Fundamental Rights for Irregular Migrants: legal entitlements to healthcare and school education across the EU28.

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Abstract

A recent study of the legal entitlements of irregular ('undocumented') migrants in national laws across the EU28 reveals a polarity of entitlements to healthcare and school education. Entitlements have in both instances been extended in some Member States in recent years but there are also instances of further restrictions being imposed. The entitlements of children to healthcare are often greater than those of adults. While in some cases entitlements are explicitly provided for in law or regulations, in other cases the entitlement is implicit in a universal provision from which irregular migrants are not excluded. The pattern of entitlements does not mirror potential explanatory factors such as national wealth or size of the irregular migrant population. The study explored entitlements in law, not the range of barriers which can in practice limit access to the service.

Introduction

Among the thousands of people who fled to Europe in recent months, the immigration status of many is, or will become, irregular. Beyond those fortunate enough to be granted refugee status on arrival, those who entered without legal status will later be joined by those whose claim for asylum is refused but who nevertheless decide to remain.

The size of the irregular migrant population in the EU was estimated at between 1.9 and 3.8 million in 2008 (0.4-0.8 per cent of the population of the then EU27), (Clandestino 2009). Low compared to the estimated 11.7 million in the United States (2012), some 3.7 per cent of its population (Passel et al. 2013), their residence without legal status is nevertheless significant for the countries and cities in which they reside, and for the individuals themselves. While some irregular migrants enter without permission, many enter legally as asylum seekers, students, labour or family migrants and remain when their permit expires. Others are born in Europe to parents who lack legal residence in the country in which they were born. Some irregular migrants are known to the immigration authorities, not least those in the 'return procedure' (under the EU Return Directive 2008/115/EC)[1] who for legal, humanitarian or practical reasons have not yet been removed. Those of whom the immigration authorities are unaware may nevertheless be known to one or more public services, at the local level.

All EU Member States have ratified the principal UN human rights instruments which provide protection for social rights; are contracting parties to the ECHR; and likewise to the European Social Charter (albeit here with variation in whether they have ratified the revised Charter and collective complaints procedure, and in relation to certain Articles of the Charter which they have

[1] Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals, OJ 2088 L348/98.

declined to support).[2] Except where migrants without legal residence are expressly excluded from such provisions, they share the protection they afford (FRA 2011a; OHCRH 2014). The extent to which access should be provided to a particular service, however, is not always explicit in the text. Moreover, the impact of international human rights commitments 'depends on a political and social 'reception' for them at the national level' (Chimienti and Solomos 2015:32) and we might expect this to be particularly true in relation to irregular migrants. We therefore set out, in a study completed in 2015, to establish the extent to which entitlements in two areas of social rights of fundamental importance to the welfare of adults and children, healthcare and school education, are to be found in the national laws of EU Member States.

Our baseline for mapping entitlements was findings of the EU Fundamental Rights Agency published in two reports in 2011 (FRA 2011a; 2011b); an overview of a range of entitlements including education, and a mapping of health entitlements across the EU, respectively. Subsequent reforms were identified from a series of academic and policy reports, including country reports from the EU funded NowHereland study (Cuadra 2012), and from the informative Bulletin of the Platform for International Cooperation on Undocumented Migrants in Europe (PICUM).[3] Supplementary evidence was secured from interviews conducted with policy makers, lawyers and civil society representatives across 14 States in which the legal framework was one topic covered. The resulting

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[2] Ratifications as last updated 26 March 2013 see http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/SignaturesRatificationsMarch2013_en.pdf. Accessed 15 October 2015

[3] PICUM Bulletins can be accessed at: http://picum.org/en/news/bulletins/

mapping of entitlements was sent to a national expert in each of the EU28 who checked the accuracy of our findings. Tables setting out the mapping of entitlements for each country can be accessed on line.[4]

Entitlements to healthcare

Mapping entitlements across countries with differing legal, governance and health systems is not straightforward. States differ, for instance, in the extent to which healthcare is subject to regional as well as national legal provisions; and in whether it is funded by taxation, social insurance or a combination of the two – funding systems which bring differing procedural requirements for accessing services.

Most significantly, some countries require patients, and irregular migrants in particular, to pay 'out-of-pocket' expenses for care received. The UN Committee on the Covenant on Economic and Social Rights has argued that the right to healthcare means care which is available, accessible, acceptable and of good quality.[5] We could not assess the extent to which those criteria are fulfilled from a mapping of legal provisions, and cost in particular is a difficult criterion to map: varying for different treatments, tests and medication, and only meaningful relative to differing income levels. Yet an unaffordable requirement to pay can render an apparent entitlement in law, void. We therefore note in Table 1 whether out-of-pocket payments are expected and explore their significance for

[4] https://www.compas.ox.ac.uk/fileadmin/files/Publications/Reports/PR-2015-Outside_In_Mapping_Annex.pdf
[5] CESCR (2000) General Comment 14 'The right to the highest attainable standard of health'. 11.08.2000. E/C 12/2000/4

those countries that in other respects appear to grant the greatest access to primary and secondary care services.

Emergency, primary and secondary care[6]

Our mapping reveals that in all EU Member States irregular migrants are entitled to emergency healthcare, that term more broadly defined in some countries than others. In some countries payment may be requested but care providers can be expected to provide care whether or not it is received. Strikingly, there are six countries where this is the limit of the care which irregular migrant adults are entitled to receive: Bulgaria, Cyprus, Finland, Lithuania, Luxembourg and Slovakia. In a further twelve countries[7] adults are likewise excluded from primary or secondary healthcare services but have access to some specialist services such as for infectious diseases. Irregular migrants may be able to secure access to additional services if they can pay the full cost, without being reported to the immigration authorities.

We found ten Member States where irregular migrant adults are entitled to some level of access to primary and secondary healthcare: in Belgium, Czech Republic, France, Germany, Ireland, Italy, Netherlands, Portugal, Sweden and the UK. The wording of that entitlement varies, for instance in Sweden it is to care 'that

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[6] We use here the definitions used by the EU Fundamental Rights Agency: 'Emergency care includes life-saving measures as well as medical treatment necessary to prevent serious damage to a person's health. Primary care includes essential treatment of relatively common minor illnesses provided on an outpatient or community basis (e.g. services by general practitioners). Secondary care comprises medical treatment provided by specialists and, in part, inpatient care' (FRA, 2011a:74).

[7] Austria, Croatia, Denmark, Estonia, Greece, Hungary, Latvia, Malta, Poland, Romania, Slovenia and Spain.

cannot be deferred' (here including dental treatment); in the Netherlands 'medically necessary care' and Belgium 'essential or urgent care'; each subject to the interpretation of the doctor who decides whether that criterion applies.

Before deeming these countries to be the most open in the entitlements granted, however, we considered the extent to which they nevertheless require patients to pay a significant proportion of the cost of care provision, drawing on evidence from Médecins du Monde (2013a), the NowHereland study (Cuadra 2012) and others who have explored access to care in practice. In the Czech Republic access to care is only on the basis of full payment, hence the entitlement cannot be considered to exist in practice; and likewise payment is required in Ireland. Although Irish law makes provision for access in cases of undue hardship, it cannot be said that an entitlement to care exists.

Germany also falls at this cost barrier, there being no entitlement to treatment without payment. Moreover, irregular migrants who the state to pay for their treatment will be reported by the Sozialamt (social security) office to the immigration authorities, it being a statutory duty on them to do so.[8] Médecins du Monde report that this in effect nullifies the entitlement to healthcare 'because they are stopped by the legal risk of being turned in' (2013a:33). The judgement of the FRA is that 'This risk renders access to non-emergency healthcare meaningless' (2011b:16).

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[8] Aufenthaltsgesetz (Residence Act, as amended 2013) s87 ('Transfer of Data and Information to Foreigners' Authorities').

For the UK the cost barrier also cuts across the limited entitlement to secondary care, but access to primary care remains (for the time being) free. Emergency care and treatment for communicable diseases are likewise free of charge.

In the remaining countries that grant entitlement to a level of primary and secondary care we found procedural barriers: as in Belgium where would-be patients have to demonstrate that they are experiencing financial hardship to qualify for free treatment; and in the Netherlands where only certain hospitals are contracted to recover the cost of the care from the state. Portugal requires residence of 90 days before the entitlement kicks in. Notwithstanding those caveats, we found entitlements to a level of primary and secondary care to be least restrictive in Belgium, France, Italy, the Netherlands, Portugal and Sweden. While irregular migrants can face barriers to securing access to that care, the obverse is that countries with restrictive legal provisions may allow greater access in practice. In Luxembourg, an informal agreement between the Ministries of Health and Immigration in 2007, for instance, enables irregular migrants to purchase social insurance without proof of legal status (Cuadra 2010:9).

Our study also explored the reasons cited by policy makers, in documentation or interviews, for the granting of entitlements to irregular migrants. We sought to know whether these are granted on the basis of human right obligations or humanitarian concerns, for instance, or prompted by broader social or economic objectives. We shall report on those findings elsewhere - including the extent to which public health concerns are regularly cited as grounds for providing access

to some healthcare services, including infectious diseases. We found this reflected in the extent to which, despite the limited access to healthcare we have reported, greater access is granted to screening and treatment for HIV AIDS, and for other infectious diseases such as tuberculosis. Fifteen Member States allow access to screening for HIV and among them ten provide access to treatment: Belgium, France, Greece, Italy, Malta, Netherlands, Portugal, Spain, Sweden and the UK. The extension of access to free HIV treatment in the UK in 2012, counter to a more restrictive trend in relation to other health services, followed a significant campaign and debate at parliamentary level which focused heavily on the public health implications of excluding this section of the population at risk.[9]

Seventeen States grant access to screening for other infectious diseases, of which 14 also provide treatment at least for tuberculosis. Nevertheless, this leaves 11 states where irregular migrants are not entitled to access screening or treatment for any infectious diseases (except potentially on payment of the full cost); that is, in Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, Lithuania, Luxembourg, Romania, Slovakia and Slovenia.

Healthcare for Children

In a striking departure from the pattern of healthcare for adults, there are eight Member States where children, with their parents or unaccompanied, have the same entitlements as children who are nationals of that country: Estonia, France, Greece, Italy, Portugal, Romania, Spain and Sweden. In most cases that

[9]See Minister in the relevant parliamentary debate at: http://www.publications.parliament.uk/pa/ld201212/ldhansrd/text/120229-0003.htm#12022983000049

entitlement is explicit in law, whereas the law in Estonia and Romania provides that all children are insured for healthcare, without exception. The detail of the entitlement varies – in Estonia it is for those attending school while in Poland children otherwise entitled only to emergency care can access some services such as vaccinations through school attendance. The age to which the entitlement extends also varies – just 16 years in Portugal but 18 in Spain. In a further three countries children with irregular status are granted the same entitlement to care as those of migrants with legal status: Cyprus, Denmark and Germany.

Elsewhere, the entitlements of children to healthcare are the same as those of their parents. Thus in countries such as Belgium, the Netherlands and the UK they have access, as we saw, to a level of primary and secondary care. At the other end of the scale, in Bulgaria, Finland, Lithuania, Luxembourg and Slovakia, it means children (other than those who are unaccompanied in some cases), are entitled only to emergency care.

As we have suggested, children who are unaccompanied are sometimes granted additional entitlements. We found this to be the case in 11 countries, in some cases (Belgium, Croatia, France, Luxembourg and the UK) securing access to the same level of care as nationals of the country. That additional protection raises the question why children who are accompanied should be treated less favourably in relation to healthcare than those who are not.

[INSERT TABLE 1 NEAR HERE]

Healthcare – direction of travel

There have been some significant advances in legal entitlements in recent years. While the UK has tightened up procedures to reclaim the cost of treatment[10] and is not alone in rowing back access to care, there have been notable extensions of access elsewhere. Sweden replaced a highly restrictive legal framework in 2013, following an extensive civil society campaign that included the Swedish Medical Association, with one of the least restrictive in Europe (albeit less so than an official inquiry recommended the Government should adopt).[11] Italy, which already allowed adults and children a level of access to primary and secondary care, extended provision for children in 2012 to provide the same entitlement as nationals, including the guarantee of specialist paediatric care, a move driven by regional tiers of government responsible for healthcare services (Delvino & Spencer 2014). In Spain, where a Royal Decree in 2012 curtailed the access of irregular migrant adults to healthcare, that provision has been challenged in the courts by regional governments [12]and is now under review. Finland's highly restrictive provisions have likewise been the subject of an official review, although reforms are currently stalled by opposition in Parliament. Even in the UK, as we saw, access to HIV treatment was extended because of over-riding public health concerns (though in the same year access in Greece was cut back,

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[10] National Health Service (Charges to Overseas Visitors) Regulations 2015; Guidance on Implementing the Overseas Visitors Regulations, Department of Health 2015.

[11] Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act 2013., which came into force on 1 July 2013.

[12] On 13 December 2012 the Constitutional Court, for instance, cited the Spanish Constitution (Art.43, Right to Health) and the ECHR to uphold the universal right to health, arguing that it had precedence over the fiscal benefit of excluding certain groups.

accessible only until the patient's health has 'stabilised'[13]), demonstrating that counter-veiling policy objectives can (but do not always) trump the enforcement priorities of immigration control.

The requirement in the Return Directive (Art.14) that, pending return, irregular migrants should have access to essential healthcare and schooling marked the first explicit requirement in EU law that Member States should provide for this group of people. A review of implementation said little on whether this provision has led to any extension of access in practice (European Commission, 2014:23), the suggestion being that the Directive merely reflected the existing position in most Member States for those known to the authorities but not yet removed. More significantly, the European Committee on Social Rights has found that legislation or practice which denies medical assistance to foreign nationals, even if there 'illegally', is contrary to the Charter (Art.13):

> 'States Parties are under an obligation to provide foreign migrants who are in an irregular situation of stay in the territory of the State with urgent medical assistance and such basic social assistance as is necessary to cope with an immediate state of need (accommodation, food, emergency care and clothing).'[14]

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[13] Directive of 2 May 2012 amending law 3386/2005 s84.

[14] European Committee of Social Rights Activity Report 2013. Strasbourg: Council of Europe. Statement on Interpretation of Article 13. Page 30. Citing in particular International Federation of Human Rights Leagues v. France, Complaint No. 14/2003, decision on the merits of 8 September 2004, § 30-32; Defence for Children International v. Belgium, Complaint No. 69/2011, decision on the merits of 23 October 2012, § 28; Defence for Children International v. the Netherlands, Complaint No. 47/2008, decision on the merits of 20 October 2009, § 19.

While lacking the force of ECHR decisions the Committee can cite instances where its decisions have led to policy reform and its clear view that protection extends to irregular migrants can prove influential in national debates.

Entitlements to education

Mapping of entitlements to school education (see Table 2) reveals, as with healthcare, striking contrasts: between a lack of any entitlement to attend school, on the one hand, and an explicit legal entitlement on the other.

There are ten countries in which an explicit entitlement for children with irregular status to attend primary and secondary school is found in legislation, regulations, Ministerial Decree or case law: Belgium, Croatia, Czech Republic, France, Greece, Italy, the Netherlands, Romania, Spain and Sweden. This is also the case for primary education in Slovenia. Thus in Italy we find not only that the constitution provides that 'School is open to everybody' (Art.34) but that a Legislative Decree (286 of 1998) specifies that 'foreign minors staying in Italy have the right to education irrespective of their irregular status', enjoying the same rights as children who are Italian nationals. Belgium, among others, explicitly affirms a right not only to schooling but to receive the end of school certificate; and through Ministerial Circular prevents police activity on or near school premises which could deter irregular migrant children attending. The

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Report accessible at: http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ActivityReport2013_en.pdf.

entitlement in the Netherlands extends to access to funds for school materials on the same basis as other children.

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In a further 23 countries these children have an implicit right to attend school – that is, legislation provides that all children shall be able to attend and no exception is made on grounds of immigration status. This weaker form of entitlement can leave room for ambiguity, for instance in Cyprus where it remains unclear whether schools are expected to report pupils in an irregular situation to the immigration authorities. In the remaining five countries, however, (Bulgaria, Finland, Hungary, Latvia and Lithuania), there is no entitlement to attend school at all (notwithstanding inclusive constitutional provisions), except for those in the returns procedure who, under Article 14 of the Return Directive ('Safeguards Pending Return'), are entitled *inter alia* to 'access the basic education system subject to the length of their stay'. The exclusion can arise from the procedural requirement to be registered in a municipal register for which holding a legal residence permit is a necessary criterion.

The existence of an entitlement to attend does not mean that the practice of that country meets the test of availability, accessibility, acceptability and adaptability which the international human rights standards require (OHCHR 2014:81). Procedural barriers or fear of being reported to the immigration authorities can deter. The extent of the entitlement also varies between countries – whether it includes pre-school education as in Italy for instance – and whether to 16 or 18 years of age.

As with healthcare, the direction of travel has been to extend access: the outcome of pressure from regional and municipal tiers of government and civil society, exercised through political channels and the courts. Thus the extension of the legal entitlement in Spain to 18 years of age followed a successful challenge in the constitutional court on the earlier ceiling of 16 years,[15] while the extension to pre-school provision in Italy followed the inclusive practice of many municipalities which secured the endorsement of the national government. Dutch municipalities successfully challenged the exclusion of apprenticeships from the definition of 'education', while in Sweden the entitlement to education followed in the slip-stream of the campaign to secure access to healthcare, in 2013. In Germany, pressure from civil society coupled with non-cooperation from some Länder, led the German government in 2011 to withdraw a statutory requirement that the names of pupils without legal residence permits be reported to the immigration authorities (Laubenthal 2011).

Discussion

Access to healthcare and to education are fundamental human rights, and irregular migrants among the most vulnerable of Europe's residents. As such it is of concern that we know so little about the protections which exist in the national legal frameworks of Member States, nor whether they comply with the

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[15] Spanish Constitutional Court ruling *Sentencia del Tribunal Constitucional* – STC 236/2007, 7 November 2007. See English translation of the judgement at: http://www.tribunalconstitucional.es/es/jurisprudencia/restrad/Paginas/JCC2362007en.aspx

standards set down in the international and European human rights instruments.

We have cited a number of instances of countries extending entitlements to healthcare and school education in recent years. Pressure from civil society, regional and municipal tiers of government, and decisions of domestic courts have played a key role in that process, as has the European Committee on Social Rights. We might also expect to find some explanation for the uneven geography of entitlements in differing characteristics of European countries: their relative wealth for instance, given the potential cost of service provision; the size of their irregular migrant population; and whether for instance irregular entry and stay in the country is a criminal offence.

A full comparative study of these potential explanatory factors was not within the scope of our study but an initial exploration finds no clear relationship with the pattern of entitlements. In relation to the relative wealth of countries, for instance, it is by no means the case that the richest countries are those that impose the fewest restrictions on accessing healthcare or education. If we take Gross Domestic Product Purchasing Parity (GDP PP) as our measure of comparison, we can see from Eurostat data for 1 June 2015[16] that one of the least restrictive countries in relation to access to healthcare, Portugal, as well as two of those least restrictive in relation to children's healthcare, Greece and Romania, have a GDP PP well below the European average. Obversely, some of those most

16 http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tec00114&plugin=1 . Accessed 17 October 2015

restrictive in relation to healthcare, such as Denmark, and to education, Finland, are among those which could most afford to pay.

We might anticipate that those countries with the greatest numbers of irregular migrants would grant the fewest entitlements, if cost is a deciding factor; or, alternatively, be among be the most open if it is the evident demand for services which creates pressure to allow greater access. Here, again, however, we find no clear correlation, although any analysis has to be qualified by recognition that estimates of the irregular migrant population are inherently problematic. Moreover, the estimates were often undertaken in different years. The overall level of the population, moreover, tells us little about their impact in particular parts of the country or cities, which may impact on national responses. Bearing in mind those caveats when looking at the data from the Clandestino project (2009), we do find no clear correlation between the size of the irregular migrant population and entitlements granted. Among the minority of countries where that population is estimated to be over 1 percent of the national population, for instance, we find countries which are among those least restrictive on access to healthcare (for adults and/or children) and education, such as Belgium, Greece and Portugal, but also countries which are less open such as Cyprus and the Czech Republic.

Among the other possible explanatory factors we might expect that the most restrictive countries would be those where irregular entry and/or stay is a criminal offence. There are currently 17 EU States where that is the case, following a trend towards criminalisation which has only recently seen some

reversal: France decriminalising irregular stay (but not entry) in 2012 and Italy both entry and stay in 2014. The Netherlands rejected a proposal that irregular stay should become a criminal offence in that same year. Nevertheless many states not only impose criminal sanctions on those whose stay is irregular but penalise some forms of assistance to them, and can require service providers to report the presence of irregular migrants to the immigration authorities (Commissioner for Human Rights 2010; FRA 2014; Provera 2015).

As with the other potential explanatory factors it is nevertheless difficult to assess whether there is any connection with the approach taken towards granting entitlements. The relative timing of decisions, for instance, is one factor: decisions on entitlements in Italy, for instance, were taken at a time when irregular stay was a criminal offence. While bearing those caveats in mind, it is striking that among the countries in which irregular entry and/or stay is a criminal offence, we find many of those which impose the fewest restrictions on access to healthcare, such as Belgium, France and Sweden. Clearly, stringent restrictions on access to services is not a necessary bedfellow of an enforcement strategy that relies on the criminal law.

Conclusion

Access to healthcare and school education are fundamental rights and yet we know little about the legal entitlements to those services granted to one of the most vulnerable populations in Europe, irregular migrants. Our mapping of provisions in the national laws of EU Member States has revealed a polarisation between a level of entitlement to both healthcare and education, ranging in the

latter case from an explicit entitlement to attend school on the same basis as children who are nationals through to no entitlement at all. While irregular migrants who live in countries with very limited entitlements may in practice gain access through the discretion of an individual service provider, those living in countries where, on paper, greater access is granted may face procedural and other barriers to securing that access in practice.

The nature of the legal entitlement itself varies significantly between countries – in the definition of the circumstances in which healthcare beyond emergency care will be permitted, in the range of infectious diseases covered for instance or the age to which a child can attend school. The entitlements of children are generally more extensive than for adults, yet there remain countries where children still have no entitlement beyond emergency healthcare nor any right to attend school. While some entitlements are clear to see in black-letter law, others exist more precariously through the mere absence of exceptions from universal provisions, clarified in some cases by Ministerial circulars that may or may not be well known. The Italian government has on a number of occasions found it necessary to clarify that irregular migrants should be granted access to a service or that reporting requirements to the immigration authorities do not apply (Delvino and Spencer 2014); while a Ministerial circular in Cyprus states that irregular migrant children should have access to treatment without cost if unable to pay and likewise pregnant women (PICUM 2015:36) yet by 2015 that circular had not been officially published.[17] A Maltese government policy

[17] Ministerial circular in Cyprus 2011(Y.Y.11.11.09(4))

document of 2005[18] states that irregular migrants are entitled to 'free state medical care and services', whereas the law provides only for access to emergency care. Codifying these Circulars and policy documents into clear legal provisions would in itself help to clarify existing entitlements, for service providers, irregular migrants, and those who advise them.

With some notable exceptions, the direction of travel has been towards an extension of entitlements. Greater understanding is needed both of the underlying demographic, legal and economic factors that may impact on each country's approach and the impact of differing civil society strategies to secure reforms. The sharp disparities between countries and the very low level of access to healthcare and education permitted in many countries should make this a priority for further study and advocacy in the human rights field.

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