Migration and Health in Nowhereland

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Access of Undocumented Migrants to Work and Health Care in Europe

Health – Work – Family – Housing – Policy – Transnationalism

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Gudrun Biffl and Friedrich Altenburg
Danube University Krems

Executive Summary

Undocumented migrants are receiving increasing attention in the public media and in scholarly research. The tendency in these discussions is to focus on specific issues, be they the legal framework, the sources of irregularity or the human rights aspects concerning undocumented migrants. While these studies are important, as they provide deeper insight into some of the most complex legal and political issues of today, we go beyond the scope of these issues and deal comprehensively with irregular migration. We draw attention to the role of informal labour markets in attracting migrants, the role of welfare models and social protection systems in determining their socio-economic status, their problems of access to health services and the impact on their health condition. We also focus on the role of migration and the various migrant groups for enabling irregular migration, and on the different access rights of the various groups of migrants to work and to health services.

Our aim is to raise awareness of the complexity of the issues involved in this subject and of the fact that legal and institutional frameworks are slow to change, while rapid economic, technological and social change impact immediately on the lives of those at the forefront of change. These developments bring about winners and losers, raising inequalities in societies and between societies. They may also change the life course of migrants, dragging some into irregularity while others, mainly natives, may profit from the availability of a group of persons with reduced access rights to work. We provide arguments in favour of actions to ensure access to health care, thereby preserving human dignity, because, as Martin Luther King, Jr. said: *"…of all of the forms of inequality, injustice in health is the most shocking and the most inhumane"*.

In this book we do not only wish to draw attention to the need of improving health protection for irregular migrants for their own sake, but also for the sake of the public health of the community in general. Thus, the aim of the book is to inform policymakers, practitioners and researchers about the multi-faceted state of undocumented migrants in order to speed up appropriate legislative and institutional reforms to deal with their needs.

Currently, some 32 million foreign citizens reside in the European Union, of whom some 1.9 to 3.8 million are undocumented migrants. The most important pull factors are prospects of work, family reunion and chain migration. This explains the increasing difficulty for EU-MS to control migration flows, as human rights regulations protect the right to family. In addition, the right to refuge continues to be a strong element justifying immigration to Europe. The countries of origin of irregular migrants tend to be the same as those of regular migrants; they also tend to follow the same routes, using transnational community networks. Moreover, the changing pattern of origin countries of asylum seekers increases the ethnic and cultural diversity of this group of migrants.

We also draw attention to the increasing inequality in health outcomes, measured by life expectancy, mortality, morbidity and self-assessed health in the European Union. This is not the consequence of a deterioration in the performance of health systems generally, but rather of the increasing disparity in socio-economic status and the widening of the social hierarchy in the various EU Member States. In general, people – especially males – in Central and Eastern Europe live shorter lives and spend more years of their lives in ill health. Southern European countries tend to have large health inequalities by educational attainment level,

while countries like France, Germany and Austria tend to have the smallest ones. The Scandinavian welfare model, in contrast, has higher educational health inequality than the Anglo-Saxon model countries, except for Sweden, where differences are quite small. Health risks vary across occupational tasks and industries, accounting for different accident rates and health problems of certain occupational groups of workers. In some of the more risky jobs, migrant workers tend to be overrepresented, contributing to their higher morbidity and accident rates. Irregular migrants, particularly those with traumatic experiences in the source countries and along the migration route, tend to have a high incidence of mental health problems.

Furthermore, a chapter in the book takes a "rights" approach in characterising the various EU-MS by the access rights of irregular migrants to health systems, differentiating between three categories – those granting minimum rights, those granting less than minimum rights, and those granting more than minimum rights to undocumented migrants. The resulting landscape of wide differences between countries on the right to access health services, cutting across different welfare and migration models, allows no sweeping generalisations.

The book also gives an overview of service providers to irregular migrants, both public and private non-profit sectors. Noteworthy is the prominent role of NGOs, some of them working with a large proportion of volunteers.

In the third section of the book we offer insight into some examples of good practice, covering public institutions, private non-profit organisations and surgeries of GPs and NGOs in different EU Member States. The important distinctions between parallel and complementary approaches between them are documented, with implications for the target groups.

To complement the picture, we give voice to irregular migrants. Living and working conditions in the informal sector and their migration history have a big impact on their health status. Mental health and the sexual and reproductive health problems of women stand out as major problems. This is a burning issue in countries which grant less than minimum rights of access to health services. Reference is also made to the impact of restrictive health access policies on the health of children born into this irregular migrant situation. The interviews identify not only the challenges to the lives of irregular migrants, but also to their survival strategies and the important role of their migrant communities in providing support.

In summing up, the book offers some recommendations which might improve the access of irregular migrants to health services, the most important ones being to raise awareness of the plight of irregular migrants not only amongst the general public and politicians, but also in the communities of the source countries. The second recommendation refers to access to work. We propose controls of working conditions in the informal sector labour market that thereby reduce the cost advantage of clandestine work and raise the awareness of health hazards in this sector. The third recommendation is to aim at universal health coverage of all residents, including irregular migrants, keeping the access threshold low and ensuring anonymity. Further, we believe it is helpful to integrate NGOs and specialist services, including migrant support groups, into the health service system – better still including intercultural mediators. In addition, education and training of health professionals, as well as managers and administrators, should be implemented on large scale, drawing attention to the specific needs of migrants and, in particular, to their mental health needs.

All that said, we suggest that migration itself should be considered a social determinant of the health of a country. In this connection, the provision of health care for migrants

should not only focus on Western-style management and treatment of diseases, but should also generate understanding of the traditional beliefs and behaviour patterns of immigrants among those supplying health services. This may well encourage those wedded only to traditional health approaches to be more amenable to complementing them with Western medical treatment.

Introduction

"There can be no real growth without healthy populations. No sustainable development without tackling disease and malnutrition. … And no hope for the spread of freedom, democracy and human dignity unless we treat health as a basic human right".
(Gro Harlem Brundtland, 2003)[1]

Whoever thought that the financial crisis of 2008/2009 would slow down migration flows from the East and the South into Europe had a rough awakening when new waves of migrants arrived at European shores in the wake of the Arab Spring. Reports of thousands of Tunisians landing in small boats in Lampedusa are reminiscent of earlier reports at other Southern shores, be they in Malta, Portugal or the Canary Islands.

These images fuel the public and political debate; at the same time they are only the tip of the iceberg, dramatic in their message, but small in numbers compared to those who arrive legally by plane, bus or train as migrants. Many of them stay or return home, but some of them become irregular migrants as they do not find the jobs they hoped for and as their legal status expires. They slowly slip into a situation they can no longer escape from as they join the ranks of "Undocumented Migrants".

While the images described above or those of 15 smuggled migrants suffocated by the heat and limited space in a truck hit the front pages of the news, the pictures of pregnant irregular migrant women turned away in the hospital wards or the news of injured men collapsing on the road on the way to their home country for treatment because they were working in the informal sector without any health coverage hardly make the news or raise public concern.

The examples that make the media provide us with a glimpse into the world of irregular migration. What happens below the waterline, to speak with the iceberg metaphor, remains invisible to the general public. We want to lift the veil with our book and identify the complex mechanisms behind irregular migration, the socio-economic driving forces, the political and legal ramifications and their changes which may put people into an irregular status, often unintended by the regulators. But the contrary can also happen, the most spectacular and recent legalisation process in the EU being EU enlargement in 2004 and 2007. Many former irregular migrants from the accession countries became legal residents of another EU-MS as a result of the right to free movement and settlement within the EU.

The public debate about migration tends to focus on the problems rather than the advantages of migration, of the clash of cultures rather than the enrichment resulting from cultural diversity, of the fear of welfare system misuse rather than the contributions migrants make to the welfare system, either as workers paying into the welfare funds or as doctors, nurses or cleaners helping to provide welfare services. Irregular or undocumented migrants are a particular target, as they potentially undermine confidence in the ability of governments to regulate migration and to integrate those involved into the general community.

1 Brundtland, G.H. (2003). Health, Dignity and Human Rights (Keynote Address at the 7th Conference of European Health Ministers, 12 June 2003), Oslo.

Public debate tends to forget that irregular migrants are, for the most part, here to work, to support themselves and their families back home. They contribute to our economies, whether in the textile factories in Northern Italy, in the vegetable and fruit plantations of Southern Spain and Austria or as domestic servants and helpers across Europe, thereby enabling others, the formal workers, to pursue decent jobs with full social protection. And what do they get in return? Do they have any rights? Are their contributions to economic output matched by adequate benefits? Does anyone in politics take their needs and human rights into account and give them a voice in the political debate, apart from NGOs and human rights activists? To the contrary, they tend to be denigrated and blamed for increasing unemployment, loss of earnings, and increasing rates of impoverishment. Is it because people are afraid that they are the vanguard of a new era of global labour markets, where many of our achievements in terms of social and labour rights may get lost? If this is so, should we not make sure that this is not going to happen? Should we not see in them the natural partners of a new work agenda, where irregular migrants may not become the instrument to undercut work relations and social protection systems we have all worked hard to obtain in the last century?

This is also what irregular migrants were aiming for, when asked about their objectives in life: decent work, access to health care and education. These factors are, of course, interrelated, each affecting and being affected by the others. Health is thus one of the most important ingredients of the quality of life. Health services satisfy a basic need. They are just as important as shelter and nutrition, and represent a human right, as Gro Harlem Brundtland (2003) stated in her speech on health, dignity and human rights.

What to do about that and how to proceed in public policy is a challenge for every EU Member State and for the EU at large. This is the subject of the book. We provide a landscape of EU Member States and their regulations as far as the access to the health system is concerned. The book provides a factual base upon which politics may act such that the principles upon which the European Union rests are adhered to.

As a first step, the book focuses on the sources of an irregular status, the role of access rights to the labour market and health services in Europe for the various migrant groups, and the consequences for the health status. We give room to the voices of migrants who tell their stories of why they left their home countries, often taking the risk of a dangerous voyage into the unknown, hoping for better opportunities in life and better living conditions.

As the access to health care and longer-term treatment is not universally given in the various EU Member States, undocumented migrants often turn to NGOs for help. The book provides insight into health care in the various policy frameworks, also giving voice to professionals working in the field and their experiences with undocumented migrants, their anxieties and major health concerns. Best practice examples are identified and presented, as are the policy implications thereof.

In the last section, we offer policy recommendations which flow from the three-year long research conducted between 2008 and 2010 under the title "Healthcare in Nowhereland – Improving Services for Undocumented Migrants in the EU", co-funded by the Public Health Executive Agency of the European Union, the Austrian Ministry for Science and Research, the Austrian Fund for Health, the Cadbury Trust, and the project partners themselves.

The book aims at improving the health protection of migrants, particularly of undocumented migrants. This is not only of value in its own right, but has consequences for public health, as health hazards may flow from insufficient attention to the health needs of undocumented migrants. Thus, the aim of the book is to inform policymakers, practitioners and researchers

about the situation of undocumented migrants and their needs. In our recommendations, we identify roads to be taken by policymakers to improve the labour and health conditions of undocumented migrants, thereby taking pressure off the working conditions of all workers in the EU and reducing a public health hazard emanating from insufficient attention to pockets of ill-health in the European Union.

Furthermore, the object of this book is to contribute to a more informed level of discussion and approach about a large group of migrants in Europe. We wish to acknowledge their contributions to our well-being, as well as identify the precarious situation they are in today in Europe.

Krems, December 2011

Gudrun Biffl and Friedrich Altenburg

Undocumented Migrants

Migration in Europe and Undocumented Migrants

Gudrun Biffl

"The passport is the noblest part of man. It comes into being in a more complex way than man. Man can come into the world everywhere and in a most frivolous way and without any good reason, but a passport never. That is why it is appreciated, if well done, but man can be as good as ever and he will still not be appreciated".[1]

The discussion about undocumented migrants and their health needs cannot be disengaged from the wider theme of migration, the various forms of migration and the concomitant differences in access to work and health care in the European Union. The health needs of undocumented migrants, which are not sufficiently attended to, are only one aspect of the larger picture of irregular migration which emanates from political, economic, social and environmental upheavals and change, on the one hand, and from the need of immigration countries to control and regulate the inflows, on the other. It is precisely our highly organised socio-economic and political systems which leave little room for uncertain events that are beyond control of the individual and the regulators.

This is why we start telling the story of migration in Europe, about the lure of employment opportunities, on the one hand, and the attempts of the various EU-MS to control and regulate inflows, on the other. In this light, the EU-MS have to acknowledge the right to family and asylum, while at the same time giving in to the call of business for labour. We try to uncover ways and means by which migrants enter, mostly on a legal basis, and how they may end up without legal papers, thereby falling sometimes through the cracks of loosely knit safety nets.

Migration

Currently, some 32 million foreign citizens live in the EU27, a little more than 6 % of the total population of 500 million. The majority, 29 million or 92 % of all foreigners, live in the EU15, constituting, on average, 7 % of the EU15 population. The number of first-generation migrants, i. e., those foreigners who were born abroad and migrated to an EU-MS, is even higher, reaching 40 million or 10 % of the EU15 population. The EU15 have about as many foreign-born as the United States of America, but as a proportion of the total population

1 Bert Brecht, Flüchtlingsgespräche (1940), Suhrkamp Verlag (2000). Own translation of: *„Der Pass ist der edelste Teil vom Menschen. Er kommt auch nicht auf so einfache Weise zustand wie ein Mensch. Ein Mensch kann überall zustand kommen, auf die leichtsinnigste Art und ohne gescheiten Grund, aber ein Pass niemals. Dafür wird er auch anerkannt, wenn er gut ist, während ein Mensch noch so gut sein kann und doch nicht anerkannt wird."*

(13.7 % in 2008), the US share is higher because of the smaller size of its population – 311 million compared to the 396 million[2] for the EU15.

International migration plays an increasing role in most EU Member States, more than migration between the various EU-MS (Herm, 2008). Of the 3 million non-national immigrants in the EU27 of the 2000s, 1.8 million were non-EU citizens, with Germany, Spain and the UK having received more than half of all recent immigrants in the EU27.

Immigration contributes to economic growth, supplying labour resources where labour is scarce, and increasing the cultural diversity of the population in almost every EU-MS. It is an inherent feature of economic integration of the EU, linked to regional specialisation of production and of globalisation. In the Lisbon agenda, the EU introduced a new feature in the migration policy debate of the1990s, namely, a focus on high-skilled immigration to promote the competitiveness of Europe, together with a general increase in immigration to alleviate the challenges of an ageing European society.

The signals the EU sends out to the world of potential migrants are, however, not always consistent. On the one hand, third country migrants are invited to come, as long as they are skilled or highly-skilled, to satisfy the labour needs of an increasingly knowledge-driven economy,[3] and, on the other hand, restrictive policy measures are introduced to stop immigration from third countries because of concern about integration costs in the face of rising budgetary restrictions. The latter arise from special integration measures in schools (Mecheril et al., 2010) and in the labour market (active labour market measures, in particular, education and training). They may also surface as price increases of scarce resources like housing and in measures to maintain social cohesion, particularly in housing and neighbourhood policies. In addition, increased demand for welfare services and for public infrastructure, such as health care, add to the cost of integration.

These concerns result in increasingly restrictive immigration regulations in relation to third country migrants, while giving preference to international trade rather than migration (Biffl, 2000; Solimano, 2001). This prioritising of trade policy also fits in with the policy of the World Trade Organisation (WTO, 2004), arguing that migration gives rise to increased inequalities and results in winners and losers, while commodity trade is generally a win-win outcome. This view is also taken by Winters et al. (2003), who favour services mobility, and thus trade, rather than temporary migration (OECD, 2011, pp. 54-56; Biffl, 2009). They argue that trade carries greater and more straightforward economic advantages than migration. This judgement is based on two assumptions which do not stand up to empirical testing. One is that posted workers will return to their countries of origin, in contrast to temporary workers; the other is that trade carries fewer adjustment costs than migration. The first is easily rejected, as it can be seen that posted workers in the EU may take advantage of employment opportunities in the receiving country and become permanent immigrants, just like temporary migrants. The second one is more difficult to contest, as the benefits of trade can be easily established, while the cost of reallocating labour and of re- and up-skilling of workers so that they may fit into the rapidly changing skill requirements of trade specialisation are harder to establish (Haynes, 2002; Krugman, 2008).

2 The population data is taken from EUROSTAT and the US Census Bureau, the data on migrants from the OECD (International Migration Outlook, SOPEMI 2011).

3 The introduction of the points system into migration policy in the UK (2005) and in Austria (2011) are only two examples of this policy reorientation.

The priority given to trade rather than migration as a development policy may be a contributory factor to the rising number of illegal migrants who try to improve their economic situation by migrating, even if it means working in the informal sector (Ghosh, 1998). In addition, the rise of informal sector production of goods and services since the 1990s is associated with deregulation[4] and "flexibility"[5] requirements of labour markets, a subject we will follow up in the coming chapters.

Large informal sector production uses irregular migrants, while irregular migration may, in its turn, feed on opportunities for clandestine work. The challenge in this context is to develop a social safety net that provides health care for all who are in an irregular situation, be they irregular migrants from third countries or from within the EU, including impoverished natives who got off the "regular" track of life and ended up without a social security or health card. While some EU-MS have developed the proper tools for providing health care to these persons, others still have a long way to go, as our good practice examples in one of the later chapters indicate.

A healthy population is not only a precondition for a healthy work force and thus for economic growth and well-being, but it is also a means of ensuring social cohesion and confidence in the government. Health promotion is money well-spent, as pockets of infectious and contagious diseases like TBC, which flow from the poor living conditions of marginalised people, may bring about costly public health problems to combat, in human as well as in financial and political terms.

As formal and informal sector employment are interwoven, so are regular and irregular migration. Accordingly, the numbers of irregular migrants are in a constant state of flux, depending on push factors emanating from where the migrants come from, and pull factors flowing from labour demand in the formal and informal sectors of the EU economies, and from legislative changes and regularisation programmes from time to time in various EU countries.

Irregular Migrants

In 2008, the estimates of the number of irregular migrants in the EU range from 1.9 million to 3.8 million, about 90 % of them residing in the "old" EU15 Member States. This means that between half a percent and one percent of the EU population on average are irregular migrants. This is significantly less than in the United States of America, where the estimates for 2008 by Passel & Cohn (2009) provide a range of 11 to 12 million, amounting to some 3.6 % of the total population.

The countries of origin of irregular migrants tend to be the same as those of regular migrants; they also tend to follow the same routes, using transnational community networks. Consequently, the ethnic and cultural mix of irregular migrants tends to conform to that of the respective EU-MS population. In addition, geographic vicinity tends to favour cross-border movement of irregular migrants in response to economic opportunities. Further, the changing origins of asylum seekers add to the pattern of irregular migrants. The latter may discontinue registering while remaining in the country as "absconded asylum seekers", or

4 For the difficulties in generalising about the case for deregulation of the labour market, see Freeman (1995).

5 Encouraged by the OECD Jobs Strategy (OECD, 1999); it should also be noted that the ILO has passed Conventions - 171 (Night Work) and 175 (Part-time Work) - to encourage greater work flexibility.

they may stay on, in breach of the conditions of temporary humanitarian stay, following the rejection of their application for asylum.

Accordingly, in France, the largest group of irregular migrants tends to come from Algeria, followed by migrants from Western and Central Africa, Chinese and Vietnamese, nationals of many Sub-Saharan countries, Haitians, Colombians, Kurds, Iranians, Iraqis, Syrians, Afghans, and, more recently, Sri Lankans. In contrast, the main source countries during the 2000s in the UK were Jamaica, Nigeria, Pakistan, China, Turkey, and India (in descending order). Italy received the largest numbers from Albania, followed by Morocco, Ukraine, China, the Philippines and Tunisia. Spain was the preferred host country of irregular migrants from South America, mainly from Ecuador, Colombia, Bolivia, Argentina, Peru and Brazil. Germany tends to receive its irregular migrants largely from Turkey, Serbia and Montenegro, Russia, Ukraine, China and Vietnam.

In addition, a large number of irregular workers come from accession countries. Their residence status has been regularized through the enlargement of the EU, but access to the formal labour market may still be inhibited by transition regulations. Citizens from the new EU-MS, mostly from Romania, tend to fill the ranks of irregular migrant workers mainly in Spain, Italy, Greece, and Germany.

The majority of irregular migrants enter legally and subsequently move into irregular status by overstaying and ignoring conditions of work restrictions. The driving forces of irregular migration are the same as those for migration generally, namely to improve one's quality of life via decent jobs, adequate health provisions and education. Our analysis of irregular migrants also identifies the desire for family re-unification as a source of irregular migration. Legal reforms as well as regularisation procedures may open up routes for eventual regularisation of their status. The many sources of irregularity and the source countries of irregular migrants are discussed in detail in the following chapters.

Conclusion

As migratory processes do not only have an economic dimension, but also political, cultural, social, humanitarian and even strategic ones, it is particularly difficult to anticipate fully the potential impact of migration on Europe at a time of major changes, both economic and social. Policy co-ordination in the field of migration will be a particularly challenging task because of different migration histories and models that tend to discriminate between immigrants from various regions of the world. This flows out of the history of immigration and the particular strategic and political ties of the receiving countries with the source countries of the major immigrant groups, especially those from former colonies.

National sovereignty is becoming increasingly weaker in the wake of the migration policy coordination of the European Commission. The Schengen agreement (of June 1990) is one pillar of legislation regulating security matters. Others include the adaptation of asylum procedures, the co-ordination of the prosecution of irregular migration and clandestine work and, more recently, the right to family reunification and free movement of permanent residents of third countries.[6]

6 For an overview of EU legislation en route to a common European Union immigration policy, see http://europa.eu.int/comm/justice_home/doc_centre/immigration/printer/doc_immigration_intro_en.htm

A system of regulated and even targeted migration is seen by EU policymakers as a prerequisite for maximising the economic advantage of migration. In order to ensure social cohesion, another factor contributing to economic growth and well-being, National Action Plans of Integration were imposed on all EU27 Member States because of the challenges of integration posed by an ethnically and culturally diverse migrant population.

The reduction of irregular immigration will remain a major challenge as long as the informal sector is large and growing. Clandestine work remains a rational coping strategy in a world of scarce formal sector jobs. However, there is a risk of permanent de-skilling of those workers who are effectively excluded from formal employment. This may seriously impair the productive potential of EU-MS with high informal sectors.

While migrants will have a role to play in alleviating the problems linked to population ageing, the eventual ageing of the migrants themselves will add yet another dimension to the already daunting task of providing adequate care for an ageing population. The comparatively poor health of older migrants relative to natives means that health care institutions will be faced with caring for people with special needs, often due to chronic and multimorbid health problems, as well as different language and cultural backgrounds. Additional challenges arise when offering adequate health care to irregular migrants. This may involve institutional adjustments, in addition to intercultural training for care personnel.

If immigration to the old EU Member States continues to take place along traditional unskilled and semi-skilled lines, it will not fit into the emerging specialisation processes of industrial production and economic integration, and will most likely result in increased unemployment of the less-skilled. These circumstances will not only limit potential economic growth, but will contribute to rising income inequality and endanger social cohesion. The need for adjustment assistance is evident, one element being a coherent approach by governments and other relevant parties in the development of a system of lifelong learning.

The development of a system of lifelong learning is a major tool to raise and adapt the skill base of the population. It is an integral part of the Lisbon Agenda towards a productive knowledge society. It may not suffice, however, to reduce the productivity gap between Europe and North America. The latter, and Australia, are more successful than Europe in attracting the highly-skilled, who almost by definition contribute more than proportionately to economic and productivity growth. In that light, Europe may have to rethink its migration policies and develop better methods to attract and retain the highly-skilled.

In order for immigration to be accepted by the host community, public education may be necessary to show that there are economic advantages associated with immigration, as well as cultural enrichment going beyond more diverse cuisine and music. In this respect, Europe should learn from other immigration countries, for example, Canada and Australia, where the media play an important role in informing the general public about the economic, social and cultural benefits accruing from immigration. However, this may partly be the result of a better-informed media in countries where considerable research on the role of immigration in socio-economic development and outcomes are readily available – a result of a long tradition of generous funding for migration research and a policy of transparency.

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Definitions and Methods of Estimation of Undocumented Migrants

Gudrun Biffl[1]

"And the ones are in the Dark, and the others are in the Light,
and one sees only those in the Light; those in the Dark one does not see".
(Bertolt Brecht, The Threepenny Opera)

Before addressing the various issues relating to undocumented migrants and their access to health services, it is helpful to learn about the various terms and definitions in use for this group of people. Depending on the definitions and demarcation lines, e. g., by country of origin or legal status, the access rights may be quite different. Definitions are therefore important for policy and administrative procedures. The terms and definitions often mark dividing lines between various administrative authorities and responsibilities. This has implications for cooperation between various functional divisions of public administration, as the integration of migrants is a horizontal issue cutting across the various ministries and administrative levels. Terms and definitions are, however, also important when wanting to identify and estimate the numbers of persons in question.

The Concept of Irregular Migration: Terms and Definitions

In the literature we find various terms for "undocumented migrants"; every one of them tends to carry a certain value judgement and may have "negative" connotations without any precise information about the human beings involved and the processes leading into the difficult situation of this group of migrants. The adjectives range from irregular to illegal, undocumented, unauthorized or clandestine; the persons affected tend to be referred to as migrants, immigrants, aliens or foreign nationals. In some cases, the group of persons is also called "sans-papiers", "clandestinos", "Schwarzarbeiter" or just "illegals".

In a narrow sense, we may use the term "illegal migration" to designate the act of entering a country in contravention to the law; it is confined to an illegal crossing of a border. In this narrow sense, this term refers to a flow; it does not refer to persons who stay longer in a country than the terms of visas or residence permits allow. Such acts would be included in a broader definition, where "illegal migration" reflects an act of migration that runs counter to legal provisions of entry *and* residence. The European Union tends to use the term "illegal migration" in this latter sense (Poulain et al., 2006). Thus, "illegal migration" refers to an illegal act, not to a human being as an "illegal". This is, however, not the value-neutral understanding of Sciortino (2004, p.17) and others who point out that the adjective "illegal" associates migrants with criminal or otherwise "illicit" behaviour. Human rights advocates argue that the term "illegal migrant" is discriminatory, because "no human being is illegal", a statement

1 This chapter builds on research undertaken by various researchers in the CLANDESTINO Project (2009), in particular, on work done by Michael Jandl, Albert Kraler and Dita Vogel.

first made by Elie Wiesel, Holocaust survivor and Nobel Peace Prize winner, which became a slogan. It was taken up by various artists[2] and human rights activists to combat the usage of words meant to marginalise immigrants, migrants or foreigners in general.

In recent years, the term "irregular migrants" has increasingly been replacing the term "illegal migrants". It denotes a form of migration that is "not regular", in the sense that it does not follow the rules, without necessarily being "illegal", "illicit" or "criminal" in the legal sense. An "irregular migrant" is, therefore, a migrant who, at some point in the migration process, has contravened the rules of entry or residence. The term "irregular" is widely understood as a very broad concept and can refer to both stocks and flows of migrants (Koser, 2005).

The term "undocumented migrant" or "sans-papiers" refers to a migrant who is not in possession of the required residence documents. It may refer to persons who receive an exceptional leave to remain by the migration authorities, such as rejected asylum applicants and persons receiving subsidiary protection for a period of time. The term "undocumented migrant" is more neutral than "unrecorded" migrant, which implies an unlawful stay (Pinkerton et al., 2004, p. 1).

"Unauthorized migrant" refers to people who enter or stay in a country without legal authorisation. Of course, not everyone residing in a foreign country needs explicit authorisation to do so, e. g., if there are free movement rights as within the EU; we need to interpret "unauthorized" as "not authorized according to the law".

In our research we will use the terms "irregular migrant" and "undocumented migrant" interchangeably for non-EU citizens, i. e., third country nationals (TCN). EU citizens cannot, by definition, be irregular residents, as they have the right to settle anywhere in the EU. They can, however, be irregular foreign workers (IFW). Irregular foreign workers may reside legally in the country, such as asylum seekers or EU citizens under transitional rules who may reside but not work, unless they have the required work permits to work in the formal sector. They may work in the informal sector as "clandestine" workers or "Schwarzarbeiter", thereby breaching labour market regulations but not residence laws. Irregular foreign residents (IFR), in contrast, are third country nationals without a valid legal residence status in the country they are residing in. Accordingly, they may not access the formal labour market and, therefore, tend to take up jobs in the informal sector as "working tourists" from non-EU countries or simply as irregular or undocumented migrants.

For the estimation of numbers of irregular migrants, it is important to distinguish between stocks of irregular or undocumented foreign residents and inflows of irregular migrants. While the former relate to the stock of foreign residents without any legal residence status at a particular point in time, the latter refer to the sum of inflows over a certain time span, usually a year.

Identifying Groups of Irregular Migrants

Estimations of the number of undocumented foreign residents (stock count) have to take citizenship into account. While *EU citizens* enjoy freedom of movement – one of the four core freedoms of the European Union – their mobility rights are not unlimited. They may be waived for reasons of public policy or public security, for example, because of criminal

2 An example is "No human being is illegal!" posters of the Myths and Realities of the Immigrant Experience. This is a travelling exhibit organised by the Center for the Study of Political Graphics, Los Angeles.

convictions or drug addiction or on grounds of lacking financial means of subsistence.[3] However, the European Court of Justice has traditionally interpreted the right to freedom of movement extensively and has frequently annulled Member States' decisions on expulsion or residence bans for Union citizens.[4]

Citizens of the new Member States may, however, be subject to transitional rules – from 2011 onwards this applies only to Romania and Bulgaria. Under the *transitional regulations*, the access of citizens of the accession countries of 2004[5] and 2007 to the labour markets of other EU Member States was subject to labour market testing (work permits). In many EU Member States, informal sector work of EU citizens from recent accession countries is treated as irregular migration without the option of expulsion. Thus, estimates of undocumented migrants that include EU citizens refer to irregular foreign workers of transition countries, not to irregular residents. In this project, we are primarily interested in the irregular residence of third country citizens and less in irregular foreign work. We explicitly differentiate between these two broad definitions when it comes to estimating the stock of irregular migrants.

The second group of irregular migrants concerns persons with a "seemingly" legal *temporary residence status*. These are persons with temporary tourist visas, which do not allow them to take-up work; if they work in the informal sector, they are referred to as "*working tourists*".[6] In some countries, "*working tourists*" are estimated to be the majority of irregular migrants; other countries tend not have any temporary irregular migrants of this kind.

In addition to working tourists, migrants with a *temporary conditional work permit*, such as seasonal and contract workers (C4 Visa), may be liable to expulsion if the terms of their contract are compromised, for example, if they overstay. In many countries, it makes a significant difference whether these persons are included in the concept of irregular migration or not. It can be expected that these groups of migrants will be of growing importance if the European Union introduces new programmes for temporary labour migration.

The third group concerns *persons with forged papers* or persons who have assumed *false identities*. They may live regular lives, unless they have to show their papers to authorities that can discover the falsification. Their lives can be very similar to those of regular immigrants and citizens, involving regular jobs and free movement in the public sphere. They can, however, also live like irregular migrants if the quality of the papers is so poor that they have to fear being found out.

The fourth group concerns *persons whose immigration status is pending*. This group includes persons whose application for regularisation is pending, who have submitted an asylum claim or who have filed a request for status prolongation and wait for a decision while their temporary residence permit has expired. This group is usually not taken into account when estimating the stock of irregular migrants.

The fifth group concerns persons who are without a valid residence status, but with knowledge and *toleration of stay by the authorities*. This may involve (1) a formal suspension

3 Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States.

4 Although EU citizens intending to move to another Member State are required to register within three months, non-registration is not sufficient grounds for expulsion or a residence ban and, in any case, cannot automatically lead to expulsion (or an ex-lege irregular status).

5 The 10 new EU-MS of 2004 are: Slovak Republic and Czech Republic, Poland, the three Baltic States – Estonia, Lithuania and Latvia – Hungary, Slovenia, Malta and Cyprus.

6 This should not be confused with the legal immigration category of "working holidaymakers" in the United Kingdom.

of enforcement action for a specific period of time, as in the case of toleration or exceptional leave to remain ("Duldung") in Germany or Austria, where the person receives a formal document informing them about the temporary right to stay, or (2) an administrative suspension of enforcement action for practical reasons.[7] Finally, (3) "toleration" may also be due to the simple inaction of authorities without a specific decision to suspend enforcement. Technically speaking, toleration – whether formal or informal – is only a suspension of an expulsion order and not in itself a legal status; in other words, toleration does not have a legalising effect and does not change the unlawful presence of the tolerated alien.[8] At the same time, there is little difference between formal toleration, humanitarian right to stay or subsidiary protection for a limited period of time. As it is difficult to obtain data on these latter groups of migrants, they tend not to be included in the stock estimates of irregular migrants.[9] In the UK, they tend to be referred to as having a "quasi-legal basis", encompassing asylum seekers and refused applicants with leave to remain.

Apart from the stock perspective, we may identify irregular migrants in a flow context, e. g., when a child is born to an irregular migrant. It represents an inflow into the stock of irregular migrants in most EU-MS. This is in contrast to the United States of America or Australia, where all children born in the territory are recognised as citizens of that territory. Most European states are not as open towards newborns, even though there is a tendency towards granting citizenship to children of permanent foreign residents.

One may also become an irregular migrant by losing a regular status. The most relevant inflow in this context concerns persons who have entered with tourist or other temporary visa and overstay the allowed period of residence (visa overstayers). Other persons have lived regularly in a country and stay after their status was withdrawn, for example, after the rejection of an asylum application or the withdrawal of a temporary or permanent status after a serious criminal offence. There is, however, also a way out of irregularity: Individuals may be regularised after marriage with a national or on humanitarian grounds; thus, large numbers may profit from a collective regularisation programme, as in Italy in 2002 and in Spain in 2005. Some persons may repeatedly change between regularity and irregularity, often in relation to opportunities to access the labour market.

Methods for Estimating Stocks

The identification of the various groups of irregular migrants is a first indication of the difficulties to be encountered in trying to establish accurate numbers of irregular migrants in the various EU-MS. In a comprehensive paper, Clarke (2000) highlights the various challenges, e. g., to account for the varying composition of the aforementioned groups of irregular migrants in the different EU-MS. He makes the point that while estimating the stocks is difficult, the establishment of numbers of irregular entrances into the European Union is nearly impossible (Clarke, 2000, p. 13). Border control data cannot be used to the same extent as in the USA or Australia, as irregular migrants may move relatively freely within the Schengen area, as there are no border controls. In addition, in the absence of

7 For example, limited capacity to organise deportation, unwillingness of the country of origin to issue required travel documents, questionable citizenship status, etc.

8 See Sinn et al. 2005, p. 42f on the legal nature of toleration status in Germany.

9 The German official line also seems to suggest that tolerated persons, although not legal migrants, are not seen as illegal migrants either (Blaschke, 2008, p. 16).

harmonised data collection at the Schengen borders, significant double counting may occur. Apprehension data may be misleading as a result. Furthermore, the lack of differentiation between apprehensions of irregular migrants wanting to enter and those wanting to leave adds to the difficulty of establishing numbers. Furthermore, today's mobility is characterised by new forms and dynamics, such as short-term or circular migration, which are particularly difficult to capture (Salt, 1999).

Thus, the numbers of irregular migrants who are identified at any point in time in one way or another are only the tip of the iceberg, and the shape and size underwater can only be estimated, but never exactly determined. Public policy, however, requires actual numbers for guidance in service provision, e. g., the provision of health care services for irregular migrants and the potential costs involved. What, then, is the number of those who "live in the dark", to quote from Bert Brecht's *Threepenny Opera*? They most likely constitute the major part of irregular migrants, as the iceberg metaphor suggests.

Jandl presents various methods for estimating irregular migrant populations (stocks and flows). He states that "ultimately, all serious methods to estimate the unknown part of such populations must be based on some form of 'hard data' on known and reported cases" (2008, p. 18). Conclusions about the dimension of unobserved phenomena such as illegal entries, illegal residence, illegal employment, etc., can only be drawn from actual statistical data, postulating or inferring a relationship between them and groups of irregular migrants. As the relationship between observed and unobserved variables is at best imprecise, all estimates of irregular migration phenomena are prone to large margins of error. A scientific approach has the advantage, however, that the method of calculation or estimation has to be made transparent, identifying the field covered, the hypotheses about the relationships, and the statistical base used, including any known bias in the data.

One may differentiate between direct and indirect approaches to estimate the stocks of irregular foreign residents.[10] Direct approaches tend to rely on data sets that contain the target population or a subset thereof, e. g., immigration enforcement data, such as apprehended illegal residents; administrative records, such as data on regularisation of unauthorized residents; survey data, such as illegal residents identified through snowball sampling techniques. Direct estimation approaches can be further classified into multiplier methods, methods of self-identification and snowball sampling methods.

Indirect methods of estimation are, on the other hand, residual methods based on the difference between, for example, the total population represented in census figures and some estimate of the legally resident population. Amongst the indirect approaches, the most import estimation techniques are demographic methods, subjective estimations (such as the Delphi method), econometric methods on the size and structure of shadow economies, comparisons of immigration and emigration statistics, flow-stock methods and methods based on indirect inferences.

There are also several combined approaches that use a combination of data sources and estimation techniques.

10 The classification proposed here has some similarities but also significant differences to the typology proposed by Delaunay and Tapinos (1998, p.36ff), which Pinkerton et al. (2004, p.33ff) bring to the fore.

Direct Methods of Estimation

One of the most prominent direct methods of estimation is based on the *"multiplier principle"*, where the actual detected number of irregular migrants or any subgroup is taken to be a proportion of the total; the problem with this method is to determine the "right" multiplier (Vogel, 2002). The way to go about finding the right multiplier is usually taken from similar fields of research, e. g., the United Nations Office on Drugs and Crime, which derives the multiplier from sampling the target group: "If a survey among heroin addicts reveals, for instance, that one-quarter of them was in treatment in the last year, the multiplication of the registered treatment population with a multiplier of four provides an estimate of the likely total number of problem heroin users in a country" (UNODC, 2007, p. 266). Similarly: "[...] if a survey among heroin addicts reveals that one out of five addicts was arrested in the previous year, a multiplication of the persons arrested for heroin possession by the multiplier (five) provides another estimate for the number of heroin users" (ibid.). Until recently, no such complex methods of estimation of irregular migrant stocks have been undertaken, as it is not only difficult to obtain an appropriate indicator, but also to derive a reliable (sample-based) multiplier.

An example of the challenges involved when trying to establish reliable information on irregular migrants in Europe is provided by CIREFI,[11] a database made available by Eurostat until recently. In this database, EU-MS entered three different types of data which somehow relate to irregular migration, namely statistics on "refusals of entry", on "removed aliens" and on "apprehensions of aliens illegally present".[12] There is no precise standard definition of any of these categories, and EU Member States tend to supply statistics they collect for their own administrative purposes, using their own definitions. Thus, data on "apprehensions of aliens illegally present" in the CIREFI database generally do not distinguish between apprehensions of aliens illegally present *inside* the country and *at or near the borders* of the country they try to cross illegally, nor do they distinguish between persons and events (Jandl and Kraler, 2006). These data can, therefore, not be added up to provide irregular migrant stock estimates in the EU. Whether available data on apprehensions of irregular migrants in individual EU Member States are suitable indicators for producing estimates must be decided on a case-by-case basis after careful scrutiny of the data.

Another aspect to be taken into account when deciding upon a multiplier is the probability of the migrants being detected. This can be exemplified by the number of illegal border crossings at the US-Mexican border: the fluctuating numbers of illegal border crossings to the USA are in direct relationship to more or less intense border controls at various points in time (Bean et al., 1994). Thus, the (estimated) multiplier has to take both the time and the risk dimension of the indicator into consideration.[13] In addition, one has to take the concentration of irregular migrants in large cities or other regions into account when wanting to establish a number representative for the whole country (Leerkes et al., 2007).

11 CIREFI stands for "Centre for Information, Discussion and Exchange on the Crossing of Frontiers and Immigration" and was established as a confidential information-sharing mechanism between EU Member States during the 1990s.

12 The CIREFI database includes two more categories of data on enforcement measures relating to irregular migration, namely data on apprehended facilitators (by citizenship) and apprehended facilitated aliens (by citizenship and type of border); see: UN Statistical Commission, UN Economic Commission for Europe & Eurostat 2003.

13 In the estimation of the multipliers for drug users mentioned above, this is done by taking the proportions of drug users in treatment (or apprehended) over the course of the year.

The multiplier method is not only used on crime data, but also on administrative records of the health system, as in the case of Belgium. Van Meeteren et al. (2007) look at emergency medical care treatment given to illegally resident foreigners in the health clinics; the clinics keep records, as they are being reimbursed by the federal government for the expenses incurred. To reclaim the expenses, detailed records on emergency medical care are kept and forwarded to the government. The ratio of foreigners without legal residence status who have used such emergency medical care services at least once during their stay in Belgium – which was obtained from a sample of 120 irregular migrants – is applied to the administrative health records. The resulting estimate for the irregular migrants was surprisingly close to the estimate based on the crime data.[14]

Another quite popular method of estimating hidden populations is the *capture-recapture method*. It derives from epidemiological research, where the multiplier is obtained by repeated sampling of the same population. The ILO estimate of global human trafficking victims is based on a capture-recapture technique by comparing two samples of reported cases in order to estimate the total population of trafficked persons (Belser et al., 2005). Van der Heijden et al. (2006) use police files on apprehensions of irregular residents in the Netherlands for establishing their total numbers, employing the repeated capture method. In their estimation, they provide a breakdown into "European" and "non-European" irregular residents and, additionally, in view of the then-imminent entry into the EU of Romania and Bulgaria, an estimate on the number of illegally residing Romanians and Bulgarians.[15]

Another option for establishing the numbers of irregular migrants is to match registers, a technique which checks various registers, e. g., police apprehension files and alien registry data, for the re-appearance or "recapture" of certain individuals. If the probability of appearing in one register is independent of appearing in the other, the identification of the same individual in both registers constitutes a "recapture" of the same individual. The total can be derived from the size and capture rate of the two samples. A somewhat more sophisticated method is *the random effects mixed model*, which was applied by Zhang (2008) to Norway, rendering plausible estimations.

Furthermore, evidence on the numbers of irregular migrants can be obtained from *self-identification*, e. g., in the wake of large-scale regularisations. These data are often interpreted as an approximate size of the illegally residing and/or working migrants, with the implicit assumption that all members of the hidden population will aim at getting a regular status in return for revealing their identity to the authorities. While this may be true, the terms, even of general amnesties, tend to have defined cut-off dates specifying the required length of residence in the country. As it is necessary to provide appropriate means of proof, which not every irregular migrant may be able to come forward with, the option of regularisation may not always be there,,. In addition, not every application leads to regularisation, as differences between applications and grants of a regular status indicate. Moreover, a regular status may be granted only for a particular period of time. What then?

Depending on the terms of the regularisation, the extent of falling back into an irregular status may vary. The OECD (2004) estimates that the majority of beneficiaries of recent

14 Health data were available only for 2004, when 7,252 persons without legal residence status had received emergency medical care. The derived health care ratio from the interviews was 13/120 = 0.1083, resulting in an estimate of 111,500 irregular migrants for 2004 in Belgium (van Meeteren et al. 2007, p. 282).

15 This method resulted in an estimate of 88,116 irregular non-European residents. For European irregular migrants, the estimate was 40,791 with a 95% reliability interval, for Bulgarians, 15,403, and for Romanians, 6,782.

regularisation programmes in Greece fell back into an irregular status, while this was not the case in Italy (Sciortino, 2008, as cited in Fasani, 2008, p. 47). In addition, an unknown number of irregular foreigners from other EU-MS may join the ranks of irregular migrants in the country of regularisation and file an application.

According to calculations by Pastore (2008) and the OECD (2004), some four million *regularisations* were granted between 2000 and 2008 in Europe. The interpretation of these numbers is, however, not reliable, as too many caveats apply.

In many countries, regularisation of residence status of foreigners does not take place in the wake of mass regularisation programmes, but rather on a less spectacular case-by-case basis. Governments tend to be reluctant to publish statistics on such procedures, as they believe that in so doing they invite potential irregular migrants. Accordingly, the recent case of legalisation of health care workers in Austria could only be established indirectly. In 2006, highly publicized court cases brought to light that care work in the household sector was, to a large extent, undertaken by foreign workers without the required legal papers and work contracts. Ensuing reform legislation, which was enacted in 2007, allowed the legalisation of some 20,000 clandestine care workers by January 2008 (Biffl, 2010, p. 85). Thierry and Rogers (2004) show for France that an average of 11 % of the adult foreigners admitted for residence between 1999 and 2002 had previously been living there as third country irregular migrants.

Another interesting example of *status change* is the "legalisation" of the residence status of citizens of the accession countries in the wake of EU enlargement in 2004 and 2007. This can be taken from the, at times, substantial increases of registration of "new" EU citizens in EU15 MS after enlargement, giving rise to the assumption that part of the newly registered had already resided in the country before the right of free movement.

Survey methods are another direct way of establishing the size of hidden populations. Two types of techniques are prevalent in this case: location sampling techniques and chain-referral sampling techniques. With the former, one tries to obtain a picture of the total target population by sampling regions with migrant populations. In those selected regions, one interviews a sample of migrants to obtain the probable proportion of irregular migrants. This method is suitable for geographically concentrated groups of migrants. In the case of chain-referral sampling, one identifies potential irregular migrants through a first set of contacts which are then enlarged by accessing the networks of the first sample. This method is also referred to as "snowball sampling" and tends to be used for hidden groups of people who are afraid of deportation or expulsion. Although privacy and confidentiality may be maintained with this method, it is based on the assumption that the people are interconnected in their communities.

Indirect Methods of Estimation

While the *"residual" estimation* method of establishing the size of the irregular migrant population is widely used in the USA, this is not the case in Europe. The reason is that European countries tend not to believe that the difference between census data and other registries of immigrants provides adequate information on irregular migrants. The two major exceptions are the UK and Spain, where the residual method has been applied for the estimation of the size of the illegally resident population. The estimate for the UK for 2001 was 430,000 irregular migrants, the range being between 310,000 and 570,000.

Spain possesses a unique database on the number of irregular migrants, as irregular migrants tend to register in the community (empadronamiento)[16] in order to obtain a health card. When comparing these registry data with the registry of foreigners with residence permits, one comes up with a total number of migrants residing in Spain. Between 2000 and 2004, the difference between the two registers rapidly increased to more than a million foreigners. This compares with about 690,000 foreigners in an irregular situation who had applied for regularisation in the regularisation campaign of 2005. Thus, registry data cannot be totally trusted, as people who leave tend not to de-register, leading to an over-estimation of the actual numbers of irregular migrants residing at any point in time in Spain. However, for the same reason, the register of residence permits is imperfect. In addition, foreigners may stay in the country without being recorded in one or the other registry, e. g., EU citizens.

Employing a residual estimation technique, Biffl (2002) estimated a sub-group of irregular migrants, namely school children (6 to 15 years old) who reside in Austria without proper papers. She compared the stock data of foreign students in grades 1 to 10, derived from school statistics, with demographic data on the foreign resident population by age groups, derived from the central population register.

Research indicates that a comparison of registers generates rather rough estimates which are, however, useful for triangulation with other methods.

Evidence on the number of irregular migrants can also be based on *estimates of the size of the informal sector* of a given country and the participation of (irregular) migrants in it. In this method, estimates of the size of the irregular foreign population are based on indirect estimates of the participation of migrants in the informal sector of a given country. Estimates on the size of the informal economy can, in turn, be based on the amount of cash in circulation or the amount of electricity consumed. In his estimations of the size of the shadow economy,[17] Friedrich Schneider uses econometric models that attempt to estimate unobserved variables (informal sector output) with the help of observed variables (e. g., cash in circulation). The so-called currency-demand approach is based on the idea that services in the shadow economy are usually paid in cash, and that the size of such transactions can be estimated with properly specified currency-demand equations, while the so-called DYMIMIC (dynamic multiple-indicators multiple-causes) model links the unobserved variable (the size of the shadow economy) with a set of indicators through a number of structural equations (Schneider and Enste, 1999 and 2000). In a comprehensive study on the economic integration of foreigners in Austria, Gudrun Biffl (2002) estimates the number of clandestine foreign workers in the informal economy on the basis of their relative contribution to the black economy. According to her estimates, 50,000-70,000 clandestine foreign workers were working in Austria in 2000, some (but not all of them) with legal residence status.

In summary, it can be said that the *indirect estimation* of the size of the illegal foreign population through *economic indicators* is a useful addition to the repertoire of estimation techniques, adding another perspective to the topic.

Another potentially promising source of data on irregular migrants is data on health, sickness, accidents or medical attention provided to persons without health coverage, which

16 Registry at the city hall turns an irregular migrant into an official member of the community without a legal residence status; it allows access to health care and schools without notification of the irregular status to the migration authorities.

17 The shadow economy is defined as "all unregistered economic activities that contribute to the officially calculated GDP"; see Schneider and Klinglmaier (2004, p. 4).

is paid out of welfare funds. France, for example, bases its estimate of the illegal resident population on the number of people who have received medical aid from the state (Coste, 2008).[18] To estimate the stock of irregular migrant residents in France on *data* of persons who have received *medical aid*, it is necessary to adjust the raw data for the number of persons who are also irregular migrants, but cannot benefit from medical aid[19] (Courau, 2008). While these afford additional estimates in order to come up with reliable figures, many EU-MS do not have such easy access to health care for irregular migrants as France does, and are therefore unable to use this estimation model.

Apart from the above indirect estimation methods, one may choose expert surveys and Delphi surveys to estimate irregular migrant stock figures. In this context, "experts" are individuals who, through their direct engagement with the research subject, are assumed to have privileged knowledge of the target population. In order to arrive at sophisticated estimates covering a sector, an economy or a nation, both a suitable *sample* of experts as well as an appropriate *aggregation* method are needed. The sample should cover experts with insights into the whole target population, while the aggregation method should (at least theoretically) lead to a representative estimate of the target population. While the first requirement may be easily realised, the second is hard to achieve, as the example of a survey carried out by Caritas Germany in 2005 shows. A questionnaire was sent out to key informants from NGOs, law firms, churches, etc., who work with (irregular) migrants. Although the survey produced valuable qualitative insights into the needs and service requirements of irregular migrants in Germany, no conclusive information on the size of the population could be produced.[20]

The Delphi method is somewhat more complex, as it involves a large number of independent experts in an interactive process of exchange through the use of written questionnaires designed to foster convergence and consensus. Experts are given the opportunity to state their views and react to the anonymous and consolidated views and assessments of other experts in the second round. While the results produce some valuable insights into the likely relative importance of irregular migrants, the quantitative results must still be seen as subjective and of low reliability. Consequently, the value of a Delphi survey lies not primarily in the quantitative reliability of its findings, but in the qualitative input of a diverse collection of experts that provide insight into a difficult and complex issue.

Coming Up with Actual Numbers

We argue in line with Triandafyllidou et al. (2010) that it is important to provide politics with the best possible estimates of the number and composition of irregular migrants, otherwise estimates which come out of the blue will be taken seriously and become the basis for policy actions. Kovacheva & Vogel (2009) provide us with high quality estimates

18 According to the Act of 25 July 1999, Aide Médicale d'Etat provides medical care to irregular migrants and others without medical insurance coverage. The government noted a sharp rise in the beneficiaries of medical assistance between 2001 and 2003, from 139,000 to 170,000. The Prime Minister's Office estimated the irregular foreign resident population on the basis of this data to be between 200,000 and 400,000 people.

19 There are at least three eligibility criteria that are likely to result in the exclusion of a significant number of illegal residents from the system: being able to produce an identity card from a list of acceptable documents; having an income of less than € 606 per month; and showing proof of residence in France for at least three months (for example, through a rental contract or an electricity bill).

20 The survey produced 310 answers (31 % return rate) that reported on a total of 5,700 contacts with illegally resident foreigners.

for Europe for three years: 2002, 2005 and 2008, based on an aggregation of differentiated analyses of available estimates in the individual EU-MS. They chose this period in order to take EU enlargement into consideration and the legalisation effect this entailed for citizens of the accession countries who were residing without proper papers in an EU15 country. In 2004, ten Central and Eastern European countries joined the European Union, followed by Romania and Bulgaria in 2007. The legalisation of the residence status did not automatically imply legal employment, as some of the major recipient countries of migrants from these regions, namely Germany and Austria,[21] implemented transition regulations, requiring a work permit on the basis of labour market testing.

Table 1: Aggregated estimates of irregular migrants in the European Union

	EU15					
	Irregular Foreign Migrants		In % of Total Population		In % of Foreign Population	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
2002	3,100,000	5,300,000	0.8	1.4	14.7	25.1
2005	2,200,000	4,800,000	0.6	1.2	8.0	18.0
2008	1,800,000	3,300,000	0.5	0.8	6.6	12.0
	EU27					
2008	1,900,000	3,800,000	0.4	0.8	6.6	13.9

Source: Kovacheva / Vogel (2009, p. 9)

During the period of 2002 to 2008, the EU population grew by 31 % from 380 million to almost 500 million, largely as a result of the two steps of enlargement. The population of foreign nationals increased by 37 %, from 21 million to 28.9 million. Of the total population of 497.5 million inhabitants in the EU27 in 2008, between 1.9 and 3.8 million were irregular migrants, or 0.5 % to 0.8 % of the total population. In relation to the total stock of 28.9 million foreign residents, the percentage of irregular migrants was between 6.6 % and 13.9 %.

If we look at the development of the number of irregular migrants over time for the EU15, we see a continuous decline, largely a consequence of the enlargement of the EU, through which the residence status of former irregular migrants of the new EU-MS was legalised. But also mass regularisation programmes in the Southern European countries like Italy, Spain and Greece regularised sizable numbers of irregular migrants between 2002 and 2005. The outflow from an irregular status was not outnumbered by new inflows into illegality, which had a net negative effect on the number of irregular migrants. As a consequence, the number of irregular migrants in the EU15 declined between 2002 and 2005 by some 900,000 or 29 % on average, from an estimated 3.1 to 2.2 million on the basis of the minimum estimate. If we take the upper limit of the spectrum of estimates, the numbers declined from 5.3 to 4.8 million, i. e., by 500,000 or 9.4 %.

In the period 2005 to 2008, the reductions were more modest but still substantial; according to the minimum estimate, the numbers or irregular migrants declined by 400,000 or 18 %, from 1.2 to 1.8 million; the remaining irregular migrants are basically third country

21 For a detailed analysis of the impact of transition regulations in Austria, see Biffl 2011.

nationals, accounting for, on average, close to 7 % of all foreign residents. According to the maximum estimate of irregular migrants, the numbers declined by 1.5 million or 31 % between 2005 and 2008, from 4.8 million to 3.3 million in the EU15. This means that in 2008, the proportion of irregular migrants in the EU15 was estimated at 0.8 % of the total population, down from 1.2 % in 2005. Relative to the foreign population, the share of irregulars declined from 18 % to 12 % between 2005 and 2008.

Kovacheva & Vogel (2009, p. 11) suggest that almost all EU-MS experienced a decline in the irregular resident population or had at least relatively stable numbers between 2002 and 2008, with the notable exception of the UK, which had some increases. The reasons for the increases cannot be learnt from aggregate data, but afford research into the various components of the irregular migrant population before one can draw conclusions which may be relevant for policy measures.

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Sources of Irregularity: The Social Construction of Irregular Migration

Gudrun Biffl

"What is regular and what is irregular migration depends on each country's legal context and migration regime".
(Anette Brunovskis and Lise Bjerkan, UDI Project 2008)

The topic of irregular migration is receiving increasing policy and media attention. One reason is that it impacts on human rights issues which are central to the EU and assured for everyone residing in the EU. Another reason is to alert people to the many faces of migration and the difficulties involved in taking them into account when drawing up legislation and regulations. A particular challenge in that context is irregular migration. Bringing it to the fore may undermine confidence in the ability of governments to regulate migration, as well as to integrate those involved into the general community. Amongst the fears in that context are that public health and social cohesion are jeopardised.

In order to document their capacity to control migration, governments have put greater emphasis on the management of migration flows. On the one hand, the detailed legislative endeavours to "manage" migration are driven by the need to ensure an adequate supply of labour to an increasingly specialised production system of goods and services. The latter is marked by regional concentrations of various stages of production of goods and services, requiring specific skills which tend not to be sufficiently provided for by the country's educational and training systems. Thus, the search for the best skills turns global, thereby contributing to the greater international mobility of labour. On the other hand, migration management aims at regulating flows driven by push factors such as family migration and student mobility, as well as wars, political upheavals and environmental disasters.

As it is difficult to account for all eventualities which may give rise to the cross-border mobility of human beings, irregular migration may occur until legislative reforms are introduced, resulting in the "legalisation" of the one or the other case of irregularity. All EU-MS have witnessed reforms of migration laws as a consequence of the deepening of European social and economic integration, as well as the endogenous dynamics of migration which come into play. Migration policy reform builds on the traditions and the history of migration in the respective countries and the specific ways of bringing about legislative change, while reacting to new requirements flowing from economic, social and cultural globalisation processes, as well as increased EU integration.

In order to gain insight into the different challenges of policy reform in the field of migration, it is helpful to first look at the basic structure of migration models across the EU27. This would throw light on why the various countries have different types of irregular migrants and, therefore, different needs for policy and legal adjustments. As noted in the previous chapter, irregular migrants have rarely committed a crime in the narrow sense of the word, but have tended to be, for the most part, clandestine workers in the informal sector

searching to improve their quality of life. Different countries have chosen different ways to regularise such migrants. In the case of Austria, for example, new legal employment options for domestic care workers were introduced in 2007, thereby "legalising" a substantial proportion of irregular workers in these occupations, while Spain preferred mass regularisation programmes in 2005, thereby "legalising" a major part of their irregular migrants.

The "legalisation" route chosen depends on the migration model, as well as the typical socio-economic organisation of a country and its endogenous dynamics and pattern of change. Political, legal or administrative systems are the result of historically grown behaviour patterns frozen in institutions. In that sense they are not value-free, but represent the norms, values and traditions of a country developed over time. They are subject to change in response to new challenges over time, such as the increasing pluralisation of society and the transnational character of migration.

Accordingly, the social construction of irregular migration flows from the migration model in combination with the model of social organisation of a country, in particular, its welfare and social protection system. The models of social organisation of work and welfare will be addressed later, when the pull factors of irregular migration and the role of shadow economies in the various EU-MS are considered.

Migration Models and Implications for Irregular Migration

In Europe, we can identify at least three different systems of migration, with different focal points of migration policy. Most of them have preserved their basic structure and orientation, although policy reform has taken place in all of them at least since the mid-1980s. This has made the migration models more complex and comprehensive, resulting to some extent in their convergence. Additional elements have been added to each model in order to accommodate economic as well as human rights aspects, such as the right to family and to refuge.

The three models we refer to are the Nordic model, the temporary worker model and the colonial or ethnic tie model or combinations thereof.[1] In all models we may find that several countries give preferential treatment to descendants of former émigrés, who may have emigrated centuries ago, e. g., in the case of Germany (Aussiedler), Greece (Pontian Greeks), Finland (Ingrians).

The Nordic Model

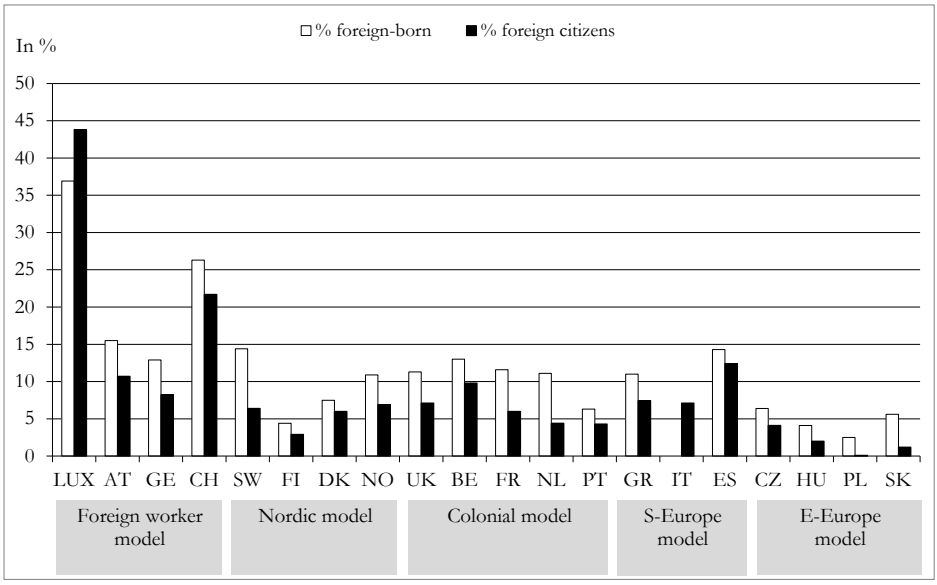
This came into being as early as 1954, based on free mobility of labour within Scandinavia. The understanding was that economic gains could be maximised by regional integration, i. e., by going beyond free trade and allowing free mobility of labour as well as capital. Sweden became a net importer of labour from other Scandinavian countries, in particular from Finland, during its industrialisation phase in the 1970s. In the early 1980s, the net inflow of migrants from Finland abated as the latter managed to catch up with Sweden in terms of factor prices and productivity.

1 Data on foreign-born and foreign nationals are taken from OECD (International Migration Outlook) and EUROSTAT databases.

Immigrants from third countries were rare until the mid 1980s, as the Nordic countries did not adopt temporary migration programmes on a large scale. Instead, they implemented incentive mechanisms to raise the activity rates of their native populations.[2]

As international refugee flows increased in the 1980s, the Nordic countries accepted substantial numbers of refugees, becoming the major source of immigration in the 1990s and the 2000s, together with family reunification. The Nordic country with the highest intake of immigrants is Sweden, with 14.4 % of the population being foreign-born in 2009, followed by Norway (10.9 %), and Denmark (7.5 %), while Finland has the smallest proportion of foreign-born (4.4 %). The proportion of foreign citizens is much lower, as it is relatively easy to obtain citizenship in the Nordic countries. Accordingly, the country with the highest share of foreign citizens in Scandinavia is Norway, with 7 %, followed by Sweden, with 6.4 % of the total population.

Graph 1: Foreign-born in % of total population by migration model around 2009



Source: OECD (2011). Foreign-born: 2007 Belgium, 2006: Greece, Poland, Czech Republic; foreign citizens: 2007 France

The proportion of EU citizens in the total population is comparatively low, the levels being comparable to the EU average; it is highest in Norway (3.3 % of the total population), followed by Sweden (2.5 %). The majority of EU citizens residing in a Nordic country are citizens of another Scandinavian country. The largest number, some 150,000 in 2009, lives in Sweden, representing two-thirds of all foreign citizens in Sweden. The high proportion of EU citizens amongst all foreign citizens is the result of equal treatment regulations of citizens of another EU-MS across the EU, reducing the incentive to adopt the citizenship of another EU-MS.

2 Today, the Nordic countries have the highest activity rates in Europe, while they were not dissimilar from the rest of Europe in the mid-1960s. This shows that policy reform to meet the requirements of the labour market in a situation of population ageing is possible and produces the results aimed for.

Implications for Irregular Migration

According to Geddes (2003), irregular migration is rare in the Nordic countries, due to strict legal regulations and an efficient registration system, leaving little room for irregular residents. All citizens and regular migrants have a social security card with a personal identification number. Without this number, it is not possible to open a bank account, receive social security benefits, claim other social services or obtain accommodation.

Accordingly, it is difficult to live in Sweden without a legal residence status. In addition, the high degree of unionisation amongst Swedish workers makes it difficult for an irregular worker to remain undetected. Research into irregular work by Polish citizens before EU accession gives a vivid account of the difficulties encountered in Sweden for those wanting to live as undocumented migrants (Berger, 2004). The internal residence and labour market access controls like the ID card are complemented by strict external border controls, making access to Sweden difficult. In spite of all these control mechanisms, Sweden still has irregular migrants, as shown by the case of Polish workers and research by Jorgensen and Meret (2010). This is reflected in the fairly high share of the informal sector economy in Sweden, which includes irregular migrants working as clandestine cleaners, gardeners, repair workers in private homes and in small business. However, these irregular migrants hardly feature in the estimates of irregular migrants in Sweden. The estimates available tend to be based on statistics of expulsion orders pending with the Swedish police, imposed by the Swedish Migration Board (Migrationsverket). They refer to rejected asylum seekers and persons with expired residence permits. According to Khosravi (2006), some 16,000 such orders were waiting to be enforced in 2005.

In 2005, asylum law was reformed in Sweden by introducing a measure to regularise rejected asylum seekers and people living in Sweden for some years under a deportation order that had not yet been carried out. Those concerned could apply for regularisation or renew their application for asylum. According to the Migrationsverket, about 30,000 applications were submitted, of which 60 per cent were granted. Accordingly, the numbers of irregular migrants have declined, but not vanished. Kovacheva & Vogel (2009)[3] estimate the figures for 2008 at 8,000 to 12,000.

The situation is not much different in Norway, according to Brunovskis, Bjerkan and Zhang (2008), except that the estimated number of irregular migrants was somewhat higher relative to the population of Norway. This may be due to a more sophisticated method of estimation. In 2005, the estimate (ranging from 10,500 and 32,000) was 18,000 or 0.4 % of the total population. This is somewhat less than the lower bound estimate (relative to the population size of the region) for the EU15 – on average in 2005 (0.6 %). Of the estimated total, more than two-thirds are rejected asylum seekers.

The Norwegian report acknowledges (ibid., p. 14): "What is regular and what is irregular migration depends on each country's legal context and migration regime". This means that irregular migration is a political construct and, as such, differs between countries. In the Nordic countries, irregularity tends to originate from the asylum system as well as the highly regulated labour market, except that little notice is taken of irregular work, as it is hidden in the shadow economy, condoned by political actors as well as the population (Khosravi, 2006, p. 290). As Norway receives increasing numbers of asylum seekers, the numbers of

3 For bibliographic details, see previous chapter.

irregular migrants rise because not everybody is accepted as a refugee. Those who are rejected are not always deported, and many prefer to remain in an irregular status in Norway before returning to their home country. Since access to the formal labour market is prohibited, many end up in clandestine work, often also in prostitution (Skilbrei & Tveit, 2007, p. 28).

In Denmark, the estimated number of irregular migrants stood at 5,000 in 2008. Of the Nordic countries, this is the smallest proportion in relation to the total population. Moreover, there the reason for being an irregular migrant tends to be included with rejected asylum cases.

The Temporary Worker Model

This migration model originated in Switzerland and was adopted by founding members of the European Community, the most prominent being Germany, as well as EFTA countries. The most important in terms of migration flows was Austria in the 1960s until its membership to the EU in 1995. The EFTA countries then gave priority to free trade rather than free labour mobility as an economic development tool. Migration focused on meeting perceived temporary labour needs and was meant to increase the flexibility of the labour market. An increase in the size of the population through immigration, i. e., settlement of foreign workers, was not the objective.

The temporary worker model allowed larger inflows of migrants than the Nordic model and the third immigration model, i. e., the colonial ties model. As it turned out, the majority of temporary migrants settled in the receiving country, putting pressure on those countries to develop integration policies to avoid creating a permanent underclass and jeopardising social cohesion.

Today, the countries which adopted the temporary migration model have the highest proportion of immigrants in their population in Europe. Switzerland[4] takes the lead with 26.3 % foreign-born, followed by Austria, with 15.5 % in 2009, and Germany, with 12.9 %. The proportion of foreign citizens in Switzerland is lower in 2009 (22 %), followed by Austria (10.7 %) and Germany (8.2 %). The difference in the foreign and foreign-born population is smaller than in the Scandinavian countries, as the acquisition of citizenship is not as easy.

While EU citizens represent the bulk of immigrants in Switzerland, they are only one-third of all foreign-born in Austria, and 20 % in Germany, i. e., between 5 % and 3 % of the total population respectively. The different ethnic mix of migrants in Germany relative to Switzerland is, to some extent, the result of preferential entry granted to German Aussiedler, descendants of former German émigrés to Central and Eastern European countries and Russia. Due to the abolition of the Volga German Republic in 1941 and the ensuing deportations, many Volga Germans ended up in Central Asia. In view of significant discrimination, many "Russian-Germans" "returned" from distant regions of Siberia and Kazakhstan from the late 1980s onwards. As a result, 992,000 "Russians" and 628,000 "Kazakhs" were registered as foreign-born Germans in Germany in 2009, representing 15 % of all foreign-born.

In addition, Germany and Austria have a long tradition of accepting asylum seekers. Austria as well as Germany tended to be the open door for refugees from the former "Eastern Block" countries during the time of the Iron Curtain; furthermore, both received exceptionally large numbers of refugees from Turkey in the late 1970s and early 1980s (Biffl, 2011). Accordingly, as a result of the combined effect of foreign workers and refugees from Turkey,

4 Luxembourg has even higher shares of migrants, with 36.9 % foreign-born in the population in 2009, largely from neighbouring countries.

the first-generation migrants from Turkey numbered 1.5 million or 14 % of all foreign-born in Germany, and 159,000 or 12 % of all foreign-born in Austria in 2009.

The countries which used to target foreign workers from the 1950s to the early 1970s to satisfy labour market needs – Germany, Austria and Switzerland – have long stopped doing so. Their migration model has turned into an immigration model, largely driven by family reunification and refugee intake. In the wake of the Single Market and increased integration of Europe in the 1990s and enlargement of the EU in 2004 and 2007, the mobility of labour within an enlarged social and economic space gained momentum. While mobility within the EU tends to be market-driven, family migration follows endogenous dynamics, and the search for asylum persists.

The new EU-MS in Central and Eastern Europe (CEEC) have joined the ranks of immigration countries, while at the same time continuing to be emigration countries, albeit at a much reduced rate compared to the 1990s, when the transition recession enticed many to leave their homes for Western Europe or countries overseas. Before CEEC countries became New Member States of the EU, many CEEC migrants were irregular migrants in Western Europe, trying to make ends meet. With EU Membership their residence status became legalised, but their work status often did not, as most EU-MS applied transition regulations for citizens of the accession countries. It was above all the low-skilled and unskilled labourers who remained undocumented, as they generally had little chance to obtain work permits, which tended to be granted for jobs with a labour shortage. The quest to "protect" unskilled labourers against competition from newcomers made unions strong advocates for implementing transition regulations for new EU-MS citizens.

As new EU-MS have entered a favourable long-term economic growth path and their economies are catching up with Western EU-MS, they are increasingly attracting third country migrants themselves. In order to get some control over migration flows, they adopted a migration policy modelled on the foreign worker model of Switzerland, Germany and Austria (Lubyova, 2001). The foreign worker model was not entirely new to them, as they had employed foreign workers based on bilateral agreements with countries under Soviet influence.

Implications for Irregular Migration[5]

The situation of irregular migration is different between the "old" and "new" EU-MS, but similar between Austria and Germany. A recent estimate based on police crime statistics and the multiplier method for **Austria** indicates that the number of persons with irregular residence status has decreased significantly in the past years, from an estimated 78,000 or 1 % of the total population in 2001 to about 36,000 or 0.4 % of the total population in 2008. The recent waves of EU enlargement in 2004 and 2007, as well as the decrease of irregular inflows (traditionally of asylum seekers) from third countries, a consequence of the shift of the Schengen borders to the East, are the main reasons for this decrease.

Some 72 % of irregular migrants in Austria tend to be male. Almost half of the persons with an irregular residence status were between 19 and 30 years old. The majority of persons apprehended had entered Austria from Italy. Some of the irregular workers are citizens of accession countries, engaging in clandestine work. Even if apprehended, the chances of removing them from Austrian territory are limited, given the right to settlement of EU citizens

5 If not stated otherwise, the estimates of numbers of irregular migrants are taken from http://irregular-migration.hwwi.net.

in another EU-MS. Only in cases of criminal conviction is this possible. As illegal border crossing is not a crime in Austria, in contrast to Germany – and since 2009 also Italy – this affects only small numbers of irregular migrants in Austria. Of the irregular third country migrants, a large proportion comprises "working tourists" and seasonal workers who overstay their work contract. On the other hand, cases of overstaying after the expiration of a visa or residence permit are rare, as the requirements for obtaining temporary work are very restrictive, entailing substantial financial guarantees from sponsors and/or visa applicants themselves; the level of control and scrutiny of visa applications in countries with "large migration potential" is very high.

"Loss" of regular residence status is another important source of irregularity in Austria. While there are few persons whose status is withdrawn (largely for a criminal offense), a larger but still relatively small number of persons – 400 to 500 annually – fail to renew their permits. Others lose their eligibility for residence in Austria, e. g., because of legislative changes. This was, for example, the case for a significant number of persons and their families who could not meet the newly introduced income requirements for the renewal of their permits when the new Settlement and Residence Law (NAG 2005) came into effect. Also, changes of regulations relative to family reunification put some thousand persons in an irregular situation.

The failure to leave the country after a negative decision on an asylum application is also a major source of irregularity in Austria, although hard evidence on their numbers is not available. In 2010 alone, 13,300 negative determinations on asylum applications were made, and only some 3,000 asylum applications succeeded. In addition, in 2010, of the 10,000 Refoulement cases listed to establish whether rejected asylum seekers should be deported, only some 1,700 were potentially liable to be sent back to their country of origin. Thus, the non-enforceability of deportation constitutes an important source of irregularity. However, this fact does not change the unlawful nature of the person's stay in Austria.

As data on adjournments of deportation are not accessible and estimates of irregularly residing rejected asylum seekers are hard to come by, the above estimate of irregular migrants in Austria is an underestimation of the actual numbers.

Austria opposes regularisations of the kind taken in Spain or Italy. On an individual case-by-case procedure, legalisation on humanitarian grounds has, however, been implemented in the Settlement and Residence Law of 2005 (NAG 2005), and most recently in the Asylum Law as well. The reform of legislation relative to the humanitarian status can, at least in theory, provide a systematic mechanism to address the situation of irregular migrants who have been staying in Austria for an extended period of time and those who cannot be deported on grounds of Article 8 ECHR (private and family life).

In the case of **Germany**, many of the sources of irregularity are the same as in Austria. Moreover, the proportion of irregular migrants in the total population is also similar. In 2008, the estimates of irregular migrants ranged between 196,000 and 457,000, constituting between 0.2 % and 0.6 % of the total population. The numbers halved between 2004 and 2008, following the enlargement of the EU.

In Germany, as in Austria, mass regularisation programmes are avoided. However, the fact that illegal border crossings are a criminal offence in Germany compounds the already difficult situation of undocumented migrants who are apprehended, as they are liable to imprisonment of up to one year.

Irregular migrants originate from Eastern Europe and the Balkans and increasingly also from countries further away, particularly where local or regional conflicts and political unrest prevail. Qualitative research studies indicate that irregular migrants may originate from all continents. In the case of Germany, the most prominent South American source countries are Brazil and Ecuador, the African ones are Ghana and Cameroon, and the Asian ones are the Philippines.

With regards to age composition, all available data indicate that the majority of irregular migrants are between 20 and 40 years old. There are, however, also significant numbers of children and elderly persons without a regular residence status. Most irregular migrants work in the shadow economy, in informal and menial jobs of arduous, dirty and unhealthy character, often badly paid. This may be why the share of irregular migrant workers is relatively low compared to that of clandestine legally-residing workers.

The case of **Switzerland** is somewhat different, as it introduced new immigration legislation in the 1990s,[6] which left many third country migrants at a disadvantage if they had not worked long enough in Switzerland to qualify for long-term residence permits. Termination of the seasonal work programme in 1991, which was part of the larger reform programme, represented a source of irregularity. Most affected were seasonal workers from former Yugoslavia, as they could neither get their work contract renewed nor return to their home country because of civil war. In 1996, this affected more than 20,000 seasonal workers (Laubenthal, 2007, p. 120).

Another route into irregularity is, as in all other countries, the asylum path. As rejected asylum seekers tended not to return to their countries of origin, and as asylum requests increased to such an extent in the 1990s that 104,700 cases were waiting for decisions by the end of 1999, the Swiss authorities began to introduce more restrictive procedures (Achermann, 2009, p. 94). This resulted in a decline of applications for asylum from over 40,000 in 1999 to some 10,000 annually from 2005 onwards. The number of positive determinations has not changed much since the 1990s, benefiting some 5,000 persons annually.

Another source of irregularity – apart from illegal border crossing, overstaying temporary resident and work visas, legislative change such as the abolition of seasonal work programme – are changes in the socio-economic situation of migrants in the wake of job loss, divorce in the case of family reunion or marriage migration, as the legal residence status is linked to the original migration sponsor. In the case of divorce, the dependent tends to lose the legal residence status; only in exceptional cases, e. g., severe cases of violence as a reason for divorce, can the right to remain be granted.

According to the most recent estimate (Bilger & Hollomey, 2011), the number of irregular resident migrants numbered some 80,000 to 100,000 in 2005. If irregular migrant workers who are legally residing in Switzerland are included, the numbers rise to 300,000 (Kaeser, 2009, p. 53). If only those who attempted illegal border crossings are taken into account, the numbers are, of course, smaller – down to about 5,300 in 2008 (ibid., p. 7).

Thus, the proportion of irregular resident migrants in Switzerland made up 1.1 % to 1.4 % of the total population in 2005, surpassing the proportions of the above countries. As a share of the foreign population, however, the shares of 5 % to 7 % are at the lower end of the EU15, where 7 % to 12 % of all foreign citizens were irregular in 2008.

6 The reforms were preparing the way for closer cooperation with the EU based on bilateral agreements, eventually leading to the right to free mobility of EU and EFTA citizens in 2002.

In the new EU-MS the situation varies somewhat between countries, as they have had different forms of temporary work arrangements before and after accession to the EU. In the **Czech Republic**, for example, during the communist regime, the loss of population as a result of emigration to the West was substituted, at least to a certain extent, by temporary workers from countries then under Communist influence – including Angola, Cuba, Vietnam, Mongolia, Poland, Laos, North Korea (Drbohlav, 2005; Horáková, 2000). They tended to work on 4- to 5-year contracts, organised via bilateral agreements. The first contract with Vietnam dates back to 1967, related largely to skilled textile workers, which was followed by an agreement on Vietnamese workers for the machine, chemical and other manufacturing industries in 1980. Thus, the rationale of foreign worker recruitment followed the one in Germany and Austria, employing foreign workers mainly in export-oriented manufacturing industries.

In addition, business contracts were signed between Czechoslovakia, on the one hand, and Poland and Yugoslavia, on the other, largely to facilitate the employment in the construction industry of workers from the latter source countries. In 1990, some 100,000 foreign workers were employed in Czechoslovakia on the basis of these contracts (Horáková, 2000, p. 13).

Cubans tended to work in the medical professions; the others were largely labourers in food-processing, textiles, shoe and glass industries, machinery, mining, metallurgy, and agriculture. While Cubans and others tended to return home, Vietnamese tended to settle and form the nucleus of chain migration, similar to Turkish foreign workers in Germany and Austria.

With the fall of the communist regime, migration policy changed. In addition to the return of Czech émigrés, immigration from neighbouring Eastern countries took place. As a result, the share of foreign-born in the total population of the Czech Republic reached 675,900 or 6.4% in 2009 (OECD, 2011). The main countries of origin were Ukraine, Slovakia, Vietnam, Poland, Russia, Germany, Bulgaria and Moldova, in that order in terms of numbers. In addition, the old system of temporary work migration was revived, mainly involving the employment of migrants from the neighbouring countries for seasonal work.

With the opening of the borders in 1990 and the absence of stringent residence rules in the early years of transition, the Czech Republic became a target for refugee inflows. As the numbers of asylum seekers did not diminish, the ban on work during the first year of processing in 2002 slowed down inflows. Those refused refugee status tended to either remain on the soil as irregular migrants or attempted to transit to a Western country. In addition, after the break-up of Czechoslovakia into two separate states in 1993, several thousand Slovak Sinti and Roma, who migrated to the Czech Republic, did not take up Czech citizenship, residing there without proper papers (Horáková, 2000). Many of them continued to be irregular migrants for lack of financial and other means to pay for the proper papers.

The number of irregular migrants continued to be high as the Czech Republic became an important transit route for migrants from Eastern Europe and Asia wanting to access a Western European country. The easy access to clandestine work, promoted by the dual economy carried over from the former communist regime to the new liberal market economy, constituted an invitation to the inflow of migrants. This is in line with the observations of Eilat & Zinnes (2002), who argue that an established system of irregular work is hard to remove. The long history of irregular work has allowed an environment highly tolerant to undeclared work to develop.

According to UN estimates, some 100,000 to 140,000 transit migrants, basically all irregular migrants, transited the Czech Republic in the early 1990s. Alien Police data, counting apprehensions at the border, usually of transit migrants wanting to cross over to Germany of Austria, amounted to 53,100 in 2000; these numbers continued to decline over time, reaching a low of 7,549 in 2007.

According to estimates by Kovacheva & Vogel (2009), some 17,000 to 300,000 irregular migrants were in the country in 2008, i. e., between 0.2 % and 3 % of the total population. This wide range indicates the presence of a large margin of error in estimates, reflecting the complexity of the sources of irregularity: the various ethnic groups, having turned from foreign workers to settlers and having kept contact with their original communities, are able to provide support for irregular migrants from those regions to enter through the transnational networks. In addition, the inflow tends to be facilitated by various mediators (brokers, labour recruitment agencies, subcontractors) who make it easier, both for irregular migrants to come and find work, and for employers to hire irregular migrants. Accordingly, Ukraine is the most important source country for undocumented economic migrants to the Czech Republic. This is shown not only in police data on foreigners apprehended for illegal migration, but also by research surveys. Other Eastern European and Far Eastern countries, namely Moldova, Russia, Belarus, Vietnam and China, are amongst the most important countries of origin of irregular migrants to the Czech Republic.

Irregular migrants tend to live in Prague and surrounding Central Bohemia or in other highly urbanised areas. Besides work opportunities, they find more anonymity there than in rural areas. They tend to work in various sectors of the economy – including construction, agriculture, hotels/restaurants, domestic services and manufacturing industries, largely textiles or food production (often of sweat shop standards). The conditions under which irregular migrants work and live are generally very unsatisfactory, involving exploitation by their employers or brokers, often of the same ethnic background as they themselves. It is, for example, a habit to violate the terms of a trade license by pretending to work as a subcontractor of a firm, while actually being totally dependent on this employer as if a dependent worker, but carrying the whole risk of a self-employed one and having to pay one's own social security dues. This is a typical pathway into irregularity for a group of migrants.

Another case is **Poland**, which had some 49,600 foreign citizens in 2009 or 0.1 % of the total population. The share of foreign-born is significantly higher, however, as the Polish government actively pursued the repatriation of ethnic Poles and their descendants who lived in former Polish territories seized by the Soviet Union in 1939, or who had been deported to the former USSR, e. g., to Kazakhstan. Accordingly, by 2002, of the 776,200 foreign-born residing in Poland, 72 % were from those countries (Ukraine: 312,000, Belarus: 105,200, Lithuania: 79800, Russia: 55200, Kazakhstan: 3800), and were given Polish citizenship.

While gaining migrants of Polish ancestry, Poland also lost large numbers of Poles to Western European countries in the wake of Solidarnosc in the early 1980s, then again after the fall of the Iron Curtain, and yet again after accession to the EU. However, in the wake of the financial economic crisis of 2008, many Polish migrants returned, such that the population decline came to an end. Since then, the population grew again, almost reaching the pre-accession level of 2003 in 2011, namely 38.2 million inhabitants.

Poland is not an immigration country in the sense that it pursues an immigration policy – quite the contrary. It is difficult to obtain a long-term residence permit in Poland, usually only

after 10 years of residence. However, large numbers of temporary migrants live and work in Poland or pass through as transit migrants, often involving irregular border crossings. Their numbers tend to be underestimated according to Grzymala-Kazlowska & Okólski (2003). The temporary migrants tend to overstay, in effect becoming irregular migrants and working in the large underground economy[7] as clandestine workers or "entrepreneurs".

In 1992, Poland, together with many former communist countries, ratified the Geneva Convention of 1951. In consequence, growing numbers of asylum seekers entered Poland. According to Grzymala-Kazlowska & Okólski (2003, p. 12), 28,000 persons applied for asylum between 1990 and 1992. Only a fraction obtained refugee status (3 %), which meant that many who had entered as transit migrants, and had applied for asylum when they were apprehended, fell back into their former irregular migrant status and went underground.

The estimated number of irregular migrants in Poland in 2008 was also widely ranging, from 50,000 to 300,000 or 0.1 % to 0.8 % of the population. This is a proportion not dissimilar to the one for the EU15 in 2008, mainly composed of rejected asylum seekers. Again, it is the community of the accepted asylum seekers that tends to support irregular ones. According to the Clandestino report of Poland, one legal Vietnamese accounts for one irregular one, i. e., between 12,000 and 22,000 irregular migrants. To what extent this ratio applies to other ethnic groups of foreign residents is unclear.

A slightly different picture is provided by the case of **Hungary**, which takes up an intermediate position between the Czech Republic and Poland as far as immigration is concerned. Accordingly, the number of foreign-born in 2009 was 407,300 or 4.1 % of the total population. The share of foreign citizens is half that figure.

At the time of the communist regime, borders were closed for migrants while tourism was highly restrictive, leaving little room for cross-border mobility. But in the case of Hungary, as for the Czech Republic, temporary work contracts were given to Cubans, Vietnamese and other citizens of communist regimes. In addition, substantial numbers of scholarships for university education in Hungary were granted, largely to students of African and Asian origin. Further, Hungary granted asylum to refugees from the Greek civil war of 1946–1949 and to Chileans following the 1973 coup d'état, which brought General Pinochet into power.

Things changed rapidly with the fall of the Iron Curtain, and Hungary became a country of emigration, immigration, as well as transit migration. All that went hand-in-hand with legislative changes, amongst them the Hungarian Citizenship Act and the Act on the Entry, Stay, and Immigration of Foreigners. Both Acts tightened regulations governing immigration. The latest migration law reform came into effect in 1998 and referred to refugees; it is with this reform step that Hungary ratified the Geneva Convention. By international comparison, the number of refugees in Hungary is low. Between 2000 and 2006, a total of 31,450 asylum seekers submitted applications. Less than 3 % of all applicants were granted refugee status.

Hungary grants ethnic Hungarians citizenship according to *ius sanguinis*, if they apply for it. This is a particularly sensitive issue to those neighbouring countries with large Hungarian minorities. In contrast, Hungarian citizenship is not easily obtained by foreigners of non-Hungarian descent, as it takes 8 years of residence to be eligible for naturalisation. Accordingly, the largest numbers of immigrants are ethnic Hungarians from Romania, Slovakia and the former Yugoslavia, constituting two-thirds of the foreign-born population in 2009.

7 The shadow economy in 2002 produced some 26 % of GDP, according to Schneider and Buehn (2009).

In addition, temporary work permits are granted (all in all 42,000 in 2002), mainly for work in the construction sector, in export-oriented manufacturing industries – mostly in the textile and clothing industry, but also in retail trade – in catering services, in the entertainment sector and in agriculture. The majority of the temporary workers are Romanian citizens, followed by citizens of the former Soviet Union, mainly from the Ukraine. Since 1997, the Chinese have become the third-largest temporary worker group. Beyond the official temporary workers with work permits, many more work on an informal basis, often commuting from neighbouring countries. Lacking relevant survey evidence, and scientifically-founded estimations, the estimates of irregular migrants in Hungary are low, as they are based on administrative data of the Alien Police and Border Guards, and on expert opinions. According to those estimates, the total stock of resident irregular migrants in Hungary in 2008 is between 10,000 and 50,000 people. This relates to 0.1 % to 0.5 % of the total population. According to expert advice, the main reason for these low figures is the accession of Romania to the EU, rendering the stay of this largest group of migrants legal. However, this does not apply to their employment, which tends to remain in the dark. The largest remaining groups of irregular migrants in 2008 were Chinese and Vietnamese migrants. They were estimated at 15,000 and 25,000 that year.

In 2004, Hungary initiated a regularisation campaign, which a total of 1,406 people applied for, 60 % of them being Chinese and Vietnamese citizens. Other irregular migrant populations include, in descending order, Ukrainians, Serbs and Kosovo-Albanians and Sub-Saharan Africans. Men account for up to 80 % of irregular migrants, and the 20-59 age group represents as much as 90-95 % of the total irregular population.[8]

All that said, the pathways into irregular migration are not much different from those in the Czech Republic and Poland. Irregular migrants may regularise their status by applying for asylum. This may be one reason for the very low acceptance rate of asylum applications, a situation similar to that of Poland.

Immigration Resulting from Colonial Ties

The third immigration model is the result of colonial ties, as in the case of Great Britain, France, the Netherlands, Belgium and Portugal. In future, this model will most likely not produce massive migratory flows as happened in the early post-colonial years. However, a steady flow of immigrants from these regions may be expected to continue to enter their respective EU-MS countries because of former ties. In terms of a migration policy framework, it is helpful to think of this type of immigration as receiving preferential treatment with the potential of unexpected large inflows.

The countries in this third group of migration models represent the bulk of the Member States of the former European Community. At about 11 % foreign-born in their populations in 2009, they tend to be at the upper end of immigration in the EU; Belgium having a somewhat higher share with more than 13 % and Portugal a lower share with 6.3 %. The share of foreign citizens is usually about half as high, as citizens of foreign colonies who have a privileged position in acquiring citizenship. Accordingly, the share of foreigners in the UK is 7.1 %, compared to the share of foreign-born at 11.3 %. In France, the respective figures are 6 % and 11.6 %, and in the Netherlands, 4.4 % and 11.1 %.

8 The figures stem from the Clandestino Final Report, 2009, p. 81.

The largest numbers of immigrants to either of these countries tend to come from the former colonies. Accordingly, apart from the most recent influx of Polish citizens in the wake of eastern enlargement of the EU (8 % of all migrants in 2009), of the 6.9 million foreign-born residing in the UK in 2009, those who originate from India, Pakistan, and Bangladesh (18 %) constitute the largest single group of immigrants.

In the case of France, the single most important group of immigrants is from Algeria, namely 1.4 million or 19 % of all foreign-born in 2007. The case of the Netherlands is not much different, as immigrants from Surinam and Indonesia represent 18 % (327,500) of all foreign-born.

Immigration from the former colonies was largely market-driven. The gap in living conditions between the European countries and the former colonies acted as a pull factor for many. As their skills and educational attainment did not always conform to the immediate labour market needs of the host country, the Netherlands, Belgium and, to some extent, also France established temporary foreign worker programmes. Thus, we find substantial numbers of Moroccan and Turkish migrants in the Netherlands, Belgium and France, with a different occupational and skill mix. In addition, many citizens of Southern European countries migrated to the "North" to work in the thriving manufacturing industries. Italians tended to move to France to work in the car industry, while the Spaniards tended to work in agriculture. On the basis of bilateral foreign worker agreements, many of the Southern European migrants moved also to Germany and Switzerland.

In spite of these "old" migratory flows from South to North, and the free mobility of labour between countries of the European Community in the private and public sector since 1968, only a small proportion of EU citizens reside in any of the old European Community Member States – some 2.5 % of the respective populations, with the exception of Belgium. As Belgium is the major seat of EU administration, it should not come as a surprise that it has a large number of EU citizens.

The above countries were not a popular destination for asylum seekers until the late 1980s. In 1988, for example, only 5,700 people lodged applications for asylum in the UK, compared to 15,800 in Austria, a country with about a tenth of the population of the UK. This situation changed in the 1990s when applications rose sharply, reaching a peak of almost 100,000 in 2000, the UK overtaking Germany as the most popular destination for asylum seekers in Europe. France began to attract larger numbers of asylum seekers somewhat earlier in the 1980s, reaching 61,400 in 1989. Part of the rise in the UK and France can be taken as a reaction to increasing restrictions on immigration. The high risk of asylum seekers being rejected tended to slow down inflows. Inflows picked up again during the 2000s, triggering the enforcement of border controls.

Implications for Irregular Migration

The implications of colonial ties for irregular migration differ between the countries due, on the one hand, to different policies towards the citizens of the former colonies and, on the other, due to different economic growth perspectives after WW II. It is not surprising that the countries with former colonial empires tended to confer citizenship on the territorial principle – *ius soli*. The origins of this practice go back to feudalism – what's born within the realm of the Lord belongs to the Lord – and to imperialism – anyone born in the realm

of the monarchy was also a subject of that monarch. Accordingly, all those born within the British Empire were subjects of the British monarch.

This meant that the immigrants from colonies, who entered the **United Kingdom**, did so as citizens of that country, at least until 1962. Therefore, their residence status was not regarded as irregular. From 1962 onwards, however, immigration legislation became increasingly restrictive, reducing the rights based on *ius soli* until then; and in 1981, the UK ended pure *ius soli* altogether. There was, however, a remarkable continuity in the British citizenship policy, leaving few stranded as irregular migrants. The large-scale arrival of refugees and of immigrants from the accession countries, however, raised the potential of their becoming irregular migrants.

Accordingly, the more recent legislative changes in the UK aimed at closer controls of immigration, e. g., by adopting in 2005 an immigration system modelled after the Australian point system (OECD, 2008, p. 286) to better target skills required in the labour market. Further, a range of measures designed to deter asylum seekers were adopted, including reduced social benefits, time limits for lodging applications, declaring British airports to be international zones, reducing appeal rights, and fast-tracking of claims. In addition, transition regulations for citizens of Bulgaria and Romania were applied to avoid repetition of the large influx from the accession countries of 2004.

All in all, the most recent policy changes in the UK aimed at reducing overall immigration. The most reliable estimates suggest that the irregular migrant population in the UK was 430,000 in April 2001, the year of the latest census, ranging from 310,000 to 570,000. This official estimate equals 0.7 % of the total UK population of that time (59 million) and 11.8 % of the UK total foreign-born population in 2001 (Woodbridge, 2005). The Woodbridge study is the only formal attempt at estimating a number of irregular immigrants in the UK that used the dataset of the 2001 Population Census, applying a satisfactory methodology. Gordon et al. (2009) recently revised and updated the Woodbridge estimate. This new estimate suggests a figure of an irregular migrant population in the UK of 725,000 in the year 2007, based on a range of 524,000 to 947,000. This represents a rise to about 1.2 % of the total population and 19 % of the foreign population, putting the UK clearly into the top range of countries in Europe with irregular migrants.

Data and research regarding the main nationalities of the irregular migrant population in the UK allow only tentative conclusions. Amongst the data sets used for identification of irregular migrants are those relating to detention centres, which show that for the years from 2001 to 2006, these migrants came mainly from Jamaica, Nigeria, Pakistan, China, Turkey, and India, in descending order. The majority were men between 25 and 29 years of age. However, these small-scale samples are taken from a very specific group and are not representative of the total irregular migrant population.

There are various pathways into irregularity: "illegal" entry, involving clandestine border crossing or entry by "means of deception". The latter involves a wide variety of practices ranging from forged documents to deception about the "purpose of stay" – also those in breach of the stated conditions for "leave to enter", e. g., students, au-pairs or working holiday makers. These conditions mainly concern employment restrictions, e. g., allowed maximum hours of work per week or overstaying the restricted length of stay; but they may also relate to the access to benefits or the right to family reunification.

Those who are overstaying and/or break conditions of work restrictions make up the largest proportion of people counted as irregular migrants. The majority of people enter legally and subsequently move into an irregular status. Although it is unknown how many people cross the borders clandestinely, it can be safely assumed that this is the smallest group, given the tight border controls, which are more easily enforced for the UK than the borders of the landlocked countries of continental Europe.

As in many other European countries, a special group of irregular residents are asylum seekers. They may discontinue registering at the given reporting centre while remaining in the country as "absconded asylum seekers" or they may remain in the country, in breach of the conditions of temporary humanitarian stay following the rejection of their application for asylum.

Cases out of irregularity are extremely limited; the Secretary of State may grant an indefinite leave to remain on a case-by-case basis on "compassionate grounds". In addition, collective regularisation was being granted in 2003, when the Home Office granted "family amnesty" to all asylum seekers. By January 2006, 16,870 families had benefited from this policy.

The situation was somewhat different in **France**, which did not grant citizenship to persons from colonies until the late 1940s. The policy reform was triggered by the upheavals in Algeria, leading France to grant citizenship to Algerians in 1947. The Algerian war led to independence for Algeria in 1962. This triggered off a large wave of migration of returning French settlers and Francophile Algerians. Large numbers of Algerians have continued to migrate to France, constituting 1.4 million out of 7 million foreign-born in France in 2007. The former colony of Indochina, which received its independence from France in 1954, is also a continued source of immigration; citizens from Vietnam alone constituted 120,000 or 2 % of all foreign-born in France in 2007.

France is, however, unique in that it signed labour recruitment treaties with Italy, Belgium, Poland and the Czech Republic as early as the beginning of the 20th century. Next to the USA, France was in the late 1920s the second largest importer of immigrant labour in the world. Back then, some 2.7 million immigrants lived in France, constituting 6.6 % of the total population (Perotti, 1983), paving the way for later immigration from these regions.

Following World War II, France participated in the general European economic upswing of the late 1950s and 1960s. This acted as a pull factor for immigration from former colonies, as well as from Southern Europe. Until 1968, French immigration policy tacitly facilitated irregular foreign worker entry. The National Immigration Office (ONI) routinely legalised the status of workers who had entered as clandestine workers or as tourists. In 1968, the year of the turning point of French immigration policy, 82 % of all immigrants had been legalised at some stage of their residence in France (Koelstra & Simon 1979). In 1968, legalisation procedures were restricted mainly in relation to unskilled irregular migrants, although the inflow of migrants continued. However, as economic growth slowed down in the wake of an international recession, France tried to control migrant inflows by stopping the legalisation of irregular migrants in 1972. This stirred unrest amongst migrants, leading the Government to legalise the status of irregular migrants in 1973 as "exceptions". However, it came to a firm decision to end the legalisation process in 1974 and to stop further immigration, not dissimilar to the cessation of recruitment by Germany in 1973. Algeria, on its part, terminated emigration to France unilaterally in 1973 as a reaction against anti-Algerian sentiment in France. Nonetheless, irregular migration continued.

These historical events highlight that irregular migration is not a new development, and that countries employ different ways and means to deal with it. France tended to react to rising numbers of irregular migrants with regularisation programmes. In 1982, for example, a programme which turned 132,000 irregular migrants into regular ones was introduced. Also the 1990s saw rising numbers of irregular migrants; as these trends were met with increasing restrictions, demonstrations of "sans-papiers" ensued in 1996, largely organised by African and Chinese undocumented migrants. They brought their plight into the public light. As a result, some of the restrictive elements of immigration law implemented by Charles Pasqua, the Interior Minister, were withdrawn and a legalisation programme for irregular migrants, who had stayed in France for many years, was implemented in 1997. Of a group of some 150,000, two-thirds received legal status.

Since 2002, although immigration policy has again become more restrictive, it did not have a dampening effect on migrant inflows. These were largely a consequence of family migration as well as large inflows of students, who were often "back-door" migrants. In 2006, a regularisation programme was implemented, focusing on children without proper residence papers. Some 30,000 children applied, but only one-quarter were successful. In 2006, French migration policy was redrawn. The instrument of legalisation programmes for irregular migrants was abandoned in favour of a case-by-case regularisation process, as in the UK. In addition, expulsion orders have increasingly been enforced since then. Thus, 23,800 irregular migrants were deported in 2006. Moreover, in the French territories overseas, irregular migrants are also being deported more and more.

According to various estimates, the number of irregular migrants was between 178,000 and 354,000 in 2008. This is one of the lowest shares of irregular migrants in the EU, with a range of 0.3 % and 0.6 % of the total population, and 5 % to 10 % of the foreign residents.

Most irregular migrants in France are young men, often well-educated, from Africa. The largest group are Algerians, referred to as "harragas" – those who burn their documents at the borders, followed by migrants from Western and Central Africa (Senegal, Mali, Mauritania, Democratic Republic of Congo); but also Egyptians, Moroccans and Tunisians are amongst the irregular migrants who enter France with false documents.

A second category of irregular migrants includes refused asylum seekers: Chinese and Romanians (mostly Roma) during the 1990s, and nationals of many sub-Saharan countries as well as Haitians, Colombians, Kurds, Iranians, Iraqis, Syrians, Afghans, and, more recently, Sri Lankans.

A third category are victims of tightened immigration legislation, in particular, members of family reunification who entered illegally, overstayers, children over a given age limit who may not enter under the family reunification programme, fake tourists and students. Legalisation of stay via marriage has been made more difficult, as it has closely been monitored since the Pasqua laws of 1993.

A fourth category consists of irregular migrants in French overseas territories, particularly on the Comoros Islands, in French-Guyana.

The last category of irregular migrants comprises transit migrants wanting to enter the UK via the Eurostar train tunnel and who are caught in Sangatte, at the entrance of the tunnel. Most of them are young, educated and English-speaking, who generally have family networks in the UK, but are not able to enter the UK as regular migrants. They tend not to apply for asylum in France.

The situation in the **Netherlands** is different to that of France in the treatment of citizens of former colonies. Those who wanted to immigrate were given Dutch citizenship status upon independence, e. g., in 1945 to Indonesians, and in 1975 to Surinamers. Many of them were returning migrants of Dutch descent. In 1985, citizenship law was amended, bringing it closer to French legislation, according to which second generation migrants have the right to citizenship at the age of maturity.

The Netherlands, however, not only attract migrants from former colonies and former foreign worker recruitment countries such as Morocco and Turkey, but also from the EU, mainly from the neighbouring countries. This is typical for the Benelux countries, which were amongst the founding members of the European Community, and which tend to be ardent Europeans.

As with many other countries, the Netherlands introduced a stop to recruitment of foreign workers in 1973. Since then, inflows have been driven by family migration, especially from Turkey and Morocco. Net immigration to the Netherlands therefore continued without a break until 2001, when restrictions on asylum and family reunion were implemented, aimed at irregular migration in the form of fake marriages. The legislative reforms of 2001 marked a turning point in Dutch migration policy, implementing reforms similar to the legal changes of France, Denmark, Germany and Austria.

The Netherlands have been concerned with irregular migration for some time, developing sophisticated estimation methods. One is the capture-recapture method, based on police data. The focus is widened by undertaking surveys in ethnic communities, interviewing immigrants and key informants, mainly labour recruitment agencies, to gain a better understanding of the size and composition of irregular migration. In 2008, irregular resident migrants were estimated at 62,000 to 131,000. These numbers conform to the EU15 average of 0.4 % to 0.8 % of the total population. Given the high propensity of third country migrants to become Dutch citizens, the proportion of irregulars amongst the foreign residents is high (9 % to 18 %).

Research indicates that irregular migrants come from as many as 200 source countries (Leerkes et al., 2007[9]). The largest groups are Turks, Moroccans and Surinamese, who are "chain migrants" arriving with the help of the transnational networks of their legal settlers in the Netherlands. Before EU enlargement, a large number also came from Poland, Bulgaria and Romania. After accession to the EU, they could establish their stay legally, but for the most part continued to work in the shadow economy. They tend to be "circular" migrants, coming and going as work opportunities arise.

Increasingly, irregular migrants come from many different countries, often with no special ties to the Netherlands, e. g., from Sub-Saharan Africa, China and, to a lesser extent, from the Middle and Far East and the former Soviet Republics.

As with all the other countries, rejected asylum seekers are a source of irregularisation, as are overstaying visa and temporary resident permits.

A Special Case: The Southern European Countries

Spain was one of the first global empires reaching out to the world in the age of exploration, comprised of colonies which spanned from America, across Africa and Asia to Oceania.

9 For bibliographical details, see the previous chapter.

Many Spaniards left for one or the other of these territories, taking the language and culture along, such that Spanish has become one of the most widely spoken languages in the world. Emigration from Spain to America was most pronounced and of a nation-building character, the likes of which we only saw with the British Empire. Spaniards continued to emigrate well into the 1970s, but the direction of emigration changed after WW II, turning from the Americas to Continental Europe, in particular France, Germany and Switzerland. Given this long history of emigration, the change from an emigration country to an immigration country in the 1980s came as a surprise. Spain had no experience with immigration legislation, turning the forging of legislation into one of the most contested political topics in the late 1980s and 1990s.

The turnaround was brought about, in the first instance, by return migration of temporary workers from Germany, France and Switzerland, as the recruitment stops in the wake of an economic recession and structural change reduced their employment opportunities. At the same time, the Spanish economy picked up and provided jobs, which increasingly attracted migrants from North Africa and Latin America as well. In consequence, Spain implemented foreign worker programmes modelled after the Swiss model, offering preferential treatment, however, to descendants of former Spanish émigrés. These translate into a fast track to citizenship, namely after two years of legal residence, compared to ten years for other nationalities, and visa-free entry into Spain.

As a result, the Spanish population has grown, particularly in the 2000s, as increasing numbers of Eastern Europeans flowed into the country. Accordingly, in 2009, 14.3 % of the population was foreign-born. The largest single group of migrants came from Romania, namely 784,000 or 12 % of the foreign-born. The next important single source country was Morocco, with 11.5 % of all foreign-born. If one takes the immigrants from South America together, they constitute the greatest group of them all, namely 1.8 million or 28 % of all first-generation migrants. The largest single group from South America originates from Ecuador, followed by Colombia and Argentina.

The Spanish authorities have come to understand that immigration, as well as the immigrants, are there to stay. Therefore, a national plan for integration, such as the GRECO Plan in 2001[10] or the Plan Estratégico de Ciudadanía e Integración of 2006, has been drawn up. In that context, some of the most spectacular regularisation programmes have been put in place to give the irregular immigrants a chance to fully participate in economic, social, cultural and political life in Spain. As a consequence of these programmes, the number of irregular migrants declined to average EU15 levels, namely some 350,000, a quarter of the 2005 estimates.

During the 1990s, most irregular immigrants living in Spain originated from Morocco. The picture changed in the years of 2000, when Latin Americans started to lead the figures in both regular and irregular migration. Romanians and Bulgarians are also significant in number, but their countries' accession to the European Union in 2007 automatically legalised their stay.

At the beginning of 2008, immigrants from Argentina, Bolivia, Brazil, Chile, Colombia, Mexico, Paraguay, Uruguay and Venezuela constituted two-thirds of the whole irregular migrant population. Bolivia contributed the highest number in relative terms, namely two-thirds of all Bolivian immigrants in Spain.

10 This regularisation plan was carried out from 2001 to 2004.

International airports have been the main point of entry of irregular immigrants. Entry across the sea is, in comparison, a minor case, contrary to the media reports, which tend to focus on irregular arrivals off the African coast. Today, only 5 % to 10 % of yearly inflows of irregular immigrants enter via the sea. It used to be an important route for Moroccans, but came to an end after the deployment of the SIVE (Sistema Integrado de Vigilancia Exterior), a sophisticated electronic surveillance system on the Southern coast of Spain and the Canary Islands, in effective collaboration with Morocco regarding the repatriation of Moroccan irregular migrants. As a result, Moroccan irregular migration to Spain almost ceased. In addition, the signing of readmission agreements with Cape Verde, Mali, Guinea Conakry, Guinea Bissau and Nigeria, and varied forms of cooperation with other states in the region during 2006–2008 led to a notable decrease of irregular migrant arrivals from Africa.

Most of the irregular migrants in Spain enter legally as tourists or students; their stay turns irregular as time goes by. Also migrants with a work contract tend to overstay when their contract does not get renewed; they then fill the ranks of irregulars. This may happen frequently, as contracts are temporary, often entailing seasonal jobs. The main jobs of irregular migrants are in tourism, agriculture, construction and domestic work.

Some migrants attempt to "legalise" their stay by applying for asylum. This gives them a regular status for some months, but less than 5 % of applicants receive refugee status, and more than half of the applicants are rejected at the first degree of examination of their case by the Spanish Office on Asylum and Refugees. Accordingly, only 4,500 people applied for asylum in 2008 and of those, only 151 obtained refugee status.

The situation in **Italy** is not much different, except that is does not have the colonial history of Spain. But also Italy has only recently become an immigration country after almost a century of emigration. As in Spain, the institutional framework has been inadequate to manage the increasing inflows of immigrants. In addition, the long tradition of informal sector work has tended to easily integrate irregular migrants into work. Data on foreign-born in Italy is hard to come by, but the share of foreign citizens in the total population amounted to 7.1 % in 2009. The largest foreign-born communities are from Albania (13 % of the total migrant population), Morocco (12 %), Romania (10 %), China (4.6 %), Ukraine (3.9 %), the Philippines (3.5 %) and Tunisia (3.3 %). Although the share of immigrants is still well below average EU levels, the increase has been quite steep in the last two decades.

As far as amnesties of undocumented migrants in Europe are concerned, Italy competes with Spain for a double record: the highest number of general regularisation processes (5 programmes since 1986) and the largest proportions of immigrants who obtained a legal status through one of these programmes. In the last two decades, Italian governments have approved five different amnesties – in 1986, 1990, 1995, 1998 and 2002 – which have jointly legalised almost 1.5 million irregular migrants.

Different sources of information can be combined and compared to obtain a sufficiently clear and updated picture of the stock of unauthorised immigrants currently residing in Italy. According to estimates from survey data collected by the ISMU Foundation, the stock of undocumented immigrants was approximately 541,000 in 2005, 650,000 in 2006 and 349,000 in 2007.

The vast majority of undocumented migrants are residing in the Northern regions, where labour market opportunities are substantially better than in the rest of Italy. Young male migrants account for slightly more than half of the undocumented population. According

to the ISMU estimates, apart from the Eastern European population, the largest numbers are from North Africa, followed by immigrants from Asia and Oceania, Sub-Saharan Africa and Latin America.

Although Italy is sadly famous for the images of clandestine immigrants landing on the shores of its Southern coasts, official records show that only a small fraction (4 %–16 % in the period 2000–2006) of the existing stock of undocumented residents arrived by boat. Indeed, between 2000 and 2006, the Italian Ministry of Internal Affairs estimated that around 65 % to 70 % of the undocumented migrants currently residing in Italy are overstayers. The remaining 15 % to 34 % managed to avoid controls at the Northern borders and at international ports and airports.

Greece is another Southern European country with a long history of emigration. Over the past 15 years, however, Greece has become a focal point of immigrants. Most of the new immigrants come from Central and Eastern Europe; despite two regularisation programmes, a good number of them continue to live in an irregular status. All in all, Greece counted 11 % foreign-born in its population in 2006; the share of foreign citizens is lower with 7.4 % (in 2009). The share of irregular migrants is one of the highest in Europe, estimated at 1.5 to 1.9 % of the population, and affecting about a quarter of all immigrants.

Early irregular migration to Greece originated by and large from its neighbouring countries in the Balkans, Central and Eastern Europe, and the former USSR. Large-scale arrivals of migrants from Albania throughout the 1990s have turned the Albanian community into the largest migrant group in Greece, followed by Bulgarians, Ukrainians, Georgians and Romanians. While the Albanians are the largest group, the irregular migrants are a diverse group of people. The Bulgarian, Romanian, Georgian and Ukrainian communities have grown during the last decade. Small Asian and African populations of Filipinos, Vietnamese, Sudanese and Egyptians have entered from the 1980s onwards. More recent arrivals include Pakistani, Bangladeshi, Iraqi and Afghani citizens and Sub-Saharan Africans. The main points of irregular entry into Greece are the land and sea borders with Turkey and the Greek-Albanian land border.

Regularisation programmes are the main means for an irregular migrant to get out of an irregular status in Greece, as asylum is hardly granted. The processing of applications for asylum usually lasts a few years, and the rate of acceptance amounted to some 10 % in 2008. In practice, most rejected asylum seekers remain in the country as irregular migrants.

Table 1 below provides summary information on irregular migrants in the various EU-MS and the respective proportions in the total population and the foreign population. As we can see, irregular migration exists in every EU-MS; the differences between the countries are at times substantial, not always reflecting real differences, however, but rather more comprehensive and sophisticated estimation methods and/or better data availability, e. g., in the case of Spain as a result of unconditional health service provision to irregular migrants, and in the case of Norway and UK due to sophisticated estimation methods.

Table 1: Estimates of irregular migrants in the various countries of the EU in 2008

Country/Region	Irregular foreign migrants		% of population		% of foreign population		Total population	Foreign population
	min	max	min	max	min	max		
EU27	1,900,000	3,800,000	0.4	0.8	6.6	13.9	497,686,132	28,931,683
EU15	1,800,000	3,300,000	0.5	0.8	6.6	12.0	394,160,807	21,109,000
Sweden	8,000	12,000	0.1	0.1	1.4	2.2	9,182,927	555,400
Norway	10,500	32,000	0.2	0.7	3.5	10.6	4,737,171	303,000
Denmark	1,000	5,000	0.0	0.1	0.3	1.6	5,475,791	320,200
Finland	8,000	12,000	0.2	0.2	5.6	8.4	5,300,484	143,300
Austria	18,000	54,000	0.2	0.6	2.1	6.2	8,318,592	867,800
Germany	196,000	457,000	0.2	0.6	2.9	6.8	82,217,837	6,727,600
Switzerland (2005)	80,000	100,000	1.1	1.3	5.3	6.6	7,415,102	1,511,900
France	178,000	354,000	0.3	0.6	4.8	9.6	64,007,193	3,696,900
Ireland	30,000	62,000	0.7	1.4	7.3	15.0	4,401,335	413,200
United Kingdom	417,000	863,000	0.7	1.4	10.0	20.6	61,191,951	4,186,000
Netherlands	62,000	131,000	0.4	0.8	8.6	18.2	16,405,399	719,500
Belgium	88,000	132,000	0.8	1.2	8.7	13.0	10,666,866	1,013,300
Luxembourg	2,000	4,000	0.4	0.8	0.9	1.9	483,799	215,500
Portugal	80,000	100,000	0.8	0.9	18.1	22.6	10,617,575	443,100
Spain	280,000	354,000	0.6	0.8	5.0	6.3	45,283,259	5,648,700
Italy	279,000	461,000	0.5	0.8	7.2	11.8	59,619,290	3,891,300
Greece	172,000	209,000	1.5	1.9	23.4	28.5	11,213,785	733,600
Czech Republic	17,000	100,000	0.2	1.0	3.9	22.9	10,381,130	437,600
Slovak Republic	15,000	20,000	0.3	0.4	28.6	38.1	5,400,998	52,500
Hungary	10,000	50,000	0.1	0.5	5.4	27.1	10,045,401	184,400
Poland	50,000	300,000	0.1	0.8	82.8	496.7	38,115,641	60,400
Estonia	5,000	10,000	0.4	0.7	2.2	4.5	1,340,935	223,600
Latvia	2,000	11,000	0.1	0.5	0.5	2.8	2,270,894	392,150
Lithuania	3,000	17,000	0.1	0.5	8.1	45.9	3,366,357	37,001
Slovenia	2,000	10,000	0.1	0.5	2.4	12.2	2,010,269	82,176
Romania	7,000	11,000	0.0	0.1	22.3	35.1	21,528,627	31,354
Bulgaria	3,000	4,000	0.0	0.1	12.6	16.8	7,640,238	23,838

Sources: EUROSTAT, HWWI, Statistics Norway, Bilger & Hollomey (2011); Foreign population: France (2007), Ireland (2006)

Implications for Migration Policy

The overview of the various migration models indicated that the various EU-MS may have started out being different in the 1950s and 1960s, but that migration policies converged over time, partly flowing from international political and socio-economic changes, partly as a result of policy coordination by the European Commission, and of human rights actions. The remaining differences are not so much a consequence of different migration policies as of other factors – the level of economic development, of functional mechanisms of labour markets, of the role of the shadow economy and of access to social rights, including health care.

In terms of the shares of immigrants and of irregular migrants in the respective populations of the various counties, the migration outcomes are beginning to converge, while the

composition of migrants may differ as a consequence of the path dependence of migration, resulting in different endogenous growth dynamics. Accordingly, the timing, direction, volume and composition of immigrants vary between the EU-MS, as well as the source countries, the occupational and educational mix, and often also the entry channel. The distinction between settlement versus short-term migration countries is no longer applicable in Europe. All countries have become migration societies, encompassing all forms of migration, accompanied by various types and degrees of social inclusion.

The large proportions of migrants in all Western European countries and the increasing numbers in the accession states indicate that migrants are ready to grasp every opportunity for improving their economic situation and for asylum seekers to obtain security. In that sense, they are contributing to economic and productivity growth, reducing labour scarcities in one or the other segment of the local labour markets. It suggests that their mobility costs are lower than those of natives, even if they are marginalised and exploited, as is often the case for low-skilled migrants, mainly irregular ones.

At the end of the day, it has to be acknowledged that the planning and control of migration flows has become increasingly difficult. While there is the general belief on the part of policymakers that migration flows are mainly determined by the demand of receiving countries, this no longer holds unequivocally. International human rights laws – the right to family, to refuge and to settlement after a certain period of legal residence – limit the room for migration policy to manoeuvre, as does the right to free mobility within the EU. Many European countries believe (at least this is the impression one gets from public pronouncements and policy formulation) that they do not have the preconditions for becoming immigration countries in the sense that they cannot pursue a population growth policy to the same extent as traditional immigration countries like the USA, Australia and Canada. The latter have large unused land resources in contrast to the European countries, which tend to be densely populated, thus providing little room for additional population growth.

Accordingly, European countries tend to embrace immigration policy only to the extent that it may help alleviate the ageing problem; in addition, highly-skilled immigrants are invited to promote economic growth. But refugees and unskilled labourers are not what Europe wants to invite, as it continues to have sizable numbers of unskilled and semi-skilled labourers. Unskilled migrants, many of them refugees from developing countries, are seen to basically contribute to population growth without giving a boost to productivity. This policy stance has to be understood in the context of a rapid decline of demand for low-skilled labour. The decline in demand is faster than the slowdown in supply growth, as it is difficult to implement lifelong learning programmes which would, in theory, continually upgrade and adjust labour skills according to market needs. In addition, minimum wage policies are upheld in order to ensure a living wage for low-skilled workers. While this policy tends to speed up unskilled labour-saving production methods and technology, thereby speeding up the decline in unskilled labour demand, it tends to shift low-productivity work into the shadow economy.

The most disadvantaged in such a scenario are irregular migrants. They do not fit into the picture public administration wants to portray, namely that it is able to control migration flows. Accordingly, governments have a certain interest in the inflow of refugees to remain invisible or, better still, to disappear. In consequence, European countries tend to apply restrictions on immigration and focus increasingly on targeting migration to satisfy labour

market needs at the higher end of the skills segment, while restricting inflows of unskilled migrants, as well as refugee inflows.

Europe has tended not to pick the brains of the world in its migration policy, giving priority to education and training of its own population, and tending to supplement its workforce at the lower end of the skill spectrum. The Lisbon Agenda, however, introduces a new feature to European migration policy, i. e., a strategy to raise the inflow of highly-skilled migrants from **outside** the EU. The application of this agenda can already be seen – e. g., in the UK in 2005, and in Austria in 2011 – by the introduction of the points systems pioneered by the traditional immigration countries, Australia and Canada. In this connection, in a global setting, the EU will have to compete with other developed countries, particularly Canada, Australia and USA, for highly-skilled immigrants. It will have to bear in mind that it may lose some of its own highly-skilled to the rest of the world, while managing to attract highly-skilled persons from other parts of the world.

In 2001, the balance in numbers between highly-skilled emigrants and immigrants has been positive for a number of EU-MS, France and Germany taking the lead, followed by Spain, Sweden, the UK and Belgium. However, the major winners in the high-skilled market are the USA, Canada and Australia. Thus, the recipient countries with the largest proportion of university graduate immigrants in the workforce are Australia, Luxembourg, Switzerland, Canada, USA and New Zealand, with more than 20 % of all university graduates (OECD, 2005).

In this increasingly competitive environment, where every country wants to attract "the brains of the world", Europe has to be careful not to lower its moral values, civil liberties and equal rights in a quest to keep out those who are the most vulnerable. History shows that massive inflows can occur quite unexpectedly due to push factors in source countries, such as the more recent inflow of North Africans in the wake of the Arab Spring. This recent increase is reminiscent of rising refugee movements in the 1980s and 1990s. They were driven by both political and environmental push factors in the exit countries and economic pull factors in the receiving countries. The migration pressure from poor to rich countries is increasing, encompassing a larger number of countries, nationalities and ethnicities of emigration, and a larger number of destination countries.

Apart from pull and push factors, chain migration continues to ensure a constant flow of migrants, building on family reunification and migration networks. Immigration does not take place only in countries and regions of low unemployment, and is now a common feature also in high unemployment countries like Spain and Hungary. Economic links and technology have created a transnational space for the mobility of capital and new conditions for the mobility of labour. It may not come as a surprise that migration regulations have changed along with the nature of migration, producing some of the most complex legal arrangements which only the specialist in the field can understand.

This chapter has tried to provide some insight into the sources of irregular migration without studying "irregular migrants" in their day-to-day plight. It has identified the political, legal and social construction of "irregular migration", clarifying that irregular migrants rarely engage in criminal acts, but that they rather follow the human quest for happiness and improved quality of life through hard work. The examples showed that crossing the border may not always be illegal, but is subject to legal changes over time, as witnessed recently with EU enlargement. Accordingly, the numbers of irregular migrants may vary over time and space,

arising from structural features of labour markets, changes in migration policy especially in relation to asylum regulations, and the application of humanitarian rights principles.

The chapter does not provide evidence of the differences in the experiences of various types or irregularity, e. g., the implications for an au pair girl who overstays beyond her legitimate period of work and residence, as compared to a person of the same origin, age and sex, who is apprehended as an illegal resident engaging in clandestine work in the informal labour market, or compared to a person whose residence permit has expired, but continues to work in the informal labour market. We do, however, look at the implications for irregular migrants' right to access social services. The latter is closely linked to where access to work in the formal labour market is increasingly difficult, where the migrant has insufficient means to pay for their livelihood and has no regular residence, where barriers to entry are maintained while complementing such policy by deportation, where clandestine work has taken place and other restrictive policies are pursued (Biffl, 2010).

Austrian unions tend to be amongst the most ardent defenders of this restrictive policy stance. They are also in favour of additional regulations to ensure better control of self-employment of migrants in order to prevent "fake" self-employment and exploitation (Österreichischer Gewerkschaftsbund, 2008). In combination with the perpetuation of labour market access barriers, such additional regulations may close the only remaining loopholes for migrants to find legal employment, thereby pushing them even more into the informal economy.

The Austrian policy is in stark contrast to practices in other countries, where unions have stopped supporting restrictive migration policy measures (see, for example, Avci & McDonald, 2000, on the UK; Haus, 1999, on France; Milkman, 2000, on the US). Their arguments are that attempts to close every legal loophole to access the formal labour market may result in merely redirecting migrants into informal parts of the labour market. In fact, Krings (2009, p. 57) quotes an Austrian union official saying, "there are huge numbers of illegally employed people, particularly in home care and in construction. [...] This shows that the strategy of simply adopting restrictions for the transitional period is not necessarily working, because an underground economy is developing".

Restrictive immigration policies tend to be essentially flawed, as they are based on the belief that there is a set amount of jobs in the economy and that immigration would therefore reduce the number of jobs available for native workers (Nonnemann 2007, p. 15). This argument does not take account of the fact that every immigrant creates additional demand, and thereby increases the need for production and also for labour. Indeed, "[the] world's richest countries are in many cases among the most densely populated, and there is no reason to assume that more migration is damaging to economic prosperity" (Nonnemann, 2007, p. 16).

The Shadow Economy and Irregular Migration

Generations of immigrants who entered labour markets in Europe in the 1950s to 1970s did so in a phase of rapid industrialisation with rising labour demand for low- and medium-skilled workers. Today, de-industrialisation and the expansion of service activities affect both the sectoral and occupational composition of employment, as well as its skill content. In the absence of a comprehensive system of continued learning and re-skilling, an oversupply of labour with obsolete skills began to build up in the early 1990s, providing an argument in favour of restrictive immigration policies. The oversupply did not lead to a rise in unemployment, but became the source of labour in casual and part-time employment, marginal occupations,

and as fringe self-employment outside the core economy, at lower wages. Self-employment of migrants was a relatively new feature in the countries with a dominant temporary work model, e. g., Austria and Germany, whereas it had been a normal feature of migrant work in countries like France and the UK for some time (Blume et al., 2003). In addition, irregular migration emerged again in the 1990s – a feature only known from the earlier migration in the 1960s, where rising demand for labour did not keep up with administrative procedures to regularise migrants. In the 1990s, few regularisation procedures occurred and work in the informal sector persisted for long periods (Ghosh, 1998; 1999).

According to research by the OECD (2002) and ILO (2002), the existence and rise of the informal sector economy in the EU may in fact have promoted irregular migration[11] (Graph 2). In 2004/05 on average, it was as high as 40 % of GDP in Latvia, closely followed by other new EU-MS, like Bulgaria and Romania, with the Southern European countries being in the middle range, with 20 % to 25 % of GDP produced in this economic sector. Countries like Austria, Switzerland and the UK came in at the lower end of the EU spectrum, with 8% to 10 % of GDP. Thus, informal sector production plays a significant role in employment creation, income generation and poverty reduction.

The rising share of informal labour in total employment is associated with the introduction of measures to raise labour market flexibility, e. g., casual and contract labour. These measures are compatible with what already prevails in the informal economy – workers employed by informal enterprises, domestic workers, outworkers, home workers, part-time and casual workers – and thus facilitate the movement from one economy to the other. Migrants play an important role in the informal sector, particularly in countries where access to formal sector jobs is difficult due to quota regulations and other institutional barriers to entry.

Also the rising number of highly-skilled migrants from third countries in the EU since the 1990s has to be seen in the light of liberalising markets, including labour markets, and less as a result of targeted migration policy. This conclusion is based on the specific occupational and skill composition of the highly-skilled migrants. The latter tend to be concentrated in business-oriented services, mainly in banking and insurance, in the information/communication technology sector, in utilities (especially in electrical engineering), as well as in education and research. Their inflow has to be seen in the context of the deregulation of the services sector.

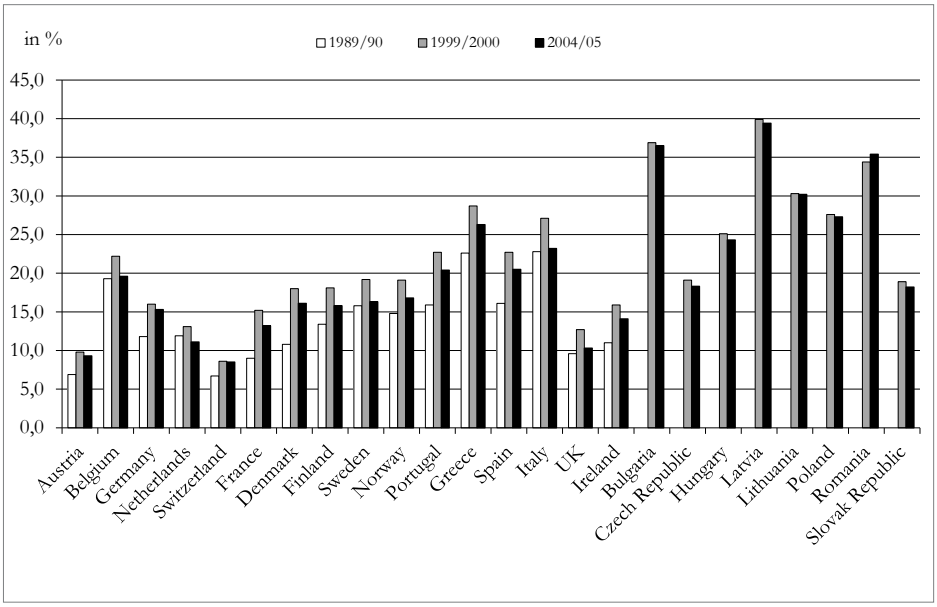
Accordingly, the general understanding is that the increasing inflow of highly-skilled migrants results from liberalising market access rather than from a reorientation of migration policy. It is argued by Borjas (2005) that the inflow will have adverse effects on the earnings of competing workers, regardless of whether they are native- or foreign-born. But it will also contribute to productivity and economic growth of Europe, thereby helping to move along the roadmap of the Lisbon Agenda.

As to the unskilled and semi-skilled migrants, they continue to flow in in large numbers, not least because of family reunification and refugee intake. Their employment opportunities are declining in Western Europe, as whole segments of manufacturing production are reallocated to CEECs and the Far East. While such reallocation of production will allow CEECs to catch up to Western Europe, it will contribute to the rising surplus of unskilled workers in Western Europe who turn to the growing services sector for employment, but are often not able to compete because they lack the necessary skills. As a result, they turn

11 The ILO claims that the bulk of new employment in the late 1990s, especially in transition countries, has been in the informal sector (ILO, 2002, p. 1).

increasingly to working on their own account or joining the ranks of the unemployed and the socio-economically excluded or making ends meet by working in the informal sector.

Graph 2: Shadow economy in % of GDP



Source: Schneider (2007); Schneider / Enste (2000)

The view that the informalisation of work follows from increased labour market flexibility is also shared by Standing (2008, p. 365), who sees in it a core element of an emerging global labour system, where the dividing line between an employer and an employee becomes increasingly fuzzy "… with labour externalisation and a global resurgence of labour broking, employment 'agencies' and labour sub-contracting. ILO Conventions begin to become inapplicable for a lot of those flexible work statuses involved".

Accordingly, it is not the ready availability of irregular workers which invites irregular work, but rather the other way around. This is also what Castells and Portes (1989) report: "Undoubtedly, immigrants provide one source of labour for the expansion of those activities, and they may be preferable to domestic workers because of their vulnerability. However, the underlying causes for the expansion of an informal economy in the advanced countries go well beyond the availability of a tractable foreign labour supply".

There is a growing convergence on the view of the structural nature of informal work in modern, liberal market economies. Accordingly, the dualist model, which may have been and possibly still is prevalent in developing economies, is losing ground against the formal-informal continuum model (MacGaffey, 1991; Kurkchiyan, 2000). According to the first model, the informal sector is associated with unregistered and unregulated small-scale activities at the margin of the economy which generates income for the poor. The second model takes a more comprehensive view. It sees formal and informal activities not as separate and independent segments of the market, but as interdependent activities, one feeding into

the other, i. e., informal work is subordinate and dependent on developments in the formal sector work. According to the ILO the "formal and informal enterprises and workers coexist along a continuum" (ILO, 2002, p. 4).

Thus, the informal sector may be likened to a sponge, which can soak up labour from the formal sector as well as release labour into the formal sector, depending on the prevailing economic and social forces. It is neither a temporary nor a residual phenomenon, and the group of workers and enterprises in that sector have diversified in the wake of internationalisation and flexibilisation of labour markets. It consists of employers, workers on own-account and wage workers. But unlike their counterparts in the formal sector, they are not subject to legal and social protection.

The implications of the rising trend of informal work for the well-being of societies are not straightforward. While labour market flexibility may increase competitive power and thus economic and employment growth at a macro level, for many countries it has been associated with a reduction in employment security for a rising portion of the working population, and a widening in the distribution of income and earnings. Informal sector work may also be a "survival tool", e. g., in the form of subsistence farming for laid-off workers in some CEECs, or a means of additional income for persons who are well-covered by social security arrangements – e. g., early retirement and disability pensioners in Austria.

Informal activities differ from formal sector jobs both in terms of supply and demand. This has important implications for policy. One question to be answered is to what extent the driving forces for informal sector work differ between old and new EU Member States and the emerging economies; another question relates to the probability of a transfer of informal sector work through migration and products via petty trade. Further, we also need to know what drives the movement of labour between the formal and informal sectors. In order to answer these questions and to better understand the underlying processes, we need standardised concepts and norms in the definition and collation of data on the informal sector. In this context, we need to be aware of the fact that the current practice of including an estimate of the informal sector production in the System of National Accounts, i. e., in GDP, without including clandestine or informal labour in the official labour accounts/statistics, understates the actual labour input into the production of GDP and thus overstates labour productivity in countries with a high share of unrecorded labour like the Eastern and Southern European countries.

Thus, greater formalisation of work may increase the recorded labour input and show up in a reduced productivity growth. This compositional change may lead to false policy conclusions. A slow-down in recorded productivity growth may not correspond to the actual productivity growth, while the increase in recorded employment numbers may not involve a corresponding rise in real income flows. The declining proportion of the informal economy may, however, increase taxes and thus the social dividend and, by that token, increase employment security and welfare protection of the workforce.

As far as the new EU-MS are concerned, a high share of informal sector production and work is not new to them. Numerous studies recount the different types of legal and illegal elements of the former command economies (Kurkchiyan, 2000). However, the breakdown of the command economies has brought about a different extent and structure of the informal sector. On the one hand, privatisation of state enterprises in the course of the 1990s introduced flexible employment relationships into the formal sector, which reduced not only job

security but also workers rights and social protection compared to the old order.[12] On the other hand, "second economy" enterprises, in particular services – which, as a result of the application of the Marxian "labour value theory", were not "productive work" and therefore did not feature in the 5-year production plans of the formal sector economy – entered the arena of the formal sector, thus recording elements of former informal employment and income, thereby increasing the number of workers with social protection of the market economy type. These processes, i. e., flexibilisation of work in the former formal sector and legalisation of former informal enterprises, are responsible for the development of similar formal-informal sector interlinkages as in the EU15.

The large proportion of informal work in GDP and in total employment is not only the result of a legacy of informal work practices and a lack of experience with a whole set of new institutions typical for market economies, but also of the massive impoverishment of large segments of the population in the wake of transition to a market economy. Transition from a command to a market economy went hand-in-hand with substantial output declines in manufacturing, mining and agriculture, and with an increase in services. The reallocation of labour was associated with a rise in unemployment and a corresponding loss of benefits traditionally provided by enterprises. A feature of the communist system of full and life-time employment was to top up wages by generous universal benefits, e. g., family allowance, pensions, subsidised food, housing and heating. The welfare system was thus linked to employment in the formal sector. The loss of formal sector jobs and the slow implementation of Western-style welfare institutions, like unemployment benefit systems, retirement pay, health provision, often made work in the informal sector a survival strategy.

There is a growing consensus that increasing flexibility in the Western-style formal economy, together with the legacy of a second economy in the transition countries, provide strong incentives for a large informal sector production in the new EU-MS (Kurkchiyan, 2000; Thomas, 1992; Sik, 1992). By drawing these countries into the EU, the expansion of informal sector activities has been reinforced. We could see that migrants and cross-border workers from the accession states were pulled into the formal-informal continuum of labour markets of today. Western EU countries saw an increased supply of informal sector labour as a result of migration on the one hand, and through petty trade with informal sector products from the accession states on the other, given the large differences in wages and consumption possibilities (Biffl, 2002).

Work in the Informal Economy

The reasons for turning to informal work are manifold. On the one hand, clandestine work is often treated as a trivial offence; accordingly, it is not prosecuted with fervour. On the other hand, there are ample unused labour resources. Undocumented migrants are only one group of potential workers who are on the lookout for a job, even if it is only in the informal sector. Due to the structure of the immigration system, there are various categories of migrants with different access rights to the formal labour market. Those excluded for various reasons, usually low-skilled third country citizens with limited years of residence, are also prepared to work in the informal labour market.

12 Musiolek (2002) points out that the CEECs have high standards of labour rights by the letter of the law, from the times of the command economy. The enforcement of these rights and the decent work concept are, however, limited.

Most informal work done by migrants takes place in households, the construction sector, in agriculture (often seasonal work) and in tourism. By definition, informal work does not conform to labour laws; pay and rest times are not regulated, there are no paid holidays or sick leave, and if a worker is mistreated or an employer withholds pay, there is no recourse to the justice system for the worker in question. In addition, the workers and their employers do not pay into the social security system, and the workers do not acquire any rights to future social security payments such as unemployment benefits or pensions.

Informal work introduces a group of workers into the labour market which is out of the reach of labour rights and which, like any two-tiered system, presents a problem for trade unions. In general, a two-pronged strategy to combat informal work should be pursued: the one is focusing on the demand side for clandestine work, e. g., by raising the status of informal workers, thereby reducing the cost advantage of informal labour. The second should focus on the supply of informal work by reducing the incentives to engage in informal work, e. g., raising the fines for clandestine work and/or by reducing the taxes on low-wage incomes, thereby reducing the wage advantage of informal work relative to formal low-wage jobs.

Informal work in the household sector has many faces. It can be carried out by native or migrant women, in an informal or formal work version. Care work is one of the main sources of work. A different organisation of care work is the major explanatory factor for the significant differences in the degree of integration of women of prime working age into formal sector employment across the EU (Biffl, 2004). This is the phase in life where women and men try to strike a balance between work and family life. Thus, a different set of taxes, transfer payments and public services in the various EU-MS results in a divergence of incentives to provide services, largely care work, at home or in the informal and formal labour market. In the Nordic countries, a tax system based on individual taxation with high marginal tax rates on individual incomes provides the incentive for every family member to engage in market work. Consequently, the state welfare system opened up formal sector employment opportunities for women, allowing female employment rates to rise to male levels. Accordingly, social services are organised by the state, rather than the family at home. A solidaristic wage policy reduced the wage gap between men and women to one of the lowest in Europe in spite of a pronounced gender segmentation of work – men are predominantly working in private industries and women cluster in care-oriented public services.[13] As wage costs are high, also Nordic countries have opted for informal work in domestic services, however, largely engaging irregular migrants, as noted earlier.

In contrast, in Austria, a complex system of family allowances (tax rebates for single-earner households and child care benefits), together with generous transfer payments to households (benefits for the disabled and [older] persons in need of care), promotes the provision of personal services by households rather than the market. While Austria introduced a system of individual taxation in the early 1970s, it cannot completely offset the incentive provided by tax benefits and transfers for service provision in the household. As the cash payments to households are not sufficient to employ a professional care taker through the formal labour market, women tend to work part-time in the formal labour market and employ domestic helpers, often irregular migrants, on a clandestine basis in the household. As a result, employment

13 Research on gender segregation of work demonstrates that high levels of occupational segregation of work exist in all modern industrial societies, also in Scandinavia. There is considerable consistency across countries in the extent to which women are concentrated in certain major occupational groups (Anker, 1998).

rates of women in Austria are lower than in the Scandinavia, particularly if calculated on the basis of full-time equivalents, and irregular migrant work has a focus on domestic work.

Informal sector work may be a rational coping strategy in a world of scarce formal sector jobs. However, there is a risk of permanent de-skilling of workers that are effectively excluded from formal employment. This may seriously impair the productive potential of a country. Therefore, in order to devise effective employment policies, it is important to learn about the structure of informal work – the demand side – and about the characteristics of the workers in the informal sector – the supply side. In the current situation, high youth unemployment could serve as an indicator of barriers to formal sector jobs of newcomers. We do not know if and to what extent young people are working in the informal sector, nor do we have systematic and comparable information on the type of jobs in the informal sector. The danger of de-skilling youth due to their high underutilisation in the formal labour market is particularly pronounced in Southern and Eastern EU-MS.

The Rationale for a Pro-Migrant Stance

"By historical standards, migration today is very restricted", writes Nonnemann (2007, p. 18). This is definitely true for the EU in relation to third countries, where new legislation, together with "stricter border controls, increased punitive employer sanctions, greater use of deportations, tighter visa requirements, redefinition of asylum criteria and the closer coordination of national policies across Europe" is designed to limit access for migrants, especially for "economic migrants" from the Third World.

As Avci and McDonald point out, it would be logical to assume that labour unions would want to restrict access to the labour market for migrants in order to keep the labour supply low and thereby strengthen their relative power against employers (Avci & McDonald, 2000, pp. 191-192). And many labour unions have, in fact, a tradition of favouring tight borders in an effort to keep the supply of labour low. Within the EU, however, this is simply not an option anymore – even the transitional restrictions that have been enacted in states such as Austria and Germany have already expired or are due to expire soon.

Accepting this reality has led labour unions in several countries to re-think their traditional approach towards migrant workers and strike new paths. In addition, there has been a growing awareness amongst union leaders and others that in spite of restrictions such as EU border controls or transitional agreements, "[it] is unrealistic to believe that illegal or irregular migration can be reduced or kept in check. [...] Restrictive measures merely ensure that legal migration is replaced by illegal forms of immigration" (Nonnemann, 2007, p. 18).

According to this view, tightening immigration controls as well as restrictions on labour market participation is either "not likely to work, as migrants will enter the labour market clandestinely" (Donaghey & Teague, 2007, p. 662) or may even *increase* the number of persons working in the shadow economy. An example of this mechanism can be seen in the case of home care workers who entered Austria in large numbers after the opening of the borders in the East. These women, largely EU citizens from the new EU-MS (EU12), could enter Austria legally, but due to Austria's transitional restrictions they were not allowed access to the formal labour market. In spite of the magnitude of the issue, it took Austria almost a decade to enact legislation that legalised some of the care work and aimed to establish a certain degree of labour standards.

Any migrant who is barred from entering the formal labour market (be it as a regular migrant, an irregular migrant or an asylum seeker) may have no choice but to work in informal jobs. By definition, these informal jobs exist outside of all the wage and labour standards that unions have fought for. Therefore, the availability of informal labour, especially in low-paid fields, exerts a noticeable downward pressure on wages (evident, for example, in the field of home care described above), thereby affecting formal sectors of the economy as well.

On the other hand, while long-term migrants with regular access to the labour market may be subject to discrimination and other disadvantages, from the perspective of a union they are no different from native workers, since the same wage and labour regulations are in place for them. Persons with only limited access to the labour market (even those in possession of a [limited] work permit), however, are often totally dependent on a particular job when it comes to both their livelihood and their migration status. Therefore, they are easier to threaten and exploit by their employers, who have greater power over them than over other workers. Therefore, for unions have, there are good reasons to contribute to a reform of labour markets, so that all residents would be allowed to engage in formal employment.

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Health and Migration in Europe

Access to Health Care in the European Union

Gudrun Biffl

"Of all of the forms of inequality, injustice in health is the most shocking and the most inhumane".
(Martin Luther King, Jr.)

It is part of the human condition to fall sick, get injured or suffer from some sort of ailment. Accordingly, all societies have developed systems of health care. The organisation of health systems flows from different historically grown ways of regulating and providing health services. The differences arise from alternative ways of funding health services and from different organisational structures of the provision of these services. They surface in differences in the share of public and private contributions in funding, in a different division of the provision of health services amongst public, private, non-profit organisations and mobile services, including the household sector. The role private households may play in providing health care differs between EU-MS in response to differences in tax and transfer systems and thus incentive systems. The relegation of different elements of care work to the household opens up opportunities for work, often clandestine work of irregular migrants. In addition, the role of general practitioners may differ. In some countries they are not only the providers of primary care, but also the gatekeepers for access to secondary care and specialised services, with important implications for the access to health services of irregular migrants.

Access to Health and the Welfare Model

It is becoming more and more difficult for all EU-MS to raise sufficient financial resources to meet the health needs of an increasingly diverse population and to achieve universal coverage, taking specific needs into account. While the ageing of societies has resulted in considerable research efforts in order for policy to respond properly to the changing needs and the costs involved (OECD, 2006; EC, 2010), fairly little has been done to identify the specific needs of migrants and the organisational and funding implications (Eurohealth, 2010). Moreover, research tended to focus on individual countries and little on comparative analysis, not taking the embeddedness of health systems in the wider welfare regime of the various EU-MS into account. A comparative approach helps understand the trade-offs each country has to face when endeavouring to change the health system in such a way that it is more inclusive and targeted to the specific needs of an ageing and more ethnically diverse society. We may join Hega and Hokenmaier (2002, p. 2) in saying that "... the specific nature of the(ir) provisions for healthcare […] bear important consequences for the socioeconomic opportunities and outcomes of individuals and groups. A nation's social programmes reflect the socioeconomic and political institutions that shaped them".

In its White Paper on Governance (COM, 2001), the European Commission asserts that institutional reforms are necessary in all EU-MS in response to the increased socio-economic and political integration and interdependence between EU Member States resulting from the implementation of a Single Market and the Single Currency. The latter represent a change in paradigm, i. e., a change of economic incentive systems, for every Member State, thus reducing the internal consistency of the national institutional architecture.[1] As the functional mechanisms of decision-making differ in the face of a different set of institutions, the outcomes may also differ as a result of different motivational forces guiding institutions and socio-economic actors. One does not have to go as far as Kohler-Koch (2005, p. 3), who argues that "… European 'good governance' may threaten the governability and democratic quality of established national systems", when wanting to draw attention to the reforms carrying the potential of raising the number of people marginalised in one or the other aspect of life, even jeopardising their access to health services, when undertaking reform steps which are not in line with the intrinsic logic of the welfare model.

In order to ensure that the reform steps are in line with the inner logic of every welfare system, the EC has introduced a new form of governance in areas such as health, which remain the sole policy responsibility of the EU-MS according to the principle of subsidiarity. The method of policy coordination chosen is the Open Method of Coordination (OMC), representing interactive, multi-level policy coordination and development which engage many levels of government, social actors (NGOs), the Commission, the Council of Ministers and academics. The overall strategy of the OMC is to preserve the European Social Model by reforming it. It does that not by traditional legal changes (directives), but by soft law aimed at hitting a compromise between hard core neo-liberal promoters of the "minimal state" and the defenders of a social democratic powerful state. Thus, the OMC represents something like a "third way" (Kenner, 1999) by promoting universal coverage and targeting needs. According to Sabel (2000), the OMC is an innovative governance method capable of solving social policy challenges of increasingly diverse post-industrial globalised societies.

In the last two decades, the issue of policy co-ordination, which is core to the EU policy agenda, has increasingly been taken up in research, often based on new ways of thinking introduced by North (1990). Social capabilities captured in institutions, be they political, commercial, industrial, financial or social, are the vehicle through which adaptability of nations to changing socio-economic frameworks is assured. Adaptability to new requirements is thus identified as an important factor in economic growth and well-being. The notion of adaptability suggests that there is an interaction between social capability and opportunity. Technological opportunity drives change, also in health service provision; if countries learn to modify their institutional arrangements, they may take advantage of the technical opportunities and thereby improve the well-being of their societies.[2] Amartya Sen (1985) goes beyond this concept of capability and extends it to an institutional framework which offers every person the opportunity to develop their capabilities, i. e., to empower the individual to actually do something (functional freedom) to improve their situation. This aspect of capacity building is an important driving force for promoting the self-fulfilment

1 On the diversity of models of social organisation and the resulting differences in incentive systems in Europe, see Soskice (1999), Hollingsworth & Boyer (1997), Aoki (1995).

2 Abramovitz (1989) points out that growth by itself can entail serious social costs by dislocating people from their established occupations and living conditions, apart from damaging the environment. Social and environmental sustainability ask for co-ordinated socio-economic policy to limit damages to the social and physical environment.

of individuals, providing continued education and training, improving the health and safety measures[3] and, in so doing, developing a sustainable European Social Model.

Research into social service provision has resulted in the development of typologies of welfare state regimes in Europe. The best known has been established by Esping-Andersen (1990; 1999), which by now is a "modern classic" (Arts & Gelissen, 2002) dominating the field of research on welfare states (Hicks & Kenworthy, 2003). His framework incorporates the interaction of the market, the household (family) and the state that "…in unison, form contemporary welfare regimes" (Esping-Andersen, 1999, p. 4). His typology is particularly pertinent for the analysis of health systems across the EU (Biffl, 2004).

Esping-Andersen distinguishes between four different basic models of social protection in Europe, which we may augment by a fifth one:

1. The Scandinavian Model (DK, FI, SE)
2. The Anglo-Saxon Model (IE, UK)
3. The Continental European Model (AT, BE, DE, FR, LU, NL, CH)
4. The Southern European Model (ES, GR, IT, PT)
5. The Central and Eastern European Model (CZ, EE, LV, LT, HU, SK, SI, PL, BU, RO)[4]

The Scandinavian Model tends to be referred to as social-democratic, the Anglo-Saxon Model as market-led (liberal), and the Continental European as corporatist (conservative). The Southern and Eastern European Models tend to combine elements of the Anglo-Saxon and Corporatist Models. These differ in their priorities of protection against risks, their composition of social expenditure, their source of funding and the organisation of service provision.

The **Scandinavian Model** focuses on individual social rights and obligations. The system of social protection is employment-centred. Work is not only the source of income, but also the means through which the social dividend is distributed. Unemployment insurance is organised by the unions, which explains the high degree of unionisation in Sweden (Gustafsson, 1996). Thus, integration into the labour market is vital for the well-being of the individuals. Work-related income and services are complemented by public sector services, like child and health care, which can be accessed by every resident. The universal character of welfare services reduces the need for special, means-tested integration measures.

The **Anglo-Saxon Model**, exemplified by the UK and Ireland, and also referred to as the Beveridge Model, is basically run by the public sector and funded out of general tax revenue. Access to health services is universal; access to welfare is subject to means testing. This basic scheme of social protection is complemented by private insurance (health and pension schemes), i. e., a system which allows those prepared to pay for it to enjoy benefits above the minimum provided for by the state (OECD, 1998A; 1998B; OECD, 1999).

3 More on the importance of Occupational Health and Safety in Smismans (2006).

4 AT – Austria; BE – Belgium; DE – Germany; DK – Denmark; ES – Spain; FI – Finland; FR – France; GR – Greece; IE – Ireland; IT – Italy; LU – Luxembourg; NL – The Netherlands; CH – Switzerland; PT – Portugal; SE – Sweden; UK – United Kingdom; CZ – Czech Republic; SK – Slovak Republic; PL – Poland; LV – Latvia; LT – Lithuania; EE – Estonia; HU – Hungary; SI – Slovenia; BU – Bulgaria; RO – Romania.

In contrast, the **Continental European Model**, also referred to as Bismarck Model, is centred on a social insurance system comprising health, unemployment and retirement insurance, which is funded out of contributions by employers and employees. This basic model is complemented by a system of tax benefits and/or transfer payments to families, based on the number and age of children, on the one hand, and to persons in need of health care, on the other. The family allowance scheme is paid out of a wage and income tax fund, thus keeping family policy separate from a market-oriented wage system; the transfer payments for care work are either paid out of general taxes (Austria) or of a specific care insurance fund, the most recent addition to the social security system in Germany (1995).

The **Southern European Model** (family-centred model) of social protection is somewhat differently organised. Health services tend to be universally accessible, while income protection schemes tend to follow the Continental European insurance model. In addition, the family plays an important role as a provider of care and income support without receiving any of the generous transfer payments for care work, as in Austria.

The **Central and Eastern European Model** is flowing from the socialist command economies, preserving elements of public sector provision of social services, increasingly introducing social security contributions to fund social protection measures, as tax revenues are not sufficient to provide comprehensive services.

Diversity of Health Systems within the Welfare Schemes

The **Beveridge Model**, which is named after the British economist and social reformer William Henry Beveridge, was introduced at the end of World War II in Great Britain. The Nordic countries of Denmark, Finland, Sweden and Norway adopted this model as well, and so did Ireland, Spain, Portugal and Italy. It is basically funded out of general tax revenues. It is a "National Health Service" in that health services are provided by public sector institutions run by increasingly decentralised public sector health providers. In principle, every "necessary" health service is free of charge and accessible to all residents. As this model of health care provision cuts across three different types of welfare systems, namely the Anglo-Saxon, the Scandinavian and the Southern European Models, it may not come as a surprise that access to health services differs in the various countries, given different roles of the state, the market and families/households in the production of goods and services, including welfare.

The **Continental European or Bismarck Model**, named after the former German chancellor Otto von Bismarck, dates back to the 19th century, insuring workers against the risk of illness. The public health insurance scheme is financed by employer-employee payroll taxes. Health insurance contributions represent wage costs, explaining the constant pressure on the level of contributions in order not to jeopardise the competitiveness of industrial production. Accordingly, France has broadened the revenue base for social security by introducing a national income tax (contribution sociale généralisée) in 1990.

Those countries which adopted this funding system are Germany, Austria, the Benelux countries and France. The health insurance bodies or sickness funds are non-profit, self-governed public institutions under limited government control. Health insurance is mandatory for dependent employees, as well as for the self-employed. The insurance body collects the

contributions and engages in contracts with health service providers, a mix of public and private institutions. Doctors and hospitals are paid directly by the insurance body on the basis of the catalogue of fixed prices for the various services. In this model, every "necessary" diagnostics or treatment is also free of charge to the patient.

The Greek health care system is a mixed one, as social insurance funds coexist with the National Health System, established in 1983 to provide free access to health care to all residents of Greece. Primary health care services are provided through rural health centres and provincial surgeries in rural areas, the outpatient departments of regional and district hospitals, the polyclinics of the social insurance institutions and specialist services in urban areas. Secondary care is provided by public hospitals, by hospitals owned by social insurance funds, as well as by private for-profit hospitals and clinics.

The third model tends to be referred to as **Semashko System**, named after Nikolai Semashko, the first minister of health of the USSR. This system used to be the prevalent system in the CEECs, funded solely out of the general tax fund and run by central government. The provider of health services was the state. In the 1990s, substantial reforms were undertaken in the various new EU-MS, decentralising services – regions very often became responsible for running public hospitals, health insurance funds were introduced, and co-decision-making was introduced by bringing in medical associations. In addition, privatisation of dentists, surgeries and pharmacists was implemented. The reforms undertaken tended to go in the direction of the Bismarck Model, i. e., social security contribution-based, rather than the Beveridge Model. Today, only Latvia continues to fund health services basically out of taxes. Also the Central and Eastern European Model cuts across various welfare models, introducing differences in the access to health.

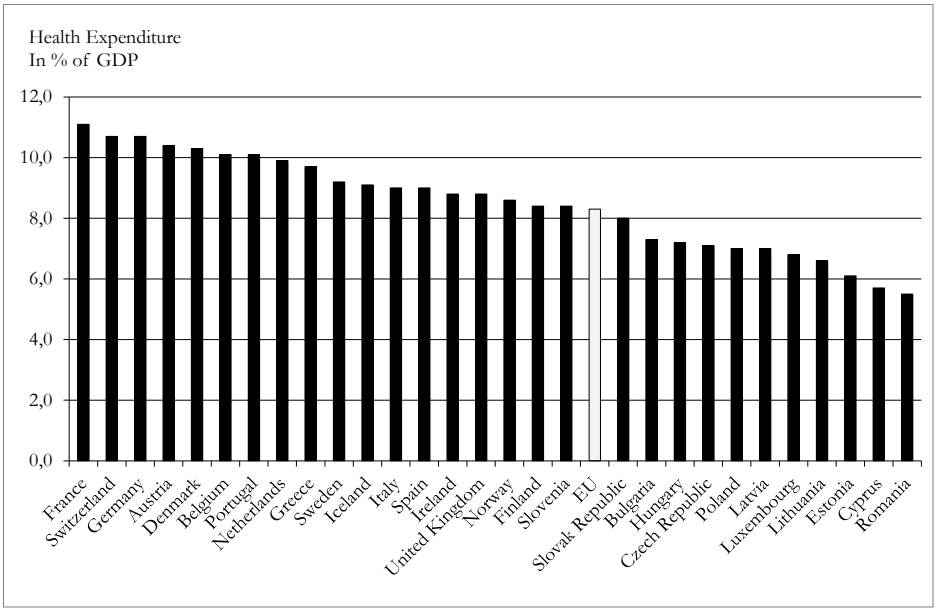
Over time, every model has evolved, each bringing in private health care providers, usually based on private insurance, which is basically only affordable for the well-to-do. Countries such as the United Kingdom have opened up their NHS to internal competition to diversify supply. Like the UK, France today has a two-tier health care system, with a state-run equivalent of the NHS – Couverture Maladie Universelle (CMU) – and the private sector. In many ways, the CMU operates as a mirror-image of the NHS in organisational terms, with hospitals acting as the centre of health care linked up by the GP practice. In some of the other traditional social insurance systems, sickness funds are being merged and cost controls imposed by the central government. In this sense, a certain convergence of models can be observed.

Health expenditures have increased over time in every model. Research indicates that public health expenditures rise with the economic development level, with rising incomes and technological changes. But also social changes, reflected in a smaller number of children per family and an increase in the number of persons living as singles, are having cost implications for health service provision. As health care is outsourced from households to the formal market, formerly unpaid family care is dwindling while professional jobs are created in the formal health care sector, thereby raising health care costs. Demographic changes, in particular the ageing of our societies, also raise health expenditures, as health costs tend to climb rapidly from a certain mature age onwards. The rising share of mature-age persons in our societies is of particular concern to public policy, as the large birth cohorts of the baby boom reach retirement age and the small cohorts of the baby slump, who are of working age,

have to bear an above average rise in health costs. This does not only put greater pressure on health budgets, but tends to increase generational tensions.

Today, health expenditures have become a significant proportion of public expenses in all EU-MS, ranging from a low of 5.5 % of GDP in Romania, to a high of 11.2 % of GDP in France in 2008. On average, the EU countries spent 8.3 % of their GDP on health.[5] Often, health expenses are increasing faster than economic growth, resulting in a rising share of GDP allocated to health. In comparison, expenses on health in 1998 were one percentage point lower in % of GDP. This means that an increasing share of the economic output goes into funding the health systems in almost all EU-MS.

Graph 1: Total health expenditure as a share of GDP (2008)



Source: OECD Health Data 2011

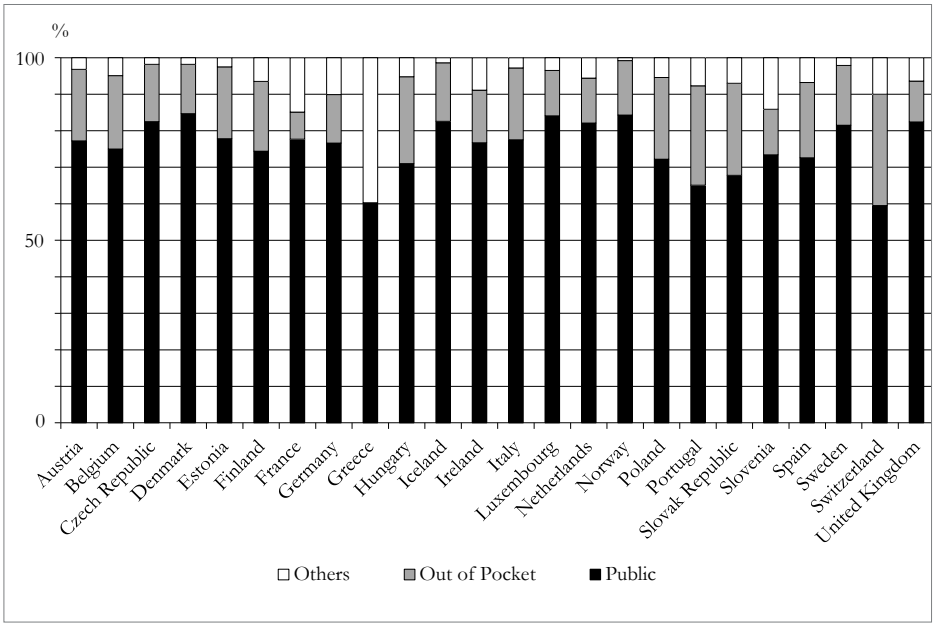
The highest health expenditures relative to GDP tend to be in countries with the so-called Bismarck system and the lowest in the new EU-MS, as can be taken from Graph 1. Luxembourg is an exception, as it has some of the lowest health expenditures relative to GDP.

The increasing complexity of health systems in terms of funding and service provision can be seen in the comparatively high share of out-of-pocket payments or other co-funding by private health insurance agencies, as illustrated in Graph 2. But also non-profit institutions and NGOs are important providers of health care services, above all in the Continental European welfare model. The growing importance of non-profit institutions and NGOs for the provision of health services at the lower end of the income spectrum can be taken as a reduction in the solidarity element of health care provisions for all.

5 Health expenditures account for about 30 % of all social benefits in the EU27 in 2008.

Given the increasing share of contributions by the individual, either via out-of-pocket payments or by paying into private health insurance funds, it may not come as a surprise that good health and longevity increasingly depend on the private means of the individuals. On average in the EU, the public sector tends to bear the costs of about 82 % of all medical services. Some services, e. g., dental services, tend to be paid in large part by the individuals through private sources. Also the consumption of pharmaceuticals carries a high proportion of private payments (OECD, 2010).

Graph 2: Share of health expenditure between public sector (including mandatory public insurance), out-of-pocket pay and other funding (2008)



Source: OECD Health Accounts 2011. Others: private insurance, corporations, NGOs

Inequality of Health Outcomes

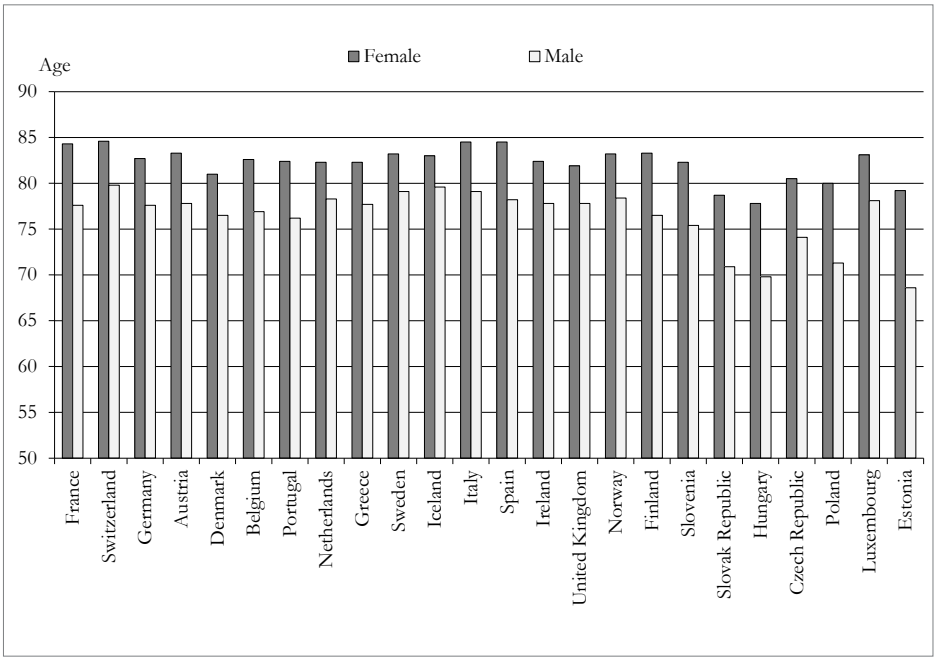
As health cannot be measured directly, indicators like life expectancy, morbidity and mortality rates are taken as proxies for health outcomes. These outcomes are, of course, not only the result of health care provision, but stem from socio-economic circumstances, the educational attainment level, as well as cultural aspects and life styles of the populations. In a number of European countries, there is increasing concern about inequality in health outcomes (as measured by life expectancy, mortality and morbidity) according to different social classes, due to inequity in treatment and large gaps in the socio-economic conditions of the populations.

If we look at the life expectancy at birth in the various EU-MS as an indicator of well-being and health (Graph 3), we see considerable differences between the new EU-MS and the "old" ones. The countries with the highest life expectancy for women are Switzerland, Italy, Spain and France, with more than 84 years, compared to some 78 years in Hungary

and the Slovak Republic. The span in life expectancy between Switzerland (the maximum) and Hungary (the minimum) amounts to almost 7 years. The span in the life expectancy of men is even higher with 11 years between Switzerland, at the upper end of the spectrum (80 years), and Estonia, at the lower end (69 years). The countries with above average differences in life expectancy at birth between women and men are Eastern European countries, as well as Finland and France; those with the lowest gender gap in life expectancy are Iceland, the Netherlands, the UK and Sweden.

The example of Estonia is particularly interesting, as the difference in life expectancy between men and women amounts to close to 10 years, almost double the average difference in life expectancy between men and women in Europe on average. This example shows that one cannot deduce the health status from the quality of the health system alone, but that one has to take other factors into account, in particular, the educational attainment level, opportunities to work, housing and nutrition, but also individual behaviour patterns and life styles.

Graph 3: Life expectancy at birth for women and men in the EU (2008)



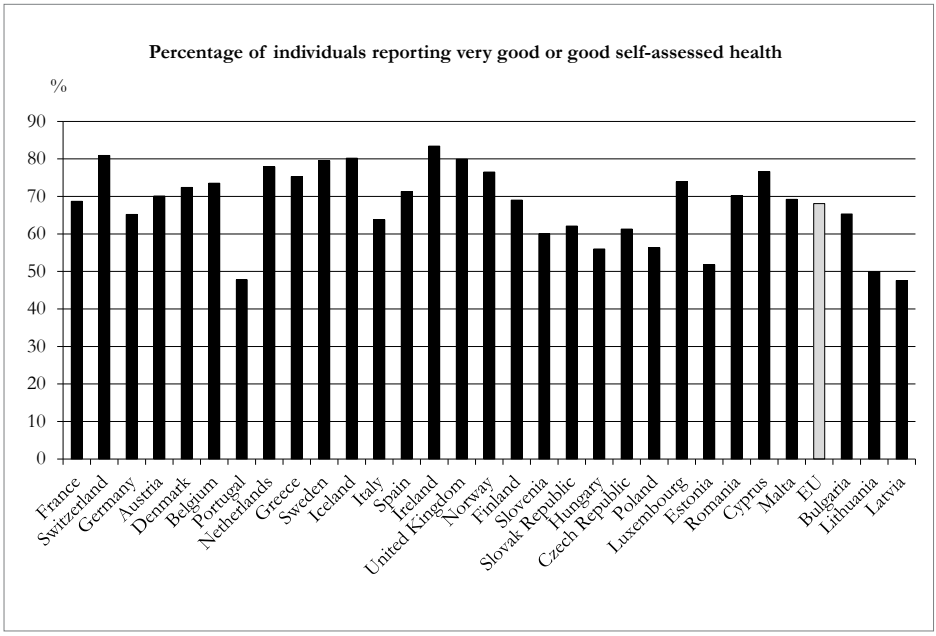
Source: OECD Health Accounts 2011

Another indicator of the health status is obtained by self-assessment, i. e., by asking people about their subjective feeling of well-being, as there is a high correlation between actual morbidity and self-rated health. The database used is the EU-SILC survey (European Union Statistics on Income and Living Conditions). According to this data, the share of the population with self-assessed good or very good health reaches 70 % or surpasses this percentage in some of the Continental welfare models (Switzerland, the Netherlands, Luxembourg, Belgium and Austria), in all Anglo-Saxon countries (UK and Ireland), in all Nordic countries except

Finland, in some Southern European countries (Greece, Spain and Cyprus) and one Eastern European country, namely Romania. These differences corroborate the above conclusion that it is not possible to deduce good health from access to health services alone.

In general, people in Central and Eastern Europe live shorter lives and spend more years of their lives in ill health – particularly men. According to Xavier et al. (2009), the largest differences between EU-MS are in mortality and morbidity of cardio-vascular diseases, injuries and violence, cancer and alcohol-related diseases. Bobak (2009) states that, while some CEECs were more successful than others when moving from a command economy to a market economy, all of them experienced large increases in income inequality after 1989, subsequently raising inequalities in health.

Graph 4: Self-assessed health in the EU (2009)



Source: EU-SILC 2009: Proportion of persons who assess their health as being good or very good

While these summary measures of the health status are useful for comparisons across countries and over time, they do not inform us about inequalities within the various countries. In every country there are substantial differences in health, measured in terms of life expectancy and morbidity rates, between different social groups. Good health and longevity are associated with the social gradient of a society; the lower the educational attainment level, the shorter the life expectancy and the higher the morbidity rate. This is indicative of the role and extent of inequality of societies, reflected in a number of inter-related factors – the social hierarchy, the distribution of incomes, employment opportunities, financial distress (Hartman, 2002; Marmot, 2004; Briggs, 2005; Mackenbach, 2006). Health risks vary also across occupational tasks and industries, accounting for different accident rates and health problems of certain occupational groups of workers. In some of the more risky jobs, we often find an

overrepresentation of migrant workers, a fact which contributes to their higher morbidity and accident rates.

Masseria (2009) points out that income inequalities are the main determinants of health in rich countries, while an average increase in income is associated with an improvement of the average health condition in poor countries. Accordingly, the rising income inequality in the 1980s and 1990s in rich EU societies was expected to result in a deterioration of health outcomes, measured by life expectancy. This was not the case due to a rapid decline in the mortality of older people because of improvements in primary and secondary preventive care. However, the increasing poverty rates not only amongst older age groups, but also amongst young ones with children, may have longer-term consequences. It may well be that we will see a reduced life expectancy at a later stage. This can be an after-effect of the widening of income differences in the last two decades, as bad living and working conditions at a younger age may lead to a reduced life expectancy or reduce the number of years in good health.

According to Aidt & Tzannatos (2002), it is above all the wage income distribution which widens, a trend that can be linked to de-regulation of the labour market and decentralisation of wage determination (Saunders, 2005; Healey, 2005). The large and rising informal sector economies add to the pressure on wages and working conditions at the lower end of the wage spectrum. The more immediate cost savings for employers may result in higher public costs for health care at a later stage. Due to the increasing importance of capital income in the top 10 % of the incomes distribution, the income dispersion also widens. This does not only hold for the USA (Piketty & Saez, 2006), but also for some of the European countries which, until recently, have been amongst the most egalitarian countries in the world, namely Sweden (Roine & Waldenström, 2006) and Germany (Fräßdorf, Grabka & Schwarze, 2008). This factor may not have an immediate impact on the health status of the population, but, as research indicates, it is the income distribution that matters for health outcomes in the long run.

In order to learn more about the causal factors of health disparities between various groups of people and across countries, one has to go beyond administrative data and consult surveys which include various dimensions of socio-economic status in combination with health-related questions. These allow us to go beyond comparing mortality and morbidity rates (O'Donnell et al., 2008) and relate the health status of a particular age group to the socio-economic status. If one wants to gain insight in the longer-run implications of income and living differences upon health disparities, one has to use panel data allowing life cycle analyses. Studies on the basis of these show that health deteriorates faster with age for persons with a lower socio-economic status, often measured by educational background. According to panel or repeated cross-section data, persons who experience an upward social mobility over the life cycle are, on average, of better health than persons who exhibit downward social mobility (Jones & López-Nicolás, 2004).

To combat health inequalities, a two-pronged approach is called for: on the one hand, measures to combat socio-economic disadvantage; on the other, measures ensuring access to adequate health care, curative as well as preventive care. In 2008, the **Dutch government** embarked upon the development of an integrated policy concept involving the various local governments towards improving the socio-economic circumstances of deprived neighbourhoods, many of them with large immigrant populations. The focus is on primary and community care, which tends to be pro-poor-oriented.

Also **France** identifies socio-economic inequalities, mainly poor housing, working and living conditions, as the principle culprit for differences in health outcomes. It therefore gives policy priority to equal opportunities in education and the labour market. France has also introduced measures directly focused on access to medical and social care for the most disadvantaged groups (Polton, 2009, p. 20). This was done by extending health insurance to all legal residents, ensuring universal coverage and facilitating access to promote uptake. This affected some 7 % of the French population. In addition, MedicAid (Aide Médicale d'Etat – AME) was introduced for irregular migrants.

Universal health coverage of all legal residents of France was achieved by the year 2000 (Universal Health Coverage Act – CMU). Beforehand, those without individual health insurance were covered by social assistance provided by local communities.[6] The expenses incurred are financed by the state through an earmarked tax on tobacco and alcohol, and a 5.9 % tax on the revenue of complementary private health insurers.

With the CMU-Act in place, co-payment has become means-tested, exempting the very poor from payment. This implies that government reimbursement of the costs incurred by the provider of the health service is higher for the poor than for persons who are able to afford co-payment.

Despite the above reforms, the French health care system continues to give total freedom of choice of health provider; no need to be registered with a GP and no need to be referred to specialists by the GP, quite in contrast to the Netherlands, where the GP is the gatekeeper for accessing specialist services. The greater liberties in the French system tend to be cost-drivers. Accordingly, in 2004, a Health Insurance Reform introduced voluntary gatekeeping also in France, giving GPs the explicit responsibility for guiding the process of health care provision. In 2009, the reform steps were reinforced by underpinning the role of the GP as a gatekeeper by granting financial incentives in return for improved efficiency and quality of the process.

The embeddedness of health care in a wider welfare model which provides collective or public resources to a different extent is of importance for the extent of the health gradient of the population. While it is reasonable to assume, from a public health point of view, that universal coverage of health care and good quality health care for all reduces health inequalities, it is still an open question if inequalities in health can be reduced by generous general welfare policies (Lundberg et al., 2008). A recent study by Eikemo et al. (2008) tries to find out if health inequalities by educational background differ between European countries with different welfare regimes, classifying countries as Scandinavian, Anglo-Saxon, Bismarckian, Southern and Eastern European. The research is based on the EU-SILC survey, taking self-assessed health as an indicator for the health status of the population. They find that Southern European countries had the largest health inequalities by educational attainment level, while countries with the Bismarckian welfare regime tended to have the smallest ones. The Scandinavian welfare model, in contrast, has higher educational health inequality than the Anglo-Saxon model countries, except for Sweden, where differences are quite small.

6 This system is still in place in Austria.

Migrant Health in Selected EU Member States

The term "migrant" conceals great diversity, encompassing labour migrants, family members, refugees and asylum seekers, irregular migrants and victims of trafficking. It may not come as a surprise that the health conditions differ between these groups, making generalisations about the health of migrants meaningless. While it is now well-accepted that labour migrants are, on average, healthier than the native-born populations of equal socio-economic status in the recipient countries, this is not the case for asylum seekers and refugees. The health status of asylum seekers is marked by the physical and mental impact of conflict and war in some of the source countries, by trauma associated with migration, including isolation, loss of social status, poverty, experiences of stay in detention centres en route and an insecure legal immigration status. Local studies in the **UK** and systematic reviews of studies across European countries point to higher rates of depression and anxiety amongst asylum seekers and refugees, compared to the national population or other migrant categories (Raphaely & O'Moore, 2010). Particularly vulnerable groups are children, and women who have suffered sexual and physical abuse. A quantitative survey of women trafficked for sex work in selected European countries found that 70 % of women had experienced both physical and sexual abuse during trafficking, and that the majority exhibited severe physical and mental health symptoms such as back and abdominal pain, headaches, dizziness, gynaecological infections, depression and anxiety (Zimmerman et al., 2008).

In contrast, labour migrants tend to have a positive "health gap" relative to the average recipient population, independent of their origins. The reasons cited for this fact are, on the one hand, self-selection effects, implying that only the fittest of a population undertake the effort of migrating; on the other, screening by the immigration countries, choosing only the healthiest. With the duration of stay in the host country, the health gap tends to decline, however (Kennedy et al., 2006).

In spite of that, migrants tend to have higher occupational accident rates than native workers (OSHA, 2007). This is due to an above average employment in accident prone jobs; the situation is often exacerbated by inadequate supervision and health and safety measures, particularly if migrants work in small-scale enterprises which are at the fringes of legality. This is particularly true for irregular migrants, as we will see in later chapters when we give voice to irregular migrants. In addition, migrants may have communication, language or literacy problems to the effect that they may not be aware of safety warnings or may misunderstand instructions. This calls for more stringent health and safety regulations and controls, ensuring that migrants are aware of particular health hazards.

According to Jayaweera (2011), a major deficiency of research on migrants in the UK is the lack of quantitative studies differentiating between the health situation of economically better-off and worse-off migrants. He draws attention to the large literature in the UK on barriers to health care for irregular migrants and those with uncertain immigration status. According to current rules, the latter are not entitled to certain services, for instance, free hospital care, except for emergency care or treatment for HIV. Voluntary sector-run clinics tend to step in and provide health for those who are unable to access necessary health care.

In addition, it can be shown that migration tends to affect life styles, reducing levels of exercise and changing eating habits, which lead to an increased risk of obesity, diabetes and cardiovascular disease. Also financial constraints, employment problems and the lack of a network of social support may negatively impact on the health of migrants. Furthermore,

follow-up treatment and long-term care is often difficult to ensure, partly as a result of financial constraints, partly due to a different understanding of health and treatment resulting from different medical traditions in the countries of origin. As a result of increased mobility and/or lacking access to care, migrants may also be unable to complete a course of treatment, which, in the case of tuberculosis, may lead them to develop multidrug-resistant tuberculosis. Similar risks exist in respect of HIV and malaria.

Migrants may also have specific diseases not common in Europe, and health services must pay due attention to these. Examples are malaria, sleeping sickness, sickle cell disease, the effects of female genital mutilation and many lesser-known tropical diseases. Learning to deal with such unusual conditions is seldom the main challenge when it comes to providing adequate services for migrants and ethnic minorities, though.

In **Austria** it could be shown on the basis of survey data that foreign children under 10 were, on average, less sick than Austrian children in 1999 (Biffl, 2005; 2003). This may be somewhat surprising, as the reports of school medical doctors indicated that migrant children tend to have psychosomatic diseases to a larger extent than natives (Körber, 2000). This does, however, not seem to translate into more days of sickness.

In contrast, the morbidity rate of mature age foreigners (45- to 59-year-olds) was significantly higher than that of natives, specifically that of Turks and persons from former Yugoslavia. Foreigners from other regions in the world in that age bracket had lower morbidity rates than Austrians. The significantly higher morbidity rate of mature-age persons from former Yugoslavia and Turkey has to be seen in the context of their socio-economic status, in particular, their lower educational attainment level – there is a clear decreasing trend of morbidity with rising educational attainment for both Austrians and foreigners. As migrants from former Yugoslavia and from Turkey are largely unskilled, this raises their morbidity rate on average relative to the one of natives. These results conform to analyses in the Netherlands, according to which health disparities of the work force increase until middle age, narrowing thereafter as persons with ill health tend to exit into early retirement, leaving the "healthy workers" in the work force. It is above all the bottom income quartile which experiences faster deterioration of health by age (Van Doorslaer et al., 2009).

The structure of the diseases of mature-aged Austrians and migrants differs as well, due to different occupational patterns. Migrants are, to a greater extent than Austrians, in the more physically demanding jobs and in unhealthy work environments. Accordingly, a much larger proportion of migrants complained about physically strenuous work (18.5 % versus 13.2 % respectively). Also the work environment is more hazardous, i. e., working with hazardous chemicals or under noisy and dusty conditions - 21.6 % of all migrants, compared to 17.9 % of Austrians, complained about that. In contrast, Austrians are working to a larger extent than foreigners under time pressure (23.7 % versus 18.6 %). These different work-related demands and health hazards between nationals and foreigners translate into a different pattern of health problems. Foreigners have, to a larger extent than Austrians, cardio-vascular diseases; in addition, they have more often than Austrians allergies, digestive and dermatological problems. In contrast, Austrians tend to have more problems with respiratory organs, with rheumatism, blood pressure and the nervous system.

Bad housing conditions also contribute to a higher morbidity rate, both for nationals and foreigners. In Austria in 1999, persons living in medium to lower status housing were

significantly more days sick during the year than persons in high status housing.[7] The average morbidity rate of persons living in medium to low status housing is about twice as high as in the case of good status housing.

Research into the health of migrants in the **Netherlands** for 2001 (Nielsen & Krasnik, 2009) showed that, similar to Austria and Denmark, Turkish immigrants had higher ratings of poor self-perceived health compared with the ethnic Dutch, after adjusting for sex, age and income. Turkish citizens tended, on average, to consult the GP more often than natives; also dental contacts were more frequent, but only in the case of first-generation migrants. In contrast, no ethnic differences in hospitalisation rates could be observed.

In **Spain**, a study based on data from the 2006 Catalan Health Survey reported that immigrants were less likely to have poor physical health, but more likely to have poor mental health than the Catalans (Gómez, 2007). The study also revealed that the behaviour of migrants differed from the resident population in that they preferred to access emergency hospital services rather than GPs or specialist doctors. In addition, a pronounced social gradient of the immigrant health status could be observed in the whole of Spain (Hernández Quevedo & Jiménez Rubio, 2009); it tended to decline between 2003 and 2006, converging to the Spanish average.

Portugal, a recent immigration country like Spain and Italy, introduced legislation in 2001 to combat the poorer health status of migrants. A study of mothers and new-born children indicated that the rate of maternal mortality was higher than with natives (Machado et al., 2007, p. 2), that levels of infections during pregnancy were greater, that the proportion of mothers with HIV/AIDS exceeded that of natives, as did the probability of having Hepatitis B and syphilis (HIV: 1.6 % versus 0.5 %; Hepatitis B: 5.5 % versus 0.7 %; syphilis: 1.3 % versus 0.4). Perinatal mortalities were higher amongst immigrants, and only 47 % of the new-born immigrant children saw a doctor during the first month after birth. This was largely due to limited registry of immigrants with GPs or health care centres. Studies in the UK and the Netherlands came up with similar results for certain ethnic groups. For example, immigrants from the Caribbean and Pakistan in the UK had infant mortality rates double those of the average population in 2004-2006 (Earwicker, 2010). In the Netherlands, both maternal and infant mortality were higher for migrants from the Antillean Islands, from Surinam, Morocco and Turkey (in this descending order) than for natives (Waelput et al., 2008). The period under analysis was, in the case of infant mortality, 1996-2006; the mortality rate could be reduced for all groups in the period 2002-2006 versus 1996-2001. Some differences between natives and migrants remained, however. Perinatal deaths were analysed for the period 2003-2005, indicating significant differences for Antilleans, Surinamese and Moroccans relative to natives. No difference between natives and Turkish migrants were observed.

In 2002, Portugal put a new Health Strategy in practice, taking a lifecycle approach to health, involving civil society organisations and emphasising fairness and equity. A major focus was on primary health care. The challenge is to promote uptake by immigrants as they tend to prefer, similar to Spain, accessing emergency units in hospitals. This may be due to

7 High status housing is defined as bath and toilet in the apartment, medium status is without bath, low status is without bath and toilet in the hall. 97 % of all natives and 87 % of foreigners were living in the first category, i. e., good housing conditions.

this being the traditional access point of health care in some of the source countries; it may, however, also be the result of greater anonymity, as Machado et al. (2010) suggests when saying: "…no questions will be asked about social problems in the hospital emergency department". Accordingly, the reform brings mobile care units into migrant neighbourhoods, hoping thereby to bring health closer to the persons in need. In addition, health service provision is becoming more ethnically diverse by raising the share of health professionals with migrant background in health centres.

According to Carta et al. (2005), many studies indicate that migrants in general do not run a greater risk of mental illness. Certain groups of migrants are prone to get depression and anxiety disorders, and particular circumstances are conducive to getting these diseases. This is particularly the case of irregular migrants, refugees and asylum seekers, as well as groups with a particularly pronounced difference in culture between the source and recipient country (ibid., p. 4). Social support and adequate social networks are regarded as important protective factors for mental health (Levitt et al., 2005), and strengthening such networks can help to combat isolation, loneliness and vulnerability (Hernández-Plaza et al., 2010).

Access to Health Services

In Europe, there is a wide range in the proportion of the population who report that they have not had their health needs met due to the costs involved or lack of availability. The data base for establishing the unmet needs are two international surveys: the Survey on Health, Ageing and Retirement in Europe (SHARE) of individuals aged 50 years and older, and the EU Survey of Income and Living Conditions (EU-SILC) of residents of private households aged sixteen years and older. These surveys present opportunities for cross-country comparative research on access to health care.

According to Allin & Masseria (2009), 2.4 % of the population above the age of 16 reported unmet needs due to the costs involved and limited availability of the care needed in the EU in 2004. The countries with the lowest shares were Denmark, followed by Austria, France, Luxembourg, Spain, Norway and Sweden, with less than 1 %; in the other countries, the proportions tended to be between 1 % and 2 %, except for some Eastern European countries, where the shares were at times much higher.

The persons who report unmet needs tend to be at the lower end of the income distribution; in addition, they tend to have greater health problems. This raises the policy question to what extent access barriers are responsible for the bad health outcome and to what extent other factors are responsible. This leads us to the question about the point of access to the health care system and what role it plays for the take up of health services, particularly for marginalised groups.

Studies in Switzerland and Italy have shown that the migrants' lack of awareness of health care and preventive services has been a main reason for the underutilisation of these services by migrants. In addition, many migrants face various communication problems when seeking health care. This can be caused by cultural differences, which prevent migrants from understanding the bureaucracies of health systems, and from language barriers, which may keep migrants from expressing their needs. This is further exacerbated by a second level of communication barrier, due to different perceptions and understandings of illness, disease and responses to them. Selahattin Günay (2011) gives an example of difficulties encountered when treating Muslim diabetes patients. While the Muslim creed exempts the sick, children

and pregnant women from fasting in Ramadan, many diabetes patients want to participate in the religious ritual, thereby jeopardising their health. Günay gives various examples of the mistrust of Turkish migrants in **Germany** against Western medicine, preferring to ask the "hodja" (Islamic preacher) for advice or referring to traditional medicine from the home country. In addition, it may be difficult to ensure continued treatment of migrants if they go back and forth between the source country and the new home country, following seasonal work patterns. Often it is believed that the disease is linked to life in the foreign country and they will be fine when going "home". It is often a sad awakening when finding out that this is not the case, and the disease is to stay and even deteriorating without proper medical treatment. Further aspects to be taken into account are different practices of substance abuse of migrants: while Muslims tend not to have diseases flowing from alcohol consumption, they tend to be more dependent on pharmaceutical drugs (Ince, 2011, p. 62).

Ali Kemal Gün (2011) tells of misunderstandings between the medical doctor and the patient because pain, sadness, grief or illness are communicated in a culturally acquired way, embedding the information in figurative speech and chiffres. If the medical professional does not understand the actual meaning, wrong diagnostics and treatment may be the consequence. For example, grief or anxiety is often communicated in relation to organs which are no longer in their proper place, e. g., my liver dropped, indicating loss and grief. The doctor or a cultural mediator has to be able to give the figurative speech medical meaning.

Of a somewhat different order are the different notions of health or rather of diseases, as noted by Petra Tiarks-Jungk (2011), who is working with patients from Africa, largely from Ethiopia, Eritrea and Sub-Saharan Africa, in Germany. In order to offer successful treatment, one has to above all integrate the notion of disease in the treatment strategy. In many of these origin countries the concept of punitive illness is widespread, meaning that a disease is not a coincidence, but a punishment for one's own wrongdoings or the result of someone wanting to take revenge. Trust in Western medicine is low and compliance is limited. This means that even when accepting Western medical treatment, traditional African medicine tends to be applied as well. This has to be taken into account. In addition, Africans tend not to turn up at the doctor's, except when in acute pain. They in turn expect immediate relief; they do not recognise the need for continuous treatment, as in the case of diabetes and high blood pressure, diseases quite frequent amongst the African population in Germany.

These examples show how important it is to have "cultural mediators" in order to provide adequate treatment and to avoid that migrants seek help from informal health care providers in their social networks.

In Spain, legal reforms were introduced in 2000, allowing immigrants to access the health services of the National Health System, provided they register in the municipal registry centre. In the case of non-registration, they have only access to emergency care. Given easy access to health services, also for irregular migrants, it may come as a surprise that immigrants tend not to go to GPs and specialised care, but rather to hospitals (Hernández Quevedo & Jiménez Rubio, 2009). The same can be observed in Portugal. In contrast, in the Netherlands, GPs are the usual access point of migrants in search of health care, while in countries like Germany, Austria and, to some extent, also Belgium, the preferred access point are NGOs and social welfare hospitals. The latter tend to instill trust in the migrants, particularly irregular ones, that their irregular situation is not reported to police authorities; on top of it, services tend to be provided free of charge.

Conclusion

The specific health challenges migrants face, partly as a result of the migration process, partly due to their socio-economic status and problems of understanding the health system of the host country, suggest that migration itself should be considered a social determinant of health. For this reason, the provision of health care for migrants should not only focus on Western-style traditional management and treatment of diseases, but include social services and multidisciplinary stakeholders in partnership towards universal coverage of migrants and the improvement of their health for the benefit of the whole society.

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Health Services for Undocumented Migrants in Europe: An Overview

Friedrich Altenburg

Some of the most important objectives of the Nowhereland Project were to alert the health system to the existence and vulnerability of undocumented migrants, to help identify undocumented migrants and their health needs, and to support the development of solutions to their systematic integration into organisational and professional routines. A first step towards that end was to collect data on existing services, make them accessible to expert knowledge and foster exchange and mutual learning between them, the respective health providers and authorities, as well as the research community.

As the main tool of data collection on health services for UDMs, a questionnaire which could be filled out by the various health service providers across the EU was developed by Antonio Chiarenza of the Azienda Unità Sanitaria Locale in Reggio Emilia. On the basis of this information, a web-based database was developed by the lead partner, the Danube University Krems. The outcome of this endeavour is a web-based living database,[1] which continues to serve as an entry platform for service providers, but which is also open for enquiries and research, beyond having served as an internet forum for the research activities of the partner institutions. In the following chapter, we present an analysis of this database and some of the main findings.

The project partners of Nowhereland addressed their network institutions to supply them with information on providers of health services to undocumented migrants. These institutions were then contacted by the partners of the project and asked to participate in the data collection. They were invited to register with Nowhereland and to share their experiences with the research team and also later with the public. The networks contacted included COST (European Cooperation in the field of Scientific and Technical Research),[2] Migrant Friendly Hospitals Task Force,[3] Health Promoting Hospitals and Health Services,[4] Regions for Health Network[5] and ETNA (European Transcultural Nursing Association).[6]

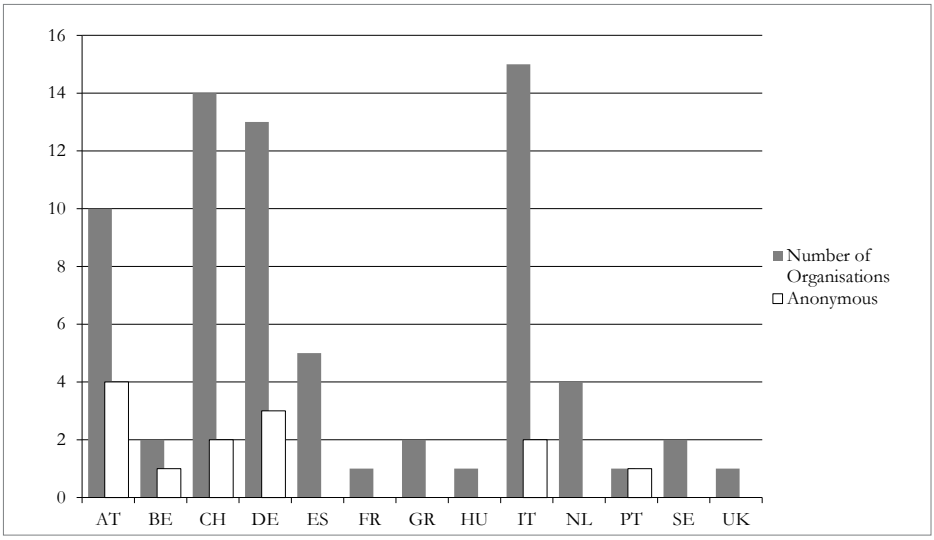
All in all, 71 organisations from 13 countries participated in the exercise, as shown in the graph below. To get the service providers to participate was just as difficult as to access UDMs and to get them to share their experiences. The fact that 18 % or almost one-fifth of the service providers asked not to have their identity published or to have their information anonymised underlines the difficulties health service providers face when helping UDMs. It shows that these institutions undergo pressure and fear, just as well as the patients they cater for.

The standardised questionnaire consisted of 18 questions asking about organisational issues, the mission statement and their funding, the composition of their staff, the special

1 The database can be accessed in the internet at http://www.nowhereland.info/?i_ca_id=370.
2 For more information see: http://www.cost.eu/.
3 http://www.mfh-eu.net/public/home.htm.
4 http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/public-health-services/activities/health-promoting-hospitals-network-hph.
5 http://www.euro.who.int/en/who-we-are/networks/regions-for-health-network-rhn.
6 For more information see: http://etna.middlesex.wikispaces.net/.

needs of the clients, and clients' perceptions about their health status and needs. Institutions participating either filled the questionnaire out on-line or filled it out on paper and sent the paper in. The researchers in the project team validated the information received before including it in the database and making it public on the website.

Graph 1: Service providers including anonymous ones per country



As the registration of health service providers on the Nowhereland website was voluntary, the graph above does not provide a representative picture of the number of service providers for UDMs across Europe. Countries such as Austria, Switzerland, Germany, Spain, Italy and the Netherlands have a considerable number of health care institutions which registered, while other countries have few, if any at all. This may have something to do with the extent to which countries are integrated in the specific networks contacted. It may, however, also indicate that some countries are affected to a larger extent by inflows of UDMs and/or health provision is seen as a humanitarian or public health concern.

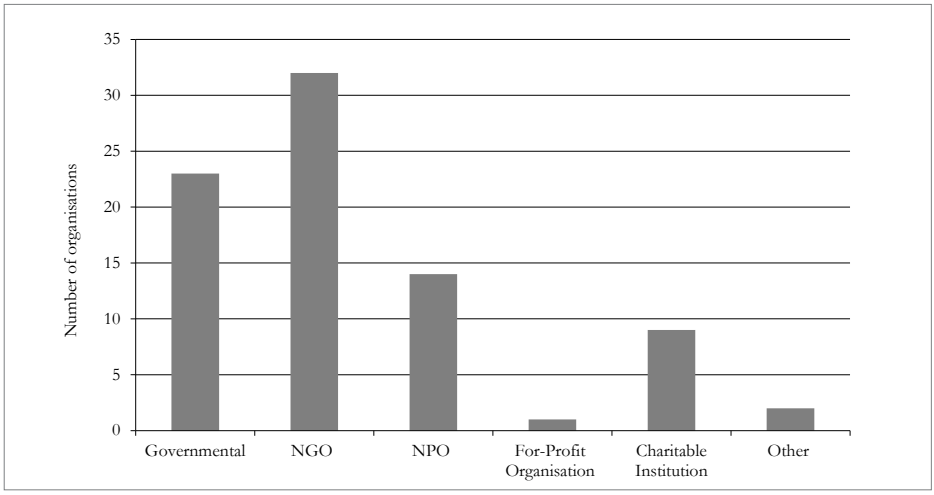
Types of Organisations

The questionnaire was specifically addressed to service providers known to be accessed by undocumented migrants. This may have limited the scope of the survey, even though the invitation to register did not only go to NGOs, but also to governmental health trusts, public hospitals and care centres. Thus, a wide gamut of health service providers was approached, including hospitals, primary care services, health clinics, specialised services and service providers explicitly targeting undocumented migrants.

The institutional background of the majority of health service providers is above all the civil society sector, and, to a lesser extent, the public sector. The overwhelming share of participating organsiations declared themselves as NGOs, NPOs or charitable institutions; only 23 out of the 71 institutions covered are from the government sector. The civic character of the organised help can also be taken from the high proportion of volunteer workers in

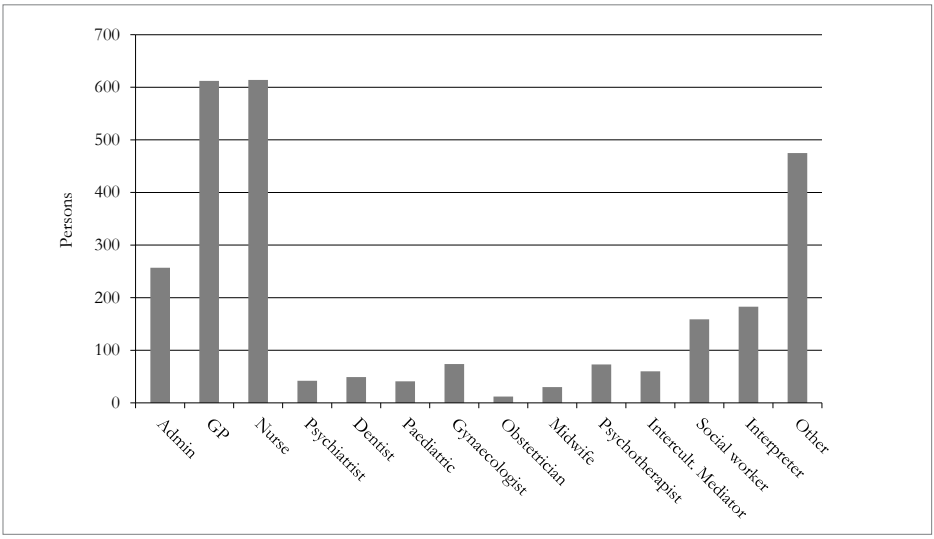
this selective group of institutions: more than 48 % of staff members involved in care for UDMs were volunteers.

Graph 2: Type of organisation of health service providers for UDMs



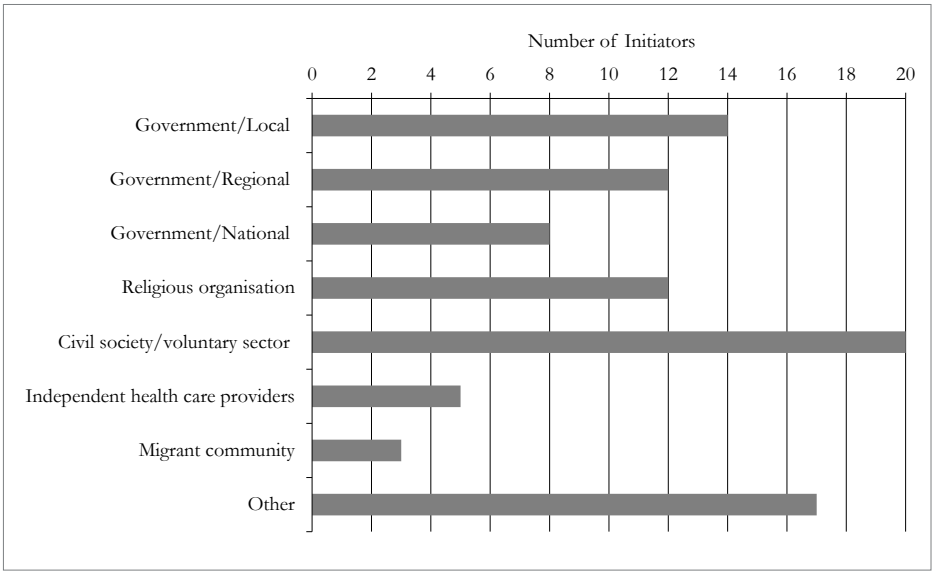
While a large proportion of the workforce in NGOs is made up of volunteers, we should not have "little old ladies in tennis shoes" in our minds (Frantz/Martens 2006, p. 25). As we will see in Chapter 5, when we talk about good practice examples, volunteer work is mainly done by general practitioners, medical specialists, nurses and administrators. In addition, intercultural mediators, social workers and interpreters are important supplements to the medical professions. The occupational background of persons engaged in helping UDMs and their composition can be taken from the graph below.

Graph 3: Composition of professions engaged in helping UDMs



Most organisations (49 out of 71) mentioned that a humanitarian cause was part of their mission statement, be it their founding principle or their motivation for work. Foundation dates go back as far as 1983. However, we can discern a sharp increase of foundations or dedications for undocumented migrants since the middle of the 1990s. Since then, a rising number of public health institutions have been entering the scene with the objective to help UDMs. More than half of the organisations either named the local, regional or national government as main or partial initiators of the service. Moreover, migrant communities are increasingly joining up to provide health services for migrants, including irregular ones. In our sample, three organisations pointed out that their founding constituencies were migrant communities.

Graph 4: Number of service providers and their sources of funding



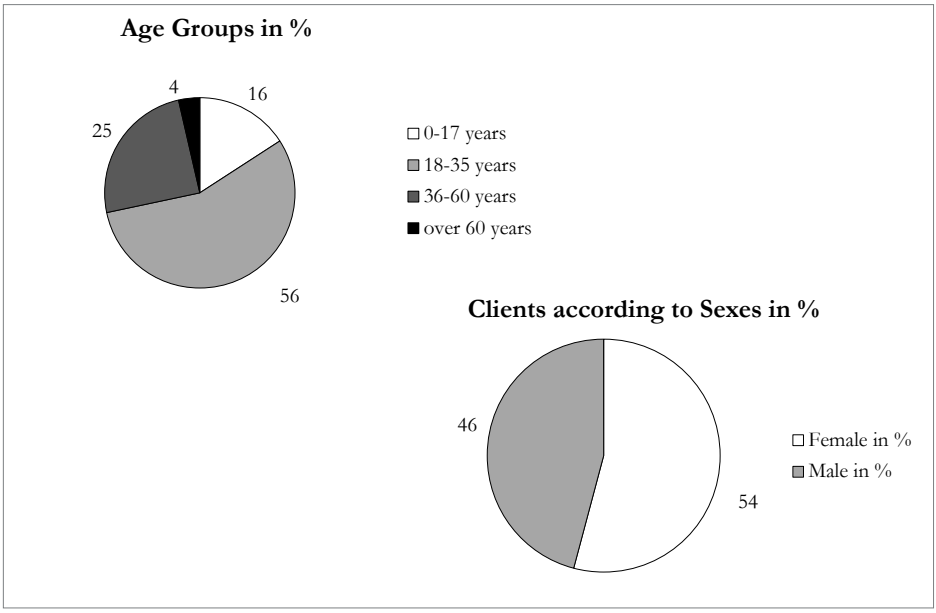
Undocumented migrants may be taken as a typical target group of NGOs, which address issues like ecology, peace, human rights, equal rights, gender equality and the like (Roth, 2005, p. 97). NGOs are, however, increasingly becoming dependent upon the financial support of the public sector; this is a difficult issue, especially when it comes to the maintenance of professional services, where donations no longer suffice to ensure quality (Frantz/Martens 2006, p. 128).

We can observe that the public sector is increasingly outsourcing some of its duties to specialist services, often NGOs or NPOs. We share with Roth (2005, p. 117) the view that the state is ridding itself of obligations, such as development aid and humanitarian aid, by privatising some of these services. This is where the link to undocumented migrants is coming in, as the state helps to fund health services but does not provide health services in the mainstream institutions. We will revisit this point about the roles and functions of actors in services provision when we come to the good practice examples.

Clients, Needs and Services

The client statistics provided by the institutions bear the mark of anonymity, i. e., the information on irregular migrants is patchwork, as for anonymity reasons some organisations do not maintain records, fuelling the myth of the uncountable and undocumented migrant. Demographic information does not carry many surprises, though, as the composition by age and gender does not differ much from migrants in general. Thus, the typical undocumented migrant client is between 18 and 35 years of age; children and senior clients are rather the exception than the rule.

Graph 5: Composition of clients by age and gender



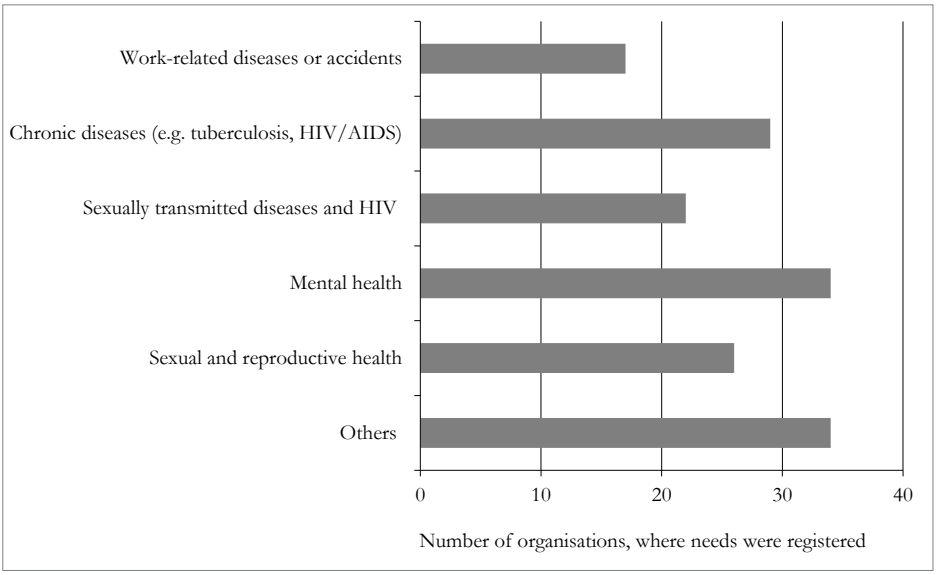
The origin of UDMs varies strongly between the receiving countries, as documented by the service providers. The latter were asked to name the three most common source countries of their clients. A compilation of answers is given by the table below.

Table 1: The three major source regions/countries of UDMs in the various EU-MS

Country of Destination	1st Source Region	2nd Source Region	3rd Source Region
Austria	Chechnya	Afghanistan	Turkey
France	Mali	Pakistan	China
Germany	Turkey	Eastern Europe	Latin America
Greece	Albania	Iraq	Afghanistan
Hungary	Somalia	Pakistan	Afghanistan
Italy	Morocco	Tunisia	Egypt
Netherlands	Georgia	Sudan	Sierra Leone; Somalia
Portugal	Mauretania	Guinea	Eritrea
Spain	Guinea Equatorial	Bolivia	Pakistan
Sweden	Balkans	Iraq	Iran
Switzerland	Africa	Eastern Europe	Latin America

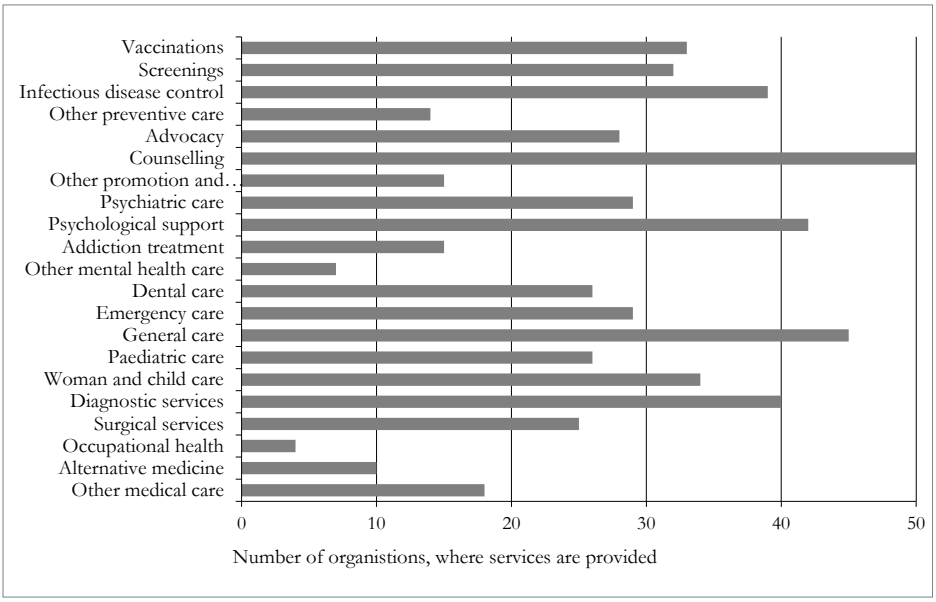
Although health needs of undocumented migrants do not vary much on average from those of the migrant and native population (Razum et al., 2008, p. 129), except for mental health issues and work-related diseases and accidents, they play a much more important role for UDMs, which is indicative of their unsafe residence and work status.

Graph 6: Health needs of undocumented migrants[7]



7 Based on the Nowhereland Database, on the internet at http://www.nowhereland.info/?i_ca_id=416.

Graph 7: Services provided to UDMs by the providers



The institutions participating in the survey respond to these health needs with a range of services, which are depicted in Graph 7. We can see a strong focus on prevention and counselling, which are even more prominent than curative general care, infectuous disease control and psychological and psychiatric support.

Word-of-mouth within the migrant communities is the most important information channel for these institutions when trying to reach their clientele. 60 out of 71 service providers name this communication channel as the most effective one, followed by information provided by other NGOs (44) and health care providers (43). Not surprisingly, media and government agencies bring far fewer patients to the services than the informal channels.

Given the moral and supportive ethos of many of the service providers and the discretion with which they treat their clients, it is difficult to establish the exact number of UDMs they service. When asked about their estimate or observation of trends concerning the numbers of UDMs, 53 % said that their numbers of clients have been increasing over the past three years. Only 4 % saw a decrease in UDMs registering with them. What can we conclude from these observations? Relatively little, as we will see in Chapter 5 on good practices. There it becomes clear that it takes time to gain confidence and trust before larger numbers of UDMs come and ask for help. In this light, the rising numbers approaching the aforesaid health service providers may therefore result from confidence building, rather than from actual increases in numbers of UDMs. It will be interesting to see if there are funding limits for providing health services to UDMs that imply limits to growth of service provision, unless institutional and funding principles are changing.

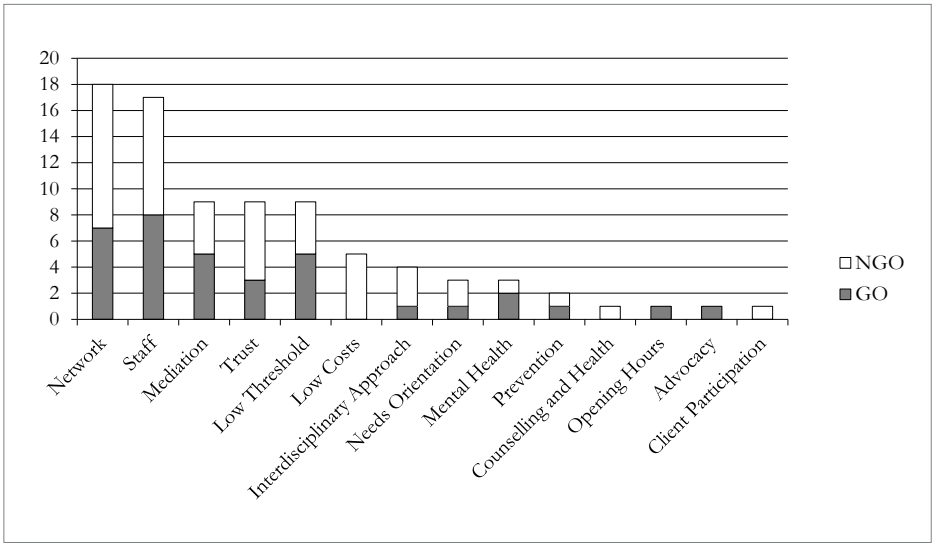
Success Factors

Another question referred to the success factors for effective service provision from the standpoint of the service providers. As we can see from Figure 8, the most important factors for both government and NGO health service providers are the embedment of the service provider in the appropriate networks. Further specifications of answers to this open question indicated that networks with other service providers are very important. They allow a specialisation and division of tasks by the one or the other, e. g., prevention, diagnostic and curative care.

It becomes clear that the complexity of health care needs of this diverse group of migrants cannot be met by one single actor or provider, and that working in close collaboration with others is of paramount importance for the success of the service to the clients. But also links to policymakers, advocacy groups and the like are important for the provider to be able to do the job it feels committed to do.

Also the composition and competence of staff are of paramount importance for the success of the service provider in reaching out to the clients and in satisfying their needs. This is true for government and private institutions alike. Further detailed answers indicate that it is a combination of skills and competences of staff that are called for, namely professional (medical) skills, as well as intercultural communication skills. In addition, an empathetic approach and cultural sensitivity are called for. Closely related to these skills are mediation and the capacity to trigger off and establish trust with the patients and the client community.

Graph 8: Success factors of service provision



Significant differences between government and non-governmental agencies are few, except that NGOs tend to elicit trust more often than government institutions; in addition, NGOs are preferred when it comes to paying for the service, as NGOs tend to provide the service at no cost or for very little money indeed; NGOs are also more often chosen than government institutions because of better counselling and client participation. Government institutions,

on the other hand, are preferred when it comes to mental health service provision; also the wider spectrum of opening hours speaks in favour of government institutions, as well as advocacy of the target group because of public health concerns.
In conclusion, we can say that both government and non-government sectors are vital for the delivery of health care services for undocumented migrants. They tend to collaborate in various ways and with different means. In addition, they tend to be embedded in the networks targeting UDMs such that their health needs are properly addressed.

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Policy towards Undocumented Migrants of the EU27

Carin Björngren-Cuadra

Introduction

In this chapter we focus on policies regarding the right of access to health care for undocumented migrants in the 27 Member States of the European Union (EU). Across Europe, undocumented migrants are subject to national regulations which differ among the Member States. The chapter aims at giving a characterisation of the respective policy. In addition, an emerging pattern relating to human rights standards will be identified, aiming at putting national policies in perspective. Moreover, the chapter draws upon data from the project *Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*.[1] The material, which corresponds to selected indicators, aiming at facilitating a comparative analysis as well as providing an descriptive overview, was obtained through various sources, including experts in the respective countries, literature, research reports and grey literature, such as official reports and reports from non-governmental organisations (see Björngren-Cuadra, 2011).

Definition of Undocumented Workers

The definition of *undocumented migrants* applied in this chapter follows, as stated by previous authors, the EU guidelines; i. e., the term "undocumented migrant" refers to so-called third-country nationals without a valid permit authorising them to reside in the European Union Member States. This includes those who have been unsuccessful in asylum procedures (rejected asylum seekers) or who have violated the terms of their visas ("overstayers"), as well as those who have entered the country illegally, most often to work. The type of entry (i. e., legal versus illegal border crossing) is thus not considered to be relevant in defining the concept. With this definition, recent estimates suggest that approximately one per cent of the entire population in the EU and, on average, ten per cent of the foreign-born population are undocumented (Düvell, 2010, pp. 3-8). The group does not include EU citizens from new Member States, nor migrants who are within the asylum-seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

The interest in this chapter in undocumented migrants' rights of access to health care is underpinned by the governing principle of the EU, namely the principle of universal access to health care. This is captured in several states' constitutions and health service founding documents, as well as incorporated into the EU Charter of Fundamental Rights (Article 35). The first part reads, "Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices". However, despite these formulations, it may be argued that universal coverage

1 Acknowledgement: To the team of researchers and assistants in the Nowhereland project. A special appreciation to Sandro Cattacin for his input and the structural design of this study, and to David Ingleby, who gave substantial support by reading an earlier version of this text. Further information and material can be found at http://www.nowhereland.info/

tends to be universal only in principle and that the entitlement status of some vulnerable groups may be unclear (Wörz et al., 2006). This is the case of undocumented migrants. Problems of access might arise also for residents or citizens from the way in which coverage is organised (ibid.), but, as regards undocumented migrants, we can identify a general *de jure* social exclusion and thus a relative lack of rights (Noll, 2010). These circumstances can partly be understood as an element of "internal control of migration" by withholding access to social protection, such as health care and forms of welfare benefits.This type of migration control refers to control based on administrative measures (Brochmann, 1999; Ingleby, forthcoming). Such control differs in extent and form among the European countries. For example, it is generally strong in the Scandinavian countries (Doomernik and Jandl, 2008).

Access to Social Protection

Undocumented migrants' access to social protection has not gained interest in terms of being problematic until fairly recently. A precarious nature of the situation has been articulated in public discourse by advocacy groups, as well as in research. Topics such as lack of rights, deprived living conditions, substandard working conditions and exploitation have been addressed along with issues on health care. Undocumented migrants have also gained increasing attention as a group exposed to high health risks and as posing a challenge to public health (see, for example, Cholewinski, 2005; MdM, 2005; Pace, 2007; PICUM, 2007a; Sager, 2011; Björngren-Cuadra, 2011).

When approaching undocumented migrants' rights to health care, we can assume that such rights are dependent upon numerous aspects and processes in each country. One factor is the current basic norms and institutions of the *welfare state* in the respective country. Another factor involves how *migration*, regular as well as irregular, is dealt with. This has not only a direct relevance to irregular migrants' rights to health care, but also to the pathways into irregularity. In the EU27 landscape, a variety of welfare regimes as well as national integration regimes can be identified (Papadopoulos, 2011).

Chance to Change the Opportunity and Incentive Structures

Our immediate interest in the welfare state concerns its capacity to change the opportunity structure and the incentive structure for individuals. The basic relevance of the welfare state for the life of an individual can be seen in the individualised rights and services provided (Leisering, 2004, p. 210). With reference to a more fundamental level, bearing in mind human species' vulnerability and incapacity to survive, unless it creates its own viable systems, social policies might form "ways of life to ensure survival" (Wronka, 1998, p. 25). Social policies can thus be understood as political measures with the (explicit) aim of influencing the life situation of individuals (ibid). Thus, social policy as a concept is broad and can involve different core fields, of which one, *risk-management*, involves health related activities, *the right to healthcare* (ibid.). In order to approach the empirical material, in this chapter policy is understood as "a standard that sets out a goal to be reached" (Dworkin, 1977). This fairly broad understanding is chosen in order to apply, given that policies regulating undocumented migrants' entitlement to health care differ widely between EU Member States. It applies both to countries in which legal norms are in place and countries which have not explicitly regulated these issues. In those cases, policies are to be deduced from and in the light of other regulations.

When discussing policies, the very implementation of their content might also be of certain interest, as implementation is not to be seen as a simple, straightforward process.

It has been suggested that there might be missing links in the process between an outlined policy and the practice that is enacted. This "gap" has been labelled the "implementation gap" (see, for example, Jain, 1990). Such a perspective turns our interest towards the staff. Health professionals such as doctors and nurses, labelled the *street-level bureaucrats*, are the key agents in the implementation processes (Lipsky, 1980). Health professionals can be seen as doing "politics in practice" (Brodkin, 2010). They are not doing what they want or just what they are told to do. They do what they can (Brodkin, 2008). In this process, they might invoke other references than official policies (Björngren-Cuadra, 2008). Principally, "implementation gaps" might be "negative" or "positive". If negative, in the case of undocumented migrants, staff might be ignorant of a certain policy that the migrants are likely to benefit from or may persistently fail to adhere. If positive, staff might create a "window of opportunity" for undocumented migrants in spite of restrictive regulations. This kind of implementation gap is very central when discussing substantial and concrete access, as they introduce a certain element of arbitrariness in the process of access. It is especially relevant seen from the individuals' perspective in precarious situations (PICUM, 2007b). However, this chapter is delimited to policy and leaves implementation gaps in either direction aside, and will not discuss the very access further. It will only discuss what is understood to be the right of access as outlined in principle terms.

Concerns of Undocumented Migrants

Before leaving the intricate relation between rights and actual access, it is relevant to note that empirical studies have shown that such undocumented migrants often experience a fear of being reported to police or immigration authorities by health workers or administrative staff, and that this anxiety constitutes a barrier to seeking care. To the extent that "denunciation" is governed by explicit rules (either requiring it or forbidding it), these rules can be considered as part of a country's policy on health care for undocumented migrants. This topic will not be pursued further here because an explicit obligation to denounce was only found in two of the 27 Member States: Lithuania and (in certain circumstances under the Aliens Act) Sweden. Rules prohibiting denunciation, on the other hand, are often indirect; the practice can, for example, be forbidden on the grounds of laws regulating the confidentiality of the medical encounter and the protection of privacy. Issues on denunciation provide a good illustration of the "implementation gaps" that may exist in this field. Health workers or administrators may choose to report migrants to the authorities when they are not supposed to do so – or refrain from reporting in spite of an obligation to do so. If the latter only occurs incidentally, it does not really remove the barrier to access for the migrant, because he or she cannot know in advance whether it is safe to seek medical help (PICUM, 2007b; MdM, 2005; HUMA Network, 2009).

Points of References

To put national policies into perspective and make comparisons possible requires points of references. Of special interest is to be able to differentiate between levels of rights of access in a terminology that grasps a possible variation.

The Human Rights Framework

In the discourse involving recognition of the undocumented migrants' precarious situation, as well as in research, a central reference has often been human rights standards as outlined in the human rights framework (see, for example, PICUM, 2007a and b; Pace, 2007). Human rights law will also serve as the main point of reference in this chapter, due to various reasons. First, the international code of human rights consists of legally binding international components which apply to all EU27 Member States. Second, the code gives an internationally agreed set of standards to guide and assess the conduct of governments which bear on medicine, public health, and the strengthening of health systems (Backman et al., 2010). Third, as human rights law is designed to protect disadvantaged and precarious individuals and groups such as undocumented people (Hunt, 2007), they appear as apt references.

The right of access to health care is a major concern within the human rights framework. It is outlined in a range of binding treaties. We find it in Article 25 in the Universal Declaration of Human Rights (UDHR), which provides the foundation for the international code of human rights (Backman et al., 2010). Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) affirms the right of everyone to health care without discrimination, to enjoy the highest attainable standard of physical and mental health without discrimination (United Nations, 1966). Other binding treaties incorporating the right to health include the International Convention of the Rights of the Child (CRC), and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). In addition, the right to health is stated in the Constitution of WHO, the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalised World (Backman et al., 2010).

With the objective to render the meaning of the right to health more concrete, The Committee on Economic, Social and Cultural Rights (CESCR), which monitors and interprets the ICESCR, formulates that states are "under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including […] asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; […]" (CESCR, 2000, para 34). From this advice follows that from a human rights perspective, health care clearly involves emergency, primary, secondary, as well as preventive care.

Access and Rights Interrelated

The right to health involves, according to the UN Committee on Economic, Social and Cultural Rights in its comments (GC 14) on implementing ICESCR, a notion of accessibility. Hence, the notions of *right* and *access* are interrelated. The committee proposes that the right to health entails being able to receive care which is: available, accessible, acceptable and of good quality (referred to as *AAAQ*, triple A-Q concept). "Accessibility" is further broken down into four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility. "Accessibility" is thus understood as an essential element of a "right". In this chapter, the issue of *economic accessibility* will be dealt with. Consequently, affordability for patients will be an issue when comparing policies on entitlement. Affordability involves the level of co-payment. From this follows that cost-sharing arrangements ("out-of-pocket payments") which may undermine accessibility for people at risk of exclusion are of special interest (Wörz and Foubister, 2006).

Against this background, we will find a financially conditioned right not consistent with the notion of right embodied in the human rights framework. We would consequently not regard care, which an undocumented migrant has a right to access only in return for payment of the full cost, as being "accessible" – since in most cases such care will not be affordable for the individual. Nevertheless, it is reasonable to expect a moderate fee, commensurate with that paid by other patients, as not seriously impairing accessibility. To give a concrete example: in Sweden undocumented migrants can access emergency care at a cost of 120-150 Euros (full cost). This sum implies that emergency care is deemed not accessible in the spirit of the right of access, and thus not congruent with human rights standards.

Those international instruments provide a point of reference inasmuch as the right to health is considered within a general approach. However, in order to further differentiate levels of care which undocumented migrants might have the right to access, the *Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants*, article 13.2, can serve as a point of reference (Council of Europe Parliament, 2006). In this resolution it is advised that – at least – emergency care should be available for undocumented migrants. Emergency care is referred to by the Council as a *minimum right.* It is also advised that states should seek to provide more than the mentioned minimum right and should offer more holistic care, taking into account, in particular, the needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly (ibid.).

Centred on the concept of *minimum right*, we can differentiate between three levels of rights of access to health care: 1) less than minimum rights, 2) minimum rights, and 3) more than minimum rights. In everyday language that would correspond to a right to less than (i. e., not even) emergency care, right to emergency care and right to more than emergency care (such as preventive care, primary care, secondary care). It is important to note a discrepancy between the resolution and the interpretation of the ICESCR given by the UN Committee on Economic, Social and Cultural Rights. According to the latter, access to emergency care falls far short of the full scope of the right to health.

Turning to the variety of welfare regimes that can be identified within the EU27, it can be hypothesised that the extent to which health care is accessible to individuals has to do with the financial characteristics of the system (European Commission, 2008).In addition, a further differentiation that bears upon the Member States concerns their system of financing health care, involving public financing (such as tax and social insurance contributions), private health insurance or out-of-pocket payments. In the European context, we can clearly differentiate between systems which are: 1) mainly tax-based and 2) mainly social insurance-based (Thomson et al., 2009). A further differentiation can be made in terms of whether taxes are collected centrally (Ireland, Malta, Portugal and the United Kingdom) or locally (Cyprus, Denmark, Finland, Italy, Spain and Sweden) (ibid., pp. 33 and 119). In social insurance-based systems, contributions can be collected by central government (Belgium, Bulgaria, Estonia, France, Hungary, Latvia, the Netherlands, Poland, Romania and Luxembourg) (ibid., pp. 34, 149 and 167) or directly by health insurance funds (Austria, the Czech Republic, Germany, Greece, Lithuania, Slovakia and Slovenia). Parallel to the collective system of financing, some Member States (e. g., Bulgaria, Greece, Cyprus and Latvia) rely most heavily on individual out-of-pocket payments (ibid., p. 29).

Of special interest in this respect concerning the affordability, is organising and financing characteristics which influence access for people at risk of exclusion, as they constitute

potential or actual *barriers* to access. Such characteristics involve population coverage and cost arrangements respectively, whilst broader issues, such as practical organisational limitations, can create barriers to accessing health care (European Commission, 2008), as stated by the HealthQUEST Project (ibid.). In general, the rules and conditions of access to health care are, to a large extent, established by contractual arrangements between payers and providers of health care according to the national legal system. This is to say that the most salient characteristic of a health system relates to those who cover the cost. From the patient's perspective, whether an undocumented migrant or not, the main question as regards cost might be formulated: "Am I covered by insurance?" The next question involves whether the care required is included in the benefit coverage (so-called health basket), as disparities may exist. And in this case "What am I expected to pay? Is there a cost-sharing arrangement applicable to my situation?", cost-sharing is defined as the patient's private spending without private insurance, so-called "out-of-pocket payment" (ibid., p. 75). Generally, there may be "cost-ceilings", tax revenue and reimbursement systems. In terms of this theme, we could also consider the existence of informal payments (and bribes) (ibid., p. 89). From our perspective, those arrangements are interesting in terms of the extent to which they come into play for undocumented migrants and affect access in terms of affordability.

Above we stated that the rights of migrants to health care, regular as well as irregular, depend, to a certain extent, upon the migration model and how it works. In this perspective, a look at certain national contexts of migration is interesting as far as it involves irregular migration. Previous chapters have presented the variety and "magnitude" of undocumented migrants, as well as the differing pathways into irregularity or categories of undocumented migrants realised in the respective Member States, as well as issues such as control of migration and practices of regularisation. We will return to those perspectives after drawing out the contours of the policies on the right to health care in the following section.

Results

This section will present the Member States in three groups referring to the level of entitlement of health care for adult undocumented migrants.[2] The respective method of funding the health system will be briefly referred to as tax-, respectively, insurance-based. In addition, special entitlements for identified groups such as children and women, particularly related to reproductive health, and HIV will also be briefly mentioned.

Member States Granting Less than Minimum Rights

This first identified group consists of Member States in which entitlement is restricted to an extent that makes even emergency care inaccessible. Those Member States do not have a special legislation implying that entitlements have to be deduced from the general legal framework, from policy documents (Malta) or from informal agreements (Luxembourg). As regards the inaccessibility, it can be due to the fact that the patient is charged a cost of care which makes care unaffordable. In some cases, the system makes the patient indebted to the health care providers. In other cases, a certain element of arbitrariness is introduced by the staffs' discretion (i. e., to provide or not to provide care, to charge or not to charge). In

2 The presentation draws upon the country report available at http://www.nowhereland.info/. Further references (such as literature or legal references) are provided by the respective country reports.

this group there are also Member States offering health care only within detention centres. Collectively, ten Member States are found which apply health care only at this level of rights. As this classification refers strictly to policies, and because of the "implementation gaps" mentioned above, it is possible that a better level of care is sometimes provided in practice; however, such exceptions are arbitrary and not predictable from the patients' perspective (Björngren-Cuadra, 2011).

Initially, we can also observe that in those countries there are no specific entitlements in terms of identified groups or diseases beyond that women in labour receive care (in Austria), and that HIV testing (but not treatment) might be accessible (in Malta and Austria) or accessible (in Finland and Sweden), as it is provided anonymously). Furthermore, children are dealt with specially (i. e., do not need to be identified in Romania) and are entitled to care if they are rejected asylum seekers (in Sweden).

Table 1: Member states, in alphabetic order, in which undocumented migrants have less than minimum rights of access to health care, subdivided according to financing of the health system

	Member States
Tax	Finland, Ireland, Malta, Sweden
Insurance	Austria, Bulgaria, Czech Rep. Latvia, Luxembourg, Romania

In **Finland**, the right of access to health care for undocumented migrants can be deduced from the general legal framework involving the Implementation of the Social Security Act. Accordingly, they may access emergency care as a person from a "third country" requiring urgent medical attention. Such persons shall receive care as is sufficient to allow them to return to their country of origin. However, as uninsured persons, they are required to pay for the cost of care. The extent of payment is unclear and different official documents provide different information (ranging between full costs to normal patient fee). HIV testing should be available anonymously.

Also in **Ireland**, undocumented migrants may access emergency care for an unclear cost. This relates to The Health Act, according to which the health authority may apply the full fee for any services provided to persons deemed not to be "ordinarily resident". Alternatively, they may provide urgent necessary treatment at a reduced charge or without charge (as deemed appropriate). However, the cost of urgent medical treatment is dependent on the providers' discretion. Patients are eligible to apply for reduced or waived hospital charges if they will incur a "financial hardship" (e. g., when they cannot pay). But these decisions are made at board level and on a case-by-case basis (regardless of the immigration status of the person).

In **Sweden**, undocumented migrants may access emergency care in return for payment of the full cost. This follows from The Health and Medical Services Act. Undocumented migrants are formally excluded from entitlement to health care over and above what follows from the provider's obligation to offer immediate care (in practice interpreted as emergency care) to persons present, but not resident in the country. Children are entitled to full care if they are rejected asylum seekers. As regards HIV/AIDS, undocumented migrants are entitled to testing, as the patient is entitled to remain anonymous. With respect to treatment, it is impeded by the doctors' obligation to report persons diagnosed with an HIV infection.

In **Malta**, undocumented migrants have the right to medical care free of charge within the framework of detention centres. This is formulated in a governmental policy document outlining the relevant principles, which is, in practice, understood to be a free health service, with the same coverage applying as with a Maltese citizen holding a "pink card". HIV screening and treatment are included.

In **Austria**, undocumented migrants may access emergency care in return for payment of the full cost. As uninsured people, undocumented migrants access first aid, in cases of emergency, at federal hospitals under the Federal Hospitals Act. In principle, the patient is invoiced after treatment. Unpaid bills may have consequences for undocumented migrants who manage to regularise, as these debts must then be paid. In cases where the patient cannot be identified, hospitals are obliged to cover the expenses out of their own budgets. As noted above, women in labour is a specifically identified group. As regards HIV/AIDS, tests are free of charge, but there is no subsidised access to treatment for undocumented migrants.

In **Bulgaria**, undocumented migrants' access to emergency care follows from The Law on Health Care. As foreign residents not enrolled in any insurance schemes, they are expected to pay the full costs. We find no specific entitlements in terms of identified groups or diseases in relation to undocumented migrants.

In the **Czech Republic**, undocumented migrants may access emergency care in return for payment of the full cost or, alternatively, upon purchasing a private insurance under the Act for Care for the People's Health. In the latter case, they access care in accordance with the contract. It is likely that a minority of undocumented migrants purchases a private insurance, and it can be concluded that they are expected to pay the full costs when seeking emergency care and can become indebted to the health care providers.

In **Latvia**, undocumented migrants may access emergency care upon payment of the full costs. This follows from the Constitution and the Medical Treatment Law.

Also in **Luxembourg**, we can find a conditioned right to receive emergency care. It is provided to undocumented migrants if they are affiliated to insurance, either through employment or privately. Considering the aspect of affordability, it is important to note that care is likely to be inaccessible. Those circumstances follow from an informal agreement between the Ministry of Health and the Ministry of Immigration.

In **Romania**, according to The Health Reform Law (95/2006), every person who requires medical assistance in cases of emergency must be provided care. However, as the services are accessed on the basis of a certificate (certifying payment), it is inaccessible for undocumented migrants unless they are under 18 years old, as children are not obliged to prove identity. However, health care is provided within the framework of detention centres free of charge under the Aliens Act.

Member States Granting Minimum Rights of Access to Health Care

In the second cluster we find Member States in which undocumented migrants are entitled to receive emergency care or care specified in constructs such as "immediate care" or "urgent care" which is not economically or in other ways conditioned. In some cases, the care is related to life-threatening events or referred to as life-saving. In this group of Member States, a common characteristic is that, from the patients' perspective, the provision of care can be understood as predictable due to a legislative framework. This implies that the legislation does not allow health care staff to exercise their discretion as to who will or will not receive

care. Twelve Member States were found to be applying this level of rights. In these Member States, health care of a more extensive kind might be accessed under certain unpredictable circumstances (e. g., at the discretion of the professional involved) or in return for payment of the full cost.

Initially it is noted that in this group, children are sometimes taken under special considerations (Denmark, Germany and Greece) and this is also the case for pregnant women (Germany, Greece, Hungary and UK). Furthermore, some Member States provide HIV testing (Belgium, Cyprus, Denmark, and UK), while a few also provide for treatment (Germany, Greece in principle, and Poland).

Table 2: Member States, in alphabetic order, in which undocumented migrants have minimum rights of access to health care, subdivided according to financing of the health system

	Member States
Tax	Cyprus, Denmark, UK
Insurance	Belgium, Estonia, Germany, Greece, Hungary, Lithuania, Poland, Slovakia, Slovenia

In **Cyprus**, the legislative framework as regards access to health care for undocumented migrants is provided by The General Health Care Scheme Law, but also by laws regulating the health system and health insurance. Accident and emergency departments are supposed to provide care free of charge to all persons, which applies also to undocumented migrants. Undocumented migrants may access HIV testing (not treatment).

In **Denmark**, the right to receive emergency care free of charge follows from The Health Act, according to which every person present in a region (even if not a resident) shall be provided emergency care if in need. Children are provided health care, children's vaccinations and preventive examinations at general practitioners, school health services and municipal dental care under a special law (on preventive care). As HIV testing is provided for anonymously, it might be accessed by undocumented migrants.

In the **United Kingdom**, a regulation targeting health services for so-called "overseas visitors", applicable to all non- ordinary residents, is thus applicable to undocumented migrants. Accordingly, treatment is to be provided free of charge in A&E departments, irrespective of the patient's status or ability to pay the costs. Furthermore, what is understood as "immediately necessary treatment" may not be withheld (incl. maternity treatment) for any reason or whilst awaiting payment, as is the case with "non-urgent treatment". This is regulated by way of circulars from the Department of Health. However, the patient remains liable for the costs, and the debts are to be pursued. Of interest is that undocumented migrants may in principle access primary care, however, only if accepted to register by a General Practitioner, which introduces a certain element of arbitrariness. Maternity services provided by midwives free of charge are accessible at primary care level. Children of undocumented migrants are entitled to health care in terms of the same regulations applicable to adults.

In **Belgium**, a law on urgent care outlines that emergency care is granted free of charge to everyone. Furthermore, undocumented migrants have, under a royal decree, the right to receive what is known as urgent medical aid (AMU) free of charge. AMU is not differentiated upon in terms of emergency, basic or universal care and is delivered by a designated

physician or provider. In principle, AMU refers to a wide variety of urgent care provisions and may be both preventive and curative, depending on the physicians' discretion. The admission is administrated by Social Welfare Centers involving a proven "destitution", a (by a doctor) certified "urgent" character and a home visit. In Belgium, unaccompanied minors (regardless of being documented or not) receive special attention. HIV tests and checkups for HIV-positive status are implied in the framework of the AMU system.

In **Estonia**, as established in the Health Services Organisation Act, by virtue of being inside Estonian territory, undocumented migrants may access emergency care. This care is free of charge for the patient and the cost is covered by the state, as is the case for all other persons without insurance. There are no specific entitlements in terms of identified groups or diseases.

In **Germany**, the legislative framework is provided by the Asylum Seekers' Benefits Law. In cases of emergency, undocumented migrants can access health care at a hospital or from a general practitioner, who is obliged by law to provide medical treatment. Beyond that, undocumented migrants are officially entitled to the same health care benefits as asylum seekers residing in Germany for less than forty-eight months. This time line involves a restriction of care in relation to regular health insurance. The care, which is free of charge, comprises: treatment in cases of serious illness or acute pain and everything necessary for recovery, improvement or relief of illnesses and their consequences, postnatal care, vaccinations, preventive medical tests and anonymous counselling and screening of infectious and sexually transmitted diseases (TB, HIV). A document (Krankenschein) is required to prove entitlement beyond emergency care. Pregnant women have access to preventive medical check-ups, services concerning child delivery and related care; however, they are conditioned by an administratively granted "tolerated status". Children can access more extensive care, and traumatised persons may access what is called "appropriate care". HIV tests can be accessed anonymously while treatment is provided for, conditioned by proved entitlement.

In **Greece**, we find legislation on Entrance, Stay and Social Inclusion of Third Country Nationals, prohibiting care beyond a certain extent (emergency or life-threatening events) for adult aliens not residing legally in Greece. Childbirth is normally considered as an emergency. Normally no fee is charged, though uninsured persons are required to pay the full cost of lab tests. HIV and other infectious diseases are also considered as emergencies, and patients may benefit from free medical care and hospital admission, provided that the appropriate treatment is not available in their country of origin, in which case they are also entitled to temporary residence and employment permits. HIV testing is free in public hospitals and screening centres.

In **Hungary**, the legislative framework is found in the Health Act and related regulations which establish everyone's right to emergency and life-saving care, as well as vaccinations free of charge irrespective of citizenship or contributions to the health insurance. Pregnant women have the right to basic care in which complications related to pregnancy is included, but not further maternity care, which is conditioned by residence. Furthermore, at detention centres entitlement to care is more extensive according to the Regulation on Detention from the Department of Justice.

In **Lithuania**, the Law on Health Insurance states that all persons have the right to emergency care, even if the person has not paid the compulsory statutory insurance, implying free emergency care for undocumented migrants. In accordance with the Health Insurance Law, persons with no residency (or stateless persons) can purchase a private insurance. It is

also relevant that under the Law on the Legal Status of Aliens, health care is provided free of charge at the special centres (for Foreigners' Registration and Refugee Reception), also for undocumented migrants.

In **Poland**, the relevant legislation is found in The Law of Health Protection, according to which organisations responsible for health protection (public as well as private) cannot refuse to provide care to a person in need of care or whose health or life is threatened. Consequently, undocumented migrants have access to emergency care, with no special requirements and free of charge. In terms of other legislation in respect to protecting foreigners within Polish territory, each person is insured in Poland if he/she is working, and this includes medical protection which might come into play in case of overstaying. HIV testing and treatment is provided in accordance with the legislation relating to foreigners within Polish territory.

In **Slovakia**, the Act on Health Care and Health Care-Related Services and the Act on Insurance apply to undocumented migrants in terms of being a person located within the territory of the Slovak Republic. All persons, even if not contributing towards the relevant health insurance, shall be given immediate medical care. At the health care provider's request and upon approval by the largest health insurance company, this will be paid by the Ministry of Health.

In **Slovenia**, the Health Care and Health Insurance Act, the Asylum Act and the Aliens Act establish that there must be a fund for providing urgent health care for individuals of unknown residence. This applies to undocumented migrants and entitles everyone to emergency care free of charge. It is also of interest that The Health Centres for Persons without Health Insurance in Ljubljana and Maribor offer general medical examinations and can also refer a person to a medical specialist.

Member States Granting More than Minimum Rights

In the third cluster we find Member States in which entitlement to health care includes services beyond emergency care, involving primary and secondary care. Those Member States are all characterised by a certain recognition of the presence of undocumented migrants. There are regulations in place and even different pathways to obtain entitlement to health care. Access to emergency care is more of a safety net in case of falling out of the system or not fulfilling certain prerequisites. The relevant provisions are laid down in legislation explicitly referring to undocumented migrants. Entitlement is associated with administrative procedures which may, in practice, impair access to care to a certain extent. Collectively, five Member States can be found to be applying this level of rights.

In those Member States, we also find that children are given special considerations as well as women in the context of reproductive health. In addition, HIV tests are provided for, as well as treatment.

Table 3: Member states, in alphabetic order, in which undocumented migrants have more than minimum rights of access to health care, subdivided according to the financing of the health system

	Member States
Tax	Italy, Portugal, Spain
Insurance	France, Netherlands

As regards **Italy**, we first note that undocumented migrants are not entitled to register in the mainstream National Health System. Due to this fact, they access "urgent" and "essential" health care by way of an alternative administrative pathway. A legislation (called Turco-Napolitano) grant them a right to seek medical assistance, free of charge, in public health institutions or accredited private facilities operating within the national health service, for urgent or primary outpatient and hospital treatment, in case of sickness or accidents, as well as for preventive medical treatment. In practice they are granted, by local administration and free of charge, a "temporary residing foreigner code" functioning as an anonymous "health card" which provides access to a wide range of health services. Furthermore, undocumented migrants are entitled to preventive care, as well as care provided for public health reasons. This includes prenatal and maternity care, care for children, vaccinations, and the diagnosis and treatment of infectious diseases, including HIV testing and treatment, TB and other contagious diseases and work accidents, which are all part of the entitlement laid down in the law referred to above.

In **Portugal**, the right to heath care is established by the constitution. Entitlements for undocumented migrants are also outlined in specific legislation and circulars. Entitlements depend upon the time residing in the country, with the exception of children and in case of certain specified diseases. The basic requirement is a stay of 90 days. However, if the stay is not officially recognised (or too short), the migrant will be entitled to access emergency care in public hospitals upon payment of the full cost of treatment, but it may not be refused if the patient lacks the means to pay. Upon proven residence (of 90 days), a document equivalent to the health card, called "temporary registration", is granted, allowing access to health care, medication and medical tests. It should be noted that all residents, regardless of their status (i. e., also undocumented migrants with less than 90 days' stay), have access to HIV screening and anti-retroviral treatments, along with other public health programmes (vaccination, dental examinations for all pregnant women). Undocumented children may, under the constitution and legislation, access public health care on equal grounds as children with Portuguese citizenship and documented children.

Also in **Spain**, access to health care is offered to all, including undocumented migrants with reference to the constitution, acknowledging the "right to health for all", but also by The General Health Care Act providing for health care, foreign citizens included. A moderate fee might occur. However, accessing universal care (primary, secondary and hospitalisation) requires registration with the city council and the possession of a "Personal Health Care Card" in accordance with a special legislation targeting foreigners. Nevertheless, regardless of status and possession of a health card, emergency treatment is provided (necessarily due to an accident or serious illness) with no specified requirements. Undocumented migrants under the age of 18 are entitled to full health care treatment under the same conditions as nationals under the general health laws. Pregnant women are entitled to treatment during

pregnancy and childbirth, as well as to postnatal treatment, even if they are not officially registered. Furthermore, HIV screening and anti-retroviral treatments are free of charge for persons in possession of the Personal Health Care Card.

In **France**, there are different laws and regulations applicable to undocumented migrants' right to health care. Entitlements for persons without regular residence status are established by law in a parallel administrative system, called "State Medical Assistance" (AME). This allows undocumented migrants and their dependants to access publicly subsidised health care under certain conditions relating to their length of stay (minimum 3 months) and income (below a certain threshold). AME involves access to all kinds of health care free of charge, including abortion. With respect to emergency care, the relevant law applies to undocumented migrants regardless of the terms of the AME and is provided through "health care centre offices". Emergency care refers to care in life-threatening situations, as well as the treatment of contagious diseases, maternity care and abortion for medical reasons. Undocumented migrants may likewise access general practitioners free of charge after a certain period of stay (3 years). In addition, health insurance obtained during legal stays might be possible to keep when losing a legal status. Children are entitled to access all kinds of health care free of charge, regardless of their eligibility for AME. Women are, to a certain degree, recognised as a specific group, as maternity care and abortion for medical or voluntary reasons are provided. Screening for sexually transmitted diseases and HIV/AIDS, family planning, vaccinations and screening and treatment of tuberculosis are provided, as are HIV tests and treatment.

In the **Netherlands**, the law targeting undocumented migrants, The Law on the Reimbursement of the Costs of Care for Illegal Aliens, does not distinguish between "primary" and "secondary" care, but between "directly accessible" and "not directly accessible" services involving a scheme for the reimbursement of providers (100 % of the cost in case of childbirth and pregnancy, in other cases 80%). To use a "not directly accessible service", a person must obtain a referral; these services provide "plannable care". For "directly accessible" services (GPs, midwives, dentists [for persons up to the age of 21], physiotherapists or hospital emergency departments), the undocumented migrants may make use of any provider available. As regards "not directly accessible" services (other hospital departments, nursing homes or dispensaries), only a limited number of specially contracted providers belong to the scheme. Other providers cannot be reimbursed for care given to undocumented migrants. Specialised services (especially hospital care) may be covered, but only if they are included in the basic health insurance package. Undocumented migrants, who obtain (non-emergency) hospital treatment or prescription medicines from non-contracted providers, are liable to pay the entire costs themselves. As regards children, they are entitled to free preventive care and check-ups at baby clinics under the Health Insurance Act. As regards HIV, it is included in the "basket" of care defined as "basic level insurance" for all residents.

Discussion

Process of Change Is On-Going

Previous sections presented an overview of characteristics of policies which regard the right of access to health care for undocumented migrants in the respective Member State. While that kind of information is interesting in its own right, the last part of this chapter will be spent on exploring immanent conclusions. However, first a certain caution regarding the interpretation is called for, due to the nature of the empirical material and the limitations

of the study. The situation on the European scene is not static, and processes of change are on-going, driven by stakeholders such as politicians and advocacy groups. A salient example might be Sweden. In May 2011 a public inquiry launched the suggestion to grant undocumented migrants the same rights as legal residents (see SOU 2011:48). In Finland, IOM Helsinki organised a working seminar in June 2011 focusing on the development needs regarding access to health care for undocumented migrants, with the participation of public stakeholders (such as The Ministry of Health and Social Affairs and National Institute of Welfare) and prominent NGOs.

In addition, we have to draw attention to the fact that this chapter does not take fully into account changes of policies that have occurred in the Member States in the last two years. For instance, the United Kingdom, France and the Netherlands, which have been acknowledging undocumented migrants as a reality for many years, have implemented procedural changes which, in the case of UK and France, imply restrictions of rights, while the Netherlands have become more "generous" with respect to secondary care. The inclusion of those changes would have widened the scope of the paper beyond the actual objective of providing insight into the "cross section" of possible approaches in the EU. It would also go beyond the material collected and covered by the project of Nowhereland, which ended in 2010.

Further Qualifications

Another aspect to be taken into account is that the above clustering of countries is based on policies regarding adults. To focus on children would have had an impact on the groupings. We must also consider that the study was concerned with policies and did not attempt to investigate the way these policies are implemented in day-to-day practice, in substantial access to care. Neither is the full picture drawn, which would be the case if the variety of providers were included. Finally, to cluster involves differentiating between categories introducing a certain arbitrariness into the picture, as it is never so clear where to draw the line. At this point, especially Belgium should be mentioned. Belgium was referred to above as a country administering "minimum rights". However, the policies in Belgium also bear some characteristics which could let us opt for the third cluster (more than minimum), as some regulations (a decree and not a law) are in place targeting undocumented migrants and as "urgent care" can be interpreted as involving a broad range of care. However, as we also defined a prerequisite in terms of certified need (by a doctor before accessing care) in combination with an explicit means of testing (economically) the right of access to care in Belgium, in a comparative perspective, it can be interpreted as not providing for the same level of right of access as the five Member States in the third cluster. With these comments of caution, we now turn to the overall picture.

Wide Differences in Entitlements

It is clear that there are wide differences in the entitlements to health care for undocumented migrants in the EU27. When upholding the clustering regardless of its weaknesses, a first observation is that in ten Member States, the right of access to health care is less than the minimum standard outlined by the Council of Europe. In twelve Member States there is access to emergency care, thus meeting the minimum standards. However, according to the interpretation of the ICESCR given by the UN Committee on Economic, Social and Cultural Rights, access to emergency care falls far short of the full scope of the right to health. There are, therefore, 22 Member States whose policies do not conform to the right

to health as specified by the UN. It is clear that such limited access to health care affects those suffering from chronic diseases or those in need of what is referred to as preventive, primary and secondary care. It is also noteworthy that some Member States in the "minimum" cluster actually relate to life-threatening events or care which is life-saving (Greece, Hungary and Poland). The definitions and implementation of those concepts are unclear, but nevertheless run a risk of falling short of what is understood as emergency care. Even if the UN Committee on Economic, Social and Cultural Rights comment on *the right to life* as an integral component (among many) of the right to health (see GC 14, para. 3), this right is not referred to as a type (or level) of care. Finally, when turning to the five Member States not enacting the general *ex jure* exclusion from social rights and offering access to a broader range of care, we have identified weaknesses in the design and implementation of policies which may, in practice, tend to undermine their effectiveness and objectives (PICUM, 2007b; MdM, 2005; HUMA Network, 2009).

No Relation to Funding System

A second observation is that the observed variations do not seem to be associated with the system of funding health services (referred to as mainly tax-based or insurance-based). There is no immediate relation between the funding system and the level of care to which undocumented migrants are entitled. We find countries with both systems in all clusters. Intuitively, it might also be expected that strong, well-established welfare states will grant more complete entitlements than newer welfare states. However, this hypothesis is not supported when comparing, for example, Sweden, on the one hand, with Portugal and Spain, which give counter- intuitive results.

An interesting way to elaborate on this theme, which would strengthen the argument that welfare systems are not solely accountable for policies relative to undocumented migrants, would be to introduce a six-fold division of welfare systems in Europe (Papadopoulos, 2011, p. 40). Accordingly, countries with *comprehensive* systems are found in different clusters (Sweden and Finland: less than minimum; Denmark: minimum). This is also the case with the countries upholding a *conservative/corporatist* system (Austria and Luxembourg: less than minimum; Belgium and Germany; minimum; France and the Netherlands; more than minimum). United Kingdom and Ireland, with *liberal* systems, represent the minimum, respectively, the less than minimum cluster. It comes as no surprise that also the countries with *conservative/familial* systems are found in different clusters (Greece: minimum; Italy, Portugal and Spain: more than minimum). The countries referred to as *post-communist/conservative* systems uphold the impression (Hungary, Poland and Slovenia: minimum; Czech Republic: less than minimum) along with the countries found to have a *post-communist/rudimentary* system (Latvia and Slovakia: less than minimum; Estonia and Lithuania: minimum).[3] However, a rudimentary pattern must be acknowledged, involving that the most generous countries tend to be found with *conservative/familial* or *conservative/corporatist* systems. In addition, we can note that the majority of the post-communist countries grant minimum rights, while only one (out of 3) of the countries with comprehensive models (Denmark) does the same.[4] Nevertheless,

3 Bulgaria, Cyprus, Malta and Romania are not covered by Papadopoulos (2011).

4 A mathematical analysis based on the value of cluster (as 1, 2 or 3) for each country, resulting in a "mean value" for each welfare system: 1.33 for a *comprehensive* system; 2 for a *conservative/corporatist* system; 1.5 for a *liberal* system; 2.75 for a *conservative/familial* system; 1.75 for a *post-communist/conservative* system, and 1.5 for a *post-communist/rudimentary* system.

given the complex mixture of welfare systems and clusters, the bottom line of this exploration allows us to draw some conclusions in regard to the connection between welfare systems and the level of health care undocumented migrants are entitled to.

Identifying Other Patterns

Can any other patterns be identified? Above it was stated that one aspect influencing undocumented migrants' rights to health care concerns migration policy and its implementation. From this perspective, it would be interesting to draw the contours of a certain imprint of the national context of migration. From our point of view, the "magnitudes" and categories of undocumented migrants in the Member States are of main interest. In addition, practices of regularisation are also relevant, as they are related to the control of migration. Regularisation is understood as a "state procedure by which third country nationals who are illegally residing or who are otherwise in breach of national immigration rules in their current country of residence are granted legal status" (ICMPD, 2009). In order to approach this topic, at least tentatively, the volume and nature of irregular migration, as well as the approach to irregular migration embodied in practices of regularisation, will now be explored.

As regards the volume of irregular migration, it is interesting to note that all the Member States found in the third cluster have high (Italy, Spain and Portugal) or medium (France and the Netherlands) proportions of undocumented migrants in a European comparative perspective when using a low-medium-high- scale with reference to proportion of population (ICMPD, 2009). In the second cluster some countries have high proportions (Belgium, Cyprus, Germany, Greece, Hungary and UK), while others have low (Denmark, Lithuania, Poland, Slovak Republic, Slovenia) or medium (Estonia) proportions. In the most restrictive cluster, countries with low (Bulgaria, Finland, Ireland, Latvia, Malta, Romania) or medium (Austria and Sweden) rates are found, while the magnitude in Luxembourg is unclear. However, we also find a Member State with high numbers in the restrictive cluster (Czech Republic) (ibid.). From this we can conclude that the volume of irregular migration is a poor predictor of policies on access to health care.

The Nature of Irregular Migration

We can also consider the nature of irregular migration, i. e., the most common pathways into irregularity. Countries in the third (generous) cluster mainly harbour undocumented migrants whose pathways into irregularity are related to the (informal) labour market, while countries in which the undocumented migrants are largely "produced" by the asylum system (rejected asylum seekers) tend to be found in the more restrictive clusters. Also the Netherlands, with its relatively large numbers of rejected asylum seekers, fit this pattern, as the largest group of undocumented migrants consists of labour migrants (PICUM, 2007b).

A last observation concerns the differing practices of regularisation which generally tend to relate to Members States' policies of external or internal control of migration (Doomernik and Jandl, 2008). "External" control focuses on the borders and entry points of a country, while "internal" control is enacted indirectly and based on administrative measures involving restricted access to welfare benefits and public resources (Brochmann, 1999).The very fact that undocumented migrants do not have the required permits and documentation make them prime targets of internal control.

Based on findings from the REGINE (Regularisation in the European Union) study of regularisation practices in Europe, it seems as if most countries in cluster three rely on

regularisation practices (France, Italy, Spain, and Portugal) (ICMPD, 2009). Only the Netherlands use regularisation on humanitarian grounds (i. e., in relation to the asylum system). Turning to the countries found in the middle cluster, we find only one relying on regularisation programmes (Greece). The rest are new Member States using small scale regularisation (Estonia, Hungary, Lithuania, Poland, and Slovak Republic) or not at all (Cyprus and Slovenia). In this cluster we also find the UK using regularisation very sparingly, while Belgium and Denmark use regularisation on humanitarian grounds; Germany is ideologically opposed to it, yet allows it to a slight extent in practice. In the most restrictive cluster we find countries that are ideologically opposed (Austria, even though regularisation on humanitarian grounds has increasingly been granted recently), new non-regularising Member States (Bulgaria, Czech Republic, Latvia, Malta and Romania), countries that only use regularisation on humanitarian grounds (Finland, Luxembourg and Sweden), and countries that use only small-scale regularisation (Ireland) (ICMPD, 2009). It seems reasonable to say that the overall impression as regards regularisation is that countries with more restrictive policies on health care entitlement also tend not to rely on regularisation practices which might imply a tendency to enact the internal control of migration. This confirms the idea that withholding access to health care forms an element of the internal control of migration.

Health Care as Risk Management

Do further patterns emerge if relationships to the logic of social policies are explored? The basic norms and institutions of the welfare state involve redistribution over the individual's life course. The aim is security, i. e., managing risks (such as sickness, disability and old age) to which the organisation of work leaves the individual exposed (Kohli, 1987). Health care is to be understood as an activity of risk-management, one of the core fields of social policy (Leisering, 2004). Redistribution is underpinned by the collectively-shared moral assumptions that define the rules of reciprocity and determine the criteria for inclusion and exclusion in the system of social care and security (Kohli, 1987). The basic collective norms and obligations characterised as the "*moral economy*" of the society (Thompson, 1971) also concern which risks should be covered, who are eligible, and what are legitimate practices (Kohli, 1987).

The "Work Society" Norm

It is reasonable to state that the current moral economy is that of a "*work society*". This notion expresses the fact that it is above all the social organisation of work that structures welfare state interventions and norms of reciprocity (Kohli, 1987). This indicates that the relation between the labour market and irregular migration may be pivotal to health care policies. Some observations, involving the tolerance towards irregular work (i. e., work within the informal economy) in the Member States, heighten this impression. If we, as Düvell (2009) suggests, differentiate Member States as tolerant or intolerant to irregular work, we can see that only one of those States that are tolerant to irregular work (Italy, Spain, The Netherlands, Poland, Czech Republic, Slovakia, Greece) do opt for less than minimum rights (Czech Republic).[5] This suggests that undocumented migrants who are active in the irregular labour market seem to be more favourably received in the EU27 than the undocumented migrants who are rejected asylum seekers. The former tend to be more often granted the right to health care, possibly underpinned by "work society" logic, in which primacy is given to considerations in

5 Only 12 Member States are covered; Italy, Spain, United Kingdom, The Netherlands, Germany, Austria, Poland, Czech Republic, Slovak Republic, Greece, Denmark and Sweden.

regard to the needs of a work force and national economic objectives, rather than to health and social policy when determining which risks should be covered and who is eligible. Hence, to fully understand the differing policy approaches regarding undocumented migrants, it may be fruitful to consider the theoretical discussion on the welfare state and its relationship to, and role within the market economy and the labour market. In particular, the relationship between the formal and informal economy and labour markets within the context of the "moral economy" may shed some light on the situation of the undocumented migrants. As we have seen, it seems that the current moral economy in Europe of today includes "irregular workers" to some extent. As regards rejected asylum seekers, we have seen that the most "hard-nosed" countries are those in which undocumented migrants mostly consist of rejected asylum seekers. This is to say that rejected asylum seekers seem to be excluded from the norms of reciprocity maintained in the EU27, and it is rendered a perfectly legitimate practice to refuse such a person access to even emergency care.

Final Thought

In sum, given that the level of entitlements to health care for undocumented migrants falls short of human rights standards, a salient question would be, to cite Doomernik and Jandl (2008): "How far can states go in the implementation of their control, particularly in terms of human rights for migrants and refugees?" It would also be fruitful to consider the role of human rights standards within the current moral economy and its implications and implementations in intersecting policy areas.

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Landscapes of Nowhereland

Situation of Undocumented Migrants in Selected EU Member States

Friedrich Altenburg

Europe as a whole may be considered as Nowhereland, where undocumented migrants may arrive and live in hiding while trying to improve their living conditions, as well as that of their families, those who came along or stayed back home. But this Nowhereland is by no means an identifiable place with common standards and rules. To the contrary, it has different faces depending on the EU-MS, every place having different hot spots and attitudes relative to irregular migrants, meaning different social climates which may range from welcoming, to ignoring and aggressive resentment.

In what follows, we provide a brief overview of commonalities and differences across Nowhereland in Europe, briefly pointing out specificities of every country. As the focus is on the provision of health services to undocumented migrants, we draw on the results of the Nowhereland project, in particular, research by Carin Björngren-Cuadra on policies,[1] and by the Platform for International Cooperation in Undocumented Migrants (PICUM) on the situation of undocumented migrants.[2]

Austria			
Total Population 2008[3]	8,318,600	Foreign Citizens 2008[4]	867,800
Estimates for UDMs 2008[5]	18,000–54,000	In Percent of Total Population	0.2%–0.6%
Access to health care	» Access to health care without health insurance limited to emergency cases. » Costs to be covered by the patient, although treatment in emergencies may not be withheld on financial grounds.		
Specific aspects and hot spots observed by experts in the field	» Undocumented migrants are heavily reliant on NGOs for both health care provision and mediation with the mainstream health services. » Ineligibility of undocumented migrants for public health insurance, but access to private health insurance possible. » Fear that failure to pay medical bills will result in arrest and deportation. » Lack of services for undocumented migrants outside big cities. » Serious difficulties in ensuring continuity of health care.		

1 Policy Country Reports can be found at http://www.nowhereland.info/?i_ca_id=369 (last access on 27/12/11).

2 PICUM Country Reports can be found at http://www.nowhereland.info/?i_ca_id=389 (last access on 27/12/11).

3 EUROSTAT. Available at: http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=de&pcode=tps00001&plugin=1 (last access on 27/12/11).

4 OECD International Migration Outlook, SOPEMI 2011, if not otherwise stated.

5 If not indicated otherwise, taken from Kovacheva & Vogel (2009). Available at: http://irregular-migration.hwwi.net

Belgium			
Total Population 2008 (EUROSTAT)	10,666,900	Foreign Citizens 2008	1,013,300
Estimates for UDMs 2008	88,000–132,000	In Percent of Total Population	0.8%–1.2%
Access to health care	» UDMs are entitled to "Urgent Medical Aid" through social service centres, which includes emergency, primary and universal care. » Costs covered by the Centre for Social Welfare.		
Specific aspects and hot spots observed by experts in the field	» Lack of information about the functioning of the health care system and the importance of health care. » Fear of being arrested and expelled from the country after seeking health care. » Access to health care is a complicated and lengthy process. » Inconsistent standards and procedures of health care between municipalities. » Access is temporary and has to be renewed every few months. » Serious difficulties in ensuring the continuation of care.		

Bulgaria			
Total Population 2008 (EUROSTAT)	7,640,200	Foreign Citizens 2009 (EUROSTAT)	23,838
Estimates for UDMs 2008	3,000–4,000	In Percent of Total Population	0%–0.1%
Access to health care	» Access to emergency care guaranteed. » Costs to be covered by the patient.		

Cyprus			
Total Population 2008 (EUROSTAT)	789,300	Foreign Citizens 2009 (EUROSTAT)	127,316
Estimates for UDMs 2008	10,000–15,000	In Percent of Total	1.2%–1.9%
Access to health care	» Access to emergency care guaranteed. » Treatment in emergencies free of charge. » Other costs have to be covered by the patient.		

Czech Republic			
Total Population 2008	10,381,100	Foreign Citizens 2008	437,600
Estimates for UDMs 2008	17,000 – 100,000	In Percent of Total Population	0.2 % – 1 %
Access to health care	» Access only to emergency care. » Costs are to be covered by the patient.		
Specific aspects and hot spots observed by experts in the field	» No health care provision by NGOs. » No access to public health insurance and very limited access to commercial insurance. » Treatment is often refused on financial grounds. » Reporting of irregular stay to police authorities happens frequently. » Language is an important barrier when seeking help..		

Denmark			
Total Population 2008	5,475,800	Foreign Citizens 2008	320,200
Estimates for UDMs 2008	1,000 – 5,000	In Percent of Total Population	0 % – 0.1 %
Access to health care	» UDMs entitled to emergency care. » Emergency care free of charge. » Other costs to be covered by the patient.		

Estonia			
Total Population 2008	1,340,900	Foreign Citizens 2008	223,600
Estimates for UDMs 2008	5,000 – 10,000	In Percent of Total Population	0.4 % – 0.7 %
Access to health care	» UDMs entitled to emergency care. » Emergency care free of charge. » Other costs to be covered by the patient.		

Finland			
Total Population 2008	5,300,500	Foreign Citizens 2008	143,300
Estimates for UDMs 2008	8,000 – 12,000	In Percent of Total Population	0.2 %
Access to health care	» UDMs entitled to emergency care. » Costs to be covered by the patient.		

France			
Total Population 2008	64,716,213	Foreign Citizens 2007	3,696,900
Estimates for UDMs 2008	178,000–354,000	In Percent of Total Population	0.3%–0.6%
Access to health care	» If longer than three months in the country, UDMs are entitled to health care (except dental prostheses and corrective lenses). » Otherwise access to emergency care is guaranteed. » Costs for medical care covered by the state.		
Specific aspects and hot spots observed by experts in the field	» Obligation to prove income and residence for three months to receive State Medical Aid. » Very few undocumented receive State Medical Aid. » Fear of reporting to police authorities due to recent arrests. » Only public emergency care and NGO services available for the majority of undocumented. » Many doctors refuse to treat patients with State Medical Aid.		

Germany			
Total Population 2008	82,217,800	Foreign Citizens 2008	6,727,600
Estimates for UDMs 2008	196,000–457,000	In Percent of Total Population	0.2%–0.6%
Access to health care	» Access to emergency care. » Access to treatment in case of serious illness and acute pain, post-natal care, preventive tests, etc., provided the UDM has a health card (Krankenschein). » Treatment is free of charge with a health card.		
Specific aspects and hot spots observed by experts in the field	» The mainstream health system is the first point of contact only in acute cases of emergency. » Obligation to prove insufficient means and the absence of insurance coverage also in emergency situations. » Contradictory rules on public service obligation to report irregular residence make health care entitlements, except emergency care, difficult to access. » Heavy reliance on NGO service providers. » No continuity in treating chronic illnesses.		

Greece			
Total Population 2008	10,666,900	Foreign Citizens 2008	1,013,300
Estimates for UDMs 2008	88,000 – 132,000	In Percent of Total Population	0.8 % – 1.2 %
Access to health care	» Access to emergency care is guaranteed. » Only laboratory costs are to be covered by the patient.		
Specific aspects and hot spots observed by experts in the field	» Routine detention of newly arrived irregular migrants. » Extremely unsatisfactory living conditions in detention and after release. » Access to only urgent care in emergencies. » Primary care only available through NGO clinics. » Very limited access to secondary care. » Very limited access to mental health services.		

Hungary			
Total Population 2008	10,045,400	Foreign Citizens 2008	184,400
Estimates for UDMs 2008	10,000 – 50,000	In Percent of Total Population	0.1 % – 0.5 %
Access to health care	» Access to emergency care is guaranteed. » If in detention, UDMs have access to hospital and specialist care. » Costs for emergency care and in detention are covered by the state.		
Specific aspects and hot spots observed by experts in the field	» All social service provision depends on the registration at a permanent address. » No specialised services addressing the health needs of undocumented migrants. » Undocumented migrants often attempt to move on to larger and wealthier European countries		

Ireland			
Total Population 2008	4,401,300	Foreign Citizens 2006	413,200
Estimates for UDMs 2008	30,000–62,000	In Percent of Total Population	0.7%–1.4%
Access to health care	» Access to urgent medical treatment guaranteed with discretion as what entails urgent treatment. » Coverage of costs depends on the provider's discretion; if patient is unable to pay, costs are covered by the state.		
Specific aspects and hot spots observed by experts in the field	» Very little information on undocumented migrants' health care needs. » No policy of immediate refusal of UDMs by health care providers. » UDMs only entitled to essential health care services. » No fixed procedures of access to care or billing undocumented patients. » Long-term care dependant on the good will of doctors.		

Italy			
Total Population 2008	59,619,300	Foreign Citizens 2008	3,891,300
Estimates for UDMs 2008	279,000–461,000	In Percent of Total Population	0.5%–0.8%
Access to health care	» Provided that undocumented migrants register with the National Health Service for a "temporary foreigner residing code" and obtain an anonymous health card, they have access to "urgent" and "essential" care, including prevention, pre-natal care and treatment of infectious diseases. » Medical care is free of charge.		
Specific aspects and hot spots observed by experts in the field	» Very inclusive national law providing extensive access to most health care services. » Availability and extent of health care services is bound to political decisions of the regions. » Many public health care providers adopt informal strategies to deter undocumented migrants from using their services. » Mental health identified as burning issue, but very poor awareness amongst migrants. » Frequent exploitation of undocumented migrant workers and many work-related accidents. » Decrease of access to clinics after law of 2009 criminalizing irregular border crossing and residence.		

Latvia			
Total Population 2008	2,270,900	Foreign Citizens 2010 (EUROSTAT)	392,150
Estimates for UDMs 2008	2,000–11,000	In Percent of Total Population	0.1%–0.5%
Access to health care	» Access to emergency care is guaranteed. » Costs have to be covered by the patient.		

Lithuania			
Total Population 2008	3,366,400	Foreign Citizens 2010	37,001
Estimates for UDMs 2008	3,000–17,000	In Percent of Total Population	0.1%–0.5%
Access to health care	» Primary care delivered within the premises of the Foreigners Registration Centre (FRC). » Costs covered by the state within the framework of the FRC.		
Specific aspects and hot spots observed by experts in the field	» Penalisation of persons assisting undocumented migrants. » Refused asylum seekers receive no social assistance. » No impartial monitoring of the quality of health care in deportation and reception centres. » All care beyond emergency care has to be negotiated and often paid by NGOs.		

Luxembourg			
Total Population 2008	483,800	Foreign Citizens 2008	215,500
Estimates for UDMs 2008	2,000–4,000	In Percent of Total	0.4%–0.8%
Access to health care	» Emergency care is provided only if the person is insured, so is primary and secondary care. » Access to insurance schemes is given, provided the person can pay for it. » Costs for treatment have to be paid in general and may then be reimbursed by the insurance.		

Malta			
Total Population 2008	410,300	Foreign Citizens 2010	18,088
Estimates for UDMs 2008	5,000–8,000	In Percent of Total Population	1.2%–1.9%
Access to health care	» Automatic detention of all irregular arrivals and asylum-seekers upon arrival. » In the context of the detention system applied by the Maltese authorities for all irregular migrants and asylum seekers alike.		
Specific aspects and hot spots observed by experts in the field	» No provisions on health care entitlements for undocumented migrants. » Migrants' health problems connected to deplorable living conditions in detention centres. » Detained migrants who experienced violence before or during migration being vulnerable for mental health problems when there is no adequate care. » Migrants faced with large linguistic and cultural barriers when accessing health care.		

The Netherlands			
Total Population 2008	16,405,400	Foreign Citizens 2008	719,500
Estimates for UDMs 2008	62,000–131,000	In Percent of Total Population	0.4%–0.8%
Access to health care	» Service providers may request reimbursement of costs for "medically necessary care" rendered to uninsured patients such as undocumented migrants. » This includes all services directly accessible to patients without referral.		
Specific aspects and hot spots observed by experts in the field	» Dental care and physiotherapy inaccessible for adult undocumented migrants. » Undocumented migrants and doctors poorly informed about health care entitlements. » Importance of community-based organisations in informing on right to health care. » Instances of health care providers forcing undocumented migrants to pay or sign debt contracts. » Undocumented migrants heavily reliant on NGO mediation.		

Poland			
Total Population 2008	38,115,600	Foreign Citizens 2008	60,400
Estimates for UDMs	50,000–300,000	In Percent of Total	0.1%–0.8%
Access to health care	» Access to emergency care is guaranteed. » Provided the UDMs are rejected asylum seekers, have over-stayed their visas or are insured, they may access primary and secondary care. » No costs are charged to the patient.		

Portugal			
Total Population 2008	10,617,600	Foreign Citizens 2008	443,100
Estimates for UDMs 2008	80,000–100,000	In Percent of Total population	0.8%–0.9%
Access to health care	» With a residence duration of less than 90 days, there is only access to emergency care. » With a residence duration of more than 90 days, there is the possibility of "temporary registration" which provides for access to medical care, medication and testing as well. » Cost-sharing model with patient's fees, with the possibility to obtain a waiver. » Emergency care without registration to be paid by the patient, but may not be withheld on financial grounds.		
Specific aspects and hot spots observed by experts in the field	» The fear of being reported is a serious obstacle to access. » Lack of mental health services. » Health care providers are not informed about undocumented migrants' entitlements. » Hospitals use psychological pressure to receive payments from undocumented migrants. » Undocumented migrants are unaware of the possibility to request exemption from payment.		

Romania			
Total Population 2008	21,528,600	Foreign Citizens 2009	31,354
Estimates for UDMs	7,000–11,000	In Percent of Total Population	0%–0.1%
Access to health care	» Conflicting regulations: emergency care must be granted, but service provision is tied to contributions to the insurance scheme. » Costs are only covered if in detention.		

Slovak Republic			
Total Population 2008	5,401,000	Foreign Citizens 2008	52,500
Estimates for UDMs 2008	15,000–20,000	In Percent of Total Population	0.3%–0.4%
Access to health care	» Access to emergency care is guaranteed. » Primary and secondary care only with private insurance or cash payment.		

Slovenia			
Total Population 2008	2,010,300	Foreign Citizens 2010	82,176
Estimates for UDMs	2,000 – 10,000	In Percent of Total Population	0.1 % – 0.5 %
Access to health care	» Emergency care is guaranteed, free of charge. » Health Centres for Persons without Health Insurance open in two cities, also accessible for undocumented migrants.		
Specific aspects and hot spots observed by experts in the field	» NGOs have very little contact with undocumented migrants who have not been in the asylum system. » Insufficient and inappropriate mental health care services. » Clinics for uninsured persons work on low capacity due to budgetary constraints. » The number of undocumented migrants seeking health care is relatively low.		

Spain			
Total Population 2008	45,283,300	Foreign Citizens 2008	5,648,700
Estimates for UDMs 2008	280,000 – 354,000	In Percent of Total Population	0.6 % – 0.8 %
Access to health care	» Emergency care is guaranteed and free of charge. » Undocumented migrants may obtain a personal health card, which assures access to universal health care. » There is a cost-sharing system, as with Spanish citizens, with the possibility to obtain waivers in order to reduce the percentage from 40 % to 10 % or even 0 %.		
Specific aspects and hot spots observed by experts in the field	» High level of decentralisation of the health system has led to great variations of access amongst autonomous communities. » Administrative difficulties experienced by some undocumented migrants in meeting the conditions for the individual health card (tarjeta individual sanitaria). » Language is a significant barrier for many undocumented migrants. » Particular difficulty faced by homeless undocumented migrants who seek to access the mainstream health system. » Prevalence of mental health problems. » Discriminatory treatment of undocumented migrants by some health care personnel.		

Sweden			
Total Population 2008	9,182,900	Foreign Citizens 2008	555,400
Estimates for UDMs 2008	8,000–12,000	In Percent of Total Population	0.1%–0.1%
Access to health care	» Undocumented migrants are only entitled to access emergency care upon full payment of the cost of the service. » Otherwise, undocumented migrants are excluded from any type of health service. » Some local authorities have extended entitlements.		
Specific aspects and hot spots observed by experts in the field	» Other types of care available only by discretion of the hospital board. » Very high cost of medical services. » Continuity of care very problematic. » Unfavourable attitudes in society and amongst some health care providers.		

United Kingdom			
Total Population 2008	61,192,000	Foreign Citizens 2008	4,186,000
Estimates for UDMs 2008	417,000–863,000	In Percent of Total Population	0.7%–1.4%
Access to health care	» Emergency care is provided free of charge. » Primary care is open to undocumented migrants as well.		
Specific aspects and hot spots observed by experts in the field	» Inclusive primary care service available to anyone. » Access to secondary care restricted since 2004. » Undocumented migrants often refused GP registration. » Secondary care virtually inaccessible. » High occurrence of mental health problems amongst undocumented migrants. » Access to mental health care services very limited.		

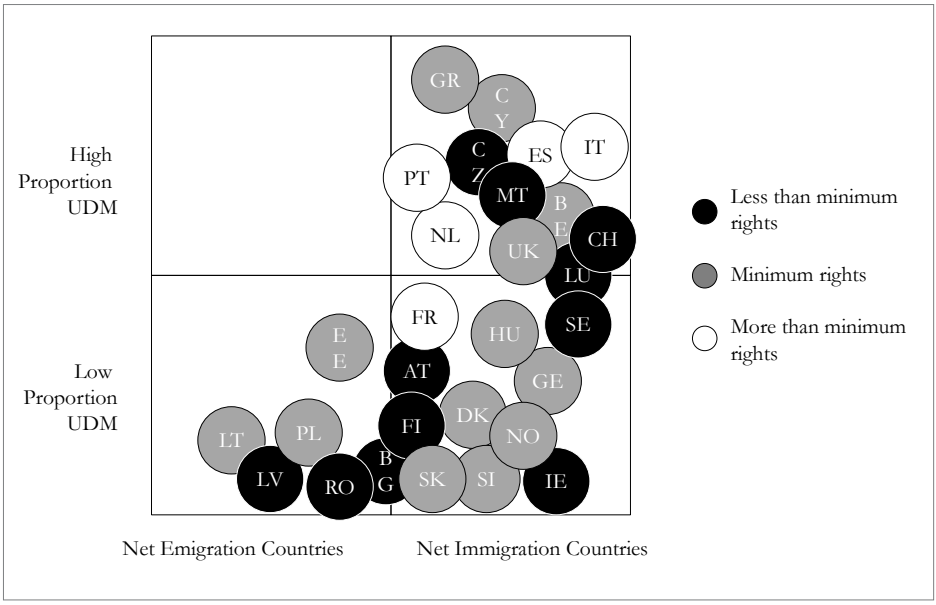
Summarising the Landscape

The 27 EU Member States exhibit a wide range of access to health services, from very liberal approaches to provision at detention centres only. The majority of countries expect public health insurance coverage for health service provision. In the absence of public health insurance, usually based on formal sector employment and social security contributions, private insurance coverage or up-front payment is expected. In recognition of lack of financial means of undocumented migrants, charges may be waived, but the welfare system has to refund the costs to public hospitals or other health service providers. In cases or countries where the welfare system is not covering expenses, NGOs tend to step in either by providing health services or by footing the bill or combinations thereof. In cases where reporting of the irregular status of the migrant by the public health service provider to the police is expected, NGOs tend to be the only source of health service provision. In Spain, France and Italy,

UDMs may access the health system on the basis of a temporary health card, which allows them to access emergency and other health services without having to identify themselves as irregular migrants.

The graph below provides a quick overview of the approaches by the various EU-MS around the year 2008. We have four quadrants, whereby the net-immigration countries and net-emigration countries are identified along the horizontal axis (taking the average over the period 2000-2008 into account, in order to provide insight in longer-term trends). The vertical axis identifies the proportion of UDMs in the total population, countries above or equal to the EU27 average are referred to as irregular migrant-intensive ones and those with below average proportions as UDM-poor countries. We then can see that countries which tend to have an above average share of irregular migrants in their populations tend to be net importers of migrants, while those with small proportions of irregular migrants tend to be emigration countries. There are, however, also net importers of migrants, like the Nordic countries, which have low shares of UDMs. They tend to offer minimum rights or less than minimum rights as far as access to health services are concerned.

Graph 1: Landscape of Health Approaches in NWL



Countries with high proportions of UDMs tend, on average, to have good access to health care services, with France, the Netherlands, Spain, Italy and Portugal taking the leading ranks. In contrast, net emigration countries do not only have small proportions of irregular migrants, but also less than minimum access rights to health care. The countries concerned tend to be the new accession states, but also Ireland. Less than minimum access to health care can also be found in net-immigration countries like Austria, Luxembourg, Sweden, Finland – with the exception of Luxembourg, all countries with low proportions of irregular migrants.

Given the complexity of the subject, it is difficult to draw conclusions about pull and push factors. This is also not the objective of the analysis. We just want to put access to health services in a wider spectrum of factors which might have an influence on service provision.

In so doing, we see that only few countries opt for granting more than minimum rights, giving access to medical care beyond emergencies and free of charge. At the same time, we see quite some variances in the medium range between emergency care free of charge and possibilities to even go into primary care, with certain obstacles. In the section with less than minimum rights, we find those countries where patients have to pay for emergency care as well, although there are variances again as to whether payment is asked before or after treatment only. We may also note two countries, Greece and Malta, where detention is the only response to undocumented migrants, not really addressing their needs and aspirations.

As we see in the chapter on good practices, none of the countries included above has easy access to health care for UDMs; all of them need institutional bridges between irregular migrants and the public health service to make access possible and affordable.

Good Practice Examples

Good Practice Examples of Health Care Provision for UDMs

Friedrich Altenburg, Gudrun Biffl

"It is a shame not to belong, not to be able to afford necessary commodities; it is often the cause for a vicious cycle; only understanding, care and mutual trust can show us the way out".
(Marienambulanz 2010)

To look for the best available solutions and for the systematic integration of health services for undocumented migrants in organisational and professional routines was the first and most important objective of the Nowhereland Project. This objective was the leitmotif for establishing the landscape of existing frameworks and services as described in Chapters 3 and 4, and for the in-depth research of service providers addressed in the course of the project.

In this chapter we will go into the details of service provision by looking at five organisations, which have been chosen as good practice examples[1]. The sample represents the full range of options of health service provision to UDMs. This pertains to the funding of the services, be it public funds or private donations and any mix thereof, or cost-sharing models, where the client has to share part of the costs. In the latter case, the service provider tends to be subsidised by public and/or private funds. As far as the institutional set-up is concerned, we have selected public institutions, NGOs, as well as private entities.

In addition, we looked at the composition and skills of the personnel involved. This implies choosing between various types of organisations in which staff is made up of salaried personnel only or in which staff is made up of a combination of employees and volunteers.

Apart from the diversity of the supply structures, we also endeavoured to reach a diversity of UDMs. This has been achieved by including specialist services, as well as mainstream health service providers. Accordingly, we look at health institutions which serve between 2,000 and 13,500 clients. The percentage of UDMs ranges from 10 % to 90 % of all clients.

The research is based on information provided by the organisations themselves in their annual reports and in the Nowhereland database,[2] as well as by original field work, which entailed visits to the institutions and in-depth interviews of staff members.

In the course of this chapter, we travel through Nowhereland from West to East, starting in Spain, one of the entry points widely known for some dramatic pictures in media coverage, and ending in Austria, the centre of Nowhereland at the crossroads of East to West and South to North flows of UDMs.

We take the different contexts, set-ups and approaches towards service provision into account when drawing conclusions from the examples. We identify lessons we can learn from them, as well as success factors. We also pay attention to aspects which call for caution in different contexts, both for service providers as well as other actors.

1 This chapter is based on reports by U. Karl-Trummer and A. Handler, by A. Chiarenza and additional original research by F. Altenburg.

2 In the internet at http://www.nowhereland.info/?i_ca_id=416.

Table 1: Overview of good practice examples

Name of Organisation	Country	Number of Clients/Year	% of UDM	Staff in FTE	Volunteers	Share of Public Funding	Type of Service Provider
Malteser Migranten Medizin, Berlin	Germany	5,600	69	0.5	15	0 %	NGO/Primary Care
Salud y Familia	Spain	13,471	62	10.5		100 %	NGO/Counselling and Mediation
GP NN	Netherlands	4,000	10	4		80–100 %	Private/General Practitioner
Center for Health of Foreign Family	Italy	8,657	90	23	1	100 %	Public/Primary Care
Caritas Marienambulanz Graz	Austria	2,270	50	3.57	50	80 %	NGO/Primary Care

Salud y Familia in Spain

Context

Spain has turned from a country of emigration to a country of immigration in the course of the last two decades of the 20th century. In 1980, the National Institute of Statistics registered some 182,000 foreign legal residents (quoted from Gonzalez-Enriquez, 2010, p. 248); this number multiplied almost 30-fold by 2009, when a foreign population of 5,262,000 persons was registered (Eurostat, 2009). Carmen Gonzalez-Enriquez (2010, p. 252) estimated the number of undocumented migrants as high as 353,000 in 2008, corresponding to 12 % of third-country nationals in Spain. She named four reasons for the growing popularity of Spain amongst migrants (2010, p. 247):

- Strong and vibrant informal economy
- Positive social attitude
- Tolerance to illegality "embedded in Southern European political culture"
- Provision of certain social rights, such as access to health services.

Indeed migrants, including undocumented migrants, have free access to health care, provided they have registered with the municipality (empadronamiento)[3] and obtained a personal health care card (Björngren-Cuadra, 2010 Spain, p. 10). This includes "access free of charge to primary and secondary health care, hospitalisation and treatment of infectious diseases" (PICUM, 2010 Spain, p. 7) and is described by some actors as exemplary. The report, however, cautions that even this favourable legislation does not necessarily guarantee effective access.

3 This is a registration as a member of the community, not as a resident. It is in the interest of the community to know how many people they have to cater for, as the community receives public funds to run the schools, hospitals, security services, etc., in relation to the number of persons registered. The registration is strictly confidential, enabling irregular migrants to participate in local life without having to be legal residents. A passport is, however, a requirement, as well as a local address of habitation.

Administrative barriers, fear of arrest and deportation, lack of respect for migrant patients and linguistic and cultural barriers remain significant obstacles (PICUM, 2010 Spain, pp. 8-9).

Description of Salud y Familia

Salud y Familia (S&F) is a private, non-profit association. In collaboration with public administrations, NGOs and individual volunteers, the association conducts projects and provides services to UDMs with the aim of improving their quality of family life and their health situation. The association receives public funding from different institutions:

- City Councils of Barcelona, Badalona, Terrassa, Sant Cugat, Madrid and Rivas-Vaciamadrid
- Department of Health, Catalan Regional Government and the Catalan Institute for Women
- The Spanish Ministry of Social Affairs and The Spanish Institute for Women and
- The European Commission

In what follows, we describe the services provided in Barcelona, a city of 1.6 million inhabitants, of whom, according to the National Statistics Institute (2010), 17.6 % are foreign citizens. Almost half of the foreign nationals originate from Latin America. The services provided are financed on a project basis, two of which we present here: namely "From Compatriot to Compatriot" and "Intercultural Mediation in Hospitals and Primary Care Centres". The aim of the projects is to facilitate access to health care for UDMs within the regular health care system, either by supporting them to get the health card or by arranging health care for those who do not possess a health card.

According to these two aims, the project has two main functions, namely to help UDMs to navigate within the legal health system and to help them communicate with the health service providers. As to the first function, to get a health card, staff members of Salud y Familia may contact the health authority and request a health card for the UDM. The card will be sent directly to the address of the UDM or to the office of Salud y Familia. In order to fulfil the second function, S&F co-operates within the project with particular public health centres (CAPs) and the public health centre for civil servants (PAMEM).

In case an UDM has no health card and cannot apply for one, e. g. if he/she does not possess a valid passport, he/she will be referred to a collaborating CAP or the PAMEM. Health care professionals at collaborating CAPs treat UDMs in the public centres within the regular working hours. As patients without a health card have to pay 100 % of the total price of medication, the project also sends UDMs to supporting pharmacies.

In their second function, S&F staff members mediate between the public health centres and UDMs, in case UDMs are rejected without justification, for example, when pregnant women or children, who are entitled to health care at any time and without precondition, are refused. In case CAPs continue to reject pregnant women and children, the staff members may communicate with the health authority, which then intervenes.

The service is open to all immigrants in Barcelona who have difficulties in accessing health care, regardless of their legal status. Nevertheless, undocumented migrants are the main target group. No documents of any sort are required to access the service. Clients either directly contact the service or are sent by public health centres (CAPs). The service is free of charge. Telephone service is available from 9:00 am to 1:00 pm to arrange appointments with

intercultural mediators. Patients can visit the service four days a week. The opening hours are Mondays from 3:00 pm to 6:00 pm and on Tuesday, Thursday and Friday from 9:00am to 12:00 noon. The wide span of opening hours is an important element of accessibility to clients.

In 2008, 858 clients accessed the project; 98 % of them were undocumented migrants, mainly between 18 and 35 years of age (62.4 %). The gender composition was 54.5 % male. The predominant reasons for consultations were:

- STDs (sexually transmitted diseases) and HIV
- Sexual and reproductive health
- General symptoms associated with stress caused by the migration process
- Paediatrics
- Back pain
- Exhaustion.

Under the second project, Salud y Familia is providing intercultural mediation, which is regarded as essential for quality health care in 27 hospitals and primary care centres in Barcelona, Gerona and Lérida. The service is open to all immigrants in Barcelona and free of charge. UDMs can directly ask for intercultural mediation at the information desk of the cooperating hospitals. According to the cultural mediator of Romanian migrants, it is essentially social workers or doctors who ask for a mediator.

Most of the mediators working at the service are trained in cultural mediation. Their tasks are:

- To explain the health care system
- To interpret
- To mediate between the patient or his family and the medical staff
- To document mediation in duplicate; one documentation goes to Salud y Familia and one remains in the hospital.

In 2007 12,613 clients benefitted from this service. As it is open to immigrants in general, there are only estimates of the share of undocumented migrants. According to the project staff of Salud y Familia, UDMs are estimated to make up some 60 % of all clients.

Staff Numbers and Professional Mix of S&F

Both projects taken together employ 24 intercultural mediators and two administrative staff members. The mediators themselves are migrants from Latin America, Southeast Asia, China, the Middle East and Eastern Europe. Amongst the latter are members of the Roma and Sinti community.

The main job and challenge of the S&F staff members is to explain their role to the hospital staff and to the clients. This was particularly difficult at the beginning of the project "Cultural Mediation in Hospitals and Primary Care Centres". The difficulties arose above all between the mediators and the staff members of hospitals and primary care centres. The hospital staff was very sceptical and feared that consultations would take longer; there was also fear that the one or the other employee might be substituted by a mediator. Furthermore, staff members did not really want to get involved with the, at times, difficult life stories of UDMs, as that put extra stress on them.

Furthermore, some nurses were critical of offering mediation for free. It was considered unfair, as Spanish people were to pay for language courses[4] while migrants did not even have to learn Spanish, let alone pay for the health service. The mediators clarify their role and ensure that the impact of cultural mediation would be positive for all involved in the process. As it turned out, the support by the hospital management was important for the project to come off. In the end, cultural mediation was welcomed as the work proceeded.

Mediators are at the interface of patients and medical staff. In this way, solutions to health problems which are in accordance with medical requirements and accepted and understood by patients can be obtained.

> "The patients and doctors have to understand that we are neutral".

Apart from the normal challenges of the everyday work, mediators have to learn to cope with individual life stories of UDMs. They receive professional coaching and have monthly debriefing meetings at Salud y Familia in order to develop coping strategies.

Lessons to Be Learned from Spain

The Spanish example can provide us with four guiding principles for ensuring adequate health service provision for undocumented migrants:

The first refers to the policy context. It is a matter of principle in Spain to provide health care for UDMs within the existing mainstream health care system and not, as in many other countries, in parallel structures.

The second pillar refers to the close cooperation between a specialised service, Salud y Familia, and public health care centres. The two organisations are complementary actors. S&F is a facilitator or rather a bridging institution between the patient and the health service provider. It is facilitating services rather than providing them, thereby ensuring an optimal diagnosis and treatment by the health authorities.

The third pillar rests on the provision of professional intercultural mediation between undocumented migrants and the health care system. It ensures high quality health care for UDMs.

The fourth principle refers to funding. Both projects of Salud y Familia are publicly funded, thereby ensuring predictability and sustainability.

General Practitioner NN in The Netherlands

Context

While Spain has turned from a country of emigration to a popular destination country of migrants from the mid-1980s onwards, the Netherlands took a different road. As the Netherlands are a country of former colonial rule, they adopted many immigrants from their former colonies from the 1970s onwards. The cultural diversity, once cherished as a national gem, became, however, increasingly restrictive towards immigrants, particularly UDMs, from the 1990s onwards (Leun & Ilies, 2010, p. 188). Of a total population of 16.6 million inhabitants in 2008, 688,000 were foreigners, i. e., 4.1 % of the total population (Eurostat, 2009). Given the long tradition of immigration and easy access to Dutch citizenship, the low share

4 Long-term Spanish unemployed have to pay for health care, which may be taken as unequal treatment of migrants relative to Spanish citizens. For more on this issue, see Mariola Moreno, 2011.

of foreigners belies the multicultural society the Netherlands are. The number of migrants is much higher, rising to 19.4 %, if one includes first and second generation migrants with Dutch citizenship, (Leun & Ilies, 2010, p. 187). As far as undocumented migrants are concerned, their numbers are estimated to range between 62,000 and 113,000 (Leun & Ilies, 2010, p. 191), some argue even as high as 129,000 (Björngren-Cuadra, 2010 NL, p. 6).

In the Netherlands, undocumented migrants are entitled to access essential medical care. Essential medical care is defined in the Health Insurance Act (Zorgverzekeringswet) of 1 January 2009 as care that is provided under the basic health care insurance package. The judgement about what is considered essential and adequate is up to the medical professionals. According to Article 122a of the Zorgverzekeringswet, UDMs have entitlements to:

- Directly accessible care, which means to general practitioners and midwives
- Indirectly accessible care, which means hospitals and medical specialists.

Dental care is not included in the general basic health care insurance package, apart from dental care for persons up to the age of 21.

A special government health fund "CVZ" (College Voor Zorgverzekeringen) covers 80 % of costs of directly accessible care; the costs incurred are reimbursed by CVC to the service provider. Also 80 % of the costs incurred by providing dental care to minors (up to the age of 21) are reimbursed. In the case of pregnancy and obstetric care, the full costs incurred are reimbursed. Indirect accessible care is also reimbursed in toto.

Undocumented migrants can access general practitioners (GPs) directly. In contrast, hospitals are not directly accessible; a referral of a GP is necessary. As only 27 hospitals in the Netherlands have contract with the CVZ and get reimbursements for health care services provided to UDMs, one may not assume that UDMs have comprehensive access to health care in the Netherlands. In addition, UDMs have to bear some of the costs of health care provision.

According to Dr. NN, there are only one or two GPs in various cities who provide services for UDMs. Most of the GPs are not informed about the possibility of reimbursement of the costs incurred or are simply not willing to provide health care services to irregular migrants. An information leaflet regarding the regulation concerning reimbursement was sent by the government and medical association to all GPs in the Netherlands with limited success, as PICUM notes (PICUM, 2010 NL, p. 12).

Description of GP NN and the Network

The general practitioner (GP) plays an important role in the health service provision of UDMs, as he/she acts as gatekeeper to hospitals and medical specialists. The activities of NN are concentrated in the municipality of Nijmegen, a city of 160,000 inhabitants, of which some 40,000 people or 25 % of the population are foreigners, according to the Municipal Department of Research and Statistics (2010).

The model of NN consists of one GP within a network or chain of collaborating institutions. Apart from the surgery of NN, two hospitals and two NGOs are part of the service provision system. They are

- Hospital Dekkerswald
- Radboud Hospital

- NGOs Stichting Gast[5] and
- Vluchtelingen & Nieuwkomers.

The two collaborating NGOs – one publicly (Stichting Gast), the other one privately funded (Vluchtelingen & Nieuwkomers) – provide help and support to asylum seekers who had their case rejected. They help by appealing against the asylum decision and by organising health care for those residing in Nijmegen. Due to the large and rising numbers of clients, they have to turn away clients who reside outside of Nijmegen. The NGOs are facilitating access to health care by referring UDMs to the GP.

The collaborating Hospital Dekkerswald is a hospital for patients with chronic diseases, and one of three hospitals in the Netherlands specialised in treating tuberculosis (TB). Patients suffering from TB are referred from their GP, the public health authority or from pulmonary specialists to this hospital. During the site visit, four out of ten patients with TB were undocumented migrants.

The collaborating Radboud University Medical Centre is one of two general hospitals in Nijmegen. The hospital has a contract with the CVZ (College Voor Zorgverzekeringen) and receives reimbursements for treating UDMs.

Dr. NN has a shared practice with three other GPs. Costs for treating undocumented migrants are covered by the government health fund CVZ, according to the usual regulations as documented above. GP NN provides health counselling, as well as psychiatric care and psychological support. The most important elements of general care provided are:

- Vaccinations
- Screenings
- Infectious diseases control
- Emergency care
- Pediatric care
- Woman and Child care
- Diagnostic services
- Surgical services.

The following services are provided by the cooperating partner institutions:

- HIV treatment and other specialist care (Radboud Hospital)
- TB treatment (Hospital Dekkerswald)
- Abortions (abortion clinic).

In general, an abortion at a clinic costs 300 Euros. The GP has contact to an abortion clinic which is often prepared to offer abortions to UDMs for free.

The service of the GP is open to regular Dutch patients, as well as undocumented migrants. No documents of any sort are required to access the service. Most of the patients are referred by one of the two NGOs: Stichting Gast and Vluchtelingen & Nieuwkomers. But UDMs may access the service directly without any intermediary. During the first visit, UDMs have to register with the GP at the reception desk with their name and date of birth.

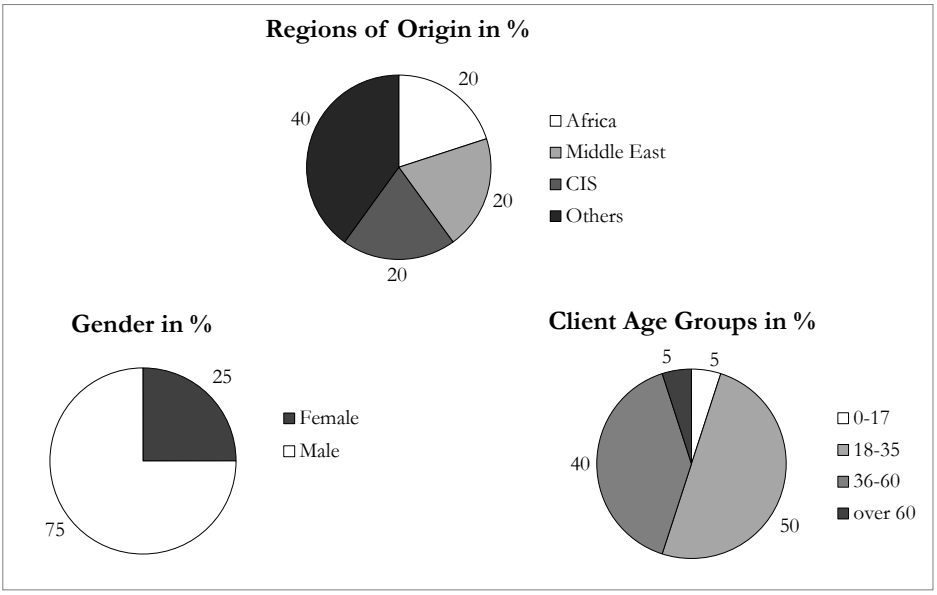
5 For more information, see http://www.stichtinggast.nl/joomla/index.php.

To recover the costs incurred, i. e., for purposes of reimbursement by the CVZ fund, only initials have to be reported.

The GP NN became involved in treating destitute migrant patients through an acquaintance, who referred an uninsured man with penis cancer. The UDM suffered extreme pain, had severe wounds and was living in an unhygienic environment which was detrimental to his health condition. From this moment on, she decided to help and support vulnerable groups of people in need of health care.

A heavy strain on the interview partners, i. e., the staff working in the health institutions, is the confrontation with the difficult working and living conditions of UDMs, on the one hand, and the fact that they can do little to improve the social and work environment of undocumented migrants, on the other. A consequence of this situation is that, after discharging patients at the Hospital Dekkerswald who have undergone extensive treatments in the hospital, chances for sustainable health are limited, given their unhygienic living situations. The latter were the cause of TB to begin with and, as there is little hope for an improved environment after hospital discharge, the disease may come back. The fact that it is not possible for hospital staff to prevent these circumstances has a depressive effect on them.

Graph 1: Client statistics NN



Staff members of the NGOs, Stichting Gast and Vluchtelingen & Nieuwkomers, have debriefings in their teams in order to learn to cope with the difficult living and working situation of UDMs. The number of UDMs accessing the one or other of the NGOs is rapidly rising. To deal with this situation, staff members try not to get involved in cases they cannot deal with. This raises the question, given limited resources, of what choice to make: to help larger numbers of people who are not so difficult or fewer people with specific and difficult health problems.

Mediation is another way of learning to cope with the challenging work. There is a free nationwide telephone interpretation service available for all medical service providers, GPs and hospital care alike. This service is mostly utilised by GPs, unless patients prefer to have family members engaging in the translations. The GP is willing to accept the help of family members, as long as the cases do not involve serious illnesses or diseases. In the latter case, the GP insists on telephone interpretation to ensure an objective and honest translation. The municipality of Nijmegen also offers mediation services for Arab- and Turkish-speaking migrants. The mediation service is paid by the municipality.

Lessons to Be Learned from The Netherlands

As in Spain, health service provision for UDMs is organised within the mainstream health structures of the Netherlands, thus avoiding the development of parallel institutions. The focus is different to Spain, however, as the general practitioners are the hub of service provision. They are the access point as well as the gatekeepers to the hospital and special care system. At least in theory, the service is easily accessible for undocumented migrants, as no proper documents are required for registry with the GP. As the GPs are the only access point, individual strategies of undocumented migrants are limited and their access to health care is dependent on the good will of the GP, respectively, the information status of the surgeries of GPs. This underlines the important role of NGOs like Stichting Gast and Vluchtelingen & Nieuwkomers as go-betweens and pathways to the gatekeepers.

Centre of Health for the Foreign Family in Italy

Context

We examine a health service provider in Reggio Emilia in the North of Italy, the region which attracts 85 % of the undocumented migrants in Italy (Fasani, 2010, p. 173). Like Spain, Italy is one of the major entry points of migrants to Europe; they may enter from the South and East. The former tend to come across the Mediterranean Sea, particularly from Maghreb countries, while the latter tend to pass though the Balkans. A large underground economy, with its demand for cheap labour, favours the influx of undocumented migrants (ibid., p. 169).

Again like Spain, Italy has turned from an emigration to an immigration country in the mid-1980s. Currently, Italy has some 3.4 million foreign residents in a total population of 60.4 million (Eurostat, 2009). It is difficult to provide an estimate of the total number of undocumented migrants in view of a tradition of amnesties and regularisation campaigns, which constantly change the stock numbers. The estimates of the number of undocumented migrants residing in Italy range from 200,000 to 1,000,000 (Björngren-Cuadra, 2010 IT, p. 6), depending on the time of estimation and the method of calculation. According to Francesco Fasani (2010, p. 172), based on the most recognised statistics of the ISMU foundation, there were 651,000 individuals in 2008.

In terms of access to health services for undocumented migrants, Italy is considered to have one of the most favourable systems for irregular migrants (PICUM, 2010 IT, p. 3). Patients have to obtain a so-called "temporary foreign residence code" (Tesserino o Codice Stranieri Temporaneamente Presente), in short an STP code, which is a digital code serving as a form of anonymous health card. Once a person has obtained such an STP code, which is valid for 6 months but renewable, it is possible to access "urgent" and "essential" care; the latter includes primary and secondary care (Björngren-Cuadra, 2010 IT, p. 10). The service

is, however, not provided by the National Health Service (NHS), as UDMs do not have the right to register with the NHS.

Although access to health care for undocumented migrants is in theory easy, the reality is not always as positive as suggested by a survey of foreign agricultural workers in the South of Italy (MSF, 2005; Ravinetto et al., 2009). The practice of providing health care by a parallel system of NGOs and specialised services (PICUM, 2010 IT, p. 9) makes the provision dependent on the provider of this service. What would be the normal procedure for persons registered in the National Health System (Björngren-Cuadra, 2010 IT, p. 10) – access to the family doctor, i. e., GPs – is not possible under this provision. Therefore, the implementation of the law varies greatly from region to region.

The regional authorities are given the responsibility of identifying the most appropriate methods such that essential medical treatment can be provided in the precincts of the Local Health Units or in public health institutions or in accredited private facilities, hospitals or out-patient clinics, possibly in partnership with professional voluntary organisations.

Description of the Health Services for UDMs in Reggio Emilia

Undocumented migrants in Reggio have the choice between two network partners if they are in need of health care. They may turn to:

- The Centre of Health for the Foreign Family (CSFS) or
- The Ambulatorio "Querce di Mamre" (Caritas).

CSFS is a service dedicated to help UDMs enter the regular health care system. The NGO is publicly funded. It is located in the city centre in the basement of the office of the Local Health Authority of Reggio Emilia. One central waiting room leads to the three examination rooms. Health information is posted on the walls, in various languages.

The Ambulatorio "Querce di Mamre" was founded by the Catholic charity organisation Caritas and is basically funded out of donations. Running costs like salaries of cultural mediators, overhead charges, like telephone costs, as well as material costs are covered by AUSL (Azienda Unità Sanitaria Locale di Reggio Emilia), the local health unit founded in 1998. Also the facilities of Ambulatorio Caritas include three surgeries and one waiting room.

There is an official cooperation between CSFS and Caritas ensuring a wide range of services for UDMs. The partnership is institutionalised and not dependant on individual agreements. Collaboration between the two services is facilitated by a shared computer system. This enables the service providers to share medical records and to book appointments in the one or other service.

Both service providers are working on a drop-in basis, and are open between four (CSFS) and five (Caritas) days a week. Around 99 % of the clients are undocumented migrants in both cases. The occupation composition of staff and the types of services offered by these two partners can be taken from the table below.

At CSFS, cultural mediators are available on-site to help UDMs. The latter may consult the different mediators within certain office hours. The working hours of cultural mediators are scheduled by a coordinator. In case of urgency, a mediator is sent on-site within 3-4 hours; if greater speed is required, telephone interpretation is provided on the spot. In addition, two social workers have fixed office hours twice a month at CSFS, supporting UDMs with services beyond health care.

Table 2: Staff composition and services provided by CSFS and Caritas in Reggio Emilia

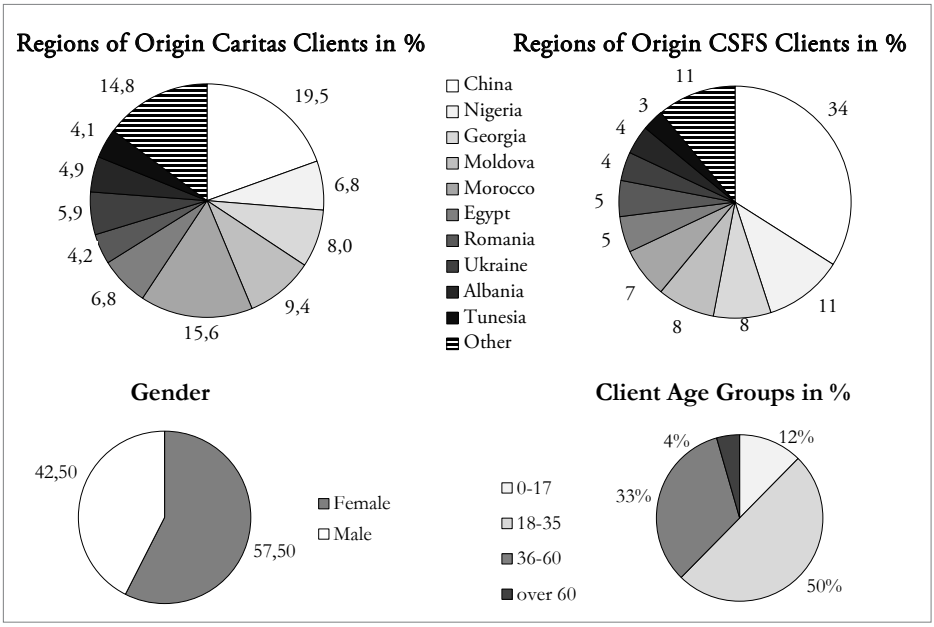
Aspects/Service Provider/	Center for Health of Foreign Families	Caritas Ambulatorio Querce di Mamre
Staff	54 employees (23 full time equivalents)	65 volunteers
Professions covered	6 general practitioners 12 nurses 3 paediatricians 2 gynaecologists 7 obstetricians 2 medical specialists 2 social workers 2 administrative staff members 6 cultural mediators, on-site on a regular basis (China, Algeria, Ukraine, Albania, Morocco and Tunisia) 4 external mediators, available on call (Pakistan, India, Ghana and Nigeria)	20 general practitioners 1 dentist 8 gynaecologists 15 nurses (incl. one head nurse) 2 intercultural mediators (Arab and Chinese) 6 administrative staff members 11 specialists (covering Neurology, Urology, Cardiology, Ophthalmology, Orthopaedics, Ear-nose and throat specialist, Dermatology) 2 IT specialists for the computer system
Services offered	Preventive care Vaccinations Screenings Infectious disease control Health promotion and education Advocacy Counselling Social support Medical care General care Paediatric care Woman and child care	Counselling Psychological and social support Medical care General care Dental care (primary dental care only) Woman and child care Surgical services Neurology Urology Cardiology Ophthalmology Orthopaedics Ear-nose and throat specialist Dermatology

Also in the Caritas clinic, the mediators play a crucial role in the treatment of UDMs. As a result, Caritas increased the opening hours for consultations in 2010. It is the first contact with the patient which is of utmost importance for confidence building. This is why new patients talk to the mediators first, before they see a doctor. Problems can be alleviated somewhat through mediators, thereby reducing the probability of a rejection of treatments by the migrants.

The mediators navigate UDMs through the health care system, starting with basic information, e. g., explaining that the health care system in Italy is free of charge to those who do not have sufficient financial resources. This is unusual for many migrants, especially Arab patients, who are not used to such a supportive health care system. According to one of the

gynaecologists, a mediator is important because he/she understands the patient, not only in terms of the language, but also in terms of the role sickness plays in the various cultures.

Graph 2: Client statistics of Reggio Emilia



As in the previous examples, staff members are under severe strain when working with undocumented migrants. Furthermore, staff members are challenged by the unclear definition of medical treatment open to UDMs. The latter may access health care in "urgent" or "essential" cases only, but what does this mean? While leaving a lot of room for interpretation, it puts a lot of responsibility on the shoulders of medical staff.

Lessons to Be Learned from the Services in Reggio Emilia

There are five factors which can be considered as success factors for this model of cooperation:

1. Administrative framework (STP code)
2. Collaboration between players
3. Pro-active use of uncertainty and clear position against denunciation
4. Staff competencies
5. Mediation as a precondition.

Ad 1) The STP code allows the provision of quality health care to irregular migrants. It is anonymous and consists of an STP number, as well as an ISTAT code for the Italian National Statistics Institute. The ISTAT code provides information about the public health authority that first issued it, as well as the public health services which offered treatment. It allows the identification of the patient's health care needs and the tracking of service providers. Therefore, proper and sustainable treatment can be assured, even if the patient moves to a

different region. Moreover, the code is used for accounting procedures, for compensation purposes and for the prescription of pharmaceutical drugs.

Ad 2) The wide range of services for undocumented migrants is ensured by the official cooperation between CSFS and Ambulatorio Caritas. The collaboration is stable due to its formal institutionalisation. The common computer system facilitates joined processes. The NGOs cooperate with the local public hospital and with public health services, as they run programmes for specific target groups which are prominent amongst UDMs, e. g., TBC patients, drug addicts, HIV patients. This intensive collaboration guarantees a high quality of health care for this special group of clients, while at the same time ensuring public health.

Ad 3) Medical definitions of urgency and emergency leave room for discretionary decisions about the scope of medical treatment. There are also no clear definitions of "urgent" and essential" care. This means that the care specialist in the service can determine the gamut of care services accessible to UDMs. CSFS is using this grey area to full capacity. "If we have to adhere to narrow definitions, we can do nothing. But if we may interpret the letter of law, we can do a lot". Accordingly, CSFS subsumes under "essential care" every health problem which has the potential to lead to major health problems if not attended to.

Ad 4) Multi-professional teams (doctors, nurses, midwives, social workers and mediators) collaborate on equal terms. The staff members are characterised by their international orientation; often they have a migrant background themselves or have gained work experiences abroad. From these international experiences flows a certain cultural sensitivity which is essential for adequate service provision to UDMs.

Ad 5) The presence of intercultural mediators on-site is considered a crucial part of treatment, particularly for the initiation of medical treatment and health care. The mediators are well-trained and experienced.

An additional observation at the site visit was that rooms for admission, treatment and consultation were identifiable via a colour code. Thus, illiterate patients can orientate themselves. Information posted on the walls is written in different languages. Thus, clients with low command of the Italian language can get all relevant information at a glance.

Malteser Migranten Medizin in Germany

We leave Italy and cross the Alps on our journey through Nowhereland, and arrive in Berlin, the booming capital of Germany. Germany is known in the literature for its "strict migration control and rejection of regularisation schemes" (Cyrus & Kovacheva, 2010, p. 125). Nonetheless, UDMs do not necessarily fare worse here than in other EU-MS, as our visit to Malteser Migranten Medizin (MMM)[6] proves. This NGO is part of the larger order of Malta, an organisation proud of its traditional hospitality, which dates back to the 11th century (Haentjes-Börgers, 2010, p. 339).

Context

In contrast to the countries visited so far during our journey across Nowhereland, Germany is a country which has had declining net inflows of migrants since 2003, a consequence of the end of the inflow of "Spätaussiedler", persons of German ancestry living in Central and Eastern Europe, Russia and Kazakhstan, who had the right to "return" to Germany. By

6 For more information, see http://www.malteser-migranten-medizin.de.

2008, net migration became slightly negative according to Eurostat. This is expected to be a short-lived phase, however, as inflows of migrants are picking up again in the wake of free mobility of labour in 2011 (Statistisches Bundesamt, 2011).

By 2009, 82 million people lived in Germany, of whom 7.2 million were foreign residents or 8.8 % of the total population. The proportion of first generation migrants, i. e., those born abroad, was even higher, at 11.6 %. The number of irregular migrants is heavily debated; estimates range between 500,000 and 1 million people (Cyrus & Kovacheva, 2010, p. 131) and thus conform to the estimated numbers of UDMs in Italy.

The right to access health services is more restrictive than in Italy, Spain or the Netherlands. UDMs have the right to health services in emergency cases, in cases of serious illness and pain, in cases of pregnancy, birth and postnatal care, as well as preventive medical tests, vaccinations, counselling and screening if infectious and sexually transmitted diseases including TB and HIV are concerned (Björngren-Cuadra, 2010 GE, p. 11; Mylius, 2011, p. 106).[7] While these access rights to health care do not differ much from the aforementioned countries, differences arise when it comes to the reimbursement of costs incurred by the hospital or other health care centres. In case the person does not have health insurance and no means to pay, the welfare service (Sozialamt) foots the bill. In order to do so, the hospital has to transmit personal data to the welfare service, providing evidence that the person was not covered by insurance and could not pay. The welfare service, in turn, has the obligation to pass the information about the irregular status of the migrant on to the immigration police (Aufenthaltsbehörde); deportation may be the consequence.

The obligation of employees in public administration to inform the migration authorities about cases of undocumented migrants de facto offsets the access right of UDMs to health services. Therefore, in order to ensure treatment, an order (Allgemeine Verwaltungsvorschrift) was put in force in 2009, allowing public sector employees, i. e., employees of the welfare service, to pay the expenses incurred without having to report personal data to the migration authorities (Mylius, 2011, p. 107). It remains to be seen how the welfare service will proceed with this new regulation. It is clear, however, that the obligation of cross-information between civil servants is of a prohibitive character not seen in the other countries analysed (Björngren-Cuadra, 2010 GE, p. 13; PICUM, 2010 GE, p. 5).

The absence of a health insurance card ("Krankenschein") is the major barrier of UDMs to access the health service (PICUM, 2010 GE, p. 8). As public sector cross-reporting on services received and reimbursed by the welfare office is an old tradition, the right to access health service, which is in principle allowed, can de facto not be assumed by UDMs in the regular mainstream health system.

This makes services like the Malteser Migranten Medizin so important, as it is the only way to get access to health services without being found out as an irregular migrant by the migration authorities.

Description of Malteser Migranten Medizin in Berlin

Founded in 2001 by the Catholic charity Malteser Germany, MMM is a non-profit organisation and charitable institution. Its mission is to provide health care for people without insurance coverage. MMM is exclusively funded by donations. Acquisition of donations is an ongoing process. Thus, according to the director, flexibility is essential when managing

7 The right to access health services is laid down in the migration legislation of 2005, in particular in the asylum law, which includes irregular migrants amongst the beneficiaries.

resources. Donations are either directed to Malteser Germany or specifically to MMM. Donations to MMM may also be dedicated to specific target groups (e. g., women and children) or to patients with specific health problems (e. g., cardiology patients).

The service of MMM is located in a residential area in the centre of Berlin, in a building adjoining a hospital. At the time of its foundation in 2001, MMM had a single room which served both as an office and examination room. Currently, MMM's facilities include three examination rooms, a general practitioner's (GP) office, a waiting room, and a reception office for the administrative staff.

The service is open three days a week and available on a drop-in basis. During office hours, one GP and at least one specialist are on-site. The following specialisations are offered by MMM:

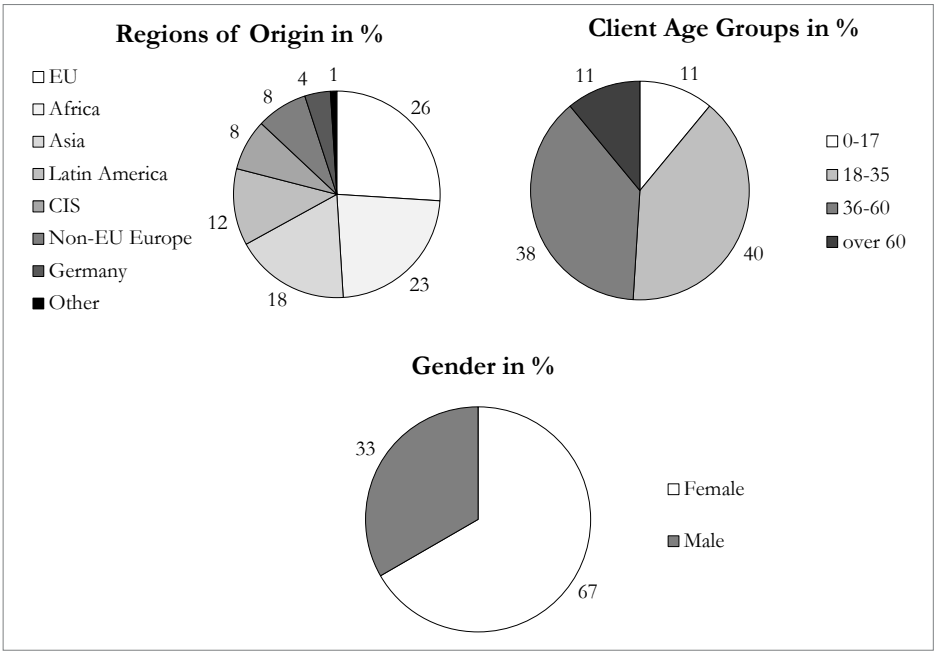
- General medicine
- Gynaecology
- Dentistry
- Paediatrics
- Orthopaedics
- Neurology
- Psychology
- Physical therapy.

MMM conducts basic diagnoses, treatment and follow-ups on-site. For further services (e. g., surgeries), patients are referred to network partners (doctors, hospitals, and diagnosis centres), thus ensuring a continuous and comprehensive treatment. Regarding maternity and child care, MMM accompanies women during the pregnancy and afterwards. The birth takes place at a collaborating hospital. Additionally, cooperation with legal counselling services has been established.

Treatments are generally free of charge. However, patients are asked for financial contributions for expensive treatments and medication. Contributions are voluntary and not specified. According to the medical director of MMM, most of the clientele wish to contribute and pay a little amount. Patients are not asked to cover minor costs such as blood tests; these costs are borne by MMM.

All in all, 16 people work at MMM on a regular basis. Most of them are volunteers, one staff member is employed part-time, and the director receives a financial allowance. There are no interpreters or cultural mediators working at the service. In case UDMs have no command of German, English, French or Spanish – these are the languages spoken by the staff members – they often bring relatives or friends as interpreters along. Sometimes, patients waiting for the check-up or medical examination help out with translations. In emergency situations, a telephone interpreter can be contacted; this is rarely necessary, according to the staff interviewed.

Graph 3: Client statistics Malteser Migranten Medizin Berlin



Patient data are collected and documented on a regular basis. They are not reported to the authorities, except data on pregnant women who gain entitlement to health care as a result of their pregnancy. Accordingly, MMM treated 5,600 patients in 2009 and the number of patients continues to rise. In 2010, 6,300 patients had already accessed the service until May. According to the director, most of MMM's patients are younger than the average clientele of regular GPs, as is usual for migrants. 88 % of patients are younger than 50.

According to the annual report of 2009, 69 % of the patients are without a valid residence permit, corresponding to about 3,900 undocumented migrants. Staff members assume that the undocumented migrant clientele know that no information is passed on to authorities. There is no standard written or verbal information about this practice, but the positive experiences of clients are spread across their communities by word-of-mouth. The increasing trust in the service of MMM shows up in increasingly correct self-identification when registering at the front desk. In this sense, the UDMs are giving up their hidden existences and coming to the fore with their real names, something nobody would have expected, as false names were the norm when the service started.

Lessons to Be Learned from the Malteser Migranten Medizin in Berlin

The Malteser Migranten Medizin is an answer of committed and courageous German citizens to a restrictive legal and administrative approach to the health needs of undocumented migrants. While the mainstream welfare system erects barriers to the provision of health services, the MMM opens a backdoor for UDMs. In principle, these services should be available, but de facto are not because, as described above, administrative procedures, which may bring about persecution by the migration authorities, may be the consequence. The single

most important aspects for the success of the services of MMM are the strict confidentiality and the funding of the service provision by one of the largest and independent NGOs in Germany. In addition, by focusing on the larger group of persons without health insurance coverage rather than the smaller group of UDMs, donations may continue to flow, as women or children in need of health care are regarded as the main target group.

The weakness of the model is, however, its complete outsider status relative to the mainstream health system. Thus, the official recognition of this health service as a need from a public health perspective, in addition to the need from a human rights perspective, is not given.

Indeed, Malteser Migranten Medizin should be seen as a parallel system, not as a complementary player in a larger picture of health service provision. As MMM is not integrated into the mainstream structure of health provision, it is also limited in its ability to prevent and cure irregular migrants in a sustainable fashion (see also Groß, 2009; Burkhard et al., 2010).

Caritas Marienambulanz Graz in Austria

For the last time we cross the Alps to end our journey through Nowhereland in Graz in Southern Austria, at the crossroads of the Balkans and the EU15.

Context

In contrast to Germany, Austria continues to be a country of immigration with an annual net inflow of 21,000 migrants in 2009 (Statistik Austria), although the public and political debate might obscure this reality. Austria' s migration history has seen many stages, moving from a foreign worker migration model to one of humanitarian intake, be it on the basis of family reunion or refugee inflows (Kraler & Hollomey, 2010, pp. 45-46). Presently, Austria is gaining in population, mainly as a result of free mobility within the EU. In 2009, out of a population of 8.4 million, 881,800 or 10.5 % were foreign citizens. If we take the foreign born into account as well, the share of migrants rises to 15.3 %, which is higher than in any other country considered so far (Statistik Austria).

As in all other countries, the precise number of undocumented migrants is hard to come by. Albert Kraler and Christina Hollomey describe "two contrasting trends: the decline of irregular entry and residence", on one hand, and the "growth of irregular employment", on the other hand (2010, pp. 49-50). In line with Michael Jandl (2009), they provide a range of undocumented migrants between 18,400 and 54,000 persons (ibid., p. 50).

As far as the access of undocumented migrants to health care is concerned, the situation in Austria does not differ much from the one in Germany, except that the situation is even more restrictive: there is a right to emergency care, but beyond that there is no access to any kind of primary or secondary health care (Björngren-Cuadra, 2010 AT, p. 10). Unless migrants are able to pay for treatment out of their own pocket, their only resort is the emergency wards or dedicated NGOs (PICUM, 2010 AT, p. 7).

One of these is the Marienambulanz in Graz, the second largest city of Austria and provincial capital of Styria, with a total population of 255,000 persons, and a share of 37,000 officially registered foreign residents.

Description of Caritas Marienambulanz

This service is situated in a central location, close to the main train station of Graz, in a facility where several low threshold services of Caritas Graz for marginalised groups are concentrated.

The Marienambulanz has one stationary and one mobile component; the first one is organised like a typical GP surgery, consisting of a waiting room, a registry and two examination rooms, plus a meeting and office room for the staff and a small storage room. Also the IT set-up is equal to a GP surgery, including a card reader for the health card issued by the Main Association of Austrian Social Security Organisations and software for client data and prescription management.

This service was started in 1996 by retired medical doctors and Caritas Graz, a Catholic charitable organisation and social service provider, as an informal service, which was then institutionalised in 1996 with proper medical facilities. From the very beginning, the target group was defined as uninsured persons, thus including both Austrian nationals, especially homeless persons, as well as refugees and other migrants, as the Balkan crisis provided for a constant influx in those years (Anderwald et al., 2009, p. 226).

The Marienambulanz is financed to a great extent by public funds; but only between 15 and 20 % of the budget are covered by private donations (Sprenger, 2009, p. 223). This calculation does not reflect the volunteer engagement of doctors, medical assistants and administration, which accounts for almost 2,000 hours of service in 2010 (Annual Report). Only the medical and administrative coordinator and the registry staff have tenured employment.

In its mission statement (Annual Report 2010), the Marienambulanz subscribes to a holistic medical approach, including cultural aspects of health and sickness, seeking not only to cure, but to prevent sickness and to empower her clients. Social reintegration and integration into the existing health system are explicit objectives of the service.

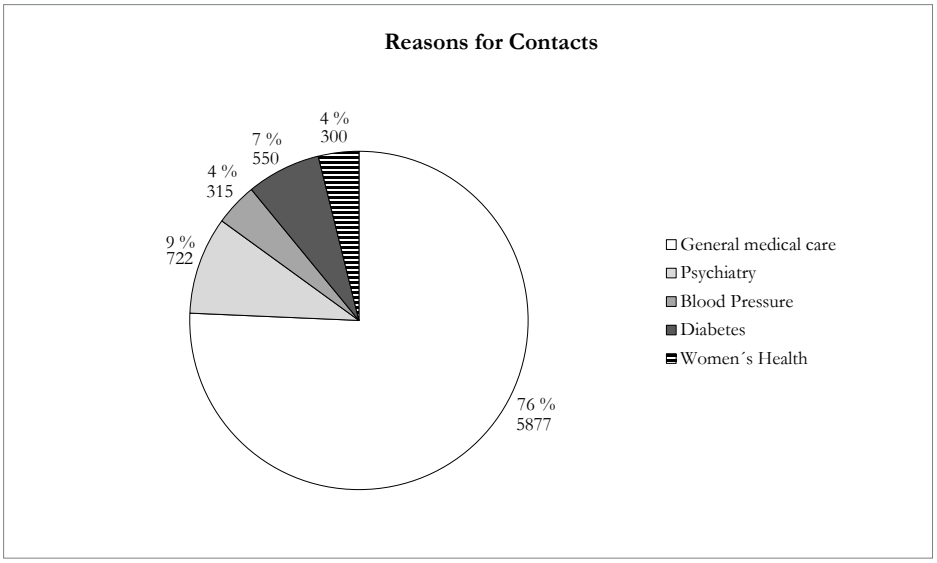
Within the stationary component, the Marienambulanz offers a large range of services to its clients on top of the general medical care, which is open five days a week for two hours:

- Psychiatry
- Diabetes
- Blood pressure
- Women's health
- Drug addiction
- Hepatitis
- Physiotherapy.

These services are available once a week; of equal importance are the accompanying services, which are delivered together with normal medical care. Counselling on various themes underlines the preventive character of the organisation to complement the curative activities.

Beyond that, the Marienambulanz is working in close partnership with AIDS Aid, a series of specialised doctors such as radiologists, hospitals both private and public, medical laboratories and pharmacies. If we look at the clients' statistics, we will find the following picture:

Graph 4: Medical statistics Marienambulanz 2010



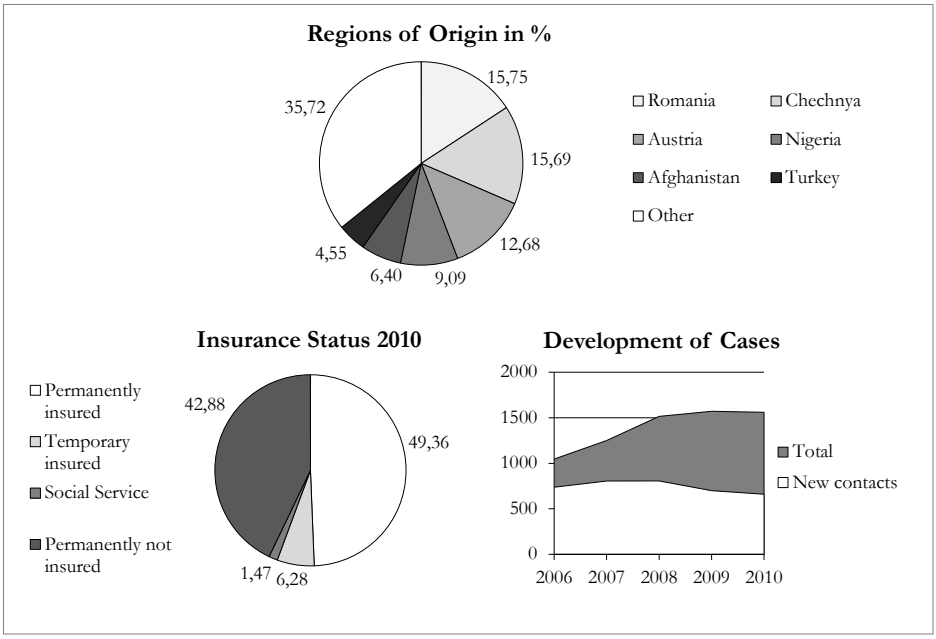
As we can see, the services of the psychiatrists are the most frequently taken up, even ahead of diabetes counselling, which is typical for a clientele which feels stressed and marginalised.

The mobile component of the Marienambulanz consists of a mini-van, staffed with a medical doctor plus an assistant, who tour the city once a week and station themselves at locations frequented by homeless people, be they nationals or migrants.

If we look further at the client data of the Marienambulanz (Annual Report 2010), we will discover that the age and gender composition does not differ much from earlier good practice examples. But if we look at nationalities and insurance status, we see distinct differences:

For once, the share of Austrian nationals is very high, with more than 12 %, and takes the third position amongst nationalities, behind Romanians and Chechens. The latter are typical representatives of recent migrant inflows: the first mainly in search of regular or irregular work, the latter in search of refuge from war, oppression and torture.

Graph 5: Client statistics Marienambulanz 2010



The really striking results of the client statistics of Marienambulanz are a fairly high proportion of clients who have social security coverage. More than half of the clients had some kind of insurance coverage in 2010, almost 50 % on a permanent basis. In addition almost two-thirds of the clients are "regulars", meaning that they are known and return to the service on a more or less regular basis, a ratio which has been built up over the past years, demonstrating a well-established relationship between the Marienambulanz and its staff, and the patients.

Lessons to Be Learned from the Caritas Marienambulanz Graz

If we look at the scope and results of the Marienambulanz run by Caritas Graz, we may note the following points which are also reflected in the final conclusions to this chapter:

a. Widening the scope from migrants to poverty in general
b. Keeping the threshold low
c. Shifting the focus from curative care to prevention and empowerment.

Although the Marienambulanz may present itself at first sight as just another example of a parallel structure for destitute undocumented migrants in a migrant-unfriendly environment as Malteser Migranten Medizin in the previous section, we discover a different approach when looking more closely.

The Caritas service then turns out to be a complementary service in a health system which is becoming too complex and over-providing for people living at the margins of society to access. As Johanna Muckenhuber et al. (2011, p. 3) points out, this phenomenon can be observed in other places like Canada as well, that non-financial barriers are even stronger than those imposed by the administration. In that sense, the Marienambulanz

has a bridge-building function in a health system "that gets more fragile, the more you get from the centre to its fringes", as the coordinator of Marienambulanz, Christine Anderwald, described in an interview.

Conclusions

We have finished our voyage through Europe or, as the project title suggests, through Nowhereland, where we visited typical and exemplary institutions which provide health care services to undocumented migrants. In the course of this journey, we found a variety of contexts, set-ups and approaches:

The contexts we might describe range between migration-friendly (Spain and Italy) and restrictive (Germany and Austria), with the Netherlands somewhere in between. This range takes the form not only of administrative regulations and laws, but is also a feature of the attitudes of the population.

The set-ups vary between public institutions (CSFS), private enterprises (GP surgery NN) and NPOs and/or NGOs (such as Salud y Familia, Malteser Migranten Medizin and Caritas in Reggio Emilia and Austria). Again we may differentiate between institutions financed by public funds, by private donations or a mix thereof. Another differentiation might be the composition of staff, be it with employees or volunteers or a combination of both.

Last but not least, we have seen different approaches, ranging from the Dutch model, where the GP is the gatekeeper to the health system, to complementary structures like in Spain and Italy (Salud y Familia and Marienambulanz) and to parallel systems like in Germany and Austria (CSFS and Caritas in Italy and MMM in Germany).

One would have assumed a priori that countries which are more tolerant towards irregular migrants would favour approaches to health care provision that are complementary to the mainstream system, while the more restrictive systems would produce parallel answers. This is more or less what we found in the good practice examples. Yet, Nowhereland is somewhat more complex, as we will try to show.

The lessons learned from our good practice examples share some common features which imply transferability into a minimum standards model of health provision for UDMs. Amongst them are:

a. Every health service provider needs collaboration with other actors in the health system.
b. Mutual trust and relationship with the clients lowers the threshold and eases access.
c. Staff attitude and mediation are vital for good relationships and curative results.

Ad a) Collaboration

All institutions were proud of their network of collaborating partners, mainly hospitals, but also other surgeries, laboratories and pharmacies, which enable them to guarantee an optimum of diagnostic and curative measures in the interest of their clients. And this will inevitably lead into the public sector, as hospitals normally belong to this sector.

Ad b) Establishing of mutual trust

It is of utmost importance to win the confidence of the clients. Confidentiality and granting of anonymity are paramount for that, not only in countries like Germany, where until recently an obligation to report undocumented migrants existed even for medical staff. PICUM (2010,

p. 6) research across Europe proved that fear of being reported and subsequent deportation are major hurdles for migrants across Europe, independent of the health system being more or less restrictive relative to services provision for undocumented migrants. This is valid for Spain and Germany, possibly the two countries positioned at each end of the spectrum.

Independence of public funding may be a factor inviting trust by the target group, as is the case with Caritas in Reggio Emilia and Malteser Migranten Medizin in Berlin, but this is not a precondition for trust, as other examples demonstrate; some of them are totally or partially funded by the government.

Ad c) Staff attitude and mediation

All service providers mentioned that the motivation of their staff, and especially of coordinators, was one of the recipes for success. The proportion of volunteer work may signal such intrinsic motivation to help. While this is a positive attribute, it is no precondition for success, as some of the examples show. However, a positive attitude towards migrants and other cultures facilitates the establishment of good relations. This can be achieved by regular employees in public or private institutions, as well as by NGOs.

Intercultural mediation or competences are important when the client and service provider do not have a common language, let alone a common understanding of health and illness. Therefore, language translation services and, even more important, mediation in the sense of translation of cultural differences are vital for a proper understanding of clients' problems and the identification of proper solutions in curative and preventive health care.

Another set of lessons is to be taken along, namely the proper positioning of the service provider within the mainstream system and the integration of the target group. Actually, all best practice models fulfil this function or rely on somebody else to bring in UDMs, as is the case between the GP surgery in the Netherlands and the NGOs Stichting Gast and Vluchtelingen & Nieuwkomers.

Go-betweens, who may lower the threshold of shame and help overcome fear of discrimination and persecution, are important in all societies.

Ursula Karl-Trummer (2009, pp. 114-115) describes three strategies of Austria to cope with the paradox of a situation where real people have real needs but are barred from basic human rights such as access to health services:

- Functional ignorance, where health staff ignore rules in order to act ethically correct
- Structural compensation, where NGOs replace public systems and are getting paid by the state in return
- Informal solidarity through volunteer work and donations.

This statement is made in relation to Austria, a country which is at the more restrictive end of the spectrum of policy stances. But when looking at the best practice models described above, we may recognise elements of these strategies in all of them. This is particularly true for those organisations where volunteers and donations are driving factors.

At the same time, we have hints on how to transform these strategies. Functional ignorance can be transformed into official recognition of the existence of undocumented migrants and acknowledgement of their contribution to work and productive output of the economy, such as is the case in Spain and Italy, where this target group has an official right to health care.

Compensation through NGOs can be transformed into the complementary approach, which is taken by Salud y Familia or Caritas Marienambulanz, serving as pathways into the system, rather than substituting for it.

There is probably no way to transform informal solidarity, and it may be debated whether this is desirable. On the other hand, all examples visited in the course of this journey proclaimed their approach to the clients as success factors, enhancing trust and building relationships. If we look at the traumatising conditions of the countries of origin and the living and working conditions of undocumented migrants in our societies, we may assume that solidarity is an essential bridge to reach the clients: now and here and nowhere else.

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Voices of Undocumented Migrants

The Voices of Undocumented Migrants

Friedrich Altenburg, Gudrun Biffl[1]

"I am afraid of being sent back. In China I would not find a job. The money here is not much, but in Yuan it is a lot. I have one child in Canada, but I can't afford the school, if I don't work. My husband is in China and takes care of the parents and in-laws, who are sick".
(Interview O3)

One aim of the project Nowhereland is to give voice to undocumented migrants, thereby giving the invisible a face and rendering their plight known to everybody. At the same time we provide valuable information for policy development, be it relative to health service provision, labour market reform or human rights issues. It is precisely in those hidden communities where we risk implementing misguided policies for want of adequate knowledge and information. We are, therefore, most grateful to those UDMs who were courageous enough to tell us about their experiences. In so doing, they contribute to the improvement in health protection of one of the neediest groups of migrants.

As the health condition cannot be isolated from the human being, we listen to the process of migration, the experiences en route, as well as the conditions upon arrival and thereafter in the host country, their living and working conditions and the strategies to protect and restore their health. We see how interdependent these factors are and we learn about the way health systems in Europe function and how one goes about health service provision for undocumented migrants.

Methodology

Giving a voice to undocumented migrants was one of the top priorities of the project, and yet the team of researchers across Europe had to find out that the migrants themselves were by no means eager to raise their voices and to make themselves heard. Researchers were often confronted with refusal for any type of recorded interview for fear of being traced either by the police or by relatives in the country of origin. The author of this chapter was even denied to take a picture of young men from Sub-Saharan Africa in the wild camps of Palos de la Frontera in Spain, as they were afraid that their families might find them on the internet and see their desperate living conditions. As we go on, we will come back to the issue of invisibility and the reasons therefore.

ILO researchers were confronted with the same reluctance of irregular migrants to cooperate or share their experiences, as one saw in them representatives of a system which marginalised and even criminalised them (Andrees et al., 2008, p.: 299); the researchers were, therefore, seen as potentially threatening to the safety of an already most unsafe existence.

1 This chapter draws heavily on work done by PICUM. For details, see the Nowhereland website.

Another barrier lies in the nature of globalised migration itself, as many migrants hardly speak the languages of the countries they go to; accordingly, research has to rely not only on translations, but on third persons to conduct the interviews. The interviewers have to know the respective language of origin and also share the respective culture or at least have convincing understanding and the concomitant behaviour patterns to invite trust. Identifying persons with these characteristics and skills, who are also trained in the methodology of interviews, proved to be another challenge.

Bearing these hurdles in mind, we used three sources of data for this chapter:

a. Interviews with migrants, undertaken in the course of the Nowhereland study

b. Interviews with professionals in the health services interacting directly with migrants, also conducted within the framework of Nowhereland

c. Scientific literature research, particularly where interviews with either side of the issue have been conducted.

Ad a) Interviews of undocumented migrants
Despite of the difficulties mentioned above, the project team managed to conduct a series of interviews with undocumented migrants in Italy through the services of the Centre for Health of Foreign Family (CSFS).[2] The questions related to the contact with the service provider, the frequency and reasons for consultations, working and living conditions and self-assessment of health status, as well as strategies to preserve the latter.

We herewith thank Laryssa, Mohamed, Nadja, Noela, Ophelia, Rabha, Shuyen and Silvana for conducting the interviews, and Ottokar Biffl and Manfred Steinkellner for translating and transcribing them from Chinese, Oyuna Lygdypova from Russian and Ukrainian, Hamza Ben Amor from Arabic and Albana Muhaj from Albanian. Without them, these stories could not be told.

Table 1: List of interviews with UDMs in Italy

Language	Country of Origin	Female	Male	Total
Albanian	Albania	3	1	4
Arabic	Algeria		1	1
	Egypt		2	2
	Morocco	1	3	4
	Syria		1	1
	Not specified	1	2	3
Chinese	China	5	3	8
English	Nigeria	4		4
Russian	Russia	2		2
	Ukraine	2		2
Total		18	13	31

2 For more information see http://www.nowhereland.info/index.php?h_id=9&i_state=health_view&i_ca_id=416.

The availability of appropriate cultural mediators and the presence of a great diversity of undocumented migrants from many continents were decisive for choosing this catchment area in Italy to select the cases for study. In agreement with services visited in the course of the project, interviews with undocumented migrants were conducted by the intercultural mediators of CSFS. This method was chosen to ensure a trusting relationship between interviewer and interviewee and to make use of the respective mother tongues. A standardised questionnaire, containing 23 questions, was developed by the research team and used by the mediators to conduct the interviews with UDMs. The interviews were all carried out in the different mother tongues and tape-recorded.

Ad b) Interviews of health service professionals

In order to give voice to the provider side of health services, interviews were undertaken with representatives of organisations which are in constant contact with UDMs, resulting in 17 country reports, which are accessible on the project website.[3] The 17 countries were chosen in order to get a representative picture of a cross section of EU15 and EU8 member states, as can be seen in Table 1. The contact details of the organisations were collected by the members of the project team from their respective networks, thus getting a sample of 80 organisations which are regularly engaged in work with UDMs.

Table 2: PICUM interviews per country and type of organisation

Country	Organisations	Health Care	Mediation	Information	Advocacy	Counselling	Legal Advice
Austria	7	6	2	2	1	3	1
Belgium	7	2	4				1
Czech Republic	3		3	3		3	
France	5	2		1			2
Germany	5	3	2	5		5	
Greece	2	2					
Hungary	3	1			1	1	
Ireland	4	2	2	4	2		
Italy	9	7	1		1		
Lithuania	2	0				2	
Malta	4	1	1		1	1	
Netherlands	7	0	3	4	4		
Portugal	3	2	3	3		3	
Slovenia	3	1				1	1
Spain	8	4	5		3		
Sweden	4	4		4	4		
UK	4	3	3		4		
Total	80	40	29	26	21	19	5

3 The country reports can be found at http://www.nowhereland.info/?i_ca_id=389.

The reports are based on structured confidential phone interviews with social workers, doctors, medical coordinators and advocacy officers working for non- governmental or local organisations that provide health care for undocumented migrants or facilitate the access of undocumented migrants to the mainstream health care system. The data collected reflect the experiences and opinions of the interviewees; they are the main source of information for the country reports. Additionally, some desk research was conducted in order to collect background information on the health care system in each country.

This research was conducted by PICUM, the Platform for International Cooperation on Undocumented Migrants.[4] PICUM is a network of primarily grassroot NGOs providing assistance to undocumented migrants in Europe and beyond. PICUM works at European and international policy levels to promote respect for undocumented migrants and ensure their human rights.

The questionnaire was designed to serve the following objectives:

- Collect information on current experiences and strategies of undocumented migrants by addressing experts of advocacy and immigrant organisations
- Determine the magnitude of the problem of insufficient access to health care for UDMs
- Identify specific health care needs of undocumented migrants
- Identify health care problems of undocumented migrants
- Identify strategies of undocumented migrants in dealing with their exclusion
- Identify strategies of undocumented migrants in dealing with their health care needs
- Identify the quality and adequacy of health care accessible for UDMs.

Ad c) Literature review
Although there is substantial literature on the combined topic of migration and health, the specific issue of the health situation of undocumented migrants is by no means thoroughly researched, certainly not in Europe.

There are some good research examples which look either at particular origin groups of UDMs or at particular regions in the EU, e.g., Ackermann et al. (2006), who analyse the situation of temporarily accepted migrants and sans-papiers in Geneva and Zurich, based on interviews with migrants from Latin America, Europe and Africa. Their research results are very similar to those of our project. We will draw on these and similar studies to compare and cross-check our analyses from the research performed in Nowhereland.

Defining and Positioning of Health

In the light of international research results on the combined topics of health and migration, we take a close look at migrants, the value they attach to their health, and how they assess their own health situation. As far as the definition of "health" is concerned, we will follow the guidelines of the World Health Organisation (1946) and describe health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". This definition necessitates abstaining from a mere deficit orientation of health, where one looks at morbidity and mortality rates, on the one hand, and at the narrow issues of health

4 For more information please see http://picum.org/en.

services provision and access to those services, on the other. Instead, we take the whole living and working situation of undocumented migrants into account. We attempt not to look at migration as a burden or problem and at migrants as victims, but we do want to focus on their specific problems, as well as the costs involved in the health system (Eichler, 2008, p. 9). Migrants themselves perceive good health not as their highest priority, except where good health is a precondition for their employability, as the PICUM reports (2010) on interviews with health professionals highlight. Priorities for the UDMs are similar in all EU-MS with some differences in the rank order, e.g., in the case of Spain (PICUM Spain, p. 6) it is:

- getting the proper papers, respectively documents
- finding work
- sending money back home.

While in the case of Austria, it is (PICUM Austria, p. 6):

- to survive
- to avoid detection
- to find work
- to find accommodation.

In the case of Sweden, it was made explicit by a health services professional, who said that health is considered only important to the extent that it ensures the capacity to work (PICUM Sweden, p. 6):

> *"Integration and earning money are higher goods, for which health is sacrificed – Whereas others [in our culture/society] sacrifice everything for health".* (FA1)

The priorities coming out of our research correspond with results in the literature (e.g., Huschke, 2011, p. 161). The relatively low priority given to one's health is also underlined by strategies of survival, such as selling their medication in order to buy food (PICUM Belgium, p. 6). An undocumented migrant from the Middle East describes this behaviour pattern as follows:

> *"Sometimes I see my cousins and they give me money for my drugs, which cost about 54 EUR. Often I give this money to my brother so that he can buy something for his children. Then I do not buy the drugs".* (RA 2)

When asked to evaluate their own health status, undocumented migrants in the interviews conducted in Italy rated themselves on the average with Good (3), given the range between Excellent (1) and Poor (5). And in line with the priorities described above, they rather gave room and spoke about problems with their living and working conditions rather than health as such. While these are their priorities, PICUM points out that living and working conditions have the biggest impact on health, together with the access to services and the fear of deportation. This comes across in the interviews with health professionals conducted by (PICUM Summary, p. 3).

Another aspect in that context are remittances; they are a sign of success and remind us of the transnational character of irregular migration, being in most cases a form of migration in the first generation, where the link with the family in the home country is still strong. A decline of remittances tends to be a phenomenon of second generation migrants who are slowly losing contacts and ties with their source communities (Lucassen, 2006, p. 32; Six-Hohenbalken, 2009, p. 239).

Living Conditions

The living conditions depend on many factors, one of them being shelter. According to Mareike Tolsdorf (2006, pp. 60-64), the preferred type of accommodation of undocumented migrants amongst the wide spectrum of housing options are the following:

1. Accommodation provided in charitable institutions
2. Accommodation provided by employer
3. Cession of a flat
4. Sub-rent arrangements
5. Mass accommodations
6. Buildings designated for demolishing
7. Emergency shelters.

The worst situation is homelessness; it also affects people in the host society, not only undocumented migrants (Schoibl et al., 2009). In our research we met migrants in their various phases of irregularity and in different housing situations, covering the whole spectrum of types of accommodation identified above by Tolsdorf. Accordingly, we cannot generalise about the housing situation of undocumented migrants. On the high end of the spectrum, we can identify situations, which UDMs find totally acceptable:

> *"Ok. I live in the factory. Everybody has his own room, everybody cleans his own room; there is heating. We are 30 persons and produce cloth. I am satisfied with my living environment, it is better than compared to China" [where he lives in a small village with demanding climate and hygiene conditions].* (OP1)

> *"It's ok. I live in the house where I babysit".* (SH3)

The two cases above have their accommodation provided for by their (irregular) employers. This is ok from a hygienic point of view, but has its drawbacks, as the interviews showed. Living in the household as caretaker/babysitter/servant may have certain advantages, but isolation and almost exclusive dependence on the employer goes hand-in-hand with such a situation. This is conceived as a problem by the undocumented migrants, as is confirmed by various cases. It is also an issue in the literature: as one loses contact and ties with other members of the community, one becomes alienated and uprooted, which can lead to depressions (McKay, 2009, p. 15). In our research, this is a situation which above all affects female migrants in irregular employment.

Another form of living along the continuum of possibilities is linked to a rapid turnover of jobs as the undocumented migrants move from one employer to the next, never having the chance to settle down. Accordingly:

> *"The worst situation is if many persons sleep in one room and there is only a curtain between. Many people snore or grind their teeth or fart. Then you cannot rest or sleep well".* (OP3)

> *"The house is old. In winter it is cold, in summer it is hot. The landlady could do something and everything would be in order".* (LA2)

But for some, these problems sound like luxury:

> *"Not good, presently I have no flat; I am living in a tent".* (RA1)

So it is not surprising that almost 42 % of the interviewees stated that their living conditions had a negative impact on their health. High blood pressure and headache (LA1), lack of recreation and sleeping problems (OP3, LA1), distress due to the suffering of family (RA1), frequent sicknesses (SH2), even chickenpox (OP4) are attributed to their living situation by the migrants themselves.

This confirms the hypothesis that the working conditions, together with housing and living conditions, are the most important factors determining the health of migrants (Eichler, 2008, p. 18). They are basic characteristics of undocumented migrants which contribute to their vulnerability (Streich, 2009, p. 302). Vulnerability is a core concept when talking about migrants. Homeless migrants are amongst the most vulnerable groups in our society, as the PICUM country reports for Belgium, the Netherlands and Sweden show; given their circumstances, it can be assumed that this observation is valid across all EU-MS and Europe at large.

Living conditions and work are closely intertwined, particularly if the accommodation is provided by the employer; in such a situation, a vicious cycle may be put in motion when the health situation deteriorates and the employer wants to get rid of the worker-tenant:

> *"If you work illegally, then you don't get everything that you should get. Often they reduce us, and that is also the case with accommodation. If you are late with the rent, then you have problems right away".* (RA3)

This is the reason why we put a focus on the working conditions of undocumented migrants, as they are one of the most important determinants for their health.

The Work Situation

It is one of the research results of the EU-funded project on Undocumented Workers Transitions[5] that economic growth in Europe, which was very dynamic until the financial crisis hit in 2008, has acted as a major pull factor for irregular migration, as it went hand-in-hand with a long tradition, on average across the EU, of large informal sector work (McKay et al., 2009, p. 49). The country reports for Austria, Bulgaria, Denmark, Italy, Spain and the

5 For more information refer to: http://www.undocumentedmigrants.eu/.

UK indicate that informal work is a common feature of the labour market in all regions of Europe, even though they may take up work in different occupations and industries and attract people from different source countries. Carmen Gonzalez-Enriquez (2010, p. 247) points out that informal work does not carry a negative connotation in Spain. On the one hand, the population has a positive attitude and approach towards it and, on the other, the provision of social rights is also ensured, at least to a certain extent.

According to Aparicio et al. (2008, p. 253), the chance of getting a better income than in the country of origin is an important incentive for undocumented migrants, and a reason for holding on to a stay in a country of transit, as one hopes to reach better shores from there (Diederich, 2009, p. 130). And this motivation on the part of migrants fits well into the demand for cheap labour in host countries, particularly in labour-intensive, low-wage industries and occupations (Andrees et al., 2008, p. 300; Aparicio, 2008, p. 254). The most prominent amongst them are:

- Food processing and packaging
- Construction
- Cleaning services
- Retail sale
- Sex work
- Hotel and restaurant services
- Household services
- Health and care services.

At least before the crisis, chances of finding a job in the informal sector were good, according to McKay (2010, p. 33). He reports that almost all undocumented migrants could find irregular employment in Spain; in Italy the informal sector is part of the social organisation of work and adds 17.7 % annually to GDP.

Francesco Fasani (2010, p. 169) provides an additional reason for the attraction of migrant workers, particularly women, to join the ranks of irregular migrants in Europe, namely the inefficient and insufficient provision of affordable, good quality care services by the market. As a result, there is a demand for domestic services and caretakers, helping women working in the formal labour market with their household work.

Accordingly, irregular female migrants tend to be concentrated in domestic service jobs (McKay et al., 2009, p. 57). These jobs are characterised by the difficulty of separating work from private life, by a great dependence on the employer, and by a tendency of exclusion from normal social life.

Even though the prospect for income drives migrants into irregular jobs, the lack of control over working conditions in this labour segment allows various breaches of conduct, such that these jobs may not be called 'decent'.[6] Andrees (2008, p. 303) and her fellow researchers identify the following employment practices as common to the informal sector: "Hiring and firing, sexual harassment, discrimination …, substandard occupational safety and health, no holidays, lower wages". Also the Undocumented Worker Transitions Report provides evidence of these employment practices, but adds that they have a negative impact on health. As the legal status of a migrant has implications for access to health services, citizens of EU-MS have better access to facilities than citizens of third countries. The latter

6 For more on the decent work agenda of the ILO, see: http://www.ilo.org/global/about-the-ilo/decent-work-agenda/lang--en/index.htm.

are facing even greater health risks in case of accidents and ill health than undocumented workers from areas in the European Economic Area (McKay, 2010, p. 50).

If we look at the interview sample from undocumented migrants in Reggio Emilia, an industrial area in Northern Italy, we find these statements confirmed. Italy receives many irregular migrants, on the one hand, due to its geographical position close to the Balkans and the Maghreb, having the Mediterranean as a an open gate, which is hard to police; on the other hand, the long history of informal work is a fertile ground for migrants. Informal sector work is part and parcel of a dual labour market in Italy where insiders know how to protect their jobs and outsiders are living in increasingly precarious conditions (Fasani, 2010, p. 169; Leonardi, 2008; Marzano, 2004).

> *"It is a crisis time now. We only work a little".* (SI2)

This is how an undocumented migrant characterises his life during the financial crisis. He is in this situation, together with 45 % of the undocumented migrants interviewed. They say that they are working, one-third of them are only casual labourers, on and off the job, without permanent income. Those without any work complain that it is hard to find work, especially without proper documents.

Not dissimilar to the general labour market behaviour, female migrants have a lower employment rate than men. Only 38 % of the women interviewed were in some kind of work. Textile industries provide most of the jobs, followed by domestic services, often only as casual helpers for babysitting and casual work. Sex work is also an option, but nobody wants to talk about that.

Working conditions are bad, especially in textile manufacturing, as described by a Chinese national, insinuating that it may even be worse than that.

> *"I get very tired from working. I don't work so long, but because I am sick, I don't have any strength left. I tailor clothes about 13 to 14 hours per day. It is not too stressful, because it does not matter if you do a lot or little, there is no quota of clothes per day. The payment is not good".* (OP2)

> *"I work too long: 16-17 hours per day. Sometimes 18 hours. The situation is better than in Padova; they work more than 20 hours there. The question of satisfaction is not valid for me. Many work for little payment (20 EUR per day). You cannot do anything, and it is not easy that you cannot speak the language and understand anything". (OP3)*

The experience of having no rights is seen by an undocumented migrant from Egypt as an invitation to exploitation:

> *"At the beginning I had many problems, when I did not have papers and the others abused us, because we have no rights. Sometimes we had even to work overtime and that had a mental effect".* (RA3)

Christine Ackerman (2006, p. 114) and her colleagues arrived at similar conclusions in their interviews. All interview partners reported of experiences with abuses at the worksite, of long and exploitative working hours and of a lack of adherence to regulations on pay.

PICUM adds another aspect, namely that working arrangements may be such that they are not conducive to taking regular medication or attending regular medical check-ups and appointments. Accordingly, migrants are often unable to follow a proper diet, which is particularly important for people with diabetes, or necessary hygiene requirements. Time spent recuperating from illness often means a loss of income; therefore, many undocumented migrants do not allow themselves the time they would need to recover or are not given sufficient time for recovery by the employer. In addition, the low priority given to one's health, together with the limited access to health care, mean that illness and diseases may not be diagnosed and treated in their early stages. For fear of losing the job or of being found out, undocumented migrants often postpone going to the doctor such that they often reach a critical health status when finally going to the doctor's for help. The interviews demonstrate to what extent undocumented migrants are vulnerable. Their undeclared work situation leaves them with no negotiating powers; a medical appointment may be taken as a sign of weakness by the employer and trigger off dismissal. This may not be surprising, as weak health may lead to marginalisation in the formal labour market as well and contributes to unemployment (Biffl, 2005).

In most EU-MS, work-related accidents were amongst the most frequent reasons for accessing health care services on the part of undocumented migrants. Working without a contract rarely involves protection against hazardous work, and safety regulations are usually not adhered to. This explains why undocumented migrants are faced with a high rate of work-related accidents that are not properly addressed. One example are harvesters who are not provided with gloves for work in the fields; this at times results in serious cuts and open wounds on hands; if those are left unattended, they may lead to grave infections.

More than half of the interviewees report about one or the other work-related accident or about bad working conditions which have a negative impact on their health. Amongst them are problems with the hips (OP2) and the back (NA3) due to long sitting and standing, mental problems (RA1), as well as problems with the eyesight (RA3). Even worse, though, is the loss of a job due to health problems:

> *"In earlier times I used to work, but since I got sick, I cannot work anymore and my health has deteriorated".* (RA1)

Women find it harder to find a job than men. Only 39 % of the interviewed women had some sort of a job, compared to 45% of women and men taken together. In comparison, the average employment rate of women in Italy was 46 % in 2009. The greatest job opportunities for irregular migrant women in the North of Italy were in factories, mostly SMEs (small and medium-sized enterprises), followed by unspecified work, often in the sex business, babysitting and domestic work.

Many of the women who were not working looked after their children or the children of relatives; they often stated that they could not work or that they did not want to work; this was particularly the case with women originating from an Arab country of North Africa or Asia Minor.

> *"My husband has no papers, and he does not work all the time. I am a Moroccan woman and I think that it is better for me to stay home and care for my family. My husband should work and I look after the children".* (NA4)

This quote shows that it is not always easy for undocumented migrant men to find a job and that women resent having to go to work, particularly if it is not the tradition in the source country. Having to perform the double task of looking after children and looking for a job or working outside the house represents a heavy burden for women and puts them under constant mental pressure:

"My difficulties? First, without documents, child, then everything". (SI1)

According to the interviews, work has the highest priority for Chinese migrants; it is more important than looking after children, as they frequently send them back to China at the age of five to six months, where the family clan tends to look after them. Also the rate of abortions is high amongst Chinese women; it peaked at the time of the economic crisis as women lost their jobs (Karl-Trummer/Handler, 2010, p. 17). Chinese tend to come to work in Europe in order to make money, often working in sweat shops organised by Chinese themselves. The money is sent back to China to support those left behind.[7]

Another source country of undocumented migrants is Nigeria. One woman described her work as "walking around" and "doing things I don't want to do" (NO2), referring to the taboo of sex work. Ursula Karl-Trummer and Agnes Handler (2010, p. 17) write in their report, which was based on interviews with cultural mediators in Reggio, that prostitution is frequently observed amongst migrant women, especially from Nigeria, and that violence, abuse and force are often observed in connection with sex work. Half of the Nigerian women report blood tests as the reason for their visit to the health centres, indicating very specific health risks linked to their job, be it venereal diseases, HIV or hepatitis.

We can thus sum up that working conditions of undocumented migrants are diverse. They may combine a variety of hardships and work stress, ranging from long working hours, work accidents and injuries to abuse and exploitation in sweat shops and in the sex industry. These working conditions are named and thus recognised by migrants themselves as unfavourable and detrimental to their health. However, they argue that they cannot do anything about that and feel powerless due to their vulnerable legal status. They see no chance for themselves to act, as they are individualised and unorganised and they see no powerful interest group acting on their behalf. They are grateful for the support they get from the various NGOs, but they do not see in them the institutions to provide them with the proper papers which would allow them to walk out of the shadows into the light and make them visible.

Health, Morbidity and Vulnerability

Migration is a demanding journey for the migrant, drawing on the physical and mental resources of all parties involved – the families and friends who stay at home, as well as the migrant who leaves. Good health is often a precondition for migration and, therefore, a focus of research. One stream of research focuses on the healthy migrant effect, namely the (self-) selection of the fittest and most courageous (Kohls, 2008; Kennedy et al., 2006). According to this literature, migrants are on average healthier than the average source as well as host populations. Another strand of research focuses on the health status of migrants after they have settled and worked in the host country. Depending on the type of work of migrants

7 More on the migration of Chinese to Europe in: http://www.zeit.de/2007/49/Euro-Chinesen.

relative to natives, their health situation may deteriorate rapidly such that it converges to the national average or even falls behind. Such is the situation of migrants on average in the United Kingdom (Jayaweera, 2011) and in many other European countries (Biffl, 2003).

The German Report on Migration and Health (Razum et al., 2008, p. 129) suggests that, on average, the health status of migrants does not differ much from the German population, even though the prevalence of one or the other disease differs. This judgement corresponds with the findings of the interviews conducted by PICUM in the course of the Nowhereland project when they write:

Although most organisations confirmed that undocumented migrants suffer from the same illnesses as the general population, it became evident that some health conditions are more prevalent with undocumented migrants either because of the lacking access to appropriate treatment or because the precarious living and working conditions make them more susceptible to those diseases.

Mareike Tolsdorf (2008) lists a series of stressors for migrants in general, some of which we have already referred to, which lead to very specific health care needs. Most important are:

- Separation and up-rooting
- Loss of close relations
- Identity problems
- Loss and diffusion of roles
- Adaptation efforts
- Higher job insecurity
- Feelings of intimidation and threat
- Critical living conditions.

For some groups of migrants, particularly refugees and irregular migrants in search of a better life, one has to add an additional hardship, namely the journey per se. Interviews with migrants stranded in Mellila (Diederich, 2009, pp. 127-128) inform about some of those ordeals, about broken families, abuse and exploitation en route leaving a long-lasting imprint on body and soul of those migrants.

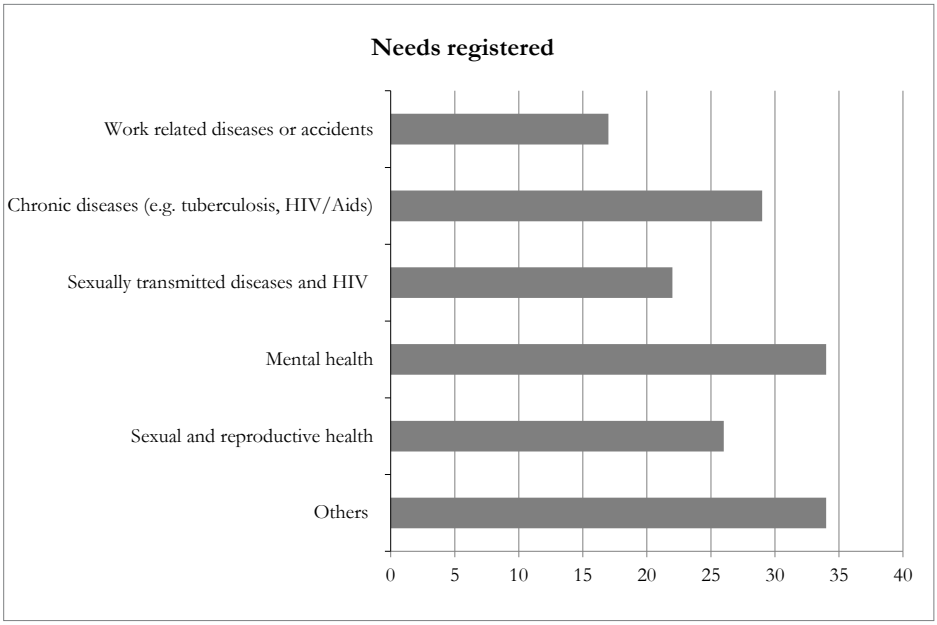
One example of the most frequent diagnoses of diseases has been provided by Marienambulanz Graz, a service for undocumented migrants and uninsured nationals in Styria, for 2008:

Table 3: List of diagnoses at Marienambulanz Graz 2008

Acute and Chronic Illnesses	Mental Health Problems
Chronic pain	Posttraumatic Stress Disorder
Acute infections	Depression
Infectious parasitosis	Adaptive disorder
Hypertonus	Addiction
Dental problems including caries	Psychoses
Diabetes	
Injuries	
Chronic gastritis	
Asthma bronchiale	
Pollinosis	

This information corresponds to data collected from other such institutions in the course of the project. Out of the lists of some 80 service providers in the various EU-MS, a database of health needs of undocumented migrants has been developed. The graph below shows the distribution of those needs across the EU.

Graph 1: Health needs of undocumented migrants[8]



The most important medical needs amongst the diverse group of 'others' are in the field of general medical care and dental medicine. Apart from these rather common features of health needs, mental health problems play a prominent role, much more so than in the general public. It is, as one of the experts put it, the single most dominant concern, a burning but hidden issue (PICUM Germany, p. 4). But also chronic diseases play an important role, as do sexually transmitted ones and work-related illness.

Mental Health

According to PICUM, mental health problems are most frequently emphasised as serious health concerns of undocumented migrants in almost all EU-MS. Undocumented migrants often suffer from depression, anxiety and sleeping problems which stem from the fears and uncertainties resulting from their undocumented status. Apart from the "normal" stressors of migrants listed above, war, conflict and torture in the countries of origin may be the source of traumata (PICUM Austria, Belgium); in addition, detention conditions (PICUM Greece and Malta) and forced marriage (PICUM Slovenia) can be the cause of mental problems of undocumented migrants. Children who were made to translate extreme life experiences of their parents have been identified as a special case of mental health problems in Austria

8 Based on the Nowhereland Database, on the internet at http://www.nowhereland.info/?i_ca_id=416.

(PICUM Austria). Mental health problems are taken to be the source of up to 80 % of somatic complaints, such as headache, digestive disorders, pain symptoms in the musculoskeletal system (FA1); this is how an undocumented migrant from Russia talked about her health problems, naming somatic complaints and not the deeper mental health problems:

> *"Yes, of course. Blood pressure is high, I cannot sleep, wake up often. That is why I have frequently headache".* (LA1)

Undocumented migrants are highly susceptible to the Chronic and Multiple Stress Syndrome, which is also referred to as the "Ulysses Syndrome" by some psychologists. This syndrome is an emerging health problem in our societies, manifesting itself in the current context of globalisation where the living conditions of a large number of immigrants are deteriorating dramatically. Undocumented migrants are under an even greater stress than regular migrants, a stress which goes beyond the typical acculturative stress.

Patients suffering from the "Ulysses Syndrome" may develop serious mental illnesses if their symptoms are not addressed adequately. Due to the many challenges in life, undocumented immigrants face a greater risk of illnesses such as alcoholism, and psychosis. Treating a psychotic migrant is extremely difficult in view of linguistic and cultural difficulties in communication and a lack of social support. All that said, preventive measures are essential for immigrants with the "Ulysses Syndrome". These would involve not only psychologists and psychiatrists, but also social workers to help migrants to achieve a secure and comfortable living environment. But reality often looks different:

> ***Lack of Maternal Care and Follow-Up (PICUM Netherlands, p. 7)***
>
> *A pregnant undocumented woman was sent by a general practitioner to the hospital for pregnancy-related tests. She was told that she has to pay 300 Euros in advance for the service. As she did not have the money, she went home without seeing a midwife. After intervention by an intermediary NGO, she managed to get an appointment at the hospital and receive an ultrasound. Her son Samuel was born three months later. Soon after the birth, Samuel became very ill. He was brought to the hospital's emergency room and admitted to the hospital for five days. Before being released from the hospital, the doctors said that he had a urinary tract infection and had to come back for two follow-up appointments: a check up and an ultrasound. When the mother came for the first appointment, she was again refused because of a previous unpaid bill. She was told at the reception that she had to pay that bill before seeing a doctor. Because she did not have money, the appointments were postponed. The mother did not go back to the hospital for the check-up or the ultrasound.*

Reproductive and Sexual Health of Women

Many undocumented women do not have access to adequate reproductive and sexual health care services. Prenatal care and childbirth are especially problematic, even in countries where this is available in theory; in practice many undocumented women are afraid to go to the doctor and postpone check-ups often as late as 6-8 months into the pregnancy.

In countries like Germany and Austria, undocumented women are not entitled to free prenatal care and childbirth, which puts the health of the mother and baby at serious risk. Childbirth is usually considered an emergency service and undocumented women will, in most cases, not be refused by the hospitals, but they may be issued a very high bill up to thousands of Euros depending on the number of hospital days and complications at birth after the procedure (Kentenich-Simo, 2009).

> ***A Case of Inappropriate Mental Health Care (PICUM Malta, p. 7)***
>
> *A severely traumatised and sexually abused asylum-seeking girl was suicidal and urgently needed therapy. An NGO working with migrants in detention decided to admit her to the mental health hospital because no other treatment alternatives were available. Since she was admitted from the detention centre, she was put in a special high security cell in the mental health hospital with a barred window to the corridor and no heating. She had no privacy and anyone could look at her 24 hours a day from the window, even when she had to go to the toilet and get dressed. There were concerns that she had been sexually harassed. These circumstances aggravated her condition, as these were mistaken mental health care measures.*

These incidents show that it is not easy for undocumented pregnant migrant women to get proper prenatal care and neither is care for their babies ensured. It should not surprise us therefore that 27 % of the women interviewed attended the clinic because of prenatal or postnatal examinations or to see the gynaecologist.

Undocumented women also have difficulties in accessing abortion. In Italy, for example, clinics are obliged to check the age of their patients before engaging in pregnancy termination procedures. As undocumented women do not have valid documents such as a passport which could prove their age, proper pregnancy termination procedures are not accessible in public hospitals. Accordingly, so the reports of Italy, undocumented women and girls under the age of 18 resort to precarious methods, such as taking certain medications which are not intended for abortion but, taken in large quantities, have that effect. One doctor in Italy confirmed that many undocumented women arrive in the hospitals with incomplete self-administered abortions and heavy bleeding.

Undocumented Children

Undocumented children are often not entitled to adequate health care services, as mentioned above, or they do not access these services, even if entitled. This is either for want of money or for lack of information of the parents. Inadequate health care has a serious impact on the development of children. Even in countries where undocumented children have sufficient entitlements for health care services, they do not receive preventive care, such as regular medical check-ups or vaccinations like other children; therefore, health problems are often detected too late.

Lack of health insurance coverage may also deter children from attending schools, as was a case in the Czech Republic where undocumented children were reported to be refused admission to schools. The reason given by the school administration was that in case of an accident on the school premises, the school would not be able to secure medical help for the child.

HIV/AIDS

"Whenever somebody is saying don't do it, you pass on the sickness to someone else". (NO2*)*

Prevention of HIV and care for AIDS patients are perceived by many service providers as one of the most prominent needs of undocumented migrants. This perception is supported by the database on health needs as shown in Graph 1, as well as by the findings of the PICUM interviews. Experts in the Netherlands, France and Austria state unanimously that there is a higher prevalence of chronic diseases like HIV/AIDS and tuberculosis amongst undocumented migrants than amongst the general public.

Even though HIV/AIDS is a problem, it is considered a taboo, particularly amongst migrants from Sub-Sahara Africa (PICUM Spain). They try to conceal their sickness, do not want to talk about it and often do not take their medication. Thus, treatment is endangered even in those countries where the health system provides it, e.g., in the Netherlands.

Other Vulnerabilities

In medicine, vulnerability is used to describe a susceptibility to certain illnesses (Streich, 2009, p. 302), whereas in the social sciences, vulnerability may refer to a certain risk of exposure to violence and abuse, circumstances mentioned above which impact on the living conditions of UDMs (ibid., p. 303). We have identified various groups amongst the undocumented migrants which are particularly vulnerable in the broader social sense, namely children, women, particularly pregnant women, single mothers with children, mental health patients and victims of trafficking.

The list may be extended by:

- Young UDMs working in the sex industry
- Victims of torture
- Single men (in Spain, isolated and not able to speak the language)
- Seasonal workers
- UDMs with addiction problems
- UDMs isolated from their community
- Chinese UDMs
- Persons accompanying sick persons.

While it is important to identify the vulnerability of undocumented migrants, one should not only focus on members of this group as victims, but also as actors in social and economic space. Waldemar Streich (2009, pp. 303-305) strongly argues in that vein and proposes to look at the fallacies of the system which bring about breaches in human rights, jeopardise living and working conditions of host country populations and raise public health risks. We therefore turn to UDMs and investigate to what extent they have developed strategies to improve their health situation and how they fare with the system of health care in the various EU-MS.

Strategies

In her analysis, Katja Eichler (2008, p. 30) differentiates between two patterns of health strategy: the one is a preventive strategy where a person tries to live a healthy lifestyle, thereby preventing illness or detecting illness at an early stage, the other is a behaviour in response to specific symptoms or illness.[9] The interviews of migrants have shown that a healthy behaviour does not have a high priority for undocumented migrants. At the same time, the interviewed migrants indicated that they are aware of their health being an important asset for survival, which led them to develop strategies to preserve their health. Almost one-third (29 %) of the interviewees engaged in sports to stay healthy and fit, some 14 % resorted to good nutrition, still 10 % tried not to work too hard and get enough rest to regain the strength needed for daily life.

> *"You simply have to do sports, smoke less and avoid drinking all together".* (NA2)
>
> *"Eat well, avoid contaminated food, stay in a clean environment".* (NO4)

Studies in Switzerland describe pro-active life strategies of 'sans-papiers' in order not to get into trouble, such as never going on public transport without a ticket (Ackermann et al., 2006, p. 89) to avoid detection of any kind. Similar strategies are described by two female interview partners from Nigeria:

> *"I am a woman. I try not to do rough things".* (NO2)
>
> *"I am not fighting. I am not looking for trouble".* (NO3)

The biggest resource of undocumented migrants is their respective community. They are important facilitators of entry into the host country; they help with accommodation, work and health care (Köhl, 2003, p. 146). The community in that context is not a narrow concept of members of the same ethnic or cultural group in the vicinity, but rather indicative of a social space across all countries transited from the source to the final host country. It is a truly transnational social space and community. These contacts provide support, appreciation and give meaning to life (Ackermann et al., 2006, p. 102).

Almost all of the interviewees declare that they have friends and relatives in the host country, "some with, some without registration" (OP4), and that they are very helpful:

> *"Every friend helps, all help, for example, when you lose a job, lose your accommodation, have financial problems …"* (OP1)

The community, be it back home or in the new country of residence, is the first source of help. They also help with heath problems, e.g., via telephone consultations with doctors in the country of origin (Ackernann et al., 2009, p. 150 c); also the supply of traditional or modern medication from 'home' is organised through relatives, as was reported by African (M'bayo, 2009, p. 171) and Latin-American migrants (Ackermann et al., 2009, p. 155; Huschke, 2011, p. 164).

9 For a detailed analysis in the context of public health, see Faltermaier & Wihofszky (2011).

If it comes to the community in the receiving country, it is the first source of information about the way things work in the country, about health care providers and how to avoid expenses for health care. All migrants interviewed named members of their community as a source of information and help, when asked how they got to know about the services of CSFS. The Nowhereland database also clearly points to word-of-mouth as the most important channel to reach the clientele of the health service providers.

But it is not only information that the community provides, but also assistance; it ranges from treatment by medical doctors, also those not recognised by the host country, as they may practice traditional medicine of the source country, to the borrowing of electronic medical chip-cards which may provide access to doctors in hospitals (Köhl, 2009, p. 152; M'bayo, 2009, p. 169).

The community often reaches its limits when wanting to help, as these voices from Morocco and China tell us:

> *"Nobody, because each of us needs help himself. Those who can, help the others, but this is rarely the case because we all have problems".* (RA1)

> *"The friends help. But because every Chinese has problems in Europe, you don't talk about every problem".* (OP4)

Indeed there are limitations to self-help within the community; especially when the situation is not good and the individual migration project turns out to be not as successful as envisaged. So when asked with whom one shares problems, one interview partner responds:

> *"With friends, sometimes with relatives. But I phone my husband very seldom in China".* (OP4)

Researchers observe a tendency to spare the family back home from bad news (Ackermann et al., 2006, pp. 106 and 155). Susan Huschke (2011, p. 162) also argues that fear of being denounced contributes to a certain discretion, even within the own community. Therefore, many turn to religion to find both strength and solace:

> *"Nobody. I resort to God".* (NO1)

> *"I tell [my problems] to my God. He is the only one who can help".* (RA2)

Christine Ackermann (2006, p. 91) and her fellow researchers describe this resorting to religion as a passively-enduring strategy which they often observe amongst their interview partners. In fact, the religious networks, such as church members and leaders such as pastors (NO3), may turn out to be just as important a pro-active resource as religion itself.

Total passivity has also been voiced, however: "I have no goals, just eating and sleeping" (RA1). This may not be regarded as a strategy, but rather an outcome of the system of migration, where refugees are "first deprived of self-assurance, then degraded to helpless children and victimised as patients of hospitals" (FA1), as one health professional stated. Addiction may follow, as in the case below:

> *"I take normal drugs first. If I don't feel comfortable, I come to this place".* (NO2)

This statement describes the tendency to solve problems very well; one first enters self-help strategies with the help of traditional medicine. After that, the pharmacy is the first station or step into the health system of the host country, which is also a typical sequence in the countries of origin of many migrants. Richard Laing (2001) reports that private spending on drugs, as a percentage of total spending, is equally high, if not higher, in developing countries like the Philippines and Senegal as in Denmark, Italy or the United Kingdom. If there are not enough means to purchase drugs, undocumented migrants may resort to left-overs of fellow migrants or use someone else's prescription (M'bayo, 2009, p. 169).

Only if all other attempts such as prevention during home visits, telephone consultations and doctors from within the own community fail (Ackermann et al., 2006, p. 150 c) will undocumented migrants turn to the official health system of the host country. This is particularly true for women, as Katja J. Eichler (2008, p. 159 c) discovered. She gives a vivid account of the experiences of migrants once they enter the health system in Nowhereland.

Undocumented Migrants' Experiences with the Health System

> *"I had the feeling of being safe, as if I was in a safe haven. … They gave me the feeling of being a daughter of this country. … I was never pushed nor looked down at. They took care of me and helped us and gave us the medication".* (RA2)

In the view of migrants, this quotation describes an ideal state which they themselves not often encounter. As it is, the above quote does not refer to a mainstream health service, but to an institution specialised in this vulnerable group of migrants. In general, the situation is far from this ideal indeed.

The obstacles when wanting to access health care are very similar in all of the countries studied, with only minor variations reflecting the legal entitlements and the presence and strength of civil society in addressing the health needs of undocumented migrants and mediating their access to the mainstream health care system.

Lack of Legal Entitlements

Lack of entitlements to access affordable health care services are the most evident obstacle. Without clear entitlements stipulated in law, it is very difficult for undocumented migrants to claim their fundamental right to health care. However, the research showed that even in countries where free access to all or some health care services for undocumented migrants is provided for by law, other factors may prevent them from accessing the health services.

Fear of Being Reported

In all countries, the fear of undocumented migrants that their irregular status is discovered and that they will be reported to the migration authorities while seeking medical help represents one of the most important factors for refraining from accessing health care. The fear of being reported exists, even if there is no legal obligation for the health practitioner or health service provider to report undocumented migrants. Whether the obligation of health care professionals and social workers to report undocumented migrants exists in law or not did not have an important influence on the feelings of mistrust and fear.

Reporting is not a routine procedure in any of the hospitals of the countries studied. There have been a few cases of reporting, but these have been either exceptional instances or a result of unintentional passing of information to the police. In some countries it is even prohibited to report undocumented migrants who access health care services; in most countries there is, however, no such general rule in place. In Germany as well as Lithuania there has been an obligation to report undocumented migrants. Recent changes in Germany led to a modification of this obligation to report back to the migration authorities, and the system has become somewhat less restrictive.[10]

In countries where there is no obligation of the health system to pass on information to the authorities, but also no explicit ban on reporting of such instances, other factors such as the cultural context on the migrant side and the education and awareness of medical personnel, knowledge about procedures, etc., on the health care side, play an important role. Informing the police or migration authorities about an undocumented migrant in medical facilities usually happens for two different reasons: Firstly, reporting may happen because of a lack of information regarding health care entitlements for undocumented migrants. Hospital staff may call the police for information about the undocumented patient in order to decide what kind of health care entitlements they are able to offer. The staff member contacting the police does not usually realise what consequences their actions may have. They usually do not want the police to come to the health care facility and to arrest and deport their patient, but they are not able to effectively foresee the possible consequences of their actions. The second reason for passing information about patients on to the authorities is a financial one, as the hospital wants to make sure that their expenses are taken care of by some sort of institution, the state or the health insurance fund. In the case that costs of the service will not be covered, a certain reluctance to help can be discerned.[11]

Costs of Health Care Services

The financial aspects of health care provision represent a serious obstacle for undocumented patients. In many countries all health care, in others health services beyond emergency treatment are available only against full payment by the undocumented patient, which, in practice, makes health care inaccessible for UDMs.

Doctors are most often willing to treat undocumented patients, but in order to proceed with treatment, approval from the board of the hospital is necessary. The hospital board grants treatment in those cases where the patient has no resources to pay if reimbursement from the health insurance system is available. In other cases the answer is not so obvious. Sometimes hospitals require advance payment from the patient before providing treatment, and if they are unable to pay, the hospital may refuse to provide help.

When being issued very high bills, undocumented migrants usually do try to pay the bill, but are mostly unable to do so. They are very concerned and are afraid that not paying the bill will have severe consequences for their chances to stay.

10 See PICUM, Undocumented Migrants' Health Needs and Strategies to Access Care in 17 EU countries, Country Report on Germany. Available online at http://files.nowhereland.info/709.pdf.

11 See PICUM, Undocumented Migrants' Health Needs and Strategies to Access Care in 17 EU countries, Country Report on Sweden. Available online at: http://files.nowhereland.info/720.pdf.

Difficulties in Paying for Health Care Services (PICUM Portugal, p. 6)

An undocumented person, who had come by boat to Spain and then to Portugal, had a serious infection in one leg. It got worse and he went for emergency care at the hospital and received medical assistance. A few weeks later he got a big bill at home. He was sick, but he tried to work overtime to pay the bill. His leg got more infected and he came to an NGO health care provider, who said he had to go back to the hospital. He refused to go, because it would have been too expensive and he had no money to pay, neither could he work anymore to pay a new bill.

Lack of Information

Apart from the major and often insurmountable obstacles mentioned above, there are other factors that hamper undocumented migrants' access to health care. Lack of information about their rights to access medical services in the host country is a very important hindrance. Lack of knowledge about entitlements and their rights in the health care system may lead to a situation where undocumented migrants do not access care even if entitled.

This lack of information is aggravated by the confrontation with a different culture, starting with the issue of languages and cultural habits and ending with administrative procedures which are foreign to many, for whom the concept of a chip-card or other procedures are alien and difficult to understand (Huschke, 2011, p. 161).

The lack of information rests not only with migrants, but also with health care providers and other staff at medical facilities. Their lack of knowledge about health care entitlements of irregular migrants may result in unnecessary passing on of information to the authorities and to denial of health care. Lack of knowledge about typical culturally nested behaviour patterns may also make communication difficult and at times offensive for either side.

Discriminatory Attitudes

Disrespectful and discriminatory attitudes of persons working in the mainstream health care system were also noted in the research as important reasons for undocumented migrants to avoid seeking health care. Patients without health insurance are often treated as a cost factor and are frequently turned away at the registration desk. In addition, undocumented migrants very often have difficulties communicating in the local language and hospital administrators lack patience and understanding necessary in such situations.

"They give you the most important things, but they do not examine you like if you had a chip-card", one of Susanne Huschke's (2011, p. 164) interview partners summarizes her experience.

In some countries, for example, the UK, NGOs have developed counselling services outside of the mainstream health care system targeting migrants subjected to violence. In other countries, counselling services are not available at all. For example, in Malta, where mental health care for undocumented migrants is only provided in a closed mental hospital, and the benefits of such a treatment were severely challenged by the interviewed organisations.

In many countries, access to mental health services, especially psychological counselling, is insufficient not only for undocumented migrants, but for everyone. Due to additional obstacles such as lack of entitlements and language barriers, undocumented migrants are, however, more affected by the lack of mental health services than the average citizen.

The following case epitomises the negative experiences undocumented migrants make with the systems in the host countries, particularly when taking their particular living conditions and biographical background into account.

Breach of Medical Ethics (PICUM Sweden, p. 5)

A family with four children from Kosovo was refused asylum in Sweden. The father had been involved with organised crime groups in Kosovo and they were worried that they would be killed if they returned there. The wife was repeatedly submitted to violence by her husband. She attempted suicide seven times. During the last attempt, she had tried to hang herself and she suffered brain damage. While she was unconscious in the hospital, her children were given in the custody of her husband, and the hospital's head doctor called the police and asked them to take her away because it was too expensive and complicated for the hospital to deal with her repeated suicide attempts. The police came to the hospital and arrested her after she had regained consciousness and deported her without her children to Kosovo.

Conclusions

The general conclusion that may be drawn from this research is that although the experience of undocumented migrants does depend to a large extent on the national legal framework, especially when it comes to funding the treatments, the personal experiences of migrants are diverse. They depend on the municipality where the migrant lives and the health care staff they came in contact with. It is not uncommon that two undocumented migrants, for example, in Italy have two very different experiences in terms of accessibility and appropriateness of care, depending on the region in which they access care. It is very important to have a favourable national legal framework which the municipalities and health care providers can refer to, and it is equally important that health care providers are aware of the legal entitlements undocumented migrants have in regard to health care.

As a rule, undocumented migrants always receive emergency treatment and have access to emergency health care in all countries, usually on the grounds of a general obligation to save the life of a human being. However, emergency assistance is not free of charge in all countries; in some countries, the medical fees for emergency assistance may reach exorbitant rates which undocumented patients are unable to pay. The other issue around emergency care is the scope, which may differ significantly from one country to another. Emergency care usually covers severe pain, bleeding and accidents.

In all countries, it is more difficult to access non-urgent care and long drawn out treatment; the latter often depends on the good will of doctors. Secondary care is, in many of the countries studied, only available against full or partial payment. These barriers will inevitably lead to protraction, chronification and proliferation of diseases, as shown in our research and the research of others (Tolsdorf, 2008, p. 102).

In some countries, alternatives to the mainstream health care system exist and are well-organised, but in other countries they do not exist at all. For example, in Sweden and the Czech Republic undocumented migrants have the same lack of entitlements, but Sweden has

a strong civil society that is creating alternative services for undocumented migrants, while such services do not exist in the Czech Republic.

In many countries, a great deal of health care provided to undocumented migrants has been transferred to civil society, which operates through outreach clinics offering mainly primary health care services and gathering a network of volunteer specialist doctors who provide pro bono secondary care. Many of the NGOs felt it was important that civil society did not become an alternative structure of care for undocumented migrants, but efforts should be focused on seeking structural and long term solutions.

"No, I am only afraid of the future. My health". (NA3)

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Conclusions and Recommendations

Gudrun Biffl, Friedrich Altenburg

In our opening statement we began with the images of "boat people" who arrive at the Southern shores of Europe and "truck people" who arrive at the Eastern borders of the EU. We likened these events to the tip of an iceberg which shows only a glimpse of a great human tragedy – the passage of undocumented migrants into Europe. Using various methods, we tried to establish the size and shape of the invisible part of the iceberg below the water level. We also ventured into the various parts of the iceberg, entering with drills and hammers into its interior in order to discover the fabric and character of the unknown, and so to learn and understand how best to deal with it and avoid doing harm.

If we stay with the metaphor of the iceberg, we are drawn into thinking about the great disaster of the Titanic, the ship with the most modern technology and safety devices on board, which crashed into an iceberg and sank in less than three hours. Did they forget that the best technology cannot save a ship if it does not take into account the unknown and invisible parts of the ocean? This is what Wolfgang Gulis (2009) meant when he referred to the famous steam liner as a model of our society, with its layers, vertical and horizontal linkages and networks, and its vulnerability. This great ocean liner may be taken as an image of Europe that cannot shield itself and its society from the outside world. But should it want to shield itself? The outside world is challenging, but also enriching, and we have to learn how to adapt our societies to adequately respond to new challenges. In so doing, we would not only avoid crashing into an iceberg at some future time, but also establish our learning and development path. We have to make sure that those in the bow as well as those in the stern of the ship are not drowned, because some of them may be the very ones who could lead us into a prosperous and happy future. It is, therefore, in our own interest to ensure that they survive, so that we survive as a humane society.

In summarising the findings of this book, we would like to continue with images and metaphors as we turn from the description of the life of undocumented migrants, their aspirations and hopes, to the realities they encounter in Europe, be they migration law and policy, labour law and policy, social and health regulations and policy, and the options open to them to survive. We give access to health the highest priority in all these policy areas, as it does not only ensure life, but protects and promotes human dignity. Accordingly, to stay with the metaphor of the ship, this book aims to help steer clear of ramming into human rights; instead it seeks to help develop the means to allow irregular migrants to make the best of their skills and competencies for the better advancement of economies and the betterment of societies generally, as well as their own future lives.

In the first leg of journey of our book, Gudrun Biffl provides insight into the existing methods available to estimate the numbers of irregular migrants and to identify their composition in the various EU Member States. This is a very difficult exercise because irregular migrants are a most heterogeneous group both in terms of their origins and legal status. The majority of irregular migrants enter legally and later acquire irregular status by overstaying temporary residence and by ignoring conditions of work. However, migrants classified as undocumented also include foreigners with forged papers and false identities, asylum seekers

waiting for their applications for residence to be approved, and rejected asylum seekers granted exceptional leave to stay. Irregular migrants also include those who, due to changes in migration legislation and revised administrative procedures, suddenly lose their legal status. This is also well-established by Triandafyllidou (2010, p. 4)

After giving an overview of the range of direct, indirect and a combination of methods, Biffl presents the numbers of irregular migrants residing in the various EU-MS, based on the best scientifically established estimates. According to these figures, between 1.9 and 3.8 million irregular migrants resided in the EU27 in 2008, equalling the total population of some smaller EU Member States, e. g., Slovenia and each of the Baltic States.

These are not small numbers, but they are the big numbers some would like us to believe. This population has come to the various countries in many ways – through transnational migrant networks, through old colonial ties, and through strategic political partnerships. These are ties that cannot be cut without paying a high price in political, economic and social terms. **Recommendation**: Therefore, we have to cooperate with the source countries in order to find a solution acceptable to both the source and receiving countries, and which also tries to cut the life-line of the big smuggling business behind the scenes.

We have learned that undocumented migrants are part of a larger picture of migration in Europe, as certain Europe Member States continue to be some of the most attractive destinations in the world for migrants. Gudrun Biffl points out that almost 32 million foreigners live currently in the EU27, providing the seed bed for irregular migration. This situation is not exceptional, but rather a well-known phenomenon in other immigration countries, e. g., the United States of America. Indeed, migration may start out as regular and turn irregular if certain procedures are not adhered to, while, on the other hand, many irregular migrants are regularised in time. These are two faces of migration dynamics, but the major driving force behind migration, regular and irregular alike, is the quest for a better life, the search for decent work and access to health and education for themselves and their families.

The motivation to work and the opportunities the large informal economies in the various EU-MS offer are at the root of irregular migration flows. This is one outcome of research into irregular migration. We explore the interconnectedness of formal and informal sector work in Europe and clarify that it is not only the household sector or small firms at the margin of legality that offer informal work. Whoever believes that grossly underestimates the size of informal sector work and the role of undocumented migrants: The strawberry fields of Palos de la Frontera or the textile factories of Reggio Emilia may not only be described as small or medium-scale enterprises, but also as well-organised industrial businesses of no minor scale. The voices of Chinese migrants in the factories of Northern Italy are a striking testimony of that.

Nor may the individualised work in domestic services and – more apparent in public discourse – of nursing and care for elderly or handicapped persons be described as a singular event. These sectors of irregular work, employing undocumented migrants, are also substantial in size and represent a major contribution to national economic output. At the same time, they do the work that natives prefer not to do, allowing them to pursue regular work under decent working conditions in the formal labour market.

Apart from the (informal) labour market, the search for asylum is the second largest source of irregular migration. This is true in all immigration countries in Europe and in all migration models, the Nordic Model, the Colonial Model, the Foreign Worker Model and the Southern and Eastern European approaches to immigration, as Gudrun Biffl points out in this book. **Recommendation**: While it is not reasonable to expect that all asylum applications will be accepted, a more humane treatment of those rejected asylum seekers who cannot be expected to return and are given an exceptional leave to remain is called for. This implies temporary access to the formal labour market as well as access to social services, in particular, access to health care.

Currently, health services for irregular migrants are supplied by public health service providers as well as NGOs. The latter pay the health fees out of their subsidies or donations or depend on health service provision by volunteer workers, including medical personnel and social workers.

The list of source countries of undocumented migrants who are clients of health service providers registered with Nowhereland reads like the "Who's Who" of the focal points of world politics, conflict and poverty: Afghanistan, Bolivia, Chechnya, China, Egypt, Eritrea, Georgia, Iraq, Mali, Morocco, Pakistan, Sierra Leone, Somalia, Tunisia and Turkey, just to name, in alphabetical order, the most frequently registered countries.

These service providers confirm the information provided by research of PICUM (2010 AT, p. 5) that irregular migrants have above average incidents of mental health problems. War and torture are listed amongst the most frequent causes for mental health disorders of adults, surpassed only by events children have witnessed, including tragic cases where children have to speak on behalf of their parents and relate their traumatic experiences, stepping in when the words of their parents fail to communicate with doctors and therapists.

However, traumatic experiences and violence suffered by migrants in their journey across deserts, seas and "green borders" (Diederich, 2009, p. 127ff.), are not the only factors at the root of their mental health problems. The working and living conditions of undocumented migrants, once they arrived in Europe, are also to blame. Their working conditions, whether in sweat shops, households or in the sex industry, have a direct impact on the physical and mental well-being. This is not only widely established in the literature but also, and more directly, in the interviews of undocumented women and men from various countries, from Africa and the Near East, the Far East or Ukraine and Albania. Their life stories close the circle of events, from the source to the bitter end, often with a very bleak outlook for the future.

In differentiating between migration models, we take a comparative look at the map of Europe. We look at different institutions and traditions, political frameworks and norms, policies and outcomes. It is interesting to note that the migration models more or less coincide with the welfare state models, where we tend to distinguish between the Scandinavian, Anglo-Saxon, Continental European, Southern and Eastern European model.

It is helpful to differentiate between systems of social organisation like the welfare system and the migration system in order to uncover ways of including the population into a social safety net. One can also identify the social norms which determine behaviour patterns not deemed acceptable by the general public, thereby uncovering mechanisms of marginalisation and social exclusion. We discover that it does not make a difference if the health system is financed by taxes or by social insurance schemes for undocumented migrants to access health services. The health status of a population is, however, influenced by the welfare model. In this connection, Continental, Anglo-Saxon and many Nordic countries tend to have above

average health outcomes. The differences between and within countries, however, show that it is not possible to deduce good health from access to health services alone.

The overview provided by Carin Björngren-Cuadra in this book offers insight into the different legislative and administrative frameworks of EU-MS. While the landscape remains fragmented, there seems to be a trend towards greater inclusion of irregular migrants into the health system in countries with large numbers of immigrants, including irregular migrants and large shadow economies.

In another leg of the journey through Nowhereland we explore the services provided to undocumented migrants, taking a closer look at some institutions which are good practice examples and which may serve as role models. It is tempting to return to the image of the Titanic when reporting the findings of that part of the research. We may liken the different health systems of the various countries of Europe to big steam liners, each one facing an iceberg, not aware of the actual numbers of undocumented migrants hidden in the water, and, therefore, not being able to estimate the potential costs involved in offering adequate care. **Recommendation**: As we tend to obtain a fairly good idea of the numbers of irregular migrants through scientific estimation methods, and as we tend to become well-informed about the type of diseases and care needs of irregular migrants in the various Member States, countries will be able to calculate the average direct costs involved in providing adequate care to irregular migrants. We may then compare these estimates with the direct and indirect public health costs of not providing adequate care, which results, for example, in irregular migrants contracting infectious diseases or in a reduced ability to work and, therefore, reducing their contribution to economic output. These calculations may well turn out to offer powerful arguments in favour of adequate primary and secondary health care for irregular migrants, independently and apart from any human rights arguments and, thus, any moral perspective.

By taking a closer look at the individual countries, we may find different approaches to providing health care and different strategies in dealing with irregular migrants. We may describe the differences between countries in terms of rescue strategies – one being a pilot boat approach, another a rescue boat approach, and a third one as a fleet management approach: In the Dutch system, the General Practitioner has the role of a pilot boat, steering the clients through the health system, integrating irregular migrants into that system; but full coverage is not always available, as not all GPs have the necessary specialist skills, nor do they have the full trust of migrants. Migrant support institutions tend to be the go-betweens providing advice and additional support, particularly by social workers and cultural mediators.

The rescue boats approach is typical for Germany – parallel structures of health care provision for undocumented migrants have evolved, as public sector hospitals are at the interface of public sector administrative procedures, requiring the latter to report irregular migrants to the police authorities, on the one hand, while being bound by the Hippocratic oath to help people in need and not to report personal information received in the course of medical treatment, on the other. Italy also shares certain characteristics of the German rescue boat – trying to save people from drowning in troubled sea. It is indeed a courageous approach, demanding high personal commitment, especially from the volunteers engaged in this work, who deserve admiration and applause. At the same time, this approach is very risky, endangering many lives and leaving it to chance for people to be saved and survive, as happened to the passengers of the Titanic in 1912.

Another strategy which may be likened to a diversified fleet management, using different vessels specialised to meet the needs of their clients, can be found in Spain and Austria.

While it is easier for irregular migrants to access health services in Spain than in Austria, because it is possible in the former to obtain a temporary health card when registering in the community (empadronamiento), special outreach activities are necessary to complement the mainstream public health system. In that sense, institutions like Salud y Familia in Barcelona or Marienambulanz in Graz reach out and provide primary care and pave the way for special health care in large hospitals and emergency units. These are not parallel health providers, but bridges and facilitators. **Recommendation**: Such bridging systems are important intermediaries and should not only be available in large cities, but also in rural areas, which until today hardly have any facilities of that kind, neither in Spain, nor in Austria, nor Italy for that matter. These are also important outcomes of research by PICUM.

In keeping with the metaphor of the Titanic, to understand the functional mechanisms and the impact of the chosen strategy, we must not only take the physical and organisational logic of service provision into account, but also the communication rules and practices as well as the personnel running the system if we want to understand the functional mechanisms and the impact of the strategy. We use the famous example of the Titanic because communication failure played a crucial role in the disaster of 1912, as was shown by Ruedi Hogger (1997), who chose this example to document the need for evaluations.

Research by PICUM and Carin Björngren-Cuadra compare legal structures and regulations with everyday life in surgeries, hospitals and care centres. They uncover contradictory rules or diffuse legal requirements which put people at the interface with patients in difficult situations where they have to use their discretion, often not knowing if they remain within the legal frameworks. The increasing complexity of migration legislation, in combination with social security provisions, is responsible for often insurmountable administrative hurdles. In addition, the limited knowledge about cultural beliefs on health issues and limited proficiency in the language of the host country may present obstacles to accessing health services and receiving adequate treatment. We must also acknowledge the cultural insensitivity of some front-line health care providers, as well as straightforward discriminatory attitudes amongst medical staff, which is in stark contrast with the commitment and humanitarian approach of volunteers and health professionals in specialised welfare hospitals and care institutions.

Back to the case of the Titanic: We have to acknowledge that it is impossible to sight the iceberg if nobody sits in the lookout with binoculars, searching the horizons for obstacles. This may be fatal, just as it is difficult to offer health services without cultural mediators at the side, who can translate from Pashtu to German or Wolof to Spanish and additionally translate behaviour and communication patterns so that ailments can be properly addressed.

In the last section of the book we focus on the health situation of migrants, particularly of undocumented migrants. We draw attention to the fact that the health condition is crucially dependent upon the quality of life, and of working and housing conditions. They all feed on each other, the irregular and insecure residence status adding to anxiety and mental health problems. Two health aspects besides mental health problems and work accidents are particularly relevant and need to be attended to – the sexual and reproductive health of women and the health of unaccompanied children.

We have already given some attention to the exploitative character of work in the informal economy and the high proportion of irregular migrants in this sector of the economy. Apart from the high risk of accidents, we also note the consequences of extreme fatigue due to intense work with hardly any resting time. The latter tends to lead to depression.

These living and working conditions make treatment of patients suffering from chronic and/or infectious diseases difficult. Lack of continuous treatment or conditions inhibiting the regular intake of medication not only pose an individual health risk, but also represent a challenge for public health.

Of all the problems cited so far, the most burning issue is, however, the vulnerability and fate of pregnant undocumented women and of their newborn children. While women tend to receive help and medical support when giving birth, prenatal care is difficult to obtain. In addition, financial costs for treatment may be out of the reach of undocumented migrant women. This also applies to postnatal care of the newborn child.

On the other hand, we should not ignore the resources undocumented migrants have at their disposal, mainly their communities and their transnational migration peers, who show considerable solidarity beyond ethnic and cultural ties. While these communities offer a safety net, they may also keep the migrant from addressing humanitarian institutions in the host country, trusting their traditional medical treatment more than Western medicine.

Based on our research and our understanding of the living and working conditions of irregular migrants, on the one hand, and the institutional frameworks in Europe, on the other, we allow ourselves to offer recommendations for policy changes and for the implementation of measures conducive to promoting the access of undocumented migrants to health services, so that human suffering may be avoided, public health be promoted, and human dignity ensured.

Recommendations

We focus our recommendations on seven issues, which we found to be of particular importance in ensuring access to health services to undocumented migrants in Nowhereland. These topics are:

1. Awareness Raising
2. Labour Market Access
3. Inclusive Health System
4. NGO Support
5. Culturally Sensitive Health Personnel
6. Mental Health Problems
7. Diaspora Community Work.

1. Awareness Raising

The issue is not only to have somebody point out that there is an iceberg ahead, but also to help find and identify a safe passage in order to avoid collisions. Measures geared towards raising public awareness should have three focal points and directions towards:

- the general public and policymakers
- health personnel
- migrants themselves.

The general public and policymakers are interdependent, influencing each other and shaping the public discourse on migration in general and on “illegals” in particular.

As for the crew and the passengers on the Titanic: Clear information about the waters is essential. As migration takes place, it is necessary to inform the public about the reasons for migration, the concomitant legal frameworks and the possible incidents arising from irregular migration, and to do so without stigmatising and marginalising migrants. It is also important to refer to the advantages of immigration for economic growth and well-being and not only to the challenges and potential problems. The aim must be to widen the focus of discussion and to recognise the work ethic of irregular migrants.

Initiatives like "Pro Planet" of the REWE group, which investigate production conditions in the vegetable and fruit industry, thereby promote ecological and social sustainability aspects to ensure decent work, health and safety measures in a sensitive industry. This is what Gro Harlem Brundtland aims at in the opening statement of this book, where she looks to the preservation of human dignity by promoting health.

If we look at personnel in health service institutions, particularly in hospitals with their complex organisational structures, we recognise that there is a lot of work to be done to raise awareness of health care workers to the needs and entitlements of undocumented migrants. Educational training programmes are necessary to inform them about migrants, their human rights and their special needs. It is of particularly importance to bridge the cultural gap between the service providers and the migrants. The development of a joint Masters Degree in Migrant Health – CHANCE – by five European universities, including the Danube University Krems, is just one example of such educational programmes. It does not only address caregivers, but also administrators and managers.

Last but not least, it is necessary to raise awareness amongst the migrants themselves and their communities about the potential problems of migration. This entails providing information not only about their rights in relation to work and living conditions and access to health, but also about the legal constraints on them. Desirably, such information should be provided in the source countries prior to their departure in order to ensure their awareness about the barriers to work and the potential of being exploited and falling sick. This may give some of them second thoughts about embarking upon a dangerous journey to Nowhereland and being faced with disappointments on arrival.

2. Labour Market Access

We have learned about the strong link between migration and the labour market, good job prospects acting as a pull factor for immigration, even if it is only in the informal sector. We also drew attention to the large extent of exploitation in the informal sector, and the higher incidence of work accidents and occupational diseases. In addition, we drew attention to the downward pressure the informal sector has on formal sector employment, particularly on those at the lower end of the wage spectrum. We therefore suggest that social partners and governments rethink their policy stance on informal work and ensure that decent working conditions also apply in this sector of the economy, thereby reducing its cost advantage and thereby possibly assisting formal sector employment. This will be to the advantage of migrants as well as natives, and make an important contribution to the health status of underprivileged workers.

3. Inclusive Health System

Just as it is necessary to strive for a more inclusive labour market, it is also desirable to aim for universal coverage of the health system. A two-pronged approach is called for to combat socio-economic disadvantage, on the one hand, and to ensure access to adequate health care, both curative and preventive, on the other. We agree with all of the organisations interviewed by PICUM, which emphasised the need for health care services to be accessible to undocumented migrants, either through extending public health insurance to them or by creating a separate assistance fund, as in the case of France.

Excluding undocumented migrants from health care services endangers their lives and potentially also those around them in cases of communicable diseases. Including undocumented migrants in the mainstream public health insurance would result in the early diagnosis and treatment of illnesses, reducing the potential for acute or chronic health problems requiring expensive emergency treatment and posing a health risk to the wider community.

Access to health care has two aspects: the financial side and the health service delivery side. As far as the funding aspect is concerned, we point to France as an interesting example of reform, ensuring universal coverage for legal residents and implementing a special assistance scheme for irregular migrants. The latter is financed by earmarking tobacco tax revenue. The additional advantage of such a system is that irregular migrants are treated within the mainstream health system. While it may take some time for a migrant-sensitive treatment to be working well, it has the advantage, as against specialised services, of avoiding the appearance of segregation and social exclusion.

This example leads us to the second aspect, i. e., the process of health service delivery. As has been noted, the majority of undocumented migrants turn to the emergency wards of hospitals for treatment not only because anonymity is more likely to be safeguarded, but also because this is the standard access to health care in many countries of origin. We suggest, as in the case of the reform in Portugal, that health care should be brought closer to the migrant communities, e. g., via mobile care, thereby offering primary care and building trust in Western medicine. The Dutch provision is similar in the sense that it puts emphasis on primary care to be accessed by the General Practitioner, who acts as gatekeeper for any further specialty or emergency care where necessary. This approach is better, both in terms of budgetary costs and health outcomes.

Whatever steps are taken, it is important to safeguard the anonymity of vulnerable groups of persons. This means that there is a need to separate migration control from health care provision. Many interview partners emphasised that health policy should focus on the needs of persons and that immigration status should not take priority over health needs. In addition, medical personnel should not be burdened with migration control tasks such as asking for documents and checking the validity of a visa. Every patient should be treated confidentially and priority should be given to health considerations.

4. NGO Support

In the chapter on health services we have seen the prominent role of non-governmental, charitable, humanitarian or not-for-profit organisations in services provision to undocumented migrants. These services go beyond the traditional role of giving voice to vulnerable groups, as they actually perform health counselling, mediation and, to a large extent, also provision of health services proper.

When looking at good practice examples, we saw that NGOs are not only important institutions in countries where the mainstream system does not offer care for irregular migrants, but also in countries where universal coverage is prevalent. We referred to the first one as a parallel system and to the second one as a complementary system. Both of them contribute to the flexibility of the service provision and reduce barriers to access of health care to individuals who are anxious of being found out or simply embarrassed about their destitute circumstances. For NGOs to be part of a larger network of service providers including secondary care is certainly one aspect of quality, as we saw in the list of success factors of service providers.

We believe that these institutions are a great asset of any society. As long as the roles are well-defined and negotiated, the NGOs will be able to live up to their mandates and not become willing or unwilling agents of governments, taking on duties intended for those in public administration.

5. Culturally Sensitive Health Personnel

On the list of success factors of access to health care, intercultural mediators ranked third. In spite of that, cultural mediators are scarce, as PICUM pointed out; in addition, language barriers are a significant obstacle for certain groups of undocumented migrants and a hindrance for accessing health care. It has to be added that intercultural mediation goes far beyond the translation from one language into another. Antonio Chiarenza, member of the Nowehereland team, describes the challenges of this job in the following way: They have to

- recognise cultural codes in order to overcome barriers and to facilitate self-determination
- facilitate exchange in order to anticipate possible misunderstandings
- encourage dialectic interaction between people of different socio-cultural backgrounds
- support organisations which make services appropriate for migrant clients.

Looking at these tasks of an intercultural mediator, it becomes evident that such a job requires effective training to raise skills and competencies. Counselling and organisational development skills are needed – on top of language skills and intercultural experience.

Studies for Italy and Belgium (Petrei & Morariu, 2009) show that the deployment of intercultural mediators leads to an increase in quality and adds to the satisfaction of clients. Accordingly, our partner in Prato, a city in Tuscany known for its textile industry and Chinese workforce similar to our case study in Reggio Emilia, provides us with information on the further development of the scope of intercultural mediation:

> *"A reorganisation of the services that will make it possible to expedite administrative tasks through a simplification of procedures and administrative language and through staff training, leaving more leeway for contacts with migrants and for listening to their needs"* (Petrei & Morariu, 2009, p. 252).

This statement, in our minds, identifies the reforms needed and provides us with a vision about the future steps to take. At the same time, we agree with Antonio Chiarenza that the challenges ahead are significant because appropriate and recognised training programmes are rare and common quality standards have not yet been clearly defined. These are important milestones yet to be established, including a monitoring system to allow progress to be

evaluated. The current shortage of trained mediators results in health staff employing informal interpreters, such as family members, at times even children, which is neither good for the health of patients, nor for family relationships.

6. Mental Health Problems

The issue of mental health problems has been raised several times by researchers, by practitioners and – most importantly – by migrants themselves. Stress and trauma in the wake of violent experiences in many countries of origin, the passage to Europe and the living and working conditions for those in hiding contribute to this phenomenon.

We are, however, confronted with a paradox, namely a high prevalence of mental disorder and restrictive access to appropriate mental health care. All interviewed organisations reported a lack of adequate mental health services for undocumented migrants in their respective countries and communities. Outpatient counselling and psychotherapy should be made available to all migrants in need of mental health support to improve their quality of life and that of their families and communities.

In addition, health professionals should be sensitised to the prevalence of mental health problems amongst undocumented migrants. They should learn about the range of mental health problems encountered by undocumented migrants in order to avoid false diagnostics and treatment.

7. Diaspora Community Work

Undocumented migrants have informed us about the support they receive from their communities, including their families and immediate relatives, as well as fellow nationals and faith communities in the countries of current residence and the countries of origin. We have also learned from them that word-of-mouth is the most important channel of communication about the availability of health services.

Accordingly, these communities are amongst the first to be addressed to draw attention to their rights of access to services and to options open for regularisation. They are also the ones to be addressed if one wants to raise the health literacy and inform about the role of a healthy diet and exercise for their health.

Removing the Iceberg

By doing all the above, we may help to remove the "iceberg" in the way of the fleet of ships approaching Europe, thereby enlarging and enriching European communities and strengthening them for an increasingly globalised world.

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