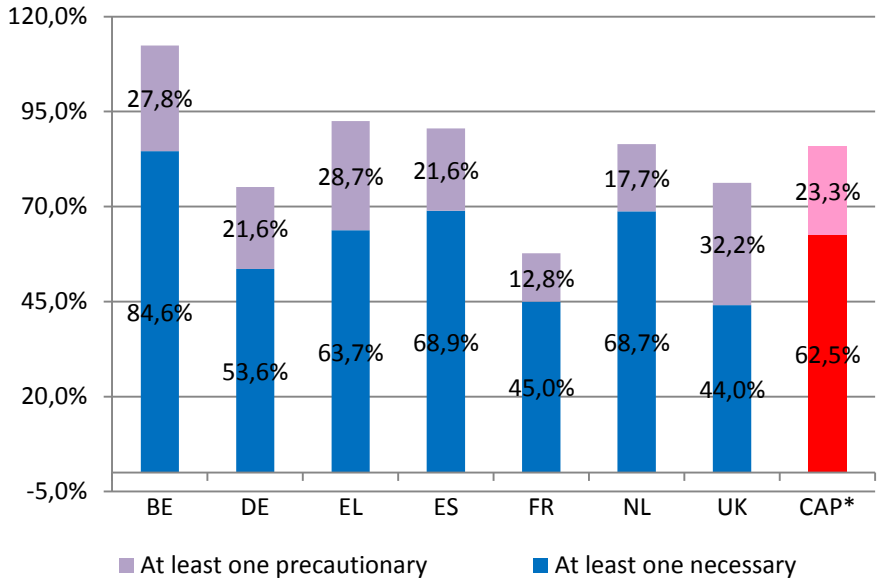
Physicians considered that 63% of people required a "necessary treatment"[61] and 23% of patients needed a "precautionary treatment". The proportion of patients requiring an essential treatment was higher in Antwerp and Brussels (corresponding to the high proportion of chronic conditions in these centres 85%) and lower in London (44%) and Nice (45%).

This means that 75.9% of all the diagnoses made by the doctors during the medical consultations **required a "necessary treatment**".

[60] MdM medical doctors expressed their difficulty in answering this question for each diagnosis, for example for an acute episode of a chronic condition.

[61] The question asked to the MdM medical doctors was to decide if a treatment was "necessary" (i.e. treatments really needed by the patients otherwise their condition would get much worse). We could also have used the words "essential treatment".

Figure 32. Proportion of consultants who needed at least a necessary and/or a precautionary treatment (as reported by the doctors), by country



**Crude average proportion*

Among patients who needed a necessary treatment, two thirds had at least one health problem fully (44%) or partially (28%) followed-up or treated. A **majority of patients (54.6%) had at least one health problem which required a necessary treatment and was not being dealt with or treated at all at the time of the consultation**. This proportion varied greatly from one country to another. It was very small in Greece, where many Greek citizens did consult and the doctors stated that these conditions had (previously) been seen and treated in the healthcare system. It was also less frequent in Amsterdam (where 22% of people with an essential treatment had been treated previously). However, at all the other sites, these patients were clearly in the majority: up to approximately two thirds of the patients in need of care in Antwerp, Brussels or London had not had any previous medical attention or treatment.

Patient story

George, 52, is a Greek national and is in receipt of a minor disability pension. He lives in his own home with his jobless wife and their two sons who are also unemployed. George came to the polyclinic looking for medication to treat his obsessive-compulsive and aggressive behaviour and an underlying anxiety disorder. During the previous eight months he had had to stop his very expensive psychiatric treatment because of financial problems, which made life extremely difficult for the family and their social environment.

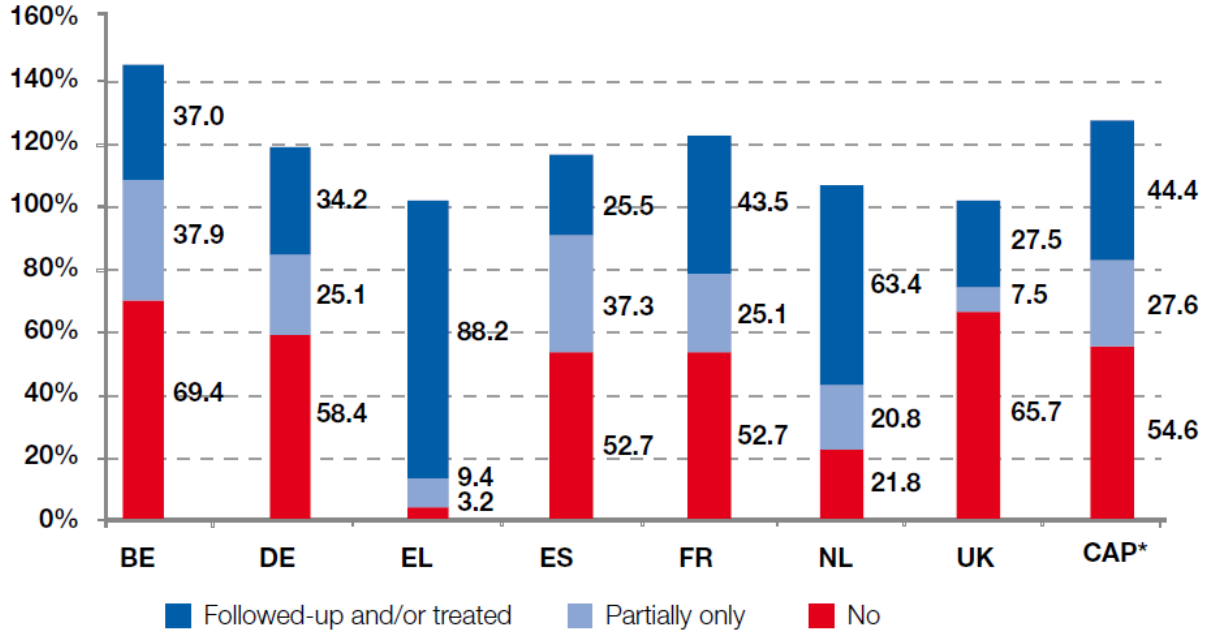
In addition, we had to break the news that he was also suffering from a hyperglycaemic syndrome that had been aggravated by his psychiatric treatment. His condition required a second treatment for diabetes.

Over the next month and after the regulation of his blood sugar level, George's psychiatric disorder unexpectedly improved. His aggressive behaviour stopped, which was a relief for the entire family. During the third month of his treatment he confided in us: "Doctor, I heard about your organisation thanks to my neighbours who came to you to ask for help. They told me about all your efforts. I was desperate because I was seeing my life fall apart more and more every day. You were my last hope. I was dashed to pieces".

Today, George is able to be an active member of society again, as well as a father and a husband. But most important of all, he knows now that he is not alone.

MdM Greece – Perama – September 2012

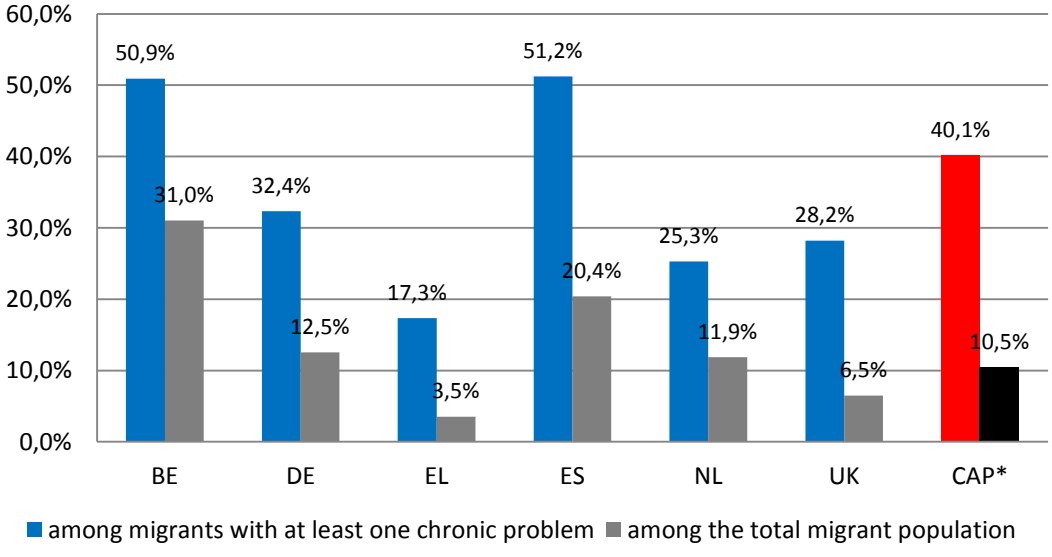
Figure 33. Proportion of consultants requiring a necessary treatment who were actually treated and followed-up (at least partially), before coming to MdM, by country



**Crude average proportion (total>100% since multiple answers were possible: a given patient might have been treated for one condition and not for another).*
Key to reading the graph: in Belgium, 37% of the patients had at least one condition which required a necessary treatment that was fully followed up or treated; while 69.4% had at least one condition which required a necessary treatment but was not treated at all.

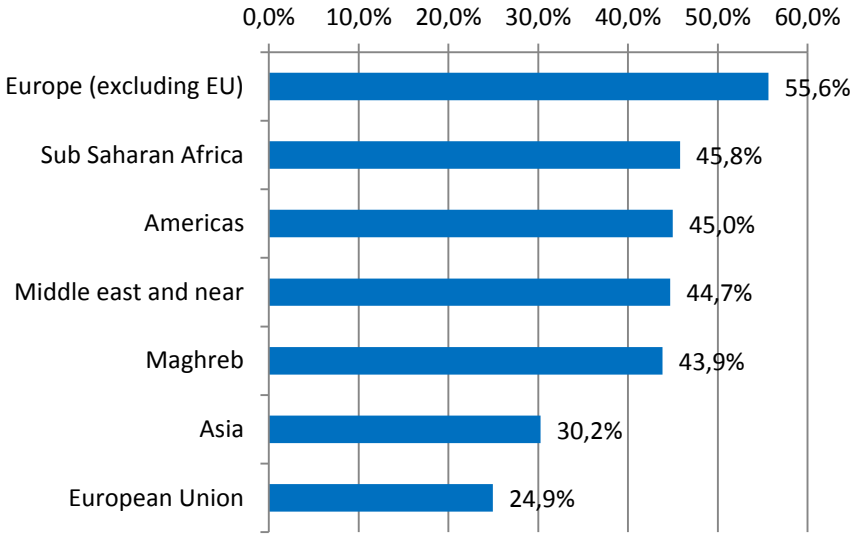
Altogether, **10.5% of migrant patients had a chronic disease that they knew of before coming to Europe**. This proportion was especially low in London and at the Greek locations (6.5% and 3.5% respectively) and higher at the Spanish and Belgian locations (20.4% and 31.0% respectively). These patients accounted for 40% of migrants with a chronic disease.

Figure 34. Prevalence of migrants with a chronic disease that they knew of before coming to Western Europe, by country



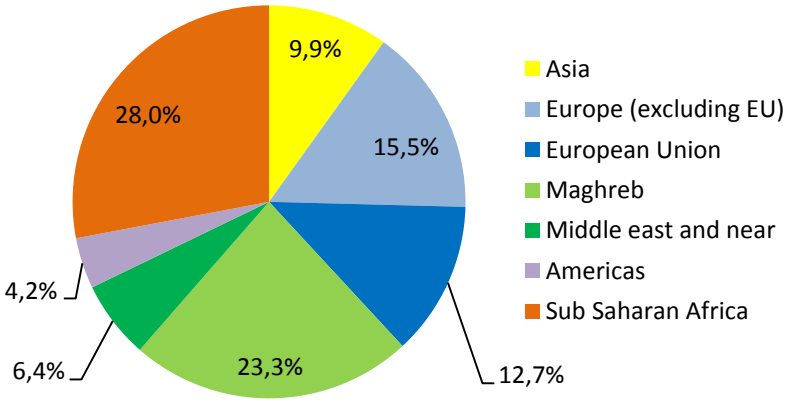
**Crude average proportion*

Figure 35. Proportion of migrants with a chronic disease that they knew of before coming to Western Europe, by geographical origin



This proportion was the same among men (40.8%) and women (39.0%) and was similar in the different age groups. This proportion was significantly different according to the geographical origin ($p<0.0001$): 56% of the non EU European migrants with a chronic disease knew it before coming to Western Europe, approx. 45% of those coming from other parts of the world, except from Asia (30%) and the EU (25%). These proportions were not different enough to change the global distribution of the geographical origins of these patients, which was globally the same as those of all the migrants.

Figure 36. Distribution by geographical origin of the migrants with a chronic disease who knew it before coming to Western Europe



When looking precisely at the diagnoses, we observed that a quarter of the total number of the cases of chronic disease among migrants who knew it before coming in Europe corresponded to 5 diagnoses: hypertension (11.8%), diabetes - whether insulin dependent (4.8%) or not (5.8%), and asthma (3.3%). Half of the total number of cases included also diagnoses such as depression (3.4%), anxiety (1.7%) and PTSD (1.3%), low back symptoms (3.4%), headache (1.5%), etc.

We have seen before in this report that, when asked about their reasons for migration, health issues represented a very small proportion of the reasons for MdM service users (1.6%), even smaller than in the 2011 results (2.2%).

As pointed out many times in our previous reports, **the preconceived notion of major immigration flows linked to people seeking healthcare does not correspond to what we have observed** in the surveyed population.

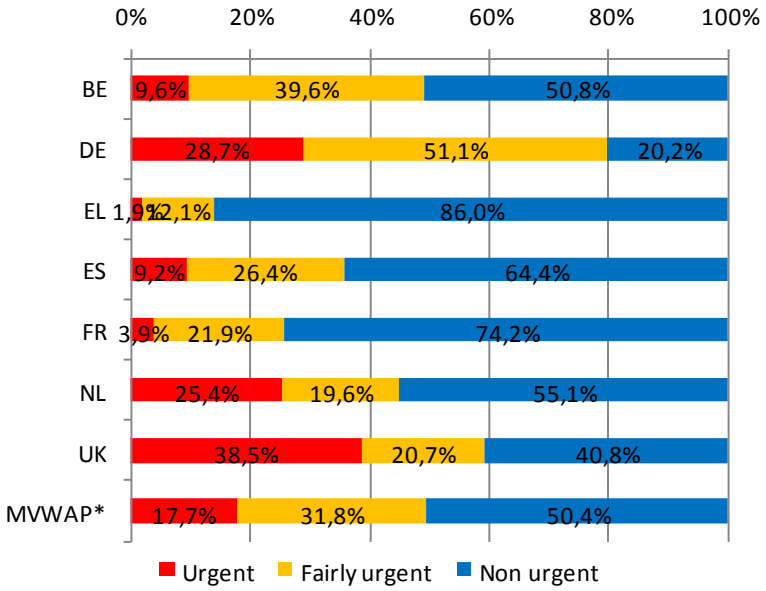
Table 12. Frequencies of the main diagnoses of chronic disease among migrants, that were known of before coming to Western Europe

	n°	%
Hypertension	217	11,76
Diabetes	196	10,62
Back syndrome and osteoarticular problems	120	6,50
Depression, anxiety and PTSD	118	6,39
Chronic abdominal pain (all types)	81	4,39
Asthma and allergic rhinitis	72	3,90
Teeth/gum symptoms and diseases	54	2,93
Chronic cough, sneezing, dyspnea, and chronic bronchitis	52	2,82
Ischaemic heart disease	41	2,23
Epilepsy	33	1,79
Eczema and psoriasis	33	1,78
Headache	27	1,46
Viral hepatitis	26	1,41
Hypothyroidism/myxoedema	19	1,03
Neurological disease unspecified	14	0,76
Obesity	11	0,60
Pain general/multiple sites	11	0,60
Glasses symptom/complaint	9	0,49
Goitre	9	0,49
Heart failure	9	0,49
Heart valve disease	9	0,49
Lump/swelling localized	9	0,49
Acne	8	0,43
Sinusitis	8	0,43
HIV-infection/Aids	7	0,38

Urgent care

Overall, half of the medical consultations were for urgent (18%) or fairly urgent (32%) cases, as reported by doctors. The proportion of urgent care was higher in London (38.5% of the medical consultations), Munich (28.7%) and Amsterdam (25.4%), whereas they were extremely rare at the Greek centres (1.9%) and in Nice (3.9%). These latter low frequencies may be for different reasons: in Greece, the MdM clinics were also used by a significant number of nationals seeking primary care who had had access to care; in France (but also in Belgium and Spain), medical emergencies were accepted in emergency units in state hospitals without much consideration of migration status.

Figure 37. Level of urgent care of medical consultations



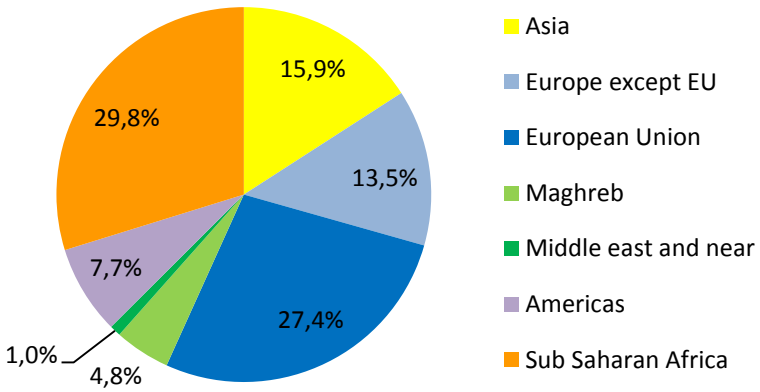
**Missing values-corrected weighted average proportion*

Access to care for pregnant women

Among the 3,511 women seen, 208 were pregnant (5.9%)[62]. They were mainly seen at the following locations: Munich (30.3%), Antwerp and Brussels (28.4%), London (21.2%), Nice and Amsterdam (7.7% each) and much less frequently at the Greek and Spanish centres (3.9% and 1% respectively).

Their mean age was 27.8 years old (median=27, interquartile=[23-32], range=[14-42]). In the first section of the medical questionnaire, the total number of previous pregnancies and the age at the first one were asked to all the women but the response rates were very low: 58% and 20% of the pregnant women (and 42% for both in all the women). For future surveys, we suggest either to increase the reporting rate for all the women, or to ask these questions among pregnant women only.

Figure 38. Region of origin of the pregnant women



[62] 26 more women had a diagnosis of pregnancy in the following part of the questionnaire (leading to a proportion of 6.6% of the total number of women), unfortunately with no information given in the pregnancy section.

Among pregnant women, approx. 30% came from Sub Saharan Africa, 28% from the European Union (corresponding to the fact that 30% of the total number of pregnant women were seen in Munich), 13.5 % from another part of Europe, and 16% from Asia.

Unfortunately, the rates of missing values were high for the questions about access to antenatal care (respectively 30% for the first question: *"Does the woman have access to antenatal care?"* and 41% for the second question: *"Has the woman received her first antenatal care after the 12th week of pregnancy?"*). If one considers that the women with or without answers to these questions are the same, then we estimate that **59% of the pregnant women**[63] **did not have access to antenatal care** and **46.7% of them received care too late** (that is after their 12th week of pregnancy). We observed no statistically significant differences in access to antenatal care (or delayed access) on the basis of women's ages or geographical origins (this may have been due to the small numbers).

Such results are similar with some surveys reported in scientific journals in various European countries. Twenty years ago, in a hospital in Brussels, a survey found that 46% of uninsured women (98% of them being immigrants and mainly undocumented) received no prenatal care and only 6.6% had prenatal care during the first trimester.[64] Another old case control study performed in 20 French sub-regions found that foreigner pregnant women were at higher risks than nationals to get inadequate prenatal care and that a lack of residency permit was cited as a reason for not seeking prenatal care by 37.5% of foreign women.[65] More recently, in Geneva in 2005-2006, only 63% of undocumented pregnant women had their first antenatal visit during the first trimester (versus 96% of the "control" population, constituted by pregnant women with an authorised residency status).[66]

A review of the literature on undocumented pregnant women published in 2013 concluded that "*undocumented pregnant women constitute a particularly vulnerable subgroup of migrants, as suggested by their reported social precariousness and under-utilization of health services. Nonetheless, it is evident from the dearth of studies identified that this population remains highly understudied. Proper documentation of this issue is paramount in preventing the further exclusion of this hard-to-reach group from health services*".[67]

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63 Unfortunately, the rates of missing values were high for the questions about access to antenatal care (respectively 30% for the first question: *"Does the woman have access to antenatal care?"* and 41% for the second question: *"Has the woman received her first antenatal care after the 12th week of pregnancy?"*).

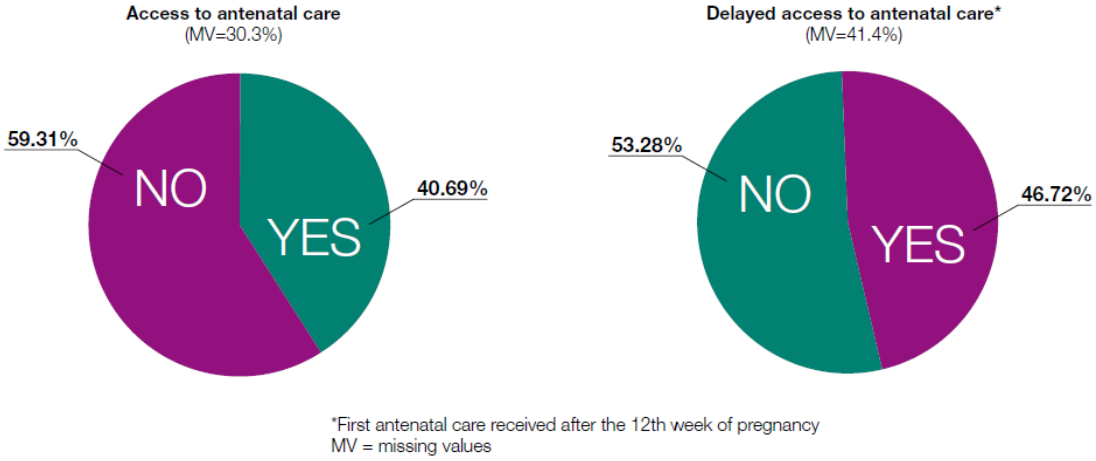
64 Barlow P, Haumont D, Degueldre M. Devenir obstétrical et périnatal des patientes sans couverture sociale. *Rev Méd Brux* 1994; 15: 366-70.

65 Blondel B, Marshall B. Les femmes peu ou pas suivies pendant la grossesse : résultats d'une étude dans 20 départements. *J Gynécol Obstet Biol Reprod* 1996; 25: 729-36.

66 Wolff H, Epiney M, Lourenco AP, Costanza MC, Delieutraz-Marchand J, Andreoli N, Dubuisson JB, Gaspoz JM, Irion O. Undocumented migrants lack access to pregnancy care and prevention. *BMC Public Health* 2008; 8: 93.

67 Munro K, Jarvis C, Munoz M, D'Souza V, Graves L. Undocumented pregnant women: what does the literature tell us? *J Immigrant Minority Health* 2013; 15: 281-91.

Figure 39. Access to antenatal care of the pregnant women



*First antenatal care received after the 12th week of pregnancy
MV = missing values

Patient story

Teresa is 22 years old, from Cuba, pregnant and has suffered type 1 diabetes since she was 15. She has lived in Tenerife since March 2012 and has no permit to stay in Spain.

Prior to her hospitalisation, she had been self-administering insulin which her mother sent her from Cuba. When she realised that she was pregnant, she went to the public healthcare centre, but was denied medical attention due to her irregular administrative status. The centre referred her to the social security office (INSS), where she explained her high-risk situation and requested a social security number so that she could receive medical treatment during her pregnancy. The INSS refused to issue her with a social security number on the basis of her irregular administrative status, stating that she was responsible for the consequences and advising her to consult a private medical centre.

Her first consultation with a gynaecologist came as a result of a car accident for which she was taken to the accident and emergency department of a local hospital. The doctor who attended her arranged an appointment for her in the gynaecology department. She was 20 weeks into her pregnancy when she received her first ultrasound scan (eight weeks late).

Two weeks later she did not feel well and went to the accident and emergency department where she was warned that her pregnancy fell into the high-risk category. The gynaecologist who attended her 20 days later referred her to the endocrinology department, where it was decided that she should receive in-patient care for "adjustment of treatment and diabetes education". At this point, the social work unit of the hospital contacted Médicos del Mundo to request that we cover the cost of the medication the patient required. The hospital provided the necessary medications only until the scheduled appointment at MdM; therefore she arrived without having taken any medication that morning.

Considering the gravity of the situation, Médicos del Mundo Canarias covered the costs of this woman's medications for one week until her next appointment. Neither she nor her partner have a regular source of income, and both rely on sporadic employment opportunities. The couple shares a room in a friend's house. We contacted the social worker at the hospital and requested a written statement confirming the denial of medical prescriptions for Teresa. Shortly thereafter a physician contacted MdM and said that no written statement would be provided and that she was only complying with the legislation in force. During the conversation she also made value judgements regarding the patient, her motives for coming to Spain and her pregnancy.

We then sent letters to the director of the hospital, the Regional Ministry of Health and the Director of Health Services for the Canary Islands. The Regional Minister of Health contacted MdM to apologise for the situation, recognising the patient's right to healthcare and coverage of 40% of the cost of medicines prescribed for her condition and making a commitment to resolve the matter.

MdM Spain – Canary Islands – October 2012

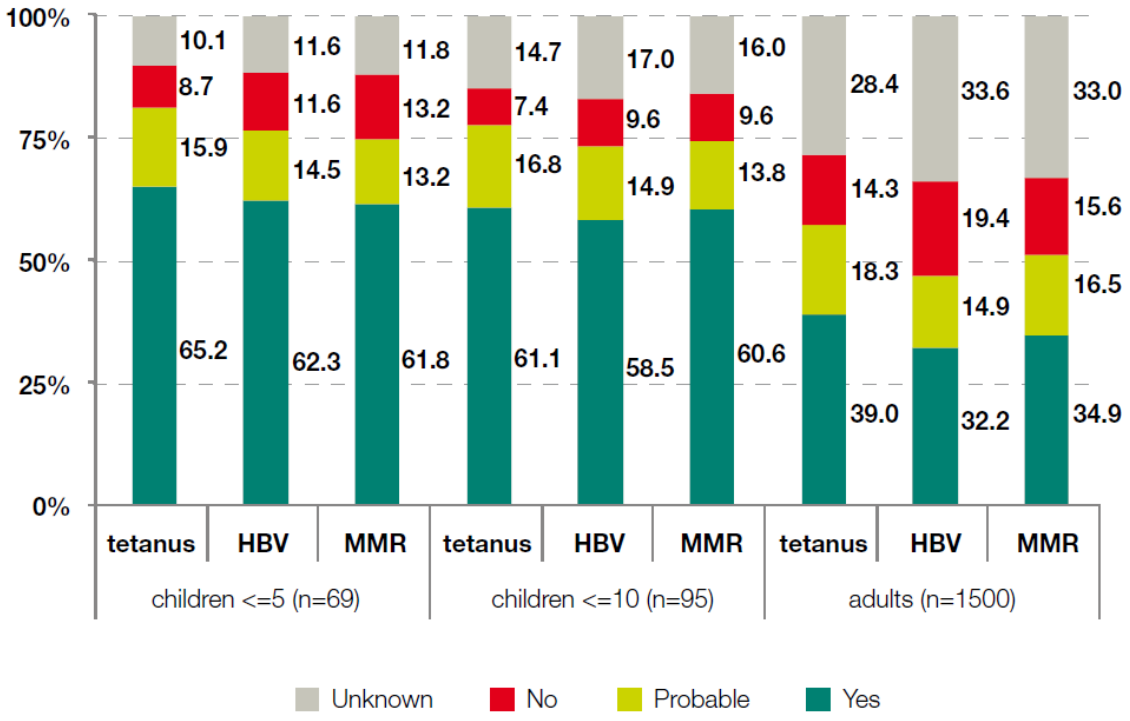
Access to vaccinations

At all the locations except in Belgium and London patients were asked by the doctors[68] about their vaccination status in relation to tetanus, HBV and MMR. Data were available for a limited number of patients due to the difficult task of asking questions about facts that sometimes happened a long time ago (in the case of adults). Furthermore, when faced with patients who seldom consult a health provider, there is a natural tendency to first and foremost respond to their expressed needs and self-perceived priorities. Any comprehensive, in-depth prevention work with patients facing accumulated factors of vulnerability requires them to be able to access low-threshold primary care services.

We nonetheless observed that only around 60% of the children who came to MdM health centres in 2012 had been vaccinated against tetanus, HBV or MMR. For adults, these figures fell to 39%, 32% and 35% respectively. This can illustrate a loss of access to healthcare very early in the course of a patient's life.

Around 10% of the children had definitely not been vaccinated against tetanus, HBV or MMR. Adults who had definitely not been vaccinated accounted for 14% for tetanus, 19% for HBV and 16% for MMR. It was reported that between 10 and 17% of the children just did not know about their vaccination status, and around 30% of the adults were in the same position (due to the lack of vaccination records that had often been lost or damaged).

Figure 40. Vaccination status among children and adults (tetanus, HVB and MMR)



It seems that fewer people seen at the Spanish centres had been vaccinated than elsewhere. The proportions observed in Greece (which seem to indicate a better vaccination status than elsewhere) must be interpreted with caution, since the rate of missing values was particularly high.

[68] Vaccination status is missing for a quarter of the patients seen in Munich, for 59% of patients in Greece, less than 10% in Spain, 79% in Nice and 28% in Amsterdam. Surprisingly, the rate of missing values is independent of the patient's age. Unfortunately, this means that the questions about vaccinations were not asked more frequently to children than to adults.

Patient story

Kostas is a 44-year-old unemployed man who visited our polyclinic in Perama 18 months ago.

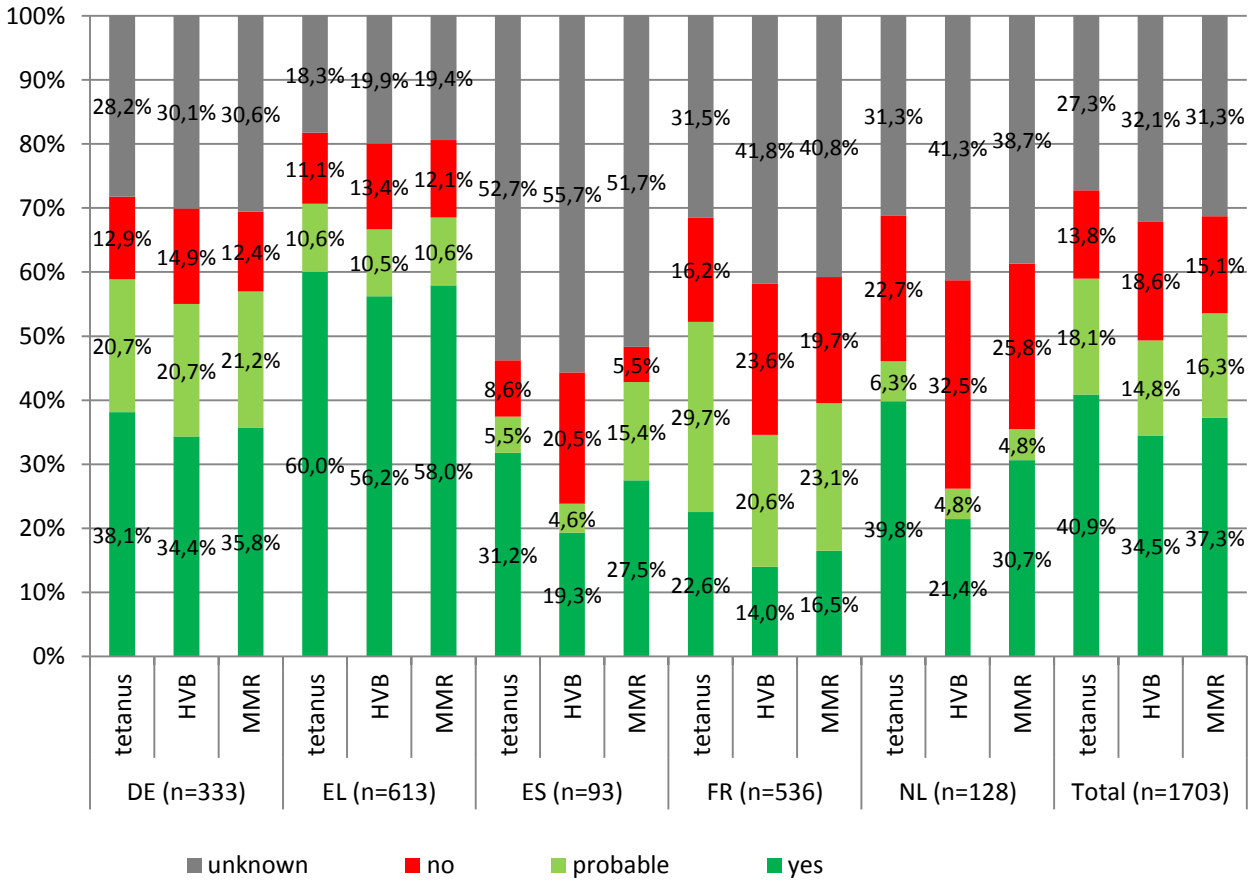
"My wife is four months pregnant and I can't afford to take her to a private doctor. I lost my job a year ago, I have no income at all and we are expecting our first child. I used to work in the shipyard zone as a mechanic but the economic crisis destroyed my life. My wife has been without a job for two years but at the time we were able to live on just my salary. But now what? My wife told me that we shouldn't keep the baby, but it was already too late. I don't even know how I'll be able to feed my child once it's born."

His wife came to visit the gynaecologist throughout her pregnancy. One morning Kostas called us to tell us she had given birth to a boy. He was so happy he couldn't talk for his tears.

After two months Kostas came to the polyclinic asking for a paediatrician. He wasn't able to bring the child because of his high fever and the very cold weather. The family lives up in the mountains. We asked if we could visit the baby at their home but he first told us it was impossible. They lived without electricity, running water or heating. They didn't want us to come because they felt too ashamed and embarrassed. When we finally examined the baby, we realised that he had not been vaccinated. Kostas and his family continue to visit our polyclinic in Perama, for care and vaccinations. We also support them with food items every month.

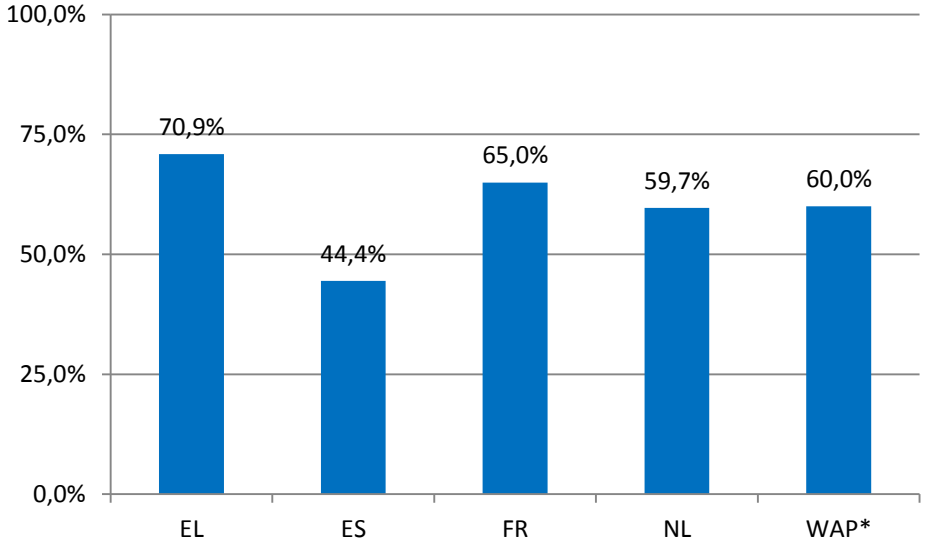
MdM Greece – Perama – 2012

Figure 41. Vaccination status by country (tetanus, HVB and MMR)



A majority of the people interviewed did <u>not</u> know where to go to receive vaccination[69]. For instance, 65% of the patients seen in Nice did not know where to go to be vaccinated even though the city runs three public vaccination services that theoretically deliver free vaccinations for all.

Figure 42. Proportion of patients ignoring where to receive vaccination by country



**Weighted average proportion*

Even though the proportion of unvaccinated population is very high, the vaccination activity of the MdM centres is very low.

With the unique exception of 3 doses of tetanus and 1 dose of HBV delivered in Greece, only the Munich centre seems to offer vaccinations on a regular basis (only to children < 5 years of age). Indeed, among the 699 people unvaccinated for tetanus, only 14 children were vaccinated at the time of the consultation (1 in Greece and 13 in Munich i.e. 100% of the unvaccinated children < 5 years of age there). For HBV, among the 839 unvaccinated people, only 11 doses were delivered, all of them to children < 5 years of age (100% of the unvaccinated children < 5 in Munich + 1 dose in Greece in the same age-group). For MMR, among the 24 unvaccinated children < 10 years of age, only 7 were vaccinated (all in Munich, i.e. 58% of the children in need there).

MdM teams refer patients to vaccination centres whenever possible, especially in France, Spain, Belgium and the Netherlands where vaccinations for children are free of charge. However, the high number of consultations at MdM centres where no questions about vaccination were asked certainly constitutes a missed opportunity to improve the vaccination status of patients.

In 2010 and 2011, a large European outbreak of measles was observed, despite the target for its elimination throughout Europe by 2015. More than 30,000 cases were reported by EU and EEA/EFTA countries in 2010 and 35,000 cases in 2011, a fivefold increase compared to the annual average for the preceding five years. More than eight in 10 reported patients were unvaccinated – which means that their illness would have been avoidable with vaccination. Between October 2011 and September 2012, the European Centre for Disease Prevention and Control (ECDC) reported about 8,000 cases, i.e. fewer than in the previous years but not yet in line with the 2015 target. France, Italy, Romania, Spain and the United Kingdom accounted for 93% of the total number of reported cases.

[69] We noticed that the only people who were asked if they knew where to get vaccination were those who had answered questions about their vaccination status in Greece, Spain, Nice and Amsterdam.

Vulnerable groups are worse hit by infectious diseases, mainly because of their poor living conditions and other social determinants of health, but also because the State health authorities fail to implement real universal public health measures such as equal access to healthcare and prevention for all. Public health policies can only be effective if they include everyone living within their geographical area. They should not exclude any segments of the population, especially not the most vulnerable groups who should constitute, on the contrary, priority target populations.

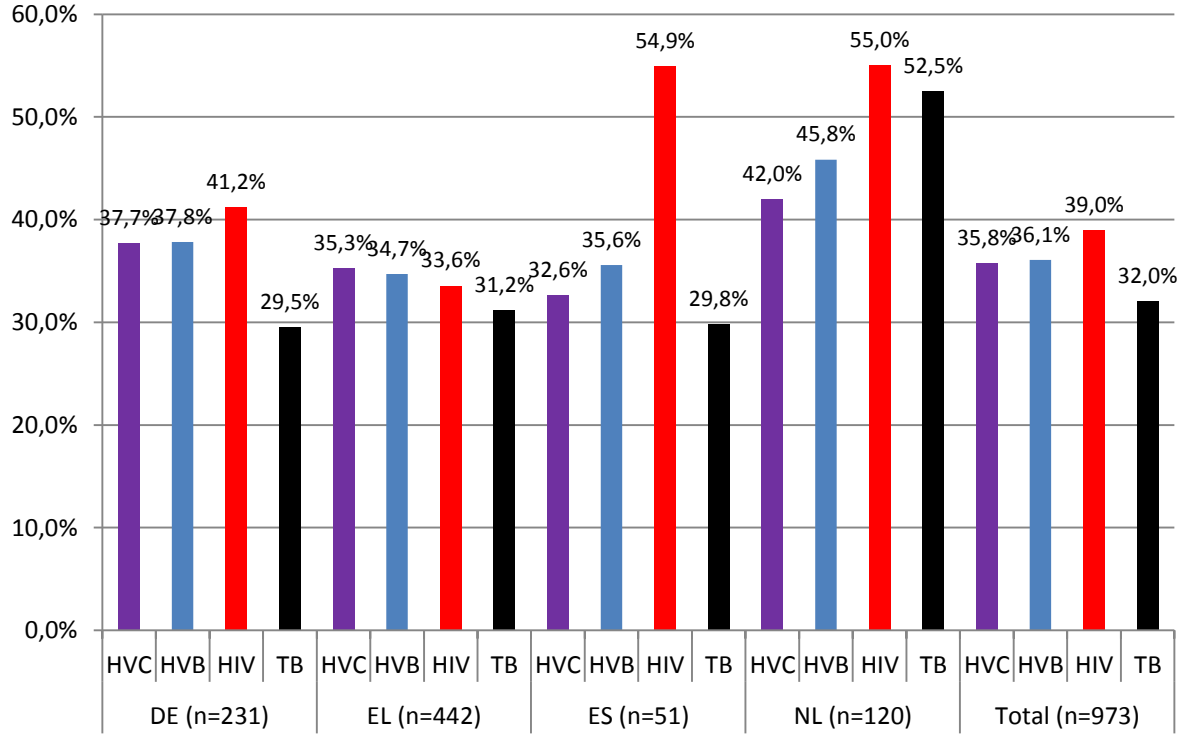
It should also be noted that the Fundamental Rights Agency is of the opinion that "every child should be entitled to the same healthcare services as nationals (including immunisations)".

Serological status

Serological status was asked for HBV, HCV, HIV and tuberculosis by some doctors (but not all) in all the sites except in Antwerp, Brussels and Nice.

Among the 973 people who were asked about this issue (a little more than 10% of all the patients and 12% of the adult population), **approximately only one third had ever been screened for these infections**: 36% for HCV and/or HBV, 39% for HIV and 32% for tuberculosis. There were no significant differences between sites or countries except in Amsterdam (more than 50% of people had been screened for HIV or tuberculosis) and in Spain (55% of the people had been screened for HIV).

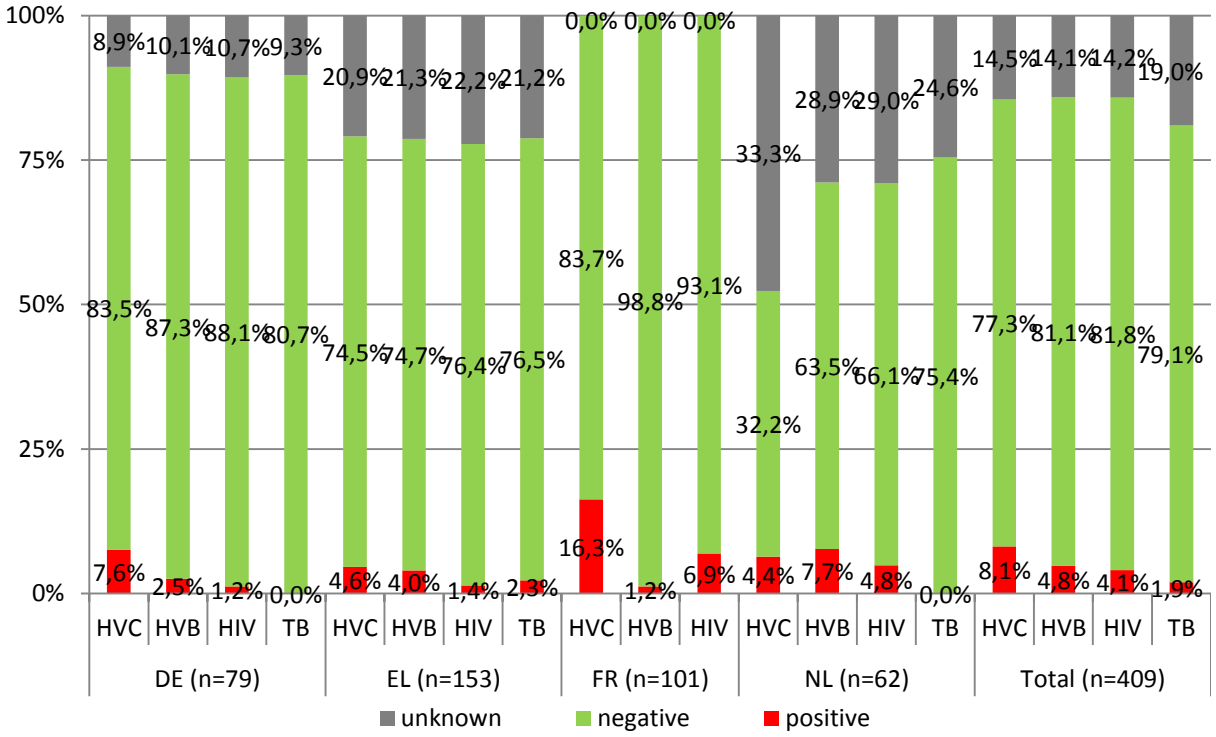
Figure 43. Proportion of patients who had been tested for HCV, HBV, HIV or tuberculosis by country



For indication only, the results of these tests are given in the figure below. Since the numbers are low, the (declared) seroprevalence must be interpreted with great caution. In particular, the highest prevalence observed in Spain was based on 14 persons only. Altogether, among the 409 people interviewed about the results of their last serological tests, 8.1% knew that they were HCV+, 4.8% HBV+, 4.1% HIV+ and 1.9% TB+. **All these proportions are far higher than the respective prevalence of these infections in the general population**.

For indication only, the results of these tests are given in the figure below. Since the numbers are low, we did not figure Spanish and London data[70]. Altogether, among the 409 people interviewed about the results of their last serological tests, 8.1% knew that they were HCV+, 4.8% HBV+, 4.1% HIV+ and 1.9% TB+. **All these proportions are far higher than the respective prevalence of these infections in the general population**.

Figure 44. Seroprevalence of HVC, HVB, HIV and tuberculosis by country



As a reminder, the prevalence of hepatitis B surface antigen (HBsAg) in the general population varies widely between European countries with intermediate carrier rates in Greece (2%) and low rates in Northern Europe (between 0.5% and 1.5% in Belgium, France and Germany; and below 0.5% in the Netherlands, for instance)[71]. So, **the prevalence of hepatitis B observed in MdM service users is at least twice as high as those of the general population.**

A recent review of the literature (and meta-analysis) on HBV infection in recent migrants and refugees arriving in low HBV prevalence countries has estimated that the overall pooled seroprevalence of infection was 7.2% (95% CI[72]: 6.3%-8.2%) and the seroprevalence of prior immunity was 39.7% (95% CI: 35.7%-43.9%), with – obviously – great variations between regions of origin (migrants from East Asia and Sub-Saharan Africa being at the highest risk and migrants from Eastern Europe being at an intermediate risk of infection).[73]

As for HCV infection, its prevalence varies from 0.4% in Sweden, Germany and the Netherlands to over 2–3% in some Mediterranean countries.[74] Some studies, like the one published in 2011 by Dutch

[70] In Spain, HVC, HBV, HIV and TB prevalence were respectively 21.4% (3/14), 21.4% (3/14), 13.04% (3/23), and 25.0% (2/8). In London, they were respectively 0% (0/23), 18.8% (3/16), 6.7% (2/30) and 0% (0/12).

[71] Rantala M, Van de Laar MJ. Surveillance and epidemiology of hepatitis B and C in Europe – a review. *Eurosurveillance* 2008; 13: 1-8.

[72] CI = confidence interval

[73] Rossi C, Shrier I, Marshall L, Cnossen S, Schwartzman K, Klein MB, Schwarzer G, Greenaway C. Seroprevalence of chronic hepatitis B virus infection and prior immunity in immigrants and refugees: a systematic review and meta-analysis. *PLoS One* 2012; 7: e44611.

[74] Hatzakis A, Wait S, Bruix J, et al. The state of hepatitis B and C in Europe: report from the hepatitis B and C summit

researchers[75] suggest that first-generation of non-Western migrants are at increased risk for HCV and that HCV screening and prevention programmes should target these people. So, **the prevalence of hepatitis C observed in MdM service users is also much higher than in the general population.**

For HIV testing and counselling, a recent review of European literature has underlined how much the HIV prevalence among migrants was higher than the general population's. The migrants also had higher frequency of **delayed HIV diagnosis**. The authors stressed that, for migrants from countries with low HIV prevalence and for ethnic minorities, socio-economic vulnerability puts them at the risk of acquiring HIV. Migrants have specific legal and administrative barriers to accessing HIV testing and care in some European countries. For all these reasons, **migrants and more generally all vulnerable, destitute or excluded populations should be offered HIV testing and full access to treatments.**[76]

For tuberculosis, the question is not so much about systematic screening but is rather the question of the accessibility of excluded people to actions taken for searching for secondary cases around a notified one, for screening programmes in the case of an outbreak and, for care and treatment. In a recent paper, the Wolfheze Transborder Migration Task Force wrote that "*despite the wide difference in TB notification in the [European] region (from 2.8 to 123 per 100,000 population), TB is considered a public health problem in most countries, particularly among the vulnerable populations (i.e. individuals at higher risk of exposure to discrimination, hostility or economic adversity) frequently located in cities of low incidence countries*".[77] This task-force pleads for intensified actions for addressing the current gaps in providing TB and drug-resistant TB control and care across borders. **It also recommends an amendment to the Dublin II Regulation on asylum applications, in order to foster and safeguard the continuity of TB care for asylum seekers.**

conference. *J Viral Hep* 2011; 18(S1): 1-16.

75 Urbanus AT, van de Laar TJ, van den Hoek A, Zuure FR, Speksnijder AG, Baaten GG, Heijman T, Vriend HJ, Op de Coul EL, Coutinho RA, Prins M. Hepatitis C in the general population of various ethnic origins living in the Netherlands: should non-Western migrants be screened? *J Hepatol* 2011; 55: 1207-14.

76 Alvarez-Del Arco D, Monge S, Azcoaga A, Rio I, Hernando V, Gonzalez C, Alejos B, Caro AM, Perez-Cachafeiro S, Ramirez-Rubio O, Bolumar F, Noori T, Del Amo J. HIV testing and counselling for migrant populations living in high-income countries: a systematic review. *Eur J Public Health* 2012; Epub ahead of print.

77 Dara M, de Colombani P, Petrova-Benedict R, et al. Minimum package for cross-border TB control and care in the WHO European region: a Wolfheze consensus statement. *Eur Respir J* 2012; 40: 1081-90.

Conclusion: Time for action

In light of the lack of access to healthcare described throughout this document, Doctors of the World invites all governments in Europe to act firmly to protect the whole population, especially the most vulnerable, living in their country. Beyond international human rights instruments, a considerable number of recommendations concerning equal access to healthcare have recently been made on a European level. It is time for national governments to put these recommendations into practice.

Some governments use access to healthcare as a policy tool to regulate migration flows: this has been proved to be unethical and ineffective. In reality, access to care is not a pull or a push factor for migration. The hard data we have collected throughout the years on the reasons for migration among Doctors of the World service users in Europe show that undocumented migrants do not know their pathologies before migrating, do not know the health systems of the European countries and do not know they could be taken care of. In 2012, health represented only a 1.6% share of the reasons for migration Health tourism does NOT concern the people that we see in the MdM centres; health tourism by undocumented migrants is a myth.

Concerning undocumented migrants, we ask EU Member States to enforce the opinions of the Fundamental Rights Agency. This means changing restrictive legal frameworks so that everyone can access all forms of essential preventive and curative healthcare (including mental healthcare, care for chronic conditions, paediatric care, ante- and postnatal care as well as sexual and reproductive healthcare). It also means that Member States should make more effort to inform undocumented migrants and healthcare professionals about their rights to access healthcare.

The Doctors of the World International Network urges the European Union and the Council of Europe to develop means to protect seriously ill migrants from being deported to countries where they will not be able to access healthcare. Both these institutions firmly oppose the death sentence, yet when some undocumented migrants with HIV/AIDS, renal failure, cancer, hepatitis, etc. are sent back to their country of origin, the serious deterioration in their health or even, for some of them, the possibility of their death, must be considered and avoided at all costs by protecting them in Europe.

Over the past few years, the European Centre for Disease Prevention and Control (ECDC) has published several reports in which it calls for further inclusion of vulnerable groups in prevention, immunisation, screening and treatment programmes. We call on governments to implement ECDC recommendations and to render treatment for infectious diseases accessible to all as a minimum public health measure. All children in all European countries must have full access to national immunisation schemes and to paediatric care. In addition, all pregnant women must have equal access to pre and post natal care.

Doctors of the World calls on the governments to ensure national public health systems built on solidarity, equality and equity, open to everyone living in a European Member State, rather than systems based on a profit rationale. This objective should be achieved through proactive and low-threshold medical services where all patients, including destitute nationals, EU citizens and third-country nationals, are cared for unconditionally, regardless of residence status. Despite and even because of the crisis, we demand financially accessible health coverage and co-payment systems that take into account the income of each patient, regardless of residence status.

Tables of tables and figures

Appendix

In this appendix, we give some breakdowns by country that have not been commented in the document, mainly for the information of the MdM coordinators.

In the tables, results are given in the format “numbers (%)”; MV for missing values or not applicable (according to the questionnaire filters).

Blue cases mean that the question was not asked in the specific version of the questionnaire used in the corresponding country.

ACTIVITIES AND RESOURCES

Variables	BE		DE		EL		ES		FR		NL		UK		TOTAL CAP		WAP	MVWAP
Do you have a job or another activity to earn a living? MV =	343	(16.92)	43	(9.79)	912	(60.60)	4	(3.88)	73	(2.81)	18	(10.17)	96	(6.15)	1489	17.70		
No	1522	(90.38)	317	(80.05)	480	(80.94)	79	(79.80)	1647	(65.18)	127	(79.87)	1118	(76.31)	5290	76.41	78.93	76.09
Yes	162	(9.62)	79	(19.95)	113	(19.06)	20	(20.20)	880	(34.82)	32	(20.13)	347	(23.69)	1633	23.59	21.07	23.91
TOTAL	1684	(100.00)	396	(100.00)	593	(100.00)	99	(100.00)	2527	(100.00)	159	(100.00)	1465	(100.00)	6923	100.00	100.00	100.00
Is your current income sufficient enough for daily living, e.g. food, clothing? MV =					1393	(92.56)	84	(81.55)			155	(87.57)	1230	(78.80)	2862	85.53		
No					89	(79.46)	14	(73.68)			9	(40.91)	45	(13.60)	157	32.44	51.91	48.49
Yes					23	(20.54)	5	(26.32)			13	(59.09)	286	(86.40)	327	67.56	48.09	51.51
TOTAL					112	(100.00)	19	(100.00)			22	(100.00)	331	(100.00)	484	100.00	100.00	100.00
In wich sector do you work? MV =			379	(86.33)			89	(86.41)			158	(89.27)			626	87.07		
Agriculture, Foresty, Fishing			1	(1.67)			0	(0.00)			0	(0.00)			1	1.00	0.52	0.54
Building, construction work			7	(11.67)			0	(0.00)			1	(5.26)			8	8.00	5.31	5.33
Business-shop			4	(6.67)			0	(0.00)			0	(0.00)			4	4.00	2.08	2.15
Cleaning			10	(16.67)			6	(42.86)			11	(57.89)			27	27.00	36.04	35.48
Hotels and restaurants			13	(21.67)			2	(14.29)			0	(0.00)			15	15.00	10.94	11.26
Other			15	(25.00)			1	(7.14)			4	(21.05)			20	20.00	16.56	16.47
Sex work			4	(6.67)			7	(50.00)			0	(0.00)			11	11.00	16.67	17.14
Transports			5	(8.33)			0	(0.00)			2	(10.53)			7	7.00	5.94	5.82
Work for individuals			5	(8.33)			0	(0.00)			2	(10.53)			7	7.00	5.94	5.82
Begging			0	(0.00)			0	(0.00)			0	(0.00)			0	0.00	0.00	0.00
TOTAL			64	(106.67)			16	(114.29)			20	(105.26)			100	100.00	100.00	100.00

PERCEIVED HEALTH

Variables	BE		DE		EL		ES		FR	NL		UK		TOTAL	CAP	WAP	MVWAP
How is your physical health? MV =			101	(23.01)	914	(60.73)	3	(2.91)		42	(23.73)			1060	47.66		
Bad			90	(26.63)	207	(35.03)	14	(14.00)		27	(20.00)			338	29.04	23.91	17.76
Fair			88	(26.04)	175	(29.61)	58	(58.00)		51	(37.78)			372	31.96	37.86	45.02
Good			132	(39.05)	139	(23.52)	22	(22.00)		52	(38.52)			345	29.64	30.77	31.69
Very Bad			4	(1.18)	40	(6.77)	6	(6.00)		3	(2.22)			53	4.55	4.04	3.42
Very Good			24	(7.10)	30	(5.08)	0	(0.00)		2	(1.48)			56	4.81	3.41	2.12
TOTAL			338	(100.00)	591	(100.00)	100	(100.00)		135	(100.00)			1164	100.00	100.00	100.00
How is your psychological and emotional health? MV =			120	(27.33)	913	(60.66)	4	(3.88)		46	(25.99)			1083	48.70		
Bad			92	(28.84)	194	(32.77)	17	(17.17)		45	(34.35)			348	30.50	28.28	24.26
Fair			98	(30.72)	153	(25.84)	48	(48.48)		40	(30.53)			339	29.71	33.90	39.96
Good			102	(31.97)	115	(19.43)	22	(22.22)		38	(29.01)			277	24.28	25.66	26.97
Very Bad			15	(4.70)	107	(18.07)	7	(7.07)		0	(0.00)			129	11.31	7.46	3.73
Very Good			12	(3.76)	23	(3.89)	5	(5.05)		8	(6.11)			48	4.21	4.70	5.07
TOTAL			319	(100.00)	592	(100.00)	99	(100.00)		131	(100.00)			1141	100.00	100.00	100.00

Variables	BE		DE		EL		ES		FR	NL		UK		TOTAL	CAP	WAP	MVWAP
How is your general health? MV =	584	(28.81)	88	(20.05)	910	(60.47)	1	(0.97)		49	(27.68)	91	(5.83)	1723	20.48		
Bad	652	(45.18)	98	(27.92)	203	(34.12)	18	(17.65)		24	(18.75)	329	(22.38)	1324	32.38	27.67	21.54
Fair	405	(28.07)	90	(25.64)	181	(30.42)	56	(54.90)		45	(35.16)	513	(34.90)	1290	31.55	34.85	41.04
Good	292	(20.24)	129	(36.75)	132	(22.18)	21	(20.59)		52	(40.63)	452	(30.75)	1078	26.36	28.52	29.69
Very Bad	88	(6.10)	5	(1.42)	53	(8.91)	6	(5.88)		5	(3.91)	91	(6.19)	248	6.07	5.40	4.24
Very Good	6	(0.42)	29	(8.26)	26	(4.37)	1	(0.98)		2	(1.56)	85	(5.78)	149	3.64	3.56	3.49
TOTAL	1443	(100.00)	351	(100.00)	595	(100.00)	102	(100.00)		128	(100.00)	1470	(100.00)	4089	100.00	100.00	100.00

VIOLENCES

Variables	BE		DE		EL		ES		FR		NL		TOTAL CAP		WAP	MVWAP
Have you lived in a country at war? MV =	1909	(97.70)	27	(36.00)	897	(75.06)	17	(28.33)	2560	(98.46)	41	(28.67)	5451	79.57		
No	21	(46.67)	26	(54.17)	183	(61.41)	32	(74.42)	21	(52.50)	78	(76.47)	361	62.67	60.94	77.00
Yes	24	(53.33)	22	(45.83)	115	(38.59)	11	(25.58)	19	(47.50)	24	(23.53)	215	37.33	39.06	23.00
TOTAL	45	(100.00)	48	(100.00)	298	(100.00)	43	(100.00)	40	(100.00)	102	(100.00)	576	100.00	100.00	100.00
Have you been physically threatened or imprisoned for your ideas or have been tortured? MV =	1915	(98.00)	34	(45.33)	896	(74.98)	19	(31.67)	2566	(98.69)	42	(29.37)	5472	79.87		
No	19	(48.72)	37	(90.24)	241	(80.60)	34	(82.93)	21	(61.76)	88	(87.13)	440	79.28	75.23	97.74
Yes	20	(51.28)	4	(9.76)	58	(19.40)	7	(17.07)	13	(38.24)	13	(12.87)	115	20.72	24.77	2.26
TOTAL	39	(100.00)	41	(100.00)	299	(100.00)	41	(100.00)	34	(100.00)	101	(100.00)	555	100.00	100.00	100.00
Have you ever been the victim of violence by police or army forces? MV =	1920	(98.26)	35	(46.67)	897	(75.06)	19	(31.67)	2562	(98.54)	43	(30.07)	5476	79.93		
No	20	(58.2)	36	(90.00)	240	(80.54)	35	(85.37)	20	(52.63)	85	(85.00)	436	79.13	75.39	76.21
Yes	14	(41.18)	4	(10.00)	58	(19.46)	6	(14.63)	18	(47.37)	15	(15.00)	115	20.87	24.61	23.79
TOTAL	34	(100.00)	40	(100.00)	298	(100.00)	41	(100.00)	38	(100.00)	100	(100.00)	551	100.00	100.00	100.00
Have you ever been beaten up or injured as a result of domestic violence or by other people? MV =	1916	(98.06)	35	(46.67)	899	(75.23)	19	(31.67)	2581	(99.27)	45	(31.47)	5495	80.21		
No	17	(44.74)	30	(75.00)	269	90.88	33	(80.49)	0	(0.00)	80	(81.63)	429	62.67	62.12	101.24
Yes	21	(55.26)	10	(25.00)	27	9.12	8	(19.51)	19	(100.00)	18	(18.37)	103	37.33	37.88	-
TOTAL	38	(100.00)	40	(100.00)	296	(100.00)	41	(100.00)	19	(100.00)	98	(100.00)	532	100.00	100.00	100.00
Have you ever been sexually assaulted or molested? MV =	1923	(98.41)	34	(45.33)	904	(75.65)	19		2576	(99.08)	45	(31.47)	5501	80.29		
No	19	(61.29)	35	(85.37)	288	(98.97)	33	(80.49)	18	(75.00)	91	(92.86)	484	92.02	82.33	93.60
Yes	12	(38.71)	6	(14.63)	3	(1.03)	8	(19.51)	6	(25.00)	7	(7.14)	42	7.98	17.67	6.40
TOTAL	31	(100.00)	41	(100.00)	291	(100.00)	41	(100.00)	24	(100.00)	98	(100.00)	526	100.00	100.00	100.00
Have you ever been raped? MV =	1922	(98.36)	36	(48.00)	905	(75.73)	19	(31.67)	2600	(100.00)	44	(30.77)	5526	80.66		
No	19	(59.38)	37	(94.87)	290	(100.00)	34	(82.93)	0	(0.00)	94	(94.95)	474	94.61	72.02	113.81
Yes	13	(40.63)	2	(5.13)	0	(0.00)	7	(17.07)	0	(0.00)	5	(5.05)	27	5.39	11.31	5.43
TOTAL	32	(100.00)	39	(100.00)	290	(100.00)	41	(100.00)	0	(100.00)	99	(100.00)	501	100.00	83.33	119.25

Variables	BE		DE		EL		ES		FR		NL		TOTAL CAP		WAP	MVWAP
Have you been a victim of psychological violence? MV =	1918	(98.16)	32	(42.67)	898	(75.15)	19	(31.67)	2600	(100.00)	46	(32.17)	5513	80.47		
No	15	(41.67)	31	(72.09)	247	(83.16)	30	(73.17)	0	(0.00)	76	(78.35)	399	77.63	58.07	96.11
Yes	21	(58.33)	12	(27.91)	50	(16.84)	11	(26.83)	0	(0.00)	21	(21.65)	115	22.37	25.26	23.92
TOTAL	36	(100.00)	43	(100.00)	297	(100.00)	41	(100.00)	0	(100.00)	97	(100.00)	514	100.00	83.33	120.03
Have you ever been confiscated earned money or identity? MV =	1930	(98.77)	36	(48.00)	902	(75.48)	19	(31.67)	2600	(100.00)	45	(31.47)	5532	80.75		
No	20	(83.33)	38	(97.44)	177	(94.54)	34	(82.93)	0	(0.00)	86	(87.76)	355	89.87	73.86	106.33
Yes	4	(16.67)	1	(2.56)	16	(5.46)	7	(17.07)	0	(0.00)	12	(12.24)	40	10.13	9.47	12.77
TOTAL	24	(100.00)	39	(100.00)	193	(100.00)	41	(100.00)	0	(100.00)	98	(100.00)	395	100.00	83.33	119.10
Have you ever suffered from hunger? MV =	1929	(98.72)	36	(48.00)	898	(75.15)	18	(30.00)	2572	(98.92)	44	(30.77)	5497	80.24		
No	21	(84.00)	33	(84.62)	183	(61.62)	33	(78.57)	20	(71.43)	66	(66.67)	356	67.17	74.48	74.09
Yes	4	(16.00)	6	(15.38)	114	(38.38)	9	(21.43)	8	(28.57)	33	(33.33)	174	32.83	25.52	25.91
TOTAL	25	(100.00)	39	(100.00)	297	(100.00)	42	(100.00)	28	(100.00)	99	(100.00)	530	100.00	100.00	100.00
Have you ever suffered from any other type of exposure to violence that has not been mentioned in the questions above? MV =	1926	(98.57)	30	(40.00)	910	(76.15)	18	(30.00)	2600	(100.00)	48	(33.57)	5532	80.75		
No	16	(57.14)	32	(71.11)	264	(92.63)	35	(83.33)	0	(0.00)	89	(93.68)	436	88.08	66.32	104.88
Yes	12	(42.86)	13	(28.89)	21	(7.37)	7	(16.67)	0	(0.00)	6	(6.32)	59	11.92	17.02	15.07
TOTAL	28	(100.00)	45	(100.00)	285	(100.00)	42	(100.00)	0	(100.00)	95	(100.00)	495	100.00	83.33	119.95
Violence since arrival																
No + MV	1948	(99.69)	60	(80.00)	1117	(93.47)	59	(98.33)	2600	(100.00)	110	(76.92)	5894	97.79	91.40	86.06
Yes	6	(0.31)	15	(20.00)	78	(6.53)	1	(1.67)	0	(0.00)	33	(23.08)	133	2.21	8.60	13.94
TOTAL	1954	(100.00)	75	(100.00)	1195	(100.00)	60	(100.00)	2600	(100.00)	143	(100.00)	6027	100.00	100.00	100.00

HISTORY OF VACCINATIONS

Children of 5 and less years old (Spain has 0 children of this age)

Variables	DE		EL		FR		NL		TOTAL CAP		WAP	MVWAP
Tetanus MV =	9	(25.71)	137	(93.20)	70	(69.31)	1	(33.33)	217	75.87		
Doesn't know	5	(19.23)	0	(0.00)	2	(6.45)	0	(0.00)	7	10.14	6.42	11.23
No	4	(15.38)	1	(10.00)	0	(0.00)	1	(50.00)	6	8.70	18.85	30.66
Probable	1	(3.85)	0	(0.00)	10	(32.26)	0	(0.00)	11	15.94	9.03	5.68
Yes	16	(61.54)	9	(90.00)	19	(61.29)	1	(50.00)	45	65.22	65.71	52.43
TOTAL	26	(100.00)	10	(100.00)	31	(100.00)	2	(100.00)	69	100.00	100.00	100.00
Tetanus : Done the day of the consultation MV =	25	(71.43)	144	(97.96)	101	(100.00)	3	(100.00)	273	95.45		
Yes	10	(100.00)	3	(100.00)	0	(0.00)	0	(0.00)	13	100.00		
TOTAL	10	(100.00)	3	(100.00)	0	(0.00)	0	(0.00)	13	100.00		
Hepatitis B MV =	9	(25.71)	136	(92.52)	71	(70.30)	1	(33.33)	217	75.87		
Doesn't know	5	(19.23)	0	(0.00)	3	(10.00)	0	(0.00)	8	11.59	7.31	11.55
No	4	(15.38)	2	(18.18)	1	(3.33)	1	(50.00)	8	11.59	21.72	30.14
Probable	1	(3.85)	0	(0.00)	9	(30.00)	0	(0.00)	10	14.49	8.46	5.16
Yes	16	(61.54)	9	(81.82)	17	(56.67)	1	(50.00)	43	62.32	62.51	53.16
TOTAL	26	(100.00)	11	(100.00)	30	(100.00)	2	(100.00)	69	100.00	100.00	100.00
Hepatitis B : Done the day of the consultation MV =	25	(71.43)	146	(99.32)	101	(100.00)	3	(100.00)	275	96.15		
Yes	10	(100.00)	1	(100.00)	0	(0.00)	0	(0.00)	11	100.00		
TOTAL	10	(100.00)	1	(100.00)	0	(0.00)	0	(0.00)	11	100.00		
MMR MV =	11	(31.43)	136	(92.52)	70	(69.31)	1	(33.33)	218	76.22		
Doesn't know	5	(20.83)	0	(0.00)	3	(9.68)	0	(0.00)	8	2.80	7.63	11.66
No	4	(16.67)	3	(27.27)	1	(3.23)	1	(50.00)	9	13.24	24.29	29.96
Probable	1	(4.17)	0	(0.00)	8	(25.81)	0	(0.00)	9	13.24	7.49	5.28
Yes	14	(58.33)	8	(72.73)	19	(61.29)	1	(50.00)	42	61.76	60.59	53.11
TOTAL	24	(100.00)	11	(100.00)	31	(100.00)	2	(100.00)	68	100.00	100.00	100.00
MMR : Done the day of the consultation MV =	29	(82.86)	147	(100.00)	101	(100.00)	3	(100.00)	280	97.90		
Yes	6	(100.00)	0	(0.00)	0	(0.00)	0	(0.00)	6	100.00		
TOTAL	6	(100.00)	0	(0.00)	0	(0.00)	0	(0.00)	6	100.00		

HISTORY OF VACCINATIONS

Children of 10 and less years old (Spain has 0 children of this age)

Variables	DE		EL		FR		NL		TOTAL CAP		WAP	MVWAP
Tetanus MV =	15	(31.25)	188	(92.61)	98	(69.01)	1	(25.00)	302	76.07		
Doesn't know	8	(24.24)	1	(6.67)	5	(11.36)	0	(0.00)	14	14.74	10.57	12.00
No	4	(12.12)	2	(13.33)	0	(0.00)	1	(33.33)	7	7.37	14.70	22.25
Probable	1	(3.03)	1	(6.67)	14	(31.82)	0	(0.00)	16	16.84	10.38	3.91
Yes	20	(60.61)	11	(73.33)	25	(56.82)	2	(66.67)	58	61.05	64.36	61.84
TOTAL	33	(100.00)	15	(100.00)	44	(100.00)	3	(100.00)	95	100.00	100.00	100.00
Tetanus : Done the day of the consultation MV =	38	(79.17)	200	(98.52)	142	(100.00)	4	(100.00)	384	96.73		
Yes	10	(100.00)	3	(100.00)	0	(0.00)	0	(0.00)	13	100.00		
TOTAL	10	(100.00)	3	(100.00)	0	(0.00)	0	(0.00)	13	100.00		
Hepatitis B MV =	15	(31.25)	187	(92.12)	100	(70.42)	1	(25.00)	303	76.32		
Doesn't know	8	(24.24)	1	(6.25)	7	(16.67)	0	(0.00)	16	17.02	11.79	12.51
No	4	(12.12)	3	(18.75)	1	(2.38)	1	(33.33)	9	9.57	16.65	22.00
Probable	2	(6.06)	0	(0.00)	12	(28.57)	0	(0.00)	14	14.89	8.66	5.59
Yes	19	(57.58)	12	(75.00)	22	(52.38)	2	(66.67)	55	58.51	62.91	59.90
TOTAL	33	(100.00)	16	(100.00)	42	(100.00)	3	(100.00)	94	100.00	100.00	100.00
Hepatitis B : Done the day of the consultation MV =	38	(79.17)	202	(99.51)	142	(100.00)	4	(100.00)	386	97.23		
Yes	10	(100.00)	1	(100.00)	0	(0.00)	0	(0.00)	11	100.00		
TOTAL	10	(100.00)	1	(100.00)	0	(0.00)	0	(0.00)	11	100.00		
MMR MV =	17	(35.42)	187	(92.12)	98	(69.01)	1	(25.00)	303	76.32		
Doesn't know	8	(25.81)	1	(6.25)	6	(13.64)	0	(0.00)	15	5.24	11.42	13.80
No	4	(12.90)	3	(18.75)	1	(2.27)	1	(33.33)	9	9.57	16.81	21.95
Probable	1	(3.23)	0	(0.00)	12	(27.27)	0	(0.00)	13	13.83	7.62	4.13
Yes	18	(58.06)	12	(75.00)	25	(56.82)	2	(66.67)	57	60.64	64.14	60.12
TOTAL	31	(100.00)	16	(100.00)	44	(100.00)	3	(100.00)	94	100.00	100.00	100.00
MMR : Done the day of the consultation MV =	41	(85.42)	203	(100.00)	142	(100.00)	4	(100.00)	390	98.24		
Yes	7	(100.00)	0	(0.00)	0	(0.00)	0	(0.00)	7	100.00		
TOTAL	7	(100.00)	0	(0.00)	0	(0.00)	0	(0.00)	7	100.00		

HISTORY OF VACCINATIONS

Adults (18 years old and more)

Variables	DE		EL		ES		FR		NL		TOTAL CAP		WAP	MVWAP
Tetanus MV =	76	(21.23)	641	(53.15)	10	(9.80)	1882	(79.81)	47	(27.81)	2656	63.34		40.38
Doesn't know	83	(29.43)	107	(18.94)	49	(53.26)	159	(33.40)	39	(31.97)	437	28.43	33.40	12.43
No	36	(12.77)	63	(11.15)	8	(8.70)	86	(18.07)	27	(22.13)	220	14.31	14.56	7.91
Probable	61	(21.63)	63	(11.15)	7	(7.61)	142	(29.83)	8	(6.56)	281	18.28	15.36	39.28
Yes	102	(36.17)	332	(58.76)	28	(30.41)	89	(18.70)	48	(39.34)	599	38.97	36.68	100.00
TOTAL	282	(100.00)	565	(100.00)	92	(100.00)	476	(100.00)	122	(100.00)	1537	100.00	100.00	
Tetanus : Done the day of the consultation MV =	357	(99.72)	1206	(100.00)	102	(100.00)	2358	(100.00)	169	(100.00)	4192	99.98		
Yes	1	(100.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	1	100.00		
TOTAL	1	(100.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	1	100.00		
Hepatitis B MV =	80	(22.35)	642	(53.23)	15	(14.71)	1915	(81.21)	49	(28.99)	2701	64.42		42.51
Doesn't know	88	(31.65)	117	(20.74)	49	(56.32)	197	(44.47)	50	(41.67)	501	33.58	38.97	20.31
No	43	(15.47)	76	(13.48)	17	(19.54)	114	(25.73)	39	(32.50)	289	19.37	21.34	8.13
Probable	59	(21.22)	63	(11.15)	4	(4.60)	90	(20.32)	6	(5.00)	222	14.88	12.46	29.05
Yes	88	(31.65)	308	(54.61)	17	(19.54)	42	(9.48)	25	(20.83)	480	32.17	27.22	100.00
TOTAL	278	(100.00)	564	(100.00)	87	(100.00)	443	(100.00)	120	(100.00)	1492	100.00	100.00	
Hepatitis B : Done the day of the consultation MV =	358	(100.00)	1206	(100.00)	102	(100.00)	2358	(100.00)	169	(100.00)	4193	100.00		
Yes	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	0.00		
TOTAL	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	0.00		
MMR MV =	77	(35.42)	642	(53.23)	12	(11.76)	1915	(81.21)	51	(30.18)	2697	64.32		41.48
Doesn't know	90	(21.51)	115	(20.39)	47	(52.22)	194	(43.79)	47	(39.83)	493	32.95	37.65	11.36
No	35	(12.46)	68	(12.06)	5	(5.56)	96	(21.67)	30	(25.42)	234	15.64	15.43	11.59
Probable	62	(22.06)	64	(11.35)	13	(14.44)	102	(23.02)	6	(5.08)	247	16.51	15.19	35.57
Yes	94	(33.45)	317	(56.21)	25	(27.78)	51	(11.51)	35	(29.66)	522	34.89	31.72	100.00
TOTAL	281	(100.00)	564	(100.00)	90	(100.00)	443	(100.00)	118	(100.00)	1496	100.00	100.00	
MMR : Done the day of the consultation MV =	358	(100.00)	1206	(100.00)	102	(100.00)	2358	(100.00)	169	(100.00)	4193	100.00		
Yes	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	0.00		
TOTAL	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	0.00		40.38

HEALTH PROBLEM BY CONSULTATION

Health problems	BE			DE			EL			ES			FR			NL			UK			TOTAL		
	n	%[1]	%[2]	n	%[1]	%[2]	n	%[1]	%[2]	n	%[1]	%[2]	n	%[1]	%[2]	n	%[1]	%[2]	n	%[1]	%[2]	n	%[1]	%[2]
A General and Unspecified	264	5.87	5.96	72	7.26	4.79	36	2.07	4.34	1	0.96	1.39	108	2.01	3.72	17	9.60	8.54	57	2.88	4.81	555	3.74	4.99
B Blood, Blood Forming Organs and Immune Mechanism	42	0.93	0.95	35	3.53	2.33	3	0.17	0.36	3	2.88	4.17	16	0.30	0.55	1	0.56	0.50	10	0.51	0.84	110	0.74	0.99
D Digestive	700	15.55	15.79	164	16.53	10.90	92	5.30	11.08	9	8.65	12.50	382	7.11	13.16	26	14.69	13.07	167	8.45	14.10	1540	10.37	13.85
F Eye	130	2.89	2.93	48	4.84	3.19	12	0.69	1.45	1	0.96	1.39	181	3.37	6.24	18	10.17	9.05	17	0.86	1.44	407	2.74	3.66
H Ear	76	1.69	1.71	31	3.13	2.06	13	0.75	1.57	0	0.00	0.00	63	1.17	2.17	3	1.69	1.51	17	0.86	1.44	203	1.37	1.83
K Cardiovascular	471	10.46	10.63	218	21.98	14.49	184	10.61	22.17	8	7.69	11.11	242	4.51	8.34	17	9.60	8.54	105	5.31	8.87	1245	8.38	11.19
L Musculoskeletal	570	12.66	12.86	154	15.52	10.24	79	4.55	9.52	12	11.54	16.67	425	7.91	14.65	31	17.51	15.58	175	8.85	14.78	1446	9.73	13.00
N Neurological	208	4.62	4.69	57	5.75	3.79	37	2.13	4.46	3	2.88	4.17	82	1.53	2.83	13	7.34	6.53	48	2.43	4.05	448	3.02	4.03
P Psychological	334	7.42	7.54	90	9.07	5.98	54	3.11	6.51	7	6.73	9.72	188	3.50	6.48	15	8.47	7.54	113	5.72	9.54	801	5.39	7.20
R Respiratory	550	12.22	12.41	70	7.06	4.65	107	6.17	12.89	5	4.81	6.94	533	9.92	18.37	7	3.95	3.52	107	5.41	9.04	1379	9.28	12.40
S Skin	371	8.24	8.37	99	9.98	6.58	54	3.11	6.51	4	3.85	5.56	302	5.62	10.41	10	5.65	5.03	100	5.06	8.45	940	6.33	8.45
T Endocrine/Metabolic and Nutritional	287	6.38	6.48	148	14.92	9.84	121	6.97	14.58	13	12.50	18.06	142	2.64	4.89	11	6.21	5.53	67	3.39	5.66	789	5.31	7.09
U Urological	101	2.24	2.28	34	3.43	2.26	11	0.63	1.33	1	0.96	1.39	51	0.95	1.76	5	2.82	2.51	39	1.97	3.29	242	1.63	2.18
W Pregnancy, Childbearing, Family Planning	91	2.02	2.05	193	19.46	12.83	9	0.52	1.08	0	0.00	0.00	63	1.17	2.17	12	6.78	6.03	77	3.89	6.50	445	3.00	4.00
X Female Genital	152	3.38	3.43	23	2.32	1.53	11	0.63	1.33	3	2.88	4.17	95	1.77	3.27	8	4.52	4.02	52	2.63	4.39	344	2.32	3.09
Y Male Genital	72	1.60	1.62	15	1.51	1.00	5	0.29	0.60	2	1.92	2.78	29	0.54	1.00	2	1.13	1.01	17	0.86	1.44	142	0.96	1.28
Z Social Problems	13	0.29	0.29	53	5.34	3.52	2	0.12	0.24	0	0.00	0.00	0	0.00	0.00	3	1.69	1.51	16	0.81	1.35	87	0.59	0.78
TOTAL	4432		100.00	1504		100.00	830		100.00	72		100.00	2902		100.00	199		100.00	1184		100.00	11123		100.00
TOTAL consultations	4501	98.47		992	151.61		1735	47.84		104	69.23		5371	54.03		177	112.43		1977	59.89		14857	74.87	

%[1] : among all the consultations, XX% concerned the problem A (total > 100% since many problems are possible for a single consultation)
%[2] : among all the different diagnoses cited during all the consultations, XX% concerned the problem A (total=100%, it is the simple frequency of all the problems cited, all consultations together)

HEALTH PROBLEMS BY PATIENT

Health problems	BE			DE			EL			ES			FR			NL			UK			TOTAL		
	n	%[3]	%[4]	n	%[3]	%[4]	n	%[3]	%[4]	n	%[3]	%[4]	n	%[3]	%[4]	n	%[3]	%[4]	n	%[3]	%[4]	n	%[3]	%[4]
A General and Unspecified	208	10.26	2.53	47	10.71	0.57	34	2.26	0.41	1	0.97	0.01	105	4.04	1.28	17	9.60	0.21	49	3.14	0.60	461	5.48	5.60
B Blood, Blood Forming Organs and Immune Mechanism	34	1.68	0.41	16	3.64	0.19	3	0.20	0.04	3	2.91	0.04	13	0.50	0.16	1	0.56	0.01	10	0.64	0.12	80	0.95	0.97
D Digestive	523	25.80	6.36	126	28.70	1.53	89	5.91	1.08	9	8.74	0.11	317	12.19	3.85	26	14.69	0.32	137	8.78	1.66	1227	14.59	14.91
F Eye	108	5.33	1.31	36	8.20	0.44	11	0.73	0.13	1	0.97	0.01	160	6.15	1.94	18	10.17	0.22	17	1.09	0.21	351	4.17	4.27
H Ear	62	3.06	0.75	14	3.19	0.17	13	0.86	0.16	0	0.00	0.00	56	2.15	0.68	3	1.69	0.04	16	1.02	0.19	164	1.95	1.99
K Cardiovascular	214	10.56	2.60	70	15.95	0.85	170	11.30	2.07	8	7.77	0.10	179	6.88	2.18	17	9.60	0.21	85	5.45	1.03	743	8.83	9.03
L Musculoskeletal	417	20.57	5.07	92	20.96	1.12	77	5.12	0.94	12	11.65	0.15	328	12.62	3.99	31	17.51	0.38	151	9.67	1.83	1108	13.17	13.46
N Neurological	144	7.10	1.75	40	9.11	0.49	37	2.46	0.45	3	2.91	0.04	72	2.77	0.87	13	7.34	0.16	41	2.63	0.50	350	4.16	4.25
P Psychological	213	10.51	2.59	44	10.02	0.53	52	3.46	0.63	7	6.80	0.09	147	5.65	1.79	15	8.47	0.18	90	5.77	1.09	568	6.75	6.90
R Respiratory	364	17.96	4.42	57	12.98	0.69	105	6.98	1.28	5	4.85	0.06	388	14.92	4.72	7	3.95	0.09	93	5.96	1.13	1019	12.11	12.38
S Skin	284	14.01	3.45	55	12.53	0.67	53	3.52	0.64	4	3.88	0.05	250	9.62	3.04	10	5.65	0.12	85	5.45	1.03	741	8.81	9.00
T Endocrine/Metabolic and Nutritional	129	6.36	1.57	54	12.30	0.66	112	7.44	1.36	13	12.62	0.16	107	4.12	1.30	11	6.21	0.13	53	3.40	0.64	479	5.69	5.82
U Urological	83	4.09	1.01	24	5.47	0.29	11	0.73	0.13	1	0.97	0.01	45	1.73	0.55	5	2.82	0.06	35	2.24	0.43	204	2.43	2.48
W Pregnancy, Childbearing, Family Planning	75	3.70	0.91	72	16.40	0.87	9	0.60	0.11	0	0.00	0.00	54	2.08	0.66	12	6.78	0.15	68	4.36	0.83	290	3.45	3.52
X Female Genital	108	5.33	1.31	19	4.33	0.23	11	0.73	0.13	3	2.91	0.04	61	2.35	0.74	8	4.52	0.10	45	2.88	0.55	255	3.03	3.10
Y Male Genital	53	2.61	0.64	10	2.28	0.12	5	0.33	0.06	2	1.94	0.02	25	0.96	0.30	2	1.13	0.02	15	0.96	0.18	112	1.33	1.36
Z Social Problems	11	0.54	0.13	47	10.71	0.57	2	0.13	0.02	0	0.00	0.00	0	0.00	0.00	3	1.69	0.04	14	0.90	0.17	77	0.92	0.94
TOTAL	3030		36.82	823		10.00	794		9.65	72		0.87	2307		28.03	199		2.42	1004		12.20	8229		100.00
TOTAL patients	2027	149.48		439	187.47		1505	52.76		103	69.90		2600	88.73		177	112.43		1561	64.32		8412	97.82	

%[3] : among all the patients, one or the other of their consultations have concerned the problem A (total> 100% since an individual may have had 2 different problems, but a given problem is only counted once, whatever the number of consultations for this problem).
%[4] : among all the different diagnoses cited at least once for a given patient, all his/her consultations considered, the frequency of problem A is… (total=100%)

CHRONIC DISEASES AND NECESSARY TREATMENTS IN THE WHOLE POPULATION

Variables	BE		DE		EL		ES		FR		NL		UK		TOTAL CAP	
At least one chronic																
No + MV	792	39.07	269	61.28	1199	79.67	62	60.19	2129	81.88	94	53.11	1203	77.07	5748	68.33
Yes	1235	60.93	170	38.72	306	20.33	41	39.81	471	18.12	83	46.89	358	22.93	2664	31.67
TOTAL	2027	100.00	439	100.00	1505	100.00	103	100.00	2600	100.00	177	100.00	1561	100.00	8412	100.00
At least one acute																
No + MV	1130	55.75	224	51.03	1238	82.26	87	84.47	2094	80.54	143	80.79	1303	83.47	6219	73.93
Yes	897	44.25	215	48.97	267	17.74	16	15.53	506	19.46	34	19.21	258	16.53	2193	26.07
TOTAL	2027	100.00	439	100.00	1505	100.00	103	100.00	2600	100.00	177	100.00	1561	100.00	8412	100.00
At least one Precautionary																
No + MV	1534	75.68	346	78.82	1322	87.84	87	84.47	2413	92.81	151	85.31	1356	86.87	7209	85.70
Yes	493	24.32	93	21.18	183	12.16	16	15.53	187	7.19	26	14.69	205	13.13	1203	14.30
TOTAL	2027	100.00	439	100.00	1505	100.00	103	100.00	2600	100.00	177	100.00	1561	100.00	8412	100.00
At least one Necessary																
No + MV	528	26.05	208	47.38	1099	73.02	52	50.49	1942	74.69	76	42.94	1281	82.06	5186	61.65
Yes	1499	73.95	231	52.62	406	26.98	51	49.51	658	25.31	101	57.06	280	17.94	3226	38.35
TOTAL	2027	100.00	439	100.00	1505	100.00	103	100.00	2600	100.00	177	100.00	1561	100.00	8412	100.00
At least one Precautionary and one Necessary																
No + MV	1848	91.17	408	92.94	1474	97.94	96	93.20	2556	98.31	165	93.22	1491	95.52	8038	95.55
Yes	179	8.83	31	7.06	31	2.06	7	6.80	44	1.69	12	6.78	70	4.48	374	4.45
TOTAL	2027	100.00	439	100.00	1505	100.00	103	100.00	2600	100.00	177	100.00	1561	100.00	8412	100.00

CHRONIC DISEASES AND NECESSARY TREATMENTS

AMONG THE POPULATION HAVING CONSULTED A PHYSICIAN

(AT LEAST ONCE: DIAGNOSIS CODE OR "NO HEALTH PROBLEM" FULFILLED)

Variables	BE		DE		EL		ES		FR		NL		UK		TOTAL CAP	
At least one chronic																
No + MV	537	30.30	261	60.56	331	51.96	33	44.59	993	67.83	64	43.54	278	43.71	2497	48.38
Yes	1235	69.70	170	39.44	306	48.04	41	55.41	471	32.17	83	56.46	358	56.29	2664	51.62
TOTAL	1772	100.00	431	100.00	637	100.00	74	100.00	1464	100.00	147	100.00	636	100.00	5161	100.00
At least one acute																
No + MV	537	30.30	216	50.12	370	58.08	58	78.38	958	65.44	113	76.87	378	59.43	2968	57.51
Yes	1235	69.70	215	49.88	267	41.92	16	21.62	506	34.56	34	23.13	258	40.57	2193	42.49
TOTAL	1772	100.00	431	100.00	637	100.00	74	100.00	1464	100.00	147	100.00	636	100.00	5161	100.00
At least one Precautionary																
No + MV	537	30.30	338	78.42	454	71.27	58	78.38	1277	87.23	121	82.31	431	67.77	3958	76.69
Yes	1235	69.70	93	21.58	183	28.73	16	21.62	187	12.77	26	17.69	205	32.23	1203	23.31
TOTAL	1772	100.00	431	100.00	637	100.00	74	100.00	1464	100.00	147	100.00	636	100.00	5161	100.00
At least one Necessary																
No + MV	537	30.30	200	46.40	231	36.26	23	31.08	806	55.05	46	31.29	356	55.97	1935	37.49
Yes	1235	69.70	231	53.60	406	63.74	51	68.92	658	44.95	101	68.71	280	44.03	3226	62.51
TOTAL	1772	100.00	431	100.00	637	100.00	74	100.00	1464	100.00	147	100.00	636	100.00	5161	100.00
At least one Precautionary and one Necessary																
No + MV	537	30.30	400	92.81	606	95.13	67	90.54	1420	96.99	135	91.84	566	88.99	4787	92.75
Yes	1235	69.70	31	7.19	31	4.87	7	9.46	44	3.01	12	8.16	70	11.01	374	7.25
TOTAL	1772	100.00	431	100.00	637	100.00	74	100.00	1464	100.00	147	100.00	636	100.00	5161	100.00

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Abdominal distension	3	0.03
Abdominal hernia other	9	0.08
Abdominal mass NOS	4	0.03
Abdominal pain epigastric	213	1.79
Abdominal pain localized other	36	0.30
Abdominal pain/cramps general	128	1.07
Abnormal cervix smear	3	0.03
Abnormal involuntary movements	4	0.03
Abnormal result investigation NOS	1	0.01
Abnormal urine test NOS	1	0.01
Abortion induced	4	0.03
Abortion spontaneous	3	0.03
Abrasion/scratch/blister	6	0.05
Acne	37	0.31
Acoustic trauma	1	0.01
Acquired deformity of limb	9	0.08
Acquired deformity of spine	12	0.10
Acute alcohol abuse	1	0.01
Acute bronchitis/bronchiolitis	140	1.17
Acute internal damage knee	5	0.04
Acute myocardial infarction	14	0.12
Acute otitis media/myringitis	31	0.26
Acute stress reaction	28	0.23
Administrative Procedure	77	0.65
Adolescent behav. Symptom/complt.	1	0.01
Adverse effect medical agent	2	0.02
Adverse effect physical factor	1	0.01
Affective psychosis	16	0.13
Allergic rhinitis	77	0.65
Allergy/allergic reaction NOS	9	0.08
Anaemia other/unspecified	11	0.09
Anaemia. Vitamin B 12/folate def.	13	0.11
Anal fissure/perianal abscess	7	0.06
Ankle symptom/complaint	36	0.30
Anorexia nervosa/bulimia	1	0.01
Antepartum bleeding	3	0.03
Anxiety disorder/anxiety state	72	0.60
Appendicitis	5	0.04
Arm symptom/complaint	12	0.10
Assault/harmful event problem	6	0.05
Asthma	140	1.17
Atherosclerosis/PVD	6	0.05
Atrial fibrillation/flutter	15	0.13
Back symptom/complaint	98	0.82
Back syndrome w/o radiating pain	129	1.08
Back syndrome with radiating pain	113	0.95
Balanitis	3	0.03
Bedwetting/enuresis	1	0.01

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Behaviour problem parent/family	2	0.02
Benign neoplasm breast female	8	0.07
Benign neoplasm female genital	5	0.04
Benign neoplasm nervous system	1	0.01
Benign neoplasm respiratory	2	0.02
Benign neoplasm thyroid	1	0.01
Benign neoplasm urinary tract	2	0.02
Benign prostatic hypertrophy	11	0.09
Benign/unspec. neoplasm gen. (m)	2	0.02
Benign/unspec. neoplasm/pregnancy	3	0.03
Benign/unspecified neoplasm blood	2	0.02
Bladder symptom/complaint other	2	0.02
Bleeding ear	1	0.01
Bleeding/haemorrhage NOS	1	0.01
Blepharitis/stye/chalazion	15	0.13
Blindness	2	0.02
Blood Test	7	0.06
Blood/lymph/spleen disease other	4	0.03
Boil/abscess nose	1	0.01
Boil/carbuncle	38	0.32
Breast lump/mass female	26	0.22
Breast pain female	14	0.12
Breast symptom/compit. female other	5	0.04
Breast symptom/complaint male	3	0.03
Breast/lactation symptom/complaint	2	0.02
Breathing problem, other	10	0.08
Bum/scald	7	0.06
Bursitis/tendinitis/synovitis NOS	19	0.16
Cardiac arrhythmia NOS	16	0.13
Cardiovascular	2	0.02
Cardiovascular disease other	44	0.37
Cardiovascular pain NOS	5	0.04
Cardiovascular sympt./complt. other	19	0.16
Carpal tunnel syndrome	2	0.02
Cataract	22	0.18
Cerebrovascular disease	1	0.01
Cervical disease NOS	2	0.02
Change faeces/bowel movements	5	0.04
Chest pain NOS	17	0.14
Chest symptom/complaint	50	0.42
Chickenpox	8	0.07
Child behaviour symptom/complaint	4	0.03
Chills	8	0.07
Cholecystitis/cholelithiasis	5	0.04
Chronic alcohol abuse	28	0.23
Chronic bronchitis	36	0.30
Chronic enteritis/ulcerative colitis	11	0.09
Chronic obstructive pulmonary dis	32	0.27

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Chronic otitis media	2	0.02
Chronic ulcer skin	4	0.03
Clarification/Discuss Patient's RFE	1	0.01
Cluster headache	1	0.01
Com/callosity	10	0.08
Complicate labour/ delivery livebirth	1	0.01
Complicate labour/delivery stillbirth	1	0.01
Concern about appearance	1	0.01
Concern breast appearance female	1	0.01
Concussion	1	0.01
Condylomata acuminata female	1	0.01
Condylomata acuminata male	2	0.02
Congen-anom. blood/lymph other	1	0.01
Congenital anom endocrine/metab.	1	0.01
Congenital anomaly cardiovascular	10	0.08
Congenital anomaly eye other	1	0.01
Congenital anomaly genital female	1	0.01
Congenital anomaly musculoskeletal	5	0.04
Congenital anomaly of ear	1	0.01
Congenital anomaly respiratory	1	0.01
Congenital anomaly urinary tract	1	0.01
Congenital geni anomaly (m) other	1	0.01
Conjunctivitis allergic	30	0.25
Conjunctivitis infectious	29	0.24
Constipation	91	0.76
Consult with Primary Care Provider	1	0.01
Consultation with Specialist	1	0.01
Contraception intrauterine	4	0.03
Contraception oral	15	0.13
Contraception other	4	0.03
Contraception postcoital	1	0.01
Contusion/haemorrhage eye	1	0.01
Convulsion/seizure	6	0.05
Cough	160	1.34
Cystitis/urinary infection other	71	0.60
Deafness	10	0.08
Dementia	1	0.01
Depressive disorder	148	1.24
Dermatitis contact/allergic	24	0.20
Dermatitis seborrhoeic	6	0.05
Dermatitis/atopic eczema	79	0.66
Dermatophytosis	82	0.69
Detached retina	4	0.03
Diabetes insulin dependent	214	1.80
Diabetes non-insulin dependent	348	2.92
Diaper rash	4	0.03
Diarrhoea	40	0.34
Digestive symptom/complaint other	12	0.10

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Disease digestive system, other	29	0.24
Dislocation/subluxation	2	0.02
Disorder pregnancy/delivery, other	5	0.04
Diverticular disease	2	0.02
Dress/Press/Compress/Tamponade	3	0.03
Drug abuse	13	0.11
Duodenal ulcer	19	0.16
Dyspepsia/indigestion	69	0.58
Dysuria/painful urination	36	0.30
Ear discharge	3	0.03
Ear pain/earache	32	0.27
Ear symptom/complaint other	10	0.08
Ear/mastoid disease, other	6	0.05
Ectopic pregnancy	2	0.02
Education problem	1	0.01
Elbow symptom/complaint	15	0.13
Elevated blood pressure	262	2.20
Encounter Initiated third person	1	0.01
Endocrine infection	1	0.01
Endocrine/Metabolic and Nutritional	1	0.01
Endocrine/met./sympt/compit other	2	0.02
Endocrine/metab/nutrit. dis. other	26	0.22
Epilepsy	72	0.60
Excessive ear wax	18	0.15
Excessive thirst	3	0.03
Excise/Remove/Biopsy/Destruction/ Debride	3	0.03
Eye	3	0.03
Eye appearance abnormal	1	0.01
Eye discharge	11	0.09
Eye infection/inflammation other	18	0.15
Eye movements abnormal	1	0.01
Eye pain	21	0.18
Eye sensation abnormal	6	0.05
Eye symptom/complaint other	13	0.11
Eye/adnexa disease, other	25	0.21
Eyelid symptom/complaint	1	0.01
Facial paralysis/bell's palsy	1	0.01
Faeces Test	2	0.02
Fainting/syncope	4	0.03
Family planning male other	1	0.01
Fear blood/lymph disease other	4	0.03
Fear cancer neurological system	1	0.01
Fear complications of pregnancy	1	0.01
Fear endocrine/metabolic dis other	2	0.02
Fear genital/breast disease other (f)	2	0.02
Fear musculoskeletal disease other	2	0.02
Fear of aids/HIV	2	0.02
Fear of breast cancer female	4	0.03

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Fear of cancer NOS	1	0.01
Fear of cancer musculoskeletal	3	0.03
Fear of cancer of digestive system	2	0.02
Fear of digestive disease other	1	0.01
Fear of ear disease	2	0.02
Fear of eye disease	1	0.01
Fear of genital cancer female	2	0.02
Fear of genital cancer male	2	0.02
Fear of heart disease	7	0.06
Fear of hypertension	9	0.08
Fear of mental disorder	2	0.02
Fear of pregnancy	7	0.06
Fear of sexual dysfunction male	1	0.01
Fear sexually transmitted dis. male	10	0.08
Fear sexually transmitted disease (f)	11	0.09
Feeding problem of adult	3	0.03
Feeding problem of infant/child	1	0.01
Feeling anxious/nervous/tense	169	1.42
Feeling depressed	113	0.95
Feeling ill	16	0.13
Feeling/behaving irritable/angry	3	0.03
Female Genital	1	0.01
Fever	32	0.27
Fibromyoma uterus	20	0.17
Flank/axilla symptom/complaint	9	0.08
Flatulence/gas/belching	17	0.14
Follow-up Encounter Unspecified	3	0.03
Foot/toe symptom/complaint	67	0.56
Foreign body digestive system	1	0.01
Foreign body in ear	1	0.01
Foreign body in eye	4	0.03
Foreign body nose/larynx/bronch	2	0.02
Fracture: femur	1	0.01
Fracture: hand/foot bone	9	0.08
Fracture: other	10	0.08
Fracture: radius/ulna	11	0.09
Fracture: tibia/fibula	8	0.07
Gastroenteritis presumed infection	18	0.15
Gastrointestinal infection	24	0.20
General disease NOS	15	0.13
General symptom/complaint other	11	0.09
Genital candidiasis female	20	0.17
Genital disease female, other	16	0.13
Genital disease male, other	7	0.06
Genital herpes female	3	0.03
Genital herpes male	2	0.02
Genital neoplasm oth/unspecied (f)	3	0.03
Genital pain female	10	0.08

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Genital symptom/compit female oth.	5	0.04
Genital trichomoniasis female	2	0.02
Gestational diabetes	2	0.02
Glasses symptom/complaint	24	0.20
Glaucoma	20	0.17
Goitre	26	0.22
Gonorrhoea male	9	0.08
Gout	4	0.03
Growth delay	1	0.01
HIV-infection/aids	26	0.22
Haemangioma/lymphangioma	1	0.01
Haematuria	16	0.13
Haemoptysis	7	0.06
Haemorrhoids	44	0.37
Hair loss/baldness	7	0.06
Hair/scalp symptom/complaint	9	0.08
Hand/finger symptom/complaint	29	0.24
Head injury other	3	0.03
Headache	157	1.32
Health care system problem	20	0.17
Health maintenance/prevention	16	0.13
Hearing complaint	26	0.22
Heart disease other	17	0.14
Heart failure	24	0.20
Heart pain	6	0.05
Heart valve disease NOS	12	0.10
Heart/arterial murmur NOS	10	0.08
Heartburn	92	0.77
Hepatomegaly	4	0.03
Hereditary haemolytic anaemia	3	0.03
Herpes simplex	12	0.10
Herpes zoster	4	0.03
Hiatus hernia	20	0.17
Hip symptom/complaint	22	0.18
Histological/Exfoliative Cytology	2	0.02
Hodgkm's disease/lymphoma	2	0.02
Housing/neighbourhood problem	8	0.07
Hydrocoele	3	0.03
Hypertension complicated	112	0.94
Hypertension uncomplicated	552	4.63
Hyperthyroidism/thyrotoxicosis	22	0.18
Hypertrophy tonsils/adenoids	6	0.05
Hyperventilation syndrome	1	0.01
Hypothyroidism/myxoedema	43	0.36
Illness problem with child	1	0.01
Impetigo	14	0.12
Impotence NOS	8	0.07
Incontinence urine	8	0.07

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Infected finger/toe	24	0.20
Infection complicating pregnancy	2	0.02
Infections musculoskeletal system	3	0.03
Infectious disease other/NOS	3	0.03
Infectious mononucleosis	1	0.01
Infertility/subfertility	5	0.04
Infertility/subfertility male	1	0.01
Influenza	54	0.45
Ingrowing nail	4	0.03
Inguinal hernia	29	0.24
Injury digestive system other	4	0.03
Injury eye other	8	0.07
Injury genital female	1	0.01
Injury musculoskeletal NOS	34	0.29
Injury nervous system other	2	0.02
Injury respiratory other	2	0.02
Insect bite/sting	12	0.10
Intermenstrual bleeding	18	0.15
Intermenstrual pain	2	0.02
Iron deficiency anaemia	28	0.23
Irregular heartbeat other	2	0.02
Irritable bowel syndrome	53	0.44
Ischaemic heart disease w. angina	37	0.31
Ischaemic heart disease w/o angina	34	0.29
Jaundice	1	0.01
Jaw symptom/complaint	5	0.04
Joint symptom/complaint NOS	22	0.18
Kidney symptom/complaint	21	0.18
Knee symptom/complaint	128	1.07
Laceration/cut	22	0.18
Laryngitis/tracheitis acute	31	0.26
Leg/thigh symptom/complaint	57	0.48
Legal problem	8	0.07
Leukaemia	1	0.01
Limited function/disability (1)	2	0.02
Limited function/disability (d)	1	0.01
Limited function/disability (f)	3	0.03
Limited function/disability (k)	1	0.01
Limited function/disability (n)	2	0.02
Limited function/disability urinary	1	0.01
Lipid disorder	24	0.20
Lipoma	17	0.14
Liver disease NOS	8	0.07
Local Injection/Infiltration	1	0.01
Loss of appetite	6	0.05
Loss/death of partner problem	1	0.01
Low back symptom/complaint	174	1.46
Lump/swelling localized	41	0.34

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Lumps/swellings generalized	7	0.06
Lymph gland(s) enlarged/painful	10	0.08
Lymphadenitis acute	2	0.02
Malaria	1	0.01
Malig. neoplasm digest other/NOS	1	0.01
Malignancy NOS	1	0.01
Malignant neoplasm blood other	1	0.01
Malignant neoplasm breast female	18	0.15
Malignant neoplasm bronchus/lung	6	0.05
Malignant neoplasm cervix	3	0.03
Malignant neoplasm colon/rectum	3	0.03
Malignant neoplasm nervous system	1	0.01
Malignant neoplasm of bladder	4	0.03
Malignant neoplasm of skin	1	0.01
Malignant neoplasm prostate	2	0.02
Malignant neoplasm respiratory, other	3	0.03
Malignant neoplasm thyroid	3	0.03
Medical Exam/Eval-Complete	11	0.09
Medical Examination/Health Evaluation-Partial/Pre-op check	15	0.13
Medicat-Script/Reqst/Renew/Inject	50	0.42
Medication abuse	12	0.10
Melaena	2	0.02
Memory disturbance	1	0.01
Meningitis/encephalitis	1	0.01
Menopausal symptom/complaint	10	0.08
Menstrual pain	17	0.14
Menstruation absent/scanty	19	0.16
Menstruation excessive	18	0.15
Menstruation irregular/frequent	14	0.12
Mental retardation	6	0.05
Migraine	34	0.29
Molluscum contagiosum	2	0.02
Moniliasis/candidiasis skin	32	0.27
Mouth/tongue/lip disease	21	0.18
Mouth/tongue/lip symptom/complt.	10	0.08
Multiple sclerosis	2	0.02
Multiple trauma/injuries	1	0.01
Mumps	1	0.01
Muscle pain	39	0.33
Muscle symptom/complaint NOS	9	0.08
Musculoskeletal disease, other	47	0.39
Naevus/mole	2	0.02
Nail symptom/complaint	3	0.03
Nausea	12	0.10
Neck symptom/complain	55	0.46
Neck syndrome	25	0.21
Neoplasm endocrine oth/unspecified	1	0.01
Neoplasm of ear	1	0.01

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Neoplasm of eye/adnexa	4	0.03
Neoplasm respiratory unspecified	1	0.01
Neoplasm skin benign/unspecified	12	0.10
Neoplasm urinary tract NOS	1	0.01
Neuraesthenia/surmenage	5	0.04
Neurological disease, other	38	0.32
Neurological infection other	2	0.02
Neurological symptom/complt. other	21	0.18
Nipple symptom/complaint female	4	0.03
No disease	50	0.42
Nose bleed/epistaxis	7	0.06
Nose symptom/complaint other	26	0.22
Obesity	69	0.58
Oesophagus disease	40	0.34
Orchitis/epididymitis	1	0.01
Organic psychosis other	6	0.05
Osteoarthrosis of hip	20	0.17
Osteoarthrosis of knee	47	0.39
Osteoarthrosis other	19	0.16
Osteochondrosis	1	0.01
Osteoporosis	17	0.14
Other Diagnostic Procedures	1	0.01
Other Laboratory Test NEC	2	0.02
Other Preventive Procedures	4	0.03
Other Reason for Encounter NEC	7	0.06
Other Referrals NEC	1	0.01
Other Therapeutic Procedure NEC	2	0.02
Otitis extema	26	0.22
Overweight	16	0.13
Pain general/multiple sites	44	0.37
Pain in penis	3	0.03
Pain in testis/scrotum	9	0.08
Pain respiratory system	18	0.15
Pain/tenderness of skin	5	0.04
Painful intercourse female	1	0.01
Palpitations/awareness of heart	21	0.18
Paralysis/weakness	3	0.03
Parkinsonism	7	0.06
Paroxysmal tachycardia	3	0.03
Partner's behaviour problem	1	0.01
Pediculosis/skin infestation other	8	0.07
Pelvic inflammatory disease	5	0.04
Pelvis symptom/complaint female	5	0.04
Penis symptom/complaint other	12	0.10
Peptic ulcer other	10	0.08
Perforation ear drum	3	0.03
Perianal itching	3	0.03
Peripheral neuritis/neuropathy	28	0.23

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Personality disorder	7	0.06
Phimosis/redundant prepuce	1	0.01
Phlebitis/thrombophlebitis	3	0.03
Phobia/compulsive disorder	2	0.02
Physical Function Test	1	0.01
Physical Medicine/Rehabilitation	1	0.01
Pilonidal cyst/fistula	5	0.04
Pityriasis rosea	6	0.05
Plugged feeling ear	3	0.03
Pneumonia	9	0.08
Post-partum bleeding	2	0.02
Post-partum symptom/complaint oth.	3	0.03
Post-traumatic stress disorder	81	0.68
Postmenopausal bleeding	1	0.01
Postponement of menstruation	2	0.02
Postural hypotension	13	0.11
Poverty/financial problem	22	0.18
Pregnancy	306	2.57
Pregnancy high risk	3	0.03
Pregnancy symptom/complaint other	5	0.04
Pregnancy vomiting/nausea	6	0.05
Pregnancy, Childbearing, Family Planning	1	0.01
Premenstrual symptom/complaint	2	0.02
Presbyacusis	2	0.02
Pressure/tightness of heart	13	0.11
Preventive Imunisations/Medications	32	0.27
Prominent veins	3	0.03
Prostate symptom/complaint	11	0.09
Prostatitis/seminal vesiculitis	10	0.08
Pruritus	64	0.54
Psoriasis	60	0.50
Psychological	1	0.01
Psychological disorders, other	17	0.14
Psychological symptom/compit other	18	0.15
Psychosis NOS/other	18	0.15
Pulmonary embolism	1	0.01
Pulmonary heart disease	2	0.02
Purpura/coagulation defect	1	0.01
Pyelonephritis/pyelitis	2	0.02
Question of pregnancy	32	0.27
Rash generalized	30	0.25
Rash localized	74	0.62
Rectal bleeding	24	0.20
Rectal/anal pain	13	0.11
Red eye	25	0.21
Referral to Physician/Specialist/ Clinic/Hospital	6	0.05
Refractive error	92	0.77
Relationship problem friend	1	0.01

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Relationship problem with child	2	0.02
Relationship problem with partner	1	0.01
Repair/Fixate-Suture/Cast/Prosthetic	3	0.03
Respiratory	1	0.01
Respiratory disease other	16	0.13
Respiratory infection other	15	0.13
Respiratory symptom/complaint oth.	5	0.04
Restless legs	1	0.01
Results Exam/Test/Record	4	0.03
Results Tests/Procedures	25	0.21
Retinopathy	2	0.02
Rheumatic fever/heart disease	10	0.08
Rheumatoid/seropositive arthritis	8	0.07
Risk factor cardiovascular disease	1	0.01
Rubella	1	0.01
Scabies/other acariasis	50	0.42
Schizophrenia	24	0.20
Scrotum/testis sympt/complt. other	5	0.04
Sebaceous cyst	5	0.04
Secondary effect of trauma	6	0.05
Sensation disturbance other	8	0.07
Sensitivity Test	1	0.01
Serous otitis media	10	0.08
Sexual desire reduced	1	0.01
Sexual fulfilment reduced	3	0.03
Sexual function sympt./complt.(m)	3	0.03
Shortness of breath/dyspnoea	27	0.23
Shoulder symptom/complaint	88	0.74
Shoulder syndrome	15	0.13
Sinus symptom/complaint	11	0.09
Sinusitis acute/chronic	52	0.44
Skin colour change	6	0.05
Skin disease, other	57	0.48
Skin infection other	22	0.18
Skin infection post-traumatic	18	0.15
Skin injury other	9	0.08
Skin symptom/complaint other	5	0.04
Skin texture symptom/complaint	6	0.05
Sleep disturbance	67	0.56
Sneezing/nasal congestion	78	0.65
Social Problems	1	0.01
Social Problems problem NOS	8	0.07
Social Problems welfare problem	14	0.12
Solar keratosis/sunburn	2	0.02
Somatization disorder	5	0.04
Speech disorder	2	0.02
Sprain/strain of ankle	20	0.17
Sprain/strain of joint NOS	3	0.03

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Sprain/strain of knee	3	0.03
Sputum/phlegm abnormal	9	0.08
Stammering/stuttering/tic	1	0.01
Stomach function disorder	53	0.44
Strabismus	5	0.04
Strep throat	3	0.03
Stroke/cerebrovascular accident	6	0.05
Suicide/suicide attempt	5	0.04
Superficial injury of ear	2	0.02
Swallowing problem	3	0.03
Sweat gland disease	3	0.03
Sweating problem	5	0.04
Swelling	9	0.08
Swollen ankles/oedema	14	0.12
Sympt/compit. Musculoskeletal other	23	0.19
Syphilis female	1	0.01
Syphilis male	9	0.08
Teeth/gum disease	216	1.81
Teeth/gum symptom/complaint	157	1.32
Tennis elbow	4	0.03
Tension headache	22	0.18
Therapeutic Counselling/Listening	7	0.06
Throat symptom/complaint	77	0.65
Tingling fingers/feet/toes	9	0.08
Tinnitus, ringing/buzzing ear	12	0.10
Tonsillitis acute	75	0.63
Toxaemia of pregnancy	1	0.01
Trachoma	1	0.01
Transient cerebral ischaemia	1	0.01
Trauma/injury NOS	14	0.12
Tuberculosis	10	0.08
Uncomplicate labour/delivery live	1	0.01
Undescended testicle	1	0.01
Unexplained abnormal white cells	1	0.01
Unwanted pregnancy	33	0.28
Upper respiratory infection acute	291	2.44
Urethral discharge	12	0.10
Urethritis	7	0.06
Urinary calculus	15	0.13
Urinary disease, other	17	0.14
Urinary frequency/urgency	24	0.20
Urinary retention	3	0.03
Urinary symptom/complaint other	5	0.04
Urination problems other	5	0.04
Urine Test	1	0.01
Urine symptom/complaint other	5	0.04
Urticaria	5	0.04
Uterovaginal prolapse	2	0.02

ICPC DIAGNOSES BY ALPHABETICAL ORDER	*n*	*%*
Vaginal discharge	22	0.18
Vaginal symptom/complaint other	8	0.07
Vaginitis/vulvitis NOS	9	0.08
Varicose veins of leg	43	0.36
Vertiginous syndrome	8	0.07
Vertigo/dizziness	34	0.29
Viral disease other/NOS	18	0.15
Viral hepatitis	104	0.87
Visual disturbance other	38	0.32
Vitamin/nutritional deficiency	4	0.03
Voice symptom/complaint	3	0.03
Vomiting	20	0.17
Vulval symptom/complaint	6	0.05
Warts	13	0.11
Weakness/tiredness general	44	0.37
Weight gain	2	0.02
Weight loss	17	0.14
Wheezing	18	0.15
Whooping cough	2	0.02
Work problem	2	0.02
Worms/other parasites	10	0.08
Wrist symptom/complaint	14	0.12
Total	11921	100.00