Access to healthcare for the most vulnerable in a Europe in social crisis

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Dr Liana Mailli vaccinates a child at the clinic in Perama, MdM Greece, 2013.

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ACCESS TO HEALTHCARE FOR THE MOST VULNERABLE

IN A EUROPE IN SOCIAL CRISIS

Focus on pregnant women and children

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 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 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 दुनिया के डॉक्टर MÉDECINS DU MONDE 世界医生组织 DOC

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EXECUTIVE SUMMARY

In this report, Doctors of the World (MdM) presents its observations for 2013 on the social health determinants and health status of patients who have received support from 25 of our 160 European programmes providing access to healthcare.

In 2013, 29,400 consultations provided to 16,881 patients were analysed (15,445 of them medical consultations) across 25 cities in eight European countries. The quantitative analyses are supported by information provided by the local teams.

This year we want to reiterate the need for unconditional access to both antenatal care for pregnant women and to essential childhood vaccinations, neither of which are currently universally guaranteed. This amounts to a denial of rights which goes against basic human rights, international conventions and respect for the fundamental principles of public health.

The results for 2013 show that, among the 285 pregnant women seen, 65.9% had had no access to antenatal care before coming to one of our health centres and 42.8% received care too late. At their first medical consultation, the doctors decided in over 70% of cases that the individuals required urgent or semi-urgent care. Thus two thirds of pregnant women and their unborn children seen by MdM were at risk.

In 2013, 1,703 children[1] attended one of the European centres. Of these, at best only half had been vaccinated against tetanus, hepatitis B, measles and pertussis (whooping cough). In some countries this rate was less than 30%, well below vaccination coverage rates for the general population of around 90%.

As the general population faces rising poverty, some political parties are taking advantage of the situation to target destitute migrants who are easy scapegoats.

At the same time, in many countries, groups which were already vulnerable before the crisis (undocumented migrants, asylum seekers, drug users, sex workers, destitute European citizens and homeless people) are seeing a deterioration or even removal of the safety nets and social networks which provided them with basic support. Health coverage systems are being eroded, leaving the patient to bear a growing proportion of the costs, despite their lack of financial resources; and this at a time when an ever larger number of vulnerable people are in increasing need. This injustice challenges the very foundation of social solidarity in Europe and must be strongly opposed.

Non-governmental organisations (NGOs) and service providers offer solidarity, but ultimately it is the role of governments themselves to ensure that vulnerable groups are protected. Yet some seem to forget this when faced with the pressure of short-term economic decisions and austerity measures. Vulnerable people need more protection in these times of crisis, not less.

Almost half the patients seen by Doctors of the World have permission to reside in Europe. For people from both the EU and beyond who do not have permission to reside, the situation is even more difficult.

A number of studies have shown the importance of identifying previous experiences of violence among migrant populations. In 2013, 76.3% of people asked reported having had at least one violent experience. The majority of these were migrants from the Middle East and asylum seekers. The types of violence most frequently reported were hunger and having lived in a country at war. Almost 20% of people reported having experienced violence in the country where they were surveyed.

Over a quarter of patients seen by MdM felt that their general state of health was bad or very bad. However, personal health only represented 2.3% of the reasons cited for migration, a figure close to that seen in previous years. These figures demonstrate once again how unfounded the rhetoric is against migrants, accused of coming to take advantage of European healthcare systems.

Almost two thirds of patients had no coverage for healthcare charges when they first came to MdM centres. The three barriers to access care most frequently cited by patients were financial problems (25.0%), administrative problems (22.8%) and lack of knowledge or understanding of the healthcare system and of their rights (21.7%). These results clearly contradict the myth that migrants come to Europe for the purpose of using healthcare services.

As healthcare professionals, and in accordance with the codes of ethics for medical professionals, we demand the right to provide care to all patients, irrespective of their administrative status, ethnic origin or financial resources.

We call for the establishment of national, universal healthcare systems built on solidarity, equality and equity and open to everyone living in the EU.

With regard to particularly vulnerable groups, such as children and pregnant women, these systems must allow unconditional access to antenatal and postnatal care, national vaccination programmes and paediatric care.

In times of crisis, access to care must be strengthened.

The European Commission and the European Parliament must encourage the Member States, who are in charge of access to healthcare in their country, to protect and consolidate healthcare systems and social protection mechanisms in times of crisis.

The European Union Fundamental Rights Agency (FRA) is a source of hope for many people: we call on Member States to act upon the opinions it issues.

The Council of Europe has an important role to play in the protection of fundamental rights in Europe. The European Committee of Social Rights has sent a strong signal by affirming that the right to healthcare as set out in the European Social Charter clearly applies to every individual, regardless of their administrative situation.

1 These are the only children recorded in the database.

IMPACT OF THE CRISIS ON HEALTHCARE SYSTEMS

The documented effects of crisis and austerity throughout Europe

A growing body of scientific evidence has recently been produced regarding the precise effects of the economic crisis on population health, even if only the very early effects of the crisis are apparent thus far, as health data[2] is published with a delay of several years. The proportion of people at risk of poor mental health increased by over 3 million in the EU between 2007 and 2011. Housing and job insecurity have predominantly been responsible for this increase[3]. The number of suicides[2] among people under the age of 65 has risen in the EU since 2007[4]. The high vulnerability to mental health problems among the most disadvantaged people may be explained by factors such as feelings of insecurity and hopelessness, poor education, unemployment, indebtedness, social isolation and poor housing[5]. Recent HIV outbreaks related to intravenous drug use in Greece and Romania have interrupted a positive trend of decline in the number of new HIV infections related to drug use[6]. The proportion of people reporting a good or very good health status significantly decreased, especially among people with a low income[7]. Among patients seen in Doctors of the World open health centres in 2013, 27.6% declared they were in poor or very poor mental health.

Strong social protection mechanisms have been shown to mitigate some of the negative effects recession has on health[5]. In many countries, people's contributions to public healthcare coverage and/or their share of out-of-pocket payments have increased[8]. Bulgaria, Greece, Portugal, Romania and Slovenia increased employer and employee contributions to statutory health insurance. In many other countries[9], users' charges for health services have been introduced or increased, in response to the crisis and to bring down the budget deficit in public health insurance plans or for health services.

Public healthcare services, especially emergency wards, often remain the only place from which some people can access healthcare.

People having to deal with a range of vulnerability factors already faced major health inequalities before the crisis hit Europe. Yet many harm reduction programmes among drug users underwent cuts in the recent years (e.g. Portugal[10], Greece, Spain, Romania and Hungary) and the stigmatising policies in some countries clearly led to an opposite 'harm induction' effect with consequent higher Hepatitis C virus (HCV) and HIV prevalence[11]. Examples of such policies are the criminalisation and incarceration of sex workers or drug users and obligatory HCV or HIV screening. These all raise the threshold for testing and treatment and render people more vulnerable. Cuts were also seen for harm reduction services and low threshold health services that support sex workers[12].

Homelessness is increasingly being criminalised through anti-begging fines (e.g. Spain, the Netherlands)[13]. Discriminatory practices are sometimes used to prevent homeless people from accessing social services and shelter[14]. Finally, the elderly are also increasingly hit by the crisis and austerity measures.

Impact on women's and children's health

In times of economic crisis, pregnant women and children should be specifically protected through social welfare nets. This is not what we have seen. According to official figures a quarter to a third of the Greek population is now without any health coverage at all. As a consequence, uninsured pregnant women have to bear the full costs for their antenatal care and delivery (around €1,300), which has become impossible for the average family. Greece has suffered a huge drop in its number of live births and the number of stillbirths has increased by 21.15% from 2008 to 2011[15].

Financial barriers preclude a growing number of children from accessing essential healthcare services such as vaccination; some national legislation also hinder children from accessing vaccination and medical follow up, when their parents are undocumented.

2 Karanikolos M, Mladovsky P, Cylus J, Thomson S, Basu S, Stuckler D, Mackenbach JP, McKee M. Financial crisis, austerity, and health in Europe. Lancet 2013; 381: 1323–31.
3 See *Impacts of the crisis on access to healthcare services in the EU.* Dublin: Eurofound, 2013.
4 Sources: WHO Mortality Database and Eurostat, 2013. Impact of economic crises on mental health: WHO Europe, 2011.
5 Stuckler D, Basu S. *The Body Economic: Why Austerity Kills.* New York: Basic Books, 2013.
6 Collective. *European Drug Report. Trends and developments.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 2013.
7 Collectif. *Impacts of the crisis on access to healthcare services in the EU.* Dublin : Eurofound, 2013.
8 Mladovsky P, Srivastava D, Cylus J, Karanikolos M, Evetovits T, Thomson S, McKee M. Health policy responses to the financial crisis in Europe. Genève : WHO and European Observatory on Health Systems and Policies, 2012, Policy Summary n. 5.
9 Armenia, Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania, Russia, Slovenia, Switzerland and Turkey.
10 For instance, see EATG (2014), The impact of economic austerity on the HIV response in Portugal: a community perspective.
11 Collective. *Who is paying the price for austerity?* Amsterdam: Correlation Network (Policy paper), newsletter 03/2013.
12 Jakobsson P. *Sex work in Europe: the legal landscape and a rights-based way forward.* Amsterdam: Correlation Network, 2013.
13 Collective. *On the Way Home? Monitoring Report on Homelessness and Homeless Policies in Europe.* Brussels: FEANTSA, 2012
14 European Parliament resolution of 16 January 2014 on an EU homelessness strategy (2013/2994(RSP)).
15 Simou E, Stavrou M, Kanavou E, Koutsogeorgou E, Roumeliotou A. *Association between birth rates and selected socio-economic indicators in a time of economic crisis: the case of Greece.* Athens: Department of Epidemiology and Biostatistics, National School of Public Health, in press.

Policies based on fear and intolerance instead of evidence based policies

Healthcare systems should be efficient and financially sustainable. In order to be efficient, they have to cover the whole population, leaving no gaps; in particular they should not exclude from the system people confronted with multiple vulnerability factors. In times of crisis, especially when crisis hits as harshly as it has in Spain and Greece, most people start fearing what tomorrow will bring for themselves and their family. In times such as these, some stakeholders and extremist groups enter into their political machinations by feeding increasingly on these fears. Solidarity is then quickly replaced by exclusion and rejection and scapegoating become widespread, with the exploitation of the legitimate fears of the people in Europe as they are confronted by a bleak present with high unemployment rates, cuts in salaries and not much hope for a better future.

For instance, in Spain, adult undocumented migrants have been excluded from essential healthcare since Royal Decree-Law 16/2012 came into effect in September 2012. Undocumented pregnant women and children were explicitly not concerned by this new law, yet they too have been frequently denied access to essential services since the decree came into force[16]: the political message on exclusion of undocumented migrants was stronger than the law.

When discussing the right to free circulation of persons across the EU, some UK politicians invoked the danger of "benefit tourism". In reality, mobile EU citizens are net contributors to national social welfare systems and the expenditures associated with their healthcare are very small relative to the size of total health spending in the host countries[17]. Nevertheless, the UK Department of Health is planning to extend and create new NHS charges for visitors and migrants. The proposed measures will include extra prescription fees, charging for emergency care and higher rates for using opticians and dentists from March 2015 onwards. It is expected that these changes will add new barriers for migrants to access healthcare. Even before these measures are put into place legally, the political message of restricting migrants' access to care leads to greater confusion among health professionals, refusal of even primary care and a general lack of understanding among migrants about what care they can access.

In Belgium, an 'urgent medical care' scheme theoretically allows undocumented migrants to access essential healthcare services (both preventive and curative). But in Antwerp, the country's second biggest city, the social welfare centre has been extremely restrictive in its interpretation of national law for many years. Local authorities are clearly convinced that by restricting care, they will be able to regulate migration flows, a policy tool proven to be unethical and ineffective.

In Greece, the brutal attacks and hate crimes against ethnic minorities that we described last year are far from over. In 2013, MdM Greece has dealt with several minors who were witnesses to acts of racist violence towards their parents or who were victims themselves.

Some positive changes in national policies, rare and all the more noteworthy

In 2013, some governments also took positive steps to protect the most vulnerable.

In Sweden, undocumented migrants and their children used to only have access to emergency care that was billed afterwards. In July 2013, a new law came into force that allows all children to access public healthcare free at the point of delivery. Adult undocumented migrants have obtained the same rights as asylum seekers: they can access healthcare "that cannot be postponed", ante and post natal care, family planning, termination of pregnancy and dental care "that cannot be postponed", provided that they pay the €6 fee for every visit to a doctor or dentist. Many healthcare professionals are still unaware of these changes. Furthermore, the law is not always correctly applied: migrants are sometimes asked to pay more than they should, or are denied access to care. The major problem is that migrants often cannot know what will be considered as care "that cannot be postponed", especially as each medical doctor will have her/his own interpretation of these criteria. Nevertheless, the new law is a major step forward in allowing the most vulnerable to seek medical care when they need to.

In France, the income threshold for applicants to free healthcare was raised, thereby granting an additional 600,000 patients access to full healthcare coverage. The same threshold is also valid for State Medical Aid for undocumented migrants. Additionally, the 30 Euros entrance fee to State Medical Aid for undocumented migrants, introduced by the previous government, was repealed in 2012.

In Germany, people who had lost their health coverage have had to pay 5% interest on their debt (payment for their health coverage) since 2007, if they wanted to regain their health coverage. According to the law of August 2013, they "only" have to pay 1% interest and now stand a chance of being exempt from their debts.

16 Collective. Un año de exclusión sanitaria, un año de desobediencia. Madrid: Yo Sí Sanidad Universal, Campaña de desobediencia al Real Decreto-Ley 16/2012, 2013.

17 Juravle C, Weber T, Canetta E, Fries Tersch E, Kadunc M. Fact finding analysis on the impact on Member States' social security systems of the entitlements of non-active intra-EU migrants to special non-contributory cash benefits and healthcare granted on the basis of residence. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2013.

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Members of Doctors of the World Belgium, Canada, France, Germany, Greece, Japan, the Netherlands, Portugal, Spain, Sweden, Switzerland, the UK and the USA in solidarity with all those without health insurance in Greece: pregnant women, children and doctors try to join hands but are prevented by the money barrier – flash mob MdM held on Monastiraki Square, Athens, 21 February 2014.

INTRODUCTION TO THE 2013 SURVEY

In 2006 and 2008, the Doctors of the World (Médecins du Monde – MdM) European Observatory on access to healthcare[18] conducted a survey which focused specifically on undocumented migrants. The survey was based on samples of patients in a number of European countries. In 2012, the International Network Observatory presented data collected from all the patients who attended MdM health centres, rather than just undocumented migrants, in five European cities (Amsterdam, Brussels, London, Munich and Nice).

All the reports produced by the MdM International Network Observatory on access to healthcare are available at: **www.mdmeuroblog.wordpress.com**

Last year, the 2013 report (based on data collected in 2012 in 14 cities across seven European countries) focused on the barriers to accessing healthcare and the living conditions of people excluded from healthcare systems in Europe in times of crisis and rising xenophobia.

This year, we are pleased to present this report with analyses of routinely collected data from 25 cities in eight European countries: Antwerp and Brussels in Belgium, the canton of Neuchâtel including La Chaux-de-Fonds in Switzerland, Munich in Germany, Athens, Mytilene, Patras, Perama and Thessaloniki in Greece, 11 cities in Spain (Almeria, Malaga, Seville, Bilbao, Madrid, Palma de Mallorca, Zaragoza, Toledo, Tenerife, Valencia and Alicante), Amsterdam and The Hague in the Netherlands, Nice and Saint-Denis in France, and London in the United Kingdom.

18 In 2011 the European Observatory was renamed the International Network Observatory.

/ 2013 IN FIGURES /

16,881 patients seen in 25 cities across eight European countries

29,400 consultations including:
- **15,445** medical consultations
- **21,913** diagnoses

285 pregnant women

52.5% living in poor housing
89.1% living below the poverty line
36.2% reporting poor levels of emotional support
63.7% without permission to reside
83.5% with no health insurance

1,703 mineurs

35% had been vaccinated against hepatitis B (except in Greece where the figure is 58%)

At best, **50%** had been vaccinated against pertussis (whooping cough) and measles

➜ Of all the individuals seen

43.7% were women

The median age was **32**

95.0% were foreign nationals

93.0% were living below the poverty line

11.4% had no fixed abode

51.1% had migrated for economic reasons
31.1% for political reasons
23.1% for family reasons

45.5% had the right to reside in Europe

38.0% were or had been involved in an asylum application

Barriers to access to healthcare :
25.0 % financial hardship
22.8 % administrative problems
21.7% lack of knowledge about or understanding of the healthcare system and their rights

22.1% gave up seeking medical care or treatment during the course of the year

16.8% had been denied care on at least one occasion over the last year

5.4% had experienced racism in a healthcare setting during the course of the year

60.7% of individuals without permission to reside said this restricted their movement or occupation due to fear of arrest

63.1% said their health had deteriorated

26.1% perceived their health to be bad or very bad

27.6% said their mental health was bad or very bad

34.3% had at least one chronic illness

30.0% had at least one health problem which doctors deemed to require treatment but which had never been treated before their consultation with MdM

77.3% of men and **42.4%** of women had lived in a country at war

47.0% of men and **26.8%** of women had suffered from hunger

10.0% of women reported suffering assault and **6%** had been raped

20.0% of acts of violence had been perpetrated since the victim's arrival in the survey country

Key figures

Of the individuals seen

15.6% were completely isolated and had no-one they could turn to

34.8% felt their housing was affecting their health or their children's health

2.3% had migrated for health reasons

64.5% had no healthcare coverage

76.3% reported having experienced violence at least once

27.6% said their mental health was bad or very bad

Among pregnant women

65.9% had no access to antenatal care

42.8% received care too late

70.0% required urgent or semi-urgent care according to the doctors

Among children

On average, only 50% had been vaccinated against tetanus.

On average, **70.0%** had not been vaccinated, or did not know whether they had been vaccinated, against hepatitis B, measles and pertussis (whooping cough)

METHODS

Each patient who had a consultation through one of the MdM programmes associated with the International Network Observatory in 2013 was interviewed using at least one of three generic, standardised, multilingual questionnaires (social questionnaire, medical questionnaire and re-consultation questionnaire(s)).

The following abbreviations are used throughout this report:

- **BE** (Belgium) for Antwerp and Brussels
- **CH** (Switzerland – Confédération Helvétique) for the canton of Neuchâtel and La Chaux-de-Fonds
- **DE** (Germany - Deutschland) for Munich
- **EL** (Greece - Ellada) for Athens, Mytilene, Patras, Perama and Thessaloniki
- **ES** (Spain - España) for Almeria, Malaga, Seville, Bilbao, Madrid, Palma de Mallorca, Zaragoza, Toledo, Tenerife, Valencia and Alicante
- **FR** (France) for Saint-Denis (in the suburbs of Paris) and Nice
- **NL** (Netherlands - Nederland) for Amsterdam and The Hague
- **UK** (United Kingdom) for London

Doctors of the World and its activities

MdM have been working to improve access to healthcare and human rights protection since 1980. We are an international aid organisation that provides medical care and aims to improve access to healthcare for people all over the world facing numerous vulnerability factors. Through our 171 national programmes we work mainly with homeless people, drug users, destitute European citizens, sex workers, undocumented migrants, asylum seekers and Roma communities. During medical and social welfare consultations we collect data on the main social determinants of health and the patients' health status to raise awareness about the difficulties they face. We provide patients with information about healthcare systems and their rights in relation to accessing care.

Our programmes are aimed at empowerment through the active participation of beneficiary groups, as a way of identifying health-related solutions and of combating the stigmatisation and exclusion of these groups. MdM supports the creation of self-support groups as a way of strengthening civil society and recognising experience-based expertise. Our activities can thus lead to social change: amending laws and practices as well as reinforcing equity and solidarity.

A summary of the programmes and locations surveyed

In Belgium, routine data were collected during medical, social welfare and psychological consultations which took place during the day at the two Healthcare and Advice Centres (Centres d'accueil, de soins et d'orientation – CASO) in Brussels and Antwerp. These free consultations provide access to care for vulnerable individuals, regardless of their administrative status. The aim is also to reintegrate people into the mainstream healthcare system, by providing them with information about their rights and helping them to exercise these rights.

In Switzerland, in the canton of Neuchâtel, MdM provides social welfare advice and nurse-led consultations. These are provided by the Health and Migration Network (Réseau Santé Migrations – RSM) in La Chaux-de-Fonds and are aimed mainly at migrants. MdM also provides nurse-led consultations at centres for asylum seekers.

In Germany, open.med, in partnership with an organisation in central Munich[19], offers free medical consultations and social welfare advice for people without health insurance, such as vulnerable European citizens (including German nationals) and undocumented migrants. The requirement for officials to report all undocumented migrants to the Federal Office for Migration and Refugees effectively means the latter have no access to the healthcare system and the only option available to them is accident and emergency services.

PATIENT STORY

Gisela is a 55-year-old German woman. *"The first time I heard about Doctors of the World (MdM) was on TV. I was amazed to realise that there were lots of other people without health insurance."* In May 2013, Gisela came to MdM. She hadn't seen a doctor for four years. After losing her job she had become severely depressed. *"I was constantly frightened, especially about losing my flat. I couldn't even manage to pay the €500 a month for my health insurance anymore."* The MdM doctor examined Gisela and ordered a blood test which showed she was severely anaemic. At a follow-up appointment the doctor, suspecting an auto-immune disease, referred her to hospital where she was denied access due to her lack of health insurance. The hospital asked for a payment guarantee of €200. Eventually, following an appeal by MdM, she was admitted to hospital for two weeks. On leaving hospital, follow-up appointments were provided free of charge by an MdM volunteer doctor. She has now made an application for her health insurance to be reactivated, after having been informed by MdM about the new law (as of August 2013)[20] in Germany. If there is no progress, the MdM team will help Gisela to regain her health insurance.

MdM Germany – Munich – January 2014

19 Café 104 : cafe104.maxverein.de
20 Prior to the law of August 2013, individuals who lost their health insurance had to pay 5 % per month interest on their debt (contributions) going back to 2007. From now on, they will pay 1% interest per month.

In Greece, MdM is stepping up its work in the country in response to the huge needs of the most vulnerable and those who have little or no access to healthcare professionals and services, living as they do in rural areas and on the islands. In 2013, an analysis was conducted of some of the medical and social data from the five centres[21] in Athens, Patras, Perama, Thessaloniki and Mytilene (on the island of Lesbos). These facilities provide primary healthcare and psychological support to anyone without access to the national healthcare system. In Mytilene, medical, psychological and legal assistance is offered to migrants arriving on the island by boat and requiring international protection. Patras also receives large numbers of migrants.

In Spain, MdM manages health and social care centres for immigrants (CASSIM), the main aim of which is to integrate people into the mainstream health and social care facilities. To this end, the teams run awareness-raising and health promotion campaigns, as well as training and information events for professionals working in public healthcare facilities, and training courses with and for intercultural mediators. For this Observatory report, the questionnaire was given to 130 patients at the CASSIM centres in Tenerife[22], Zaragoza, Bilbao, Seville, Malaga, Madrid, Alicante and Valencia over the course of three weeks in December. The questionnaires were also given out in Mallorca, Almeria and Toledo. The responses to the 130 questionnaires were incorporated into the analysis, even though they did not result from routine data collection over the whole year, as was the case in the other countries.

In France, MdM has established, since 1986, specially tailored facilities to respond to the needs of the most excluded groups (especially those without adequate health coverage and/or with minimal financial resources). These facilities are, in 2013, the 20 Healthcare and Advice Centres (Centres d'accueil, de soins et d'orientation – CASO) in France. They offer social welfare and medical consultations, as well as assistance for individuals seeking to access the mainstream healthcare system. The data from the CASO in Saint-Denis and Nice were analysed for the International Network Observatory report.

In the Netherlands, MdM offers undocumented migrants weekly advice clinics in Amsterdam and The Hague. People are provided with information about their rights and directed towards health professionals in the mainstream healthcare system, especially general practitioners, in order to guarantee continuity of care.

In the United Kingdom, MdM runs a healthcare and advice centre in east London where volunteers, doctors, nurses, support workers and social workers offer primary healthcare to excluded groups, especially migrants and sex workers. A large part of the centre's work involves helping patients to register with a general practitioner, the entry point to the healthcare system.

Statistics

This report contains data in three different types of proportion.
The proportions by country are all crude proportions and include all the survey sites (irrespective of the number of cities or programmes[23]).

The total proportions were calculated and are, for most of them and unless otherwise indicated, weighted average proportions (WAP) of all the countries; this allows actual differences between countries to be corrected and they then each have the same weight in the overall total. Where there are significant differences between this *weighted average proportion* (WAP) and the *crude average proportion* (CAP), the latter (which does not account for the relative contribution of countries with low numbers) is sometimes also given for information purposes.

Numbers surveyed

This report is based on the analysis of data from 16,881 individuals, of whom 1,703 were children and 285 were pregnant women. Of those surveyed, 43.7% were women.

➜ NUMBER OF PATIENTS AND SURVEY PERIODS BY COUNTRY

Country	No. of patients	% of total	Survey period
BE (2 cities)	2,382	13.2	01/01/2013-31/12/2013
CH (1 city)	237	1.3	03/01/2013-30/12/2013
DE (1 city)	520	2.9	04/01/2013-27/12/2013
EL (5 cities)*	3,430	19.0	01/01/2013-31/12/2013
ES (11 villes)**	130	0.7	02/12/2013-26/12/2013
FR (2 cities)	9,002	49.7	01/01/2013-26/12/2013
NL (2 cities)	133	0.7	03/01/2013-19/12/2013
UK (1 city)***	1,047	5.8	01/01/2013-20/12/2013
Total (25 cities)	**16,881**	**100**	

* In Greece, a very small percentage of the patients was recorded in the database in at least two of the five cities (16 % of patients recorded in total).
** In Spain, 105 files relate to three weeks of activity in ten of the 11 cities and 25 cases were recorded during 2013 for the Canaries.
*** In London, the medical consultations were interrupted for a period of five months between 14/05/2013 and 21/10/2013.

21 In 2013 in Athens only around 3% of patients were included in the database analysed in this report; in Thessaloniki it was around 13%, in Patras 50%, in Perama 57% and in Mytilene 91%.
22 In Tenerife 25 surveys were handed out over the course of 2013.
23 Within one country, if a programme in one city sees ten times fewer patients than another programme in another city, the former will count for one tenth of the latter.

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Greece, 2014.

FOCUS ON PREGNANT WOMEN

A total of 285 pregnant women were seen for consultations (mainly in Belgium, Germany and France), representing 6.2% of patients. The average age of the pregnant women was 27.6 and 3.2% of them were children – the youngest was 14 years old. With regard to living conditions, 52.5% of the pregnant women who attended consultations were living in an unstable housing situation. One third (32.3%) of them were living in conditions they believed were affecting their health and 4.8% had no fixed address. The vast majority (89.1%) were living below the poverty line[24].

PATIENT STORY

Anthea, a 34-year-old Greek woman, was admitted to a public maternity unit following the birth of her child. She had no health coverage and no income. Both she and her husband were unemployed. She told us that the hospital staff refused to issue a birth certificate "because the hospital bill had not been paid". This is against the law. MdM intervened to ensure that the family would receive the document in accordance with the law which guarantees all children the right to legal existence.

MdM Greece – Athens – 2013

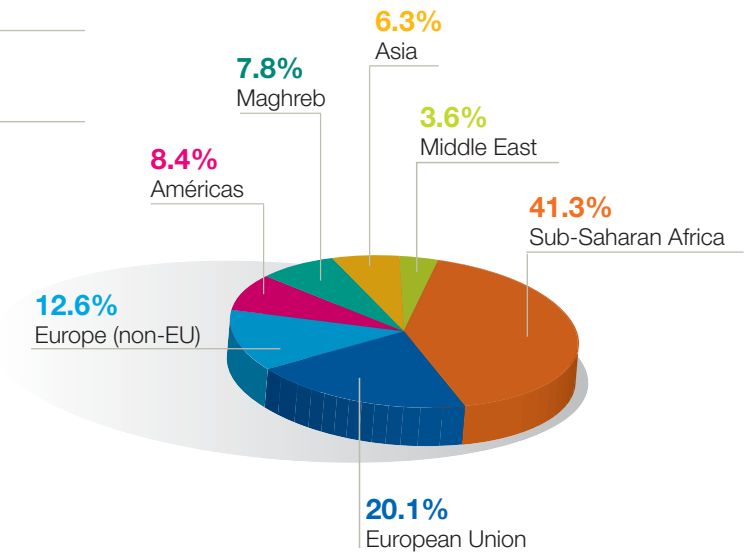
➜ NUMBERS OF PREGNANT WOMEN BY COUNTRY AND AS A PERCENTAGE OF TOTAL WOMEN SEEN

	No. of pregnant women	% of total
BE	94	33.0
CH	6	2.1
DE	57	20.0
EL	17	6.0
ES	5	1.8
FR	65	22.8
NL	14	4.9
UK	27	9.5
Total	**285**	**100.0**

24 The applicable poverty line is that of the country surveyed. It should be noted that the financial resources reported by the patients do not take account of the number of people living with them: if we were to ask them about this, the number of people living below the poverty line would be even higher and, in all probability, would in fact be all of them.

Almost all the pregnant women seen (94.7%) were foreign nationals, mainly originating from sub-Saharan Africa (41.3%), the EU (20.1%) and European countries outside the EU (12.6%).

➜ GEOGRAPHICAL ORIGIN OF PREGNANT WOMEN



PATIENT STORY

Adjoua, 28, from Benin, was three months pregnant when she first went to the CASO. She was homeless and had had no antenatal care. We contacted SAMU Social so that she would be allocated a room in a hostel. During her pregnancy she was accommodated in two different hostels, meaning she had to change maternity hospital. After the birth of her daughter she returned to her hostel room, despite the fact that it had a serious damp problem: the walls of the room were covered in mould, with water running down and it was difficult to breathe in the room. At three weeks old, her daughter was admitted to hospital for a week as an emergency case. It was not until three weeks later that she was offered a different room.

MdM France – Saint-Denis – June 2013

Among the pregnant women surveyed, 41.8% reported having one or more minor children. Of these women, 44.3% were living apart from one or more of their minor children (38.5% were living apart from all their minor children).

PATIENT STORY

Macire, 28, is originally from Kenya: *"I arrived in Germany a year ago. I came here with my two children (aged seven and three) to join my boyfriend who is a German citizen. Shortly after I arrived in Germany I realised I was pregnant. I didn't know what to do about the pregnancy: our income was very low and I had no health insurance. Unfortunately, we couldn't afford it. As I wasn't working I would have had to pay the full monthly contributions. I had my first consultation at open.med and since then I have been going back every month for antenatal appointments. They gave me a booklet with all the information about my pregnancy. At the moment they are trying to find a health insurance plan for me that I can afford. Open.med has really helped me realise I can be a mother again. Even though the future is uncertain, I do have hope now. I hope I'll have my own health coverage before my due date. I'm worried that the bill for my delivery will be very high."*

MdM Germany – Munich – January 2014

It is noteworthy that 36.2% of pregnant women said they had a poor level of emotional support and, of these almost 10% had no emotional support at all[25]. These pregnant women are therefore just as isolated as the other women surveyed.

An analysis of the administrative status of the 285 pregnant women who attended consultations shows that 63.7% had no right to reside: of these 15.8% were EU nationals and 47.9% were nationals of non-EU countries.

25 Only 94 women (one third) were asked about emotional support.

➜ ADMINISTRATIVE STATUS OF PREGNANT WOMEN

	n	%
No residence permit requirement (nationals)	16	6.0
For EU nationals		
No permission to reside*	42	15.8
No requirement for a residence permit (in the country for less than three months)	14	5.3
Permission to reside (adequate financial resources and valid healthcare coverage)	6	2.3
For non-EU nationals		
No permission to reside	127	47.9
Asylum seeker	20	7.5
Tourist, short-stay or student visa	16	6.0
Valid residence permit	14	5.3
Residence permit for another EU country	5	1.9
Work visa	3	1.1
Humanitarian protection	2	0.8

* in the country for more than three months, without sufficient financial resources and/or healthcare coverage.

Of the pregnant women surveyed, 7.5% were in the process of claiming asylum, 34% were or had at some point been involved in an asylum claim and, of these half had been refused asylum.

PATIENT STORY

Lisa, 33, is from Mongolia. She has just been refused asylum and is now considered to be an undocumented migrant. Before she received the asylum rejection, she had been able to access the public healthcare system. After two failed medical abortions, she went back for a third time to the hospital which had carried out the procedures. She was suffering from upper abdominal pain and vomiting.
The gynaecologist was unwilling to see her unless she paid several hundred Euros. Lisa and her boyfriend turned to MdM who told them about the new law on undocumented migrants which contains the right to obstetric care and pregnancy termination.
Two weeks later, Lisa's boyfriend returned to the hospital with the information about the new law on undocumented migrants. No one at reception was aware of the law. Eventually, Lisa received a bill for €45 for the visit and pregnancy termination procedure.

MdM Sweden – Stockholm – 2013

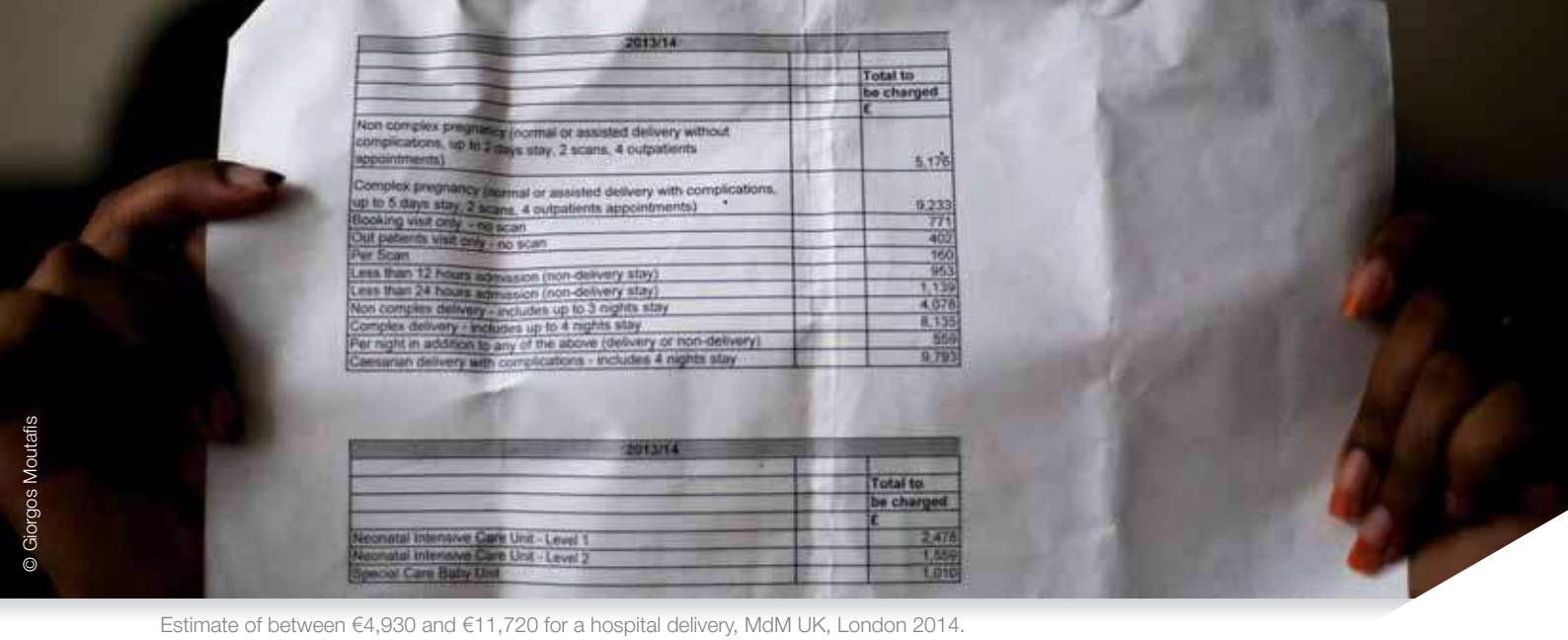
As a result of their administrative situation, almost half of the pregnant women (45.1%) restricted their movements to varying degrees for fear of arrest: sometimes (18.3%), frequently (18.3%) or very frequently (8.5%). This creates a significant additional obstacle to accessing antenatal care.

Regardless of their administrative status, 83.5% of pregnant women seen by MdM had no healthcare coverage[26]. In most countries this means that they have to pay for their care, except, for example, in France where antenatal care is available free of charge for all women, regardless of their healthcare coverage and, theoretically, their administrative situation. Similarly, in Spain pregnant women without permission to reside are supposed to be provided with antenatal and postnatal care, as well as care during their delivery, in the same way as any other woman.

➜ MEDICAL CARE AND TREATMENT FOR PREGNANT WOMEN

	n	% of pregnant women
No coverage / all charges must be paid	156	65.8
Access to emergency services only	42	17.7
Healthcare coverage in another European country	15	6.3
Full healthcare coverage	11	4.6
Partial healthcare coverage	9	3.8
Access on case-by-case basis	4	1.7

26 We have aggregated women with no healthcare coverage and those who are only entitled to use emergency services, which indicates that they do not have access to healthcare and have no healthcare coverage.



© Giorgos Moutafis

Estimate of between €4,930 and €11,720 for a hospital delivery, MdM UK, London 2014.

PATIENT STORY

Nina, a Moroccan woman who was seven months pregnant, applied for a residence permit in April 2013. She went to the social security services to obtain a health insurance card. As she had no valid foreigner identification number (NIE) and no work and was not able to register as a beneficiary as of right (she was not married), the social security services refused to issue the card on the pretext that she had applied for her residence permit after 24 February 2012. The health centre's administrative department later sent her back to the social security centre to "sort out the problem with the card". One day Nina felt unwell and went to the accident and emergency department where the doctor was very concerned about her condition. Not knowing what to do, she sent Nina to MdM where they both learnt that pregnant women have the right to access care regardless of their administrative situation. The doctor found out about the procedures at MdM and promised to pass on the information to the administrative staff at the health centre. Nina was then able to provide the necessary documents and obtain "medical assistance for special circumstances".

MdM Spain – Castilla La Mancha – June 2013

Among the pregnant women, 65.8% had not had access to antenatal care when they came to our treatment centres and, according to the doctors, 42.8% received their care too late, that is after the 12th week of pregnancy.

When the women first presented for a medical consultation, the doctors considered that over 70% of them required urgent (35.6%) or semi-urgent care (36.7%).

Refusal to issue birth certificates to babies of women unable to pay.

The MdM teams are now providing assistance where the authorities have refused to issue a birth certificate, despite the fact that having their existence recognised is a fundamental right for all human beings. Patients' stories from Belgium and Greece demonstrate the downward spiral which is triggered by an obsession with recovering costs, even when this is contrary to basic human rights.

Should we be in a situation in Europe where children whose parents are unable to pay for their delivery do not legally exist? How can we tolerate such a situation? We demand that the European institutions and governments guarantee legal existence for every child.

PATIENT STORY

Maritza, a 33-year-old Armenian woman, has been living in Belgium for seven years. Initially, she survived by doing casual work. However, she then started to suffer from psychiatric problems (anxiety). Having applied for leave to remain on medical grounds, for a few months she received basic services and medical assistance from the Public Social Welfare Centre (*Centre public d'aide sociale – CPAS*). When her application for leave to remain on medical grounds was eventually rejected, this medical care ceased.
Maritza came to the MdM centre when she was six months pregnant for antenatal care and care during her delivery. She also asked to see a psychiatrist for her anxiety. She should have been eligible for Urgent Medical Care (*l'Aide Médicale Urgente – AMU*) specifically for undocumented migrants and provided by the CPAS. No longer able to work or pay her rent, Maritza was taken in by fellow Armenians. The CPAS asked for written evidence of her living arrangements, proof of identity and evidence from her landlords of their income. Landlords are always very reluctant to provide this sort of documentation. The CPAS therefore decided that this counted as a refusal to cooperate. Her request for AMU was rejected, because it hadn't been possible to complete the paperwork. However, it was possible to refer Maritza immediately to the "Child and Family" centre for her antenatal care. She gave birth in early spring. She was admitted to hospital, but since she had still not been granted AMU and despite being in labour for 21 hours, she was discharged the day after the birth. In addition, the hospital refused to provide the record of birth needed to register the child with the local authority. Intervention by MdM's social welfare service ensured that the document was issued.

MdM Belgium – Antwerp – 2013

© Asier Alcorta Hernández

Paediatric consultation at MdM Spain.

FOCUS ON CHILDHOOD VACCINATION

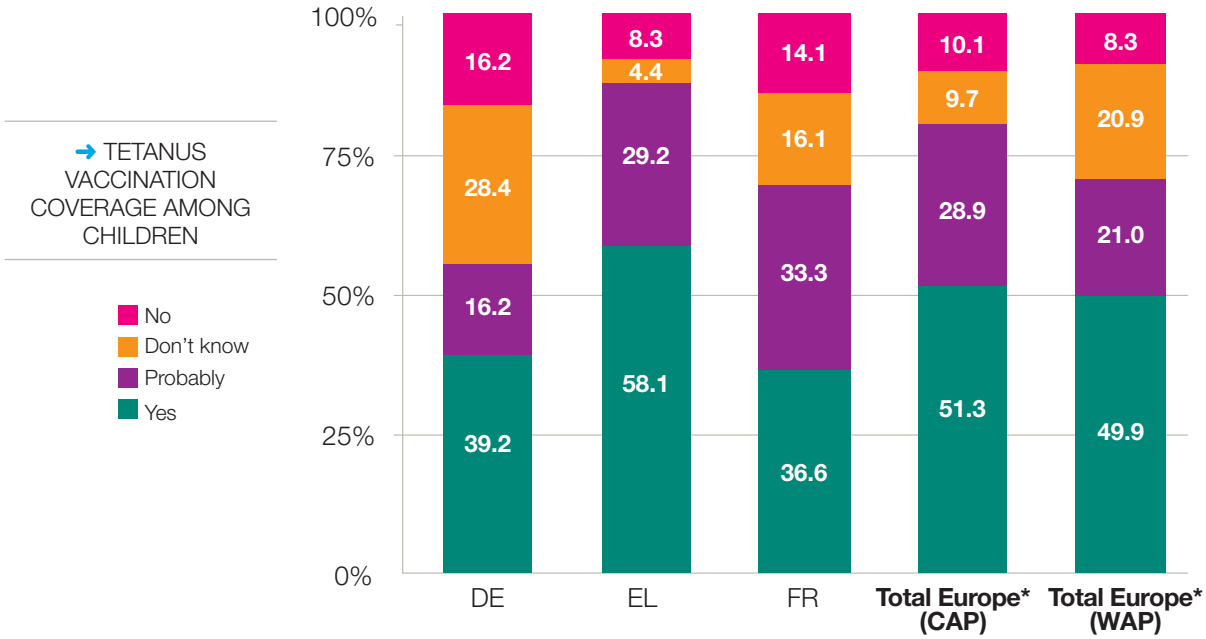
A total of 1,703 patients who were minors attended one of the centres taking part in the survey, representing 10.4% of the patients who provided their age.

Overall, in the six European countries for which we have immunisation data (Spain did not collect any data on minors in 2013 and in London the question was not asked), only one in two children had been vaccinated against tetanus (49.9% weighted average proportion); at worst, just 36.6% of children had been vaccinated. One third of children had definitely not been vaccinated against tetanus or did not know whether they had (which amounts to the same thing in terms of need for vaccination) and 21% had probably been vaccinated but this could not be established for certain (which similarly means they must be re-vaccinated owing to the potential seriousness of the disease).

➜ NUMBER OF MINORS BY COUNTRY

	No. of minors	% of total
BE	257	15.1
CH	23	1.4
DE	79	4.6
EL*	713	41.9
FR	608	35.7
NL	5	0.3
UK	40	2.3
Total	**1,703**	**100**

* Only around 13% of children who attended the five Greek centres were recorded in the database analysed here.



*Total including BE, CH, DE, EL, FR and NL[27]

It should be noted that the vaccination activity carried out within MdM programmes nevertheless remains the exception rather than the rule: only the Greek centres and the one in Munich vaccinated children[28].

The vaccination rates against hepatitis B were even lower: Greece was an exception (where 58.7% of children were vaccinated), but the rate was no more than 35% in the other countries where the question was asked.

The majority of European countries have followed the World Health Organisation (WHO)[29] recommendation to incorporate this vaccine into national vaccination programmes. In these countries, vaccination coverage in the general population is around 93%[30].

The rates for pertussis (whooping cough) and mumps, measles and rubella (MMR) vaccinations are almost the same as for hepatitis B. At best, one in two children has been vaccinated against pertussis (at worst 33.3%) and the same proportion has received the MMR vaccine (at worst 25.7%). Yet, in the majority of countries participating in the survey, vaccination coverage for pertussis and measles at the age of two years has reached (and often exceeded) 90%[30].

PATIENT STORY

Anton, 5, and his family left Bulgaria in 2013 and moved to Munich. *"To start with, the whole family had healthcare coverage through my work, but I lost my job and since then we've had no healthcare coverage. When Anton had a fever we took him to open.med for the first time. We were also concerned about an issue with his skin pigmentation and the fact that his hands were swollen",* said his mother. The open.med team gave him an appointment with a dermatologist who diagnosed 'genetic dysmorphia' and recommended a genetic test. Neither his parents nor MdM could pay for this very expensive test. The MdM paediatrician asked for Anton's immunisation record, but his parents had never seen such a record and were unable to say what immunisations Anton had already had. MdM also asked them about their health insurance status in Bulgaria. Even if Anton was able to obtain medical care in Bulgaria, his parents didn't have a European Health Insurance Card. *"I hope open.med will be able to help us get healthcare coverage in Germany so we can take Anton for the genetic test."*

MdM Germany – Munich – January 2014

Knowledge of where to go for vaccinations

Patients asked about vaccination for their children were also asked whether they knew where to go for vaccinations. Almost 40% (39%) did not know where to go. After Switzerland (where virtually everyone knew), France was the country where people were most well-informed about where to go for vaccinations.

27 To enable comparison between countries, we have only used those for which we have responses for over 75 children.
28 To clarify, 5,596 children were seen at the five Greek centres and 5,327 vaccinations were given. Our database only includes around 13% of the children seen in Greece. This doesn't include the 7,654 children seen by the mobile units where 3,261 immunisations were given.
29 De Franchis R, Marcellin P, et al. EASL International Consensus Conference on Hepatitis B. *J Hepatol* 2003; 39: S3-25.
30 OECD (2011), "Childhood vaccination programmes", in *Health at a Glance 2011: OECD Indicators*, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2011-50-en

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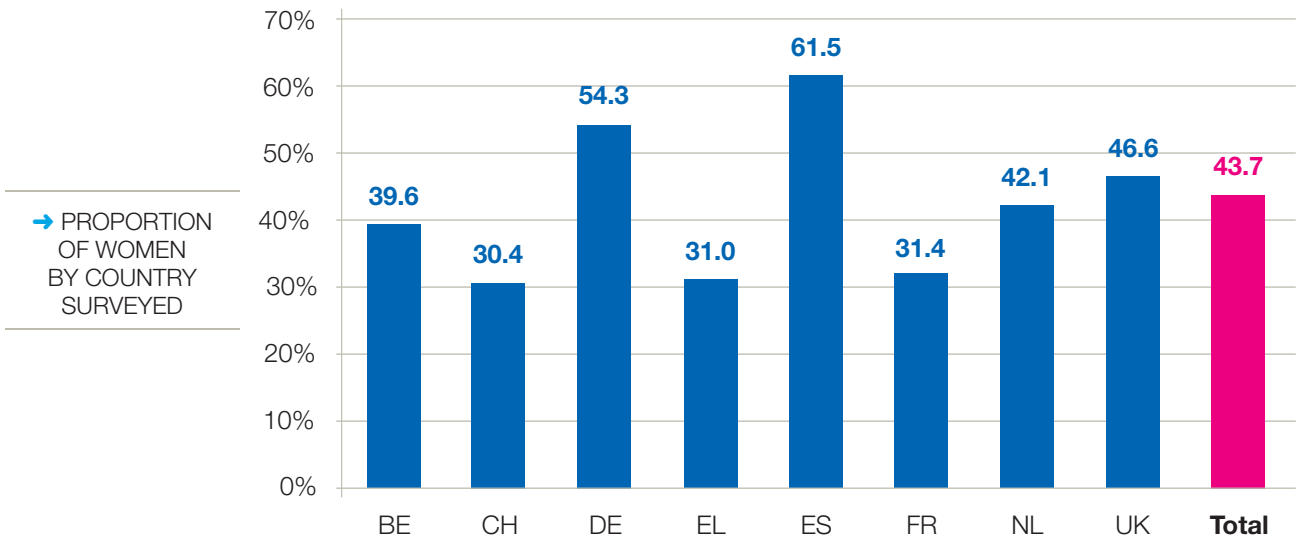
Healthcare and Advice Centre, Marseille, France, 2013.

DEMOGRAPHIC CHARACTERISTICS

Sex and age

A total of 43.7% of patients seen by MdM in 2013 were women.
The average age of the patients seen was 33.1 years (median = 32). Half of the patients were between 24 and 42 years old.

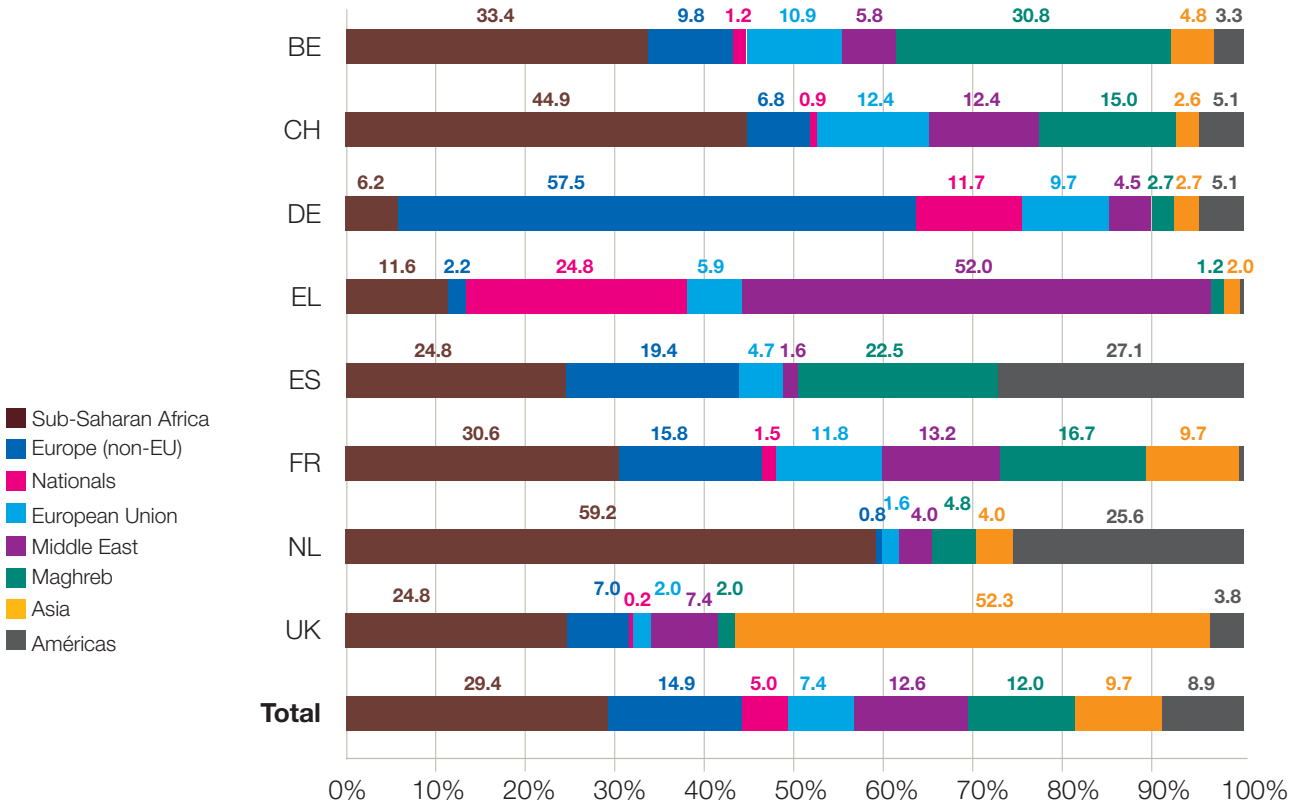


Nationality and geographical origin

A substantial majority of patients seen by MdM programmes and centres were immigrants (95%). Their geographical origins were sub-Saharan Africa (29.4%), Europe (EU: 14.9%; non-EU: 7.4%), Middle East[31] (12.6%), Maghreb (12.0%), Asia (as a whole, 9.7%) and the Americas (essentially Latin America: 8.9%).

European Union citizens thus rank in second place.

➜ PATIENTS' GEOGRAPHICAL ORIGINS BY COUNTRY SURVEYED



At the centre in Saint-Denis, in France, the three most common nationalities were Romanian, Pakistani and Indian; in Nice the patients were mostly from the Maghreb and sub-Saharan Africa.

In Belgium, most people attending the MdM centres originated from Morocco, Guinea and the Democratic Republic of Congo.

In the Netherlands, there were more Nigerians and Ghanaians than Surinamese people.

In London, people from the Indian subcontinent (Bangladesh and India) were still the largest group, followed by Filipinos.

In Munich, the largest group were Bulgarians, followed by Germans and Romanians.

In Greece, the largest numbers of patients were Afghans, followed by Greeks and Syrians, among whom there has been a large increase this year (last year they were the tenth nationality).

31 For the purposes of this report, Middle East comprises Afghanistan, Egypt, Iran, Iraq, Kazakhstan, Kurdistan, Kuwait, Jordan, Lebanon, Pakistan, Palestine, Syria, the United Arab Emirates and Yemen.

➜ TOP TEN MOST FREQUENTLY RECORDED NATIONALITIES, BY COUNTRY

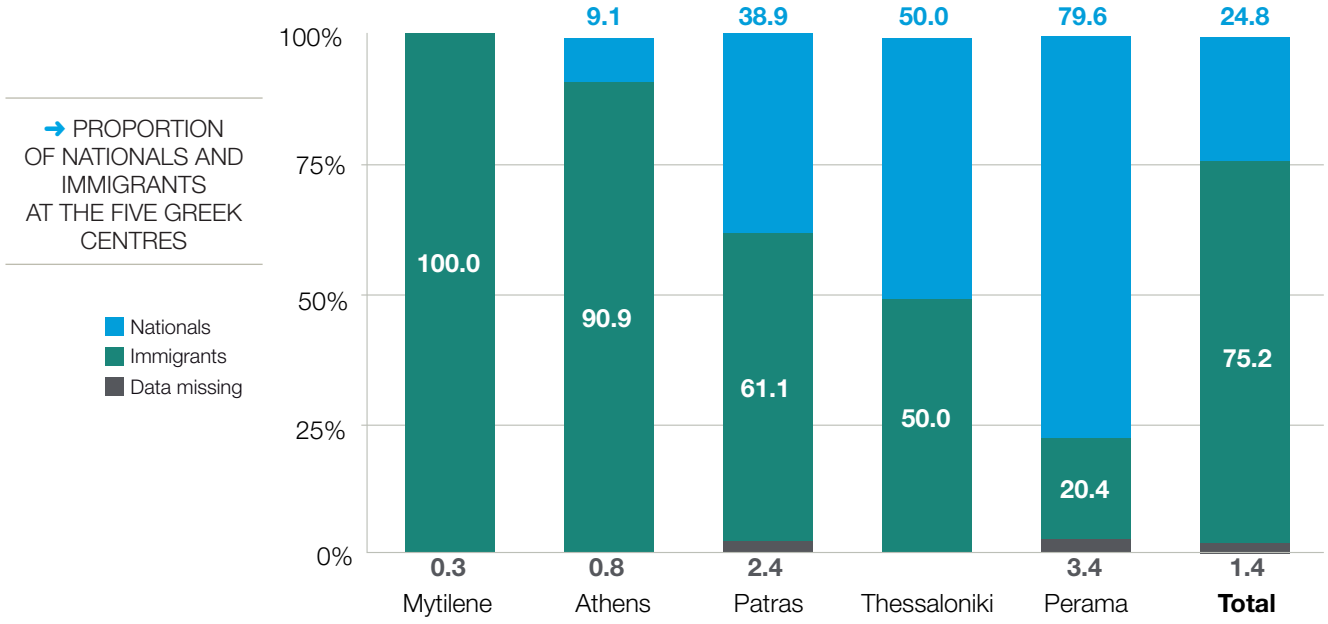
Belgium	Switzerland	Germany	Greece	Spain	France	Netherlands	United Kingdom
Morocco (545)	Nigeria (26)	Bulgaria (190)	Afghanistan (1151)	Morocco (24)	Romania (1031)	Nigeria (35)	Bangladesh (165)
Guinea (137)	Eritrea (17)	Germany (60)	Greece (838)	Romania (19)	Pakistan (873)	Ghana (22)	India (117)
DRC (137)	Afghanistan (15)	Romania (59)	Syria (530)	Nigeria (8)	India (575)	Suriname (13)	Philippines (108)
Algeria (123)	Algeria (14)	Serbia (22)	Albania (173)	Cuba (6)	Tunisia (514)	Brazil (5)	Uganda (99)
Cameroon (113)	Morocco (13)	Poland (14)	Somalia (170)	Guinea (6)	Côte d'Ivoire (512)	Colombia (3)	China (76)
Nigeria (65)	Gambia (10)	Hungary (10)	Sudan (64)	Senegal (5)	Mali (470)	Egypt (3)	Nigeria (63)
Romania (63)	Guinea-Bissau (8)	Mongolia (10)	Bangladesh (59)	Honduras (4)	Morocco (417)	Ecuador (3)	Vietnam (43)
Afghanistan (62)	Georgia (6)	Afghanistan (8)	Eritrea (57)	Nicaragua (4)	Algeria (370)		Romania (39)
Senegal (62)	Portugal (6)	Croatia (8)	Bulgaria (52)	Venezuela (4)	Moldova (351)	-	Pakistan (30)
Bulgaria (46)	Tunisia (6)	Iraq (8)	Pakistan (51)		Cape Verde (254)		Afghanistan (28)

The proportion of patients originating from the Middle East[32] increased significantly between 2012 and 2013, reflecting the political problems in that part of the world. The figures in 2013 were 30.8% in Belgium, 22.5% in Spain, 16.7% in France and 15% in Switzerland. In Greece, Syrians were the third most frequently recorded nationality in 2013 (15.5%).

In France, the inclusion of a second centre (Saint-Denis, in the suburbs of Paris), in addition to the one in Nice, explains why the proportion of people from the Maghreb and sub-Saharan Africa reversed between 2012 and 2013. In 2012 the figures in Nice were 36% Maghreb compared with 19.9% for sub-Saharan Africa. This year, the total for the two centres resulted in there being a larger number of people from sub-Saharan Africa (31%), considerably ahead of the Maghreb (17%).

In Greece, the proportion of Greek nationals remains the most significant of any country covered by the survey: one quarter of patients seen in Greece were Greek. The apparent reduction in 2013 compared with 2012 (when half of all the patients were Greek) is explained by the fact that a new centre was included in the survey which is attended solely by immigrants (Mytilene, which opened in 2013). In Thessaloniki[33] and Perama, the majority of patients attending a consultation in 2013 were still Greek nationals (50% and 79.6% respectively).

➜ PROPORTION OF NATIONALS AND IMMIGRANTS AT THE FIVE GREEK CENTRES



32 For the purposes of this report, Middle East comprises Afghanistan, Egypt, Iran, Iraq, Kazakhstan, Kurdistan, Kuwait, Jordan, Lebanon, Pakistan, Palestine, Syria, the United Arab Emirates and Yemen.
33 Only 13% of patients seen in Thessaloniki were recorded in the database, and 57% in Perama, which largely explains the reduction in the proportion of Greeks seen.

Length of stay by foreign nationals in the survey countries

In some of the countries surveyed, for patients who are non-nationals the last date of entry into the country may determine their administrative position in relation to accessing healthcare. On average they had been living in the country for almost three years (32.5 months). Half of them had been there for between four months and three years. Patients had been living for the longest periods in Spain and London (average = 64 months, i.e. just over five years), the Netherlands (average = 87.8 months, i.e. just over seven years) and Belgium (average = 40.8 months, i.e. almost 3.5 years) compared with the other countries (where the average was around 20 months).

This illustrates once again that migration for the purposes of seeking healthcare is a myth, as the patients seen only presented at the centres after having lived in Europe for long periods.

Reasons for migration

As they are every year, the migrants were asked about their reasons for deciding to migrate (except in Belgium and France). Multiple responses were offered.

➜ REASONS FOR MIGRATION BY COUNTRY

	CH	DE	EL	ES	NL	UK	Total (CAP)	Total (WAP)
For economic reasons, unable to earn a living in home country	28.2	65.9	69.9	60.0	41.9	38.1	48.1	47.2
For political, religious, ethnic or sexual orientation reasons	23.6	4.6	40.2	4.8	31.0	28.5	23.7	24.2
To join or follow someone	18.2	31.8	3.8	22.4	14.0	10.7	15.2	14.6
Because of family conflict	10.0	3.5	2.9	5.6	13.2	7.2	6.7	8.5
To escape from war	16.4	5.8	8.4	5.6	6.2	4.7	6.0	6.9
To safeguard children's future	0.0	4.6	2.1	10.4	2.3	2.1	3.1	3.9
To study	1.8	3.5	0.8	1.6	1.6	4.9	3.6	2.6
For personal health reasons	**3.6**	**4.1**	**2.5**	**6.4**	**0.8**	**0.9**	**2.3**	**3.0**
Other	9.1	11.3	2.5	4.0	2.3	15.6	11.2	7.8
Total*	110.9	135.0	133.1	120.8	113.2	112.8	119.9	118.8
Response rate	*46.8*	*94.3*	*9.2*	*96.2*	*97.0*	*95.0*		

** Multiple response were permitted – in France the question was not asked, in Belgium one patient in seven was meant to be asked, in Greece the response rate was very low (9.2%).*

As in 2012, the reasons most often cited were, overwhelmingly, economic reasons (48.1%), political reasons (23.7% in total + 6% "to escape from war") and family reasons (whether for family reunion: 15.2%, or to escape from family conflict: 6.7%)[34].

Health reasons were extremely rare (2.3%, which is a similar rate to that reported in 2008 and 2012[35]). In countries where access to healthcare is particularly difficult for people whose residence status is precarious (Germany and Switzerland), the rate of migration for health reasons, although still very low, was among the highest[36] (4.1% and 3.6% respectively). In London only 0.9% of people gave health as a reason for migration, demonstrating once again that the discourse against migrants said to come to take advantage of the British healthcare system is without foundation.

PATIENT STORY

Victor, 56, is Romanian: *"I was born in 1958 and grew up in B. in Romania. I got married and had two children. As I was no longer able to find work in my country, I decided to come to Germany to work. I arrived in May 2008 and found work in the construction industry. I worked long hours every day but didn't know that my employer was legally obliged to pay for my healthcare coverage. In 2012 I started to suffer increasingly from muscle pain so I decided to go to MdM. Soon afterwards the pain became much worse, especially in my leg. Although I continued to go to work, it was difficult because I was physically very tired. In May 2013, I went back to open.med. The doctor told me I needed urgent treatment and sent me to hospital. I was diagnosed with herniated lumbar disc and was operated on immediately. After spending 11 days in hospital, I was dreading the bill. It came to €4,000. I turned to MdM for help and they contacted several welfare organisations and sent me to one which helps people like me (Caritas). I was hugely relieved to learn that I wouldn't have to pay for the cost of the operation. The doctor at the hospital told me that patients usually need some physiotherapy sessions after surgery, but with no healthcare coverage this wasn't an option for me. Luckily, open.med was able to organise some physiotherapy sessions for me during which I was given exercises I could do at home. I gradually began to recover."*

MdM Germany – Munich – January 2014

34 These values are crude average proportions (CAP) (to ensure that comparisons could be made with the 2012 data).
35 In 2008 and 2012, 6% and 1.6% respectively of those surveyed cited health as one of their reasons for migration.
36 We are not taking the figure for Spain into account where the patients seen in 2013 had been in the country for the longest, meaning that the immigrants who had lived there the longest had access to healthcare at that time, which is no longer the case if they are undocumented.

Slum dwellings in France, 2013.

LIVING CONDITIONS

Housing conditions

Overall, in the seven countries where the question was asked, 62.4% of patients were living in unstable or temporary accommodation[37] (this was particularly common in Switzerland and the Netherlands).

One third (34.8%) of those surveyed believed their housing was affecting their health or that of their children.

Housing appears to pose the least risk to health in Munich and London.
Of the patients seen by MdM programmes, 11% are homeless (20% among men) and 7% had been provided with accommodation by a charity or other organisation (15% of women), while 5% were living in slums and 3% in squats.

PATIENT STORY

Christian, 47, is Belgian and spent a year living on the streets of Brussels. He suffers from a severe form of Type 1 diabetes. *"How did I look after myself on the streets? I did my own wound dressings in the disabled toilets because there was room in there. I could sit down, take off the dressings and put on new ones or wash the original ones. I dried them under the hand drier. My blood sugar was stable. If you don't have anything to eat or you're eating less than before, your sugar levels are OK, they hold up quite well. My blood glucose level was perfect, no problem, and I wasn't doing anything for it, for a change* [laughs]. *As far as my health was concerned, MdM listened to me and supported me. One day I went to the hospital, I was feeling faint because of the diabetes and the pain in my feet. I already owed them €250 so when I went there they threw me out. I walked and walked to try and ease the pain, I walked all night."*

MdM Belgium – Brussels – January 2014

Administrative situation

The majority (56.5%) of people seen at the MdM centres do not have permission to reside: 48.6% are non-EU citizens and 7.9% are EU citizens (who have been in the country for over three months and do not have adequate financial and/or valid health insurance). Most of the EU citizens are Romanians, Bulgarians, Poles and Slovakians but the figure also includes Dutch, Spanish, Portuguese and Italian nationals, among others.

37 The question was not asked in Greece. Here, the notion of unstable accommodation was given by patients when they were not sure they would be able to stay where they were living – it is their own perception of the instability of their housing which is of significance.

➜ ADMINISTRATIVE STATUS BY COUNTRY

	BE	CH	DE	EL	ES	FR	NL	UK	Total
No permission to reside	63.2	15.4	8.5	23.8	53.5	67.8	90.2	61.5	48.6
EU citizen with no permission to reside[1]	15.9	2.1	30.9	2.4	8.5	5.7	2.3	1.1	7.9
Total with no permission to reside	*79.1*	*17.5*	*39.4*	*26.2*	*62.0*	*71.9*	*92.4*	*62.7*	*56.5*
No residence permit requirement (nationals)[2]	1.8	0.9	12.4	47.1	3.1	5.1	0.8	0.5	8.8
Asylum seeker (application or appeal ongoing)	6.3	69.7	3.0	13.0	1.6	7.5	5.3	16.7	15.5
Valid residence permit	3.5	7.3	4.7	5.6	19.4	5.7	0.8	2.3	6.2
EU national staying for less than three months (no residence permit required)	2.3	1.3	20.1	2.8	1.6	2.5	0.0	0.7	3.9
Visas of all types[3]	2.5	1.3	10.2	0.4	5.4	2.5	0.0	6.2	3.6
EU national with permission to reside[4]	1.8	0.9	6.5	4.3	6.2	1.1	0.0	1.8	2.8
Residence permit for another EU country	1.8	0.4	1.8	0.0	0.0	2.2	0.0	0.1	0.8
Specific situation conferring right to remain	0.0	0.0	1.4	0.0	0.0	0.0	0.0	4.5	0.7
Subsidiary / humanitarian protection	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.3	0.1
Total with permission to reside	*20.1*	*81.6*	*60.4*	*73.2*	*37.2*	*28.1*	*6.8*	*33.1*	*42.5*
Don't know	0.8	0.9	0.2	0.6	0.8	0.0	0.8	4.2	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Data missing	*6.5*	*1.3*	*5.4*	*86.5*[5]	*0.8*	*28.7*	*0.8*	*7.4*	
No. of respondents	*2,227*	*234*	*492*	*463*	*129*	*6,057*	*132*	*969*	

[1] Without adequate financial resources and/or health coverage.
[2] In France and Greece, children who are foreign nationals do not require a residence permit and are therefore included in this category.
[3] Tourist, short-stay, student, work.
[4] Adequate financial resources and valid healthcare coverage.
[5] In the case of Greece there is too much missing data for it to be analysed.

In Germany, 30.9% of patients were EU nationals who do not have permission to reside, due to a lack of adequate financial resources or valid health insurance (compared with an average rate of 7.9% in the other countries). In addition, 20.1% of patients were EU nationals who had arrived in the country less than three months ago (compared with fewer than 3% in the other countries) and 6.5% were EU nationals with permission to reside. Germany was the country with the largest numbers of EU citizens (excluding German nationals).

In Spain, 19.4% of patients were non-EU nationals with a valid residence permit (compared with fewer than 7% in most other countries). This is due to mass unemployment and economic problems in the country (which have primarily affected immigrants).

In Switzerland, a significant majority of patients were asylum seekers (69.7%), in contrast to the other countries surveyed (asylum seekers represented 16.7% of the total in London and less than 10% in most other countries). One of the two programmes is actually aimed at asylum seekers housed in three reception facilities in the canton of Neuchâtel and accounted for 68% of the patients.

In London, 61.5% of those coming to the centre were foreign nationals who do not have permission to reside and 16.7% were asylum seekers.

PATIENT STORY

Muenda, 35, is a Ugandan man who fled to Kenya in 2005. Involved in support for an opposition party and fearing for his life, he sought asylum in Kenya but was returned to Uganda where he was then imprisoned. He eventually managed to escape and travelled to the United Kingdom. In 2011 he fell ill. *"I had a problem when I was in prison in Uganda which was diagnosed as chronic prostatitis. I don't have enough money here to pay for private medical care, so I went to the hospital. I was feeling unwell; I was weak and when I arrived I could hardly walk. When I got there they asked me for the name of my GP… and told me they couldn't help me. They just gave me paracetamol. So I borrowed money from my friend and went to see a private doctor who sent me to hospital for my prostate, liver, kidneys and bladder to be scanned and a blood test to be taken. The total cost of these tests was around €454 but I didn't have enough money. I asked the doctor to leave out one of the tests. I had an infection and I needed to go to hospital. Then the private doctor gave me a prescription for medication which I couldn't afford. Living without the medication, knowing I had a prescription which would make me feel better, was like a living hell. In 2012, I went to MdM. I was losing blood and had lost weight. The MdM doctor gave me a prescription and medication free of charge. I felt much better. I took the medication for 21 days but the infection had spread. It took a year for MdM to help me register with a GP, after two rejections... My father and my brother died and I couldn't go to their funerals. When they sent me away from the accident and emergency department, despite the fact I was so ill, it was as though they were saying to me, go away and die."*

MdM United Kingdom – London – September 2013

In Greece a quarter of the patients were Greek citizens[38].
Overall, in the six countries where sufficient numbers of patients were asked this question[39], 38% of them were or had been involved in an asylum application.

Only a very small minority of asylum seekers had been granted refugee status (between 2.1% and 4.1% depending on whether a crude or weighted average proportion is calculated), while four out of ten had already been rejected (43.9%).

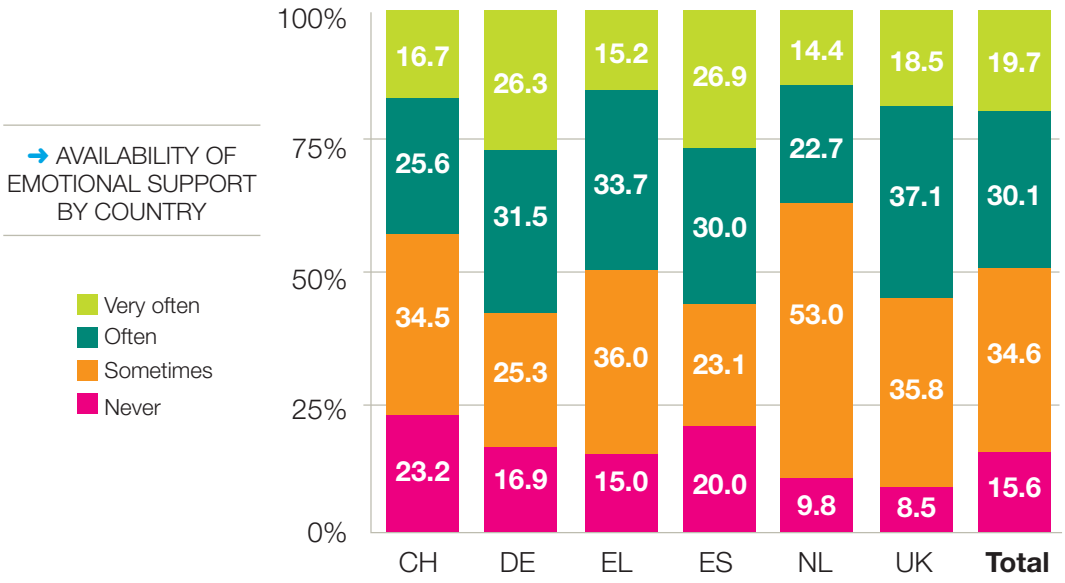
Work and income

A slim majority of people attending MdM centres had no permission to reside and therefore did not have permission to work. It is therefore unsurprising that only 21% of them reported working to earn a living.

Almost all of the people surveyed (93%) were living below the poverty line[40] (on average, over the preceding three months, taking into account all sources of income).

Emotional support

When asked about moral support[41], 15.6% of patients replied that they had never had anyone they could rely on for emotional support or whom they could turn to in case of need. One third (34.6%) only sometimes had someone they could turn to. Overall, one in two people said they could rarely or never rely on support if they needed it.



In all the countries (except for in London), men were significantly more isolated than women. Overall, 56.9% of men had emotional support only sometimes or never, compared with 41.3% of women ($p<10^{-6}$).

PATIENT STORY

Hélène is Belgian: *"I took several casual jobs in order to get by and ended up working for 15 hours a day. I was falling asleep at work from exhaustion. I was starting to lose my strength… I had serious health problems and I gradually had to stop working. I had to spend all my savings to survive. I was so exhausted I no longer had the energy to do the things I needed to do… Fortunately, I met someone who helped me to rebuild the fabric of my life – social, administrative and medical – and to find the support I was entitled to. I just didn't have the energy any more to find information, apply for things and sort out things like unemployment benefit, health coverage and all that…"*

MdM Belgium – Brussels – January 2014

38 It should be noted again that only 13% and 57% of patients were recorded at the two centres which saw the most Greek nationals, meaning the rate is significantly reduced.
39 The response rates in Germany (DE= 14.0%) and Greece (EL= 4.6%) were too low to be made use of specifically, but the data were included in the totals.
40 This does not include the number of people living on the financial resources of the respondent. If they were included, the percentage of people living below the poverty line would be much higher and may actually represent virtually all the patients seen by MdM.
41 The question was not asked in Belgium or France. The response rate in Greece was very low: 14.3%.

Patient after a racist attack, Greece 2013.

VIOLENCE

A number of studies have shown the importance of identifying previous experiences of violence among migrant populations, taking into account their frequency[42] and their impact on the mental and physical health of the victims, including in the long term, many years after the original episode.

In a context where stigmatisation of "foreigners" is one of the main obstacles to a better awareness of the situation of exiles fleeing torture and political violence[43], and also knowing the countries of origin and the conditions experienced by migrants during their journey to the destination country, it is important to listen attentively to accounts of previous experiences of violence. Otherwise, there is a risk of missing psychological problems (depression or post-traumatic stress disorder[44]), sexually transmitted infections, female genital mutilation and, very often, domestic violence.

In 2013, 76.3% of people asked about this topic reported having had at least one violent experience. The vast majority of people asked about violence were in Greece and, consequently, almost 80% of cases reported came from patients seen through the Greek programmes.

Migrants from the Middle East were disproportionately highly represented among the victims of violence: 72% of victims of at least one form of violence came from this region[45] compared with 3.6% of patients overall from other regions.

Asylum seekers, as might be expected, were disproportionately highly represented among victims of violence (24.1% compared with 15.5% among the overall population, $p<0.001$).

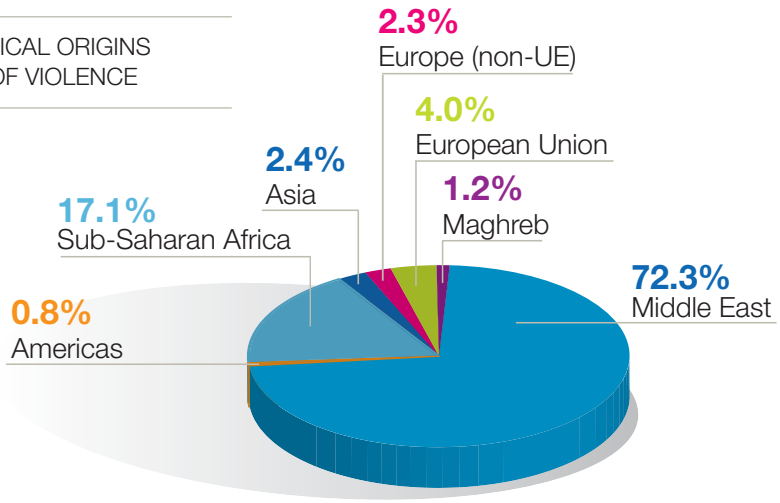
42 Baker R. "Psychological consequences for tortured refugees seeking asylum and refugee status in Europe". *In:* Basoglu M., ed. *Torture and its consequences.* Cambridge, Cambridge University Press, 1992, pp. 83-106.
43 Collectif. *Soigner les victimes de torture exilées en France. Livre blanc.* Paris, Centre Primo Levi, May 2012, p.9.
44 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". In *Bull Soc Pathol Exotique* 1997; 90: 233-7. Vannotti M, Bodenmann P. "Migration et violence". In *Med Hyg* 2003; 61: 2034-8.
45 Afghans (65.5%), Syrians (29.9%), Iraqis (0.8%), Iranians (0.5%), Palestinians (0.5%), Egyptians (0.1%) and Yemenis (0.1%).

PATIENT STORY

Aicha, 35, an undocumented migrant from Cameroon, went to the Migrant Health Network (*Réseau Santé Migration – RSM*) with dental and gynaecological problems and abdominal pain. After two weeks of tests she discovered she was pregnant and HIV positive. The father of her child didn't want any more to do with her, her sister had thrown her out and so she had nowhere to live and no money. We went with her to the Advice Centre for Victims of Offences (*Centre d'aide aux victimes d'infractions*). Following long discussions, she explained that she had been a victim of trafficking and had been locked in a room for four months. She had managed to escape with the help of a client. She was provided with emergency accommodation and decided to initiate the process of filing a criminal complaint. The local social services assumed responsibility for her treatment and accommodation. She had a follow-up antenatal appointment at the hospital and was given anti-retroviral treatment. She was also referred to a psychiatrist for psychological support.

MdM Switzerland – Neuchâtel – September 2013

➜ GEOGRAPHICAL ORIGINS OF VICTIMS OF VIOLENCE

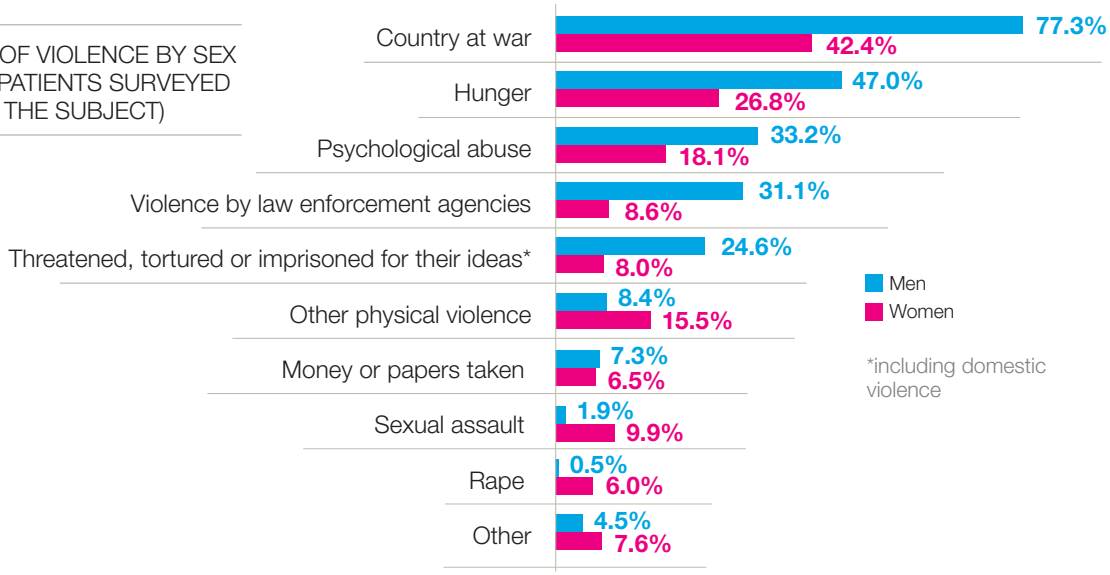


The types of violence most frequently reported were having lived in a country at war (cited by 77.3% of men surveyed and 42.4% of women) and hunger (47% of men and 26.8% of women).

Between a quarter and a third of men asked about violence reported violence perpetrated by law enforcement agencies, psychological abuse and/or having been threatened, tortured or imprisoned for their ideas.
Almost one in five women reported suffering psychological abuse.

Sexual assault was reported by 10% of women (compared with 2% of men) and rape by 6%. The youngest victims were children aged eight.
One third of sexual assault or rape was reported by men.
The victims (of both sexes) were not from the same geographical origins as the victims of violence in general. Incidents of sexual assault and rape were reported most often by people from sub-Saharan Africa (38.5%), the Middle East (25.3%) and Europe (both EU and non-EU) (22%), while the Middle East accounted for 72% of cases of violence in general.

➜ RATES OF VIOLENCE BY SEX (AMONG PATIENTS SURVEYED ON THE SUBJECT)



Workshop at MdM Spain on preventing female genital mutilation.

It is not unusual for people to suffer violence after having arrived in the countries surveyed: almost 20% of the incidents of rape, sexual assault, other physical assault and having money or papers taken were reported to have taken place after the victims' arrival in the country being surveyed. A quarter of people who had experienced hunger had experienced it in the host country.

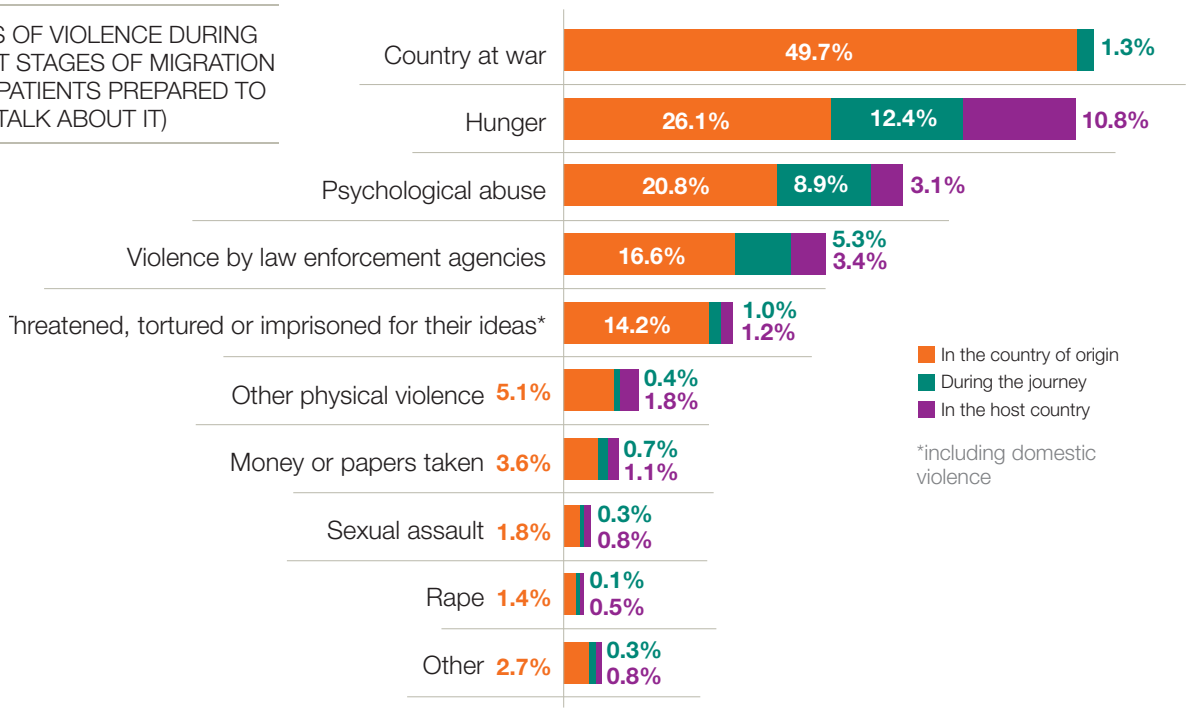
Overall, in the host countries, 11% of people surveyed on this issue had suffered from hunger, 3% from violence perpetrated by law enforcement agencies and 3% from psychological abuse.

PATIENT STORY

Shaid is an Iranian migrant who was attacked at Metaxourgiou Square in Athens. "*I was walking in the street, talking on the phone, when three men dressed in black attacked me. They hit me. Then one of them put his arm around my neck and immobilised me and he tore my ear off with his teeth. I was bleeding and my ear fell on the ground. I didn't realise at first. A friend of mine saw me, came, and picked me up. He found my amputated ear and took me to the hospital. I had surgery to reattach my ear but it was not successful. So they removed my ear. I was discharged from hospital two weeks later. I went to MdM and they helped me with changing my dressings. I would like to say to migrants who are leaving their countries that maybe it's better in their own countries. I saw no civilisation in Europe. No civilisation and no love.*"

MdM Greece – Athens – 2014

→ RATES OF VIOLENCE DURING DIFFERENT STAGES OF MIGRATION (AMONG PATIENTS PREPARED TO TALK ABOUT IT)



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MdM Flashmob Monastiraki Square, Athens 21 February 2014.

ACCESS TO HEALTHCARE

Coverage of healthcare charges

Two thirds (64.5%) of patients had no coverage for healthcare charges[46] when they first came to MdM centres.

➜ COVERAGE OF HEALTHCARE CHARGES BY COUNTRY

Variables	BE	CH	DE	EL	ES	FR	NL	UK	Total
No coverage / all charges must be paid	89.9	14.9	0.0	61.5	0.0	92.3	20.3	94.1	46.6
Access to emergency services only	0.0	1.3	68.6	14.2	59.4	0.0	0.0	0.0	17.9
Full healthcare coverage	5.2	72.4	3.8	18.1	25.0	3.8	3.1	1.3	16.6
Partial healthcare coverage	0.4	9.6	4.0	6.0	4.7	2.8	76.6	0.1	13.0
Healthcare coverage in another EU country	2.4	1.8	19.0	0.2	0.8	1.2	0.0	0.0	3.2
Access on case-by-case basis	2.1	0.0	4.6	0.0	10.2	0.0	0.0	0.0	2.1
Free access to GP services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.7	0.5
Chargeable access to secondary healthcare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100**
Missing data	*10.2*	*3.8*	*13.1*	*86.0*	*1.5*	*30.2*	*3.8*	*11.2*	*36.2*

46 We have aggregated the figures for people who have no healthcare coverage and those who only have access to emergency treatment.

In London, almost all patients (94.1%) had no healthcare coverage whatsoever when they came to the MdM clinic: at that point they had still been unable to register with a general practitioner, the entry point to the healthcare system. This was in a political context where the government was increasingly questioning access to healthcare for undocumented immigrants.

The proportion of patients in this group was particularly high in France (92.3%) and Belgium (89.9%). These rates can be explained in part by the fact that the centres concerned (Nice, Saint-Denis, Brussels and Antwerp) mainly accept patients with no effective right of access to healthcare, while people who do have a healthcare coverage are redirected to facilities within the public healthcare system. In theory, undocumented migrants in both countries have relatively favourable conditions of access to healthcare; in practice, however, administrative barriers and the time taken to process case files and applications for periodic renewal of access increase the frequency of situations and interim periods where they have no effective healthcare coverage.

In Greece, where the largest group of patients seen were Greek nationals, almost two thirds (61.5%) had never had healthcare coverage or had lost it. Foreign nationals without permission to reside in effect had no rights to any healthcare coverage, while Greek nationals and those with permission to reside had lost their healthcare coverage due to their inability to pay or lack of contributions through their employment.

In Switzerland, 72.4% of patients seen had full healthcare coverage. It was observed that these people were primarily asylum seekers, who have the right to coverage during their application process (although the procedures involved can be complex and the context rather restrictive). The other patients seen either did not have or no longer had any (adequate or effective) form of healthcare insurance.

In Germany slightly more than two thirds (68.6%) of patients only had access to emergency healthcare and 19% had rights to healthcare coverage in another European country (which is in line with the high number of Europeans among the patients treated, as noted above).

In Spain[47], almost 60% of patients seen also only had access to emergency healthcare through accident and emergency departments.

In the Netherlands 76.6% of patients seen in Amsterdam and The Hague could not obtain healthcare coverage due to their irregular administrative status (although their treatment charges can be reimbursed to the healthcare provider on a case-by-case basis if the patient cannot pay).

Barriers to healthcare access

Only 24.5% of all patients surveyed reported that they had experienced no difficulty in accessing healthcare. This percentage is even smaller if the exceptional figures for Switzerland (where 84.8% of patients stated that they had experienced no difficulty in accessing healthcare) are not taken into account[48]: across all other countries, only 15.9% of patients stated they had experienced no difficulty in accessing healthcare. A further quarter (24.9%) had not tried to access healthcare. While some of these people may not have needed healthcare, or had no reason to seek access, others have undoubtedly internalised the various barriers to access to such an extent that they gave up seeking healthcare.

As in our previous surveys, the three barriers most frequently cited by patients were: financial problems (25.0%) (a combination of charges for consultations and treatment, upfront payments and the prohibitive cost of healthcare coverage contributions); administrative problems (22.8%) (including restrictive legislation and difficulties in collecting all the supporting documentation needed to obtain any kind of healthcare coverage, as well as administrative inefficiency); and lack of knowledge or understanding of the healthcare system and of their rights (21.7%). Since the first studies by the MdM International Network Observatory in 2006, nothing seems to have changed with regard to these problems: around one in two patients had no knowledge either of the healthcare system or of their rights and/or was at a loss when confronted with the administrative procedures of the host country. These results clearly contradict the myth that migrants come to Europe for the purpose of using healthcare services.

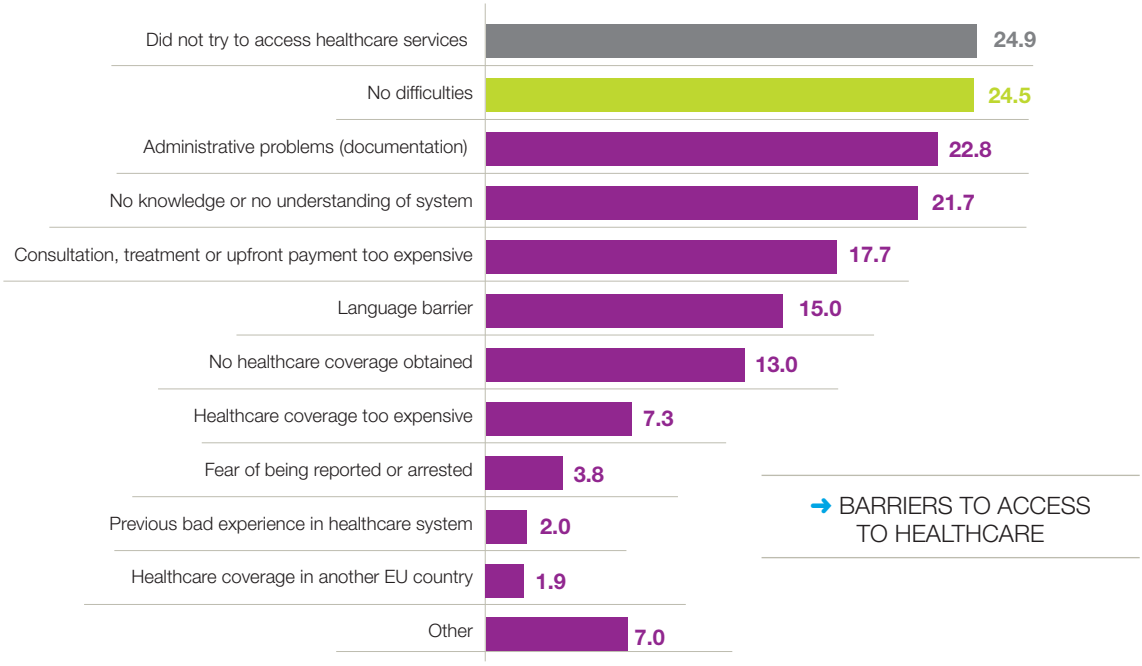
PATIENT STORY

Adama, 31, is originally from Kenya. He has no documentation. He came to the MdM clinic because he was experiencing chest pains spreading to his arm and frequent nausea. The MdM team referred him to a public healthcare centre. *"At the health centre, I showed the receptionist the papers explaining the new law on access to healthcare for people without documentation which MdM had given me. The receptionist then asked me quite a lot of questions: what was I doing in Sweden? Why had I come here? and other things. It was like being at the Immigration Office and it was really unpleasant. Then she told me I would have to pay €200 to see a doctor. This was in spite of showing her the paper about the new law. I knew that it should cost €6. Then I went to another health centre and paid €6 and they gave me an appointment with a doctor. The doctor gave me a prescription for two types of medication. At the pharmacy I had to pay €30."*

MdM Sweden – Stockholm – 2013

47 It should be noted that since September 2012 between 750,000 and 873,000 migrants in Spain have lost their healthcare coverage. (Legido-Quigley, H., Urdaneta, E., Gonzales, A. et al., "Erosion of Universal Health Coverage in Spain", *The Lancet,* Vol.382, No 9909, 14.12.2003, p. 1977.)

48 The patients attending the Swiss centres were predominantly asylum seekers who have access to healthcare coverage during their application process.



Giving up seeking healthcare

More than one patient in five (22.1%) said that they had given up trying to access healthcare or medical treatment in the course of the previous 12 months.

Racism in healthcare services

Fortunately, experiences of racism within healthcare services remain rare: an average (crude) of 5.4% of patients had been faced with racism during the previous 12 months[49]. The figures for Greece are based on only a very small proportion (13.9%) of those surveyed, specifically because many patients were Greek and were not asked this question, but also because when migrants are seen at Mytilene (which, of the five Greek centres, has the largest number of patients recorded in its database), they have just arrived in the country and have not yet had any contact with healthcare services.

In contrast, behaviour of this kind was frequently reported in Spain, where it had increased fivefold between 2012 (6.3%) and 2013 (33.6%, $p<10^{-3}$)[50]. We are witnessing a clear deterioration in the perception of migrants in Spain, as a result of political discourse at the highest government levels, targeting migrants in the reform of the health system and claiming that their access to healthcare must be restricted, as they cost the health system too much money. Migrants have thus also become scapegoats in the economic crisis in Spain.

Denial of access to healthcare

Denial of access to healthcare is defined as any behaviour by health professionals which results, directly or indirectly, in failure to provide healthcare or medical treatment appropriate to the patient's situation.

Denial of access to healthcare (over the previous 12 months) was reported by 16.8% of patients seen by MdM.
As in 2012, denial of access to healthcare was most frequently reported in Spain, by over half the patients (52.4%) surveyed. These patients – who expected to be treated as they had been before the changes introduced by the new legislation – discovered when they went to healthcare facilities that they no longer had any right of access to medical services.

PATIENT STORY

Alpha Pam, a 28-year-old Senegalese man, has been living in Spain for eight years. He had been trying to see a doctor for six months, but had been turned away on seven occasions by a health centre and twice by a hospital. For his third and final attempt at the hospital, he even asked a friend to go with him, as he no longer had enough strength to walk on his own. Once there, he was seen for five minutes, but no chest x-ray or other examination was made. He was prescribed medication, which he took, but experienced no improvement. He died at his home, 11 days later, of tuberculosis, which could and should have been diagnosed and treated when he first attempted to access medical treatment.

MdM Spain – Balearic Islands – April 2013

Ranked second after Spain in this respect is London, where a quarter (24.9%) of patients was denied access to healthcare.
The figures for Belgium, Greece and France should be interpreted with caution, given the low response rates in those countries.

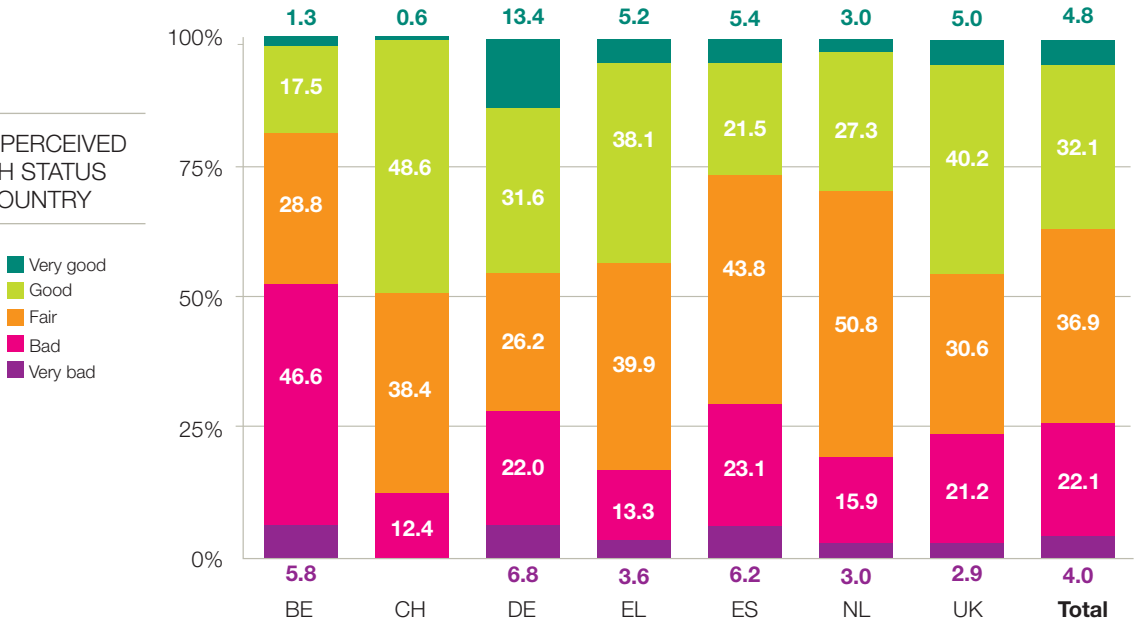
49 This question was not asked in Belgium or France.
50 Although the number of patients in Spain were very low in both 2012 (103 patients) and 2013 (130 patients).

HEALTH STATUS

Self-perceived health status

Almost two thirds (63.1%) of patients seen by MdM perceived their health status as no better than fair. Around a quarter of patients felt that they were in bad or very bad health and for patients in Belgium this rose to 52.4%[51]. It should be borne in mind that the median patient age is 32 years.

→ SELF-PERCEIVED HEALTH STATUS BY COUNTRY



In six countries (Switzerland, Germany, Greece[52], Spain, the Netherlands and the United Kingdom), patients were also asked questions on their perception of their physical and psychological health. In general, the perceived psychological health of the people surveyed appeared even worse than their physical health: in total, 27.6% of patients stated that their mental health was bad or very bad.

This applied particularly to Spain, where a rate of 40% for bad or very bad perceived mental health was reported (compared to 23.9% for bad or very bad physical health). In Switzerland too, 27% of the patients felt that their mental health was bad or very bad, while 18.2% perceived their physical health as bad or very bad.

PATIENT STORY

Asya, 38, a Chechen journalist, arrived in Nice with her seven-year-old daughter in December 2012. She then applied for asylum. She came to see a doctor at the MdM clinic (CASO) at the end of the month. She told the doctor she had been treated for breast cancer in 2008 and for pulmonary and bone metastases in 2012. She complained of severe fatigue, weight loss and a heavy, persistent cough. The doctor referred her to a centre for tuberculosis prevention for a pulmonary X-ray, which showed anomalies urgently requiring the opinion of an oncologist.

At the same time, the MdM team contacted the government organisation responsible for finding accommodation for asylum seekers (DDCVS) and asked them to find accommodation for Asya and her daughter who were quickly allocated places in a reception centre for asylum seekers (CADA).

The cancer centre in Nice is a private institution which has a public service mission. A first appointment was quickly arranged where several metastases were diagnosed and the cancer was found to be at an advanced stage. The hospital doctor recommended a course of chemotherapy as a matter of urgency.

But Asya had no healthcare coverage. The MdM team completed the necessary documentation for her and asked the local healthcare insurance office (CPAM) to treat her application as urgent. A letter explaining Asya's situation was sent to the hospital admissions office.

An appointment was made for the first session of chemotherapy at the beginning of January. The hospital admissions office asked for a deposit cheque for €3,000, without which she would not receive treatment. When they were told this, the MdM team phoned the administrative department of the cancer centre, which responded by pointing out their private status (but omitting to mention their public service mission). The MdM team then intervened directly with the doctor who had prescribed the chemotherapy, and Asya was able to receive her treatment.

MdM France – Nice – January 2013

51 This question was not asked in France.
52 The data for Greece should be interpreted with caution, in view of the high rate of missing responses (85% for the two questions on self-perceived physical and mental health).

Chronic health conditions and treatments

One third of patients (34.3%) who consulted a doctor were diagnosed with at least one chronic health condition.

In total, more than half (55.2%) of patients needed treatment that was either essential or precautionary[53]. In three quarters of these cases treatment was regarded as essential by the doctors, which is a very significant proportion.

Patients who received little healthcare before coming to MdM

Almost 30% of patients had at least one health problem which had not been treated before they came to MdM.

In Greece the rate was particularly low (3.3%), indicating frequent breaks in continuity of healthcare: health problems which had previously been diagnosed and treated were no longer being treated, which meant patients had to come to MdM. It must be remembered that the economic crisis and subsequent austerity measures have hit the Greek healthcare system extremely hard. Cuts in expenditure on hospitals and pharmaceuticals have even gone beyond the targets imposed by the Troika: the most under-privileged are obviously the worst affected[54].

The proportion of patients who required treatment but did not receive any before they came to MdM is broadly similar: almost 30% of patients were in this group and for them MdM was therefore the primary healthcare provider for problems requiring treatment.

The prevalence in this group was even higher in Switzerland and the Netherlands, where it exceeded 45%. In Greece, as noted above and for reasons already stated, the rate was remarkably low.

Overall, 13.8% of all patients seen in our clinics had at least one chronic health condition for which they had received no treatment before they came to MdM.

Slightly more than four patients in 10 (40.5%) with chronic health condition(s) did not receive treatment before they came to MdM (for at least one of their chronic health conditions).

Health problems largely unrecognised prior to arrival in Europe

Of the entire migrant population surveyed, 13.6% of patients[55] had at least one health problem which they had known about before they came to Europe. However, as has already been observed, healthcare reasons represented only 2.3% of all reasons for migration cited.

This confirms the general finding, cited above, that "migration for healthcare" is comparatively rare, despite what is frequently claimed in the rhetoric of some populists and demagogues. There are only two countries where the rates are higher: Switzerland (where there are large numbers of asylum seekers) and Spain[56].

Diagnosed health status

Overall, around half of all medical consultations concerned nine health problems. These were: gastrointestinal symptoms (8.6%), hypertension (7.0%), non-specific osteoarticular symptoms (6.7%), diabetes (insulin-dependent and non-insulin-dependent, 5.7%), anxiety, stress or psychosomatic problems (5.6%), upper respiratory tract infections (5.2%), other gastrointestinal diagnoses (4.6%), non-specific spinal problems (3.9%) and upper and lower back problems (3.6%).

If these health problems are grouped under broader disease categories, psychological problems were identified at 10.4% of medical consultations. The most frequently reported mental health problems were anxiety, stress and psychosomatic problems (5.6% of consultations: 4.8% affecting women and 6.1% affecting men, $p<10^{-5}$) and depressive syndromes (2.8% of consultations, 3.6% affecting women and 2.3% affecting men, $p<10^{-8}$).

A total of 10% of medical consultations for women patients dealt with gynaecological problems: normal pregnancy and postnatal issues (8.8%) were most frequently reported, followed by other unspecified gynaecological problems (2.3%), sexually transmitted infections (STIs) (2.0%) and finally, abnormal pregnancies and postnatal problems (0.8%).

Dermatological problems were reported at 6.1% of consultations.

53 Treatments were regarded as essential in cases where their lack would almost certainly mean a deterioration in the patient's health, or a significantly poorer prognosis: in other cases they were classed as precautionary. There is no question here of "unnecessary" treatment, nor of simply providing for "comfort".
54 Kentikelenis, A., Karanikolos, M., Reeves, A., McKee, M., Stuckler, D., "Greece's health crisis: from austerity to denialism", The Lancet; Vol. 383, No 9918, 22.02.2014, pp. 748-53.
55 This question was not asked in France.
56 The rates for Switzerland and Spain for patients who had at least one health problem which was known about before migration were 25.5% and 26.9% respectively.

SPAIN: TURMOIL IN THE HEALTHCARE SYSTEM AND SOCIAL RESISTANCE

Dismantling of a previously universal healthcare system

On 20 April 2012 the Spanish government and the parliament approved Royal Decree-Law 16/2012 'On urgent measures to ensure the sustainability of the national health system and to improve the quality and safety of its services'. This law excludes undocumented migrants from access to healthcare and ties healthcare coverage to employment status, instead of the previously universal health system; out-of-pocket charges for medication were also increased. In addition to undocumented migrants, anyone (including Spanish nationals and migrants with regular administrative status) who lives outside Spain for periods longer than three months without paying social security contributions automatically loses their healthcare entitlement card. They must then go through the entire reapplication process for social security registration.

The law creates serious ethical problems for health professionals (medical staff, nurses, pharmacists, administrative staff, social workers, etc.) and violates codes of professional ethics. It also imposes changes to the Spanish healthcare model which are unjust in regard to human rights, economically inefficient and dangerous for public health.

With the introduction of the new law, 750,000[57] foreign nationals with no permit to reside[58] were abruptly deprived of their health coverage. Although the law explicitly retains healthcare protection for pregnant women and children, their access to healthcare is nevertheless made impossible in practice by administrative barriers in some autonomous communities, as well as by the failure to issue individual health cards, and by the increasingly widespread impression created by political discourse that all undocumented foreign nationals are excluded from the healthcare system.

Moreover, the non-access to the health system can result in health risks both for the individual and for the population in general: communicable diseases are no longer identified and treated within general medical practice, nor are injuries resulting from violence. The only remaining point of entry for many people is through hospital accident and emergency services, which means that, increasingly, diseases and victims of violence are not identified and given the necessary care and treatment.

A system of personal health insurance, which costs €60 per month for those below 65 years of age and €157 per month for those aged 65 and above, is only open to people who have been resident in Spain for longer than one year and who can afford to pay these amounts. However, this option is available in only two of the autonomous communities (April 2014).

It is also essential to stress the effects of the increase in out-of-pocket charges for medication, already somewhat high in Spain at 40%, with no upper limit, for people with an annual income of less than €18,000 (in effect, a potential maximum of €1,500 per month), and at 50% for those with an annual income between €18,000 and €100,000. People with chronic health conditions are not exempt from charges and must pay 10% of the cost of their medication (irrespective of their income), limited to a maximum of €4.13 for each medication (but with no upper limit on the total monthly amount). The patients who were seen by the MdM teams were all living on incomes below the poverty line, which in Spain is currently €645. For these people, buying medication is a particularly substantial expense[59].

The response by Médicos del Mundo

57 This figure was given to the United Nations High Commissioner for Human Rights by the Spanish government in February 2014.
58 The Clandestino Project report estimated that in 2008 the number of people residing in Spain without permission was 354,000. (Triandafyllidou A, ed., Clandestino Project. Final report. Brussels: European Commission, 2009). http://clandestino.eliamep.gr/wp-content/uploads/2010/03/clandestino-final-report_-november-2009.pdf
59 The only exemptions are for retired people who receive the basic minimum pension and unemployed people who are not in receipt of benefits or receive benefits of less than €400 per month. In addition, there is an out-of-pocket payment limit of €8.14 per month (in March 2014) for retired people whose annual income is less than €18,000.

In 2012 MdM, in collaboration with the Spanish Society for Family and Community Medicine (Sociedad Española de Medicina de Familia y Comunitaria – semFYC), one of the principal medical associations specialising in primary healthcare, launched the *"Derecho a Curar"* (Right to Care) campaign. The first and most important action of this campaign was to mobilise medical personnel, calling on them to object on grounds of conscience to the new measures[60].

The campaign also had the support of other important organisations involved in primary and specialist health services, as well as a range of social sector organisations and European networks engaged in defending migrants' rights.

Various promotional materials are available online from the www.derechoacurar.org website, including posters, videos, car stickers and widgets for social media, created to provide publicity for the campaign and disseminate information. These tools are among the measures which health professionals, users of the healthcare system and the general public can use to support the campaign.

There is no doubt that the campaign video, featuring health professionals who refuse to implement the new law, gained the most positive response, and it rapidly went viral, not only among other health professionals but also among the general public. Confronted with this law excluding migrants of irregular status from the healthcare system, MdM urges health workers to exercise their individual and collective right to resist and to object to the law on grounds of conscience, and to continue to treat all people in need of healthcare, regardless of their administrative status.

When the protest campaign against the law was re-launched in the social media in summer 2013 with the video series #leyesquematan (laws that kill), it became a trending topic on Twitter, which is a clear indication of the significant amount of attention it attracted.

In the course of just a few months, over 253,000 people had viewed the Médicos del Mundo videos.

During the first phase of the campaign, more than 2,000 health professionals took the risk of formally declaring their refusal to implement the exclusions required under law. This also gives an indication of the total number of health professionals who quietly and privately continue to treat people with no healthcare coverage. In addition, we collected 19,000 signatures in support of a letter submitted to the Minister of Health at the beginning of January 2014 as part of the "Derecho a Curar" campaign.

Médicos del Mundo is an organisation with a long experience (24 years) of projects within Spain: this is why Médicos del Mundo groups in several of the autonomous communities are key drivers for networking among organisations opposed to the reforms in the healthcare system. We currently operate 45 programmes providing access to healthcare in 12 autonomous communities.

The context created by Royal Decree-Law 16/2012 is of such serious concern to organisations and groups engaged in the defence of human rights and the fight against discrimination and xenophobia, that it has led them to reinforce and intensify their network activities. While this effect could already be seen in 2012, it would be confirmed in September 2013, when the first anniversary of the law coming into force gave renewed impetus to the social mobilisation.

The negative consequences of the new regulations and other austerity measures have also been documented in articles published in The Lancet and the British Medical Journal.

Some experts have already predicted that, as a result of denial of access to healthcare and medications for about 2% of the population, there will be an increase of communicable diseases such as HIV and tuberculosis in the population as a whole[61]. Other experts have warned of the probability of an increase in mental health problems, including cases of suicide.

With the aim of documenting as accurately as possible cases encountered and barriers to accessing healthcare, Médicos del Mundo has promoted the establishment of 'observatories' similar to those already operating successfully in the Valencian community (ODUSALUD), with 63 member organisations and entities (April 2014), the Observatory on the Right to Health (ODAS), recently launched on the Balearic Islands, and the Platform for Universal Healthcare in Catalonia.

In 2013, the Nadie Desechado campaign revealed how the healthcare reform, announced as affecting 'only' migrants, also excludes all of society's most vulnerable groups from the healthcare system, in particular people with chronic health conditions. Tens of thousands of signatures in support of the campaign have been collected.

Médicos del Mundo has so far recorded more than 1,000 cases of violation of the right to healthcare, and has prepared reports which have been submitted to the Health Commission of the Congress of Deputies and to the Ombudsman.

Médicos del Mundo calls on the government to repeal this law and to restore the system of universal healthcare in Spain.

The health authorities must in the meantime ensure that all children and pregnant women have unrestricted access to healthcare, and at the very least that undocumented migrants who need emergency healthcare services receive them free of charge.

Finally, we urge all medical and social workers to object on grounds of conscience and to exercise their right to refuse to collude in the violation of fundamental human rights.

60 From the Hippocratic oath to the Declaration of Geneva adopted by the World Medical Association (WMA) in 1948 and revised in 2006, the medical profession has expressed in its code of ethics its strong commitment to protect the health of the population, without discrimination: "I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient." *The WMA Declaration of Lisbon on the rights of patients: "Whenever legislation, government action or any other administration or institution deny patients these rights, physicians should pursue appropriate means to assure or to restore them."* http://www.wma.net/en/30publications/10policies/l4/

61 See the story of Alpha Pam, the 28 years old Senegalese man who died of tuberculosis on the Balearic Islands, page 28.

GREECE, CAN PUBLIC HEALTH BE SAVED?

In Greece, the crisis and austerity measures have led to a much deeper recession than expected, as acknowledged by the International Monetary Fund[62]. In December 2013, unemployment had risen to 28%[63]. The massive decreases in health expenditure have led to: a reduction in the benefit packages from EOPYY (the National Organisation for Healthcare Provision); reduced public healthcare services; cuts in prevention programmes; and to an increase in user charges for consultations and medication, including for chronic conditions such as diabetes, coronary heart disease, cancer.

According to official figures the number of uninsured citizens in Greece is close to 3 million, out of a total population of 10.815.197. The last Memorandum of Understanding between the Greek authorities and the Troika[64] contained a Health Voucher programme that was supposed to provide free access to primary healthcare services (including up to seven antenatal visits) for the uninsured. In reality, the programme is estimated to theoretically cover only 230,000 uninsured citizens for 2013-2014, less than 10% of the actual number of uninsured people. Moreover, between the announcement of the programme in July and October 2013, only 21,000 health vouchers were actually issued[65] (less than 1% of uninsured persons). At the time the current report was drafted (March 2014), a shutdown had been ordered by the Minister of Health for at least a month of most public primary healthcare facilities to reorganise the new Primary National Healthcare Network (PEDY). A wide protest movement is taking place among medical professionals against the entrance fee of 5€ in health facilities which is a real barrier to care for the most destitute living in Greece.

Vaccination, antenatal and delivery care

Although the national immunisation schedule in Greece has not been changed, more and more children remain unvaccinated, because public health services, where children used to have free access, are slowly disappearing. According to a study conducted by the National School of Public Health, published in May 2013, 65-70% of children are vaccinated by private paediatricians, increasing still further the financial burden on unemployed and uninsured parents. It costs around 1,200€ to fully vaccinate a child when uninsured. This is why the teams of Doctors of the World vaccinated around 9,000 children in 2013, in the open polyclinics and in the mobile units going to remote villages and islands, where we also saw children and people with no access to healthcare because previously existing health facilities have been closed.

Access to Public Maternity Clinics has become extremely difficult or even impossible for uninsured pregnant women. They must pay for antenatal care during their pregnancy and must bear the cost of delivery. Although asylum seekers can theoretically access antenatal and delivery care, they are now faced with many administrative barriers. More specifically, they need to prove their inability to pay before they are allowed to have free access to healthcare in Public Hospitals.

The cost of antenatal care for uninsured women during a normal pregnancy is around €650. Then, they have to pay a further €650 for an uncomplicated delivery and about €1,200 for a caesarean section. Termination of pregnancy is a legal procedure in Greece, but it costs about €350 when uninsured.

Not being able to pay for antenatal care makes new born children more vulnerable, and puts the health of mother and child at serious risk. It also causes a lot of anxiety among the women who arrive at hospital on the day of their delivery without any previous care, prevention or counselling. It is also a source of additional stress for the medical teams.

Some public maternity wards have refused to deliver birth certificates to children whose mothers could not pay the cost of the delivery. Sometimes the employees of public maternity wards have threatened the parents with refusing to hand over the child to them if they fail to bring the requested amount of money to pay for the delivery…

Stigmatised groups already facing exclusion before the crisis

In April 2013, in massive sweep operations called **"Thetis"**, the Greek police picked up drug users in the centre of Athens, lead them handcuffed either to the migrant detention centre of Amygdaleza (a distant area outside of Athens), or just dropped them off in the countryside, hours away from Athens. In Amygdaleza, the drug users had mandatory HIV testing[66]. These operations were repeated many times, increasing the victims' vulnerability.

However, there is also some good news. At the end of 2013, a major step forward was taken in Athens through the opening of a small safe consumption room for drug users, near Omonia Square. It can serve only 2 drug users at a time and cannot stay open in the evenings or during weekends. We hope that the OKANA organisation that runs the room will get more funding in order to extend the opening hours and number of persons who can safely use drugs as the open air drug scene in Athens is the biggest in Europe.

62 Gordon J, Karpowicz I, Lanau S, Manning J, McGrew W, Nozaki M, Shamloo M. Greece: Ex Post Evaluation of Exceptional Access under the 2010 Stand-By Arrangement. Washington DC: International Monetary Fund, Country Report No. 13/156, 2013.
63 Eurostat. Harmonised unemployment rate by sex. http://epp.eurostat.ec.europa.eu, last access on 3 March 2014.
64 Samaras A, Stournaras Y, Provopoulos G. Greece: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding, 17 July 2013. Available on the International Monetary Fund website : https://www.imf.org/external/np/loi/2013/grc/071713.pdf
65 Zafiropoulou M, Kaitelidou D, Siskou O, Oikonomou B. *Impact of the crisis on access to healthcare services: country report on Greece.* Brussels: Eurofound, 2013.
66 Kokkini E. Greece... the country of harm induction. Amsterdam: Amsterdam: Correlation Network (Policy paper), newsletter 03/2013. Who is paying the price for austerity?

Sex workers lived through terrible times in April 2012 just before the new set of elections, when a law was issued that allowed for forced testing for infectious diseases. Some of them were dragged by their hair to State medical teams (!) who tested them for HIV and other diseases, against their will. The photos of the HIV positive women were then published in the newspapers. They were even accused of contaminating their clients and faced heavy fines. These kinds of severe breaches of human rights go against the recommendations of all international bodies, whether they are public institutions or NGOs, for instance those of UNAIDS, the Global Commission on HIV and the Law, WHO, the EU Fundamental Rights Agency, the ECDC, or Human Rights Watch. Non voluntary testing without the guarantee of anonymity leads to distrust towards testing facilities. All NGOs and infectious diseases specialists are waiting for this decree[67] to disappear once and for all.

Unfortunately, migrants are still suffering from hate speeches and harsh violent acts. They are still designated as responsible for the economic crisis that hit the country. As social safety nets fall apart, destitute people face growing despair, and fear for the future is widespread. The social crisis has been widely exploited by extreme right parties.

Violence against migrants in Greece does not spare children as seen with the 14 year old Afghan boy, Ismail, who was beaten by three people when he told them he was Afghan. He required 30 stitches after his assailants disfigured him with broken bottles. They left him on the pavement covered in his own blood. He was brought to a hospital by a passer-by and received emergency care. Unfortunately he was discharged from the hospital a few hours later, alone, as he had no residence permit or health coverage. MdM treated him, found him accommodation and provided him with social support so he could find his family

Extremists indiscriminately attack women (including pregnant women), children, and lone men, mainly at night; they organise racist sweeps against Albanians, foreign market stall holders and openly threaten humanitarian NGO workers, calling for hate crimes…

Response of MdM Greece to the crisis

In response to the crisis and the massive needs it generates, Doctors of the World Greece has multiplied its areas of action. Every day hundreds of volunteers and 30 paid staff members run 22 domestic projects of which 13 began after 2010. For example, the organisation runs 5 polyclinics, a shelter for refugees and asylum seekers in Athens, and four mobile units offering medical services to people living in isolated and remote places across Greece[68]. Social assistance and legal support are offered to migrants who may be in need of international protection on the islands of Lesbos and Chios.

Other projects target the homeless of Athens (including a night shelter), intravenous drug users (a harm reduction project called “Streets of Athens”), the Roma children living in camps around Athens and the elderly (the “Message for Life” programme).

The “Enough!” programme, in collaboration with the Greek Council for Refugees, aims to promote tolerance, fight racist violence in Greece and provide medical, psychological, social and legal assistance to victims of racist violence. The project also aims to contribute to a better understanding of the extent of the phenomenon.

In 2013, MdM Greece treated 75 victims of xenophobic violence. In many cases, the use of clubs, chains, knives, broken bottles, and dogs was reported. All but one attack included multiple perpetrators who in the majority of cases, were dressed in black and bearing neo-Nazi insignia. Four attacks took place inside police headquarters. As half of the victims were undocumented, they could not file any complaint. The EU Victim’s Directive 2012/29/EU established minimum standards on the rights, support and protection of ALL victims of crime, specifically including undocumented migrants[69]; it will have to be transposed and implemented also in Greece. Some perpetrators were minors themselves: this is the reason why the MdM Greece “Enough!” project also goes into schools to meet children aged 12 to 16.

Nineteen discussions in schools were organised with 770 kids aged 12 to 16. The presentation in schools starts with a photo showing children’s hands of different ethnicities holding the globe. This inaugural slide emphasises the aim of the presentation which is social cohesion and solidarity without discrimination. In order to show that we have to overcome the negative connotation of the word “foreigner (xenos)” examples of some well-known personalities from the academic and athletic world are given and we demonstrate that even though they are migrants (either Greeks living abroad or foreigners living in Greece) they play an important role in society for young people as positive role models. In addition, we show photographs of the mass migration of Greeks in the 50s and explain that Greeks are also migrants in other countries and that “everyone is a foreigner somewhere”. After explaining that Greece today is a gateway to other European countries, there is a brief reference to the work done by MdM, presenting some services and medical care provided to vulnerable groups aiming to induce solidarity. During the presentation, the students are asked to share their personal opinions and experience of the issue of “acceptance and difference”. The presentation closes with encouraging them to adopt good practices which include accepting diversity, preventing racist behaviour and strengthening social solidarity. Students are also asked to write a short essay on the issue of racism. These texts are collected and used as material in the anti-racist campaign.

67 This decree 39A was reactivated in July 2013 by the Ministry of Health who said at a meeting at the EU commission on 18 March 2014 that it would be changed at the latest in April 2014.
68 A paediatric mobile unit, a dental mobile unit, an ophthalmological mobile unit and a general medicine unit focussing on women and children.
69 (http://ec.europa.eu/justice/criminal/files/victims/guidance_victims_rights_directive_en.pdf) Unfortunately, Greece has not yet implemented the Directive.

INTERNATIONAL AND EU BODIES COMMIT TO HEALTH PROTECTION

During the last two years, a growing body of international and European institutions has asked governments to protect the most vulnerable populations from the consequences of the economic crisis and austerity measures.

UN Committee on Economic, Social and Cultural Rights

Article 12 of the International Covenant on Economic, Social and Cultural Rights specifies the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health". Already in May 2012, the Committee expressed its concern over reductions in the levels of protection afforded to the rights to housing, health, education, and work, among others, as a consequence of austerity measures taken by the Spanish government. With regards to the exclusion of undocumented adult migrants from healthcare, the Committee called on Spain to ensure that all persons residing in its territory, regardless of their administrative status, have access to healthcare services in compliance with the principle of universality of health services[70].

Council of Europe

In February 2013, Human Rights Commissioner Nils Muižnieks firmly condemned the xenophobic violence and impunity in Greece[71]. Concerning Spain, the Commissioner criticised the fact that migrant children with undocumented parents have, on various occasions, been denied access to a health card or healthcare (misinformation concerning RDL 16/2012 that only excludes adult undocumented migrants). He also denounced the disproportionate impact of the austerity measures on children's access to healthcare[72].

In June 2013, following a report on equal access to healthcare, the Parliamentary Assembly of the Council of Europe issued resolution 1946 (2013), drawing attention to the negative impact of austerity measures on social rights and their effects on the most vulnerable. The Assembly *"believes that the crisis should be viewed as an opportunity to rethink health systems and be used to increase their efficiency and not as an excuse for taking retrograde measures".* The Assembly particularly calls on Member States to ensure access to vaccination for all and universal access to healthcare for pregnant women and children, irrespective of their status. Finally, the Assembly also calls for a *"dissociation of security and immigration policies from health policy",* e.g. by abolishing the obligation on health professionals to report migrants in an irregular situation.

In November 2013, the Parliamentary Committee on Migration, Refugees and Displaced Persons asked Member States to guarantee universal access to HIV prevention and treatment, strongly denouncing the myth of health tourism[73]. The Committee expressed their concern about obligatory HIV testing. Furthermore, the Committee considered that a migrant living with HIV *"should never be expelled when it is clear that he or she will not receive adequate healthcare[74] and assistance in the country to which he or she is being sent back. To do otherwise would amount to a death sentence for the person."*

In January 2014, the European Committee of Social Rights of the Council of Europe published its country conclusions. The Committee warned that the exclusion of adult undocumented migrants from healthcare (RDL 16/2012 in Spain) is contrary to Article 11 of the Charter, which states that *"everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable".*

"The Committee has held here that the States Parties to the European Social Charter have positive obligations in terms of access to health care for migrants, whatever their residence status. […] The economic crisis should not have as a consequence the reduction of the protection of the rights recognised by the Charter. Hence, the governments are bound to take all necessary steps to ensure that the rights of the Charter are effectively guaranteed at a period of time when beneficiaries need the protection most."

70 Committee on Economic, Social and Cultural Rights of the United Nations Office at Geneva. Concluding Observations on Spain May 2012, available at http://www.unog.ch/80256EDD006B9C2E/%28httpNewsByYear_en%29/C2126B1B80ACCE10C1257A020032D5C3?OpenDocument, last access on March 31 2014.

71 "Greece must curb hate crime and combat impunity" (Muiznieks N. Report following his visit to Greece from 28 January to 1 February 2013. Strasbourg.

72 Muiznieks N. Report following his visit to Spain from 3 to 7 June 2013. Strasbourg.

73 Draft resolution adopted by the Committee on 20 November 2013: Migrants and refugees and the fight against AIDS (see http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=20322&lang=en, last access on March 31 2014).

74 Adequate healthcare in the country of origin "should be evaluated based on geographical and financial availability of treatment for the concerned individual in that particular State. Special attention should be given to the accessibility of continuous treatment and of specialised follow-up care (e.g. sufficient qualitative and quantitative availability of physicians and care structures that specialize in HIV as well as necessary blood tests and other equipment, etc.). The absence or presence of treatment also needs to be evaluated in light of the specific state of health of the individual applicant (progression of the illness, complications)."

European Union institutions

In July 2013, a large majority of the European Parliament (EP) voted in favour of a resolution on the "Impact of the crisis on access to care for vulnerable groups" (2013/2044(INI)), reminding people that the fundamental values of the EU should be respected even in a crisis situation. And yet "*the most vulnerable groups are being hit disproportionately in the current crisis*". The EP acknowledges that "*groups presenting several vulnerability factors, such as Roma, persons without a valid residence permit or homeless people, are at an even higher risk of being left out of risk prevention campaigns, screening and treatment*." The EP called on the Commission and on Member States to not only focus on the financial sustainability of social security systems but to also take into account the social impact of austerity measures. The Parliament considered that *"leaving vulnerable individuals without access to healthcare or care services is a false economy as this may have a long-term negative impact on both healthcare costs and individual and public health."*

Concerning the Troika, in March 2014, the EP criticised the fact that "*among the conditions for financial assistance, the programmes included recommendations for specific cuts in real social spending in fundamental areas, such as pensions, basic services, healthcare and, in some cases, pharmaceutical products for the basic protection of the most vulnerable […]* [75]." The Parliament called on the Commission and the Member States to "*consider public health and education spending not as a spending exposed to cuts but as a public investment in the future of the country, to be respected and increased so as to improve its economic and social recovery*."

In 2011, the EU Fundamental Rights Agency (FRA) published *"Migrants in an irregular situation: access to healthcare in 10 European Union Member States"*. The FRA formulated the opinion that undocumented migrants should, as a minimum, be entitled by law to access to necessary healthcare. Such provisions should not be limited to emergency care only, but should also include other forms of essential healthcare such as antenatal, natal and postnatal care, child healthcare, mental care and care for chronic conditions.

In March 2014, on the occasion of the International Day for the Elimination of Racial Discrimination, the heads of three human rights institutions[76] made a joint declaration: "*When leaders speak out against hate crimes, it sends a strong reassuring message to communities that are affected. Political leaders also play a key role in developing policies to combat hate crimes. First they must put in place a system for reporting racist incidents, thereby providing policy makers with the information they need to introduce strong and effective responses*".

During a Doctors of the World round table in the European Parliament (*"Impact of the crisis on women's and children's access to healthcare"*) in November 2013, the Secretary General of the European Popular Party Antonio LÓPEZ-ISTÚRIZ declared *"there are cases when people come and really need healthcare services and are rejected, and these people who do not have the means, nor health coverage, whether they are in a regular or irregular situation, should have access to free universal healthcare and this is what we need to maintain in the whole of the EU.[…]Pregnant women and children must obviously have immediate access to healthcare…"*

75 Committee on Employment and Social Affairs. Report on employment and social aspects of the role and operations of the Troika (ECB, Commission and IMF) with regard to euro area programme countries (2014/2007(INI) Strasbourg: European Parliament (plenary sitting), 20/02/2014

76 Ambassador Janez Lenar i , Director of the OSCE department for the Office for Democratic Institutions and Human Rights, Christian Ahlund, President of the Europe Commissions against Racism and Intolerance (ECRI) and Morten Kjaerum, Director of the EU Fundamental Rights Agency (FRA)

RECOMMENDATIONS FOR MEMBERS OF THE EUROPEAN PARLIAMENT

In 2013 and at the beginning of 2014, with the forthcoming European Parliament elections, Doctors of the World invited all political groups to clearly explain how they intended to protect health and healthcare systems in times of crisis, as demanded by the European Parliament and many other European institutions.

Despite the subsidiarity of Member States in matters of health, the Commission plays an increasingly important role when it comes to protecting access to healthcare for the most vulnerable: through the European Semester and country-specific recommendations on healthcare reforms; as a member of the Troika negotiating the terms of financial help for countries that are in an excessive deficit procedure; and as an actor organising the exchange of best practices concerning public healthcare policy between Member States. MEPs will need to work closely with the Commission in order to limit the negative consequences of the crisis on access to healthcare.

Furthermore, MEPs are being urged to keep up the fight against xenophobia, hate speech and scapegoating, anti-migrant discourse in the European Parliament and when they meet national politicians, decision makers and Member State representatives.

AN INVITATION TO HEALTH PROFESSIONALS

In 2009, 147 health professional bodies signed the European declaration of health professionals[77] in which they stated that discriminatory access to healthcare goes against professional ethics. Health professionals' ethics give joint responsibility to recognise and uphold the rights of the patient, as the World Medical Association stated in 1981: *"Whenever legislation, government action or any other administration or institution denies patients [their] rights, health professionals should pursue appropriate means to assure or to restore them."*[78]

Health professionals' words and actions have made the difference for the rights of vulnerable groups to healthcare on many occasions. By refusing legal measures that alter professional ethics and that exclude certain patient groups, they send a strong signal to authorities. We call on all health professionals to join us in demanding that medical ethics should come first, whatever patients' social or administrative status or practices.

77 European declaration of health professionals. Towards non-discriminatory access to health care http://mdmeuroblog.files.wordpress.com/2014/01/european-declaration-health-professionals.pdf
78 World Medical Association Declaration on the Rights of the Patients in Lisbon (1981), available at http://www.wma.net/en/30publications/10policies/l4/, last access on March 31 2014.

RECOMMENDATIONS FOR NATIONAL GOVERNMENTS

Doctors of the World urges national governments and EU institutions to ensure universal public health systems built on solidarity, equality and equity, open to everyone living in a European Member State.

Start with universal vaccination coverage and ante- and postnatal care…

We ask Member States to build public health policies based on scientific evidence. Excluding population groups from essential healthcare services is dangerous, unethical and very costly. European governments have committed to achieve the Millennium Development Goals of universal access to reproductive care and of beginning to reverse the incidence of infectious diseases such as HIV or TB by 2015. They have also committed to achieving the eradication of measles (which requires sustained vaccination coverage above 95% with two vaccine doses).

All children must have full access to national immunisation schemes and to paediatric care.
All pregnant women must have access to ante- and postnatal care.

Invest in care that is adapted to everyone, including people facing multiple vulnerability factors

MdM has been experimenting for nearly 30 years, with domestic healthcare programmes that take into account the social determinants of health such as living conditions, available moral support, work and income, residence status, experience of violence, etc. Firstly, an important lesson learned is that people who face multiple vulnerability factors need a multidisciplinary approach.

Our data show that many patients do not have any form of healthcare coverage at the time we first meet them. Consequently, a good practice for authorities, besides simplifying access procedures, is to fund services that can inform patients about their healthcare rights and help patients referred by healthcare providers with complex administrative procedures.

Community based primary healthcare structures, open to all, are a key tool to guarantee universal access.

Some migrants, especially those who do not speak the host country's language, might need interpretation or intercultural mediation. Studies suggest an important increase in the quality of care when adequate use of mediation is made,[79] and it can also have a direct impact on the number of consultations needed and on therapeutic compliance.

More than a quarter of the patients received by MdM indicate being in bad or very bad mental health. Many have limited social support. Some even suffer from post-traumatic stress syndrome and need psychiatric treatment. Many migrant parents live separated from at least one of their children. Undocumented migrants are particularly at risk of mental suffering: every time they go out they risk arrest. Furthermore, being undocumented makes it difficult to make plans for the future. For all these reasons, it is particularly useful to organise multidisciplinary work between mental and general healthcare professionals: the latter can facilitate orientation towards an effective access to mental healthcare professionals; the former can raise awareness among general healthcare practitioners in recognising and dealing with symptoms.

Patients can be empowered by involving them in healthcare programmes. This can be achieved by inviting service users to participate as full members of the team: as peer educators, outreach experts… And there are many other low-threshold techniques that allow involvement (surveys, community activities, etc.). Patient involvement improves the quality of health programmes and leads to innovative and cost-effective approaches.

Outreach activities are a necessary tool in bridging barriers to accessible healthcare. For instance, street work, home visits, or mobile units visiting squats, slums or geographically isolated areas provide access to where the most vulnerable live. Mobile units with adapted working hours (at night) are more efficient at reaching sex workers, drug users and homeless people.

79 For instance, see Verrept H. Intercultural mediation. An answer to health care disparities? In: Valero Garcés C, Martin A, eds. Crossing Borders in Community Interpreting: Definitions and Dilemmas. Amsterdam: John Benjamins Publishing, 2008

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"I am a lesbian. I had a forced marriage which is why I'm pregnant. I had to flee for my life. At the hospital here they gave me an estimate for the cost of my delivery of €12,000."
MdM UK, London, 2014

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