

2017 Observatory Report

EUROPEAN
NETWORK
TO REDUCE
VULNERABILITIES
IN HEALTH

FALLING THROUGH THE CRACKS:

The Failure of Universal Healthcare
Coverage in Europe





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This report uses the term “EU/EEA migrants” to refer to citizens of European Single Market states – members of the European Union (EU) countries, the European Economic Area (EEA) and Switzerland – who are living in another EU or EEA country, or Switzerland. “Non-EU/EEA migrants” are those who are not citizens of EU or EEA countries, or Switzerland.



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EXECUTIVE SUMMARY

This European Observatory Report provides a snapshot of those who fall through the cracks in European healthcare systems, and calls upon stakeholders at global, European, and national level to achieve universal healthcare coverage as a priority.

Testimonies and data collected from 43,286 people attending programmes run by Doctors of the World/Médecins du Monde (MdM) and partner non-governmental organisations (NGOs) across Europe present a powerful and rare insight into those who cannot access healthcare services, how they are excluded, and their healthcare needs. They show what should be done to ensure everyone can access healthcare when they need it.

The global agenda is unequivocal. The World Health Organization (WHO) and United Nations (UN) urge all governments to provide universal coverage.¹⁻² Yet over half of the people surveyed told us they had no healthcare at all and almost one in five could only access care in an emergency.

People were often in desperate need of medical care. Some had acute and chronic conditions but had not been able to see a doctor, and over half of pregnant women were not accessing antenatal services. Many people said their psychological health was bad, and children had vaccination levels below recommended standards.

The programmes saw a wide range of people who were excluded from healthcare, nearly a quarter of which were children. Most were migrants from outside of the EU/EEA, with the largest number of people coming from Syria. The study also shows that nationals and EU/EEA migrants struggle to access European healthcare systems.

Many were living on the edge, in circumstances that have a detrimental impact on their health, wellbeing and access to healthcare. The overwhelming majority were living in poverty, and almost a quarter were street homeless or living in emergency shelters, camps, slums, squats, or hotels. Predictably, nearly two in five people told us they could not afford to pay for healthcare.

Social isolation was common. Over a third of people did not have someone they could always rely on to help them when needed, and half faced language barriers. It is not surprising that nearly a fifth were unable to navigate the bureaucracy to get the treatment they needed.

Many people were under incredible emotional strain. Some were fleeing war and conflict, other were escaping persecution because of their political opinions, religion, race/ethnicity, or sexual orientation. Nearly two thirds of patients were separated from their children (under 18 years) and half of people talked to us about their experiences of violence.

1. WHO. "Universal Health Coverage". Health systems, 2017 (accessed on September 22, 2017, www.who.int/healthsystems/universal_health_coverage/en/).

2. United Nations. "Sustainable Development Goal 3: Ensure Healthy Lives and Promote Well-Being For All at All Ages". Sustainable Development Knowledge Platform, 2017 (accessed on September 22, 2017, <https://sustainabledevelopment.un.org/sdgs>).

2016 IN FIGURES

WHO WE SAW

- 22.2% of people seen were children under 18 years (9,626/43,286), 8.3% were children under 5 years (3,578/43,286), and 2.3% were adults 70 years and over (988/43,286).
- 79.1% were non-EU/EEA migrants (34,227/43,286), 12.1% were nationals (5,227/43,286) and 7.5% were EU/EEA migrants (3,257/43,286).
- The highest proportion of migrants came from Syria, 13.0% (5,613/43,286), followed by 11.3% from Afghanistan (4,874/43,286).

VULNERABILITIES IN HEALTH AND HEALTH ACCESS

- The overwhelming majority of people, 89.0%, were living below the poverty threshold in the country they presented in (6,725/7,560).
- 23.8% (1,954/8,197) of people were living in precarious circumstances, this includes 11.9% (976/8,197) who were street homeless or living in emergency centres, 2.1% living in camps or slums (173/8,197), 1.7% in squats (141/8,197), and 7.1% in a charity, organisation or hotel (581/8,197). Higher levels of street homelessness were reported by EU/EEA migrants (26.7%).
- 38.9% reported the absence of a reliable social network (2,500/6,421) this included 12.0% (769/6,421) who reported that they did not have anyone to help, support or comfort them in their current town, or city.
- 61.7% (1,496/2,425) were separated from some or all their children aged under 18 (5.9%, 55.8% respectively).
- 56.2% of non-EU/EEA migrants talked about violence during their consultation (8,857/15,749).

When asked why they left their country of origin, 18.0% of responses from non-EU/EEA migrants reported discrimination due to their political opinion, religion, race/ethnicity, or sexual orientation (799/4,441). 14.1% of responses reported escaping war or conflict (628/4,441), and 5.6% reported escaping family conflicts (248/4,441).

49.7% had permission to reside in the country they were living in (4,882/9,832).

- 49.7%; of non-EU/EEA migrants with irregular immigration status limited their movements in public for fear of being arrested (684/1,377).

HEALTHCARE ACCESS

- The majority of people, 55.2%, reported having no healthcare coverage (5,582/10,120). A further 18.3% (1,847/10,120) had coverage for emergency care only.
- When asked about barriers to accessing healthcare, 18.9% of responses reported the person did not try to access healthcare services (1,734/9,184), 17.0% reported administrative barriers (1,558/9,184), 16.3% reported economic barriers (1,493/9,184) and 2.2% (205/9,184) of responses reported that they did not access healthcare services for fear of being arrested.

HEALTH CONDITIONS AND STATUS

- The most common chronic pathologies were cardiovascular (19.9%; 1,945/9,774), followed by musculoskeletal (13.2%; 1,293/9,774), digestive (12.2%; 1,191/9,774), endocrine, metabolic and nutritional (11.6%; 1,133/9,774), and psychological (10.0%; 975/9,774). Higher levels of chronic pathologies were observed in nationals (71.0%).
- The most common acute pathologies were respiratory (19.4%; 1,639/8,435) followed by digestive (16.0%; 1,347/8,435), musculoskeletal (13.5%; 1,137/8,435), and skin (13.4%; 1,128/8,435).
- The majority of pregnant women had not accessed antenatal care prior to visiting the programmes (58.4%; 215/368).
- 42.3% of acute pregnancy pathologies were reported by EU/EEA migrants (161/381).
- 14.9% said their psychological health was 'bad' (1,122/7,515) and 5.8% said they were 'very bad' (433/7,515). Nationals reported higher levels of 'very bad' psychological health at 11.2% (101/906).

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89%

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55.2%

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RECOMMENDATIONS

Everyone must have equitable access to healthcare coverage, regardless of their immigration status or economic resources.

To achieve universal coverage, healthcare services must be available, accessible, acceptable, and of adequate quality. This principle is in line with the UN International Covenant on Economic, Social and Cultural Rights of 1966 (ICESCR, 1966)³ and the ambitions of the UN Sustainable Development Goals (SDGs)⁴ and WHO.⁵

ON THE RIGHT TO HEALTH AND UNIVERSAL HEALTH COVERAGE

Member states must ensure universal healthcare coverage for everyone residing within their state, regardless of their immigration status.

To the EU institutions

- Promote the European Pillar of Social Rights⁶ by engaging in new legislative initiatives that ensure access to social protection in particular to “affordable, preventive, and curative healthcare of good quality” as proclaimed in the EU Commission recommendations.⁷

To national governments

- Implement international commitments to the “full realisation of the right to health for all” (UN International Covenant on Economic, Social and Cultural Rights of 1966)⁸ and the UN Convention on the Rights of the Child including the right to “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” including “appropriate pre-natal and postnatal healthcare for mothers”.⁹

- Commit resolutely to achieving universal healthcare coverage as per SDG 3 and WHO’s top priority.

- Adopt the recommendations made by the UN Committee on Economic, Social and Cultural Rights in its ‘Concluding Observations’ on their country.¹⁰

ON ACCESS TO HEALTHCARE

National public health policies should be progressive, equitable, evidence-based, and include accessible, affordable, and quality primary antenatal, and postnatal care, vaccines, medicines, and health promotion.

To the EU institutions

- Continue to fund member states cooperation and research into public health, health inequalities, and healthcare systems to enable European-wide solutions, informed by evidence, to assist policy making.

To national governments

- Take positive steps to end administrative barriers and discrimination within healthcare services, and to raise awareness of rights and entitlement amongst patients and healthcare workers. These steps could include information campaigns and training frontline staff.
- Develop outreach policies to increase coverage at community level in order to access excluded people, including cultural mediators within health services.
- Reinforce the first line of care with an integrated medical, social, and psychological approach.

ON SOCIAL PROTECTION AND ECONOMIC CONDITIONS

Better social protection and economic conditions are key to ending poverty, promote wellbeing and reduce inequalities.

To the EU institutions

- Promote the European Pillar of Social Rights by engaging in new legislative initiatives that ensure access to social protection. The EU Parliament should vote new directives aiming at asking the Member states to translate into national law the recommendations of the Communication COM (2017)¹¹ 2600 on the social pillar, especially the recommendation number 16 on health care “Everyone has the right to timely access to affordable, preventive and curative health care of good quality”.
- Propose an implementation and monitoring strategy involving all relevant agencies for the achievements of SDG 1, 10, and 11 by the EU member states.

To national governments

- Endorse and proclaim in the next European Social Summit the European Pillar of Social Rights especially social protection and inclusion.
- End reductions to social security benefits and provide a basic level of financial support to all to meet obligations under SDG 1 and 10 to end poverty in all its forms everywhere.
- Provide safe and adequate housing to all in order to meet obligations under SDG 11.
- Tackle social exclusion, discrimination, and inequalities through the provision of services and partnerships with NGOs and community organisations.

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ON REFUGEES AND MIGRANTS

The principle of universal and equitable health coverage should be applied to all persons residing de facto in a country, regardless of their legal status.

To the EU institutions

- The future reform of the Common European Asylum System¹² should make provision for the regularisation of seriously ill third country nationals and their protection from expulsion when effective access to adequate healthcare cannot be ensured in the country to which they are expelled.

To the Council of Europe

- Take a clear and renewed stance on the protection of medical confidentiality and the doctor-patient relationship confidentiality. Healthcare staff, services, and medical records must not be compromised by immigration policy objectives.

To the United Nations

- The Global Compact on Refugees¹³ and the Global Compact on Migration¹⁴ must both include universal access to healthcare in their principles, and contain commitments for UN member states to provide access to health coverage for refugees and migrants, and that the provision of public service including healthcare should not be limited as a deterrent for people to migrate or seek asylum.
- The Global Compact on Refugees and the Global Compact on Migration should both guide member states to engage in concrete action to create safe migration route free of violence and legal pathways to destination countries and make provision for each member state to ensure compliance to human rights standards when cooperating with third countries on return policies and asylum proceedings.

To national governments

- Engage in the implementation of the Commission Communication on the protection of children in migration of April 12 2017.¹⁵ Especially ensure that all children have timely access to healthcare and psychosocial support, and to strengthen child protection systems along the migratory routes, end unreliable, and intrusive medical age assessments.
- Establish a firewall between health, welfare and protection services, and immigration agencies. Reporting patients to immigration authorities by healthcare workers or social services should be explicitly prohibited, and this should be robustly enforced and clearly communicated to healthcare workers and patients.

ON EU/EEA CITIZENS

The principle of free movement and residence of EU citizens should be extended to a right to health.

To the EU institutions

- Engage in a new EU legal framework that will ensure access to healthcare for all EU/EEA migrants irrespective of their resident or social security status.
- Prioritise access to healthcare coverage for both EU citizens living in the UK and UK citizens living in Europe in Brexit negotiations.

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2017 OBSERVATORY REPORT

The annual Observatory Report is produced by the European Network to Reduce Vulnerabilities in Health, which brings together MdM programmes, partner NGOs and academics who seek to reduce EU-wide health inequalities. It is an observational study of people who are excluded from mainstream healthcare services.

The purpose of the report is to present data, analysed and validated by a leading epidemiologist, on people who are excluded from mainstream healthcare services, alongside testimonies and photos collected in programmes run by MdM and partner NGOs. It is aimed at policy makers at local, regional, national and EU level, providing them with the evidence base on reducing vulnerabilities in health and identifying ways that health systems could become more responsive and adapted. It is also valuable for academics to acquire greater understanding about how vulnerabilities contribute to health inequalities, and vice versa.

Since 2006, the seven observatory reports have seen a gradual expansion in the geographical coverage of the data collection, as well as in the focus – from irregular migrants to all patients who attended programmes run by MdM and partners. Previous reports are available at: www.mdmeuroblog.wordpress.com

This 2017 Observatory Report includes data, testimonies and photographs collected from thirteen programmes from January to December in 2016. The programmes are both medical and non-medical, collecting the social and medical data. There was a total of 110,277 medical and social consultations.

The report was produced in partnership with the Institute of Global Health, University College London. With over 160 staff and access to expertise of over 200 staff from across UCL, the Institute collaborates across disciplines to find solutions to global health problems with cross-disciplinary approach at the heart of its research and teaching.

STRUCTURE

This Observatory Report:

- provides a brief look at the political, policy and legal context whilst the data and testimonies were being collected;
- describes what we saw from the data relating to the demographics and country of origins;
- observes what vulnerabilities in health and healthcare access patients faced;
- records levels of healthcare coverage and barriers patients faced when accessing healthcare;
- describes the diagnosed health conditions and health status reported by patients;
- provides an overall discussion on the key findings; and
- presents recommendations to the relevant institutions, national governments, and organisations to improve access to healthcare for people facing multiple vulnerabilities in health.



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The MdM and partner programmes are diverse, and provide a range of medical and social services. Some are tailored to meet specific need, such as harm reduction programmes, others are open to anyone.
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PARTICIPATING PROGRAMMES

The MdM and partner programmes are diverse, and provide a range of medical and social services. Some are tailored to meet specific need, such as harm reduction programmes, others are open to anyone. Diversity is the Observatory Report's strength: it provides an insight into a broad range of excluded patients. All programmes provide free primary healthcare (unless specified), social support, and information services. Whilst all programmes collect data on a patient's social circumstances, only clinical programmes collect medical data.*

Belgium: The MdM programmes in Antwerp and Brussels provide dental care, psychological support, access to screening, family planning, and specialist clinics for women.

France: Three MdM clinics in Bordeaux, Nice, and Rouen provide medical consultations and referral to the mainstream healthcare system. The Nice clinic also provides psychiatric consultations.

Germany: The MdM programmes in Munich and Hamburg provide specialised paediatric, gynaecological, and psychiatric consultations, as well as legal advice. The Hamburg clinic is run in collaboration with a Hoffnungsorte, a support organisations for destitute people, and the Munich clinic provides legal advice in partnership with Café 104.

Greece: Six MdM clinics in Athens, Chania, Lesbos, Patras, Perama, and Thessaloniki provide vaccinations, antenatal care, and specialist consultations; in some clinics, there is also psychological support. The Lesbos programme exclusively addresses the refugee population and provides specific support for unaccompanied children and refugees.

Ireland: Migrant Rights Centre Ireland in Dublin offers a drop-in centre for migrants to learn about access to employment and labour law and for legal advice on immigration cases.

Luxembourg: Two MdM clinics in Esch-sur-Alzette, Luxembourg provide social and medical services to people without access to care.

The Netherlands: MdM Netherlands run programmes in Amsterdam and The Hague, including a mobile unit, which provide social support and referral to general practitioners and over the counter medication.

Norway: The Health Centre for Undocumented Migrants in Oslo is run by the foundation Church City Mission and the Norwegian Red Cross Oslo. The clinic provides primary care, dental services, mental health, and psychosocial support and activities.

Romania: Carusel, an NGO, run a programme designed to improve the quality of life for drug and alcohol users, sex workers, people who are street homeless, and those on a low income.

Slovenia: Slovene Philanthropy have been working in border camps since 2015, providing social services, medical consultations, and psychosocial support to those without health insurance.

Spain: MdM Spain provides social and referral services from their programmes in Alicante, Bilbao, Malaga, Sevilla, Tenerife, Valencia, and Zaragoza. These include health awareness campaigns and organise health promotion training, intercultural mediation between professionals, and programme users, peer education courses, rapid HIV testing, and HIV testing training for professionals working in public facilities.

Sweden: In addition to primary care, the MdM programme in Stockholm provides legal advice for European citizens and asylum seekers.

Switzerland: MdM Swiss have a programme in Canton of Neuchâtel and a newly opened clinic in La Chaux-de-Fonds. The new centre provides nurse-led consultations and social care advice for irregular migrants and asylum seekers during their first year in the country.

United Kingdom: The MdM London clinic provides primary care and assistance to register with a doctor (GP), as the entry point to mainstream primary and secondary healthcare. A specialist family clinic provides services to pregnant women and children.

*Note: the report does not include data from all individuals who accessed MdM and partners' programmes. See Limitations.

THE POLITICAL CONTEXT: HEALTH AND SOLIDARITY IN EUROPE

The experiences of our patients must be addressed within the context of a series of policy decisions that were the result of a lack of political will to achieve universal healthcare and a lack of desire to respect the right to healthcare, both at a national and European level.

The WHO Director-General has made universal healthcare coverage a priority: "It is ultimately a political choice. It is the responsibility of every country and national government to pursue it".¹⁶ But in 2016, universal access to health is experiencing significant declines in Europe, especially for people facing vulnerabilities.

The rise of populism appears to have resulted in a move away from a discourse of austerity in Europe.¹⁷ However, member states' restrictive accounting measures, particularly in the area of health, continue to weigh on vulnerable populations, including migrants.

In 2017, the European Commission recommended¹⁸ the health sector be reformed to reduce public deficits by ensuring cost-effectiveness and safeguarding fiscal sustainability. The main measures member states should be concerned with are: outpatient rather than inpatient care; improving governance; more primary healthcare and integrated care; and rationalisation of prescriptions. But these

relate to more budget cuts that actually increase health inequalities that can affect the needs of the most vulnerable such as staff reductions; health privatisation;¹⁹ reduced hospital stay; and reduced benefits.

In 2016 the Irish government dropped its commitment universal coverage,²⁰ made in a 2014 the Irish published a White Paper published by the Department of Health,²¹ as it was unaffordable.²² In 2012, Spain amended its health system, ending universal access despite the ongoing social, political, and regional government's opposition.²³ In 2017, the UK followed Germany²⁴ by implementing measures increasing the risk of irregular migrants being reported to the Immigration Office when they access healthcare.²⁵ Moreover, in Germany, a new law restricts access to social services for some EU citizens legally residing in Germany.²⁶

The approach to health in Europe is entering a critical phase. The Commission's White Paper on the Future of Europe,²⁷ attached more importance to concrete and attainable achievements and failed to include health as a human right and the essential condition of wellbeing and all human progress. The academic world recognises Europe's progress in health, whilst recalling the growing disparities on the continent and the need to increase cooperation and research as it has done in the areas of tobacco, food security,

and infectious diseases.²⁸ Likewise, citizens of the EU recognise health as a priority area²⁹ and civil society state it cannot result from the economic progress of a single market, but rather from a precondition. And as a result, whether chronic diseases, ageing populations, antimicrobial resistance, and excessive costs of innovative treatments, member states can no longer work alone.³⁰

In this context, the Commission's efforts to revitalise the social pillar of Europe, reflected in the Commission Communication of April 26 2017,³¹ marked a turning point for the health sector and the social responsibility of the EU for more than 220 million of its working citizens. It is therefore, within the framework of this social pillar of Europe that member states will further strengthen the field of health.

2016 was the deadliest year for migrants and asylum seekers who tried to cross the Mediterranean; 363,348 succeeded and 5,079 lost their lives.³² The migrant crisis continues to take its fatal toll on an entire population that has sought security or fled the social impasse into which its community is stuck. At the moment, when just celebrating its 60th anniversary, Europe is not fulfilling its promise of a more solidary continent. And if there is a crisis, it is indeed that of solidarity.³³

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33. Leroux, Luc. "Aide aux migrants: jugé en appel, Cédric Herrou estime «faire le travail de l'Etat»." *Police et justice*, June 19, 2017 (accessed on September 04, 2017, www.lemonde.fr/police-justice/article/2017/06/19/aide-aux-migrants-juge-en-appel-cedric-herrou-estime-faire-le-travail-de-l-etat_5147639_1653578.html).

It was a Europe in crisis that met the Malta summit in February 2017. Following the signing of an agreement with Libya from which 90.0% of the exiled candidates will leave for Italy (UNHCR, 2017) and 10 months after the Aegean Sea route was locked, the EU priority is still not to secure and make asylum accessible, but to support and train the Libyan coast guards,³⁴ to break the business model of traffickers and to strengthen the capacities of the host communities and the Libyan state. The day before, the UNHCR and the International Organization for Migration issued a communiqué stating that Libya was not a safe country.³⁵ For many human rights agencies, the rights of asylum and certain fundamental rights of migrants, inscribed in the EU Charter of Fundamental Rights, are flouted.³⁶⁻³⁷

One year after the “European Union-Turkey Deal”, Europe maintains a policy of delegating its responsibilities to so-called safe states, located in its periphery, which causes a part of its political class to react, including the UN Secretary-General’s special representative stating that: “protection cannot be outsourced”.³⁸ The stay in Libya for migrants is indeed torturous without legal remedies³⁹ in detention centres with conditions of precarious hygiene and where diseases and malnutrition prevail.⁴⁰

For Human Rights Watch, the host countries “have increased the deterrence with the hopes of keeping new arrivals from entering”.⁴¹ Europe is suspected of offering unsatisfactory reception conditions for those who have reached the countries of the EU, both in terms of protection and access to essential services most of the time in overcrowded camps.⁴² This is particularly the case in Italy and also in Greece, where authorities have just taken over the activities of NGOs in hotspots without achieving a higher level of services.⁴³ In this context, the lack of preparation for winter and the Lesbos incidents of 2016 are likely to be repeated,⁴⁴ especially as efforts to relocate asylum seekers – though is making significant progress – is still insufficient⁴⁵ and that some member states are opposed to it.⁴⁶

However, a wider consensus is emerging around the ‘migratory crisis’ where some have criticised its impact on development aid. Since the Valletta conference held in November 2015 and its action plan⁴⁷ to tackle “the root causes of migration”, the European Council has definitively endorsed the principle of aid against migration controls. Some see it as an additional political lever to revive the political momentum and maintain the financial support to the countries of the South.⁴⁸ Others are more critical⁴⁹ and perceive a diversion in the principles of aid whose main risk is the mismatch with the genuine needs and therefore, the lack of effectiveness and ownership of the target countries.⁵⁰

On September 19 2016, the New York Declaration was adopted at the Summit on Large Scale Movements of Refugees and Migrants. It requested the UN to engage with member states and other stakeholders to develop two Global Compacts, one on migration and another one on refugees, to be adopted in 2018.⁵¹

Let us hope that Europe has the political will to take a step towards health and solidarity to achieve universal healthcare coverage, and to respect the right to healthcare both at a national and European level.

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44. MdM Greece. “How Many People Have to Die Before We Stop Talking About ‘Random and Exceptional Incidents?’” Press release, February 10, 2017 (accessed on September 27, 2017, <http://mdmgreece.gr/en/many-people-die-stop-talking-random-exceptional-incidents/>).

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THE LEGAL CONTEXT: RECENT LEGISLATIVE CHANGES

The data and testimonies in this study were collected against a backdrop of legislative changes that largely restricted access to healthcare. This section covers recent developments in healthcare, social welfare, and migration legislation across Europe. For a comprehensive summary of the legal situation in European countries, see *MdM Legal Report*.⁵²

FRANCE

France has a third-party payment system, which is free at the point of use and was intended to be applicable to everyone covered by social health insurance before the end of 2017. In July 2017, the French Minister for Solidarity and Health stated that this provision would not be in effect until the end of 2017.

A new law states that the medical examination to determine age alone cannot be sufficient proof for the denial of protection.⁵³ The law on real equality for overseas French territories was adopted on February 2017, meaning complementary universal medical coverage will be in place in Mayotte by 2025.⁵⁴

GERMANY

A new law on access to social welfare, in effect since the beginning of 2017, reduces the rights of some EU citizens residing legally in Germany to access social services including healthcare. It applies to people coming from new EU member states, those who are unemployed, and those who do not have sufficient means to support themselves, or those acquiring permanent residence

through their children. The law applies for the first five years of their stay in Germany. For these people, healthcare is limited to acute conditions only, for up to one month (and only once within two years).

IRELAND

The Universal Health Insurance plan was abandoned by the government after it was deemed unaffordable. Free general practitioner (GP) care for children under 12 years was initially supposed to be introduced in October 2016, but has now been delayed.

ITALY

A new law for the protection of unaccompanied minors was adopted in March 2017. The law provides a better protection and reception system, which will be standardised at national level. It bans the deportation of children, sets a maximum period of detention in the reception centres of 30 days (instead of 60 days), and strengthens children's rights to access healthcare and education.⁵⁵

In July 2017, the government approved a decree making vaccination against measles and nine other diseases compulsory for children under the age of 17. Any vaccines included in the compulsory list should also be free.

The co-payment system (ticket sanitario) is currently under discussion at government and regional levels.⁵⁶

SWEDEN

A temporary law came into effect in July 2016, which limits asylum seekers ability to obtain permanent residence, and be eligible for family reunification. Prior to this, refugees and people in need of subsidiary protection would receive a permanent residence permit.⁵⁷ In accordance with the new temporary law, refugees are granted a three-year residence permit, and those in need of subsidiary protection are granted a 13-month residence permit.⁵⁸

UNITED KINGDOM

In January 2017, a memorandum of understanding came into effect allowing NHS digital to share non-clinical data with the Home Office of those suspected of committing immigration offences; this includes names and addresses of immigration offenders. The memorandum is intended to "[encourage] voluntary return by denying access to benefits and services to which [those staying in the UK illegally] are not entitled" thus, creating another deterrent for migrants to access healthcare.⁵⁹

52. "2017 Legal report on access to healthcare" will be available at <https://mdmeuroblog.wordpress.com/resources/publications/>

53. Mission Mineurs Non Accompagnés. « Rapport annuel d'activité 2016 Mission mineurs non accompagnés. » 2017 (accessed on September 27, 2017, http://www.justice.gouv.fr/art_pix/1_RAA_MMNA_2016.pdf).

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WHO WE SAW

DEMOGRAPHICS

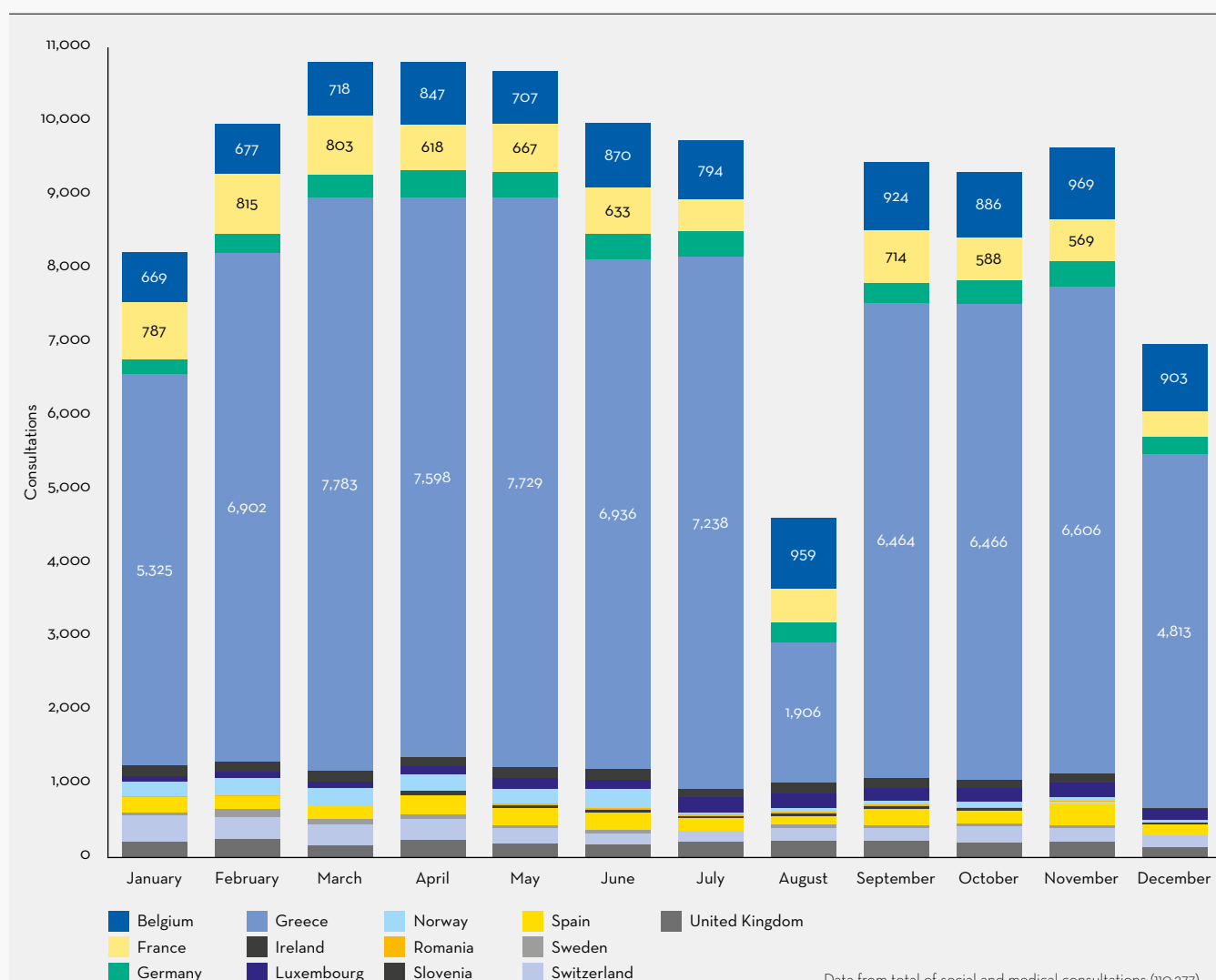
Data was collected in a total of 110,277 consultations over the course of the year. Figure 1 shows there were 36,409 medical consultations and 73,868 social consultations. The highest number of consultations were carried out in Greece at 68.7% (75,766/110,277), while the programme in Romania held the lowest number of consultations at 0.2% (208/110,277). April was the busiest month, with 9.8% (10,811/110,277) of all consultations occurring during that period. August was the quietest month, with just 4.2% (4,616/110,277) of all consultations.

The programmes saw 43,286 unique individuals in medical and social consultations. There were more service users who were men at 58.2% (25,183/43,286) than women at 41.5% (17,963/43,286). The median age was 31. Around 22.2% of people seen were children (under 18 years) (9,626/43,286), 8.3% were children under 5 years (3,578/43,286), and 2.3% were 70 years and over (988/43,286).

Figure 3 (and subsequent figures) present the data grouped according to service users' self-reported country of origin, categorised as: nationals, EU/EEA migrants, and non-EU/EEA

migrants. This categorisation is based on a person's reported country of origin in relation to the country in which they presented at one of the programmes. There are limitations to this categorisation, which must be considered (for further details see the section on 'Limitations'). **Nationals** are those who presented at a programme in their country of origin; **EU/EEA migrants** are those whose country of origin is a member of the EU or the EEA or Switzerland, but who presented in another EU/EEA country or Switzerland; and **non-EU/EEA migrants** are those with a country of origin that is not the EU/EEA or Switzerland.

Figure 1.
Medical and social consultations by month and country

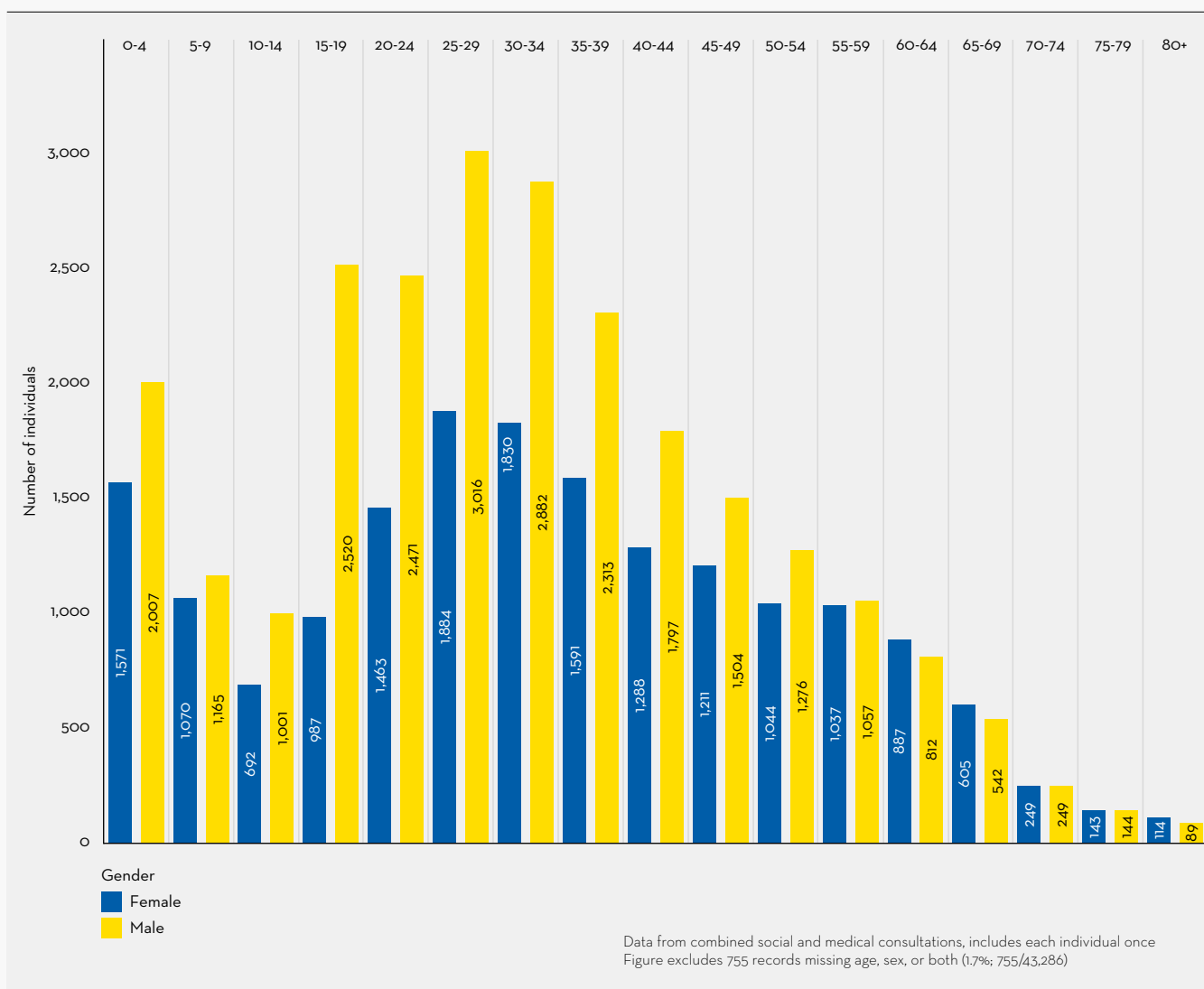


Data from total of social and medical consultations (110,277)

Of all people seen, 79.1% (34,227/43,286) were non-EU/EEA migrants, 12.1% (5,227/43,286) were nationals and 7.5% (3,257/43,286) were EU/EEA migrants. In all age groups, the majority of people were non-EU/EEA migrants. The highest proportion of non-EU/EEA migrants was in the 15–19 age group at 92.0% (3,222/3,502). The proportion of EU/EEA migrants increases with each age category. In general, the age profile of non-EU/EEA migrants is younger than EU/EEA migrants.

In 2016, 0.5% (213/43,286) of people seen in our programmes were unaccompanied minors, defined as a person who is under the age of 18, who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.⁶⁰ Greece reported the highest number of unaccompanied minors, with 24.4% of all unaccompanied minors seen in the programmes (52/213).

Figure 2.
Age group and sex of individuals



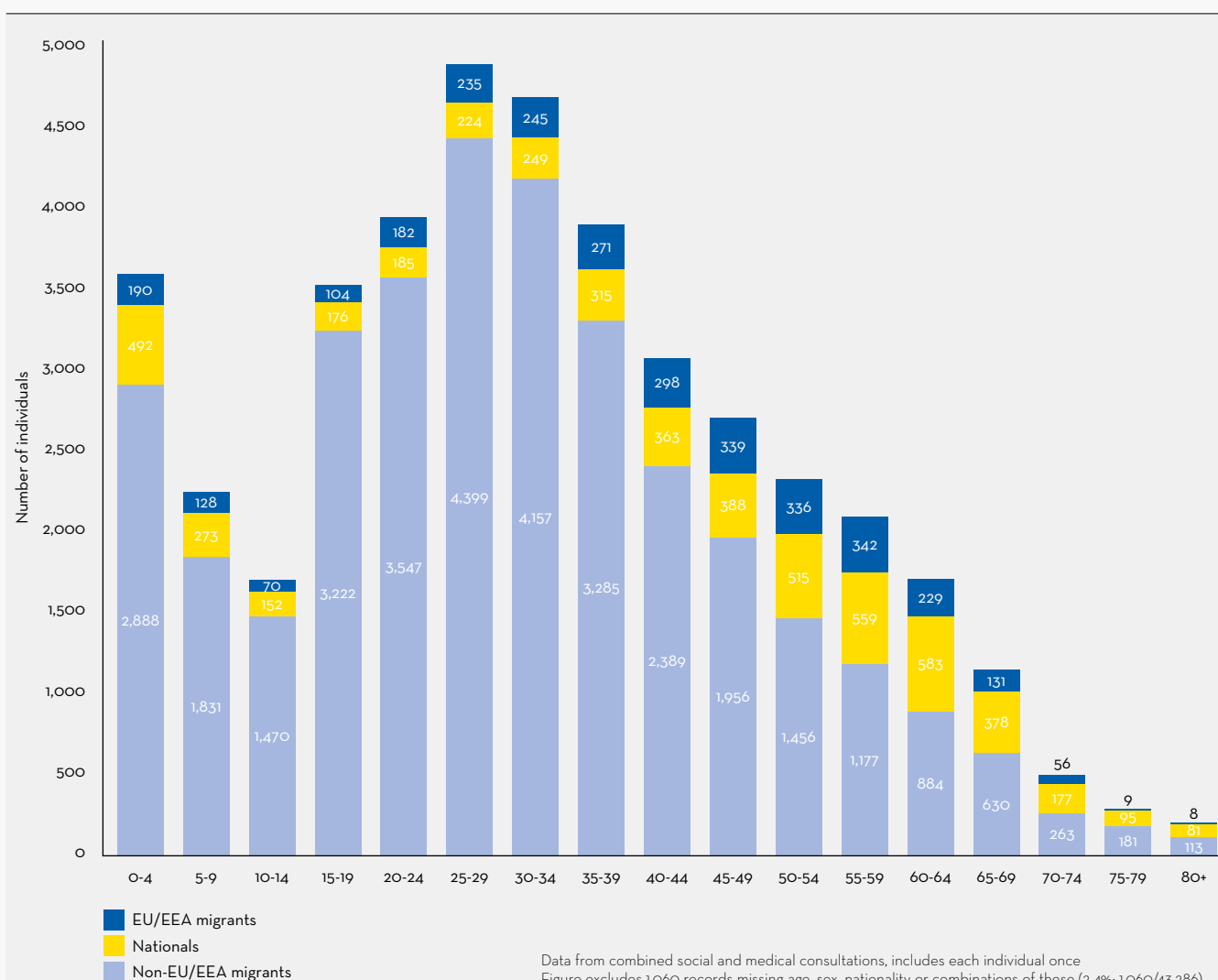
⁶⁰ UNHCR. "Guidelines on Policies and Procedures in Dealing With Unaccompanied Children Seeking Asylum." Geneva: UNHCR, 1997 (accessed on October 10, 2017, www.unhcr.org/3d4f91cf4.pdf).

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Nationals are those who presented at a programme in their country of origin; EU/EEA migrants are those whose country of origin is a member of the EU or the EEA or Switzerland, but who presented in another EU/EEA country or Switzerland; and non-EU/EEA migrants are those with a country of origin that is not the EU/EEA or Switzerland.

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Figure 3.
Age group of individuals; by nationals, EU/EEA migrants, non-EU/EEA migrants



COUNTRY OF ORIGIN

Of all patients seen, Figure 4 shows that majority were from Asia at 43.0% (18,593/43,286), followed by Europe at 29.4% (12,713/43,286) and Africa at 23.4% (10,110/43,286).

Figure 5 shows the country of origin of patients seen in the programmes. The highest number of patients came from Syria at 13.0% (5,613/43,286), followed by Afghanistan at 11.3% (4,874/43,286), Greece at 10.7% (4,616/43,286), Albania at 5.7% (2,459/43,286) and Pakistan at 4.8% (2,063/43,286).

Figure 4.
Continents of origin for individuals

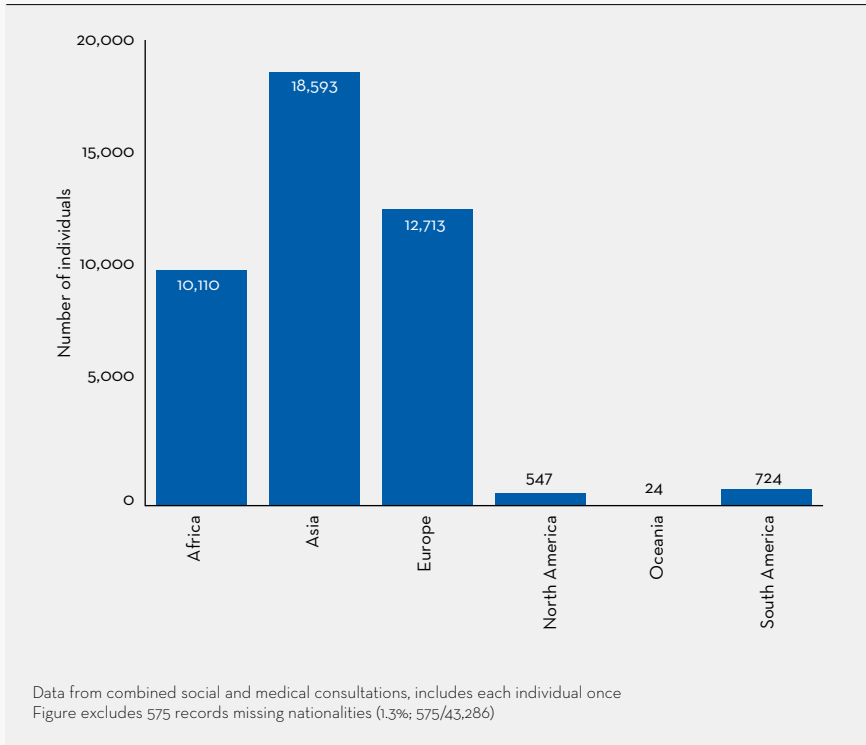
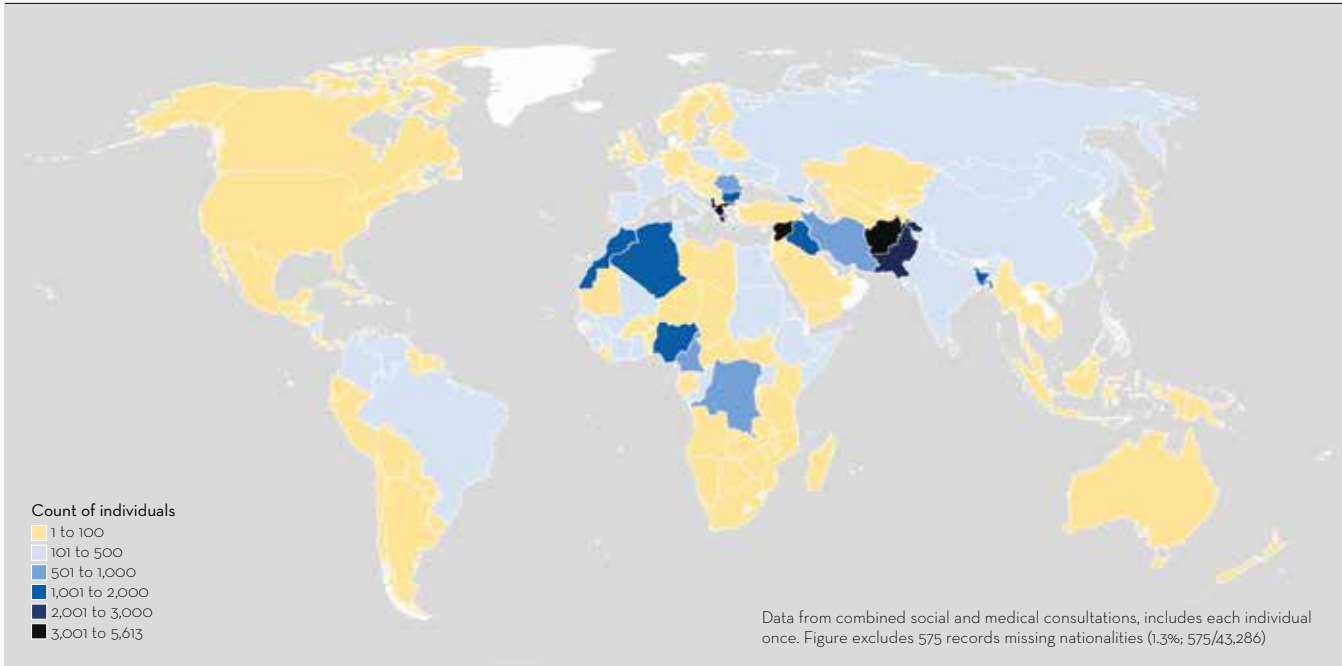


Figure 5.
Nationalities of individuals





VULNERABILITIES IN HEALTH AND HEALTHCARE ACCESS

Research demonstrates that the socio-economic circumstances in which a person is born, grows up, lives, and works, impacts on their health and wellbeing.⁶¹ There are various factors and external influences that increase both a person's vulnerability to ill health and their access to healthcare services. These 'vulnerability factors' are multidimensional and operate on different levels: economic; psychosocial; and political. A person may experience multiple factors at the same time, which is likely to increase their vulnerability to ill health and poor health access. And they are fluid, as anyone can experience vulnerability factors at any point during their life course.

By collecting data on the economic, psychosocial, and political circumstances of our patients, we are able to observe the prevalence of different vulnerability factors.

MATERIAL VULNERABILITIES

The impact of poverty on health is well documented: a wealth of evidence shows low income has a detrimental impact on physical and mental health outcomes.⁶²⁻⁶⁵ Similarly, poor housing conditions are bad for health. Health outcomes for people who are street homeless are stark in comparison to the general population, particularly in terms of prevalence of mental health conditions and early morbidity.⁶⁶⁻⁶⁷ Living in camps, slums, and squats contributes to ill health and injury, they rarely provide adequate protection from the weather and extreme temperature nor the necessary security and privacy.⁶⁸ Unstable housing situations are also associated with poor mental health and wellbeing.⁶⁹⁻⁷⁰



Name: Klaus
Country: Germany

Klaus is a 60-year-old German national. He got divorced in 2006 and moved out of the flat he shared with his wife. Since then, Klaus has found it difficult to cope financially. In 2016, he lost his job and has struggled to find work. Without employment, Klaus has no health insurance.

“ I could never afford the medication I need, by myself. The social benefits I am receiving are just not sufficient for my monthly expenditure and subsistence allowance, which I pay for my son. ”

After months of not seeking medical help for his high blood pressure and being too ashamed to ask for help from a family friend who is a doctor, Klaus saw a flyer for Doctors of the World. The clinic identified his high blood pressure and now provide medical treatment.

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WORK AND INCOME

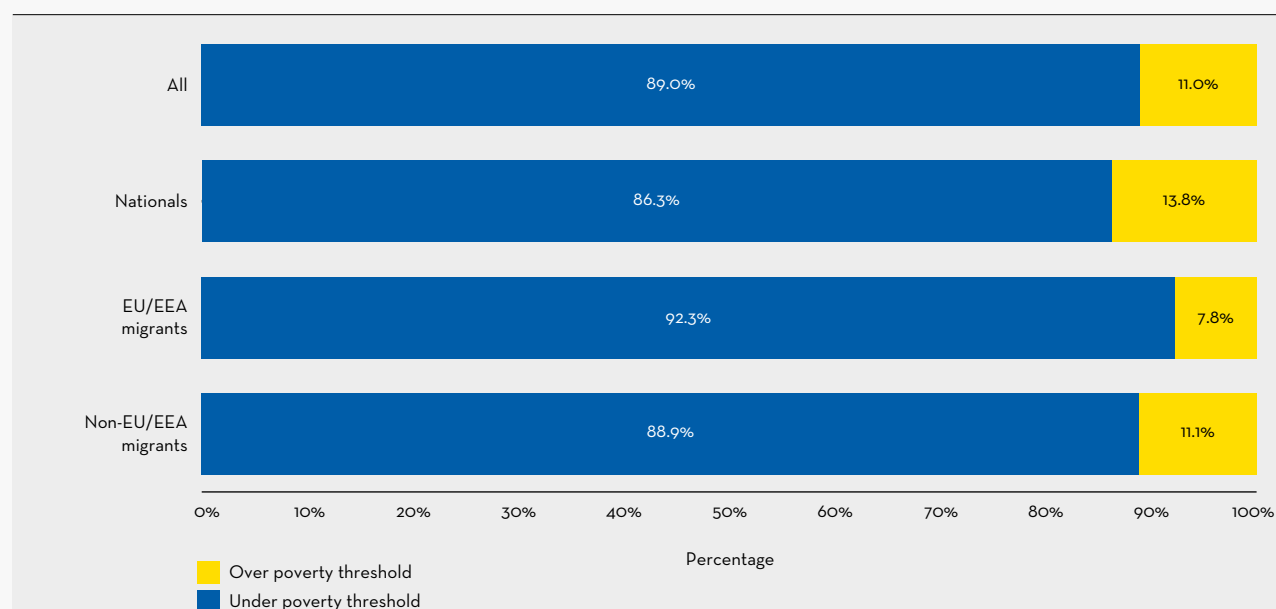
Of those who responded, 77.3% of patients were unemployed (7,216/9,338).⁷¹ Figure 6 shows the vast majority of people 89.0% (6,725/7,560) were living below the poverty threshold in the country they presented in, meaning their income was below the level needed to secure the minimum resources necessary for long-term physical wellbeing and to meet their basic needs (such as food, clothing, and shelter).⁷²

There was evidence that a higher percentage of EU/EEA migrants were under the poverty threshold (92.3; 95% CIs [90.4, 93.8]) compared to nationals (86.3; 95% CIs [83.8, 88.5]). There was no evidence of a difference in poverty levels between non-EU/EEA migrants and nationals.



Figure 6.

Money to live on per month for the last three months, under or over the country poverty threshold; by nationals, EU/EEA migrants, non-EU/EEA migrants



Data from social consultations, includes each individual once
 Figure excludes missing data for people seen (74.8%; 22,937/30,659) and no answer (0.5%; 162/30,659)
 The ALL bar includes individuals for which no nationality was recorded (20)

71. Excludes missing data for people seen (67.4%; 20,674/30,659) and not applicable/unknown (2.1%; 647/30,659).

72. Assessment of above / below the poverty threshold is based on established poverty threshold in the country that the individual presented in.

HOUSING CONDITIONS

52.8% of people considered their living arrangements as temporary (4,011/7,590).⁷³ Figure 7 shows that, of those who responded, the highest proportion of people 46.3% were living with friends and family (3,797/8,197), meaning they were relying on personal networks to accommodate them. Overall, 23.8% (1,954/8,197) of people were living in precarious housing situations, this includes 11.9% (976/8,197) who were street homeless or living in short-term (under 15 days) emergency centres, 2.1% living in camps or slums (173/8,197), 1.7% in squats (141/8,197), and 7.1% in a charity, organisation or hotel (581/8,197).

Higher levels of street homelessness or living in emergency shelter were reported by EU/EEA migrants (26.7; 95% CIs [24.3, 29.3]) compared to nationals (6.7; 95% CIs [5.2, 8.4]) and non-EU/EEA migrants (9.8; 95% CIs [9.1, 10.6]). However, these figures should be interpreted carefully as missing data varied across the three groups.



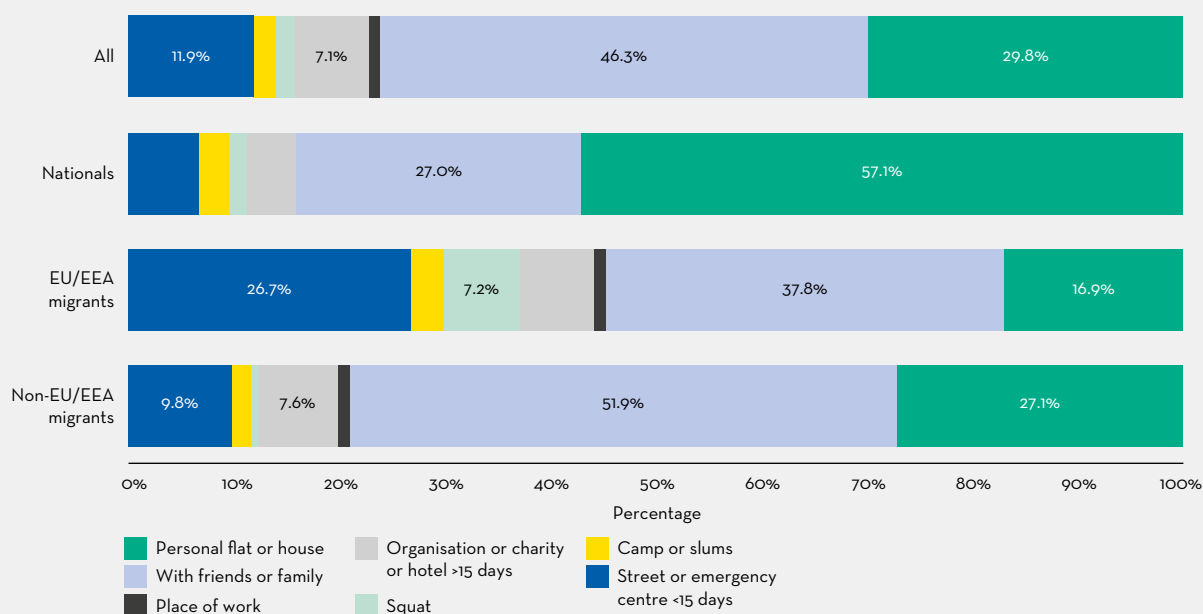
Name: Arabella
Country: Netherlands

Arabella, a care bus volunteer in Amsterdam, was called to a homeless shelter, Bed Bath Bread (BBB), when there were fears over the health of one of the residents. The man had been sick for several days; he could not eat or drink and had nausea and diarrhoea. His illness was further complicated by his diabetes and low blood pressure. As his condition was not considered life-threatening, the ambulance service refused to take him to hospital and GP practices would not see him as an emergency appointment.

It was clear that this gentleman had to see a doctor who could refer him to the hospital. After contacting eight GP's, there were two doctors who were maybe willing to help. One of the doctors believed that the shelter was too far away from him and that he had to find a doctor who was closer to the BBB. Fortunately, another practitioner called back and said he was willing to help if the man came to him.

The GP willing to help was unable to make a house call, even when Arabella explained how sick and immobile he was. With few options available to them, Arabella and the shelter employees eventually managed to arrange transport for the sick man to go directly to the GP surgery and receive medical attention.

Figure 7.
Housing situation; by nationals, EU/EEA migrants, non-EU/EEA migrants



Data from social consultations, includes each individual once
Figure excludes missing data for people seen (67.2%; 20,599/30,659) and not asked (6.1%; 1,863/30,659)
The ALL bar includes individuals for which no nationality was recorded (107)

⁷³ Excludes missing data for people seen (66.0%; 20,237/30,659) and not asked (9.2%; 2,832/30,659).

PSYCHOSOCIAL VULNERABILITIES

Health and social isolation are connected: strong social networks are a protective health factor whereas loneliness is associated with increased risk for morbidity and early mortality.^{74–75} Evidence shows that living apart from children is a source of emotional strain and contributes to poor health.⁷⁶ Language is also important: those who cannot speak the national language are less likely to make friends, engage in social activities, find work, and access services.

Migration can be a vulnerability factor. In moving country, most migrants will experience a degree of change in circumstances, family and social relations, climate, language, culture, and diet,⁷⁷ all of which are associated with poor mental health. Forced migration due to war, conflict, or persecution increases the risk of psychological ill health,⁷⁸ and dangerous migration journeys present very real risks of injury and death.⁷⁹

SOCIAL NETWORKS AND FAMILY LIFE

Figure 8 shows that, of those who responded, 35.5% reported that they could frequently rely on someone in their current town to help, support, and comfort them if needed (2,280/6,421). Overall, 38.9% reported the absence of a reliable social network (2,500/6,421). This included 12.0% (769/6,421) who reported that they never had someone to support them when needed, and 27.0% (1,731/6,421) who could only sometimes rely on someone's support.

A higher percentage of EU/EEA migrants reported the complete absence of a social support network (see Figure 8: 'never') compared to non-EU/EEA migrants and nationals. A lower percentage of nationals reported the absence of a social support network ('never') compared to non-EU/EEA migrants and EU/EEA migrants. However, these figures should be interpreted carefully as missing data varied across the three groups.

Of the people seen in the programmes, 3,051 had children under the age of 18. Figure 9 shows that of those who answered the question, 55.8% reported that none of these children were living with them (1,352/2,425), a further 5.9% (144/2,425) reported that only some of their children were living with them, and 38.3% (929/2,425) were living with all of their children.

There was evidence that nationals were more likely to be living with all of their children (67.9; 95% CIs [60.7, 74.5]) compared to EU/EEA migrants (30.7; 95% CIs [26.2, 35.4]) and non-EU/EEA migrants (36.7; 95% CIs [34.5, 39.0]).

In Figure 10 shows that the majority of people (54.6%) seen in the programmes required an interpreter during their consultation (21,937/40,208). This includes 48.4% (19,448/40,208) who had an interpreter present in their appointment, 2.0% (812/40,208) who had an interpreter by phone, and 4.2% (1,677/40,208) who did not have an interpreter, despite needing one.

There was evidence that nationals had much lower need for interpreters (97.2; 95% CIs [96.7, 97.7]) compared to EU/EEA migrants (57.4; 95% CIs [55.6, 59.2]) and non-EU/EEA migrants (36.0; 95% CIs [35.5, 36.5]).

It is important to note that the presence of an interpreter in a consultation is not indicative of a patient having 'poor' language skills, as an individual can have a firm grasp of a language whilst also requiring support with medical terminology. It is, however, a potential indicator of limited knowledge of the local language.



Name: Nancy
Country: France

Nancy, 30, is from Cameroon. Her family arranged for her to go to France, whilst her two children remained in Cameroon with the family. Before arriving in France, Nancy passed through the Maghreb and got lost on the Libyan boarder. It was there she was raped by a Libyan soldier. The trauma she suffered during her journey to France continues to plague her and she has terrible nightmares.

“I'm frightened, I see him all the time, everywhere, I'm frightened.”

When Nancy arrived in France her family had arranged for her to stay with a woman who she was to refer to as her 'cousin'. Nancy became pregnant shortly after arriving in France, and sought help from CASO and the State Medical Aid/Aide Médicale de l'Etat, but was unable to claim expenses. Her first appointment at CASO revealed her HIV status, Nancy was shocked by the news and refused to believe that she was HIV positive.

“I can't have the [HIV] virus, if I'm ill why do I feel well? Why can't it be seen? Why didn't I know about it beforehand?”

Nancy worried about what her 'cousin' would think of her HIV status:

“I won't be able to return to Cameroon. There, in Cameroon, it's very badly thought of, I would be banned from my family and people die, if my cousin knows of it she will reject me and throw me out.”

Her relationship with her 'cousin' deteriorated rapidly after Nancy learnt of her HIV status, leaving her scared to go home, but with nowhere else to go. Finding Nancy permanent residence has been difficult due to her legal status. After waiting to get into a maternity centre for months, Nancy finally secured a single room and gave birth to a healthy baby girl. To this day though, she has no news about her legal status and is unable to gain access to permanent housing.

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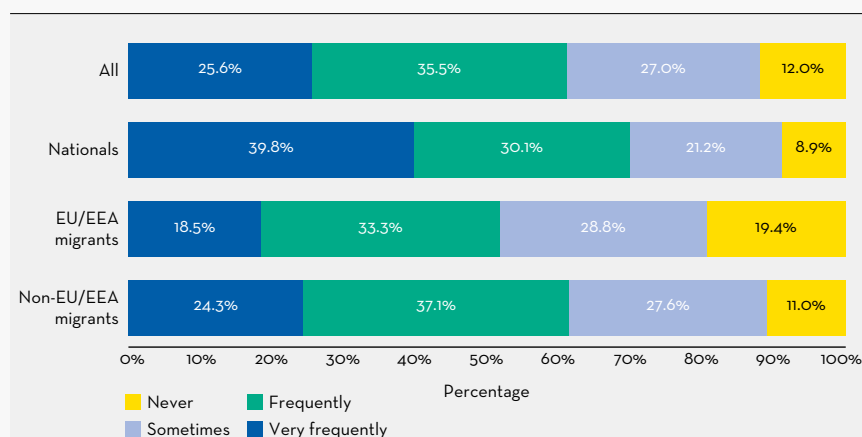
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Figure 8.

How often the individual can rely on someone in their current town to help, support, and comfort them, if needed; by nationals, EU/EEA migrants, non-EU/EEA migrants



Name: Touba
Country: France

Touba, 16, is a farmer from Guinea; he lost both his parents young and farmed a loaned piece of land alone. He lived with another man, whom he had a sexual relationship with.

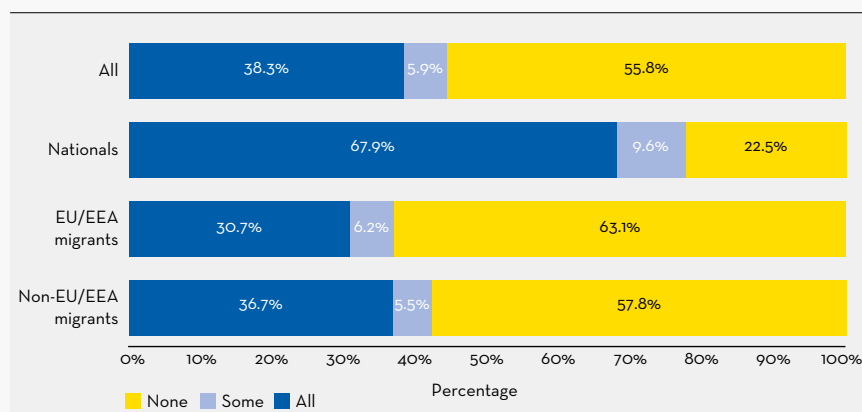
I had to leave Guinea because with the Muslim religion, one has not the right to be with a man. They searched us out. They beat him up. My friend must be dead.

A man helped him leave Guinea and travel to France via Libya. Touba stayed in Libya for two days, and the man took him to Rouen. His wife did not want Touba to stay with them, so he went to the ASE. He tried to relate his story to an ASE worker but they could not understand him, another ASE worker came out and claimed Touba was not a minor and told him to leave. That night, Touba slept outside the ASE, sheltering under the porch when it started raining. The next day he went to the police, who were unable to find him a hostel to stay in and adult accommodation was not available to him either.

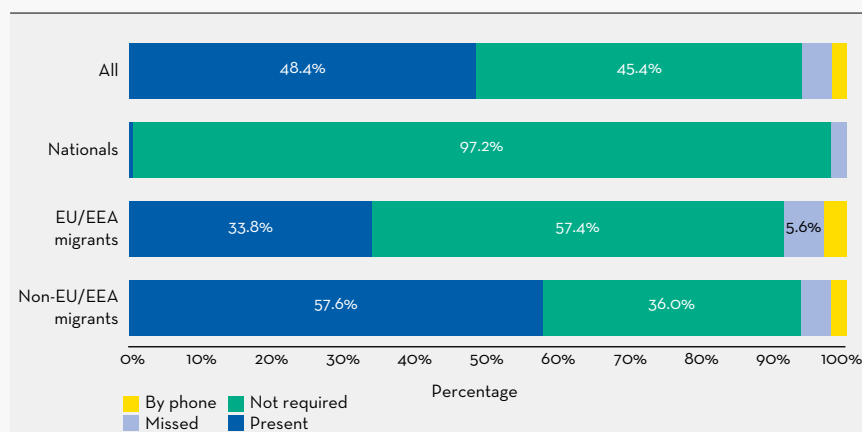
I went to Médecins du Monde. They arranged [a place] for me to sleep, but it was only for several days whilst a solution was found. I still had the same clothes on so they took me to a charitable association to get some [clothes]. I would like to learn a trade. I am very fearful of returning to Guinea and being killed.

Figure 9.

For individuals with children under 18 years, how many of these children are currently living with them; by nationals, EU/EEA migrants, non-EU/EEA migrants

**Figure 10.**

Proportion of patients who required an interpreter during consultation; by nationals, EU/EEA migrants, non-EU/EEA migrants

**Fig 8.**

Data from social consultations, includes each individual once. Figure excludes missing data for people seen (6999; 21,416/30,659) and not asked (9.2%; 2,822/30,659). The ALL bar includes individuals for which no nationality was recorded (98).

Fig 9.

Data from social consultations, includes each individual once. Figure excludes missing data for people seen (8.9%; 270/3,051) and not asked (11.7%; 356/3,051). The ALL bar includes individuals for which no nationality was recorded (22).

Fig 10.

Data from combined social and medical consultations, includes each individual once. Figure excludes missing data for people seen (3.8%; 1,637/43,286) and not asked (3.3%; 1,441/43,286). The ALL bar includes individuals for which no nationality was recorded (369).

EXPERIENCE OF VIOLENCE

In Figure 11 shows that just over half of people 51.8% discussed violence during their consultation (9,667/18,650). Bearing in mind the limitations of the data, there is evidence that violence was discussed in a different proportion across all groups ($p < 0.001$). Violence was discussed most often by non-EU/EEA migrants (56.2%; 8,857/15,749), followed by 37.6% of nationals (593/1,579) and by 18.6% of EU/EEA migrants (205/1,104).

The prevalence of conversations about violence can be influenced by the practice of the programme collecting the data and the individual healthcare worker. Some programmes routinely ask all people about their experience of violence, while others wait to see if the topic arises.

In discussions about violence, people reported a wide range of violent experiences including: war; armed conflict; torture; violence or imprisonment as a result of ideology or sexuality; violence at the hands of police or armed forces; being beaten up; domestic abuse; rape; sexual assault; psychological violence; confiscation of identity documents or money; and deliberate inflicted hunger.

REASONS FOR LEAVING COUNTRY OF ORIGIN

As migrants often leave their country of origin for a number of reasons, this question recorded multiple answers. Therefore, Figures 12 and 13 show the count each time a 'reason for leaving country of origin' was reported; it does not reflect individual people.

Taking into account the considerable limitations of this data, Figure 12 shows the most commonly reported reason for leaving a country of origin by EU/EEA migrants was 'to make a living' at 67.6% (696/1,030) followed by 'to follow or join someone' at 13.9% (143/1,030). 2.5% of responses reported leaving a country of origin for health reasons (26/1,030).

Figure 13 shows the most common reason for leaving a country of origin reported by non-EU/EEA migrants was 'to make a living', at 39.0% (1,732/4,441). However, 16.9% (292/1,732) of those who said they left their country of origin 'to make a living' also mentioned at least one other reason for leaving.

The second most common response from non-EU/EEA migrants was 'to escape discrimination or persecution because of political opinions, religion, race/ethnicity, or sexual orientation' at 18.0% (799/4,441). 14.1% of responses reported leaving their country of origin 'to escape armed conflict or war' (628/4,441), and 5.6% did so to escape 'family conflict(s)' (248/4,441). 2.9% of (130/4,441) of responses reported leaving a country of origin 'for health reasons'. These figures should also be interpreted carefully as missing data varied across the three groups.



Name: Gabriel
Country: France

Gabriel, 16, was born in Kinshasa, the Democratic Republic of Congo (DRC). His father, a cemetery worker, opposed the political regime. Gabriel's father witnessed the burials of 421 bodies, who were all victims of government brutality. The same day his father saw the burials, soldiers came to Gabriel's family's house to arrest his father, and he was accused of alerting outside sources of what he had seen the night the bodies were buried in the cemetery. They viciously beat up his family, including his mother, and took his father away.

Gabriel's father managed to escape incarceration, but it led the soldiers back to his family's home. This time, Gabriel's injuries were so severe, his Uncle had to take him to the local hospital in Kisandu. They took refuge in his mother's village, but Gabriel knew he had to leave the DRC. His Uncle took him to Brazzaville, and entrusted him to a man who promised to take him to France.

When Gabriel reached Rouen, he was homeless. He had nowhere to go and ran into legal issues with the l'Aide Sociale à l'Enfance (ASE), who were insisting he was not a minor and therefore, did not have to provide shelter for him. A Healthcare, Advise and Referral Clinic (CASO) is now providing Gabriel with legal aid, and are hopeful they can help him find shelter in France.

Figure 11.

Was violence discussed during consultation; by nationals, EU/EEA migrants, non-EU/EEA migrants

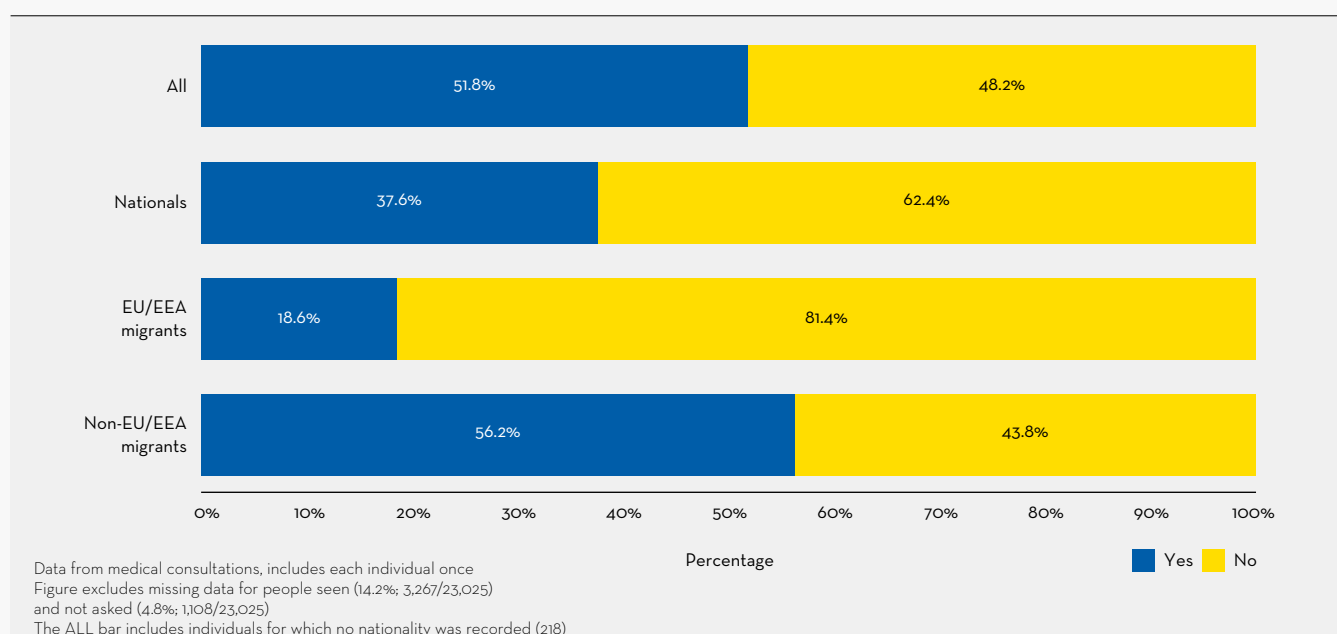


Figure 12.
Reasons for leaving country of origin for EU/EEA migrants

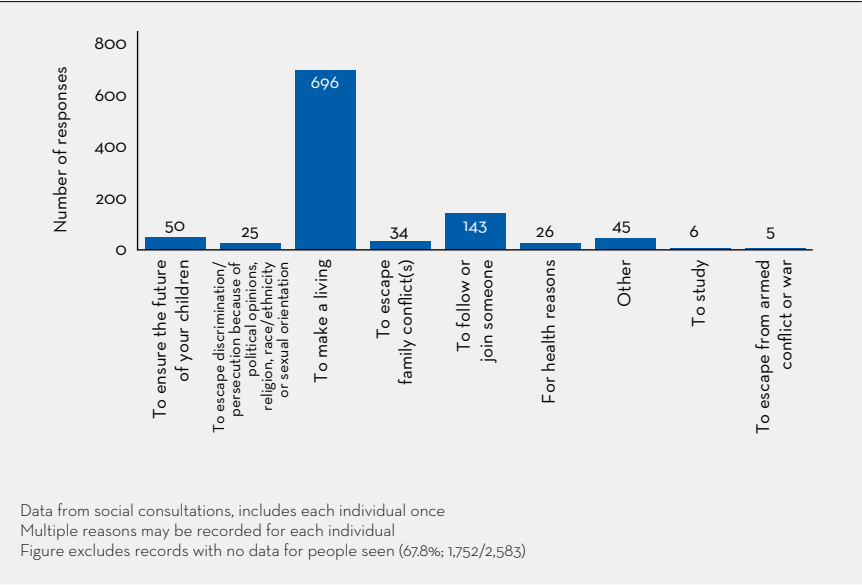
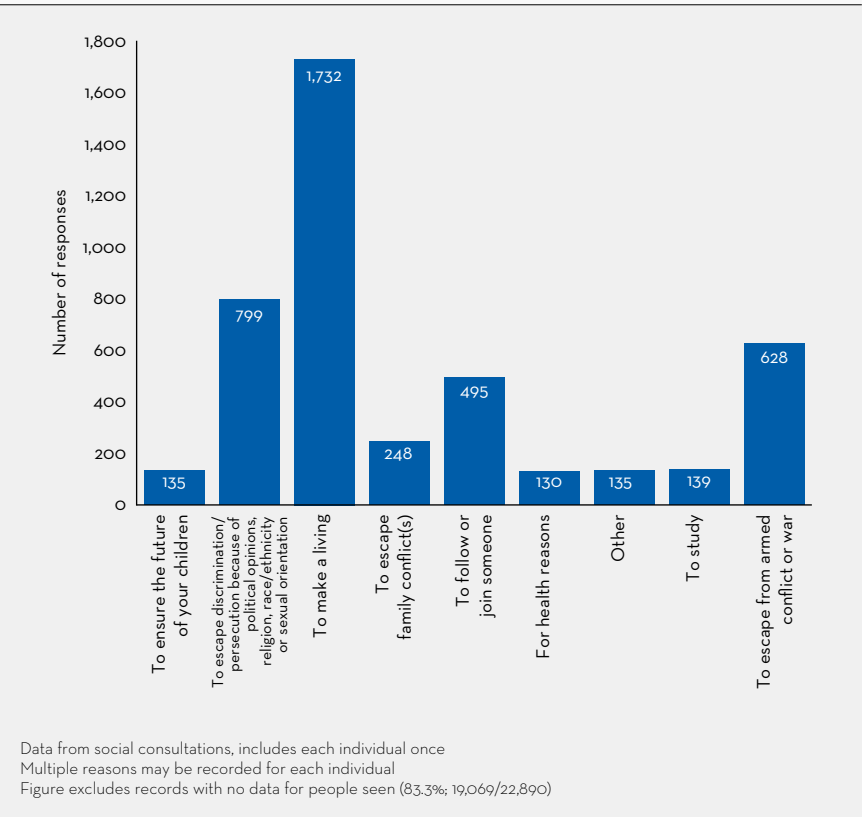


Figure 13.
Reasons for leaving country of origin for non-EU/EEA migrants



Name: Hakeem
Country: Greece

Hakeem and his family fled the Taliban occupied Afghanistan in 2015, three days of extreme violence and terror in Kunduz led to the death of two of Hakeem's children. Hakeem, his wife, and their four children fled to Iran and travelled through Turkey where they were separated. Hakeem's wife and three of his children made it to Greece whilst Hakeem remained in Turkey with his disabled son, Tahir.

We arrived in Lesbos in November 2015. Our condition was bad. My son is handicapped, has colostomy bags, and has to do insulin injections. On the other hand, I have serious heart problems. We stayed in the island's camp for one month. The conditions there were bad, it was really cold, we didn't have food, and we didn't know when we're going to travel to Athens.

Fourteen-year-old Tahir has significant health issues, caused by the violence they experienced in Afghanistan. He is partially blind and deaf and one of his kidneys has failed. Hakeem and Tahir travelled to Greece, but were left homeless for ten days without food or medication. The Doctors of the World mobile clinic found them in a park and immediately arranged medical care and shelter for father and son. Whilst Tahir was in hospital, Hakeem had a heart attack. Doctors of the World arranged Hakeem's treatment and hospitalisation and made sure he was in good health when he was discharged.

It was the first time in so long that I felt safe and that someone truly cared about me, listened to me, and understood my problems. It was thanks to the help he received from MDM that my son's health condition improved, and tomorrow we are going to travel to Austria where I will be reunited with my daughters and my wife after approximately five months.

POLITICAL VULNERABILITIES

Having agency and a voice is important for a person's health and wellbeing. Those who are not empowered in this way are less likely to have access to welfare and social support services, including health services. Indeed research shows those who are politically disempowered are more likely to experience poor health.⁸⁰

Irregular immigration status is a source of vulnerability and disempowerment. Despite international human rights instruments that ensure certain rights for everyone,^{81, 82, 83} in practice those with irregular immigration status can seldom enjoy many of these rights without bringing themselves to the attention of the state.

The realisation of economic and social human rights is often undermined by national policy and legislation: entitlement to welfare support services and healthcare is often linked to citizenship or legal permission to stay in a country^{84, 85} meaning irregular migrants are excluded from these important social safety nets.

Migrants with precarious immigration status (i.e. time-limited permission to reside, for example those on a temporary visa or asylum seekers) also experience a degree of vulnerability. They are often not entitled to the full suite of welfare and health services, and face barriers to accessing them.

IMMIGRATION STATUS

In Figure 14, the largest number of people reported that their immigration status was 'non-EU/EEA migrant with irregular status' at 44.2% (4,344/9,832). Irregular immigration status is defined as 'not fulfilling conditions for entry, stay, or residence in the country the person is living in'. It includes those who enter Europe regularly on documents that have since become invalid, those who entered irregularly, and asylum seekers whose claims have been refused.

The second most common immigration status was 'non-EU/EEA migrant with a visa or permit' at 22.4% (2,202/9,832), followed by 14.9% who were asylum seekers (1,469/9,832). 1.4% (142/9,832) were non-EU refugees (including humanitarian protection and discretionary leave).

6.2% (606/9,832) of people were EU/EEA migrants without permission to reside, meaning they were residing in their host country for over three months but did not have sufficient resources for themselves and health insurance as required by European Directive 2004/38/EC.⁸⁶

Overall, 50.3% (4,950/9,832) did not have permission to reside in the country they were living in. This includes non-EU/EEA irregular migrants and EU/EEA migrants without permission to reside. 49.7% did have permission to reside (4,882/9,832).

FEAR OF ARREST

Figure 15 includes only individuals without permission to reside in the country they were living in.⁸⁷

Patients without permission to reside in the country they were living in were asked if they restricted their movements in public because they feared arrest, and 47.3% reported that they did (715/1,512). 8.1% (123/1,512) reported that they did so very frequently, 10.8% (163/1,512) limited their movement frequently and 28.4% did so sometimes (429/1,512). Almost half of responses from non-EU/EEA migrants reported limiting their movement to some extent (49.7%; 684/1,377).

Although the limitations of the data must be considered, there is no evidence that the non-EU/EEA migrants limited their movements 'very frequently' more than the EU/EEA migrants did. However, the data does indicate that more EU/EEA migrants 'never' limit their movements (77.0; 95% CIs [69.0, 83.8]) than non-EU/EEA migrants (50.3; 95% CIs [47.7, 53.0]).



Name: Yana
Country: Greece

Yana, is a refugee from Syria, she travelled to Greece with her two sons when she was eight months pregnant with her third child. She and her two sons stayed in the Attica refugee camp in Greece; whilst in the camp, Yana gave birth.

“When I arrived on the island, a relief washed all over me, I kept thinking that in a few days I would meet my husband in Germany. But then we were transferred to the camp, where things were really difficult. My biggest concern was my pregnancy and the safety of my children.”

She was forced to leave the camp after she refused to give her fellow refugee's money to stay, and found herself homeless with her three children. The family found shelter in an apartment with two other Syrian families, but it was a short-lived solution. Doctors of the World had helped Yana through her pregnancy in the Attica camp, so were able to track her down through their mobile clinic. When they found Yana her baby was suffering from skin allergies and asthma and Yana had untreated gynaecological problems as well as worsening panic attacks.

“Before the intervention of MdM, I had visited a public hospital where I was badly treated by its accountant, who asked me for money for a necessary test that had to be done - I had been informed by the Asylum Service that as long as I had the asylum card the expenses of any medical exams would be covered and I wouldn't have to pay anything. Left crying and very distraught, I was feeling hopeless and alone.”

Doctors of the World organised for the family to receive medical care, counselling, and shelter. They also helped Yana with the family reunification process so that in February they were finally able to reunite with Yana's husband in Germany.

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83. OHCHR. "International Covenant on Economic, Social and Cultural Rights, 1966." OHCHR, 2017 (accessed on September 29, 2017, www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx).

84. Spenser, Sarah, and Vanessa Hughes. "Outside and In: Legal Entitlement to Health Care and Education for Migrants with Irregular Status in Europe." Oxford: COMPAS, 2015 (accessed on September 27, 2017, www.compas.ox.ac.uk/2015/outside-and-in/).

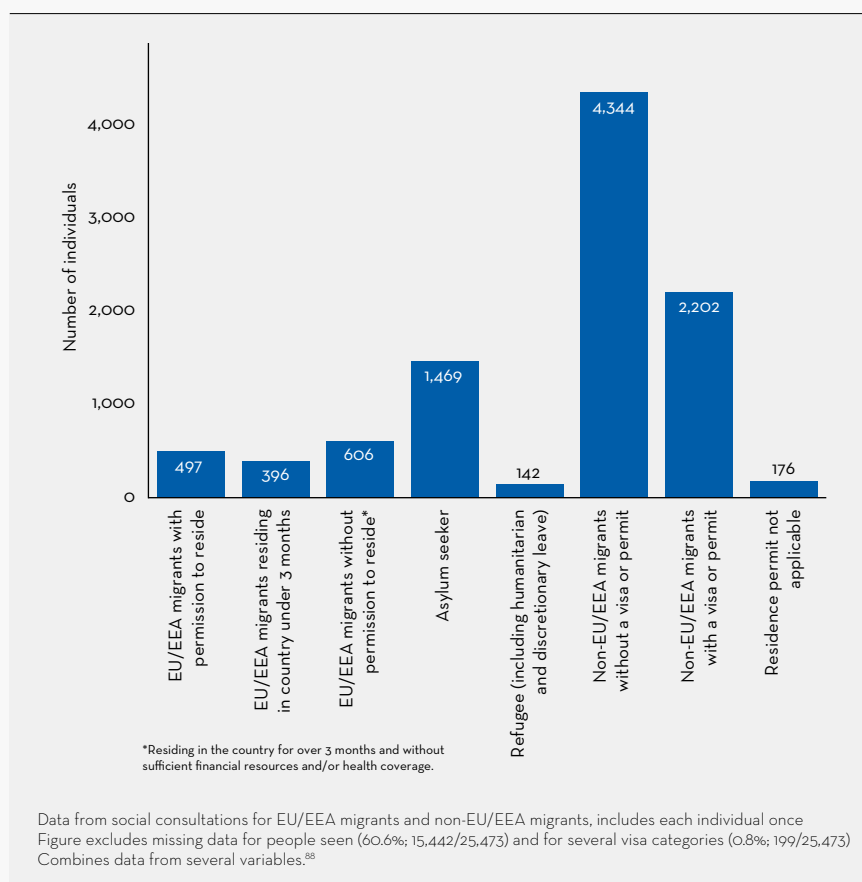
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87. 'Non-EU/EEA migrants with irregular immigration status' and 'EU/EEA migrants without permission to reside'.

88. 'Non-EU/EEA visa or permit': includes migrants with a work visa; a residency permit; or a tourist/student/short stay visa. 'Non-EU/EEA undocumented': includes migrants with permit to stay in another EU/EEA country and are here for less than 3 months; or are undocumented.

Figure 14.
Immigration status of individuals; by EU/EEA migrants, non-EU/EEA migrants



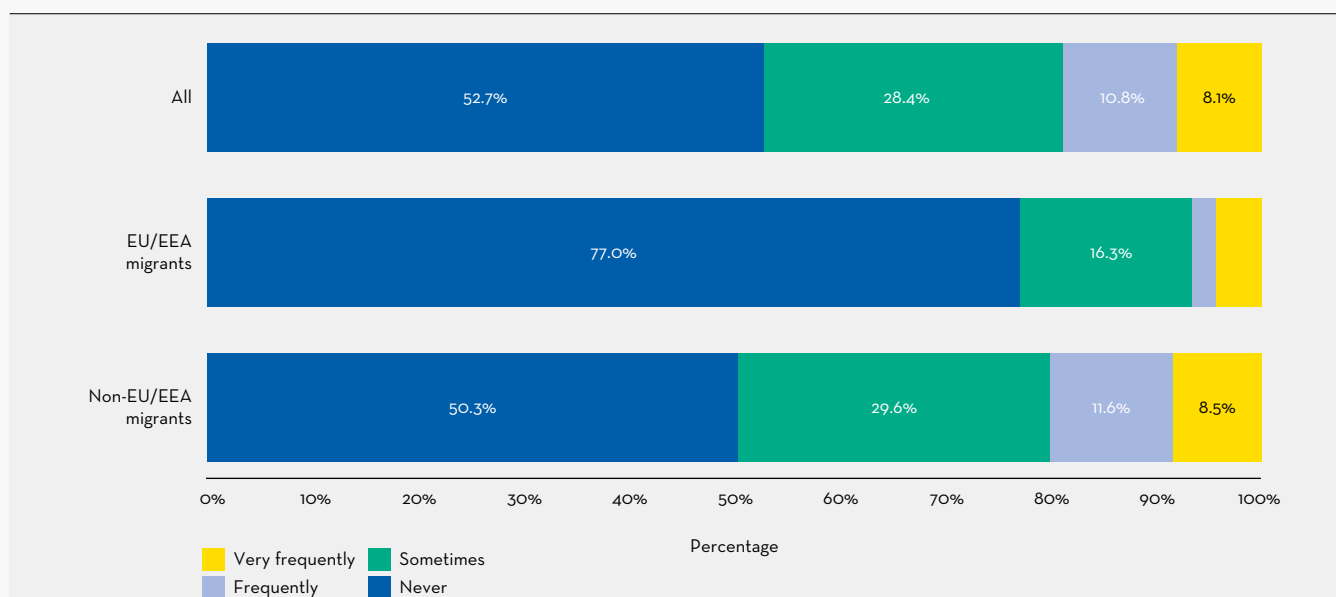
Name: Joyce
Country: Netherlands

Joyce, 29, fled Nigeria in 2009 after family pressured her to undergo female genital mutilation. She fled to the Netherlands, but found it difficult to find work without valid papers. Joyce has an 11-month-old daughter and is 28 weeks pregnant with her second child. She developed kidney stones and sought help from Doctors of the World. Joyce is dependent on a friend for shelter and food banks.

“The only food I get is carbohydrates, which is not healthy for me and the baby. There are no vegetables, fruit, or meat. I also didn’t get baby food. I have no money. I can’t buy healthy food for myself, my little daughter, and the baby.”

Doctors of the World are helping Joyce to secure food and vitamins for her and her daughter. After the birth of her second child, Joyce is hoping to apply for asylum and stay in the Netherlands permanently.

Figure 15.
Did the individual limit movements for fear of arrest if their immigration status is irregular; by EU/EEA migrants, non-EU/EEA migrants



Data from social consultations for EU/EEA migrants and non-EU/EEA migrants only, with immigration status EU/EEA migrants without permission to reside and non-EU/EEA with irregular immigration status, includes each individual once. Figure excludes missing data for people seen (49.2%; 2,433/4,950) and not asked (20.3%; 1,005/4,950). The All bar ONLY includes EU/EEA migrants and non-EU/EEA migrants.



HEALTHCARE ACCESS

The previous sections of this report looked at economic, social, and political factors known to impact on health and wellbeing. As this next section will show, these same factors also impact on a person's access to healthcare, whether they are legally entitled to healthcare coverage, as well as the practical barriers they face when trying to access healthcare coverage and services.

The WHO defines universal health coverage as “ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, whilst also ensuring that people do not suffer financial hardship when paying for these services”.⁸⁹ The broad recognition (by the UN and WHO) of the importance of achieving universal healthcare coverage is based on recognition that, for most people, healthcare coverage rather than paying for the full cost of care is needed. In all 28 member states, everyone is entitled to access emergency healthcare.⁹⁰



Name: Nipuni
Country: United Kingdom

Nipuni, 84, is from Sri Lanka. She came to the UK to visit her daughter, Hiruni, and her grandchildren. Shortly after arriving in the UK Hiruni noticed that her mother's health was starting to deteriorate.

“ Me and my sister noticed that my mum was not my mum. She wouldn't talk much, she would stay in a corner, she wouldn't say anything. The only time she lit up was with the grandkids. ”

Nipuni was suffering from high cholesterol and high blood pressure; she also showed signs of anxiety and depression. Hiruni sought immigration advice to enable Nipuni to stay in the UK so she could care for her. But there was no way to renew Nipuni's six-month visitor visa. Hiruni tried to register her mother with her GP, but was told that was not possible on a 'visiting visa'. Without access to healthcare Hiruni took responsibility for her mother's health, monitoring her blood pressure daily and buying medication from a doctor in Sri Lanka.

“ I was doing her blood pressure and everything at home, keeping a chart, getting all the medicine sent here. I did it for one and a half years. ”

The family suggested that Hiruni should go to Doctors of the World to seek advice. Doctors of the World provided Nipuni with a letter showing proof of address, to help her register with the GP practice. When they tried to register, the practice manager refused to do so without seeing a valid visa.

“ You won't believe how I felt, it was like something I have never ever done in my life, like a criminal, like I had murdered somebody. And then I basically gave up hope. ”

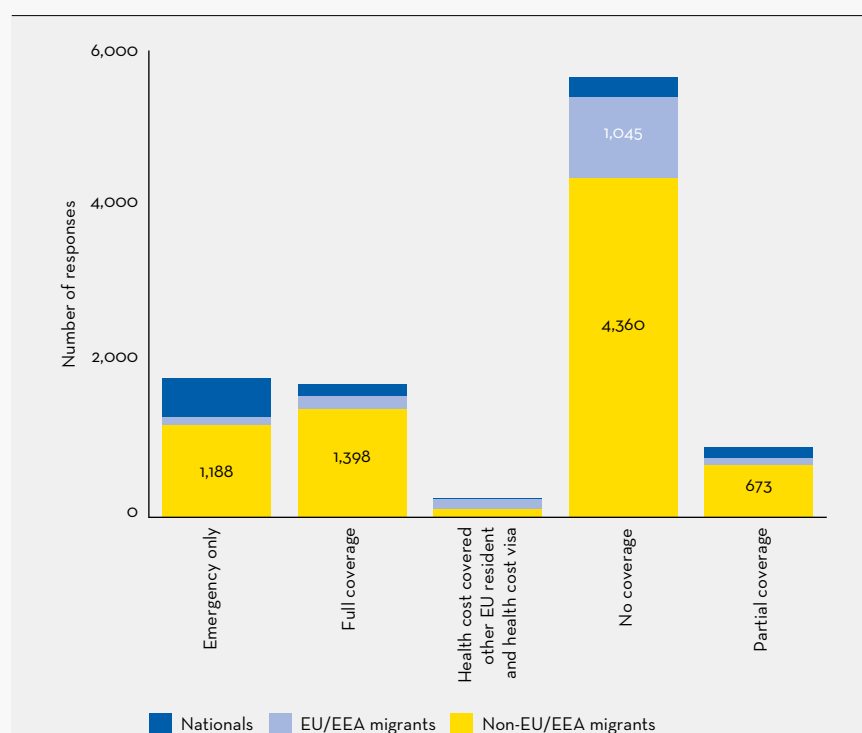
Doctors of the World approached the GP practice on Nipuni's behalf and they finally agreed to register Nipuni and monitor her health status. Nipuni's blood pressure and cholesterol medication are now managed by her GP and she is also receiving cataracts treatment.

“ It was as though the practice manager was a different person. He assisted in the registration and asked if any urgent appointments needed to be made. I still have that message on my phone. I don't want to delete it because it makes me so happy. ”

⁸⁹ WHO. “Universal Health Coverage.” Health systems, 2017 (accessed on September 22, 2017, www.who.int/healthsystems/universal_health_coverage/en/).

⁹⁰ Spenser, Sarah, and Vanessa Hughes. “Outside and In: Legal Entitlement to Health Care and Education for Migrants with Irregular Status in Europe.” Oxford: COMPAS, 2015 (accessed on September 27, 2017, www.compas.ox.ac.uk/2015/outside-and-in/).

Figure 16.
Healthcare coverage for individuals; by nationals,
EU/EEA migrants, non-EU/EEA migrants



Data from social consultations, includes each individual once
Figure excludes records with no data for people seen and no nationality (67.8%; 20,787/30,659)
Combines data from several variables.⁹¹

HEALTHCARE COVERAGE

Taking into consideration the limitations of the data, in Figure 16, the majority of people reported having no healthcare coverage (55.2%; 5,582/10,120) meaning they had to pay the full cost of their healthcare. A further 18.3% (1,847/10,120) had coverage for emergency care only, and 17.8% (1,804/10,120) had full coverage. These figures should also be interpreted carefully as missing data varied across the three groups

BARRIERS TO HEALTHCARE

Those who presented at the programmes were asked about the barriers they faced when accessing healthcare. As people often faced more than one barrier, this question recorded multiple responses for individuals. Figure 17 represents counts of responses, rather than individuals.

Taking into consideration the limitations of the data, the highest number of responses reported was the individual did not try to access healthcare at 18.9% (1,734/9,184). This was followed by 17.0% for administrative barriers (1,558/9,184) and 16.3% for economic barriers (1,493/9,184). Patients also reported a lack of knowledge of the healthcare system (9.1%; 833/9,184), language difficulties, at 6.4% (584/9,184), denial of healthcare at 3.8% (353/9,184), and 2.2% of responses reported that the individual did not access healthcare because they feared arrest (205/9,184).

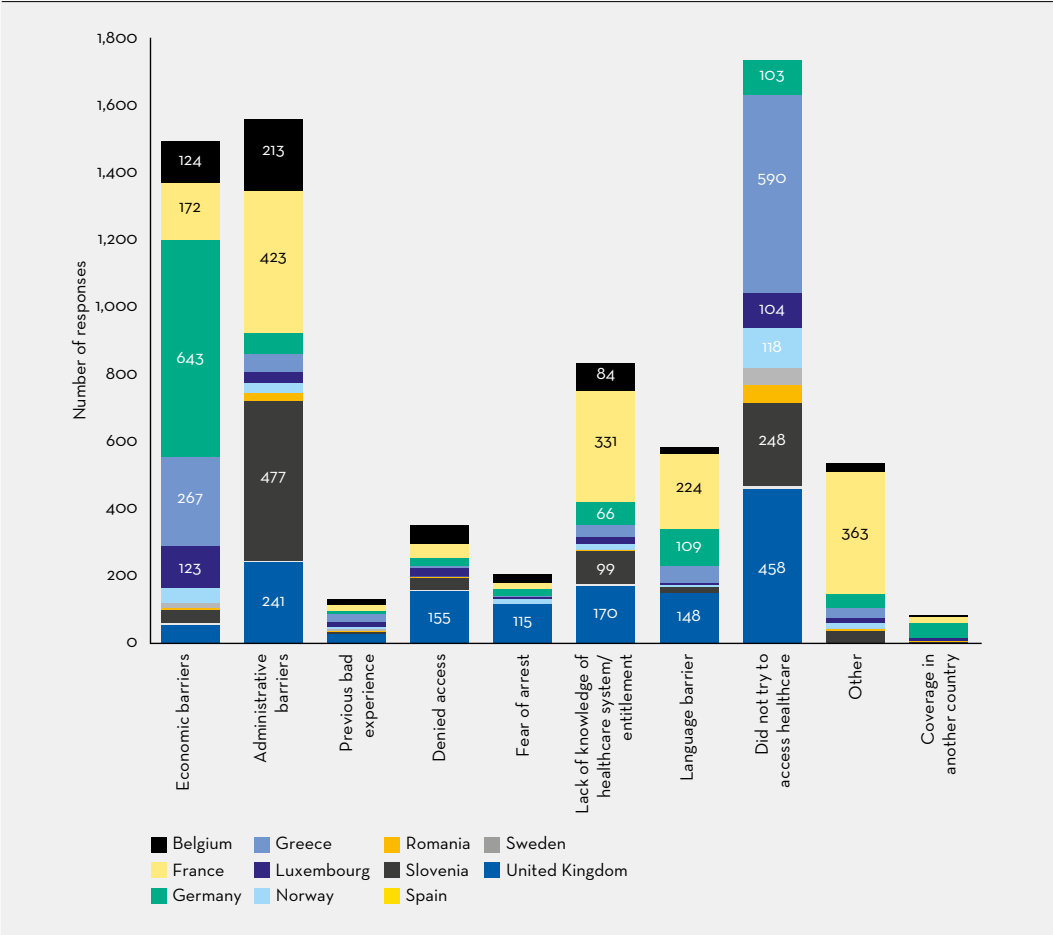
Figure 17 shows the largest number of responses reporting an economic barrier was recorded in Germany with 43.1% (643/1,493), and the largest number of responses for those who did not try to access healthcare was 34.0% in Greece (590/1,734). The largest number of responses reporting an administrative barrier was 30.6% in Spain (477/1,558) followed by 27.2% in France (423/1,558).

The largest number of responses reporting 'fear of arrest' as a barrier to healthcare were recorded at 56.1% in the UK (115/205), as were the highest number of responses at 43.9% reporting being denied access to healthcare (155/353).

Figure 18 shows the largest number of responses from nationals was 17.1% for 'did not try' (296/1,734), for non-EU/EEA migrants it was 84.5% for 'administrative barriers' (1,307/1,546 and for EU/EEA migrants it was 39.0% for 'cannot afford healthcare costs or coverage' (580/1,489).

⁹¹ 'Other': includes healthcare coverage included in visa; valid health coverage in another EU country / European Health Insurance Card. 'Partial healthcare coverage': includes health coverage for part of costs; free GP; access to GP but must pay part; and access to secondary care. 'No coverage': includes no cover at all; and access on a case-by-case basis.

Figure 17.
Count of obstacles to seeking healthcare
reported by patients



18.9%

of responses reported the individual did not try to access healthcare at 18.9% (1,734/9,184).

17%

of responses reported administrative barriers to healthcare (1,558/9,184).

Fig 17.
Data from social consultations, includes each individual once. Multiple reasons may be recorded for each individual. Figure excludes records reporting 'no difficulties' (5.5%; 1,676/30,659) and with no data for people seen (76.5%; 23,465/30,659). Economic barriers combines: consultation too expensive; treatment too expensive; and health insurance too expensive.

Figure 18.
What were the obstacles to seeking healthcare; by nationals, EU/EEA migrants, non-EU/EEA migrants

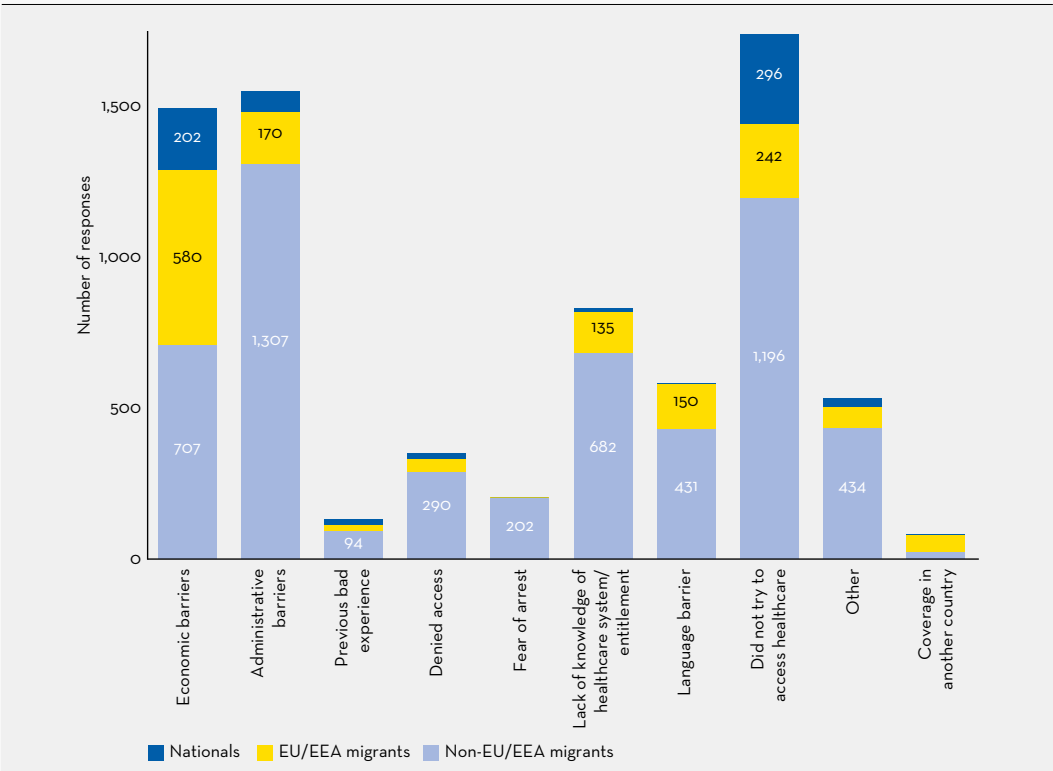


Fig 18.
Data from social consultations, includes each individual once. Multiple reasons may be recorded for each individual. Figure excludes records reporting 'no difficulties' (5.5%; 1,676/30,659) and with no data or no nationality for people seen (76.6%; 23,485/30,659). Economic barriers combines: consultation too expensive; treatment too expensive; and health insurance too expensive.



HEALTH CONDITIONS AND STATUS

Here we cover the health conditions and pathologies diagnosed by a clinician, and self-perceived health status reported by our patients.

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Cardiovascular diseases account for the highest proportion of NCD-related deaths globally, whilst cancers, respiratory diseases, and diabetes are other contributors.
 • •

COMMON PATHOLOGIES

An emerging challenge for public health is the rise of non-communicable diseases (NCDs). Also known as 'chronic diseases', they are often defined as diseases that have a slow progression over an extended time. Cardiovascular diseases account for the highest proportion of NCD-related deaths globally, whilst cancers, respiratory diseases, and diabetes are other contributors.⁹²

Figure 19 and 20 exclude records with missing ICPC chapter variable (6.8%; 2,300/33,878) and missing acute or chronic variable (42.3%; 14,324/33,878)

Overall, the highest proportion of reported acute problems were respiratory (19.4%; 1,639/8,435) followed by digestive (16.0%; 1,347/8,435), musculoskeletal (13.5%; 1,137/8,435) and skin (13.4%; 1,128/8,435).

EU/EEA migrants reported 42.3% of acute pregnancy pathologies (161/381).

Overall, the highest proportion of chronic pathologies were cardiovascular (19.9%; 1,945/9,774), followed by from musculoskeletal (13.2%; 1,293/9,774), from digestive (12.2%; 1,191/9,774), from endocrine, metabolic and nutritional (11.6%; 1,133/9,774), and from psychological (10.0%; 975/9,774).



Name: Ioana
Country: Romania

Ioana, 37, has been living on the streets of Bucharest since she was 12. Ioana is an injecting drug user and has been a client of the Caracuda drop-in centre for the past two years. In 2016, she went to the centre for a pregnancy test, which came back positive. In Romania, pregnant women benefit from free medical insurance for the duration of their pregnancy and for a short while after the birth.

“After two or three months, I went by myself [to hospital], but they didn't want to see me. I explained that I was pregnant and I wanted to see if the baby was ok and also told them that I knew that I had the right so be seen, yet they still refused.”

Desperate to see a doctor to make sure her baby was healthy, Ioana went to another hospital.

“After waiting for a couple of hours, a female doctor saw me, but she just looked at me and didn't do any tests. I left, as I had come knowing nothing new about the pregnancy or the baby. I know that if I use drugs I endanger the baby, but I can't just stop cold-turkey. I am trying to reduce the dose, ease off the drugs. This is why I wanted to go the hospital, to make sure the baby is fine. I just hope the baby is ok and will be healthy when born.”

92. WHO. "Non-Communicable Diseases." WHO-Media Centre, June, 2017 (accessed on September 22, 2017, www.who.int/mediacentre/factsheets/fs355/en/).

Within each group (non-EU/EEA migrant, EU/EEA migrants and nationals), cardiovascular chronic pathologies were most common (1,102/6,796, 509/1,963 and 334/1,015 respectively). However, musculoskeletal were the second most common chronic pathologies recorded in non-EU/EEA migrants (981/6,796), endocrine, metabolic and nutritional were the second in EU/EEA migrants (307/1,963), and psychological pathologies were second in nationals (134/1,015).

After considering the limitations of the data, there is evidence that chronic pathologies are higher in nationals (71.0; 95% CIs [68.6, 73.3]) than both EU/EEA migrants (49.9; 95% CIs [48.3, 51.4]) and non-EU/EEA migrants (53.4; 95% CIs [52.5, 54.2]). Similarly, there is evidence that non-EU/EEA migrants had higher chronic pathologies than EU/EEA migrants as the 95% CIs do not overlap.

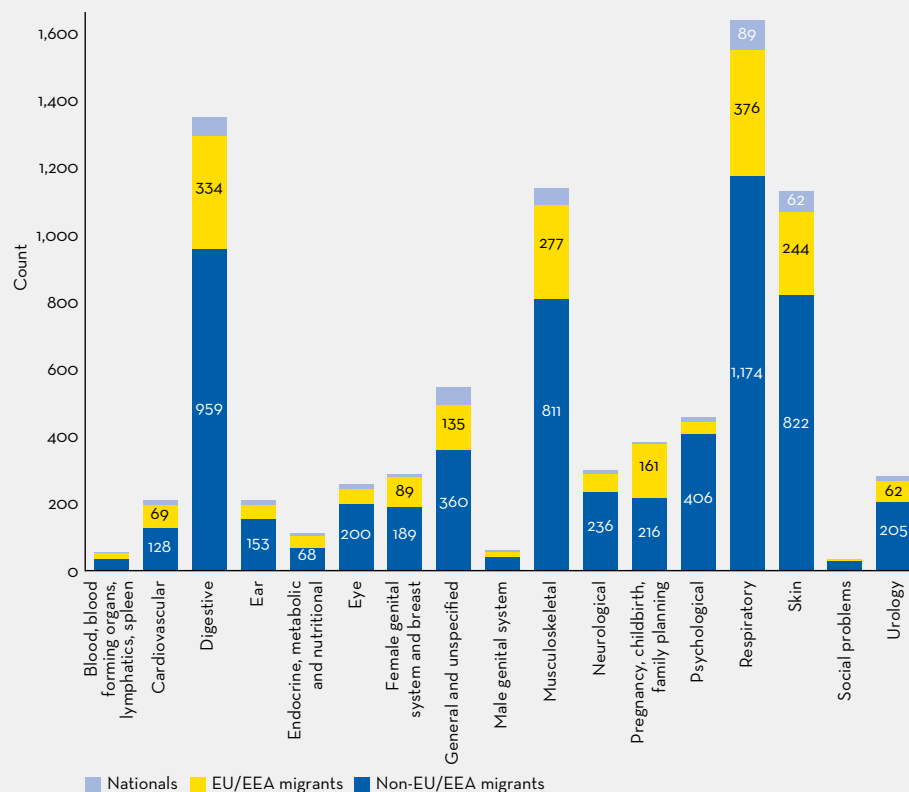


Name: Maria
Country: France

Maria, 50, and her husband are both from Honduras and have been living in Spain for several years. They are only entitled to partial healthcare coverage, which does not cover medical treatments or transport. Both Maria and her husband are diabetic, but their partial coverage does not cover the costs of their insulin medication. Maria does not have the money to pay for the insulin medicine herself, and they need constant access to avoid further health complications. They also cannot afford to pay for regular travel to and from the hospital.

They went to Doctors of the World seeking legal advice on how to access health benefits and fund the cost of their treatment. Doctors of the World applied for social benefits through the social services department and sought aid from NGO's to help fund Maria and her husband's treatment in the interim.

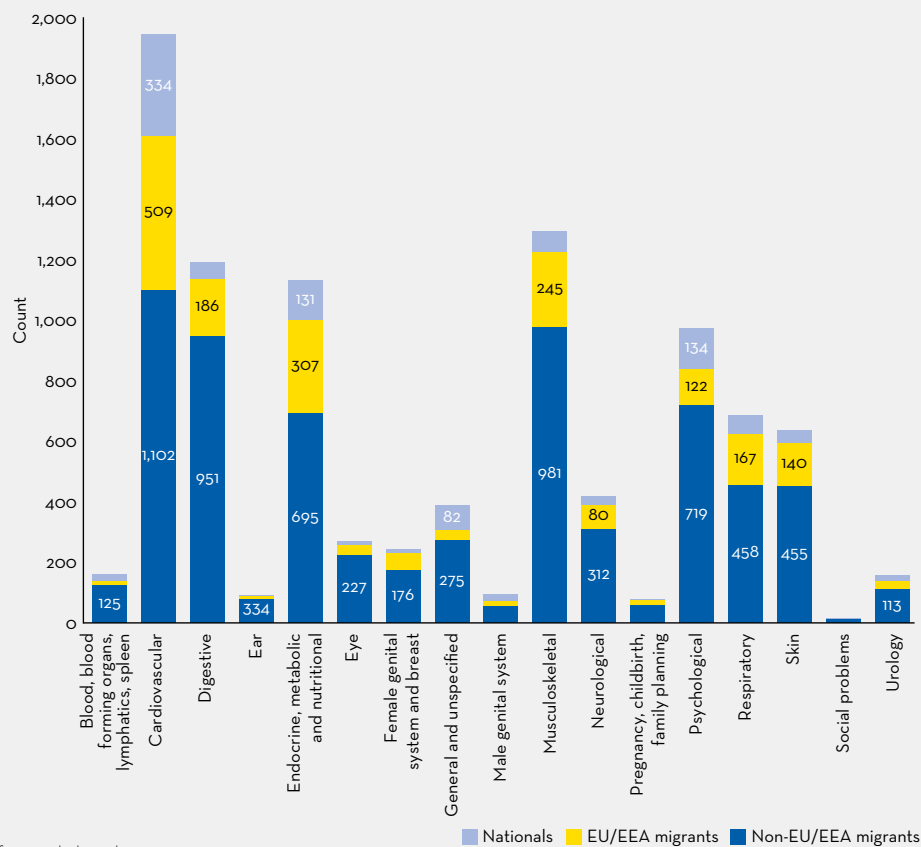
Figure 19.
Consultations for acute pathologies; by nationals, EU/EEA migrants, non-EU/EEA migrants



Data from pathology dataset

Figure excludes records with missing ICPC chapter variable (6.8%; 2,300/33,878) and missing acute or chronic variable (42.3%; 14,324/33,878)

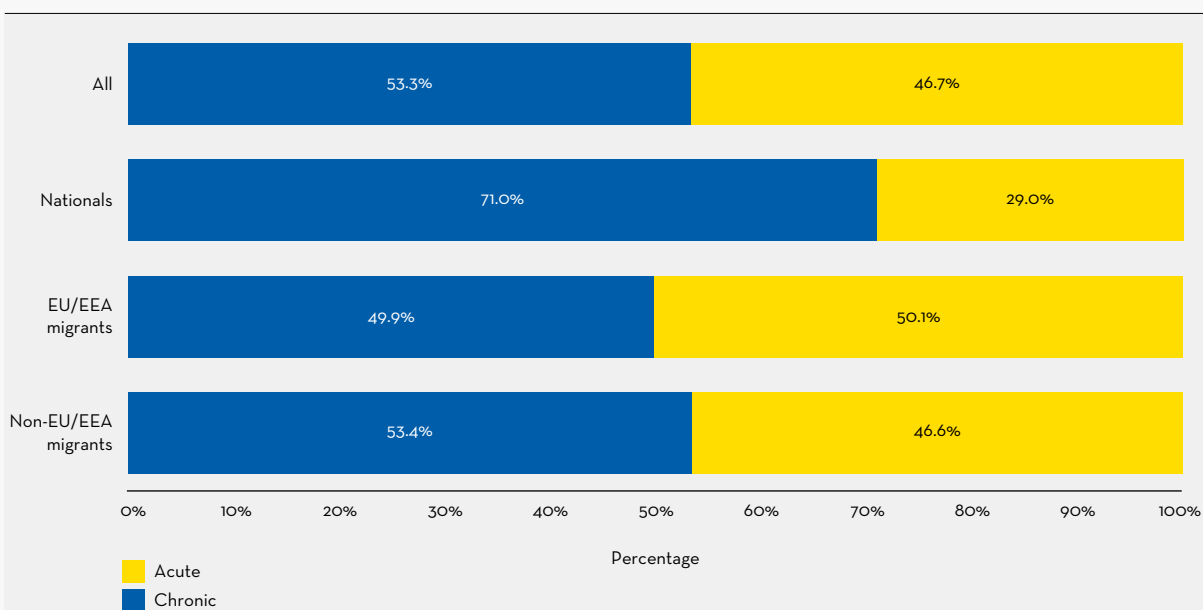
Figure 20.
Consultations for chronic pathologies; by nationals,
EU/EEA migrants, non-EU/EEA migrants



Data from pathology dataset

Figure excludes records with missing ICDPC chapter variable (6.8%; 2,300/33,878) and missing acute or chronic variable (42.3%; 14,324/33,878)

Figure 21.
Acute and chronic medical conditions; by nationals,
EU/EEA migrants, non-EU/EEA migrants



Data from pathology dataset

Figure excludes records missing acute or chronic variable (42.3%; 14,324/33,878)

The ALL bar includes individuals for which no nationality was recorded (857)



SELF-PERCEIVED HEALTH STATUS

Collecting data on self-perceived health status can help us understand the healthcare needs of excluded patients; it can provide insight into a holistic approach to health, encompassing both physical and mental wellbeing. Studies have also demonstrated that self-perceived health is a reliable predictor of morbidity.⁹³ Some studies have even reported that over a long period of time self-reported health is more stable than clinician's ratings.⁹⁴ Studies have shown that overall, migrants and minorities report worse self-perceived health than the baseline population.⁹⁵⁻⁹⁷

In Figure 22 most patients who responded to this question perceived their physical health as 'good' by 34.7% (2,652/7,643). However, over half (53.4%; 4,080/7,643) did not perceive their physical health as 'good' or 'very good'.

16.7% rated their physical health status as bad (1,274/7,643), and a further 4.3% rated theirs as 'very bad' (329/7,643). Keeping in consideration the limitations of the data, there is evidence of higher levels of 'very bad' self-perceived health from nationals (6.5%; 95% CIs [5.0, 8.3]) compared to non-EU/EEA migrants (3.8%; 95% CIs [3.3, 4.4]).

When asked about their psychological health, (Figure 23), 49.4% did not rate theirs as 'good' or 'very good' (3,714/7,515). 14.9% said it was 'bad' (1,122/7,515), and a further 5.8% said it was 'very bad' (433/7,515). There is evidence that nationals reported higher levels of 'very bad' psychological health (11.2; 95% CIs [9.2, 13.4]) than EU/EEA migrants (6.6; 95% CIs [5.1, 8.4]) and non-EU/EEA migrants (4.8; 95% CIs [4.3, 5.4]).



Name: Tomas
Country: Germany

Tomas is a 39-year-old Romanian citizen living in Germany. In late 2015, he left his hometown of Timisoara in search of a new life. As a Type 1 diabetic he had hoped his Romanian health insurance would be valid in Germany, but when he arrived in Germany, he found out it was impossible for him to access the German healthcare system.

“ My insulin supplies ended and I fell into a coma. I went to hospital for a week and after waking up I was released with a supply that lasted me nearly one week. Since I don't speak German, I encountered great language barriers. I couldn't understand the doctors and the doctors couldn't understand me. ”

Tomas was admitted back into hospital in February after insufficient insulin regulation led to his toe being amputated. He was once again sent away with a week's worth of insulin supplies. The day his insulin was due to run out, a panicked Tomas found Doctors of the World.

“ I had a piece of paper in my hand with two German words on it: 'Insulin, please!'. ”

Doctors of the World provided a Romanian translator to help him write the family medical history the hospital required. They were also able to get Tomas access to medication, check-ups, and a blood sugar testing device. Tomas found a place to stay thanks to help from another charity and is now optimistic he can find work and settle into his new life.

93. Kaplan, George A., Debbie E. Goldberg, Susan A. Everson, Richard D. Cohen, Riitta Salonen, Jaakko Tuomilehto, and Jukka Salonen. "Perceived Health Status and Morbidity and Mortality: Evidence from the Kuopio Ischaemic Heart Disease Risk Factor Study." *International Journal of Epidemiology* 25, no. 2, (1996), 259-265. doi: 10.1093/ije/25.2.259.

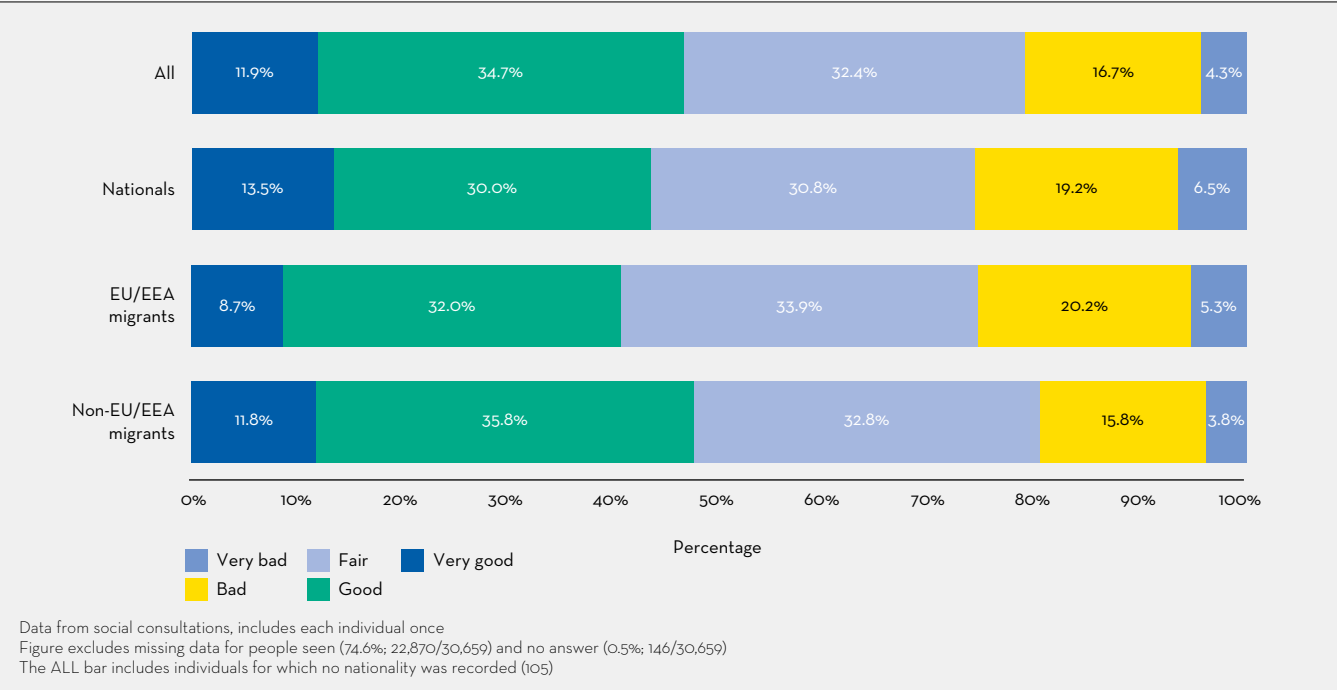
94. Shields, Margot, and Shahin Shooshtari. "Determinants of Self-Perceived Health." *Health Reports* 13, no. 1, (2001), 35-52.

95. Nielsen, Signe Smith, and Allan Krasnik. "Poorer Self-Perceived Health Among Migrants and Ethnic Minorities Versus the Majority Population in Europe: A Systematic Review." *International Journal of Public Health* 55, no. 5, (2010), 357-371.

96. Koochek, Afsaneh, Ali Montazeri, Sven-Erik Johansson, and Jan Sundquist. "Health-Related Quality of Life and Migration: A Cross Sectional Study on Elderly Iranians in Sweden." *Health and Quality of Life Outcomes* 5, no. 60, (2007). doi: 10.1186/1477-7525-5-60.

97. Wiking, Eivor, Sven-Erik Johansson, and Jan Sundquist. "Ethnicity, Acculturation, and Self-Reported Health: A Population Based Study Among Immigrants from Poland, Turkey, and Iran in Sweden." *Journal of Epidemiology and Community Health* 58, no. 7 (2004), 574-582.

Figure 22.
Perceived physical health; by nationals, EU/EEA migrants, non-EU/EEA migrants



● ●

Collecting data on self-perceived health status can help us understand the healthcare needs of excluded patients; it can provide insight into a holistic approach to health, encompassing both physical and mental wellbeing.

● ●



Name: Yasir
Country: Norway

Yasir, 29, is an asylum seeker from Somalia. His home village was devastated by conflict, and Yasir feared for his life. He sought refuge in Norway, leaving behind his friends and family. He applied for asylum, but his application was rejected and he has no means to access healthcare.

He started having trouble breathing after moving to Norway. A friend he lived with had tuberculosis (TB), concerned he also had TB Yasir decided to go to hospital for a check-up. The check-up cleared Yasir of TB, but instead it revealed a serious heart condition. He needed a heart valve replacement, and will need life-long care and medication.

“ I am very sick and cannot go back to Somalia. But UNE [appeals body for immigration cases] and UDI [the Norwegian Directorate of Immigration] do not believe I am from Somalia that is the reason why my application for asylum was rejected. ”

Yasir now receives regular health checks from the team at the Health Centre for Undocumented Migrants. He is hopeful he will be able to stay in Norway, if he returns to Somalia he fears he will not be able to access the necessary medication and follow-up treatment.

53.4%

Over half (53.4%; 4,080/7,643) did not perceive their physical health as 'good' or 'very good'.

16.7%

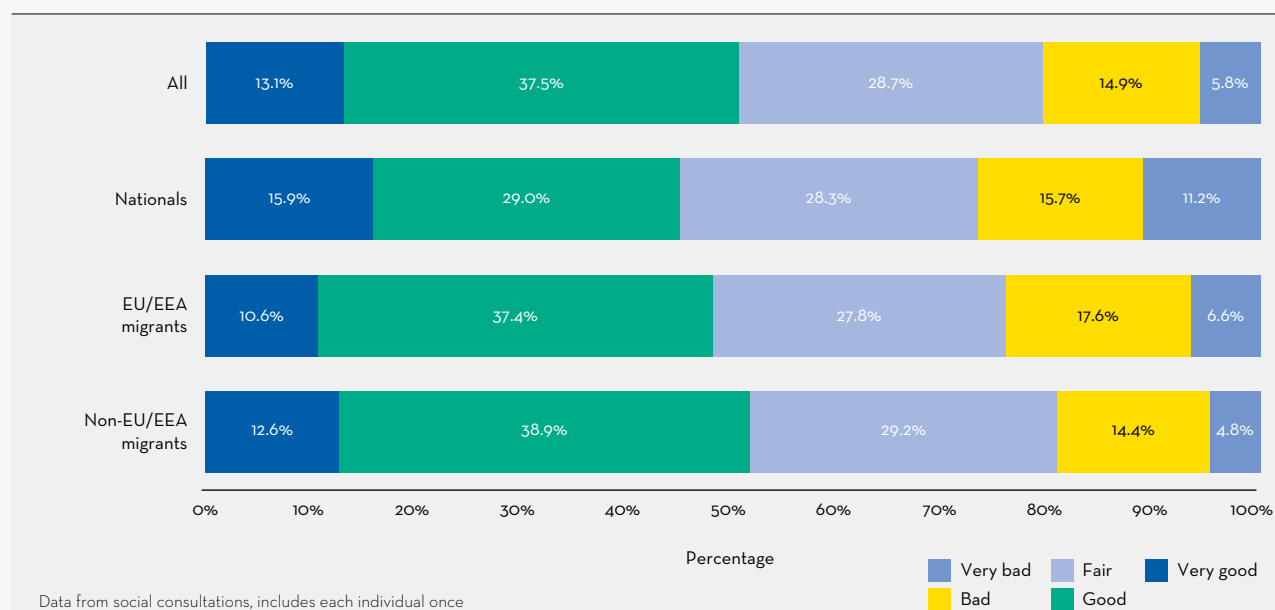
16.7% rated their physical health status as bad (1,274/7,643).

49.4%

did not rate their psychological health, as 'good' or 'very good' (3,714/7,515).

Figure 23.

Perceived psychological health; by nationals, EU/EEA migrants, non-EU/EEA migrants



Data from social consultations, includes each individual once

Figure excludes missing data for people seen (75.0%; 22,995/30,659) and no answer (0.5%; 149/30,659)

The ALL bar includes individuals for which no nationality was recorded (104)

**Name: Femi****Country: Switzerland**

Femi, 56, is a musician from West Africa. He sought asylum in Switzerland when he first arrived in 2007, but after a lengthy process he was refused in 2014 and has been living in Switzerland illegally ever since. Femi suffers from several mental health issues, including severe depression and sporadic psychotic episodes. He is homeless, and sleeps in churches and cellars, and can only find casual work that is poorly paid. Femi's living situation exacerbates his mental health issues, as without employment and shelter he cannot access health insurance. This prevents Femi from receiving any psychiatric help, so he regularly attends the Doctors of the World clinic where the nurses do their best to support him and help him purchase medication and find emergency accommodation.

Femi was recently hospitalised after a severe psychotic episode. Doctors of the World are working with the hospital to find a long-term solution for Femi and provide psychiatric follow-up care and improve Femi's living situation.

PUBLIC HEALTH

For public health initiatives to have maximum impact, they must reach excluded people. The recent measles epidemics in Europe⁹⁸ illustrates the essential role of vaccinations as part of preventive public healthcare, protecting both the individual and the population as a whole.

The data shown in Figure 24 shows the reported vaccination status of children under 18 years. The 'yes' group indicates there is documented evidence of vaccination. The 'probable' group indicates that the individual thinks they are vaccinated, but has no documented evidence. The 'unknown' group does not know their vaccination status, and the 'no' group indicates that they are certain they have not been vaccinated.

There is statistical evidence demonstrating that those who have been vaccinated ('yes' group) are different across each vaccination group: hepatitis B (43.4; 95% CIs [42.1, 44.7]); MMR (53.0; 95% CIs [51.7, 54.3]); pertussis (56.4; 95% CIs [55.1, 57.8]); and tetanus (59.1; 95% CIs [57.9, 60.4]).

Because of the sample size of the data, it is not possible to draw population level conclusions about these vaccination levels. However, the data does suggest vaccination levels are below the WHO recommended standards.⁹⁹

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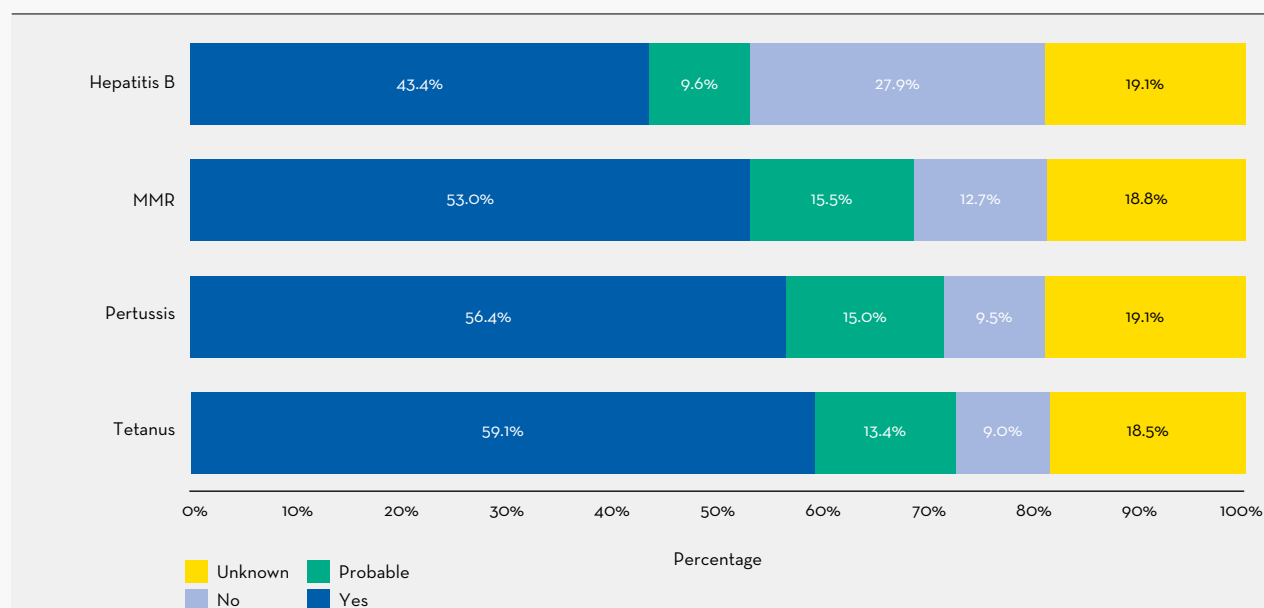
For public health initiatives to have maximum impact, they must reach excluded people. The recent measles epidemics in Europe illustrates the essential role of vaccinations as part of preventive public healthcare, protecting both the individual and the population as a whole.

• •

98. WHO. "Measles Outbreaks Across Europe Threaten Progress Towards Elimination." WHO-Media Centre, March 28, 2017 (accessed on October 03, 2017, www.euro.who.int/en/media-centre/sections/press-releases/2017/measles-outbreaks-across-europe-threaten-progress-towards-elimination).

99. WHO. "Global Vaccine Action Plan", 2016 (accessed on September 9, 2017, <http://apps.who.int/gho/cabinet/gvap.jsp>).

Figure 24.
Reported vaccination status of children under 18 years



Data from medical consultations, includes each individual once
Figure excludes no data for people seen (21.0%; 1,528/7,283)



Name: Mihai
Country: Romania

Mihai, 29, is an injecting drug user living in Bucharest. He has been injecting heroin since he was 13 and he has been a client of Caracuda drop-in centre since it opened.

In 2016, Mihai went to the drop-in centre and asked for betadine and sterile gauze to self-treat wounds on his legs. A week later he consented to being examined by the doctor at the centre who immediately referred him to the hospital. The staff at the hospital refused to see him.

“ They said I was HIV positive, without actually testing me, and refused to look at me. They sent me to another hospital, Victor Babes Infectious and Tropical Diseases Hospital, where they work with HIV positive drug users. But once I arrived there, doctors said that they cannot see me until another doctor sees my leg wounds and dresses them and I get an antibiotic prescribed, which they can't do there, and I should go back where I came from. ”

The staff at the drop-in centre obtained official documentation showing he was HIV negative so he could be treated. The doctor at the hospital said that Mihai only qualified for emergency care as he did not have insurance. Carusel, an NGO, covered most of the cost of Mihai's medical insurance, so his legs could be treated. Mihai has recovered well, but is constantly concerned about maintaining his medical insurance. To remain covered by the medical insurance, Mihai needs to pay 5.5% of the minimum monthly wage, which he currently cannot afford.



Name: Nazaneen

Country: Norway

Nazaneen is pregnant and she is an irregular migrant in her 20s living in Norway. She was in an abusive relationship, but when her partner started to threaten her life and throw objects at her stomach, Nazaneen fled to protect her unborn child.

Nazaneen went to the Health Centre for Undocumented Migrants to receive antenatal care during her pregnancy. The Health Centre staff arranged accommodation for her in a local women's shelter, but she was asked to leave after her first night, when they discovered she was an irregular migrant. Although healthcare for pregnant women in Norway is free regardless of residency status, Nazaneen faced discrimination from healthcare staff when she went to the local hospital. They made reproachful comments about why she had chosen to get pregnant and scared her by informing her she had been billed for all the healthcare services they had provided.

MATERNITY CARE

Despite a global effort to reduce maternal mortality (the SDGs include a target of less than 70 maternal deaths per 100,000 live births by 2030),¹⁰⁰ 830 women globally still die every day from preventable causes related to pregnancy and childbirth.¹⁰¹ One of the most essential elements in reducing the risk of complications during pregnancy and birth is antenatal care.

Accessing care late on in pregnancy is associated with increased risk of poor maternal outcomes;¹⁰² according to the National Institute for Health and Care Excellence first contact with antenatal services should be made early.¹⁰³ WHO guidelines recommend a first antenatal appointment in the first 12 weeks and a minimum of eight antenatal appointments during pregnancy, although globally only 64.0% of women are receiving antenatal care four or more times during their pregnancy.¹⁰⁴

In 2016, 627 pregnant women were seen in our clinics and programmes across eleven different countries.

When asked if accessing antenatal care, Figure 25 shows that 41.6% of pregnant women who responded had accessed antenatal care prior to visiting one of our programmes or clinics (153/368). The remaining 58.4% indicated that they had not accessed antenatal care (215/368).

The number of EU/EEA migrant women reporting no antenatal care access prior to their consultation is concerning, particularly as Figure 25 shows 42.3% of acute pregnancy problems were reported by EU/EEA migrants.

It should be noted that the data does not record how advanced a pregnancy is. Those in the early stages of pregnancy (under 12 weeks) do not necessarily need to access antenatal care. However, all pregnant women will need antenatal care in the later stages of their pregnancy. The presence of pregnant women at programmes, none of which provide full antenatal care services, indicates these women are at risk of not accessing antenatal care and not receiving the WHO recommended level of antenatal care.

41.6%

of pregnant women had accessed antenatal care (153/368).

42.3%

42.3% of acute pregnancy problems were reported by EU/EEA migrants.

100. United Nations. "Sustainable Development Goal 3: Ensure Healthy Lives and Promote Well-Being For All at All Ages." Sustainable Development Knowledge Platform, 2017 (accessed on September 22, 2017, <https://sustainabledevelopment.un.org/sdgs>).

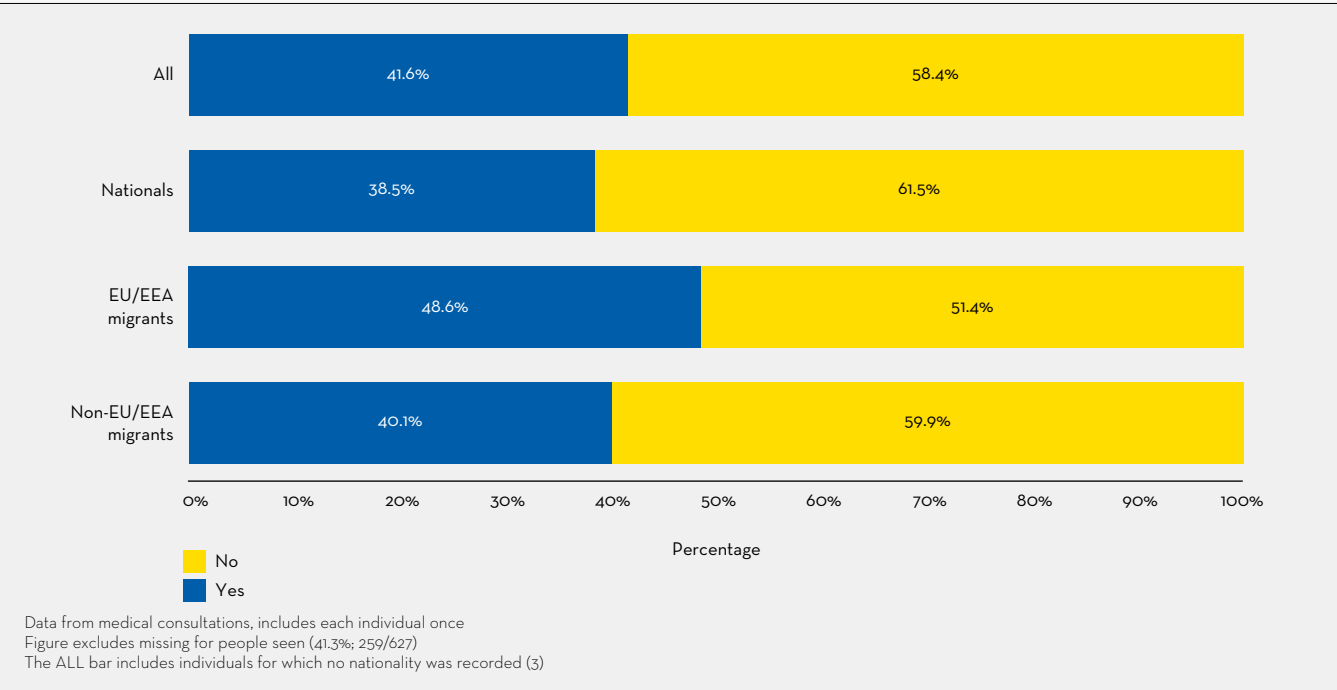
101. WHO. "Maternal Mortality." Factsheet, 2016 (accessed on September 27, 2017, www.who.int/mediacentre/factsheets/fs348/en/).

102. WHO. "WHO recommendations on antenatal care for a positive pregnancy experience." Sexual and Reproductive Health, 2016, pp13 - 105 (accessed on accessed October 10, 2017, <http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf>).

103. National Institute for Health and Care Excellence. "Antenatal Care." NICE Clinical Guideline 62 (2008). 227.

104. WHO. "WHO recommendations on antenatal care for a positive pregnancy experience." Sexual and Reproductive Health, 2016, pp13 - 105 (accessed on accessed October 10, 2017, <http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf>).

Figure 25.
Percentage of pregnant women who have accessed antenatal care before attending an MdM clinic; by nationals, EU/EEA migrants, non-EU/EEA migrants



Name: Miri
Country: Germany

Miri is a 32-year-old Bulgarian Roma living in Germany. She and her husband cannot find employment and therefore, cannot access healthcare, or housing. They have two children and are expecting a third child, a little boy. Miri needed regular access to antenatal checks, as well as shelter for her family. The family got in touch with Doctors of the World, who made sure Miri had access to antenatal care and provided clothes and school materials for her elder children.

“ I was happy to hear that there is an organisation that provides free medical care for individuals who cannot afford it and do not have any health coverage, not even in the country of origin, like us. ”

DISCUSSION

SUMMARY OF KEY FINDINGS

Universal healthcare coverage is posed as the solution to exclusion from healthcare. The WHO defines universal healthcare coverage as “ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, whilst also ensuring that people do not suffer financial hardship when paying for these services”.¹⁰⁵ It is often assumed that European countries have achieved universal coverage. However, this study has shown this is not the case. 55.2% of people told us they did not have any healthcare coverage.

The study is a snapshot of those who fall through the cracks in European healthcare systems. Whilst most people were young adults, 22.2% were children (under 18 years). The majority were non-EU/EEA migrants (79.1%), with the largest number of people coming from Syria (13.0%). The data shows nationals (12.1%) and EU/EEA migrants (7.5%) also struggle to access healthcare systems.

The study observes the prevalence of the social determinates of health (the economic, psychosocial, and political factors known to increase vulnerability to poor health and wellbeing) in this patient group and found that many were living on the edge. 89.0% of people were living below the poverty threshold and 77.3% were unemployed. 23.8% were living on the street, or in camps, slums, or squats.

Social isolation was common: 38.9% of patients did not have a reliable social support network, and 54.6% had limited knowledge of the local language. There was evidence that EU/EEA migrants reported the highest levels of poverty, street homelessness and social isolation.

Many people were living under incredible emotional strain: when asked why they left their country of origin, 18.0%, of the responses from non-EU/EEA migrants said they were escaping persecution or discrimination because of their political opinions, religion, race/ethnicity, or sexual orientation. 14.1% were fleeing because of war, and 5.6% escaping family conflict. 61.7% of people were separated from their children (under 18 years); and 56.2% talked about their experiences of violence. Half of people did not have permission to reside in the country they were living in (50.3%) and 47.3% restricted their movements in public because they feared arrest.

We asked patients about challenges they faced in accessing healthcare services. An analysis of their responses showed that these economic, psychosocial, and political factors also increased vulnerability to poor access to healthcare. The most common response was that the individual did not even try to access care (18.9%). Of those that did, most were defeated by administrative barriers (17.0%) or the inability to understand the healthcare system (9.1%). These barriers speak to high levels of social isolation and exclusion: those without a social support network and with limited knowledge of the local language are less likely to be able to navigate bureaucracy.

Economic barriers were significant: 16.3% of the responses told us they could not afford to pay for healthcare coverage, appointments, or treatment.

We also saw patients' access healthcare undermined by political factors. 3.8% were denied access to healthcare services, and a number (2.2% of responses) told us they were too afraid to access care because they feared it would lead to them being arrested.

Data on the health status of excluded patient groups is, by default, difficult to collect. By recording pathologies, self-perceived health status of patients and vaccination levels, this study, along with previous Observatory Reports, adds to the available data.

The most frequently reported acute conditions were respiratory at 19.4% followed by digestive at 16.0%, musculoskeletal at 13.5%, and skin at 13.4%. The most frequently reported chronic pathologies were cardiovascular at 19.9%, followed by musculoskeletal at 13.2%, digestive at 12.2%, endocrine, metabolic and nutritional at 11.6%, and psychological at 10.0%. Chronic pathologies were higher in nationals (71.0%).

Data on four vaccinations in children showed; of those who responded (and had proof of vaccination) 43.4% had been vaccinated against hepatitis B, 53.0% against MMR, 56.4% against whooping cough and 59.1% against tetanus.

The study shows there are pregnant women across Europe who are not accessing antenatal care, and are at risk of not receiving the WHO recommended level of antenatal care. Over half of the pregnant women had not received any antenatal care prior to attending the programmes (58.4%). A high proportion of EU/EEA migrants reported they had not accessed antenatal care, which is concerning as this group presented with a high proportion of acute pregnancy pathologies (42.3%).

¹⁰⁵. WHO. “Universal Health Coverage.” Health systems, 2017 (accessed on September 22, 2017, www.who.int/healthsystems/universal_health_coverage/en/)

UNIVERSAL HEALTHCARE COVERAGE REQUIRES MORE THAN JUST 'EMERGENCY' HEALTHCARE COVERAGE

Of people seen in the programmes, 18.3% had coverage for 'emergency care only', reflecting a trend amongst European governments to provide coverage for 'emergency care only' to certain groups of people.¹⁰⁶⁻¹⁰⁷ There is no suggestion in either international human rights law nor the UN's aspirations and WHO guidance that emergency care is an acceptable minimum level of healthcare.¹⁰⁸ The fact that patients with 'emergency care only' coverage presented in our clinics for care supports the case that emergency coverage only is not sufficient to meet healthcare needs.

Coverage for 'emergency care only' presents many challenges. Ignoring the importance of prevention, primary care and early intervention, it forces people to wait until conditions are advanced and more complex to treat. Research suggests restricted access to healthcare may cost governments more in the long run.¹⁰⁹⁻¹¹¹ It also undermines efforts to tackle the global rise of NCDs, which requires that people with chronic condition have continued access to care.



106. Spenser, Sarah, and Vanessa Hughes. "Outside and In: Legal Entitlement to Health Care and Education for Migrants with Irregular Status in Europe." Oxford: COMPAS, 2015 (accessed on September 27, 2017, www.compas.ox.ac.uk/2015/outside-and-in/).

107. International Organization for Migration. "Summary Report on the MIPEX Health Strand and Country Report." IOM Migration Research Series no. 52. Geneva: IOM, 2016 (accessed on September 27, 2017, https://publications.iom.int/system/files/mrs_52.pdf).

108. Ingleby, David, and Roumyana Petrova-Benedict. "Recommendations on Access to Healthcare Services for Migrants in an Irregular Situation: An Expert Consensus." Brussels: IOM, 2016 (accessed on September 27, 2017, <http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus>).

109. Trummer, Ursula, Sonja Novak-Zezula, Anna-Theresa Renner, and Ina Wilczewska. "Cost Analysis of Health Care Provision for Migrants and Ethnic Minorities." Vienna: C-HM, 2015. A thematic study developed and implemented by C-HM under the overall guidance of the International Organization for Migration Regional Office Brussels, Migration health Division within the framework of the IOM/EC EQUI-HEALTH project "Fostering health provision for migrants, the Roma, and other vulnerable groups".

110. Bozorgmehr, Kayvan, and Oliver Razum. "Effects of Restricting Access to Health Care on Expenditure Among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013." *Public Library of Science, ONE* 10, no. 7 (2015). e0131483. doi:10.1371/journal.pone.0131483.

111. EU Fundamental Rights Agency (FRA). "Cost of Exclusion Healthcare: The Case of Migrants in an Irregular Situation." Vienna: FRA, 2015 (accessed on September 27, 2017, http://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-cost-healthcare_en.pdf).

DISCUSSION

PROGRESSIVE APPROACHES TO PUBLIC HEALTH

Most European governments recognise the importance of protecting public health, and as such provide access to vaccination, infectious disease screening, and treatment for certain infectious diseases to everyone.¹¹² The data highlights the need for policy makers to take a progressive and broad approach to public health when looking at healthcare access. Such an approach would, in addition to infectious disease prevention, prioritise good access to primary, antenatal, and postnatal care, public mental health services, and health promotion. It would also properly consider the social determinates of health.

The varying compliance levels across the different vaccinations in the data indicates current approaches to healthcare access are not achieving recommended levels.¹¹³ For infectious disease prevention programmes to have maximum impact, everyone within a community needs to have good and regular access to primary care. People are much more likely to take up infectious disease screening, comply with treatment and complete vaccination programmes.

Reducing perinatal and maternal mortality and morbidity is a high priority for most countries. The provision of good antenatal and postnatal care is essential to public health, as a mother's ill health undermines the healthy development of a child. Yet the data in this report highlights poor access to antenatal care: 58.4% of women had not accessed antenatal care prior to attending their consultation at one of our programmes.

HEALTHCARE AS A TOOL OF IMMIGRATION CONTROL

Restricting migrants' access to welfare and health services as a means of reducing migration is increasingly becoming an overt policy objective of governments.¹¹⁴⁻¹¹⁵ The sharing of information on irregular migrants between health and welfare services and immigration enforcement agencies is often a central part of these policies. In 2015, five European countries required healthcare professionals or services to report irregular migrants to authorities, and more had information sharing mechanisms with immigration enforcement bodies.¹¹⁶ Since then more European governments have followed suit.¹¹⁷

The assumption behind such policies is that, through accessing these services, irregular migrants can be more easily identified, apprehended, and deported, or the fear of immigration enforcement will be so great they will not access services and 'self-deport'.¹¹⁸

The data indicates these policies do prevent people from accessing healthcare services (2.2%). However, there is no evidence they are effective in achieving their intended goal of lowering migration.¹¹⁹ The data in this report (and previous Observatory Reports¹²⁰) shows that healthcare services are not a factor that pulls migrants to Europe: 2.9% of all responses from non-EU/EEA reported leaving a their country of origin for health reasons. For EU/EEA migrants, this was 2.5%.

These policies raise problems beyond their unproven effectiveness and the ethical questions they raise. They present a very real risk: to public health, of increasing overall healthcare costs, public trust in confidential healthcare systems, of undermining the doctor-patient relationship, and to the protection of human rights.

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115. German Government. "Gesetz zur Regelung von Ansprüchen ausländischer Personen in der Grundsicherung für Arbeitsuchende nach dem Zweiten Buch Sozialgesetzbuch und in der Sozialhilfe nach dem Zwölften Buch Sozialgesetzbuch." Berlin: 2016 (accessed on September 02, 2017, <http://diptb.bundestag.de/extrakt/ba/WP18/772/77237.html>).

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118. Platform for International Cooperation on Undocumented Migrants (PICUM). "PICUM Key Messages to the 2nd Convention of the European Platform Against Poverty and Social Exclusion." Brussels, December 5 to 7 2012. PICUM, 2012.

ASYLUM AND HEALTHCARE

When asked why they left their country of origin, 14.1% of the responses from non-EU/EEA migrants said they were fleeing because of war or armed conflict, 18.0% were escaping persecution or discrimination because of their political opinion, religion, race/ethnicity, or sexual orientation, and 5.6% left because of family conflict. 14.9% had made an asylum application, and 1.4% had been granted refugee status, humanitarian protection or discretionary leave. The presence of these people in our clinics indicates European healthcare systems are not meeting the healthcare needs of refugees and asylum seekers.

Entitlement to mainstream healthcare services for refugees and asylum seekers varies by member state, but EU Directive 2013/33/EU requires all states to ensure asylum seekers “receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders”.¹²¹ Living in a new and unfamiliar country, refugees and asylum seekers are likely to be particularly impacted by obstacles such as lack of knowledge of healthcare systems and administrative barriers. The exclusion of refugees and asylum seekers from healthcare services, either by law or by practical barriers, is concerning given their specific medical needs, both physical and psychological.¹²²

14.1%

When asked why they left their country of origin, 14.1% of responses from non-EU/EEA migrants said they were fleeing war or armed conflict.

18%

18.0% were escaping persecution or discrimination because of their political opinion, religion, race/ethnicity, or sexual orientation

119. Ingleby, David, and Roumyana Petrova-Benedict. “Recommendations on Access to Healthcare Services for Migrants in an Irregular Situation: An Expert Consensus.” Brussels: IOM, 2016 (accessed on September 27, 2017, <http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus>).

120. For previous Observatory Reports, see: <https://mdmeuroblog.wordpress.com/resources/publications/>

121. European Union. “Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 Laying Down Standards for the Reception of Applicants for International Protection.” EUR-Lex, 2017 (accessed on September 26, 2017, <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32013L0033>).

122. Kane, Jeremy C., Peter Ventevogel, Paul Spiegel, Judith K. Bass, Mark van Ommeren, and Wietse A. Tol. “Mental, Neurological, and Substance Use Problems Among Refugees in Primary Health Care: Analysis of the Health Information System in 90 Refugee Camps.” *BMC Medicine* 12 (2014): 228.

METHODOLOGY AND LIMITATIONS

The purpose of this report is to undertake common data collection process in order to generate robust data, analysed, and validated by a leading epidemiologist. The data is valuable for policy makers at local, regional, national, and EU levels, enlarging the evidence-base on reducing vulnerabilities in health and identifying ways that health systems could become more responsive and adapted. It will also be valuable for academics to review and acquire greater understanding about how vulnerabilities contribute to health inequalities.

The data was collected from January to December in 2016. There was a total of 110,277 consultations (36,409 medical consultations and 73,868 social consultations) recorded for this report in 2016.

DATA SOURCE

Data for this report were taken from face-to-face consultations at 13 MdM health centres (Belgium, France, Germany, Greece, Ireland, Luxembourg, Norway, Romania, Slovenia, Spain, Sweden, Switzerland, and United Kingdom) and partner programmes by volunteer doctors, nurses, and support workers. Data were collected throughout 2016 and consisted of two core parts – social and medical consultations. Social consultations focused on social determinants of health such as housing status, health access, and health coverage. Medical consultations focused on issues such as medical history, current health status, pregnancy, and vaccination status. Within medical consultations, specific diagnoses were recorded using the ICPC-2 (International Classification of Primary Care – second edition) pathology classification system.¹²³

Data collection were not complete.

- MdM Spain: provided data from 7 of their 20 health centres representing approximately 10.0% of all individuals seen.
- MdM Greece: 1 in 10 patients were interviewed for data collection at each polyclinic with the exceptions of the polyclinic in Athens (1 in 20) and Mitilini (100.0% of all medical patients).
- MdM Germany: provided data from Hamburg (100.0% of all medical patients and 50.0% of social patients) and data from Munich (100.0% of all medical and social patients).
- Migrant Rights Centre Ireland: provided only social data (100.0% sampling).
- Slovene Philanthropy (Slovenia): sampled 100.0% of new patients and 1 in 3 of returning patients.
- All other MdM health centres: sampled 100.0% of the patients through social or medical data collection.

Individuals may have had multiple face-to-face social or medical consultations. We analysed data using one social consultation record and one medical consultation record per individual. Consultation records selected for an individual was that which contained the most completed data, with a preference for the first consultation record.

An algorithm was used to score and identify the records with the most completed demographic data and key points of study. Where a patient had multiple records and if the first consultation record had the highest score, or equal to the highest score, it was selected. There are two exceptions to this rule. First, as the data used in Figure 1 (in section 'Who We Saw') provides an overview of all consultations by country in 2017, all data are included and therefore, Figure 1 contains duplicate records for individuals. Second, pathology data consisted of all pathologies recorded for each person from all their medical consultations – there was no exclusion or selection process and as a result, individuals may appear in this dataset more than once, dependant on how many pathologies were reported.

¹²³. World Health Organisation, *International Classification of Primary Care, Second edition (ICPC-2)* (Accessed on 1 October 2017, available at <http://www.who.int/classifications/icd/adaptations/icpc2/en/>)

STATISTICS

Before analysing the data, all variables were standardised such that the answers to questions were consistent in type across the MdM health centres. For example, immigration status as provided according to each country's status was equated to a set of statuses as defined by the International Observatory. Country of origin was used to classify individuals into nationals, EU/EEA migrants, and non-EU/EEA migrants.

Data are presented throughout the Observatory Report as either simple counts or crude percentages – no weighting of percentages was performed. Statistical tests performed were either chi-square tests for a proportion, or 95% confidence intervals (CIs) associated with an estimate.

LIMITATIONS

The data used in this Observatory Report were collected as part of the MdM health centre operations and as a result many items presented contained high levels of missing data. This has been reported routinely in the figure notes and highlighted in the report in situations where missing data may be particularly important to consider, as it is likely to bias comparisons between groups. It is also important to note that some data items were not collected by individual countries and so underlying data for each figure is not necessarily representative of all included MdM health centres.

The individuals attending consultations at the MdM health centres were not a random sample. The results should be considered to describe the issues of excluded populations seen by MdM, but as representative of excluded populations more generally within each partner country. However, the individuals seen in the MdM health centres include some of the most vulnerable and marginalised within society who are not included in a majority of routine and vital statistics systems. Therefore, this International Observatory Report is an important source of information on some of the most excluded individuals of society.

Classification of individuals into nationals, EU/EEA migrants, and non-EU/EEA migrants by country or origin has limitations as country or origin does not necessarily equate to nationality or citizenship. It does not take into consideration the possibility of dual nationality.

Figures 14 and 16 combine data from several variables:

- **Figure 14. Immigration status of individuals by EU/EEA migrants, non-EU/EEA migrants**
- 'Non-EU/EEA visa or permit' includes: migrants with a work visa; a residency permit; or a tourist/student/short stay visa. 'Non-EU/EEA undocumented' includes: migrants with permit to stay in another EU/EEA country and are here for less than 3 months; or are undocumented.
- **Figure 16. Healthcare costs for individuals by nationals, EU/EEA migrants, non-EU/EEA migrants**

'Other' includes: *healthcare coverage included in visa; valid health coverage in another EU country / EHIC*. 'Partial coverage' includes: health coverage for part of costs; free GP; access to GP but must pay part; access to secondary care. 'No coverage' includes: no cover at all; access on a case by case basis.

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ABBREVIATIONS

ASE	l'Aide Sociale à l'Enfance
BBB	Bed Bath Bread
CASO	Healthcare, Advice and Referral Clinic (Centre d'accueil, de soins et d'orientation)
CHAFEA	Consumers, Health, Agriculture and Food Executive Agency
CI	Confidence interval
DRC	Democratic Republic of Congo
EPIM	European Programme for Integration and Migration
EU	European Union
GP	General practitioner
HIV	Human immunodeficiency virus
ICPC-2	International Classification of Primary Care – second version
MdM	Médecins du Monde / Doctors of the World
MMR	Mumps, measles, and rubella
NCD	Non-communicable disease
NEF	Network of European Foundations
NGO	Non-governmental organisation
SDG	Sustainable Development Goal
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
WHO	World Health Organization





All the reports of the Doctors of the World International Network and other documents and information about the European programme can be found at:
www.mdmeuroblog.wordpress.com