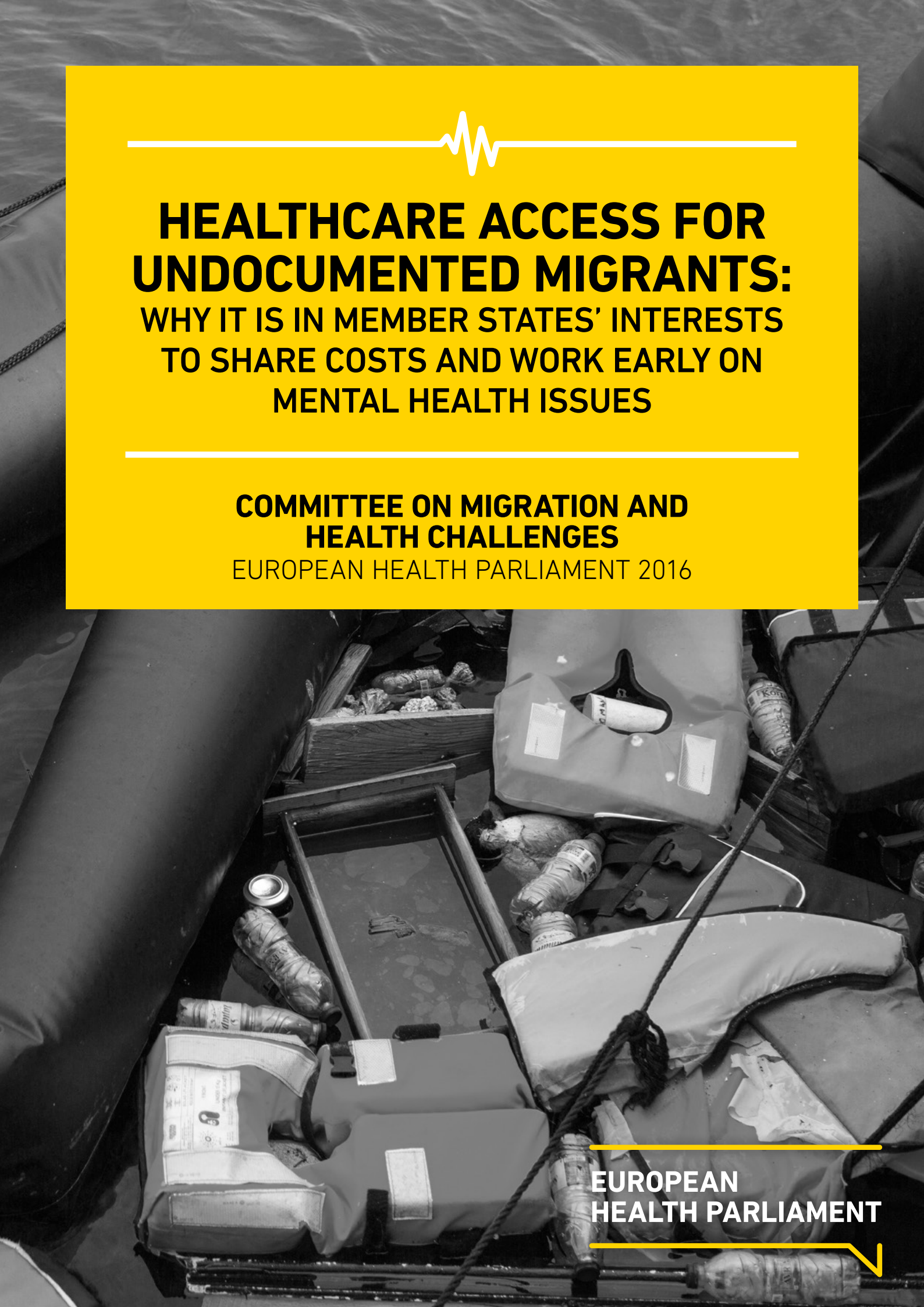
HEALTHCARE ACCESS FOR UNDOCUMENTED MIGRANTS:

WHY IT IS IN MEMBER STATES' INTERESTS TO SHARE COSTS AND WORK EARLY ON MENTAL HEALTH ISSUES

COMMITTEE ON MIGRATION AND HEALTH CHALLENGES
EUROPEAN HEALTH PARLIAMENT 2016



EUROPEAN HEALTH PARLIAMENT

EXECUTIVE SUMMARY

In the context of the current migration crisis, concerns related to migration management tend to overshadow the actual needs of migrants arriving in Europe. Among these needs, access to healthcare is crucial. Currently, providing access to healthcare is often left to those volunteer-based organizations that normally operate in humanitarian crises.

This paper argues that providing primary healthcare to migrants with a focus on mental health, independently of migrants' legal status, is legally grounded and economically efficient. Under international and European human rights law, every person has a right to access healthcare. Yet in most European countries this right is granted to asylum seekers and refugees, but not to undocumented migrants, who are entitled only to emergency care. Member States have a common interest in containing national healthcare spending, and reducing expensive emergency treatment and avoiding costs related to mental health treatment can play a role in this. Early treatment and access to basic primary care is not only beneficial for undocumented migrants, but also cost-efficient in the long-term, since it eases demand for emergency care by providing cheaper – and more effective - primary care.

Early treatment is also important for tackling mental health problems. Migrants, frequently exposed to multiple traumas from war and conflicts as well as from travels and resettlement in Europe, face higher risks of mental health disorders. The result can impair physical health and the capacity to integrate into new surroundings. Mental healthcare is consequently crucial, especially for children and unaccompanied minors, who are often the most vulnerable.

Budgetary pressures resulting from healthcare expenditures for migrants, who are often on the move, differ from one government to another. Coordinating their responses and sharing costs could prove beneficial to all Member States.

This paper makes two main recommendations:

1. ***An innovative cost-sharing scheme to ease access for undocumented migrants to national health systems. This would be independent of legal status, reducing fear and other possible obstacles, while simultaneously sharing the financial burden among Member States.***

2. ***A set of recommendations on how to better address mental health in migrants in the EU with a particular focus on unaccompanied minors.***

INTRODUCTION

The European Union (EU) is dealing with an unprecedented migration crisis that has seen more than 1.5 million arriving on European soil in 2015, legally or illegally. This influx includes economic as well as forced migrants, many fleeing war in Syria, but also many from Afghanistan, Eritrea, Iraq, Nigeria, Pakistan and other countries suffering conflict. Migrants from Syria and Iraq are more likely to seek asylum and acquire the status of refugees or international protection in one of the EU Member States.

Member States face many challenges, from suitable accommodation and timely registration of migrants to geographical allocation and integrating them into the job market, and there is not yet political consensus on the response – in terms of policy, and also from a social, cultural and economic perspective.

The health needs of migrants need to be addressed by the receiving countries. Access to healthcare is a human right, but most Member States restrict access for migrants, both to reduce incentives for further migration and to contain related costs to national health systems.

This paper focuses on (1) access to healthcare for undocumented migrants and (2) the need for a new European approach on mental health for migrants. It makes two main recommendations and suggests implementable solutions.

WHAT IS AT STAKE?

The majority of migrants report health needs similar to most EU citizens. But poor conditions for travel, sanitation, hygiene and housing pose additional risks and can increase healthcare needs, particularly for the vulnerable - pregnant women, women in general, and minors. In addition, mental health is one of the greatest long-term threats, particularly for those fleeing war, political instability, prosecution or discrimination. In minors, undetected and untreated mental illness affects social and psychological development into adulthood, and can impair integration.

In 2015 the German Chamber of Psychotherapists reported that at least 50% of refugees settling in Germany suffer from trauma-related mental issues, out of which more than 70% of refugees witnessed violence and 50% experienced it.[1] 40% of refugee children witnessed violence, also affecting their own family structure.[2] Moreover, many women and children experienced sexual violence, considered as torture or cruel, inhuman and degrading treatment in international law.[3] As a result, tackling mental issues within primary care is crucial.

The right to access healthcare is enshrined in various international human rights instruments, as well as in EU law. However, in practice access to healthcare is not guaranteed for *everyone*. Among Member States, access to healthcare is regulated in different ways. For migrants, legal status can be a major formal barrier, along with language, cultural, and economic barriers.[4] Asylum-seekers generally have legal entitlement to some healthcare, and once they have obtained refugee status or other international protection in a Member State they enter its national healthcare system. But for mental health, even when they have access, migrants also often lack the awareness of their illness or the possibility of treatment and do not consider the opportunity for healthcare in this respect.

For undocumented migrants (UM - estimated at around 1% of the population of the EU[5]), access is limited to emergency treatment in many Member States[6]. These are predominantly migrants who have entered the EU without documentation or on illegal routes without asking for asylum (although it can include those whose visas expired, and guest workers who overstayed their work permits).

Belgium, France, Portugal or Spain offer better UM access to medical care,[7] but most UM access healthcare as a last resort, through emergency care, when treatment cannot be denied because it would endanger life. Emergency care costs are then absorbed by national health budgets.[8] Some national laws oblige healthcare professionals to denounce illegal migrants that access healthcare, further discouraging UM from seeking treatment.[9]

Member States remain reluctant to provide more than emergency healthcare to UM for fear of increasing their attraction as a destination country and giving incentives to UM to seek regular status such as refugees.

We argue that it could be rational for Member States to accept costs and focus more on mental health.

WHY THIS PARTICULAR APPROACH?

Instead of debating the reallocation burden of migrants, Member States should provide better health conditions for migrants.

1. **Legal argument**: all Member States have recognized the right of everyone to the '*highest attainable standard of health*' and to receive medical care in the event of sickness or pregnancy – reading together:

    a. Article 25 of the Universal Declaration of Human Rights (UN 1948)

    b. Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (UN 1965)

    c. Article 12 of the International Covenant on Economic, Social and Cultural Rights (UN 1966)

    d. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (UN 1979)

    e. Article 24 of the Convention on the Rights of the Child (UN 1989)

    More recently, Member States have ratified the Charter of Fundamental Rights of the European Union (2000), which, in its Article 35, recognizes 'the right of everyone to access to preventive health care and the right to benefit from medical treatment'. Member States are consequently clearly obliged to allow every person on European soil to access healthcare. Denying this right would violate international law.

2. **Scientific argument:** Studies by the European Fundamental Rights Agency and others argue that delaying treating until a health condition becomes an emergency not only endangers UM physical and mental health, but also damages public health in general[10]. This is not because migrants pose a greater threat to public health than regular international travellers: migrants are exposed mainly to the infectious diseases that are common in Europe.[11] With regard to mental health, a study by the OECD has shown that the earlier treatment is given, the fewer other diseases will arise and the less the spill over effects will be.[12]

3. **Economic argument:** The European Fundamental Rights Agency study argues that delayed treatment results in a greater economic burden to healthcare systems, especially when health services are provided through emergency care.[13] Emergency care is substantially more costly than primary care and the cost of excluding migrants from healthcare is ultimately higher than granting regular access to care.[14] Disregarding mental health in early treatments is particularly harmful to national budgets, especially in the long-term. The financial burden posed by migration, should be shared among Member States. Art. 80 of the Treaty of the Functioning of the European Union commit Member States to share the responsibility in financial burden sharing in asylum policy.

RECOMMENDATIONS

RECOMMENDATION 1

ALLOWING UNDOCUMENTED MIGRANTS TO ACCESS *FREE* BASIC PREVENTIVE AND PRIMARY HEALTHCARE ACROSS THE EUROPEAN UNION THROUGH A FAIR AND TRANSPARENT COST-SHARING SCHEME SUPPORTED BY ALL MEMBER STATES

We suggest Member States can comply with their legal and moral obligations at a lower cost by reducing emergency care spending and allowing (UM) free access to basic primary healthcare. The logic is simple: when UM have the same rights in all Member States, there would be no pull-factor for specific countries. UM travel across Europe, and some Member States provide more healthcare than others, so it would be fairer to share the costs among the Member States according to their size and wealth. Sharing the burden would also share the benefits, since UM could settle and register in any Member State.

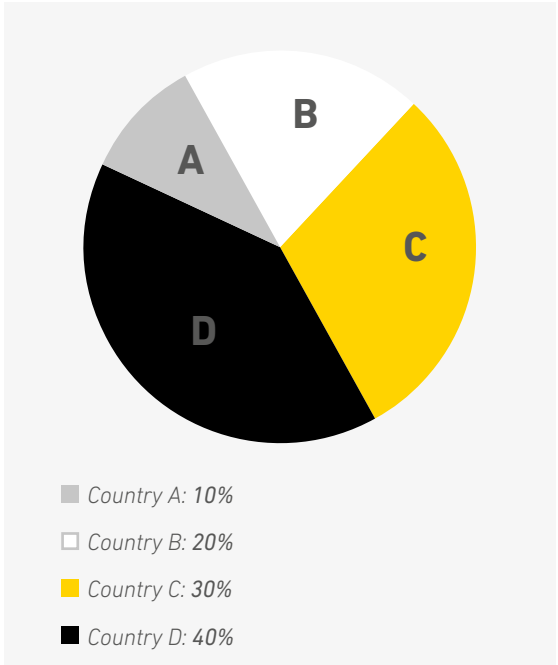
UM should have free access to basic preventive and primary health care, and the total costs should then be pooled among Member States. Reimbursement would be linked to the "Personal Health Record for refugees and migrants" developed by the European Commission and IOM in autumn 2015, and would work as follows:

A. ADOPTION OF A CONTRIBUTION KEY

Member States (MS) would adopt *ex-ante* a contribution key: each MS would agree to contribute to X % of the total costs imputable to healthcare delivered to undocumented migrants in the European Union. This key should be based on the wealth and the size of the country and could be the one the Commission has recently been using for allocating asylum applications among Member States under the reform of the Dublin system[15].

In Figure 1 a simplified example is shown. It is composed of 4 countries that commit to different shares of the total costs. Country A commits to 10%, country B to 20%, country C to 30% and country D to 40% of the total costs.

FIGURE 1: **CONTRIBUTION KEY**



B. STANDARDIZED MEDICAL SCREENING PROCESS

A standardized EU process should be established for migrants, including screening for infectious and contagious diseases (listed in Annex 1), immediate treatment when necessary (see Annex 2), vaccination (a core minimum, listed in Annex 3, and where possible with consent), information and the attribution of an identity number that would match a file in a dedicated EU-wide online database.

*A **European Online Database** accessible to authorised hospitals and medical centres should allocate a unique number for the Personal Health Record issued by a hospital, granting a "health identity", with a picture, some basic personal data, as well as the prescribed treatment and drugs*

Migrants would also be offered mental health screening through a questionnaire relevant to age, so as to allow identification of severe disorders, and to permit the provision of information and advice for possible follow-up treatment. Severe mental illness would be treated immediately in case of a threat to life (listed in Annex 2).[16]

The standardized screening process should be linked to the Personal Health Record that can be delivered by any authorised hospital, medical centre or non-governmental organization (see paragraph C).

C. ATTRIBUTION OF A "HEALTH IDENTITY"

Health screening would result in a "health identity", regardless of a migrant's legal status or future country of settlement, and linked to the Personal Health Record for refugees and migrants. Practically, an **identity number** would be inserted into the health passport along with a photograph, matching a personal file in a dedicated online database. The costs of the screening process would be covered by the reimbursement scheme (point H).

This "Health Identity" would make UM eligible for free basic primary healthcare (Annex 4) across the European Union on presentation of their Personal Health Record. Each UM would also be entitled to one hour of consultation with a psychologist or a psychiatrist free of charge, to assess any needs for further treatment.

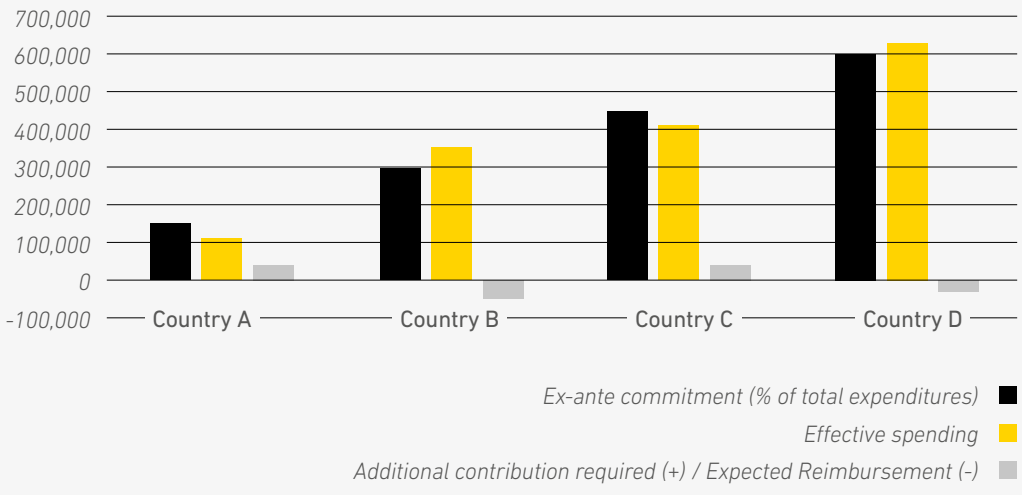
D. PRESCRIPTION OF DRUGS

Any prescribed drugs (generics where available) would be encoded on the UM file on the online database, and the UM could obtain that medication at the pharmacy without charge on presentation of a valid health identity.

E. EUROPEAN COST-SHARING MECHANISM

The prescriber and the dispenser of the drug would encode consultations, treatments, procedures, drugs and costs in the online database and report them also to the national healthcare system, which would reimburse the costs, then report them to the responsible supra-national authority.

FIGURE 2: **EXPENDITURES BY COUNTRIES AND EXPECTED TRANSFERS** ***(FOR A TOTAL EU SPENDING OF 1.500.000 EUR)***



Each year, a summary of total costs in each the country would be transferred to a **central European authority** (e.g. the Commission), along with the list of identity numbers that were treated and their corresponding list of treatments and related costs.

The central authority would aggregate the costs at European level and the costs for UM would be pooled, with Member States paying (or being reimbursed) according to the key mentioned in point (A). This accounting-based reimbursement scheme would compare *ex-ante* commitment in percentage to *ex-post* effective relative spending and automatically ensure that every country spends exactly the share of the total spending it had committed to (see figure 2).

Taking the example from point (A), we have 4 countries in the scheme that committed to a certain share of the costs. Country A committed to 10%, country B to 20%, country C to 30% and country D to 40%. The table below shows that some countries have effectively spent more and others less under the scheme. Countries A and C will have to provide additional contribution, while countries B and D can expect reimbursement.

When an UM registers in any of the 28 Member States (as an asylum-seeker, for example), the authority registering him/her in the EURODAC database will ensure that the identity number is deactivated in the dedicated online database and that it is no longer valid in the framework of this scheme.

For the scheme to be effective it must be delinked from immigration control. The dedicated online database mentioned above should only be used for the purpose of this scheme and not for immigration control purposes.

IMPLEMENTATION – IMMEDIATE ACTIONS REQUIRED

1. Member States to adopt the contribution key in a binding agreement

2. The Commission to integrate the attributed identity number and photograph into the existing health passport system

3. Member States to establish a catalogue of hospitals/medical centres/NGOs authorised to carry out the screening process

4. The Commission to oversee the creation of the dedicated online database and the technical features that would allow healthcare professionals to access it

5. Member States to establish the process for national healthcare insurance authorities to reimburse, file and report the costs imputable to the scheme

6. Member States to repeal legislation requiring healthcare professionals to report UM to immigration authorities

7. The Commission to oversee the automatic financial transfers each year

8. The Commission to establish controls to limit abuses by healthcare professionals for personal gain (abusive reimbursement, false prescription, etc.) and by national authorities (inaccurate reporting, excessive reimbursement, etc.).

RECOMMENDATION 2

ENHANCING MEMBER STATES' AND EU COMMITMENT TO INCREASE THEIR SUPPORT TO COMBAT MENTAL HEALTH ISSUES AMONG MIGRANTS

Many migrants face a range of health challenges, physical and psychological, as described earlier. Mental health can be a major issue, and minors (more than 50% of all migrants) deserve special attention in this respect because they are particularly vulnerable and have specific needs relating to mental health.

Providing mental health care to migrants has a legal and scientific, but also an economic, rationale. Ignoring the mental health would render physical health treatment less efficient where recurring physical ill-health patterns are connected to mental issues. Costs of ignoring mental health issues rank high with regard to healthcare budgets and levels of failed integration, which can in turn trigger radicalisation and hinder educational success – with further implications for integration and employment. Tackling mental health issues can also be regarded as a legal obligation for Member States in light of their duty to ensure each person's *right to the highest attainable standard of health*.

Reimbursing the costs of mental health care through the scheme in Proposal 1 would not be possible, because distinctions cannot be adequately drawn between emergency, primary and secondary care. We therefore make recommendations for targeted projects.

RECOMMENDATIONS FOR MEMBER STATES

1. Local authorities to develop and implement community-level programmes

In order to move away from purely psychiatric healthcare models, which involve high costs due to mostly individual and time-consuming consultations, focus should be put on community-based programmes, which allow for a greater number of recipients at lower costs.

Communication platforms for medical staff and migrants should be provided, since communication is a factor in preventing exclusion. Community programmes should be linked to language programmes, but should also be supported by translators and interpreters.

2. Education ministers to develop school-based intervention programmes

As minors are particularly exposed to mental health problems, school based intervention programmes should reach out directly to those suffering mental health disorders. The framework of education permits addressing several challenges simultaneously: language barriers, integration obstacles and mental health issues. Schemes should be based on the exchange of best practices as well as already existing school based group treatment for children at risk.

Intervention should also take account of existing language programmes – but should not replace mental health intervention programmes with language courses.

RECOMMENDATIONS FOR THE EU

3. The Commission to increase coordination and support for best practices of migrants' mental health under EquiHealth

The EquiHealth initiative launched by the European Commission and the International Organization of Migration to augment the exchange of best practices between Member States and non-governmental organizations with regard to migrants' health still focuses more on physical rather than mental health. Non-governmental organizations and local authorities working with mental health and migrants should be included and be given the opportunity to share their best practices.

4. The EU to focus more on migrants' mental health within its Health Programme (2014-2020)

Annual work plans within the Health Programme (2014-2020) should include pilot projects and the exchange of best practices in relation with mental health of migrants. The Commission should open calls for projects that target migrants' mental health focusing on the following variables:

(1) Support children regardless of legal status *to target the most vulnerable and to connect mental health to the reimbursement mechanism of the first proposal. Existing EU funded projects such as KITU to provide psychiatric treatment services to asylum seeker children could be an example. Particular attention should be given to traumatic disorders as a consequence of sexual abuse or homicide, as exemplified in the German initiative 'TreatChildTrauma' targeted at children of 7-16 years.*

*(**2) Parenting support** to increase children's self-esteem and their social and academic competence, and to protect against later disruptive behaviour influenced by parents' mental health problems. With a focus on migrants' mental health, existing projects such as STAKES, a nationwide development and training programme for professionals who work with children and families at high risk, could serve as an example.*

(3) Against violence *to protect children from violence as mentioned in the International Charter of Children's Rights, to promote mental health and wellbeing among children in order to prevent future mental disorder. Projects such as the Belgian HERGO programme of group conferencing in education would be an example. Projects that train children in coping with conflict situations and violence prevention should be considered.*

(4) Against detention *to prevent criminal detention of young people. Funding should be directed at projects that coordinate personnel in schools, the police force and NGOs. Such an initiative is now in place in Poland, where the National Programme for Prevention of Social Maladjustment and Crime among Children and Adolescents has been developed and implemented by an inter-sectorial governmental committee.*

(5) Against stigma and discrimination *campaigns promoting acceptance and integration of migrant minors within school settings to improve children's mental health by positive community experience instead of fear and discrimination.*

These recommendations offer direct solutions to mental health problems among migrants. They could be directly developed and implemented but could also be starting points to increase the focus on mental health in EU policy.

CONCLUSION

Our first recommendation encourages the creation of a cost-sharing mechanism among Member States to allow undocumented migrants to access primary healthcare, and our second recommendation proposes a new European approach to mental health needs of migrants, with a particular focus on minors and children.

From a legal, scientific and economic point of view, it is in the interest of Member States to share the challenges. Access to healthcare for undocumented migrants is neither satisfactory in terms of compliance with international obligations nor cost-efficient. This paper proposes a single mechanism to allow undocumented migrants to access national healthcare services across the European Union, and at the same time reduce the related burden on national healthcare budgets. These arguments should offer enough incentives for Member States to come together around this proposal. For the migrants this means that they can be cured earlier and thus need less treatment, which is also an advantage for Member States in the long run.

A new approach to mental health would take into account the traumatic experiences many migrants experienced. By focusing on specific and tailored projects, it will help governments to better deal with the broader challenge of integration, at an early stage, and at lower costs. While most projects need to be decided and implemented by national governments, the EU can support these efforts by encouraging coordination and exchange of best practices. The Commission should also include a stronger focus on migrants' mental health in its Health Programme.

ANNEX

ANNEX 1

GENERAL PHYSICAL EXAMINATION AND DISEASE SCREENING

When conducting the screening patient confidentiality needs to be fully respected, as well as national reporting mechanisms in cases of public health concerns.

The screening should be adapted according to the country of origin and of transit. Specific disease epidemiology, depending on the countries should influence the diseases to consider.

Intake forms and Medical Histories:

- Dietary history (food allergies)
- Anthropometric measurements, including weight, height, and head circumference for children
- Pregnancy test (Urine test)
- Breastfeeding ability, if applicable

Vector Borne diseases

- Malaria (Blood test and detection of pathogens by PCR)
- Leishmaniosis (Blood test and detection of pathogens by PCR)

Parasitic diseases

- Roundworms/nematodes (Stool and blood test)
- Lice and flea

Bacterial and viral contagious diseases

- Tuberculosis (Tuberculin Skin Test (especially for children under 5 years of age), IGRA or X-ray)
- Cholera (Stool test)
- Diphtheria (Swab test and cell culture)
- Sexually transmitted diseases (STD) such as genital herpes, ulcers, syphilis, gonorrhoea, HIV (Blood and/urine test and detection of pathogens by PCR)
- Acute respiratory infections (Blood test, cell culture and detection of pathogens by PCR)
- Measles (physical examination)
- Rubella (physical examination)

Non-communicable diseases

- Dehydration (Blood test and physical examination)
- Mental health (using specific questionnaires or technological approaches as well as physical examination and screening for intense stomach pain, physical and mental fatigue and insomnia, hallucinations, anxiety crisis

Others

- Anaemia (Blood test and blood cell count)
- Lead levels (Blood test of children 6 months-16 years of age)
- Type 1 Diabetes test in children with family history (metabolic and autoantibody screening)

ANNEX 2

DISEASES TO BE TREATED IMMEDIATELY

Contagious diseases

- Tuberculosis
- Cholera
- Diphtheria
- Measles
- Rubella
- STDs
- Influenza and common respiratory infections
- Typhoid Fever

Vector Borne diseases

- Leishmaniosis
- Malaria
- Salmonellosis

Invasive parasite

- Nematodes

Others

- Prenatal care including vitamin and iron supplementation
- T1D in children
- Severe mental health disorders including schizophrenia, bipolar disorder, major depression or traumatic brain injury

ANNEX 3

VACCINATIONS

- Polio
- DTap: Diphtheria, Tetanus and Pertussis combination vaccine
- MMR: Measles, Mumps and Rubella combination vaccine
- MenC: Meningococcal conjugate vaccine

ANNEX 4

PRIMARY CARE COVERED UNDER THE SCHEME

- Treatments of diseases mentioned in Annex 2
- Pre and post-natal care
- Autoimmune diseases such as diabetes, asthma, arthritis
- Cardiovascular diseases including hypotension
- Chronic diseases such as back pain, thyroid dysfunction
- Basic dental and ophthalmology services
- One consultation session for mental health
- Basic family planning services (including reproductive diseases and sexual education)
- Children under 18 years old and pregnant women should be given extended access to care and treatments

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