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Access to healthcare services for the Roma and undocumented migrants in the EU in light of the COVID-19 pandemic

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Date of publication: September 15th, 2020
Edition period: September 2020 – March 2021

To cite this article: Varga, B.M. (2020). Access to healthcare services for the Roma and undocumented migrants in the EU in light of the COVID-19 pandemic. *International Journal of Roma Studies, 2*(2), 4-27. doi: 10.17583/ijrs.2020.5952

To link this article: http://dx.doi.org/10.17583/ijrs.2020.5952

IJRS – International Journal of Roma Studies Vol. 2 No. 2 September 2020 pp. 4-27

Access to healthcare services for the Roma and undocumented migrants in the EU in light of the COVID-19 pandemic

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Abstract

The rising number of the EU Roma citizens from the CEE countries, non-EU Roma citizens from the Western-Balkans, and of undocumented migrants in the European Union makes it interesting to see that most of them face barriers when accessing health services [with a European Health Insurance Card (EHIC)] or have no health coverage at all [no legal entitlement]. European migrant health policies are seemingly well structured and responsive to the needs of migrants; however, results of recent studies raise the question whether the legislations are responsive enough to the needs of the Roma and undocumented migrants when accessing health services. Given the circumstances of the COVID-19 pandemic these groups are now at an increased risk and they might not be able to understand how the virus transmits and how they can protect themselves from it. Methods: Literature review focusing on the access to health services and migrant health policies in the EU and the UK was carried out. The target groups of this research were Roma citizens and third-country national undocumented migrants residing in the European Union. Results: In theory the legal entitlement for accessing healthcare for migrants in general is satisfactory, while in practice these groups face difficulties, such as prejudice, discrimination and other barriers (language, logistical) when approaching health services. Migrants lack trust in the health system and the healthcare professionals and are not aware of their fundamental rights to healthcare either.

Keywords: Health, Access, Roma, Undocumented, Migrants, Rights, COVID-19, Pandemic, Coronavirus, SARS-CoV2

ISSN: 2462-425X
DOI: 10.17583/ijrs.2020.5952

Hipatia Press
www.hipatiapress.com

IJRS – International Journal of Roma Studies Vol. 2 No. 2 September 2020 pp. 4-27

Acceso a los servicios sanitarios para los gitanos y los inmigrantes indocumentados en la UE a la luz de la pandemia COVID-19

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Resumen

El creciente número de ciudadanos romaníes de la UE de los países de Europa central y oriental, ciudadanos romaníes de los Balcanes occidentales que no pertenecen a la UE y de inmigrantes indocumentados en la Unión Europea hace que sea interesante ver que la mayoría de ellos enfrentan barreras para acceder a los servicios de salud [con un Tarjeta Sanitaria Europea (TSE)] o no tienen ninguna cobertura sanitaria [sin derecho legal]. Las políticas europeas de salud para migrantes aparentemente están bien estructuradas y responden a las necesidades de los migrantes; sin embargo, los resultados de estudios recientes plantean la pregunta de si las legislaciones responden lo suficiente a las necesidades de los romaníes y los migrantes indocumentados cuando acceden a los servicios de salud. Dadas las circunstancias de la pandemia de COVID-19, estos grupos ahora corren un mayor riesgo y es posible que no puedan comprender cómo se transmite el virus y cómo pueden protegerse de él. Métodos: Se llevó a cabo una revisión de la literatura centrada en el acceso a los servicios de salud y las políticas de salud para migrantes en la UE y el Reino Unido. Los grupos destinatarios de esta investigación fueron los ciudadanos romaníes y los inmigrantes indocumentados nacionales de terceros países que residen en la Unión Europea. Resultados: En teoría, el derecho legal de acceso a la salud para los migrantes en general es satisfactorio, mientras que en la práctica estos grupos enfrentan dificultades, como prejuicios, discriminación y otras barreras (de idioma, logísticas) al acercarse a los servicios de salud. Los migrantes desconfían del sistema sanitario y de los profesionales sanitarios, y tampoco conocen sus derechos fundamentales a la asistencia sanitaria.

Palabras clave: Salud, Acceso, Roma, Indocumentados, Migrantes, Derechos, COVID-19, Pandemia, Coronavirus, SARS-CoV2

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The rising number of the EU Roma citizens from the CEE countries, non-EU Roma citizens from the Western-Balkans, and of undocumented migrants in the European Union makes it interesting to see that most of them face barriers when accessing health services [with a European Health Insurance Card (EHIC)] or have no health coverage at all [no legal entitlement]. European migrant health policies are seemingly well structured and responsive to the needs of migrants, however, results of recent studies raise the question whether the legislations are responsive enough to the needs of the Roma and undocumented migrants when accessing health services. Given the circumstances of the COVID-19 pandemic these groups are now at an increased risk and they might not be able to understand how the virus transmits and how they can protect themselves from it.

The overall topic of the research

Currently there is an estimated number of one billion migrants with 272 million international and 740 million internal migrants in the world, indicating an increase of 51 million since 2019. Regionally Europe hosts the largest number of international migrants of 82 million people (UN, 2019) and the United Nations Migrant Stock of 2019's data shows that among Europe's total nearly 50 000 000 migrants 170 977 are Albanians, 109 550 are Bulgarians, 322 536 are North-Macedonians and 525 028 are Romanians, while estimates count 200 000 to 300 000 Roma migrants from Eastern Europe to the West (Council of Europe), suggesting a high number of these migrants to be of Roma ethnicity, and a recent data estimates that 4.8 million undocumented migrants lived in Europe in 2017 (Pew Research Center, 2019).

The rising number of the EU Roma citizens from the CEE countries and undocumented migrants in Europe makes it interesting to see that most of them face barriers when accessing health services [with a European Health Insurance Card (EHIC)] or have no health coverage at all [no legal entitlement]. Furthermore, according to the WHO (2010) undocumented migrants are not allowed to use certain health services in several European countries due to their illegal status and in most countries they are entitled to urgent medical care only, which requires an obligatory administrative procedure, too.

Most European countries lack ethnic data due to the law on privacy, which prohibits ethnic censuses and so studies on the Roma ethnic minority are hard to be carried out. However, studies that have been carried out on the challenges migrants face when accessing health services suggest that migrants are more vulnerable to infections, psychiatric disorders, emotional distress and digestive problems than the mainstream society (Dauvrin et al, 2012). Taking into consideration the current COVID-19 pandemic, these groups are at an increased risk (Kirby, 2020).

The Roma minority

The Roma, Europe's largest ethnic minority group with its approximately twelve million members, live in all European countries and in most cases in segregated areas or settlements without proper access to healthcare services (European Commission, 2014) as well as without proper health coverage in general (Kühlbrandt et al, 2014). The Roma minority lives in every European country holding the nationality of the country of origin and belonging to its ethnic minority but this research focuses on the migrant Roma, who live mainly in Western-Europe from the CEE countries, like Romania, Bulgaria, Hungary or Slovakia and the Western-Balkan countries, such as Albania or North-Macedonia.

The terminology: migrants

In order to understand the objectives of this study and to distinguish between documented and undocumented migrants, clarification of the terminology referring to them is essential as Europe-wide there is a difference between the entitlements of regular (documented) and irregular (undocumented) migrants. There has been an evolution and an international debate on the proper terminology (PICUM, 2013) of migrants who reside in a country illegally. An irregular migrant without having official documents to enter, work or stay in a certain country cannot be documented. In other words the term undocumented refers to those who are illegal, but the terminology undocumented or irregular is agreed to be less harmful.

Legal EU migrants are citizens who move from and leave their EU country of origin to another EU country for any reason (e.g. the Roma) [their entitlement to healthcare is secured by their EHIC] while legal third-country nationals are non EU-citizen individuals (e.g. Moroccans) [their entitlement

to healthcare is secured by an obligatory obtained health insurance based on their valid visa for long term purposes].

Undocumented migrants "are persons who do not fulfill the requirements established by the country of destination to enter, stay or exercise an economic activity" (PICUM, n/d), more precisely undocumented EU migrants are those who have lost their legal authorization [see chapter 'Entitlements of EU migrants' for details] to reside in another Member State (Macherey, 2015, pp.12) and undocumented third-country nationals are non EU-citizens who have lost their visa at a certain point of their lives or have never held one.

Entitlements of EU migrants

Free movement of EU citizens across the European Union is ensured according to the fundamental principle of the Treaty enshrined in Article 45 of the Treaty on the Functioning of the European Union and developed by EU secondary legislation and the Case law of the Court of Justice (European Commission, 2014). EU citizens do not need a visa to visit, stay, live, work or study in another EU country, however, they need to register at the local town hall upon their arrival to another EU country. If the stay is longer than ninety days EU citizens also have to apply for a long stay visa and a temporary residence permit based on the purpose of the stay. Upon failing to do so and staying in the country without work or health insurance for more than ninety days EU citizens fall out of the legal entitlements and become undocumented; resulting in the loss of their legal entitlement for social services (including healthcare) and requiring them to return to their home countries (The European Directive 2004/38/CE).

Entitlements of undocumented migrants

The right to healthcare is a fundamental human right (United Nations OHCHR, 2008) and as such, access to healthcare should be ensured to every human being without regards to race, religion or legal status. European health systems respond to the health needs of undocumented migrants, too, but in most cases only in case of emergency care through emergency services and they have the right to healthcare above the emergency care free of charge in five EU countries only (FRA, 2016). In theory undocumented migrants also have entitlements to receive emergency healthcare provision; however, European systems seem to be loaded with barriers. The purpose of

this research among others is to determine these barriers and future consequences, especially in light of the COVID-19 pandemic.

EU Roma and undocumented migrants as target groups

The reason of examining the access of Roma and undocumented migrants to healthcare in particular is their growing number in Europe and their perception by the mainstream society based on their cultural similarities. According to a study carried out among migrants [including EU migrant citizens and all patients outside the EU/third-country nationals] in 2014 (Médecins du Monde) in Belgium most of the participating third country nationals originated from Morocco (473) while most of the participating migrant EU citizens originated from Romania (96) and from Bulgaria (43). The study also assumed a correlation between the growing number of these nationals and the significant number of Roma people from these countries.

This research aims to examine what health services EU Roma citizen and undocumented migrants have (should they reside legally or illegally in Europe or the European Union) in theory and in practice, and whether these migrants are aware of their fundamental right to healthcare.

Furthermore, it also aims to investigate whether there are discriminative approaches towards these two groups when it comes to healthcare services based on their cultural differences or discrimination may rise only in case of a not clarified legal status (showing up at a healthcare service without valid documents).

The COVID-19 pandemic

Coronaviruses are infectious diseases of zoonotic origin that can infect humans and cause severe or acute respiratory syndrome. SARS coronaviruses belong to a family of single-stranded RNA coronaviruses, however, a study found that the SARS-coronavirus is only moderately related to other known coronaviruses (Marra et al., 2003). The new virus, SARS-CoV-2 emerged in Wuhan, China, in December 2019 and is responsible for the COVID-19 pandemic outbreak. According to the World Health Organization there have been 21,549,706 confirmed cases, including 767,158 deaths globally as of 17 August, 2020 (WHO, 2020). A recent review on the disparities in the risk and outcomes of COVID-19 (Public Health England) found that death rates from the pandemic among patients

from ethnic minority backgrounds are higher than among white patients suggesting that health inequalities have increased due to the pandemic.

Background

European migrant flows

In the late 1960s Western-European countries were affected by migration and received an intensive immigration flow due to bilateral labor agreements between France, Belgium, Germany and Southern European, North African countries and Turkey. Most of the migrants arrived in Europe for studies or by family reunification (Eurostat, 2009), while most of the Roma migrant population arrived from Southern Serbia and Macedonia due to their asylum applications to European Union countries by 2010 (Eurostat, 2011), however, recent data from *t*he United Nations Migrant Stock of 2019 shows that among Europe's total nearly 50 000 000 migrants 170 977 are Albanians, 109 550 are Bulgarians, 322 536 are North-Macedonians and 525 028 are Romanians, while estimates count 200 000 to 300 000 Roma migrants from Eastern Europe to the West (Council of Europe), suggesting a high number of these migrants to be of Roma ethnicity.

European restrictions to the migrant flows

EU citizens may have an easier method to enter another Member State; however, EU citizenship itself is not enough to reside in another Member State for more than three months. The European Directive 2004/38/CE foresees EU citizens to lose their residency permit and so they can also become undocumented, which requires them to leave the hosting Member State and return to their home countries (Macherey, 2015).

After the eighties and upon limiting the labor migration to Europe, rise of family reunification and asylum immigration started. The response of the Western-European Member States was to establish policies both on labor migration and asylum. Upon realizing the growing number of CEE countries' Roma population, many EU countries urgently responded and created a list of safe countries including Albania, Bosnia - Herzegovina, Macedonia – Former Yugoslav Republic of Macedonia - FYROM, Kosovo, Serbia, Montenegro, and India.

International agreements on the right to health

Access to health care is a fundamental right (UN, 2008) and as such, it should be universally applied and access to healthcare services should be ensured to every human being without regards to race, religion or other criteria, including legal status. Including a chapter for the right to health in this paper is important in order to see whether the target groups of this research benefit from this fundamental right or they are deprived of it and if so, why. As access to healthcare services is a fundamental right it is important that ethnic minority groups, such as the Roma minority and the undocumented migrants also benefit from it (with or without legal residency). Although the nature of the legal status determines the level of entitlement to health care services; the right to health ensures that all human beings shall be provided with medical treatment equally.

The social and cultural determinants of health

Social determinants of health influence, health equity and social determinants of health are mostly responsible for health inequities (Marmot et al, 2012). According to the WHO health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups, and in fact there are differences in the access to health services of vulnerable groups such as the Roma citizens – that reside in EU Member States – and undocumented third world migrants living in Europe (Devillé et al, 2011). Article 12 of the International Covenant on Economic, Social and Cultural Rights set the "right to everyone to the enjoyment of the highest attainable standard of physical and mental health", which later was recognized by the European Convention for the Protection of Human Rights and Fundamental Freedoms of the Council of Europe and the European Social Charter, adopted in 1961 and revised in 1996 (Rechel et al, 2013).

Culture as a social determinant of health affects health especially in the context of ethnic and religious minority groups and their condition derives from their culture which they are part of and the culture of the hosting facility or country. The absence of diversity adapted health systems results in negative health outcomes both for patients and institutions (Knib et al., 2013).

Migrant health related policies in Europe

An overview on the existing European migrant health policies is also a part of this paper in order to see and to compare these policies. According to the WHO (2010) there is no proper collaboration between departments responsible for immigration policy and public health Europe-wide. By 2009 only eleven EU countries (Austria, United Kingdom, France, Germany, Italy, Ireland, The Netherlands, Portugal, Spain, Sweden, Switzerland) have established national policies that are to improve migrant health and by 2020 fourteen EU Member States have policies or legislation on cultural mediators in healthcare (European Commission, 2020). Most of these initiatives target the improvement of migrant health and focus on training health care professionals, offering interpreting services to patients free of charge, fostering a network for mediators and on improving data collection (Mladovsky et al., 2012). France established a new immigration policy as a response to the increasing number of the migrants in France, while on the contrary it has also been deporting Roma migrants originating from Central and Eastern Europe (CEE) in the last few years (BBC News, 2010). Following the refugee and migrant flows arriving in Europe in 2015 several countries started issuing recommendations for good practices in migrant healthcare, such as Finland, the UK or Italy, but by the end of 2017 no EU Member States had an ongoing strategy or action plan by health ministries specifically targeted to migrants.

As of 2017 Sweden, Germany, Greece and Croatia have made measures to address the health needs of migrants and asylum seekers, Finland has introduced indicators on health and migrants, and Malta has become an exceptionally good example by setting up a department dedicated to migrants and their access to healthcare services, as well as Belgium by being the only Member State that provides cultural mediators to migrants in its healthcare system. Interpreters on the other hand are provided in 13 Member States (Austria, Belgium, Cyprus, Denmark, Finland, Germany, Ireland, Italy, Luxemburg, Portugal, Spain, Sweden and the United Kingdom) where patients have to pay parts of the fees of the interpreter services in five countries (Czech Republic, France, Hungary, Malta, The Netherlands). Denmark provides migrants with informational clips about its health system, health insurance and pharmacy in 8 languages.

In a study carried out in European countries (Belgium, France, Germany, The Netherlands, UK, Spain, Sweden, Switzerland, TR, Greece), Turkey and Canada among migrants [including migrant EU citizens and all patients outside the EU/third- country nationals] in 2014 (MdM) 23.0 per cent of all respondents that took part in the research reported that they had not experienced difficulties in accessing healthcare, while another 33.9 per cent of the respondents had not even tried to access it.

In general 62.9 per cent of the respondents had barriers when accessing health services [with EHIC] or did not have healthcare coverage or access at all [due to legal entitlement]. In more details while this number in France was 92.3 per cent, in Spain 84.9 per cent and in Belgium 91.9 per cent of them [including migrant EU citizens and all patients outside the EU/third-country nationals] faced barriers when accessing health services [with a European Health Insurance Card (EHIC)] or had no health coverage at all [no legal entitlement], resulting them to cover their charges themselves. The four main barriers according to them were:

- Financial barriers (27.9 per cent)
- Administrative problems (21.9 per cent)
- Lack of information about their rights and the health system (14.1 per cent)
- Language barriers (12.7 per cent)

Barriers of accessing health services

According to the Tallinn Charter (WHO Regional Office for Europe, 2008) there is a difference between accessibility and entitlement. Accordingly, accessibility relates to service provision, while entitlement is about financing and stewardship. Meanwhile in practice accessibility can also refer to the dimensions of Health System Performance Assessment (HSPA), which has its own barriers.

Several European studies have been carried out to measure the level of access to health services of vulnerable and minority groups, such as migrants or ethnic minorities (European Commission, 2014) and most of the studies show that undocumented migrants without legal entitlement face difficulties when accessing healthcare services other than emergency care services (Dauvrin et al, 2012).

Conceptual Framework and Theory

Health system performance can be assessed through different dimensions, such as accessibility, quality, safety, equity, fairness, appropriateness, responsiveness, continuity, sustainability and efficiency (Belgian Health Care Knowledge Centre, 2012). There are different barriers when accessing health services, such as legal entitlements (including coverage), language barriers, financial barriers, accessibility, etc. Among these dimensions the focus of this research is on access, which has several components.

One pre-assumption of this research is that Roma migrant citizens from CEE countries and undocumented migrants are not well aware of their fundamental right to health care and that they lack information both on the health system and their rights to health services (Kühlbrandt et al, 2014), which might put them at an increased risk in light of the COVID-19 pandemic. Another pre-assumption is that they lack trust both in the system and in the medical staff (European Commission, 2014). However, there is no study on the different barriers of accessing these services, except for the language barriers (Nielsen et al, 2009) and this justifies the need for this research. It focuses on barriers to access in general, including accessibility, legal entitlement, such as the obligation to register in the health system and it presumes the lack of trust these migrants have in the health system as well as in the healthcare professionals.

Variables

Independent variable is the two migrant groups, the Roma ethnic minority group, and undocumented migrants residing in Europe, and the healthcare professionals. Dependent variable is the migrants' access to healthcare services, and the approach of the healthcare professionals, while the intermediate variables are these migrants' lack of trust, their access to the health services as well as their awareness about the health system and their fundamental right to access it.

Figure 1 presents the variables and the relationship between them as well as the complexity of the problem. It shows the needs of the documented (Ms) and undocumented migrants (UMs) and the healthcare professionals, e.g.: the figure shows the lack of information and trust as a main problem between the two groups. Legal status and entitlement is also an important element of the figure, but in general migrants as well as healthcare

professionals need to resolve the language barriers and need non- formal education on human rights and on culture. While undocumented migrants need confidentiality when showing up at the health system, the healthcare staff needs documentation in order to proceed with their treatment.

Methodology

The research of this study is based on a literature review. Literature review will guarantee gaining deeper knowledge and a broader overview on the existing literature.

Data collection

As a first step literature review on existing literature, regulations and legislations on access to health services of migrants was carried out. The literature review served as a basis of the findings. The literature review focused on the existing migrant health related policies in Europe, but did not focus on broader migration policies. It also focused on the studies on access to health services of migrants without time limitations. Data was collected from highest ranking journals, databases and international public health journals, such as PubMed in English and French languages, with the following key words: Roma, undocumented, migrants, health, right, Europe, access, COVID-19.

Data analysis

Literature review was carried out and legislations as well as the literature were analyzed.

The knowledge thus gained was summarized and served as a basis of the findings. As this study aims to exploit expert knowledge the most appropriate data analysis style is the conventional content analysis (Hsieh & Shannon, 2005).

Process of the data analysis

The data analysis process started with reading the literature and grouping the gained information about existing policies, projects, programs, and

regulations on migrant health. According to Morse & Field (1995) there are four steps of the data analysis process, which were applied with slight modifications as a basis of the analyzing process.

1. Comprehending: To learn "what is going on" and to merge the gained information from the literature review.
2. Synthesizing: To synchronize the data from the several pieces (Hsieh & Shannon, 2005).
3. Theorizing: To sort the data systematically.
4. Recontextualizing: To further develop the theory and to create answers to the research questions. In the Discussion section a summary will reflect the findings of the study including future suggestions as well as an analysis of the literature review.

Validity and reliability

As the study examines a group of people within a national and an ethnic minority, therefore a segment of the population, it aims to generalize the results to the wider population. The credibility will be guaranteed by peer-debriefing with academics and persistent observation; the transferability will guarantee the applicability and adequacy of the research.

Results

This chapter focuses on the link between the theoretical framework and the findings of the research. As the pre-assumption of this research based on the literature review was that Roma citizens from CEE countries and undocumented migrants in Europe are not well aware of their fundamental right to healthcare, they lack information both on the health system and their rights (Kühlbrandt et al, 2014) and that they lack trust both in the system and in the medical staff (European Commission, 2014) it will mainly focus on the findings of the literature review.

Migrants, ethnic minorities and the COVID-19 pandemic

Although upon arrival third-country national migrants are generally healthier than native-born European populations (European Commission, 2020), this effect deteriorates with the time of residence and studies have found a disproportionate share of migrants among the populations with low health outcomes (OECD, 2015) suggesting that migrants are disproportionately exposed to risk factors. A recent review on the disparities in the risk and outcomes of COVID-19 (Public Health England) also found that death rates from the pandemic among patients from ethnic minority backgrounds are higher than among white patients suggesting that health inequalities have increased during the COVID-19 pandemic. While studies show that migrant and ethnic minority groups face poverty, discrimination and language barriers, which limit their access to healthcare services, ongoing studies try to examine the reason behind the proportional difference between death rates of colored and white populations.

Although the WHO created a section of Questions and Answers related to COVID-19 (WHO, 2020) with several topics, including tobacco and COVID-19, violence against women during COVID-19, adolescents, youth and COVID-19, older people, pregnancy and COVID-19, it has not dedicated a section to ethnic minorities, migrants and COVID-19.

Although scientific evidence shows that migrants have a low risk of transmitting communicable diseases (WHO, 2018), given the current circumstances of the pandemic, migrants and ethnic minority groups are at an increased risk for several reasons. Roma in most cases live in segregated areas without access to clean water and without proper access to health services and without proper health coverage at all (Kühlbrandt, 2014), and Roma communities face more challenges than the majority population with respect to access to waste management, environmental hygiene, appropriate housing and hygienic living environment (Anthonj et al., 2020).

More than half of the migrants need interpreters when visiting a health facility (Chauvin et al, 2014). Out of fear of getting deported, however, migrants, and undocumented migrants in particular contact medical staff only if they have not found another solution within their networks (New York Times, 2020). As fifteen per cent of them are denied medical care and nearly five per cent of them experience racisms while visiting health facilities, more than twenty per cent of them stop seeking medical care as

they don't trust the health system, nor the health workers (Chauvin et al, 2014).

While some European states provide newcomer migrants with free language courses upon their arrivals (European Commission, 2020), undocumented migrants are not entitled to benefit from these as they are invisible to the authorities. On the other hand the Roma population has a low level of health literacy (Stoynovska et al, 2018, Karlsson et al, 2019), which might not be sufficient to understand the precautionary measures and the ways of transmission of the virus.

As data collection on ethnicity and migrant status is forbidden by law in most of the EU countries, most data are of unrepresentative samples, which does not contribute to researches on the effect of the pandemic on ethnic minorities, such as the Roma.

Health coverage of undocumented migrants following the pandemic

European health coverage schemes of undocumented migrants did not vary in particular following the outbreak of the COVID-19 pandemic, except for Portugal who later granted undocumented migrants and asylum seekers full citizenship (Independent, 2020), and Italy who granted undocumented migrants work permits during the outbreak (CBSNews, 2020).

The Migrant and Integration Policy Index (MIPEX)

The Migrant and Integration Policy Index (MIPEX) is a tool to measure how migrant and integration policies are implemented in certain countries. This is an important and objective tool to measure the performance of a country's health system. As this research includes migrant related health policies and their successful implementations, it is useful to include the indicators of MIPEX, too. By 2017 only Austria, Croatia, Germany and Portugal have defined indicators to measure the integration of their migrants within their healthcare settings.

Recommendations

Although newcomer migrants could benefit from free language courses provided by some European states, undocumented migrants don't have access to this service due to their irregular status. As a result, extending the group of beneficiaries to undocumented migrants so that they can also benefit from these services should take place. This could be achieved by introducing and applying the universal health coverage scheme Europe-wide. A general training about the hosting country's social system and fundamental rights with the collaboration of mentors or mediators who would serve as bridges between the system and the migrants should take place.

Universal health coverage should be provided for all regardless of nationality or ethnicity as it is in Spain for instance. Collecting data on ethnicity based on the language of assistance migrants need is recommended and would serve as an indicator to estimate the origin of the migrant. It is also important to emphasize that there is no need for new legislations or law on migrant health Europe-wide, rather the role and the position of the existing ones should be clearly clarified and simplified.

A community-based approach should be strengthened and European health systems should be more proactive regarding ethnic and migrant health needs. The role of the civil society organizations and NGOs as key actors is crucial, fostering trust building between migrants and the health workers, and a cultural education system educating about fundamental rights should be created.

Discussion

Discussion about the results

This study investigated what the legal entitlements are of the EU, non-EU Roma and undocumented migrants in the European Union in terms of accessing health services and whether their access to health services is as satisfying in practice as it is in theory.

The results of this study show that in theory the legal entitlement to access health care for migrants is sufficient and satisfactory, while in practice these migrants face difficulties, prejudice, discrimination and other barriers when approaching health services. The literature review gave a basic

overview about the current policies, the regulations, and the legislations as well as about the operative structure of the European health systems in general; however, there was no literature found focusing on the barriers in particular.

Legal entitlements of the EU Roma citizen do not differ within EU countries, based on their EU citizenship, but undocumented migrants are concerned with various legislations Europe-wide. According to a study carried out in the 27 Member States on the right of access to health care for undocumented migrants in the EU (Cuadra, 2012) undocumented migrants had the right to healthcare above the emergency care in five countries only, whereas in 2016 Belgium, France, The Netherlands, Portugal, the UK, and partially Italy provided undocumented migrants with free emergency, primary and secondary healthcare services (FRA, 2016). Bulgaria and Poland provided undocumented migrants with free emergency health services with conditions, while Denmark, Germany, Estonia, Ireland, Lithuania, Spain, Romania, Slovenia, Slovakia provided emergency healthcare services free of charge. As of 2018 Spain provides universal health coverage to everyone, including undocumented migrants and has also eliminated the need to register at the municipalities for newcomers (El Pais, 2018).

In France the legislation is more focused on social protection. The "Convernture médicale universelle" (CMU), which includes asylum seekers and documented migrants, provides them with the same access to health services as French nationals. In terms of undocumented migrants they offer the "Aide médicale d'etat" (AME), which serves more of an emergency care and is open to every person who fails to meet the criteria of the CMU (Duguet & Bévière, 2011).

In Germany undocumented migrants, EU citizens without formal employment, and asylum seekers don't have full access to healthcare services, for which the UN Committee on Economic, Social and Cultural Rights published its concerns in its observation report about the right to health for migrants in Germany (2018).

The literature agrees on the fact that migrants face difficulties when accessing health and other public services, but it does not talk about the challenges and the barriers in particular, except for language barriers. Although some European governments provide newcomer migrants [with

EU citizenship or valid visa] with language courses, undocumented migrants are not entitled to it due to their invisibility in the system. There seems to be a group of undocumented migrants who do not speak the language of their hosting countries, and remain invisible to the system without the opportunity to learn one of those languages and to smoothly integrate into the society.

The literature review gave an outline about the good will of European governments in terms of integrating their migrants, and in terms of providing them with access to health services, however, in practice the situation differs and undocumented migrants avoid contacting authorities as they prefer staying away from social workers and services. Apparently, the system does not take the preference of privacy needs of these migrants into consideration.

The impression given by the results of this study is that most of the European states seemingly try to act responsively in terms of integrating their migrants but in reality they do not have a strong will to do so and it seems that there is a mismatch between the legislations and their implementations.

Relationships between the results

There is a clear relationship between the results, which shows that in case of requesting registration and address from undocumented migrants to be eligible for healthcare services will decrease their participation in it. They are afraid of being reported and deported; therefore, they try to stay away from the system. Furthermore, it also explains why language barrier exists, in more details if undocumented migrants are not entitled for language trainings provided by the state, they would prefer to stay away from authorities.

Conclusions

Summarizing the findings and results of this research there are two layers of the system. One is the layer of theory, which includes the responsiveness of the EU health system to provide legal and undocumented migrants with healthcare, including the system and structure of the medical urgent care. In theory most European frameworks are well structured and responsive to the needs, while in practice the results show that migrants [documented and

undocumented] face logistical and language barriers, they are discriminated against by healthcare workers, which results in the lack of trust and it also shows that they are not aware of their fundamental right to healthcare.

The conclusion of this study is that there are missing pieces of migrant health policies in European countries and although apparently there is a sufficient and satisfactory coverage for migrants, the reality does not reflect it regardless of their legal entitlement. Limitations of this study include the lack of ethnic data and the focus group or individual interviews with these migrants but due to time limitations the current study did not allow this methodological measurement. Further research on the topic with the involvement of these vulnerable groups is necessary and would be useful in order to have a clear picture and understanding of the obstacles they face. The demonstration of this study indicates the need of further studies in the field and calls upon European governments to take measures in order to tackle discrimination and social injustice its undocumented migrants and ethnic minorities face.

The study also recommends re-structuring the eligible criteria for language trainings, in more details to eliminate the need of registration of undocumented migrants in order to be eligible to attend these trainings. Another kind of training is also recommended, which is two-folded. On the one hand it includes cultural education for healthcare professionals in order to cease prejudice and discrimination, on the other hand it includes education of fundamental rights – and to health in particular – as well as cultural education for migrants about the history and heritages of the hosting country in order to achieve a smoother integration into its society. Finally, adapting EU health systems to diversity along with introducing the universal health coverage scheme Europe-wide is encouraged and necessary.

List of Abbreviations

CEE – Central and Eastern European
EC – European Commission
EP – European Parliament
EHIC – European Health Insurance Card
EU – European Union
HCP – Health Care Professionals

IOM – International Organization for Migration
MdM – Médecins du Monde
MIPEX – Migrant and Integration Policy Index
MS – Member State
NGO – Non-governmental Organization
PICUM – Platform for International Cooperation on Undocumented
TCN: Third country nationals; Non-EU Nationals; nationals of NO, IS, LI and CH are not considered to be third-country nationals. This is consistent with Art. 2(6) of Regulation (EU) 2016/399 (Schengen Borders Code).
UM – Undocumented migrants
UN – United Nations
WHO – World Health Organization

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