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Restricted health care entitlements for child migrants in Europe and Australia

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Background: More than 300 000 asylum seeking children were registered in Europe alone during 2015. In this study, we examined entitlements for health care for these and other migrant children in Europe and Australia in a framework based on United Nations Convention of the Rights of the Child (UNCRC). **Methods:** Survey to child health professionals, NGO's and European Ombudspersons for Children in 30 EU/EEA countries and Australia, supplemented by desktop research of official documents. Migrant children were categorised as asylum seekers and irregular/undocumented migrants. **Results:** Five countries (France, Italy, Norway, Portugal and Spain) explicitly entitle all migrant children, irrespective of legal status, to receive equal health care to that of its nationals. Sweden and Belgium entitle equal care to asylum seekers and irregular non-EU migrants, while entitlements for EU migrants are unclear. Twelve European countries have limited entitlements to health care for asylum seeking children, including Germany that stands out as the country with the most restrictive health care policy for migrant children. In Australia entitlements for health care are restricted for asylum seeking children in detention and for irregular migrants. The needs of irregular migrants from other EU countries are often overlooked in European health care policy. **Conclusion:** Putting pressure on governments to honour the obligations of the UNCRC and explicitly entitle all children equal rights to health care can be an important way of advocating for better access to primary and preventive care for asylum seeking and undocumented children in Australia and the EU.

Introduction

In September 2016, UNICEF estimated that 11 million children were living as refugees or asylum seekers outside their country of birth.¹ During 2015, 1.3 million asylum seekers were reported in the 28 EU member states alone, including more than 300 000 children below 18 years of age, of whom 96 500 arrived unaccompanied by an adult caretaker.² Asylum seeking and newly settled refugee children in northern Europe have considerable health care needs primarily due to mental health problems^{3,4} [with unaccompanied minors (UAMs) having the highest rates⁵], but also due to infectious disorders and lack of basic health care and immunizations.^{6–9}

The right to health care is a universal, basic social right inscribed in various international treaties and texts. These texts include binding international State commitments under the United Nations and the Council of Europe, as well as EU agreements and 'soft' recommendations issued by their respective institutions and agencies. Children's right to health care is especially codified in the Convention on the Rights on the Child (CRC), a convention which has been signed by all nations in the world with the exception of the USA. Article 24 of the CRC recognises 'the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health'. The CRC considers a child as a child first and foremost. This is underpinned by a principle of non-discrimination meaning that the rights in the convention apply to all children regardless of race, colour, sex, language, religion, political or other opinion,

national, ethnic or social origin, property, disability, birth or other status. The EU Reception Conditions Directive also obliges member states to ensure medical or other assistance for asylum applicants with special needs, such as children and minors,¹⁰ but does not define this as an equal right to nationals.

Two categories of particularly vulnerable migrant children are *asylum seekers* and *children with an irregular migrant status*. They may be accompanied or unaccompanied, but regardless they have the same rights according to the United Nations Convention of the Rights of the Child (UNCRC). Asylum seekers usually have experienced armed conflicts and/or political persecution in the country of origin. While seeking asylum they live under circumstances characterized by temporality and uncertainty about their situation and future. *Children with irregular migrant status* are also referred to as 'undocumented' or 'unregistered' migrants. These children often live 'under the radar' in precarious situations with no or limited access to basic social rights and exposed to poverty, exploitation, social exclusion and violence.¹¹ Among the 'irregular migrants' there are also EU nationals who have made use of the right to free movement within the EU, but cannot make use of the directive on cross border-health care.¹² They have either overstayed the 3 months legal period or lack the European Health Insurance Card—the pan-European proof of entitlement to health care. The aim of this study was to compare national entitlements to health care for children who are asylum seekers or have an irregular migrant status, with those of resident children, using the framework of the UNCRC signed by their host countries.

Methods

Data for the study were derived from a questionnaire prepared for the European project 'Models of Child Health Appraised'¹³ (MOCHA), where one focus is on equitable health care for all children. The questionnaire surveyed national legal entitlements to health care for the three categories of migrant children (0–17 years). *Asylum seekers* were defined as persons who were in the process of applying for refugee status under the 1951 Geneva Refugee Convention or children of such persons. Children with an *irregular migrant status* were defined as children who lived without a residence permit, had overstayed visas or had refused immigration applications and who had not left the territory of the destination country subsequent to receipt of an expulsion order or were passing through or residing temporarily in a country without seeking asylum. *UAMs* were defined as children who have been separated from both parents and other relatives and are not being cared for by any adult.

The questionnaire was distributed to 31 European national Country Agents and Australia (MOCHA participants) who were all experienced child health professionals familiar with their national settings, of which 26 responded (83.9%). Furthermore, it was distributed to 31 national Human Rights Institutes and NGOs (19 responded—61.3%) and 25 members of the European Network of Ombudspersons for Children (ENOC) (7 responded—28%). The country agents were asked to report on the extent to which national policies granted different groups of migrant children equal entitlements to health care to those of national children regarding access, coverage, costs, funding and location of treatment, and if there were systemic barriers to these entitlements.^{14,15} Questions on whether UAMs had special entitlements to health care were also posed. The questionnaires were open ended to enable respondents to focus attention on issues they found most relevant. Supplementary data from governments in Europe and Australia and reports from NGOs and the European Union were included to coherence test the responses and provide additional information on the countries.^{11,16–27}

Findings are reported against entitlements. 'Entitlements' describe the *potential entry* of migrant children to the health care delivery system as defined in national laws and regulations. Based on the responses from the questionnaires we have categorised entitlements as: *Same entitlements* as national children (similar cost, coverage and location of treatment), *Dissimilar entitlements* (differences either in cost, coverage or location of treatment) or *Minimum entitlements* (entitled to emergency care only free of charge). The final summary of entitlements was re-circulated to the national Country Agents for final validation.

Results

No country reported age-specific entitlements within the 0–17 year age range. In *France, Italy, Norway, Portugal* and *Spain* all categories of migrant children regardless of legal status are granted equal entitlements and included in the same health care system as national children. Sweden and Belgium offer equal entitlements to asylum seeking children and children of irregular third-country migrants, however, entitlements for children of irregular EU-nationals are unclear. Greece is a special case, where the regulations that entitle asylum seeking and irregular non-EU-migrant children to equal care have in practice been very much limited by economic constraints.¹⁷

Asylum seekers

Table 1 shows that 19 European countries include asylum seeking children equally in health care services offered to national children and in the same healthcare system. Twelve countries have been identified as providing dissimilar entitlements to asylum seeking

Table 1 Legal entitlements to health care for children in asylum seeking families and children from a country outside of EU/EEA/Australia in an irregular migrant situation

	Similar entitlements	Dissimilar entitlements	Minimum entitlements
Australia	• ^a		▲
Austria	•		▲
Belgium	• ▲		
Bulgaria		•	▲
Croatia	•	▲	
Cyprus	•	▲	
Czech Republic		•	▲
Denmark		• ▲	
Estonia		• ▲	
Finland		•	▲
France	• ▲		
Germany		•	▲
Greece		▲	
Hungary	•		▲
Iceland		•	▲
Ireland	•		▲
Italy	• ▲		
Latvia	•		▲
Lithuania		•	▲
Luxembourg	•		▲
Malta		▲	
Netherlands		• ▲	
Norway	• ▲		
Poland		•	▲
Portugal	• ▲		
Romania	•	▲	
Slovakia		•	▲
Slovenia		•	▲
Spain	• ▲		
Sweden	• ▲		
UK	•	▲	

a: In Australia, health care entitlements for asylum seeking children depend on their whereabouts, see text.

children. In this category *Bulgaria, Czech Republic, Estonia, Finland, Lithuania, Poland* and *Slovenia* grant the children equal services free of charge, but health care is performed in parallel primary health care organisations. Services are primarily located at the asylum centres or reception facilities and designated health care staff assigned to the families. *Denmark, Iceland, the Netherlands, Germany* and *Slovakia* grants asylum seeking children 'basic' or 'necessary' health care, which can range from emergency care to further care, but in reality depends on assessments by individual service providers or the authorities in charge of the asylum facilities. Of these, *Denmark* and *Netherlands* also use parallel health care systems to provide care.

In Australia, health care entitlements for asylum seeking children depend on how they have arrived. If they arrive by plane on relevant visas they have similar health care entitlements to residents; similarly, if they arrive by boat but have appropriate visa status granted. Entitlements are restricted and delivered by a parallel primary health care organisation if they have arrived by boat and are confined to community detention or detention on Pacific islands.

Irregular migrants

For children with irregular migrant status and originate outside of EU/EEA, only seven countries provide equal entitlements. Three countries; *Cyprus, Denmark* and the *Netherlands*, provide 'basic' or 'necessary' health care, while in the UK irregular children have free

access to emergency and primary care, but have to pay full cost for non-urgent secondary care and dental care. Policies in Croatia, Estonia and Malta indirectly provide all children with necessary care, but the policies are very vague when it comes to irregular children.

In 15 countries, children with irregular migrant status are only entitled to emergency care free of charge. In most of these countries no specific health care provisions for children in an irregular situation exist, and it is therefore assumed they are entitled only to minimum care. In *Germany* irregular migrants must go through the social welfare office in order to receive health care. Since this office has a duty to report irregular children to the authorities, in effect this limits children's access to health care. In *Finland* some municipalities, including the capital Helsinki, have decided to provide all health care services for irregular children and pregnant women. In *Poland* entitlements are tied to school attendance. In *Australia* irregular (undocumented) migrants have no entitlements to regular health care.

Entitlements for children of irregular migrants that originate within the EU are unclear in many countries (data not presented in table 1). These children are in a legal vacuum despite having EU citizenship. Although health and social care provisions are national responsibilities under the concept of 'national competencies', they fail to qualify for services in the new country of arrival as they are not residents. They also fall outside EU social security regulations and regulations applicable to irregular migrants originating outside of EU.

Unaccompanied minors

In 12 countries, UAMs have broader entitlements to health care than accompanied migrant children. In *Germany*, asylum-seeking UAMs' health care is based on the child's individual needs, including access to psychological care. In the UK, UAMs in the asylum seeking system are entitled to NHS treatment on the same terms as national children and other children in care facilities.

Discussion

From our survey no more than a handful of EU/EEA member states have a policy that provides equal entitlement of care to children in the host population for all migrant children. This is an obvious breach of the non-discrimination principle in article 2 of the UN Convention on the Rights of the Child, signed by all countries included in the study. Considering the large number of migrant children who have arrived in the participating countries during recent years, this gap leaves a large number of children without access to basic health care in violation of their rights.

'Asylum seeker' is the legal category of children most often entitled to health care on equal terms with resident children. Nineteen out of 31 states have such entitlements, while only 7 nations have such entitlements for irregular or undocumented children from non-EU/EEA countries. Of the countries having dissimilar entitlements for asylum-seeking children to the host population, nine do so in a parallel primary health care organisation outside the general primary health care system. Providing care in this manner potentially gives health care professionals a better understanding of the context of the asylum seeking child, but these organisations may also be vulnerable because of limited funding and reliance on a small staff.²⁸

Children in migrant families from other EU countries who have overstayed the three months period of free mobility within Europe, or who lack formal identification, are often overlooked in European migrant and health policies. This group falls outside categories defined in most European national migrant policy documents; as well as outside current EU regulations aimed at providing better health care to migrants, such as the Reception Directive, the

Directive on Free Movement and the Directive on Cross-border Healthcare.

In at least 12 countries, unaccompanied migrant children have broader entitlements to health care than accompanied migrant children. Although this is certainly beneficial for this most vulnerable group of children, it is also a policy that discriminates children by family status.

France, Italy, Spain, Portugal and Norway stand out because they have explicit policies that aim to provide care on equal terms to the host population for all categories of migrant children, subscribing to the CRC view of children as children first and foremost instead of migrants with different legal status. In contrast, Germany and Slovakia stand out as the European countries with the most restrictive policies. Germany is the country that received the highest number by far of asylum seekers within the EU/EEA area in 2015. Therefore, their national policy has implications for tens of thousands of asylum seeking and irregular minors. The restricted rights of health care for asylum seeking children in detention on the Pacific islands outside of Australia or in detention centres on the mainland, despite the well documented dire conditions under which these children and their families live,¹⁷ is another low water mark among the countries in this study.

Health care provided in a primary care setting is in most societies the most cost-effective way of providing psychological care for migrant children, and thus a way to fulfil the rights of rehabilitation for victimised children as expressed in paragraph 39 of the UNCRC. It also has the potential to meet their accumulated health care needs, for early detection of communicable disorders and the provision of preventive interventions such as vaccinations and screenings for malformations and disabilities.²⁹ A number of countries use concepts such 'basic', 'necessary' or 'emergency' care to define the entitlements to care for migrants. These vaguely defined entitlements make decisions on access to health care arbitrary and dependent on the judgement of individual health care providers, and often leads to the exclusion from access to primary care.

Fear of police or immigration authorities is a major barrier for irregular migrants to access the care to which they are entitled. Thus, to make health care truly accessible for irregular migrants, health services should be entirely independent from immigration authorities, and the principles of medical confidentiality should be upheld for these patients. In this sense, the policy in Germany and Bulgaria of a legal duty for health services to report irregular migrants stand out as the most obvious negative policy example.

The way health care is funded differs considerably across the EU/EEA and Australia. Some countries have a tax-based system while others are funded insurance schemes. Although it is often more administratively complicated to fund health care for migrant children in insurance-based systems, we found no obvious relationship between the funding system and health care policy for migrant children. The Netherlands, for instance, has overcome this administrative challenge in an innovative way by the creation of a national fund where costs for irregular migrants can be reimbursed to health care providers. In France children in irregular migrant situations are eligible for State Medical Assistance (Aide Médicale Etat—AME) free of charge which covers all kinds of health care. These children have the right to AME immediately without any administrative requirements.

Finally, there are economic and societal arguments for why we should make the modest investment in equal health rights for all children including child migrants. The European Union Agency for Fundamental Rights has pointed to the economic incentives for providing health care on equal terms for migrants in an irregular situation. Not providing care in the early stages of a disease, or excluding migrants from preventive programs can lead to very high costs for hospital care.³⁰ A report from Médecins du Monde shows that only 60% of irregular migrant children who were cared for in their clinics in London and Belgium had been vaccinated against MMR, tetanus and HBV. This puts these children at risk

of developing these disorders, and, in the case of measles, also puts the host population at risk,¹⁸ with very large potential costs involved.

Limitations

The results in this article are based on national policies in the early spring of 2016. In countries where health care is the responsibility of regional governments, it is possible that regional entitlements may differ from those presented here. For example, in federalized countries such as Germany two regions have more generous entitlements for asylum seekers than others regions in this federal state. Similarly, in Australia there are variations in health care provision with the details beyond the scope of this study.

The report primarily covers entitlement to care for migrant children derived from policies. Further studies, potentially based on interviews with migrants, are needed to better understand the actual access to care for migrant children.

Implications

Action is needed to improve entitlements to care for migrant children in Europe and Australia. In Europe, the EU Reception Conditions Directive needs to be much clearer on children's rights to health care. The legal situation of irregular and destitute EU migrants has not been sufficiently addressed in national legislation and urgently needs to be modified to include these children.

The cross-country comparisons of this report calls for national action in many countries. This is particularly pertinent for Germany, the economic pillar of the EU and the country that absorbed the largest numbers of asylum seekers in 2015. In German health care policy, a distinction between adult and child migrants is rarely made. Another country where change is particularly called for is Australia, with its restricted entitlements for children in detention. Thus, the German and Australian governments have yet to accommodate their legislation and policies on health care for migrant children to the UN Convention of the Child.

Conclusion

All countries in the EU/EEA and Australia have endorsed the rights of children including the right to health care. However, in times of challenge the great majority of these countries have been found by this study to be operating restricted health care policies for these most disadvantaged migrant children. Thus 25 out of the 31 countries appear to be failing the children's rights to which they claim allegiance—they are consequently disadvantaging the vulnerable children they have the opportunity to help at minimal cost.

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Key points

- Previous studies have demonstrated that migrant children have significant health care needs, particularly psychological support and accumulated needs of preventive and curative health care.
- This study shows that most countries in Europe and Australia have national health care policies that limit entitlements for some or all categories of migrant children, with Germany standing out as the country with the most restrictive policy. This is an obvious breach of the non-discrimination principle in article 2 of the UN Convention on the Rights of the Child.
- The legal situation of irregular and destitute EU migrants has not been sufficiently addressed on the European level or in national health care legislation.

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Barriers to cervical cancer screening faced by immigrants: a registry-based study of 1.4 million women in Norway

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Background: Immigrants from certain low- and middle-income countries are more prone to cancers attributed to viral infections in early life. Cervical cancer is caused by human papillomavirus but is highly preventable by regular screening. We assessed participation among immigrants in a population-based cervical screening programme and identified factors that predicted non-adherence within different immigrant groups. **Methods:** We used data from several nationwide registries. The study population consisted of 208 626 (15%) immigrants and 1 157 223 (85%) native Norwegians. Non-adherence was defined as no eligible screening test in 2008–12. We estimated prevalence ratios with 95% confidence intervals (CIs) for factors associated with non-adherence by modified Poisson regression. **Results:** In total, 52% of immigrants were not screened. All immigrants showed 1.72 times higher non-adherence rates (95% CI 1.71–1.73) compared with native Norwegian women when adjusted for age and parity. The proportion of non-adherent immigrants varied substantially by region of origin and country of origin. Being unemployed or not in the workforce, being unmarried, having low income and having a male general practitioner was associated with non-adherence regardless of region of origin. Living <10 years in Norway was an evident determinant of non-adherence among most but not all immigrant groups. **Conclusions:** An increasing proportion of immigrants and low screening participation among them pose new public health challenges in Europe. Immigrants are diverse in terms of their sociodemographic attributes and screening participation. Tailored information and service delivery may be necessary to increase cancer screening among immigrants.

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Introduction

Immigrants from certain low- and middle-income countries are more prone to cancers related to infections experienced in early life.^{1,2} Cervical cancer is caused by human papillomavirus (HPV)^{3,4}

but is highly preventable by regular screening. However, immigrants tend to be less adherent to screening, and this is not only attributable to demographic or socioeconomic factors.^{5–13}

Lack of time is a barrier to screening for all women.^{12–17} In addition, immigrants face special problems related to poor proficiency in the new