

B3 Access to health care for migrants and asylum-seekers

Migrants, refugees and displaced people

In a world where one in thirty-five of us are migrants, migration has been described as 'one of the defining issues of the 21st century'. The International Organisation for Migration estimates that the number of international migrants increased from 76 million to 191 million between 1960 and 2005. Of the 191 million people living outside their country of birth in 2005, 8.7 million were refugees and 773,000 asylum-seekers. By the end of 2006, there were approximately 9.9 million refugees worldwide, an increase of 14 per cent from late 2005 (UNHCR 2007a). There were also 24.4 million 'internally displaced persons' who had been forced to flee their homes but not crossed national borders (IDMC 2007). Many of the internally displaced persons live in 'refugee camps', mostly in low- and middle-income countries (IDMC 2007). While the unmet health needs of the millions of people living in makeshift camps across the world are a public health challenge, this chapter mainly draws attention to the plight of migrants, refugees and asylum-seekers.

Migration has tended to be seen as either *forced* or *voluntary*. 'Forced migration' includes movement of people displaced by conflict, political or religious persecution, natural or environmental disasters, famine, chemical or nuclear accidents or 'development projects'. 'Voluntary migration' has been used to describe those who migrate of their own accord, for instance to find work. For example, in the Middle East, a large number of foreign contract workers from Asia and Africa have fulfilled the demand for unskilled workers. In other instances, workers migrate for shorter-term, seasonal work. However, there is growing recognition that it is difficult to distinguish between forced and voluntary migration.

BOX B3.1 Some definitions

Refugees are defined by the 1951 Convention Relating to the Status of Refugees as people who 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' are outside the country of their nationality and who are unable to or, owing to fear, unwilling 'to avail (themselves) of the protection of that country'. Asylum-seekers are people who have fled to another country where they have applied for state protection by claiming refugee status, but have not received a final decision on their application.

Contrary to the impression given by Western media, developing countries host 70 per cent of the global refugee population. Africa hosts 25 per cent of all refugees, Europe 18 per cent, North and South America 10 per cent, and Asia/Pacific 9 per cent. Pakistan hosts the greatest number of refugees with over a million. Iran and the United States host the next highest numbers of refugees, respectively. Most refugees in 2006 came from Afghanistan (21 per cent of all refugees). Iraqi refugees quintupled in 2006, with Sudan following behind (UNHCR 2007a). Tanzania has the highest number of refugees in relation its economic capacity: between 2001 and 2005 it hosted 868 refugees for each US dollar of gross domestic product (GDP) per capita. This compares to 21 refugees per GDP\$1/capita in Germany, the highest ranking industrialised country (UNHCR 2007b).

In developed countries, public attention and debate are often focused on people who have entered a country without authorisation or who have overstayed their authorised entry. They are variously labelled as 'irregular', 'undocumented', 'illegal' or 'unauthorised' migrants. There are an estimated 30 to 40 million such migrants worldwide, of which 4.5 to 8 million are thought to be in Europe and an estimated 10.3 million in the United States (European Commission 2007; IOM 2007). Another group of people, mostly women and children, who can also be classified as migrants are the estimated 2.5 million victims of 'human trafficking'.

Migration, health and rights

People who migrate tend to be stronger and healthier than the populations they leave behind. Despite this 'healthy migrant' effect, migrants, especially 'forced migrants', face considerable threats to their health and barriers to receiving health care. Not only do many flee from hazardous situations,

BOX B3.2 Stuck, ignored and isolated in transit

‘Fatima’, a young Nigerian woman who found herself stuck in Morocco, gave birth to a baby in a forest near Oujda. Because her baby suffered an infection of the umbilical cord, she sought medical help from an NGO and was referred to the hospital. She was then transferred to a penitentiary centre and detained for five days, after which she and her baby were taken to the Algerian border in the desert and abandoned with the prospect of a perilous journey across no-man’s land.

‘Edwin’ was trying to migrate to the United States from Guatemala by travelling on the infamous train known as ‘the Beast’, which travels through Mexico. Dizzy from fatigue and hindered by the crush of migrants, he fell off the train and lost his left leg. Edwin was lucky enough to be cared for by nurse and human rights activist Olga Sanchez. Although Mexican laws recognise the right of migrants to health care, most Central American migrants are unaware of these rights or are too afraid to contact services.

Sources: MSF 1997; Miller Llana 2007.

but they are exposed to risks during their migration journey; these include exposure to physical danger, violence, extreme temperatures and lack of access to food. Furthermore, as border control policies become tighter, migration routes become more risky. In 2006, for example, 7,000 people were estimated to have died making the dangerous crossing to the Canary Islands from the African coast (EU 2007).

The tightening of border controls in developed countries has also resulted in many migrants being stuck in low- and middle-income ‘transit countries’. For example, North Africa is a transit area for people trying to reach Europe. Many transit countries, however, do not have the resources to respond to the needs or to protect the rights of this vulnerable population (see Box B3.2).

Migrants also face health-related problems after being settled in their host country. Poor mental health is commonly due to social isolation, poverty, loss of status and hostility from the local population. For those already suffering from distress caused by persecution, torture and violence, these exacerbating factors can result in serious mental illness and suicide. Migrants are also often overexposed to poor living conditions and more likely to be involved in jobs that are ‘dirty, difficult and dangerous’ (IPPR 2006) and that lack basic occupational safeguards and workers’ rights (EC 2007).

BOX B3.3 Access to health care for ‘internal migrants’ in China

In China, the migration of 150–200 million people from rural areas into cities has been called the ‘world’s largest ever peacetime flow of migration’ (Tuñón 2006). Many of these internal migrants end up in hazardous occupations and poor housing, often in overcrowded factory dormitories. Many are officially registered as ‘temporary residents’. These temporary residents are also known as ‘floating citizens’ and have restricted entitlements to local health care. They are often ineligible for urban health insurance schemes and unable to afford private insurance or health-care fees (Amnesty International 2007). Thus, when Cha Guoqun left his village to do work in the city of Hangzhou and ended up with a leg injury that got infected, the doctor at the local state hospital gave him two options: either pay 1,000 yuan (US\$120) a day for treatment (the equivalent of his entire monthly income), or have his leg amputated. Cha got lucky. He received subsidised treatment from a charity hospital, and was able to save his leg. As he said, ‘I was lucky this time, but, on the whole, medical treatment is too expensive for people like me.’

Source: Amnesty International 2007.

Finally, migrants tend to experience poorer access to health care compared to the rest of the population. National health systems often discriminate against migrants and asylum-seekers in spite of several international treaties and commitments protecting their rights. The most vulnerable group are ‘unauthorised’ or ‘undocumented’ migrants. In Europe, the prevailing official attitude has been to treat them as though they are ‘rightless’, without basic legal protection or avenues to claim their entitlements (Human Rights Watch 2002; Jesuit Refugee Service 2001).

Access to health care in Europe***Asylum-seekers***

A recent study of the legal situation in the twenty-five European Union (EU) countries found some restrictions on the access of asylum-seekers to health care in ten of them (Norredam et al. 2006), in spite of their being ‘documented’ migrants. The same study found that in five countries pregnant asylum-seekers were allowed access to emergency care only and that the entitlements of children were restricted in seven countries.

In Germany, for example, asylum-seekers do not have the same rights as citizens until they have lived in the country for three years (Médecins

BOX B3.4 Migrants' rights

Article 25 of the Universal Declaration of Human Rights states that *everyone* has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care and necessary social services.

The 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' is also laid down in the International Covenant on Economic, Social and Cultural Rights (ICESCR). The 156 countries that have ratified the Covenant must 'refrain from denying or limiting equal access for all persons' to preventive, curative and palliative health services, including 'asylum-seekers and illegal immigrants'.

The 1951 Convention Relating to the Status of Refugees states that 'refugees shall be accorded the same treatment' as nationals in relation to maternity, sickness, disability and old age.

The 2003 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families has set out the rights of migrant workers to health care (although it fails to address their rights to preventive measures and early treatment).

du Monde 2007). In Sweden, asylum-seeking children have the same access to health care as other children, but asylum-seeking adults do not have the same access as other adults (Hunt 2007).

Undocumented migrants

Relatively little is known about the access to health care of 'undocumented migrants'. However, in 2007 findings from a Médecins du Monde survey of 835 'undocumented migrants' in seven European countries were published. Although they are not a representative sample of undocumented migrants, the findings illustrate some of the problems faced in accessing health care. Some of these findings were:

- Although 78 per cent of the informants had in theory some right to access health care, only 24 per cent had any real access to it.
- As many as 32 per cent of those who had legal entitlement to health care were not aware of that right.
- More than two-thirds of the chronic health problems identified were untreated.
- Some 47 per cent of those with at least one health problem had suffered a delay in treatment.



IMAGE B3.1 Undocumented migrant seeking care from Médecins du Monde UK's Project, London

The survey also revealed major differences between countries. Both Belgium and France have special schemes to ensure some free medical care for 'undocumented migrants'. However, because of poor awareness of these rights and complex administrative procedures, these health-care entitlements are often unrealised.

In Spain, the law recognises 'the right to health protection and assistance for medical care for all Spanish citizens and foreign nationals residing on Spanish soil'. Undocumented migrants must register with the local municipality to obtain a health-care card. Although this does not require legal residence, the law allows the police to access local registers, thus deterring many undocumented migrants from registering. Migrants who do not have a health-care card are only able to access emergency treatment, except for children and pregnant women, who are entitled to the same health care as Spanish citizens.

Under Greek law, undocumented migrants have no right to health-care cover, with a few exceptions – emergencies including maternity care and treatment of certain infectious diseases.

In the United Kingdom, various reports have documented the poor access to health care for refused asylum-seekers and undocumented migrants. They point to a particular problem with access to maternity care for pregnant women (Refugee Council 2006; Médecins du Monde UK 2007). Of the

BOX B3.5 Aisha and Jacob

Aisha and her husband Jacob fled to the UK after they had been threatened because of their inter-faith marriage. Their claim for asylum was refused. They were not allowed to work and were surviving on £35 in vouchers and support with accommodation. Then Aisha became pregnant. 'Four months into the pregnancy the overseas visitors officer started telling us that they would stop access to the hospital ... when we questioned her on where my wife should deliver her baby she said we can deliver it at home.'

Source: Médecins du Monde UK 2007.

women attending Médecins du Monde UK's clinic in London in 2006, 23 per cent were pregnant women needing access to primary care, antenatal care or termination of pregnancy. Over half had not had any prior antenatal care, and of these 40 per cent were more than twenty weeks pregnant.

Regarding Sweden, Paul Hunt, UN Special Rapporteur on the right to the highest attainable standard of health, commented that when 'examined through the prism of the right to health, some health policies are a genuine cause for concern' (Hunt 2007). Undocumented migrants have no right to publicly funded health care, including emergency treatment, and have to pay for care received. Thus many tend not to seek health care at all or delay seeking care.

A common feature across Europe is the lack of awareness among migrants, refugees and asylum-seekers about their entitlements. Another is that claims to these entitlements are often blocked by administrative barriers. The fear of being reported to immigration authorities also deters 'undocumented migrants' from seeking health care, especially when there are real or perceived links between health professionals and immigration officials. In Germany, for example, since 2005, health administrators are required to report the presence of undocumented migrants to immigration officials. Another important issue is that there are few well-developed plans to address the diverse and complex health requirements of migrants. There are few measures designed to overcome cultural and language barriers, for example.

Detention centres

Many asylum-seekers, refused asylum-seekers and undocumented migrants are held in detention centres. Some are waiting for their claim to be processed. Others await deportation. There has been a lot of criticism of the

arbitrary nature of detention. In the UK, immigration detention has been criticised as being ‘protracted, inappropriate, disproportionate and unlawful’ (Amnesty International 2005). In Europe, there were 218 detention facilities for migrants and asylum-seekers in twenty-three different countries at the end of 2007. As of June 2005, there were 885 persons in immigration detention centres in Australia (Phillips and Millbank 2005).

Virtually all asylum-seekers apprehended at US borders are subjected to lengthy detention regardless of their circumstances. Examples include:

- a Burmese woman, a member of a religious and ethnic minority group, detained for nearly two years in a Texas immigration jail, even though she would clearly face torture and persecution if returned to Burma;
- a pastor who fled Liberia after criticising the use and abuse of child soldiers was detained for three months in a New Jersey immigration jail;
- a young human rights worker from Cameroon, who had been arrested, jailed and tortured on three occasions, was detained for sixteen months at New York and New Jersey immigration jails before being granted asylum and released.

Studies in many countries point to unmet health needs and inadequate health care in centres. Research in the UK, Australia and the US has also shown the detrimental impact of detention on the mental health of an already traumatised population (Cutler and Ceneda 2004; PHR 2003).

In the UK, the management of detention or removal centres is often contracted out to private companies, and health-care services are further subcontracted. An inquiry by the Chief Inspector of Prisons into the case of a Ugandan asylum-seeker ‘who was reduced to a state of mental collapse’ at Yarl’s Wood removal centre, criticised the inadequate mental health care provisions, unclear management arrangements and weak clinical governance. Further concerns have been expressed in the UK about the detention of pregnant and breastfeeding women, contrary to UNHCR guidelines, and the inadequate provision of pre- and postnatal care; and about the detention of people with serious health problems, including mental illness, in spite of guidelines that such people, including torture survivors, should not normally be detained.

According to Human Rights First (2007), asylum-seekers in the US are detained in conditions that are inappropriate, often for months and sometimes years. The US Commission on International Religious Freedom reported the following findings from visits to nineteen detention centres:

- widespread use of segregation, isolation or solitary confinement for disciplinary reasons;

BOX B3.6 Not a criminal but held in detention

In his South Asian country, HN was forced into hiding to avoid arrest because of his political activities. Fearing for the safety of his family, he fled to the US. There, he endured three and a half years of detention, with extended periods of solitary confinement. 'I was sick in my mind, had nightmares, stomach pain, and couldn't sleep. Always I was thinking someone's going to kill me. I don't know why they kept me to a small room with no people there. I felt like I was dying. I cannot breathe there.' After repeated requests over several months, HN saw a psychiatrist, although no translation was provided. HN finally won asylum (PHR 2003).

- significant limitations on privacy;
- use of physical restraints in eighteen facilities;
- lack of staff training focused on the special needs and concerns of asylum-seekers, particularly the victims of torture or trauma.

Detained asylum-seekers suffer extremely high levels of anxiety, depression and post-traumatic stress. In a US study, 86 per cent of the interviewed asylum-seekers suffered significant depression, 77 per cent suffered anxiety and 50 per cent suffered from Post-Traumatic Stress Disorder (PTSD). They also suffer verbal abuse by immigration inspectors at US airports, as well as verbal abuse and other mistreatment at the hands of officers staffing detention facilities (PHR 2003).

Migrating for health care; deportation because of ill health

Within this context of increased migration, some commentators have expressed concern about people migrating with the specific purpose of obtaining health treatment which is not available in their country of origin. There is, however, little evidence of this so-called 'health tourism'. The UK government admitted in testimony to the Parliamentary Health Select Committee that it did not have any such evidence. According to the Committee (2005), the evidence 'suggests that HIV+ migrants do not access NHS services until their disease is very advanced, usually many months or even years after their arrival in the UK, which would not be the expected behaviour of a cynical "health tourist" who had come to this country solely to access free services.'

There have also been examples of governments using illness as a reason for restricting migration or leading to deportation. For twenty years, the US has had a 'policy of inadmissibility' which prohibits non-US

citizens with HIV from entry into the country. This policy is contrary to WHO/UNAIDS guidance. In 1998 the United Arab Emirates carried out a screening programme and deported all the migrant workers who tested positive for HIV/AIDS (WHO 2003).

Discussion

Without even covering the plight of refugees, migrants and ‘internally displaced persons’ in low-income countries in any detail, this chapter paints a bleak picture of access to health care for migrants and asylum-seekers.

The issues raised in this chapter cannot be discussed without placing them in the context of a hostile global political economy for hundreds of millions of people. The World Commission on the Social Dimensions of Globalisation (2004) described the ‘deep-seated and persistent imbalances in the current workings of the global economy’ as being ‘ethically unacceptable and politically unsustainable’, explaining how ‘the rules of world trade today often favour the rich and powerful’.

Hundreds of millions of people, mainly in low- and middle-income countries, have been socially and economically disenfranchised by a brutal and predatory system of global capitalism. The governments of many poor countries are increasingly unable to manage their economies and fulfil their duties and obligations. Added to this is the tolerance of corruption and oppression within low- and middle-income countries by world powers when it suits them. It is no surprise that millions of people are prepared to risk death to escape their countries for a better life.

Under these conditions it is fitting that all migrants, including temporary migrants, refugees, asylum-seekers and ‘illegal’ or ‘undocumented’ migrants, are accorded clear rights and entitlements to health care. In fact, all nations that have signed the ICESCR have a legal obligation to ensure that proper health care is accessible to all. However, countries do not always comply with this obligation.

In this increasingly globalised world, there is a need to rework the definition of citizenship so that it includes a more robust set of social and health rights for all global citizens, irrespective of their nationality, country of residence or immigration status.

As a starting point, the discrimination and persecution of migrants from poor countries who have successfully reached the shores of wealthy countries must be stopped. Exaggerated press stories about the negative impact of migrants must be countered with a more reasoned and honest account of the nature of the global political economy and the underlying causes of migration.

More countries should follow the Spanish example of incorporating into national law the rights of migrants to health care, irrespective of their status. Governments should also actively inform potential beneficiaries of their rights to health care and how to access it, and remove any administrative obstacles to health care. Health workers must resist measures that compromise their independence by ensuring clear boundaries between health services and immigration law.

While there are strong moral reasons for providing access to health care for all groups of migrants, it also makes public health sense. Not only does it help with the control of communicable diseases; easier access to health care will allow treatment to be provided earlier, thus avoiding the costly provision of emergency care or expensive treatment of diseases in an advanced stage.

There are encouraging examples of civil society defending the rights of ‘undocumented migrants’ to health care. In Europe, the Platform for International Cooperation on Undocumented Migrants (PICUM) has found that health professionals ‘are reluctant to accept national government pressure to preclude vulnerable migrants’ from health services (Flynn and Duvell 2007). And in recent years several countries have seen hundreds of thousands of people peacefully demonstrating in defence of migrants’ rights.

There are also examples of regional or local governments adopting positive initiatives. In Belgium, some Flemish mayors have said that they will refuse to sign deportation orders. A municipal council in Switzerland passed a resolution to ensure that undocumented migrants have access to services. And in the US, several cities have declared themselves ‘sanctuary cities’ which seek to provide services and protection to all residents, regardless of their status, and to prevent city employees from cooperating with immigration enforcement.

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