Costs of Exclusion. Pros and Cons of Health Care for Irregular Migrants

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Access to health care is defined as a human right laid down in various documents and has been ratified by all European member states (Pace, 2007). Beside the human right perspective, European public health policies on equitable health care argue for health care services that are sensible for the needs of vulnerable groups, e.g. in the European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU (2010/2089(INI)). At the same time, access to health care is regulated by national law, which in most cases connects access to certain preconditions like insurance, citizenship, or another defined regular status.

It can be shown that in a majority of European countries, be it tax based or insurance based systems, irregular migrants are excluded from regular health care services, with emergency care being the only official gateway into the system. It is often argued that this causes humanitarian costs as it violates in some respect the human right to health, but that such restrictions are necessary as open access would cause high costs for treatments of people who do not pay into welfare systems. Additionally, open access irrespective of regular status and/or financial contributions would cause unwanted additional attraction for irregular migration.

Those migrants without a regular status, addressed as undocumented / irregular migrants however, are a specific group of interest concerning access to health care. Recent studies show that despite they take part in informal labour markets, they have no whatsoever right to participate in a system of social protection. They live in a parallel world that is characterised by exploitation, insecurity, and constant fear of being trapped. Their health is a key issue in several aspects,

- They face extreme physical and mental strains.
- Although a majority seems to be working, they have no insurance as they do not hold regular work contracts.
- They increase the overall risk of communicable diseases as they do not appear in any monitoring and do not have access to preventive treatments.

This gets visible in the growing body of knowledge about public health regulations that has been built up in the last years in the framework of various projects funded by the EU (IOM, 200; HUMA, 2009; PICUM, 2007; Karl-Trummer, Novak-Zezula, 2011; FRA, 2011). Reliable numbers on irregular migrants in the EU are not at hand. A database on irregular migration states that only estimates are available, in most cases of low quality (Clandestino, 2009). Estimates on the share of irregular migrants in 2008 for EU 27 vary with 0.39 %-0.77 % of the total population or 7% and 13% of the foreign population (Vogel 2009).

Regulations in Austria

Policy approaches in Austria about restrictions of access to health care for irregular migrants are similar to many other European member states.
Concerning national regulations, Austria is characterised by an insurance based health system with compulsory health insurance linked to employment and occupation. Migrants in Austria with a regular status and included in the insurance system, have the same right to access health care than natives. In this system, coverage is close to universal with 99.3%, although around 60,000 people of the documented population are named in official statistics (Hauptverband der österr. Sozialversicherungsträger, 2011) as being without health insurance. Older studies point out that people with an undocumented residing status are not included in official numbers but need further consideration (Fuchs 2003). This is underlined by recent European reports that name undocumented migrants as a highly vulnerable group (FRA 2011). For uninsured people in principle services are only available when paid out of pocket.

While for asylum seekers regulations concerning limited access to health care are defined, there are no such provisions specified for irregular migrants. Nevertheless, some general regulations may be applied for irregular migrants; two are presented here:

1) The KAKuG/Bundesgesetz über Krankenanstalten und Kuranstalten StF: BGBl. Nr. 1/1957, Fassung 2012, (hospital law), in §22 defines that people must not be rejected, whose physical or mental condition requires immediate hospital treatment or otherwise would lead to life-threatening situations or to danger of non avoidable severe damage to health. This includes pre-birth women.
According to § 23, essential medical first aid may not be denied in public hospitals.

2) §2 of the Tuberkulosegesetz StF: BGBl. Nr. 127/1968 (Law on tuberculoses) says, that persons with an infectious tuberculoses are obliged to undergo medical treatment, in the length of time of condition.
For doctors and hospitals there is the obligation to report patients with tuberculoses and such patients who do not comply with continuous medical treatment to local authorities. If patients cannot be convinced to comply, they are retained at hospital.

With this in mind it becomes visible that the only access to medical treatment for irregular migrants in Austria despite care paid out-of-pocket is emergency or being a severe public health threat.

The Austrian case can serve as a good example for the situation in many other developed European countries. Its highly developed health care sector is tailored and ready to handle the most delicate health problems. At the same time, it shows a kind of “system blindness” for a small population group that is excluded from basic health care provision.

It may be argued that, recognising that "there will always be a number of irregular migrants present in Europe, regardless of the policies adopted by governments to prevent their entry or to return them speedily." (European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU, 2010/2089(INI) this exclusion from regular care causes not only costs in a humanitarian dimension, but also unnecessary economic costs due to inefficient postponed treatment processes and resulting "forces emergencies". In addition to this, other dimensions of costs may be considered, e.g. social costs or costs on level of professional ethics.

Recent debates in the framework of the European Research Network COST ADAPT (Trummer, 2013) bring into the discussion three domains or arguments:

1. Humanitarian arguments - Health as a human right
2. Equity arguments - Equity in health as European public health goal
3. Economic arguments - exclusion may be more expensive than inclusion

Humanitarian arguments
"Everyone has the right of access to preventive health care and the right to benefit from medical treatment *under the conditions established by national laws and practices*." This is stated in Article 35 of the Charter of Fundamental Rights of the European Union (EC 2000/C 364/01) which has been ratified by all European member states. The Council of Europe (CoE) names access to *emergency care as minimum standard* to ensure the fundamental right to health care (Art.13.2 CoE 1509, 2006), but this standard has just recently came into discussion in another thematic domain: the Equity debate.

Equity arguments
In its resolution of 8 March 2011 on reducing health inequalities in the EU, 010/2089(INI), the European Parliament: "Calls on the Member States to ensure that the most *vulnerable groups, including undocumented migrants,* are entitled to and are provided with equitable access to healthcare; calls on the Member States to *assess the feasibility of supporting healthcare for irregular migrants* by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation".

Economic Arguments
Given the steadily rising costs of health care provision and the magnitude of the health care sector, the economics of health, which "…studies the allocation of resources to and within the health economy" (Folland et al, 2010, p.24), is an important field of research. Economic aspects in general are hot topics of discussion and high on the agenda of strategic development of health care systems and services (Brown, Thurecht, Nepal 2012; Dahrouge, Devlin, Hogg, Russell, Coyle, Fergusson, 2012). Avoidable emergencies are widely discussed, especially in the US literature (Pappas, 1997; Kruzikas, 2000; Russo, 2007). Recent European studies (Caminal et al., 2004; Rizza et al., 2007) on public health also propose that medical emergencies can be avoided by a system of effective primary and preventive care.
Another type of diagnoses that can be discussed from a health economic perspective are infectious diseases as TB, Hepatitis and STDs. Costs related to these diagnoses do not only include direct treatment costs of a patient but also costs arising from spreading of the infection.

The evidence on costs of exclusion within these domains so far is scarce.
The Center for Health and Migration Vienna in cooperation with Asian research partners (University Singapore, University Hongkong) currently conducts a study on „The Nature and Magnitude of the Costs of Exclusion of Documented and Undocumented Migrants from Health Care“. The study is commissioned by the Asian European Foundation Public Health Network. It asks experts on their opinions on costs of exclusion.

Be part of this study and give your opinion answering 5 questions either in German or English:
German: http://de.surveymonkey.com/s/V66RRC9
English: http://de.surveymonkey.com/s/L9TSX69

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Important information regarding this article:
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http://www.asef.org/index.php/projects/themes/public-health#: Website of the ASEF Public Health Network – Joint Research on Health and Migration in Asia and Europe, a participatory platform that encourages public health dialogue in Asia and Europe.

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http://c-hm.com/chm

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