

2019 OBSERVATORY REPORT



**LEFT BEHIND:
THE STATE OF
UNIVERSAL
HEALTHCARE
COVERAGE
IN EUROPE**

MÉDECINS DU MONDE 2019



ACKNOWLEDGEMENTS

We would like to express our deepest appreciation to the service users of Médecins du Monde/Doctors of the World (MdM) programmes, that generously contributed their time and stories to this 2019 Observatory Report.

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Front cover – *MdM Belgium*: volunteers from the Medibus helping a homeless man in the streets of Brussels



This report uses the following terms: “EU/EEA migrants” to refer to citizens of European Single Market states – European Union countries, European Economic Area, and Switzerland – who are living in another EU or EEA country,

or Switzerland; “non-EU/EEA migrants” to refer to those who are not citizens of EU or EEA countries, or Switzerland; and “nationals” to refer to those who presented at a programme in their country of origin.

FOREWORDS

This year's Médecins du Monde/Doctors of the World (MdM) report *Left Behind: The State of Universal Healthcare Coverage in Europe* is a timely reminder of the dismal health situation faced by many including very vulnerable groups in seven countries of the European Union/European Economic Area (EU/EEA); a region with a clear commitment to collaboration, human solidarity and vast wealth. That nation states can declare "leave no one behind" and sign up to multiple global declarations and commitments to ensure access to health as a human right and yet purposely exclude the most vulnerable in our societies is a telling indictment and a failure of our humanity.

In September 2019, the United Nations (UN) published a Political Declaration following the High-level Meeting on Universal Health Coverage titled: "Universal Health Coverage: Moving Together to Build a Healthier World". The declaration builds on the UN sustainable development goals and other important instruments such as the Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees. The political declaration explicitly acknowledges the need to ensure that no one is left behind in Universal Healthcare Coverage especially "vulnerable, stigmatized or marginalized, among others, children, youth, women, older persons, persons with disabilities, migrants, refugees, people on the move, people with mental health problems or pre-existing medical conditions, regardless of race, religion and political belief or economic and

social conditions". And yet, this report conclusively demonstrates that there is a long way to go to achieve this laudable objective.

While there is ample anecdotal evidence and some data that show that many UN member states are failing to meet these egalitarian commitments, there is paucity of high-quality data about the health of individual excluded migrants. This report is a stellar example of what is possible with the right commitment in terms of the collection, analysis and reporting of health data on vulnerable excluded populations. The vast majority of the individuals who accessed healthcare in MdM clinics were living below the poverty line, had no access to healthcare from the formal sector, and many suffered from adverse physical and mental health. Nevertheless, the report also shows that it is possible to provide healthcare to excluded and neglected communities of migrants, refugees and other people on the move as well as the key challenges faced in the provision of care.

The report, based on data and evidence, makes recommendations to the European Commission and member states reminding them of their obligations to provide health as a social right as well as the need to address the wider determinants of health such as housing. I highly recommend this excellent report to our politicians, policymakers, healthcare workers and administrators and those directly involved in providing services to migrants in the community across all EU/EEA states.

Professor Ibrahim Abubakar
Director, UCL Institute for Global Health

This report fills a gap in the existing knowledge base and helps develop a more accurate understanding of the true nature of health inequalities in Europe. It provides a necessary and solid analysis of the health situation of the most vulnerable parts of the population in Europe which are usually not captured in official statistics.

And this report shows that their situation is a serious cause of concern. Most people helped by MdM are very vulnerable, have no health insurance, suffer from multiple health problems, and are very worried about their health and their inability to access proper care and treatment.

I welcome the focus in this report on the health situation of homeless people. Homelessness is as much a health issue as a housing issue, but policymakers rarely grasp this. The adverse life circumstances homeless people are facing and the disconnection from the mainstream public health system have a terrible impact on their health. The life expectancy of people who are chronically homeless and move between the street and emergency shelter is 50 years or less. And most people who are homeless die of perfectly preventable and treatable illnesses. That is a scandal that cannot be tolerated in a region of the world as wealthy as the EU, which prides itself on a strong welfare system.

Most of the people surveyed in this report live in bad quality housing or have no housing at all and as a result have no other "choice" than to live on the street or in shelters. For many of them, MdM is the only connection to healthcare. I support the call of MdM to focus on housing as one of the starkest social determinants of health. A recent research of the Europe Office of the World Health Organization (WHO) found that additional investment in public housing is twice as effective to reduce the health equity gap than extra money going to the public health system. Good quality affordable housing is probably one of the most impactful health interventions for the most marginalised communities.

The findings of this report begs the question: Why not consider funding housing through the public health insurance system for certain very vulnerable groups as a more courageous form of social prescribing? But then it must be housing, and under no circumstances temporary shelter. Recent Danish research showed the use of shelter accommodation contributed to increased morbidity levels among homeless people. In other words, shelter makes homeless people sick.

I welcome the recommendations of this report. The European Commission indeed needs to make sure that official EU data are available on the health status of people that are not captured by traditional household surveys like EU-EU-Statistics on Income and Living Conditions. It is inevitable that social problems will be ignored at EU level when no official comparative data exist.

I also support the call on the European Commission to make sure the most vulnerable are not overlooked when the action plan on the Pillar of Social Rights will be developed and implemented in the next year. Too often policymakers forget that homeless people and other very vulnerable people are service users too ...

Health inequality is an urgent issue and must become a policy priority in Europe. The European Commission and WHO Europe Office should encourage and support member states in a more dynamic and proactive way to reach out to the most vulnerable. MdM is probably the most authoritative voice to call for European action on health inequalities. But the two organisations I represent, the European Federation of Organizations working on Homelessness and the European Public Health Alliance, are certainly willing to join forces. Health inequalities need to be tackled before they become public health threats linked to certain marginalised communities. That only fuels populism and extremism ...

Congratulations with this excellent report.

Freek Spinnewijn
Director of FEANTSA
President of EPHA



MdM Belgium: a volunteer doctor treating a wounded hand in La Louvière

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EXECUTIVE SUMMARY

This 2019 Observatory Report presents a unique insight into the state of Universal Healthcare Coverage (UHC) in Europe and highlights those who are left behind in European health systems. The report gathers data and testimonies collected from 29,359 people attending Médecins du Monde/Doctors of the World (MdM) programmes in seven countries in Europe (Belgium, France, Germany, Luxembourg, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018.

The overwhelming majority of the people that MdM saw did not have healthcare coverage. This report hence, provides evidence that the member states of the European Union (EU) are not meeting United Nations (UN) and the World Health Organization (WHO) standards on UHC, nor respecting the human rights frameworks that protect UHC. This report shows that those excluded from European health systems include the most vulnerable and marginalised individuals – children, including very young children and unaccompanied children; pregnant women; homeless people without any shelter; people without permission or right to reside; and the elderly – suggesting the 2030 Agenda for Sustainable Development pledge to “leave no one behind” is not being upheld in Europe.¹

In 2017, the EU took an important step to strengthen the social rights of its citizens through the proclamation of the Social Pillar, which calls on member states to protect the rights of its citizens and measures compliance through a Scoreboard. Article 16 states: “Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality”.² Nevertheless, this report shows that not only is the EU far from the fulfilment of this right, it also demonstrates that the EU does not have an adequate instrument for measuring the magnitude of the problem. One-fifth of the people we saw were living in a personal flat or house, meaning that the majority fall outside this category and experience different forms of homelessness. MdM

also saw children under the age of 16 unable to access healthcare services. Both groups (people experiencing homelessness and children under 16) are excluded in the Social Scoreboard indicator measuring level of compliance with Article 16. For the development of health policies to be effective it is vital to include the most vulnerable groups in health reporting.

This report aims to give a voice to people not included in national statistics. As MdM sees individuals that do not have access to national healthcare systems the report offers insight into the extent of UHC even in countries that have officially achieved universal access.³ The people seen were often in desperate need of healthcare but unable, for various reasons, to access mainstream services, and respondents frequently reported both poor physical and mental health. A majority of pregnant women had not been able to access antenatal care and many people suffered from chronic disease, some with acute symptoms. Many of the children seen had not received the recommended levels of vaccination.

In light of our findings, it is imperative that in order to reach the commitments of the Social Pillar and the UN proclamation of UHC – to first reach those who are furthest behind – European governments and EU institutions need to:

1. improve the accessibility of regular healthcare systems to include full entitlements to health for people in vulnerable situations such as homelessness, migration, and poverty, especially for children;
2. improve methods to identify barriers to health for the most vulnerable by including them in data collection; and
3. implement a rights-based approach as it is the only way we can make sure that no one is indeed left behind.

1. World Health Organization. (2019). “Universal Health Coverage.” 2030 Agenda for SDGs. Retrieved 30 September 2019, from https://www.who.int/health-topics/universal-health-coverage#tab=tab_3

2. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles*. Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights-and-monetary-union/european-pillar-social-rights-20-principles_en.

3. World Health Organization and International Bank for Reconstruction and Development/The World Bank 2017. (2017). *Tracking universal health coverage: 2017 global monitoring report*. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank 2017. Licence: CC BY-NC-SA 3.0 IGO.



MdM United Kingdom: a medical consultation performed at the London clinic



MdM Sweden: a volunteer doctor performing a medical examination at the Stockholm clinic

2017/2018 IN FIGURES

WHO WE SAW:

- 29,359 people attended MdM programmes in seven countries in Europe (Belgium, France, Germany, Luxembourg, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018. In these countries, MdM conducted a total of 71,094 consultations, comprised of 42,178 medical consultations and 28,916 social consultations.
- 7.5% of the people seen were children (under 18 years) (1,616/21,415), 1.5% were children under 5 years (330/21,415), and 1.7% were adults 70 years and over (356/21,415).
- 81.6% of all individuals seen at MdM country clinics were non-EU/EEA migrants (18,064/22,136), 15.9% were EU/EEA migrants (3,527/22,136), and 2.5% were nationals (545/22,136).
- The highest proportion of people seen came from Côte d'Ivoire at 10.6% (2,345/22,136) followed by Morocco at 6.2% (1,371/22,136), and Bulgaria at 5.8% (1,287/22,136). A total of 175 different nationalities were recorded across the programmes.

DETERMINANTS OF HEALTH AND HEALTHCARE ACCESS:

- 81.7% of people seen reported having no healthcare coverage (14,848/18,164), and only 9.7% of non-EU/EEA migrants (1,418/14,594) and 9.3% of EU/EEA migrants had either full or partial healthcare coverage (286/3,082).
- 92.6% of the people seen were living below the poverty threshold in the country they presented in (7,660/8,268).
- 43.3% – the highest proportion of individuals – lived with family or friends (8,785/20,285). 35.1% were living

in other precarious circumstances (7,130/20,285) including: 20.4% who were recorded as street homeless or living in emergency centres (4,141/20,285); 7.3% living in a charity, organisation or hotel (1,483/20,285); 6.4% living in squats (1,292/20,285); 0.7% living at a place of work (134/20,285); and 0.4% living in camps or slums (80/20,285). 21.5% of individuals lived in a personal flat or house (4,370/20,285).

- 37.1% of people seen, felt that they could frequently rely on someone in their current town to help support and comfort them, if needed (2,236/6,024). Nevertheless, 44.0% reported that they only sometimes or never had someone to rely on for support (2,648/6,024).
- When asked about barriers to accessing healthcare, 20.8% of responses reported “economic barriers” (3,960/19,020) and 14.3% reported “lack of knowledge of health system/entitlements” (2,718/19,020).

HOMELESSNESS AND HEALTH:

- Only 21.4% of people seen, lived in a personal flat or house (4,308/20,097), 6.5% reported inadequate housing (1,311/20,097), 44.3% reported insecure housing (8,895/20,097), 7.3% reported houselessness (1,476/20,097), and 20.4% reported rooflessness and were therefore living on the streets or in an emergency shelter (4,107/20,097).
- Nationals and EU/EEA migrants had the highest proportion of roofless individuals at 30.3% (154/509) and 29.4% (968/3,287) respectively.
- 30.1% of individuals aged 15-19 (280/930) and 25.2% of individuals aged 20-24 were living on the streets or in emergency shelters and were therefore roofless (490/1,942).

- People that were roofless had lower physical (39.0%; 414/1,061 “bad” or “very bad”) and psychological (40.7%; 430/1,056 “bad” or “very bad”) self-perceived health status compared to people that reported living in a personal flat or house (22.5%, 760/3,375 “bad” or “very bad” physical health status and 19.2%, 637/3,317 “bad” or “very bad” psychological health status).

HEALTH CONDITIONS AND STATUS:

- The most common pathologies were musculoskeletal (13.8%; 5,476/39,751), respiratory (12.6%; 4,991/39,751), and digestive (12.4%; 4,946/39,751).
- The highest proportion of chronic pathologies were circulatory (17.1%; 2,642/15,495) followed by musculoskeletal (14.2%; 2,202/15,495), endocrine, metabolic, and nutritional (13.8%; 2,127/15,459), digestive (11.7%; 1,818/15,495), and psychological (9.6%; 1,495/15,495).
- The highest proportion of acute pathologies were respiratory (21.2%; 2,518/11,857), followed by musculoskeletal (15.5%; 1,841/11,857), digestive (14.7%; 1,747/11,857), and skin (13.4%; 1,588/11,857).
- The majority of pregnant women had not accessed antenatal care for this pregnancy prior to visiting the MdM programmes (66.9%; 230/344). Notably, 32.3% had not accessed antenatal care and were in their second or third trimester of pregnancy (111/344).
- Nationals reported higher proportions of “bad” or “very bad” self-perceived psychological health (43.5%; 128/294) compared to non-EU/EEA migrants (23.7%; 1,408/5,949) and EU/EEA migrants (28.5%; 505/1,769).

7.5%

of the people seen were children (under 18 years) (1,616/21,415), 1.5% were children under 5 years (330/21,415).

44.3%

reported insecure housing (8,895/20,097), 6.5% reported inadequate housing (1,311/20,097) 7.3% reported houselessness (1,476/20,097), and 20.4% reported rooflessness (4,107/20,097).

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RECOMMENDATIONS

“Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality”⁴ (Article 16, European Pillar of Social Rights)

European governments and the EU have committed⁵ to ensuring UHC and leaving no one behind. Our data shows the gaps that need to be bridged in order to reach those furthest behind in UHC. The following recommendations for political action can be drawn from the analysis:

ENSURE THAT MONITORING INSTRUMENTS PROVIDE RELEVANT INFORMATION ON EXCLUSION FROM HEALTHCARE

Unmet need for healthcare has been recognised as an important aspect of social protection by EU member states and is thus, included in the Social Scoreboard monitoring EU member states’ performance in relation to the European Pillar of Social Rights. However, the population base for the indicator “self-reported unmet need for medical care”, drawn from the EU Statistics on Income and Living Conditions (EU-SILC) is defined as “people living in private households above 16 years of age”. The data from this 2019 Observatory Report indicates that 78.4% of our participants do not live in private households and 4.4% are under 16 years. The unmet healthcare needs described in this report are thus not represented in the official reporting. People living in communal housing or institutional care, undocumented people, homeless, or children under 16 years are left out. To create a valid evidence base for policymaking, we recommend the following:

To the EU Commission:

1. Ensure that the EU-SILC and other monitoring instruments of the EU Social Pillar include information on people living in communal housing or institutional care, undocumented people, homeless, and children under 16 years.
2. Provide systematic and continuous information on the results of the monitoring and additional analyses

within all tools of the European Semester cycle.

3. Based on these results, the EU Social Protection Committee should systematically and explicitly advise the member states and the EU Commission with country-specific policy recommendations targeting inequalities and exclusions in health.

To the EU member states:

4. Governments should agree, support, and adapt nationally any initiative from the EU Commission aimed at improving the EU Social Pillar and its Social Scoreboard to implement new surveillance indicators of the Joint Assessment Framework (JAF) and particularly the EU-SILC.
5. The EU member states should actively develop and employ additional methods, such as participatory qualitative research to include currently excluded groups in health reporting. Specifically, government officials need to meaningfully include service providers, civil society organisations as well as affected communities, into the development of methods and data analysis for country assessments.

ENSURE THAT THE RIGHT TO HEALTHCARE IS NOT UNDERMINED

Barriers in accessing healthcare reported by our service users clearly show that member states’ governments’ policies can be a hindrance to the fulfilment of everyone’s right to health. For example, undocumented migrants, or non-EU/EEA migrants without a right or permission to reside, (55.4% of our participants) do not have access to healthcare in some countries because their data is shared with immigration authorities when they seek medical care (Germany and the United Kingdom) or coverage of costs. They thus avoid accessing healthcare due to fear of expulsion. In most countries, EU/EEA migrants (16.2% of our participants) lack access to healthcare if they are unemployed or not insured in their country of origin. Some groups are only entitled to restricted healthcare services, such as asylum seekers (8.8 % of our

participants) in Belgium, Germany, Luxembourg, and Sweden. Preventive care and management of chronic disease, which are both often excluded from entitlements, are integral parts of UHC. Limiting the service package to acute or emergency care is against the right to health and has shown to be more costly.⁶

To the EU Commission:

6. The EU needs to translate Article 16 of the European Pillar of Social Rights, “everyone has the right to timely access to affordable, preventive and curative health care of good quality”⁷ into concrete and ambitious policy work. The EU Commission should communicate a roadmap leading the member states to long-term efforts to achieve the principles in the pillar.
7. The Fundamental Rights Agency should systematically report to EU member states on breaches of the right to health and discrimination against people who have been denied access to healthcare. Those reports should also be included in the semester reporting cycle.

To the EU member states:

8. Governments should reaffirm and fulfil the right of every human being within their jurisdiction, without distinction of any kind, to the enjoyment of the highest attainable standard of health. This includes a comprehensive people-centred approach, with a view to leave no one behind. To do this and fulfil their obligation under the Agenda 2030 they should without delay ensure full entitlements to promotive, preventive, curative, rehabilitative, and palliative health services for everyone living in the country, regardless of immigration status. EU member states should take special care to ensure equitable access to sexual and reproductive health and rights, children’s right to health and endeavour to reach the furthest behind first, including refugees and migrants, both EU/EEA citizens and those of other nationalities.

4. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles*. Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

5. United Nations. (2019). *Political Declaration of the High-Level Meeting on Universal Health Coverage, “Universal health coverage: moving together to build a healthier world”*. New York, NY: United Nations. Retrieved 7 October 2019, from <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>

6. Bozorgmehr K. & Razum, O. (2015). Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994–2013. *PLoS ONE*, 10(7), e0131483. Retrieved 3 October 2019, from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0131483>.

9. EU member states should implement laws and practices to ensure “firewalls” between those working in the provision of social services and healthcare on the one hand and the immigration authorities on the other so that undocumented migrants can access healthcare services without fear.

MAKE HEALTHCARE SYSTEMS MORE ACCESSIBLE

In addition to the legal framework, our data also shows that barriers within the regular healthcare system need to be addressed in order to allow wider access. An important pillar in the provision of care is to ensure that it is available, accessible, acceptable, and of high quality (the UN availability, accessibility, acceptability, and quality criteria).⁸ However, the data shows a multitude of barriers affecting a person's ability to access healthcare:

- Language: In more than 35.8% of social consultations at MdM sites, an interpreter was used (5,994/16,760).
- Lack of information: our data shows that a lack of understanding of the healthcare system is a major barrier in accessing the services that are needed (14.3%; 2,718/19,020).
- Cost: our data shows that economic barriers, such as cost of consultation, cost of treatment, and cost of insurance are perceived as serious barriers for people to access healthcare (20.8%; 3,960/19,020).

To the EU Commission:

10. Make sure that financial instruments such as the European Social Fund Plus (ESF+) are available to fund initiatives and programmes responding to the healthcare needs of those who have been excluded from healthcare. Funds must be made available in the new Multiannual Financial Framework of the EU to encourage innovative low threshold accessibility healthcare services throughout Europe.

To the EU member states:

11. Reduce administrative barriers to the healthcare system often experienced by people in vulnerable situations, such as homelessness or migration.
12. National healthcare systems need to provide comprehensible and targeted information on services and entitlements, eg for migrants and homeless people.
13. National healthcare systems need to ensure sufficient availability and financing of translation services necessary for adequate communication between patients and healthcare professionals, also using technological support systems.
14. National healthcare systems should issue clear guidelines and training for healthcare professionals for non-discriminatory healthcare provision, including on specific vulnerabilities, healthcare needs, and existing referral services.
15. Low threshold health services and support structures for people in vulnerable situations, such as homelessness and in migration should be set up and securely funded. Mobile clinics and outreach of healthcare professionals have proven effective to target the most excluded and to recover trust in the healthcare system. Coordination between social services and healthcare providers needs to be improved in order to provide effective follow-up treatments and housing, especially for homeless people suffering from chronic illness, drug users, mental health patients, and discharged hospital patients.

CREATE HEALTHIER LIVING CONDITIONS

The conditions under which people are born, grow, live, work, and age determine their health more than their ability to access healthcare. A health in all policies approach is thus urgently needed, in which the health consequences of policies in all sectors are systematically considered.

With its focus theme “housing”, this report clearly shows that people that were roofless have a lower self-perceived physical health status (38.1%; 404/1,061) than people living in a personal flat or house and are at the same time more likely to experience barriers in accessing healthcare.

Measures for affordable housing and improved conditions in shelters are thus important for improving health outcomes and reducing health inequities.

To the EU Commission:

16. Innovative solution towards integrated and coordinated social and healthcare services that take into account the specific needs of homeless people should be supported, funded, and disseminated through various financial instruments, especially the ESF+. In order to be effective, the initiatives should be low threshold, flexible, needs-based, dignified, and organised in a people-centric way (outreach and drop-in rather than appointment-based).

To the EU member states:

17. National governments in close cooperation with affected communities and civil society should ensure that there is a legal base for the right to housing, improve data on housing conditions, implement preventive measures against homelessness, and provide sufficient and adequate shelters.

7. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles*. Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

8. United Nations. (2000). *CESCR General Comment No. 14: the right to the highest attainable standard of health (Art. 12)*. Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000. Geneva: Office of the High Commissioner for Human Rights. Retrieved 15 October 2019, from <https://www.refworld.org/pdfid/4538838d0.pdf>.

2019 OBSERVATORY REPORT

INTRODUCTION

Since 1976 and the entry into force of the International Covenant on Economic, Social and Cultural Rights, the signatory states have pledged the recognition of Article 12 stating: “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, containing the essential elements of availability, accessibility, acceptability, and quality.⁹

With the establishment of the Sustainable Development Goals (SDGs) in 2015¹⁰ nations have renewed their commitment to health for all by accomplishing Universal Healthcare Coverage (UHC). The World Health Organization (WHO) defines UHC as: “ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship”.¹¹ This definition confirms that both accessibility and affordability are central components of UHC. Recognising that development, including the improvements in healthcare systems, was not benefiting everyone equally, the 2030 Agenda put ensuring “no one is left behind” at the centre of the SDGs.¹²

In 2017, the WHO Director-General Dr Tedros Adhanom Ghebreyesus, asserted: “health is a human right, not a privilege for those who can afford it”, calling on all countries to “respect and protect human rights in health – in their laws, their health policies and programmes. We must all work together to combat inequalities and discriminatory practices so that everyone can enjoy the benefits of good health, no matter their age, sex, race, religion, health

status, disability, sexual orientation, gender identity or migration status”.¹³

In response to international calls for sustainable development and more inclusive health rights, the European Union (EU), in 2017, proclaimed its Social Pillar to deliver more effective rights to citizens. The Social Pillar contains 20 principles and calls on EU member states to prioritise certain areas of social rights, such as healthcare. Article 16 of the Social Pillar states that: “Everyone has the right to timely access to affordable, preventive and curative health care of good quality.”¹⁴

In 2019, the commitment to improve universal access to health coverage was reaffirmed through the United Nations (UN) high level meeting in New York that reiterated the WHO definition.¹⁵ All of the EU member states surveyed in this report have been part of and signed the political statement from the UN meeting.

Despite positive efforts from the EU, such as the Social Pillar, some people are still excluded from healthcare services. The WHO global monitoring report states that at least half of the world’s population still lacks access to essential health services¹⁶ and previous Médecins du Monde/Doctors of the World (MdM) Observatory Reports have shown there are populations living in Europe with little or no access to healthcare. Moreover, the MdM clinics are often located in major cities, which means that the health needs and status of people not able to visit MdM is unknown, implying we might not know the health status of those worse off.

To fully grasp the true extent of healthcare coverage in Europe, there

is a need for comprehensive data on population groups who are many times left without access to health services and who are often excluded from national data collection and research – such as migrants, refugees, homeless people, Roma, travellers, children, and the elderly.¹⁷ Since most governments rely on healthcare services to gather data and information on the health needs of the population, the health needs of those unable to access these services will inevitably be missing. As MdM’s Observatory Reports are based on data collected from people seeking healthcare outside of the regular health system, it provides a unique insight into the extent of unmet healthcare coverage needs in Europe, and the extent to which the right to health as a fundamental right is protected and promoted. The Observatory Report tells us about *who* is excluded from the regular health system, it explores *why* they are excluded, and it tells us about their health status.

Recognising the importance of collecting data on the access to rights for its citizens, the EU established a data collection instrument known as the Social Scoreboard. The Scoreboard rates EU member states compliance with the principles under the Social Pillar and collects data on “self-reported unmet need for medical care”.¹⁸ Yet, to be included in this data, individuals must be both over 16 years of age and part of a private household. Children under 16 and people living outside of a private household are consequently excluded. The omission of these populations in the EU’s data severely undermines policymakers’ ability to address unmet healthcare needs in Europe and achieve

9. United Nations. (n.d). *International Covenant on Economic, Social and Cultural Rights*. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with Article 27. Geneva: Office of the High Commissioner for Human Rights. Retrieved 23 October 2019, from <https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf>.

10. United Nations. (2019). *Sustainable Development Goal 3: ensure healthy lives and promote wellbeing for all at all ages*. Targets and Indicators. New York, NY: Sustainable Development Goals Knowledge Platform. Retrieved 20 September 2019, from <https://sustainabledevelopment.un.org/sdg3>.

11. World Health Organization. (2019). *Health systems: universal health coverage*. Retrieved 2 August 2019, from http://www.who.int/healthsystems/universal_health_coverage/en/.

12. Renner, S., Bok, L., Igloi, N., & Linou, N. (2018). *What does it mean to leave no one behind? A UNDP discussion paper and framework for implementation*. New York, NY: United Nations Development Programme. pp. 6–9. Retrieved 23 October 2019, from https://www.undp.org/content/dam/undp/library/Sustainable%20Development/2030%20Agenda/Discussion_Paper_LNOB_ENIRES.pdf.

13. World Health Organization. (2017). *Health is a fundamental human right*. Human Rights Day 2017, Statement by Dr Tedros Adhanom Ghebreyesus, WHO Director-General, 10 December 2017. Retrieved 24 September 2019, from <https://www.who.int/mediacentre/news/statements/fundamental-human-right/en/>.

14. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles*. Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

15. United Nations. (2019). *Political Declaration of the High-Level Meeting on Universal Health Coverage, “Universal health coverage: moving together to build a healthier world”*. New York, NY: United Nations. Retrieved 7 October 2019, from <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>.

16. World Health Organization and International Bank for Reconstruction and Development/The World Bank 2017. (2017). *Tracking universal health coverage: 2017 global monitoring report*. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank 2017. Licence: CC BY-NC-SA 3.0 IGO.

17. Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., et al. (2018). The UCL-Lancet Commission on Migration and Health: the health of a world on the move. *Lancet*, 392(10164), 2606–2654.

universal coverage. The limitations of data on groups currently left behind is also recognised by the Agenda 2030 and highlighted in the SDGs outcomes document.¹⁹ This 2019 Observatory Report will therefore, focus one chapter to delve into the issue of homelessness and health. In doing so, we are able to provide data on unmet healthcare needs that are missing from EU statistics and hence, offer a basis for informed policymaking.

PURPOSE

The 2019 Observatory Report is an observational study of people who are excluded from mainstream healthcare services across Europe. Continuing the work produced by the European Network to Reduce Vulnerabilities in Health,²⁰ the report draws on data and testimonies collected at 14 MdM programmes in seven European countries (Belgium, France, Germany, Luxembourg, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018. The programmes provide medical and non-medical services, collecting social and medical data. There were a total of 29,359 unique individuals attending the aforementioned MdM programmes during this period.

This report was produced in partnership with University College London (UCL). UCL academics have breadth and depth of expertise across the entire range of academic disciplines and a strong commitment to enhancing the lives of people around the world.

The purpose of this report is to provide policymakers at national and EU level with the robust evidence base needed to continue the strive towards UHC. By presenting quantitative data, analysed and validated by epidemiologists at UCL, on people who are excluded from mainstream healthcare services, alongside testimonies, the report provides insight into who is excluded from healthcare, their social, economic and political circumstances, and health status. Data on barriers to healthcare shows policymakers how inclusive healthcare policies and systems can be designed and implemented.

This report will be:

1. a valuable resource for policymakers and health service providers interested in addressing health inequalities and tackling the determinants of health, providing insight into how policies and services can be designed to include those not living in private households;
2. a beneficial resource with regards to missing data on excluded populations and offers a greater understanding of the problem at hand; and
3. useful for academics interested in gaining a greater understanding of excluded populations and patient groups across Europe, and organisations and campaigners working to strengthen the right to healthcare and advocating for UHC.

STRUCTURE

This report:

- presents recommendations to the relevant institutions, national governments, and organisations to achieve UHC across Europe;
- provides an overview of the political context in Europe while the data and testimonies were being collected;
- describes who is excluded from healthcare services, including demographics and country of origin;
- observes the socioeconomic circumstances of our participants;
- observes the issues our participants faced regarding healthcare access, including barriers to healthcare coverage and barriers to healthcare services;
- offers a closer look, through a focused chapter, at the relationship between housing and homelessness, healthcare access, and health status;
- presents the diagnosed health conditions and health status reported by our participants; and
- provides an overall discussion on the key findings.

PARTICIPATING PROGRAMMES

The participating MdM programmes were from the seven European countries:²¹

Belgium: The MdM programmes in **Antwerp** and **Brussels** provide primary medical, psychological and dental care, and social counselling for people without access to care as well as close partnerships with hospitals for specialised care. The objective of the programmes is to (re)integrate all patients into standard medical care facilities.

France: Three MdM clinics in **Bordeaux**, **Nice**, and **Saint Denis** provide medical consultations as well as specialised care such as gynaecological, dental, psychological and psychiatric consultations, ophthalmology, etc. All three MdM clinics also work with preventable diseases, such as human immunodeficiency virus (HIV), hepatitis, tuberculosis (TB), and sexually transmitted infections (STIs).

Germany: The MdM programmes in **Munich**, **Berlin**, and **Hamburg** offer medical treatment and social counselling. The projects' long-term aim is to (re)integrate all patients into standard medical care. The MdM clinics provide primary care as well as specialised care such as paediatric, gynaecological, and psychiatric consultations. The project in Hamburg is run in collaboration with the organisation *hoffnungsorte hamburg/ Verein Stadtmission Hamburg* and the project in Berlin in cooperation with *Medizin Hilft e.V.*

Luxembourg: One MdM clinic and one medical office in the **City of Luxembourg** and one MdM clinic in **Esch-sur-Alzette**, provide social and medical services to people without access to healthcare.

Sweden: The MdM clinic in **Stockholm** provides primary care for, mainly, European citizens and undocumented

migrants. In addition, the MdM clinic offers legal advice and psychosocial support to European citizens, undocumented migrants, and asylum seekers.

Switzerland: The MdM Switzerland runs a programme in **Canton of Neuchâtel** with an MdM clinic in **La Chaux-de-Fonds**. The centre provides nurse-led consultations and social care advice for undocumented migrants and for asylum seekers during the first stage of their asylum procedure.

United Kingdom: The MdM London clinic provides primary care and assistance to register with a doctor (general practitioner – GP), as the entry point to mainstream primary and secondary healthcare. A specialist family clinic provides services to pregnant women and children.

18. The European Commission. (2019). *European Pillar of Social Rights: social scoreboard indicators*. Retrieved 2 August 2019, from <https://ec.europa.eu/eurostat/web/european-pillar-of-social-rights/indicators/social-scoreboard-indicators>.

19. United Nations General Assembly. (2015). *Resolution 70/1. Transforming our world: the 2030 Agenda for Sustainable Development*. Resolution A/RES/70/1. New York, NY: United Nations. Retrieved 14 October 2019, from <https://undocs.org/A/RES/70/1>.

20. The European Network to Reduce Vulnerabilities in Health observatory reports can be accessed from <https://mdmeuroblog.wordpress.com/resources/publications/>.

21. Note: this report does not include data from all individuals who accessed MdM and partners' programmes. See "Limitations".

THE POLITICAL CONTEXT

With the proclamation of the European Pillar of Social Rights in 2017,²² and its Article 16, the EU called on member states to ensure social rights to its citizens and furthermore endeavoured to measure member state performance in social issues. In doing so, the Social Scoreboard, measuring unmet healthcare needs, revealed significant disparities within Europe and an alarming rate of people excluded from care. According to the European Health Interview Survey (EHIS), more than one-quarter of the EU-28 population aged 15 and over in need of healthcare, reported unmet healthcare needs in 2014 that was due to costs, distance, or waiting lists.²³ In this regard, proposals are coming in, particularly around the next Child Guarantee, which is currently under discussion and, which should allow all children living in Europe to access, among other things, healthcare. Another brand proposal is the revision of the Social Scoreboard and the establishment of an SImP (“Social Imbalance Procedure”) that would accurately reveal the social imbalances in general and health in particular.²⁴

Looking forward, the prioritisation of health and UHC in the EU institutions looks uncertain, especially due to the weakened health component of the Multiannual Financial Framework (MFF). As the health programme is merged into the European Social Fund Plus (ESF+) and becomes more coordinated with other strands of the EU’s social programmes (employment, poverty, and social innovation), the budget allocated for 2021–2027 is lower and will certainly restrict the EU Commission’s capacity to go beyond the priorities of its previous health programme (mainly cross-border health threats, disease prevention,

the promotion of healthy lifestyle, innovative, efficient, and sustainable health systems, challenges posed by the ageing population, and antimicrobial resistance).

European governments have yet to broaden healthcare entitlements and honour the commitment to achieve universal coverage. This in spite of the mobilisation of civil society, calling for the most marginalised and excluded to be covered in healthcare systems and in spite of a wealth of academic publications providing evidence-based recommendations and pointing at violations of human rights as well as the cost of failing to include.

In the 2017 Observatory Report,²⁵ MdM noted that EU member states failed to construct a common rights-based narrative on healthcare coverage for the most vulnerable. Since then the public debate has been even further polluted by xenophobic myths. Reduction of the entitlement to healthcare is being increasingly used by European governments as part of a migration policy of deterrence and expulsion. Despite a lack of evidence for concepts such as “health tourism”, “exploitation of the social welfare state”, or “pull factors for illegal immigration” governments are willing to compromise on the right to health in order to avoid that right-wing parties can profit from the fears thereof. The academic world, while highlighting the positive benefits of migration in our societies and health systems and recalling health for all as a human right, calls for decision-makers to rely on evidence base rather than public debate. The UCL-Lancet Commission on Migration and Health added to the evidence by putting the spotlight on “the cost of failing to be healthier-inclusive,

to national economies, health security, and global health than the modest investments required”.²⁶

In line with global efforts and under the leadership of its director, the WHO this year published its “Draft Global Action Plan ‘Promoting the Health of Refugees and Migrants’ (2019–2023)”.²⁷ It aims at mainstreaming objectives in regional and country agendas, some of which being to counter misperceptions with supporting evidence and measures to counter xenophobia.

While limited in scope and non-binding, the global compact on migration was adopted on 19 December 2018 by the UN General Assembly. Among other things, it proclaims, the “highest attainable standard of physical and mental health”, the development of “gender-responsive migration policies to address the particular needs and vulnerabilities of migrant women, [...] which may include assistance, healthcare, psychological and other counselling services” and the incorporation of “the health needs of migrants into national and local healthcare policies and plans”.²⁸ However, the negotiation process and post-hoc government responses showed a widespread reluctance to opt for a progressivist approach towards migrants.

Not all is worse and according to a WHO report, life expectancy and the level of wellbeing are on the rise and some flagship indicators such as maternal and child mortality and households’ share of out-of-pocket payments have made significant progress in Europe.²⁹ Similar progress is even observed globally.³⁰ What this report shows is the need to dig deeper to ensure that progress is made for those furthest behind and not increasing the gap.

22. The European Commission. (2019). *The European Pillar of Social Rights in 20 principles*. Retrieved 2 August 2019, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

23. The European Commission/EUROSTAT. (n.d). *Access to Microdata: European Health Interview Survey (EHIS)*. Retrieved 3 October 2019, from <https://ec.europa.eu/eurostat/web/microdata/european-health-interview-survey>.

24. The European Economic and Social Committee. (2019). *Integrating the European Pillar of Social Rights into the roadmap for deepening Europe’s Economic and Monetary Union*. Brussels: The European Economic and Social Committee. Retrieved 23 October 2019, from <https://www.eesc.europa.eu/en/our-work/publications-other-work/publications/integrating-european-pillar-social-rights-roadmap-deepening-europes-economic-and-monetary-union-study#related-links>.

25. Aldridge, R. W., Miller, A. K., Jakubowski, B., Pereira, L., Fille, F., & Noret, I. (2017). *Falling through the cracks: the failure of universal healthcare coverage in Europe*. 2017 Observatory Report. London, UK: The European Network to Reduce Vulnerabilities in Health. Retrieved 23 October 2019, from <https://mdmneuroblog.wordpress.com/resources/publications/>.

26. Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. et al. (2018). The UCL-Lancet Commission on Migration and Health: the health of a world on the move. *Lancet*, 392(10164), 2606–2654.

27. World Health Organization. (2019). *Draft global action plan ‘promoting the health of refugees and migrants’ (2019–2023)*. Geneva: WHO. Retrieved 23 October 2019, from <https://www.who.int/migrants/GlobalActionPlan.pdf?ua=1>.

28. United Nations General Assembly. (2019). *Resolution 73/195. Global compact for safe, orderly and regular migration*. Resolution A/RES/73/195. New York, NY: United Nations. Retrieved 23 October 2019, from https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_73_195.pdf.

29. World Health Organization. (2018). *European health report 2018: More than numbers – evidence for all*. Copenhagen: WHO Regional Office for Europe. Retrieved 23 October 2019, from <http://www.euro.who.int/en/publications/abstracts/european-health-report-2018.-more-than-numbers-evidence-for-all-2018>.

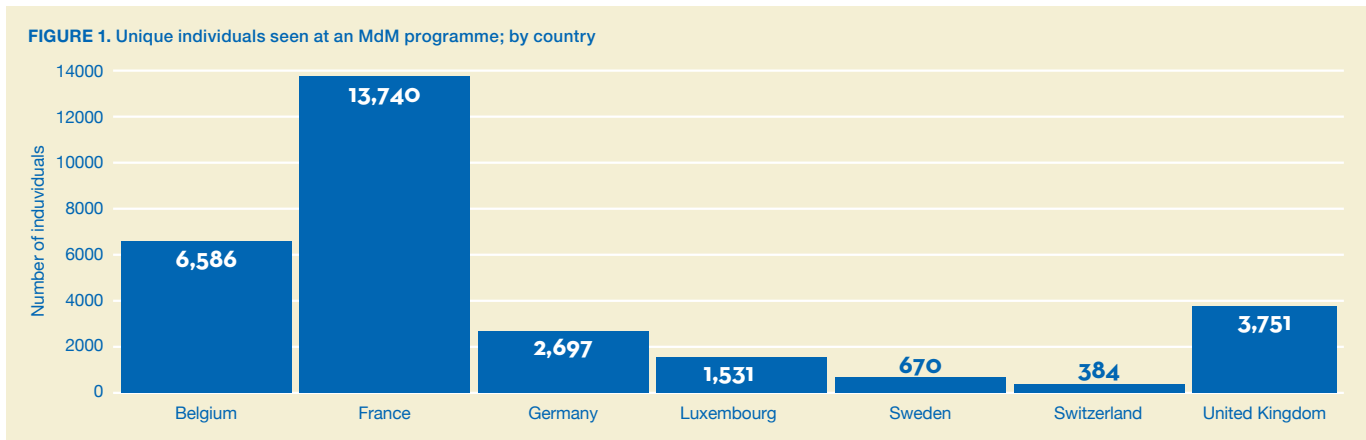
30. World Health Organization. (2018). *Promote health, keep the world safe, serve the vulnerable*. Retrieved 7 October 2019, from <https://www.who.int/news-room/detail/21-03-2018-promote-health-keep-the-world-safe-serve-the-vulnerable>.



MdM Belgium: volunteers from the Medibus exiting the Brussels Gare Central metro station where many homeless people are living

WHO WE SAW

PEOPLE SEEN

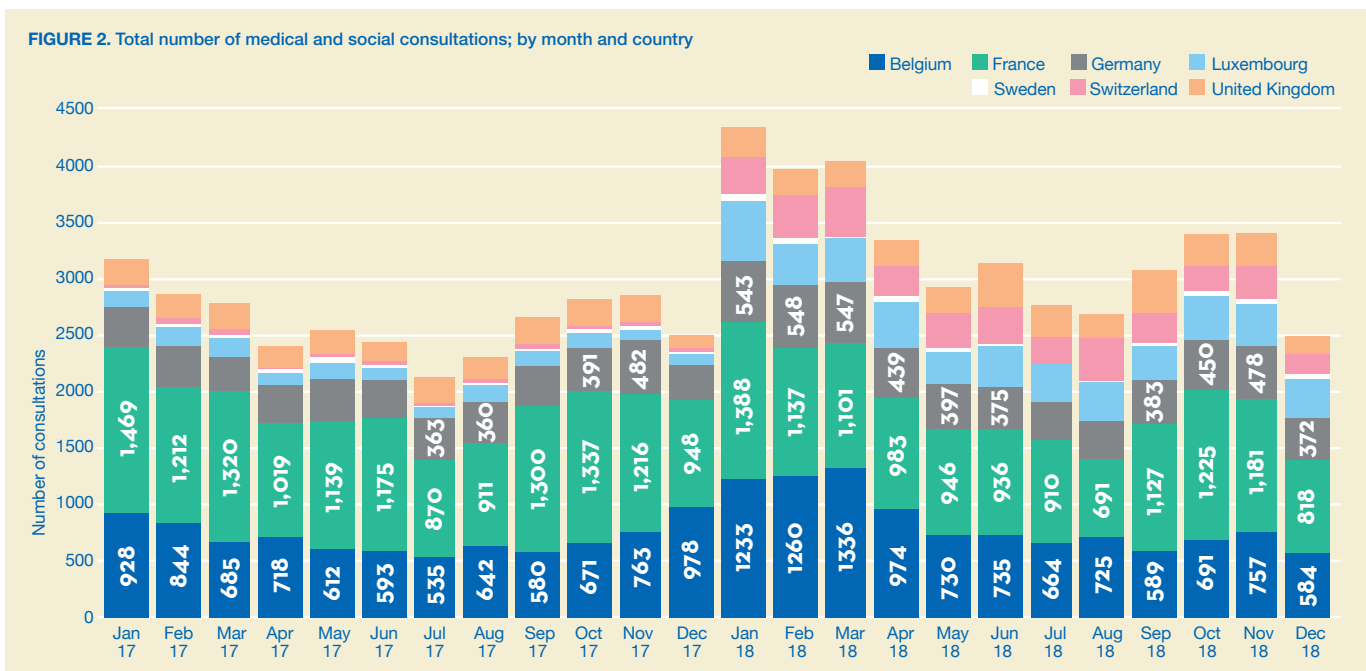


The data was collected from 29,359 unique individuals attending Mdm programmes in Belgium, France, Germany, Luxembourg, Sweden,

Switzerland, and the United Kingdom in 2017 and 2018. The greatest amount of data was collected from individuals in France (46.8%; 13,740/29,359) and the

smallest amount of data was collected from individuals in Switzerland (1.3%; 384/29,359).

CONSULTATIONS



The data was collected in 71,094 consultations carried out in the Mdm programmes between 1 January 2017 and 31 December 2018. In total, there were 42,178 medical consultations, carried out by clinicians, which focused on medical history, current health status, pregnancy, and vaccination status. 28,916 were social consultations, which focused on addressing social determinants of health such as housing status, health access, and health coverage. The greatest number of

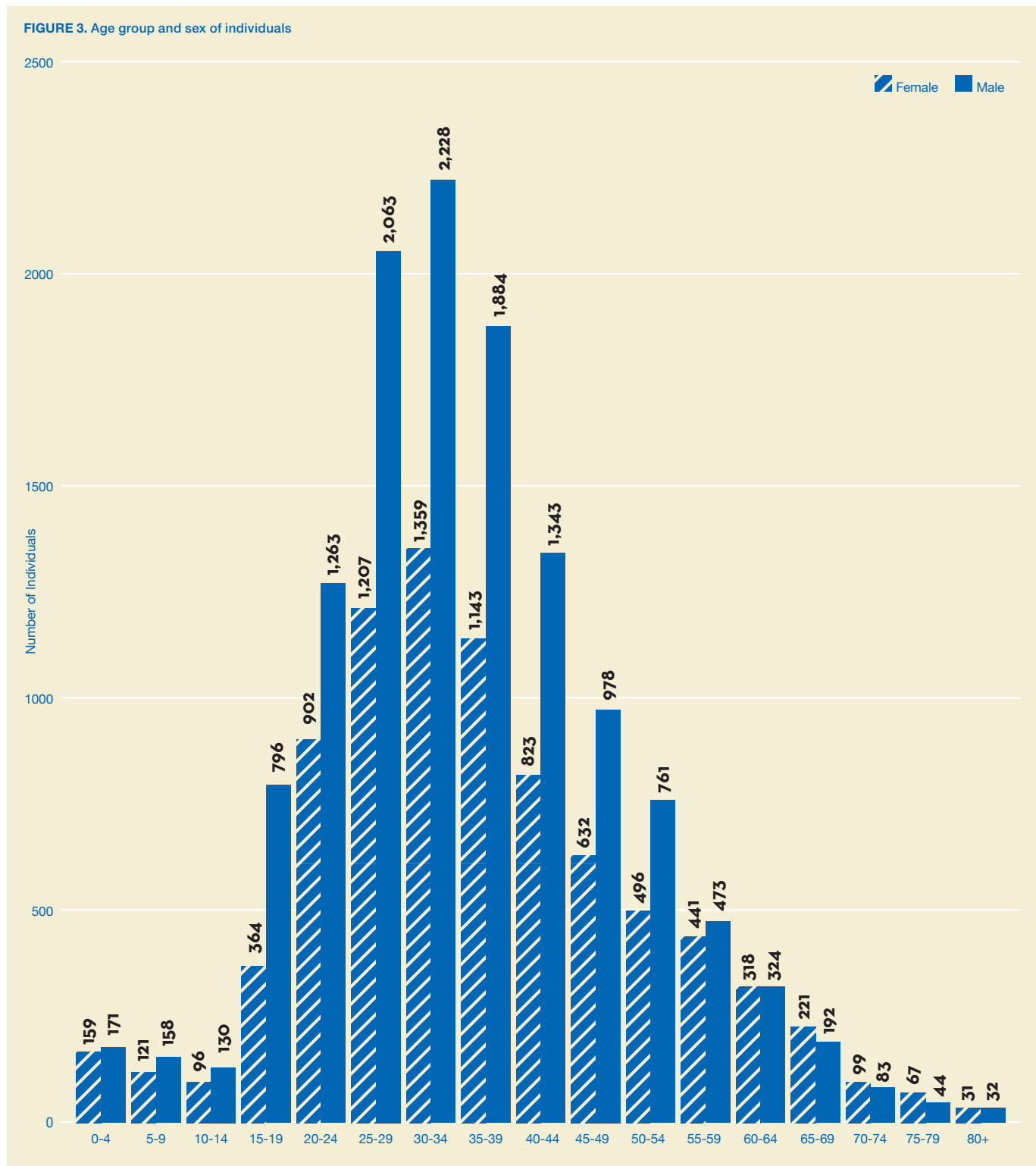
consultations were carried out in France (37.2%; 26,459/71,094) and the smallest number of consultations were carried out in Sweden (1.1%; 757/71,094).

Figure 2 shows the total number of medical and social consultations by month. There were 31,514 medical and social consultations in 2017 and 39,580 in 2018, with the greatest number held in January 2018 (6.1%; 4,349/71,094).

Fig 1. Data from combined social and medical consultations includes each individual once. Figure excludes 245 records without a user number and/or demographic data to determine unique identity (0.8%; 245/29,604).

Fig 2. Data from total of social and medical consultations (71,094). Disclaimer: The Mdm France data only includes individuals who visited an Mdm programme for the first time in either 2017 or 2018. For the medical consultations, all consultations with a specialist were excluded.

DEMOGRAPHICS



In total, 60.4% of the people seen, were men (12,932/21,415) and 39.6% were women (8,479/21,415).³¹ The median age was 34 (interquartile range 26-44). In all age groups under 65, there were more men than women. In age groups over 65, there were more women than men, except in the age group 80+. 1.7% of people seen were 70 years and older (356/21,415). 7.5% of the people seen were children aged 0-17 (1,616/21,415) of which 1.5% were under 5 years (330/21,415) and 4.4% were under 16

years (940/21,415).

A total of 21.5% of children (under 18) were unaccompanied minors (347/1,616),³² meaning they were separated from both parents and were not being cared for by an adult who by law or custom has the responsibility to do so.³³

Fig 3. Data from social consultations includes each individual once. Individuals recorded as transgender (<10) were not shown. Figure excludes 950 records missing age, sex, or both (4.2%; 950/22,365).

31. The questionnaire also contains “other/do not want to identify” besides “man” and “woman”, but the sample size was too small to be included in the figure.

32. Data from social consultations includes each individual once. Denominator based on the total number of individuals under the age of 18. Figure excludes records missing age.

33. United Nations High Commissioner for Refugees. (1997). *Guidelines on policies and procedures in dealing with unaccompanied children seeking asylum*. Geneva: UNHCR. Retrieved 20 September 2019, from <http://www.unhcr.org/3d4f91cf4.pdf>.

NATIONALITY

FIGURE 4. Nationalities of individuals

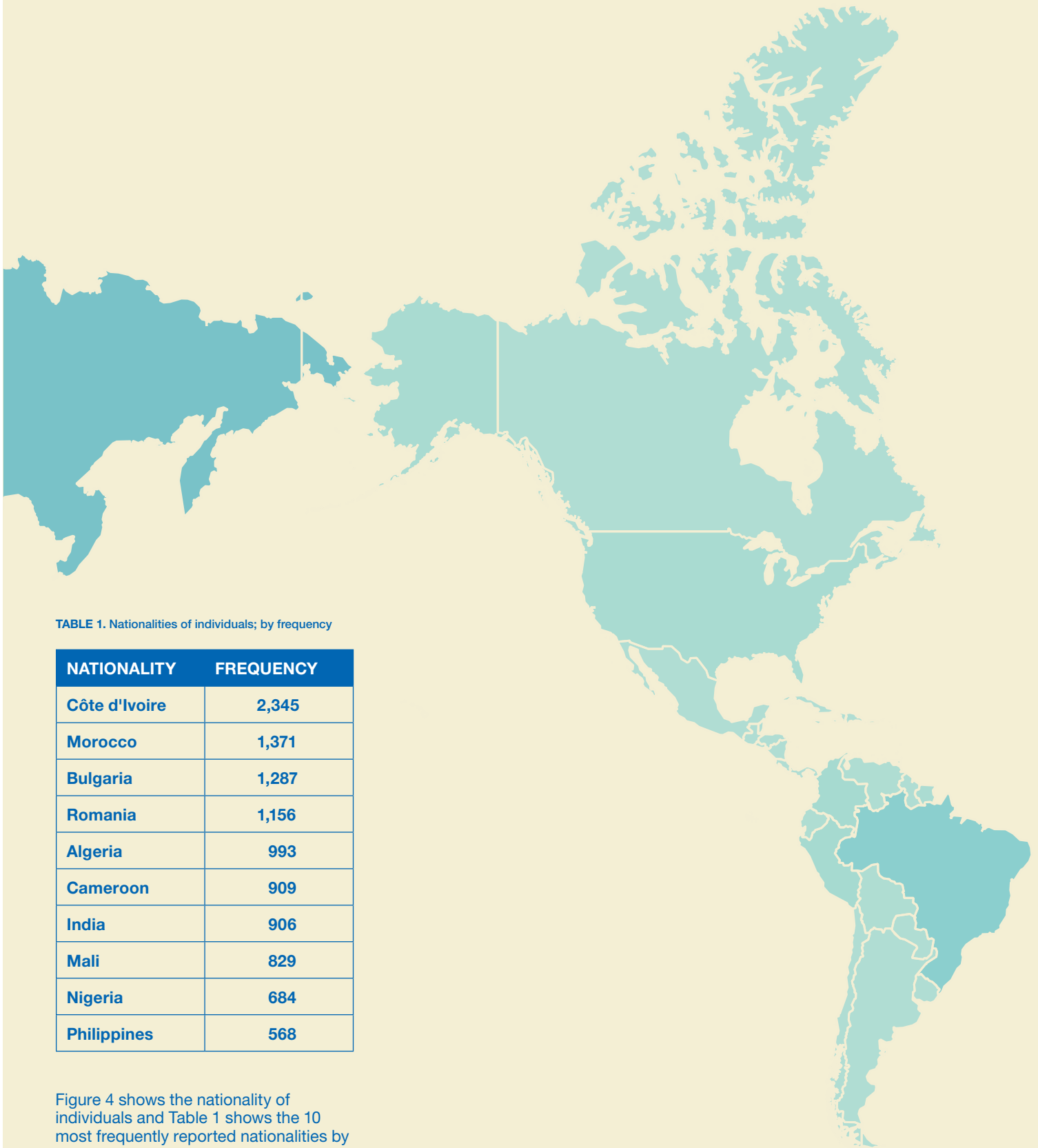


TABLE 1. Nationalities of individuals; by frequency

NATIONALITY	FREQUENCY
Côte d'Ivoire	2,345
Morocco	1,371
Bulgaria	1,287
Romania	1,156
Algeria	993
Cameroon	909
India	906
Mali	829
Nigeria	684
Philippines	568

Figure 4 shows the nationality of individuals and Table 1 shows the 10 most frequently reported nationalities by individuals. The most common country of origin was Côte d'Ivoire at 10.6% (2,345/22,136), followed by Morocco at 6.2% (1,371/22,136), Bulgaria at 5.8% (1,287/22,136), Romania at 5.2% (1,156/22,136), and Algeria at 4.5% (993/22,136). In total 175 different nationalities were recorded.

Fig 4. Data from social consultations includes each individual once. Figure excludes 229 records missing nationalities (1.0%; 229/22,365).

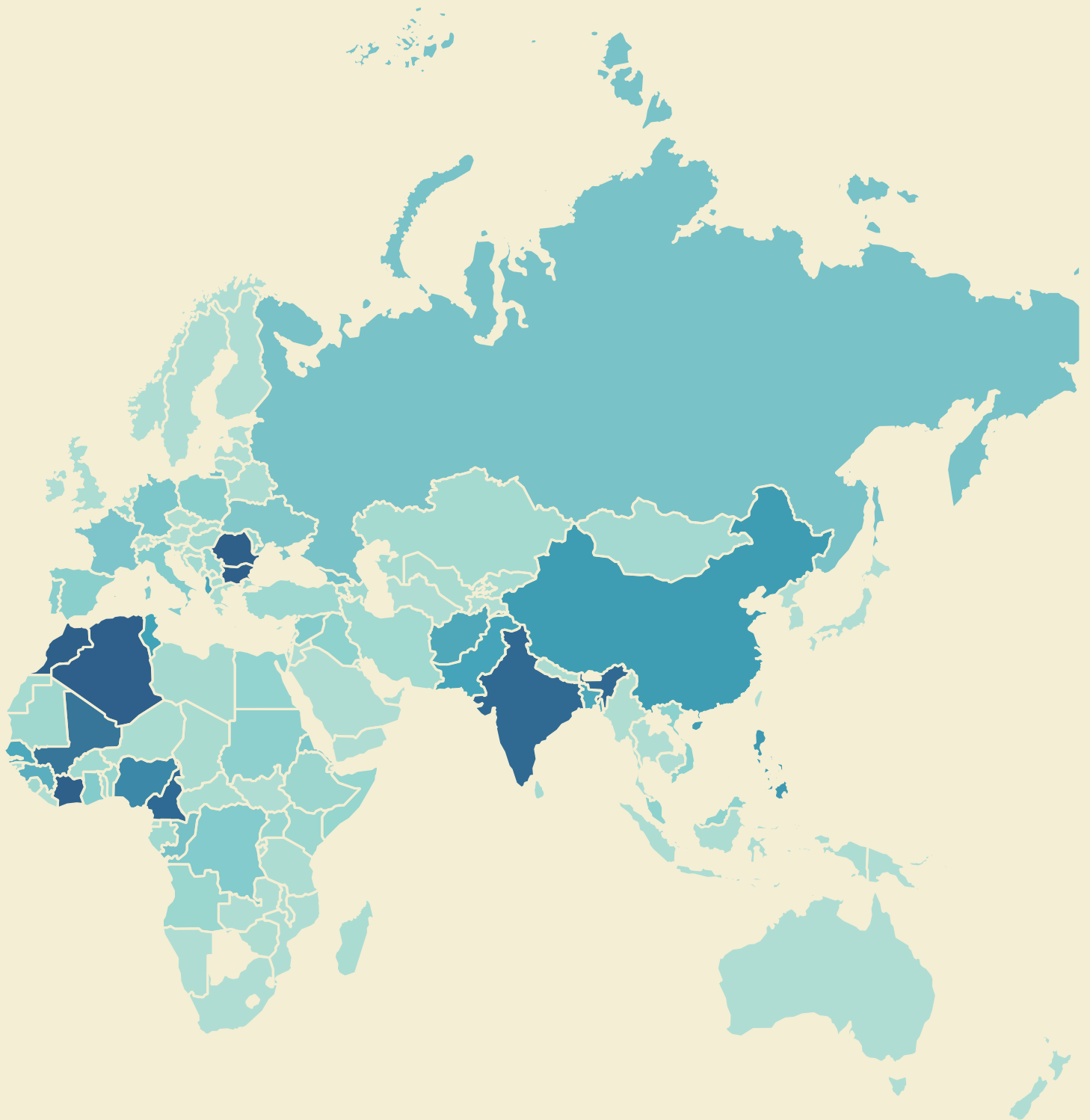


FIGURE 5. Nationality; by continent

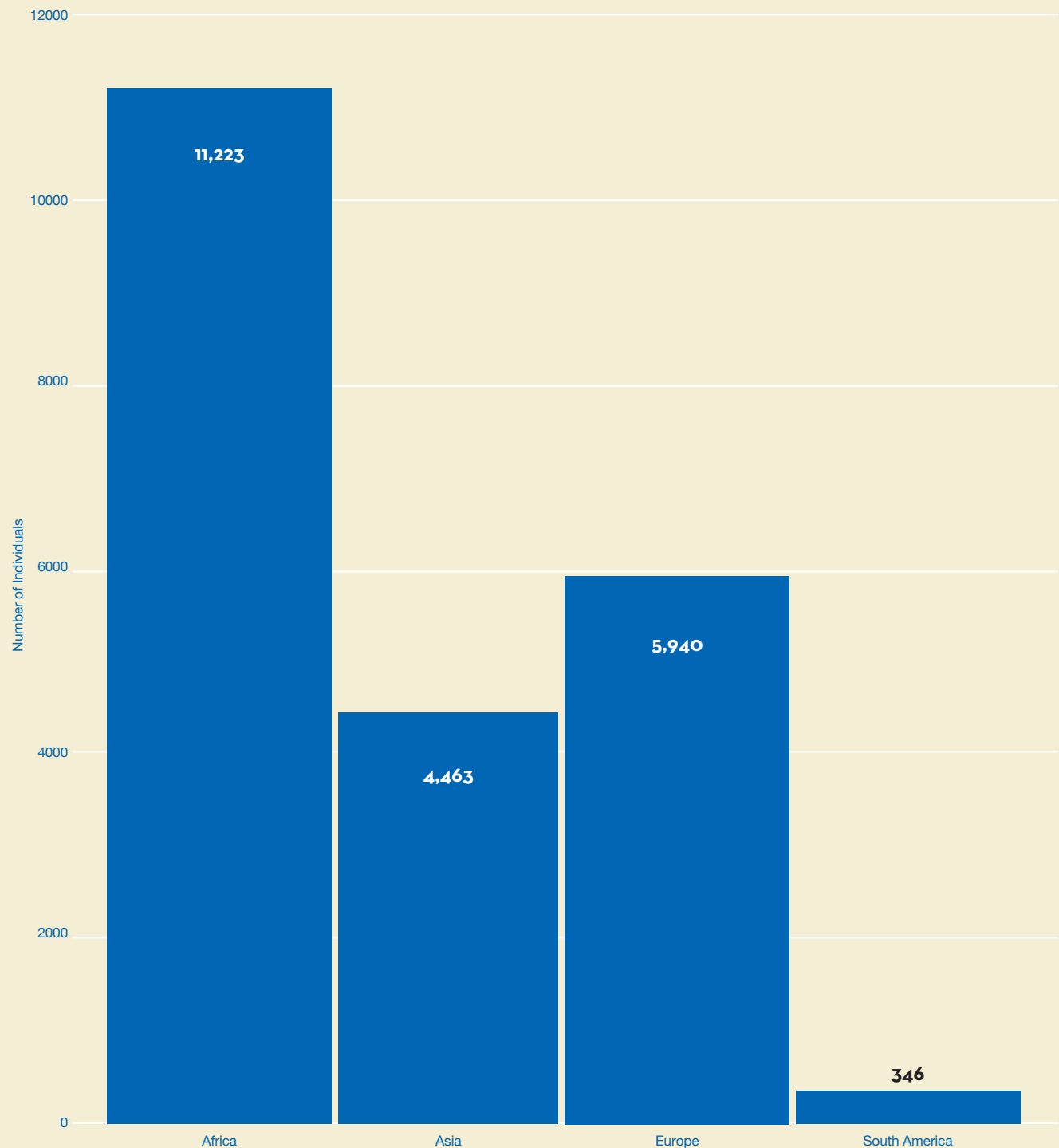


Figure 5 shows that half of the individuals seen at the MdM programmes were nationals from an African country (50.7%; 11,223/22,136), 26.8% were nationals in a European country

(5,940/22,136) and 20.2% were nationals from an Asian country (4,463/22,136). Just 1.6% were nationals from a South American country (346/22,136).

Fig 5. Data from social consultations includes each individual once. Continents with less than 200 individuals not shown. Figure excludes 229 records missing nationalities (1.0%, 229/22,365).

MIGRANT CATEGORISATION

FIGURE 6. Age group of individuals; by nationals, EU/EEA migrants, non-EU/EEA migrants

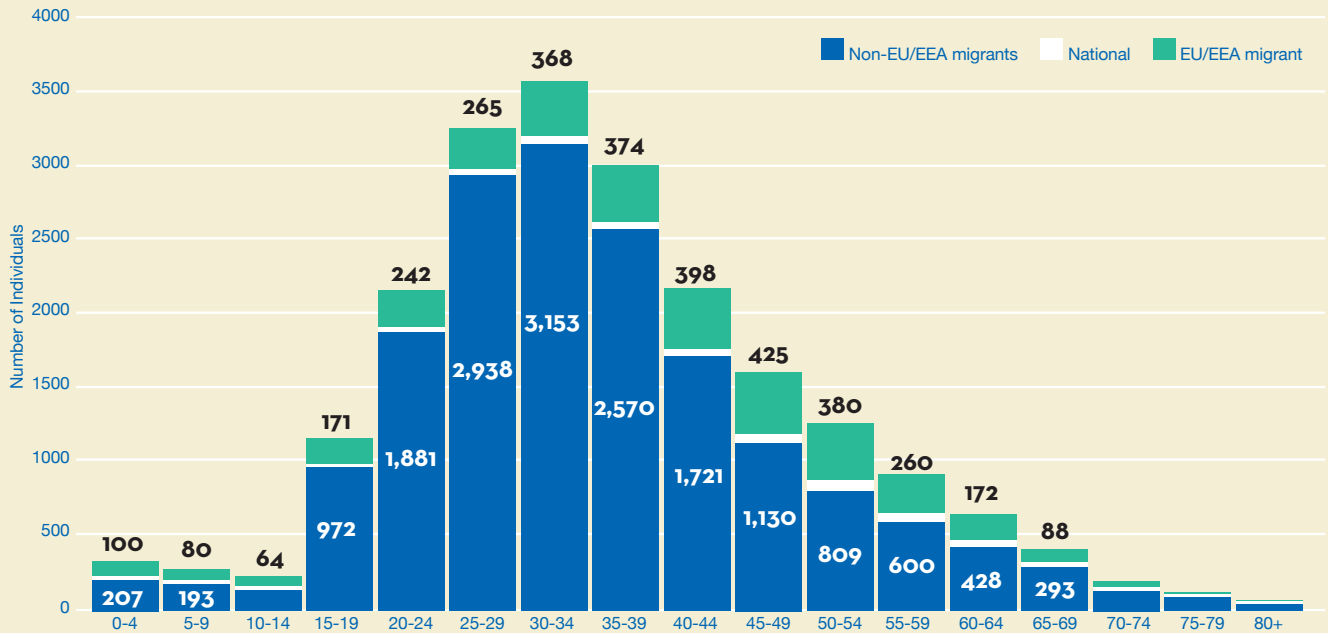
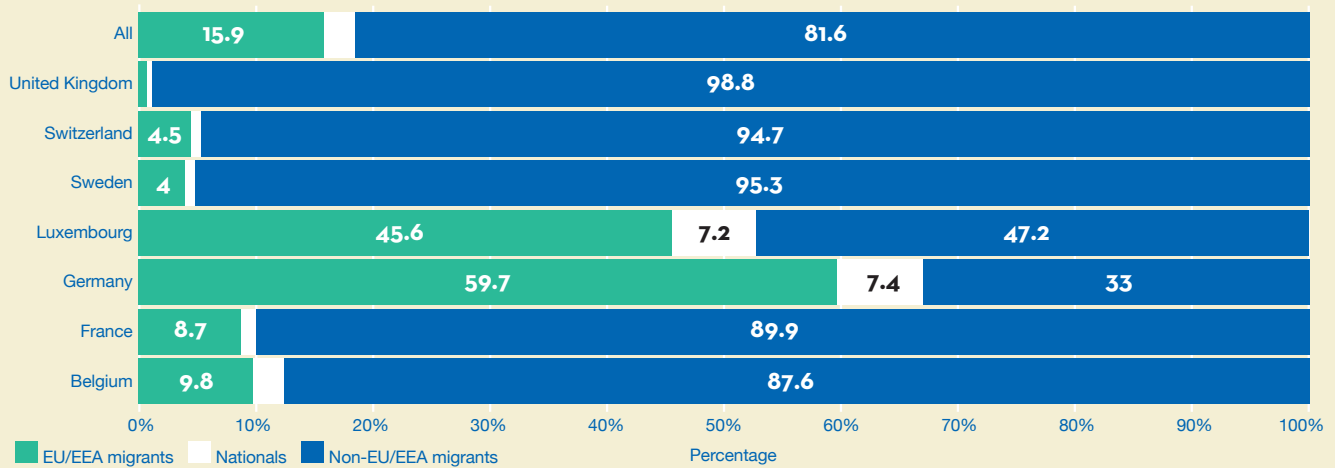


FIGURE 7. Country of Mdm programme; by nationals, EU/EEA migrants, non-EU/EEA migrants



Figures 6 and 7 present the data categorised by EU/EEA migrants, non-EU/EEA migrants and nationals.^{34, 35} The majority of individuals were non-EU/EEA migrants (81.4%; 17,332/21,294), followed by EU/EEA migrants (16.2%; 3,439/21,294) and nationals (2.5%; 523/21,294).

Figure 6, in which data is categorised by age groups, shows that in all age groups the majority of individuals were non-EU/EEA migrants. The greatest proportion of non-EU/EEA migrants was in the 25-29 age group (90.5%; 2,938/3,248). In

general, the age profile of the non-EU/EEA migrants is younger than the EU/EEA migrants. However, higher levels of EU/EEA migrants were observed in children in comparison to the other age groups; 30.5% of individuals in the 0-4 age group (100/328) were EU/EEA migrants as were 28.9% of the 5-9 age group (80/277) and 28.3% of the 10-14 age group (64/226).

In Figure 7, the data is categorised by the country of the Mdm programme in which the individual was seen. The majority of people attending programmes in the

United Kingdom (98.8%; 3,153/3,190), Sweden (95.3%; 614/644), Switzerland (94.7%; 360/380), France (90.0%; 9,972/11,087) and Belgium (87.6%; 2,416/2,758) were non-EU/EEA migrants. The highest proportion of EU/EEA migrants were observed in Germany (59.7%; 1,571/2,633) and Luxembourg (45.6%; 659/1,444). The Mdm programmes saw 545 nationals in total, with the highest proportions in Germany (7.4%; 194/2,633) and Luxembourg (7.2%; 104/1,444).

34. This categorisation was calculated based on individuals' nationality in relation to the country where they had a consultation. There are limitations to this categorisation, which must be considered (for further details see the section on "Limitations").

35. This report uses the terms: "EU/EEA migrants" to refer to citizens of European Single Market states – European Union countries, European Economic Area and Switzerland – who are living in another EU or EEA country, or Switzerland; "non-EU/EEA migrants" are those who are not citizens of EU or EEA countries, or Switzerland; and "nationals" are those who presented at a programme in their country of origin.

Fig 6. Data from combined social consultations includes each individual once. Figure excludes 1,071 records missing age, sex, nationality or combinations of these (4.8%; 1,071/22,365).

Fig 7. Data from social consultations includes each individual once. Figure excludes 229 records missing nationality (1.0%; 229/22,365).

DETERMINANTS OF HEALTH AND HEALTHCARE ACCESS

Health is a dynamic process that depends on different influencing factors. This chapter shows socioeconomic determinants of health as well as barriers in access to healthcare, frequently faced by the people we saw.

SOCIOECONOMIC DETERMINANTS OF HEALTH

WORK AND INCOME

Of all the respondents, 80.6% reported having no job or activity to earn a living (13,938/17,287).³⁶ The majority of people (92.7%; 7,919/8,546), lived under the poverty threshold in the country they presented in: 95.4% of EU/EEA migrants (2,126/2,229) and 91.9% of non-EU/EEA migrants (5,502/5,986). This means that their income was below 60.0% of the median equivalised net income of the population in a private household and therefore were at risk of not being able to secure the minimum resources necessary for long-term physical wellbeing and to meet their basic needs (such as food, clothing, and shelter).³⁷ However, these figures should be interpreted carefully since missing data varied across the three groups.

FIGURE 8. Money to live on per month for the last 3 months, under or over the country poverty threshold; by all nationals, EU/EEA migrants, non-EU/EEA migrants

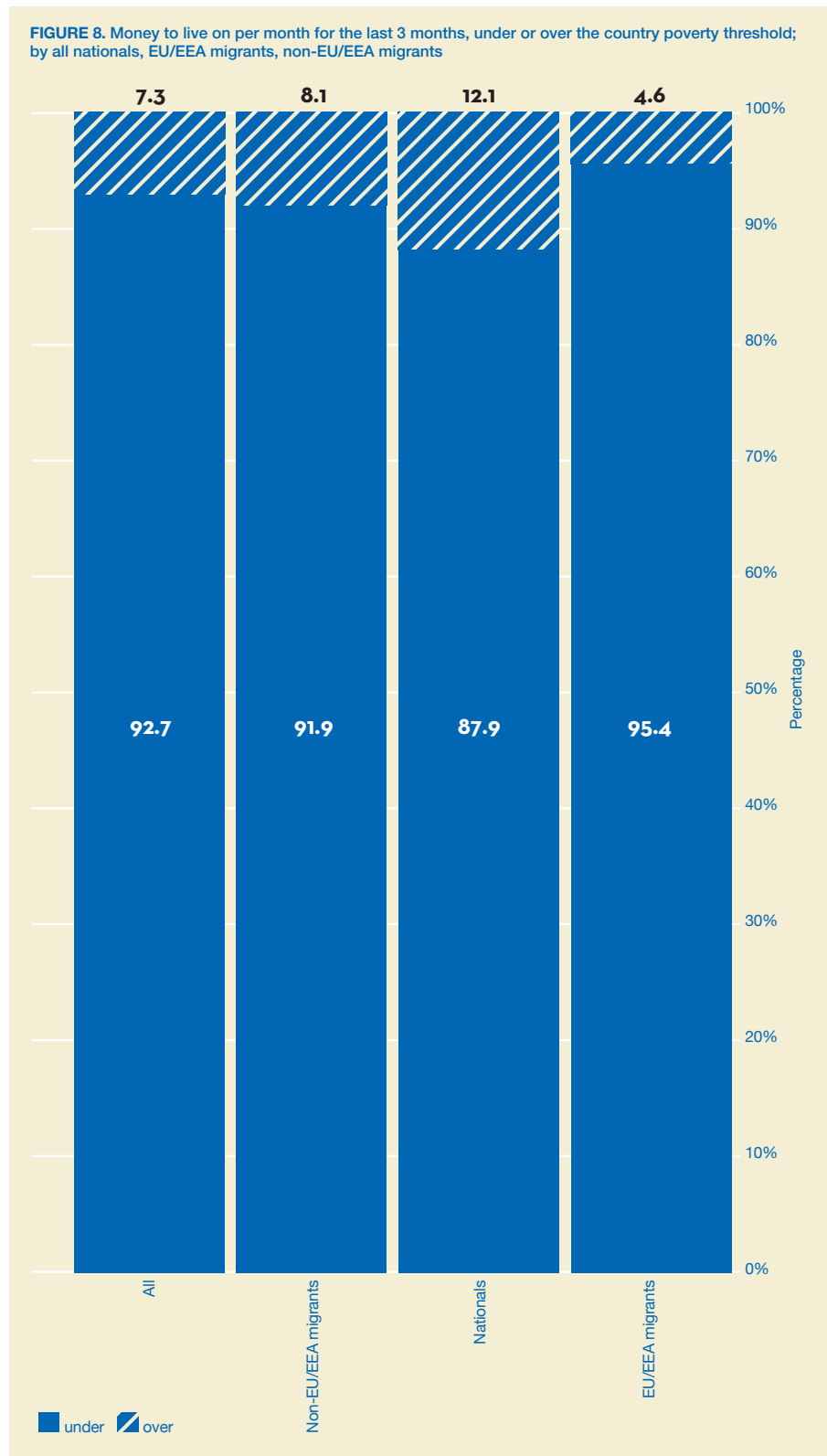


Fig 8. Data from social consultations includes each individual once. Figure excludes missing data for people without income recorded (61.6%; 13,770/22,365).

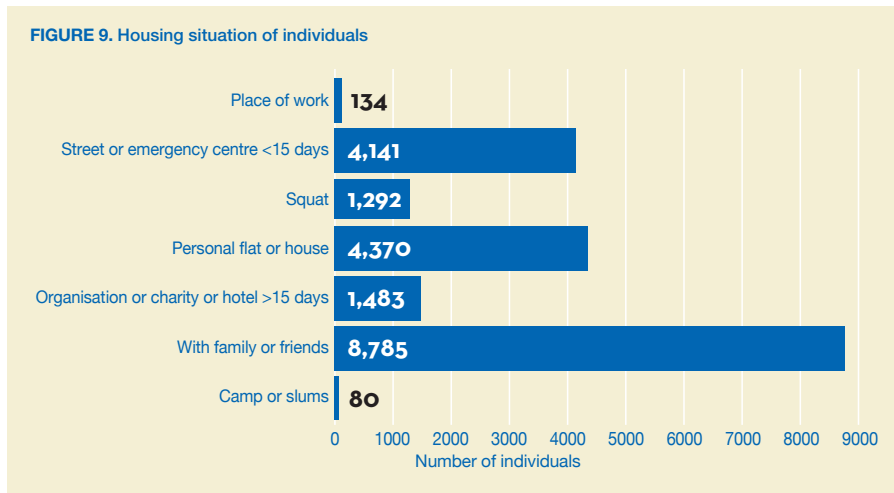
36. Data from social consultations includes each individual once. Figure excludes missing data for people without job status recorded (22.7%; 5,078/22,365).

37. Assessment of above/below the poverty threshold is based on established poverty threshold in the country that the individual presented in. Note: 60.0% of the median equivalised net income is the median of total income of all households, after tax and other deductions, that is available for spending or saving, divided by the number of household members converted into equivalised adults.



MdM Sweden: a volunteer doctor performing a medical examination at the Stockholm clinic

LIVING CONDITIONS



Since living conditions can have a severe impact on a person's health, the people seen were also asked about their accommodation status. The results are displayed in Figure 9 and of those who responded the highest proportion of people, 43.3%, were living with friends and family (8,785/20,285). Whereas 21.5% reported living in a personal flat

or house (4,370/20,285), and 20.4% of the respondents lived on the street or in emergency centres <15 days (4,141/20,285).

Of all respondents, 16.9% thought their housing situation was affecting their health (1,102/6,526).³⁸

NAME: KLAUS
COUNTRY: GERMANY

Klaus, 65, is a musician living in Germany. He underwent major surgery twice and has kidney failure and diabetes.

Klaus previously ran a business, which went bankrupt leaving him with over 100,000 euros of debt. In Germany, every citizen must have health insurance, something Klaus feels like he cannot afford with his estimated monthly contribution of 800 euros.

He explained: *"I desperately searched the internet for a place where I could get medical help. That is how I came upon Médecins du Monde Germany. Without them, I would probably be dead in five, six years. They saved my life."*

MORAL SUPPORT

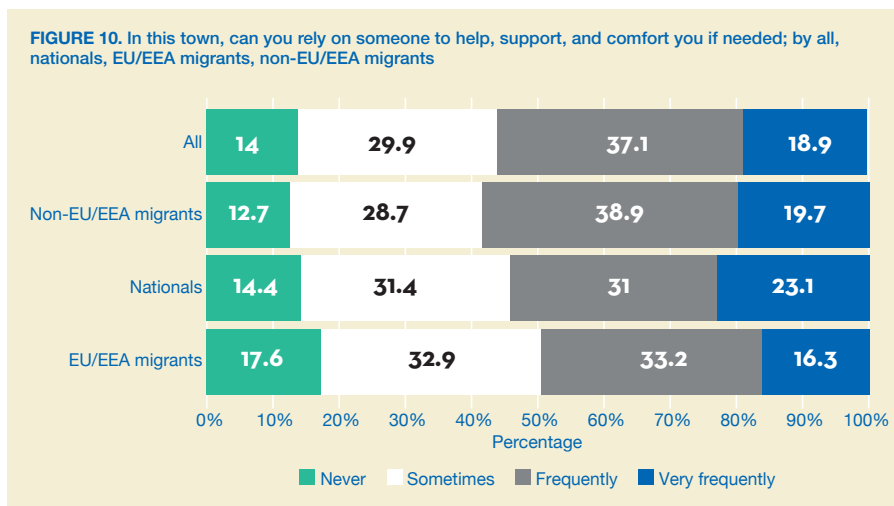


Figure 10 shows that 37.1% of those who responded to the question felt that they could frequently rely on someone in their current town to help, support, and comfort them, if needed (2,236/6,024). Nevertheless, 44.0% reported not having a stable network to rely on (2,648/6,024). This included 14.0% responding they never have someone to support them in their country of residence (846/6,024)

and 29.9% who only sometimes had support from others when the need arose (1,802/6,024).

EU/EEA migrants had a slightly larger proportion of people who recorded never having someone to rely on (17.6%; 275/1,560) but mostly the proportions were similar across migrant type.

NAME: KAREEM
COUNTRY: SWEDEN

Kareem is from Morocco, and is living in Sweden as an undocumented migrant. He has been an outcast in society and from his family for a long time due to his sexual orientation. He has been threatened and physically abused on multiple occasions in his home country, which has led him to develop psychological problems. The journey from Morocco to Sweden was stressful and has caused Kareem to experience depression and difficulties sleeping. This aside, Kareem said that he is physically fine and that he does not have pains or complaints.

Kareem has been unaware of his rights to healthcare as an undocumented citizen and therefore did not seek treatment for his problems. The fear of not having a residency permit is also something that deters him from seeking care. During his consultation with MdM Sweden, volunteers informed him about his rights and directed him to healthcare providers websites in different languages.

38. Data from social consultations includes each individual once. Figure excludes missing data for people without housing health impact recorded (70.8%; 15,839/22,365).

Fig 9. Data from social consultations includes each individual once. Figure excludes missing data for people without housing situation recorded (9.3%; 2,080/22,365).

Fig 10. Data from social consultations includes each individual once. Figure excludes records with missing nationality and individuals without moral support recorded (73%; 16,341/22,365).

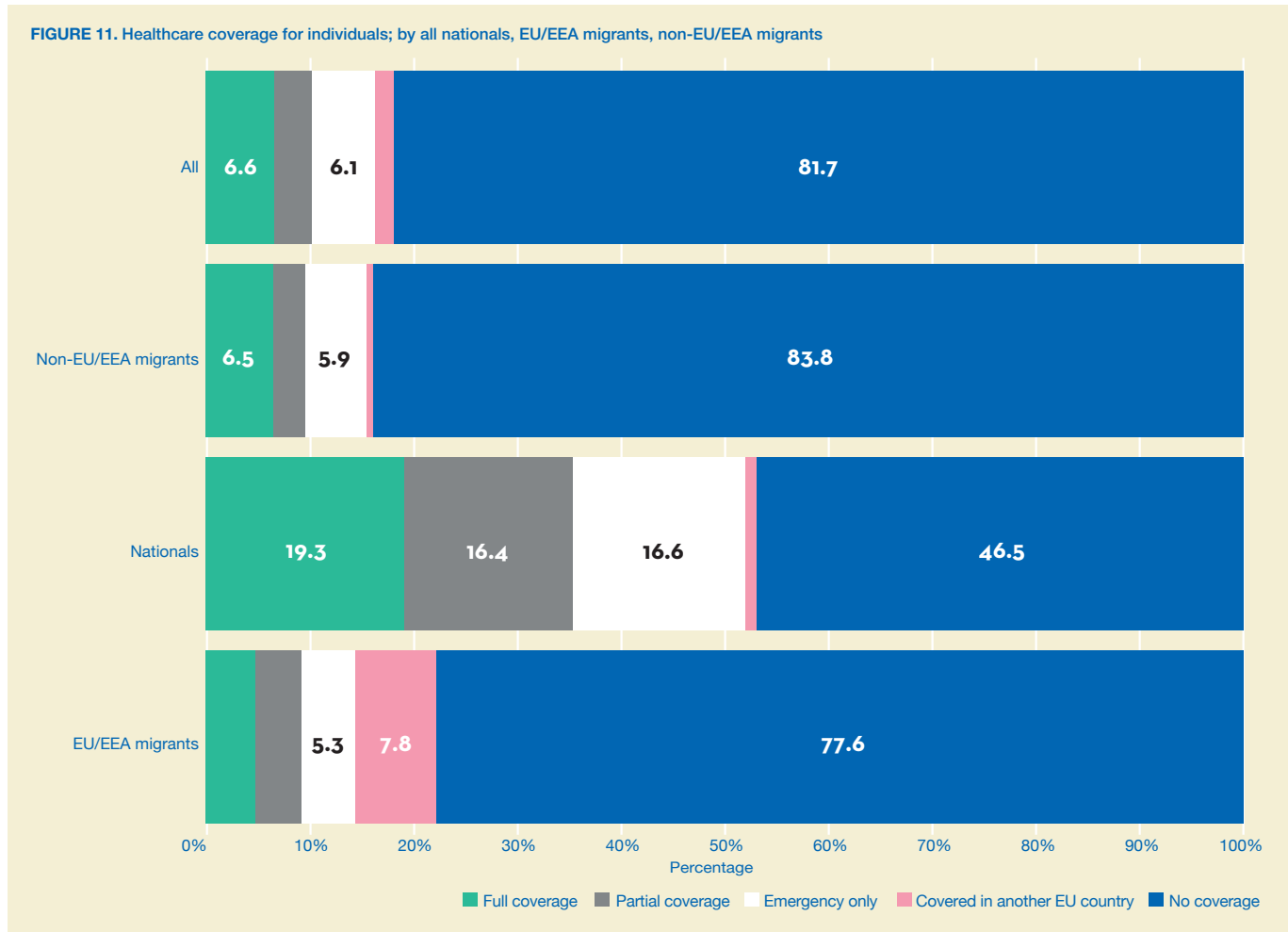
HEALTHCARE ACCESS

Medical care in Europe is of a high standard, but can also be expensive. In recognition of this, it is broadly accepted that healthcare must be financed either by an insurance system or a social service rather than out-of-

pocket payments by individuals. All 28 EU member states have adopted Agenda 2030 with the goal of achieving UHC to ensure “all people have access to needed health services (including prevention, promotion, treatment,

rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship” (WHO).³⁹

HEALTHCARE COVERAGE



As demonstrated in Figure 11, the majority of people seen at the MdM programmes reported having no healthcare coverage (81.7%; 14,848/18,164). Of which, 83.8% of non-EU/EEA migrants (12,229/14,594) and 77.6% of EU/EEA migrants had no health coverage (2,392/3,082).

Only 9.7% of non-EU/EEA migrants (1,418/14,594) and 9.3% of EU/EEA migrants had either full or partial health coverage (286/3,082). Nationals had the highest proportion of full coverage at 19.3% (94/488).

**NAME: AJOLA
COUNTRY: LUXEMBOURG**

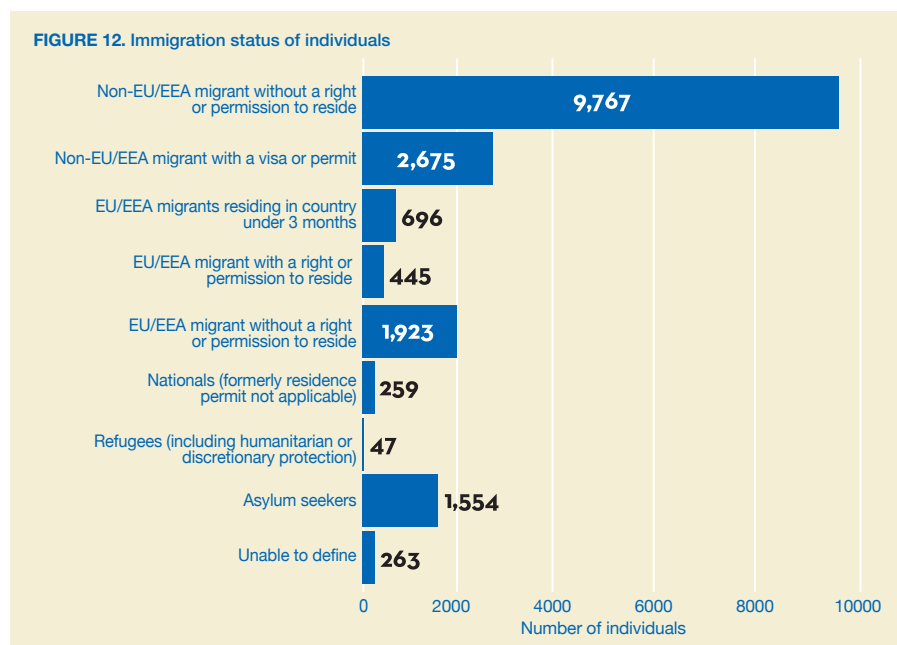
Ajola, from Albania, came to Luxembourg as a refugee with her family, but the family’s refugee status was dismissed.

“My 2-year-old little boy got sick, I went to my usual paediatrician who said that my son did not have anything serious and that I could go back home. Yet, a week later, the health of my little baby started to deteriorate; he had a very high fever and rashes everywhere on his body. I went to the hospital where my child was born. What a surprise when the lady from the reception told me I have no health coverage! I do not understand any of it, I have been to the paediatrician a week ago and he did not mention anything about my social security.”

39. World Health Organization. (2019). *Health systems: universal health coverage*. Retrieved 2 August 2019, from http://www.who.int/healthsystems/universal_health_coverage/en/.

Fig 11. Data from social consultations includes each individual once. Figure excludes records of individuals missing nationality (229 records) and individuals without health coverage status recorded (4,063). In total, 4,201 records were excluded (18.8%; 4,201/22,365).

IMMIGRATION STATUS



National legislation on access to healthcare for migrants often varies and immigration status has a profound impact on people's abilities to access care. The majority of people seen at the MdM programmes during the period 2017–2018 reported not having a right or permission to reside in the country they presented in (66.3%; 11,690/17,629). The most common immigration status was non-EU/EEA migrants without a right or permission to reside at 55.4% (9,767/17,629). The term "without a right or permission to reside" for non-EU/EEA migrants means "not fulfilling conditions for entry, stay, or residence in the country the person is living in". It includes those who enter Europe regularly on documents that have since become invalid, those who entered irregularly, and asylum seekers whose claims have been refused. However, 24.3% of non-EU/EEA migrants had a right or permission to reside (4,276/17,629), this includes: non-EU/EEA migrants with a visa or permit (15.2%; 2,675/17,629); asylum seekers (8.8%; 1,554/17,629); and refugees (0.3%; 47/17,629).

10.9% of the people seen were EU/EEA migrants without a right or permission to reside, (1,923/17,629), meaning they were residing in their host country for

over 3 months but were not fulfilling the requirements of the European Directive 2004/38/EC (meaning they were not either employed or self-employed or did not have sufficient resources for themselves and no health insurance as required by the European Directive 2004/38/EC)⁴⁰ (1,923/17,629). Immigration status is complex and sometimes, in the absence of legal expertise, individuals can be uncertain or incorrect about their immigration status, especially in the case of EU migrants who are not automatically issued residence permits.

Looking at immigration status by country of presentation, Belgium had the highest proportion of EU/EEA migrants without a right or permission to reside at 82.7% (415/502). While France had the highest proportion of non-EU/EEA migrants without a right or permission to reside at 72.1% (6,596/9,143) and the United Kingdom had the second highest at 65.7% (2,081/3,169).⁴¹

The majority of people seen in Germany at 54.4% (1,375/2,527) and Switzerland at 58.6% (222/379) had a right or permission to reside. Whereas 10.0% of individuals in Sweden were unable to define their status (62/623).⁴²

NAME: MIRCEA COUNTRY: BELGIUM

Mircea, 44, is suffering from serious chronic neuro-problems and has poorly controlled hypertension. His medical case is serious and requires a series of specialised medical examinations and regular follow-ups with a referring physician.

When Mircea came to MdM Belgium, a social worker analysed his administrative situation and referred him to the CPAS (Public Centre for Social Action) of the municipality in which he resides, so that he could benefit from his right to urgent medical assistance.

When Mircea presented himself at the CPAS, the duty social worker explained that he was not entitled to urgent medical assistance because he did not meet the required criteria. Mircea came back to the MdM social worker to understand why he did not fall under the conditions of urgent medical assistance. The MdM social worker wrote a letter detailing Mircea's situation and had to prove through various documents that he indeed met the conditions required to benefit from the urgent medical assistance coverage.

Despite regular contacts between the social workers (CPAS and MdM), and Mircea presenting the letter to the CPAS, Mircea was refused access to medical assistance. Instead of deciding whether or not Mircea met the criteria required for urgent medical assistance, the CPAS refused to grant him access to care based on his irregular residence situation and further recommended that Mircea is returned to his country of origin in order to apply for a medical visa.

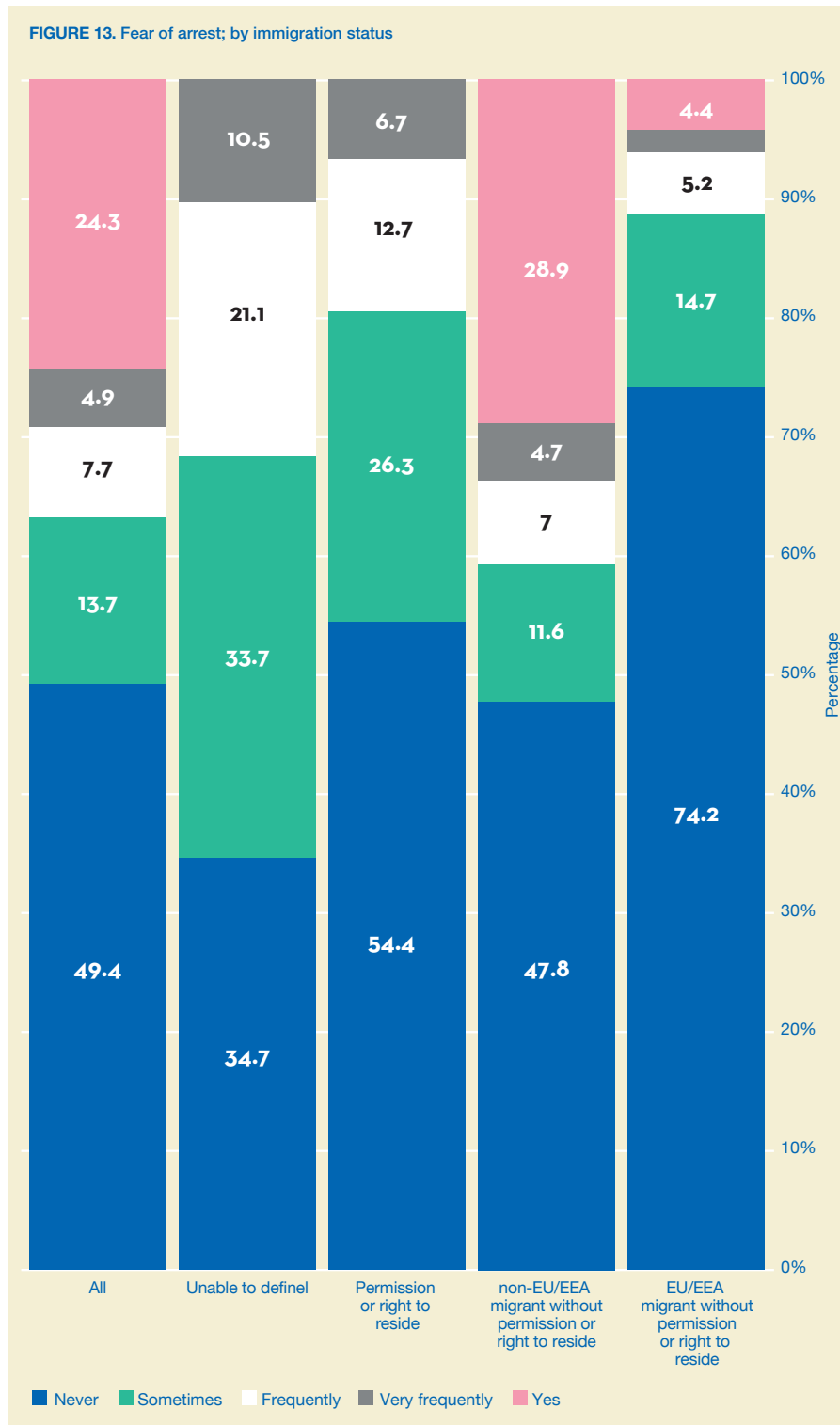
40. European Parliament, Council of the European Union. (2004). Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member amending Regulation (EEC) No 1612/68. *Official Journal of the European Communities*, L158, 77–123. Retrieved 22 September 2019, from <https://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX:32004L0038>.

41. Figure excludes records with missing immigration status. In total, 4,736 records were excluded (21.2%; 4,736/22,365).

42. *ibid.*

Fig 12. Data from social consultations includes each individual once. Figure excludes 4,736 records with missing immigration status (21.2%; 4,736/22,365).

FEAR OF ARREST



NAME: SAMAD
COUNTRY: UNITED KINGDOM

Samad has been living in the United Kingdom for 17 years after fleeing political persecution in his home country. He claimed asylum, but was turned down. Twice the Home Office has tried to return him to his home country, but local authorities have refused to allow him back – leaving Samad living in limbo in the United Kingdom. In 2016, Samad was diagnosed with cancer and told that he was in need of surgery.

Samad's medical notes explained that there was a risk of the cancer spreading if he did not receive treatment. Despite this, the hospital cancelled his operation and declined to treat him because his asylum case had been refused and because he could not pay for the surgery in advance. Samad says that when he was refused cancer treatment he was "very scared and desperate [...] and worried that [his] days were numbered".

Unable to pay upfront or return home, Samad came to MdM, who supported Samad to get legal help to challenge the hospital's decision. The treatment was provided after a significant delay.

After receiving treatment, the National Health Service Trust placed great pressure on Samad to pay the £3,900 for his care and debt collectors visited his home.

Samad died in late 2018 from a stroke.

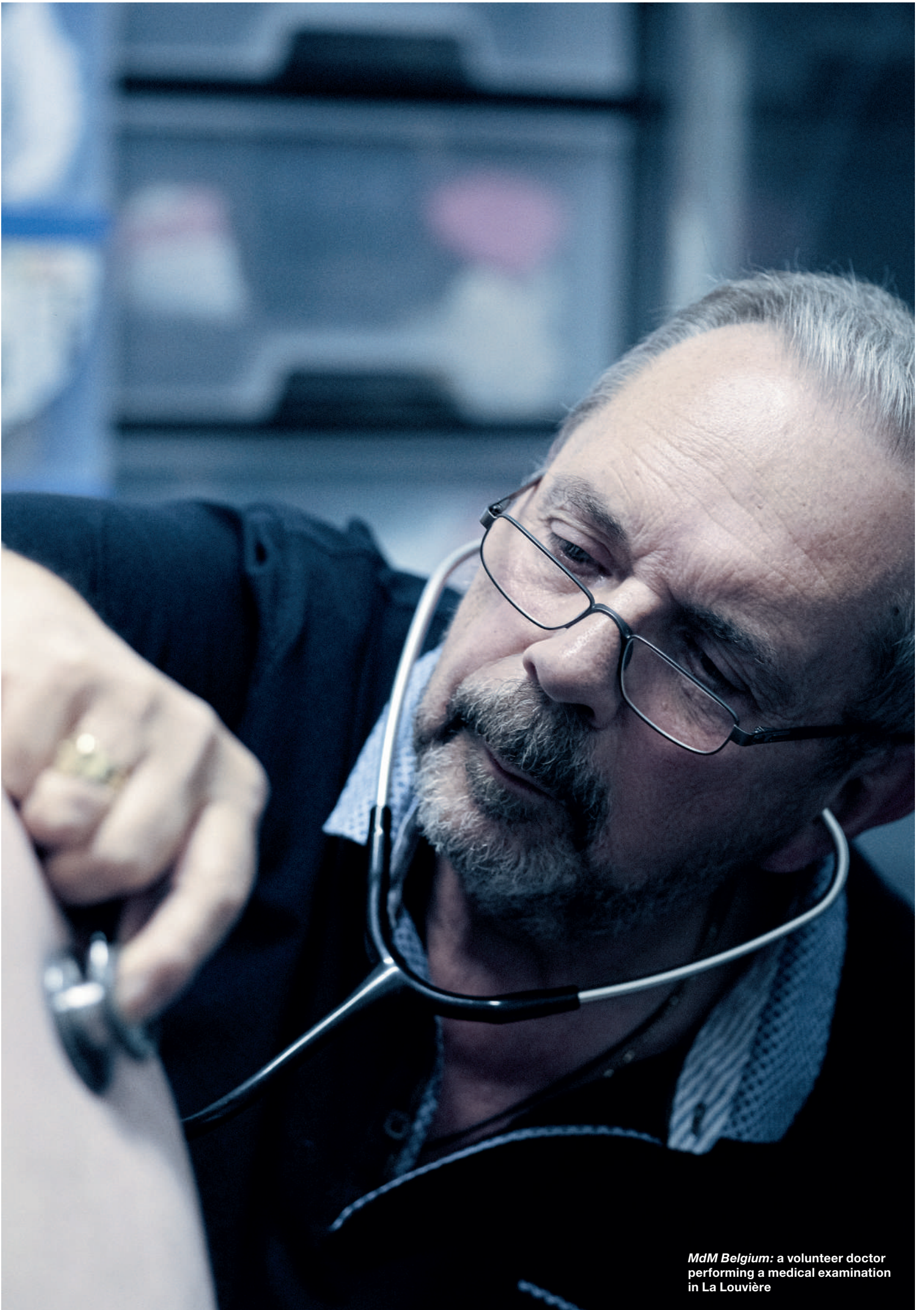
When presenting at the MdM programmes, people were asked if they restricted their movements in public because they feared arrest. Out of all the respondents, 24.3% reported doing so (1,407/5,811).

28.9% of non-EU/EEA migrants without a right or permission to reside reported

that they feared arrest (1,396/4,824). Of those, 7.0% "frequently" feared arrest (336/4,824) and 4.7% "very frequently" feared arrest (227/4,824). Even in the group with permission to reside⁴³ 19.3% feared arrest "frequently" or "very frequently" (119/616).

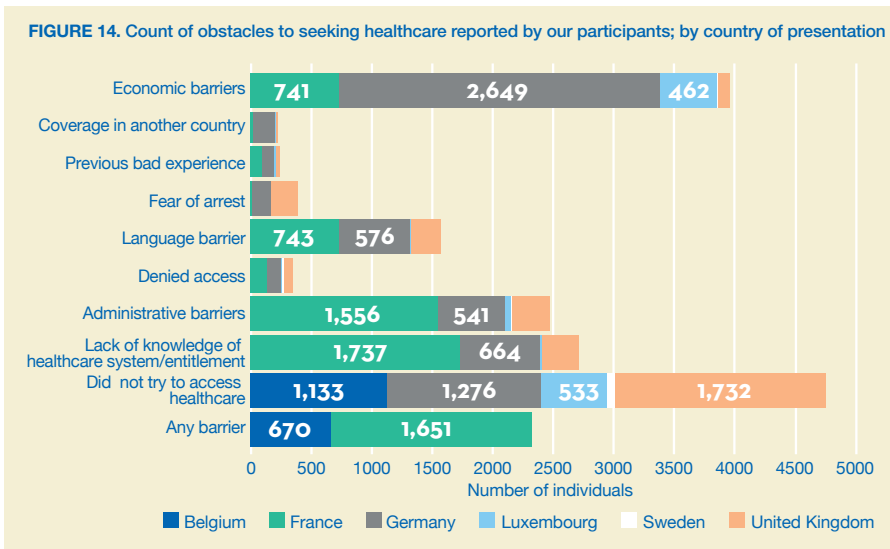
Fig 13. Data from social consultations includes each individual once. Figure excludes records of individuals without immigration status recorded (4,736 records) and individuals with missing data for fear of arrest (16,553 records). In total, 16,578 records were excluded (74.1%; 16,578/22,365).

43. "With right or permission to reside" includes the following groups: EU/EEA migrants with a right or permission to reside; EU/EEA migrants residing in the country under 3 months; refugees (including humanitarian protection or discretionary leave); asylum seekers; non-EU/EEA migrants with a visa or permit; and nationals (formerly residence permit not applicable).



MdM Belgium: a volunteer doctor performing a medical examination in La Louvière

BARRIERS TO HEALTHCARE



When presenting at an MdM programme, people were asked about barriers they faced when trying to access healthcare. This question allowed for multiple responses since people often face more than one barrier. Figure 14 reports the number each answer was given and should not be interpreted as individuals. The barriers stated are not expert opinions on what constitutes a barrier to health, but our participants' experiences.

"Economic barriers" to care (20.8%; 3,960/19,020) and "lack of knowledge of healthcare system/entitlements" at (14.3%; 2,718/19,020) were frequently

mentioned barriers among the respondents (2,718/19,020). The highest number of responses reported was "did not try to access healthcare" (25.0%; 4,747/19,020). That a person reported "did not try to access healthcare" could imply a number of barriers such as: the person had given up on trying to access care; stigma; experiences of discrimination; too far to travel; was not allowed to seek care by family members; etc, making it difficult to interpret.

Interpreting this data must be done with caution since missing data levels are high for some of the indicators, such as healthcare access denied.

NAME: MATEEN
COUNTRY: SWEDEN

Mateen, 16, is from Afghanistan, and has been living in Sweden for a year as an asylum seeker. Due to a car accident in Afghanistan just before Mateen fled to Sweden he had problems with his knee and his leg. He has been in pain for over a year and it gets worse with cold weather. Mateen also experiences psychological distress, partly from the dangerous journey to Sweden, but also from the straining asylum process. Even so, Mateen insists that he is happy and positive.

Mateen has, until now, been unaware of his rights to healthcare and has not dared to contact any healthcare provider and has only recently visited a health centre for his leg problems. During the visit, Mateen was not awarded an interpreter and he found the reception poor. He says that the medical staff looked at and felt his knee and then prescribed medication.

Once he returned to the refugee shelter the staff became contemplative over his medicine. They researched the medication and it was discovered that the doctor had prescribed Mateen antidepressants. This medication was given in spite of Mateen being a child under 18 years old and not having stated any psychological problems. He was also not given a referral or information on what he should do to get further treatment.

TRANSLATOR

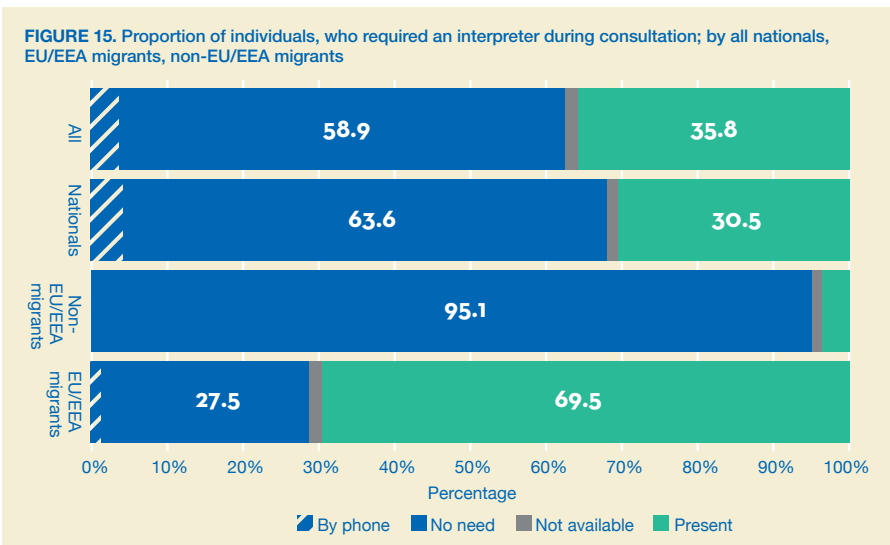


Figure 15 shows that a significant part of the people that were seen at the MdM programmes were in need of an interpreter during their consultation. Where 69.5% of EU/EEA migrants had an interpreter present (1,738/2,500)

compared to 30.5% of non-EU/EEA migrants (4,243/13,892). Overall, 35.8% of all individuals seen used an interpreter during a social consultation (5,994/16,760).

Fig 14. Data from social consultations includes each individual once. Multiple reasons may be recorded for each individual. Figure excludes records reporting "no difficulties". Economic barriers combines: consultation too expensive; treatment too expensive; and health insurance too expensive.

Fig 15. Data from social consultations includes each individual once. Figure excludes 5,442 records missing for people without interpreter recorded (24.3%; 5,442/22,365).

HOMELESSNESS AND HEALTH

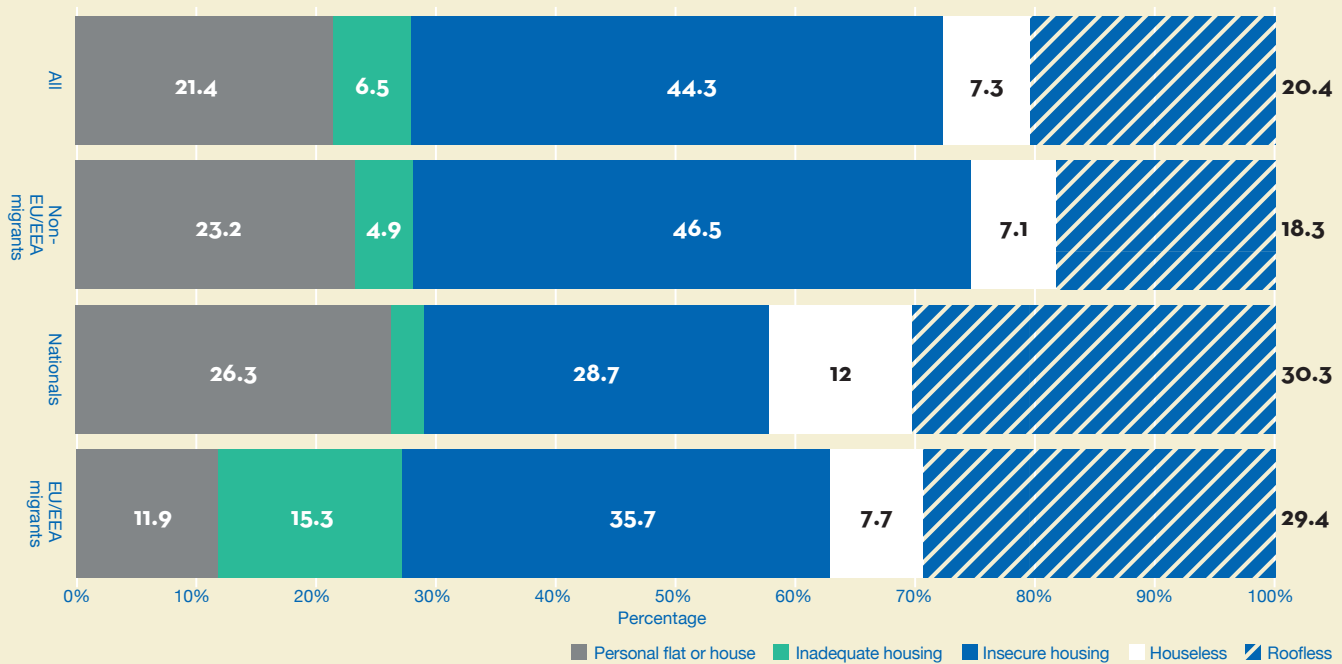
DEFINITION AND CLASSIFICATION

For this report we have adopted the official European Typology of Homelessness and Housing Exclusion (ETHOS),⁴⁴ which covers the range of circumstances a homeless person can be living in. This includes:

- **personal flat or house** – living in a personal flat or house;
- **inadequate housing** – living in unfit or overcrowded conditions;
- **insecure housing**⁴⁵ – living with friends or family in conventional housing, but without secure tenancy or under threat of eviction or of violence;
- **houselessness** – living in various types of temporary shelters or institutions; and
- **rooflessness** living on the street or emergency shelter.

DEMOGRAPHICS AND OTHER FACTORS INFLUENCING HEALTH

FIGURE 16. ETHOS housing situation; by all, nationals, EU/EEA migrants, non-EU/EEA migrants



Using the above definitions by ETHOS, 21.4% (4,308/20,097) of the respondents lived in a personal flat or house (Figure 16). However, the majority of individuals recorded living in precarious conditions: 6.5% reported inadequate housing (1,311/20,097); 44.3% reported insecure

housing (8,895/20,097); 7.3% reported houselessness (1,476/20,097); and 20.4% reported rooflessness and were hence living on the streets or in an emergency shelter (4,107/20,097). Nationals and EU/EEA migrants had the highest proportion of roofless individuals

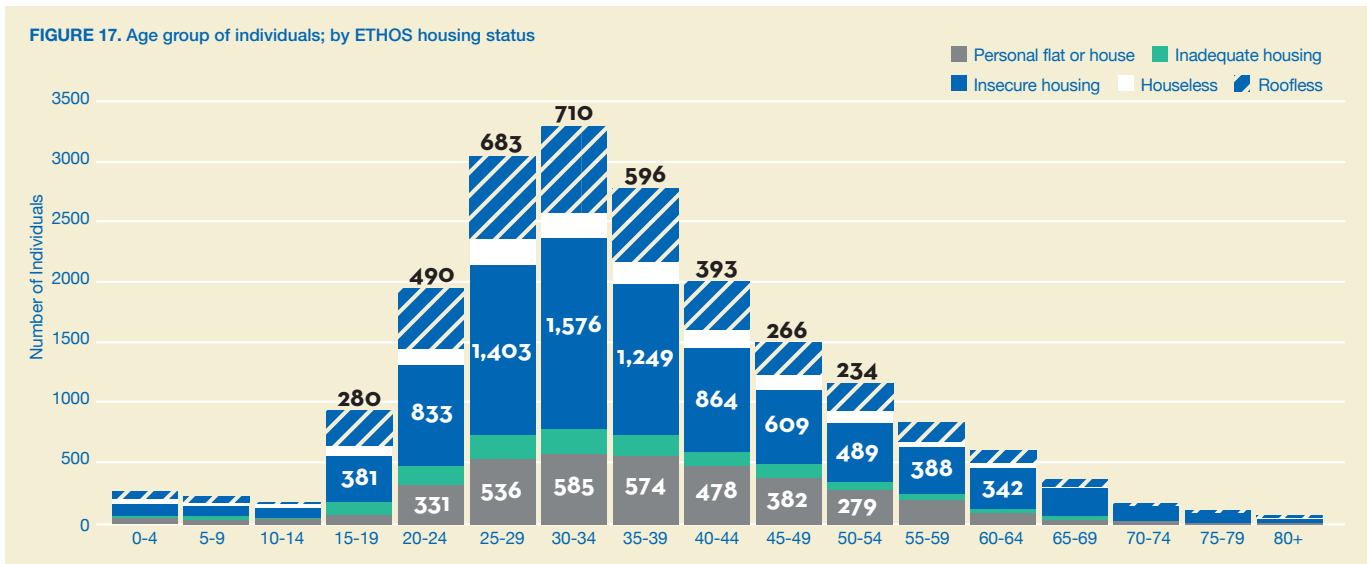
at 30.3% (154/509) and 29.4% (968/3,287) respectively. There were similar proportions of men and women across the categories with the exception of rooflessness where 73.3% of the individuals seen were male (3,021/4,121).⁴⁶

44. FEANTSA. (2005). *ETHOS typology on homelessness and housing exclusion*. Retrieved 7 October 2019, from <https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion>.

45. "Insecure housing implies people living in conventional housing or accommodation but without rights or tenancy agreements to secure long-term occupation, meaning they are at risk of eviction, includes: Living with family and friends, accommodation for formerly homeless people, living under threat of eviction or violence, without tenancy or through illegal occupation of land." ETHOS, *ibid*.

46. Data from social consultations, includes each individual once. Figure excludes missing data for sex (685 records) and for housing situation (2,080 records). In total, 2,736 records were excluded (12.2%; 2,736/22,365).

Fig 16. Data from social consultations includes each individual once. Figure excludes records with missing nationality (229 records) and individuals with missing data for housing situation (2,080 records). In total, 2,268 records were excluded (10.1%; 2,268/22,365).



30.1% (280/930) of individuals aged 15-19 and 25.2% (490/1,942) of individuals aged 20-24 were roofless; so the highest

two proportions of individuals living in a roofless situation were between the ages of 15-24.

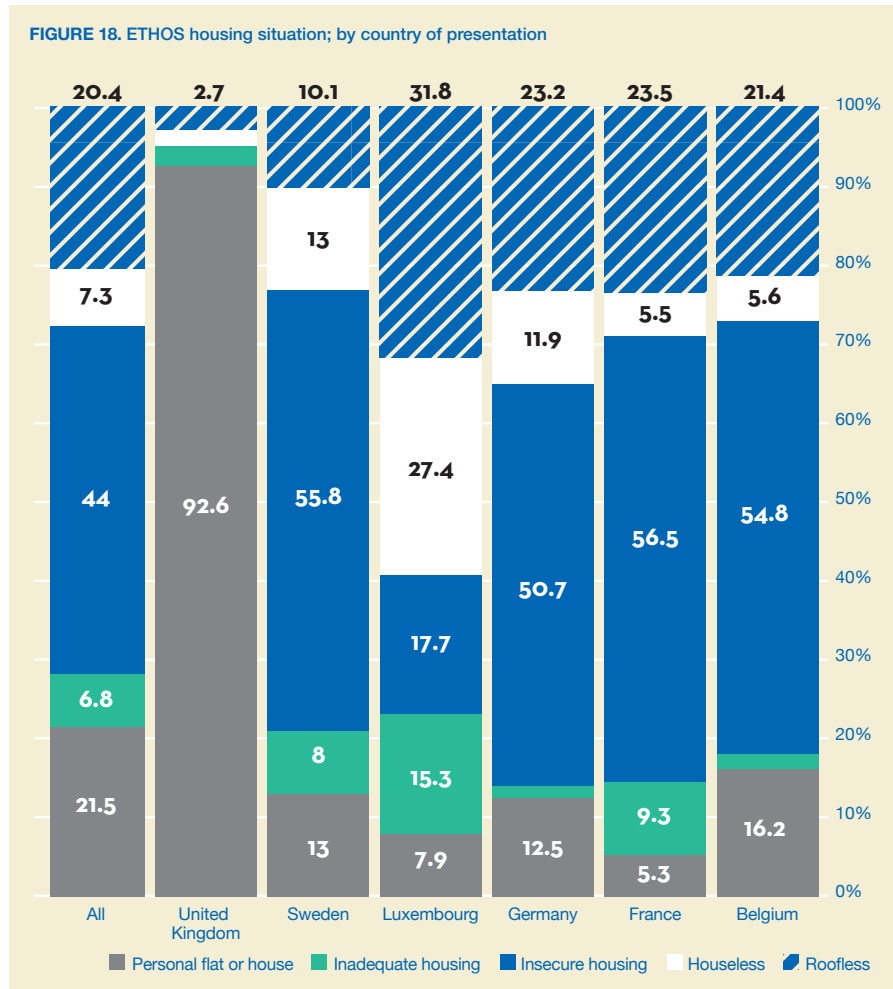


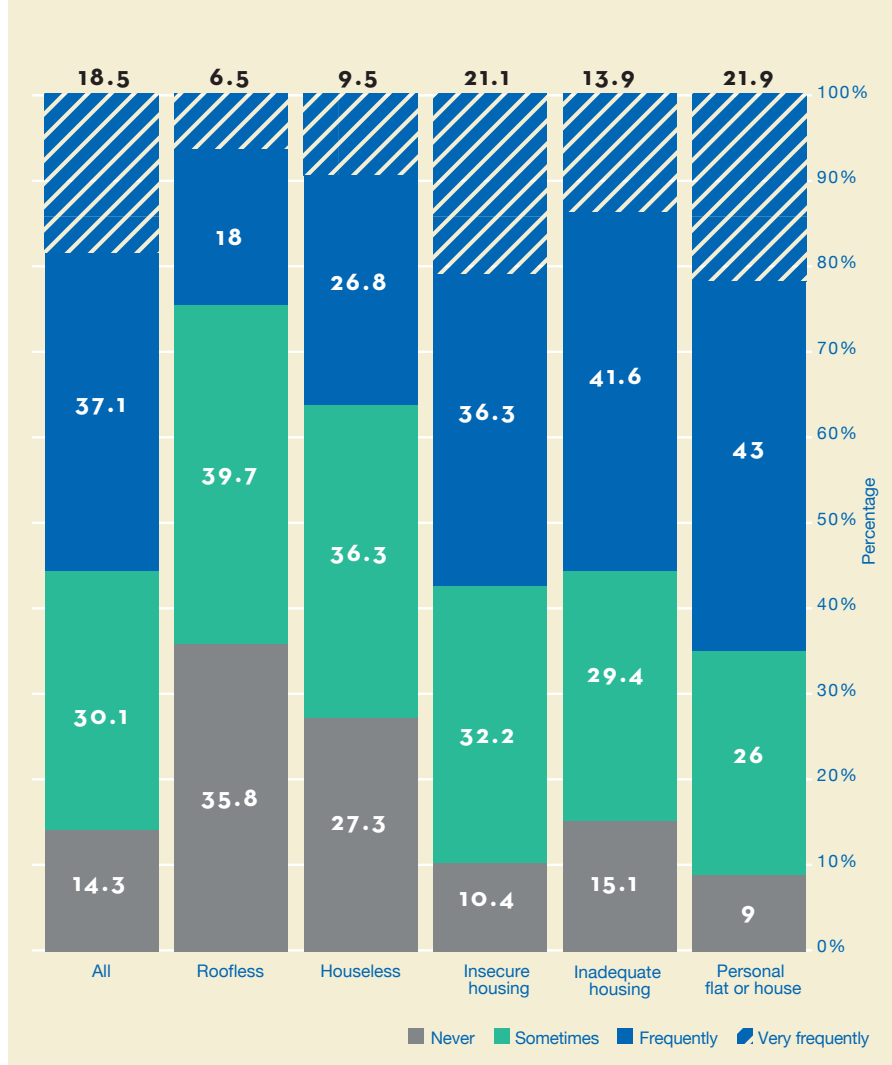
Fig 17. Data from social consultations includes each individual once. This figure excludes 872 records missing for age and 2,080 records missing for housing situation. In total, 2,886 records excluded (13.0%; 2,886/22,365).

Fig 18. Data from social consultation includes each individual once. Figure excludes missing data for people without housing situation recorded (9.3%; 2,080/22,365). Note: Housing data is not collected in Switzerland.

The housing situation of the people that were seen was very different depending on the country of presentation (see Figure 18). In France, 56.5% (5,957/10,550) were recorded as living in insecure housing and 23.5% (2,479/10,550) were recorded as roofless. On the other hand, in the United Kingdom, 92.6% (2,968/3,204)

were recorded as living in a personal flat or house. Luxembourg had the largest proportion of individuals recorded as roofless (31.8%, 440/1,382), and Germany (23.2%, 593/2,551), France (23.5%, 2,479/10,550), and Belgium (21.4%, 527/2,460) had the next highest proportion of individuals recorded as roofless.

FIGURE 19. How often can the individual rely on someone in their current town to help; by housing situation



NAME: ANDREI
COUNTRY: BELGIUM

Andrei, 57, is living with a friend in Belgium and has major heart problems due to a heart attack 2 year ago.

At MdM Belgium the social worker advised Andrei to apply for an urgent medical assessment to the CPAS. The application was refused on the grounds that there were “serious indications of income”. However, Andrei has no residence permit, no income, and is living with a friend who is hosting him to help him out. MdM Belgium contacted the CPAS’s social worker in charge of the case in order to understand what income was being considered, as Andrei is living in extreme poverty and has been visiting other associations for vulnerable groups and other food parcel services. However, the CPAS’s social worker refused to disclose the elements of the social investigation under professional confidentiality.

Taking into consideration high levels of missing data, moral support is reported distinctly lower by roofless people. 35.8% of roofless individuals

felt like they never had anyone to rely on (236/660) compared to 9.0% of those living in a personal flat or house (275/3,058).

NAME: LAURA
COUNTRY: BELGIUM

Laura, 34, is an undocumented migrant living in Belgium with her five children. Before she was welcomed to a centre for the homeless, she and her children were sleeping on the streets near a metro station.

After getting in contact with MdM Belgium the social worker in charge of the case has been working closely with the social workers at the night shelters to support Laura in her efforts to access care. Since Laura is housed in a centre in the territory of Brussels, the social worker referred her to the CPAS in order to submit a request for urgent medical assistance for her and her children. Once at the CPAS, Laura was told that she was unable to submit her request and that it was not competent for territorial reasons.

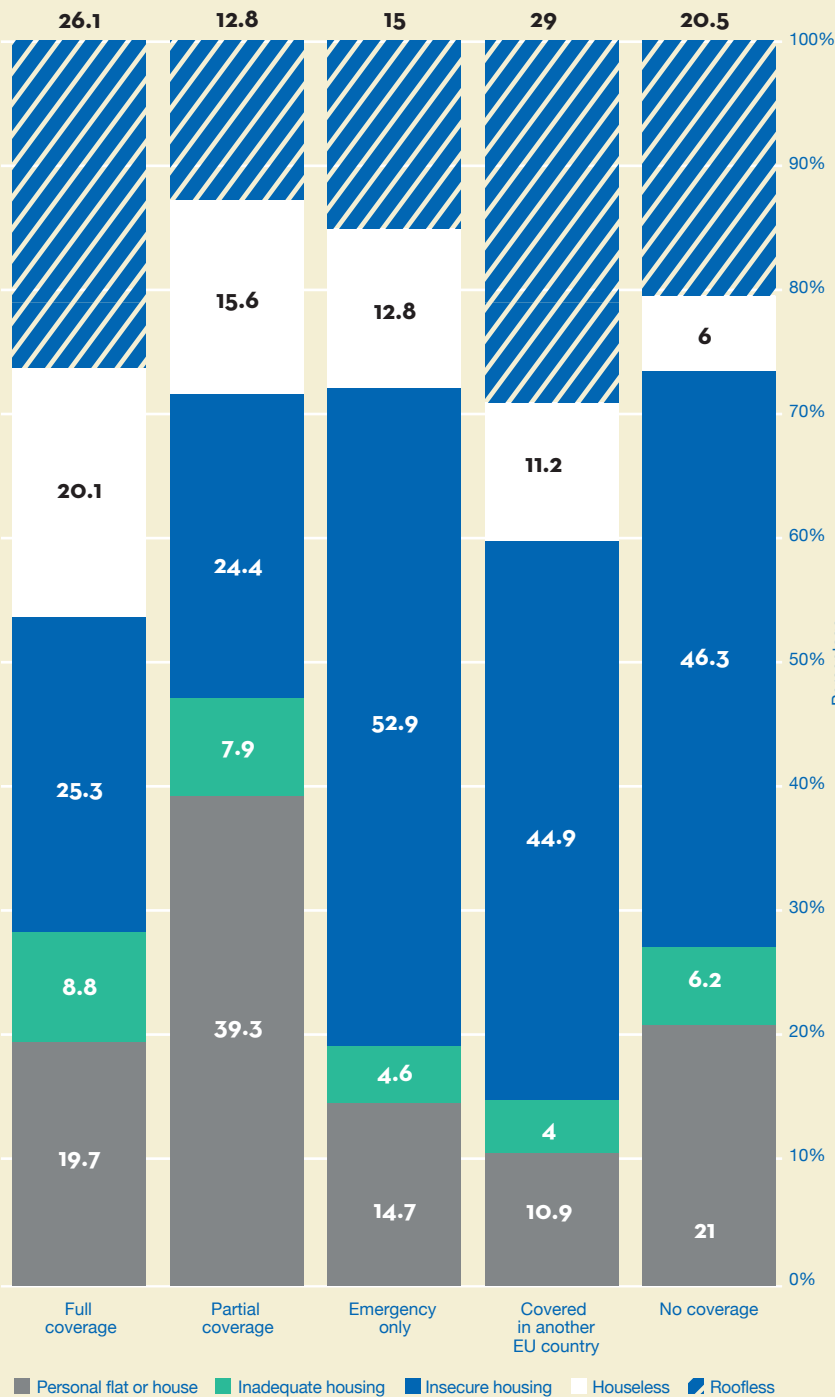
After many difficulties and multiple

refusals Laura no longer wanted to start new administrative procedures. She explained that she no longer trusts the institutions and that undocumented migrants unfortunately have no rights. In order to assist Laura in accessing her right, the social worker at the centre where she is staying at and the social worker at MdM together convinced Laura of the importance of accessing healthcare, particularly for her underage children. A social worker from the centre accompanied Laura to the CPAS to file an application, and 4 weeks later Laura was granted urgent medical assistance for herself and her children. Between the first interview at the CPAS and the acquisition of urgent medical assistance, it took 3 and a half months for Laura to open up her access to care.

Fig 19. Data from social consultations includes each individual once. Figure excludes 16,294 records of individuals without moral support recorded and 2,080 records for individuals missing housing situation. In total, 16,454 records were excluded (73.6%; 16,454/22,365).

HOMELESSNESS AND BARRIERS

FIGURE 20. Healthcare coverage; by ETHOS housing situation



NAME: DANA
COUNTRY: GERMANY

Dana, an immigrant from another EU country, is living in Germany. She was employed as a cleaner in the low-income bracket and her funds did not stretch to health insurance. After an accident where a gas heater exploded due to poor housing conditions, she was brought to a city hospital as an emergency. This left Dana with hospital bills she was unable to pay. She was later refused a further operation on her eye, both because she was uninsured and the resultant gap in cost coverage.

Dana at first came into contact with MdM Germany because she could not afford the medication she was prescribed. The team managed to establish contact with a volunteer specialist from another charity, who carried out the eye surgery free of charge. Without this operation Dana might have gone blind.

Almost 2 years after the horrible incident Dana received a private bill from the hospital. She has been asked to cover her treatment costs, which amounts to more than 115,000 euros.

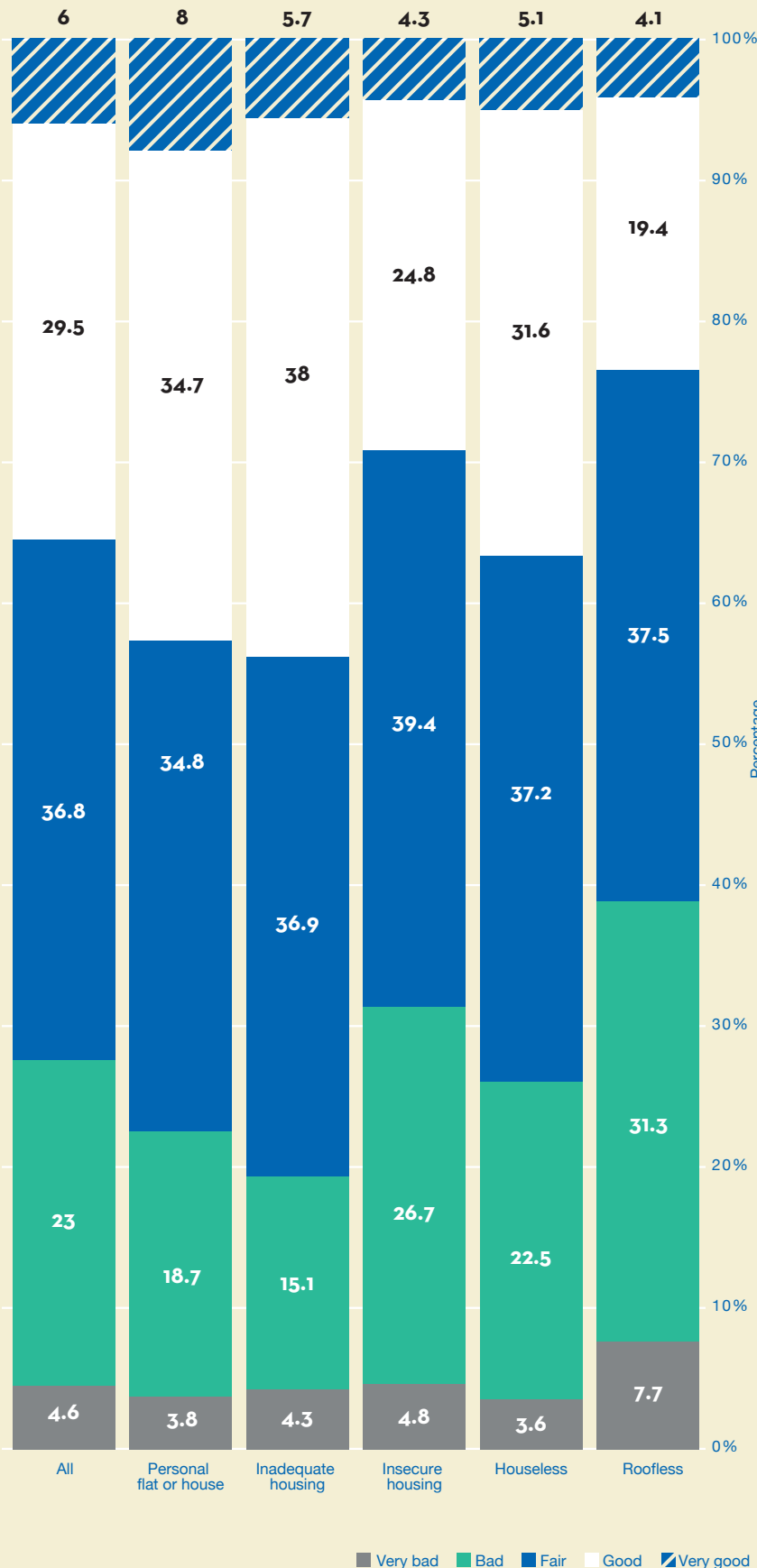
As demonstrated in Figure 20, 46.3% of people with no healthcare coverage were at the same time living in insecure housing (6,702/14,471) and 52.9% of people with emergency only coverage were living in insecure housing

(433/819). Of the people covered in another EU country, 29.0% were recorded as roofless (93/321); this is probably due to high numbers of EU/ EEA migrants in countries where mobile clinics were used.

Fig 20. Data from social consultations includes each individual once. Figure excludes 4,063 records of individuals without health coverage and 2,080 records for individuals missing housing situation. In total, 5,045 records were excluded (22.6%; 5,045/22,365).

HOMELESSNESS AND HEALTH STATUS

FIGURE 21. Self-perceived physical health; by ETHOS housing situation



NAME: BELA
COUNTRY: GERMANY

Bela, 47, from Eastern Europe, has been living in Germany for a year. He is homeless and has no health insurance. Bela has deteriorating eyesight and he is afraid he is going to go blind.

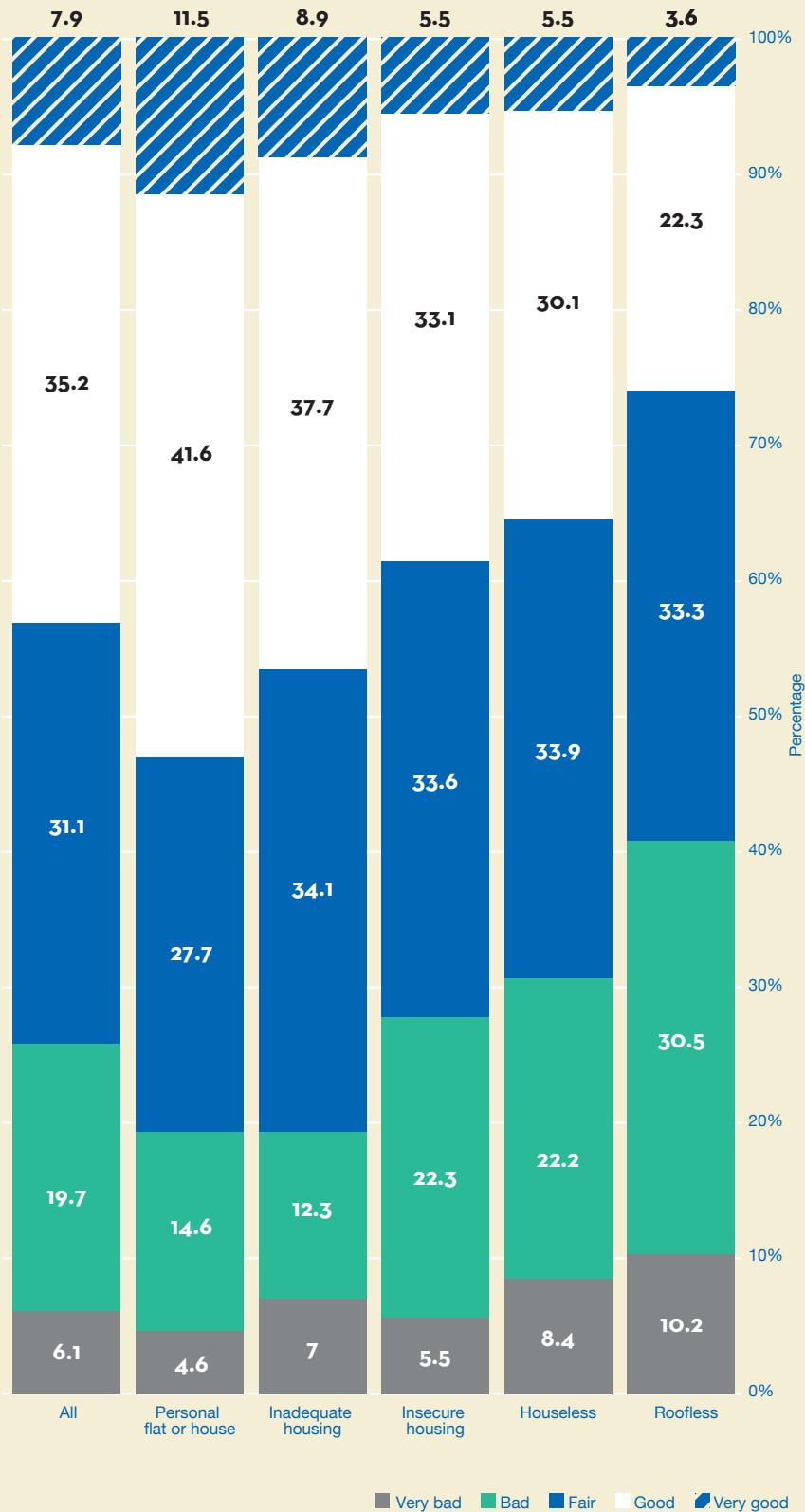
Through MdM Germany, Bela was able to get an ophthalmologist appointment and an MRI (magnetic resonance imaging) scan free of charge. A life-threatening tumour was discovered. Neurosurgeons from the MdM network concluded that Bela had to undergo surgery as soon as possible.

The request for reimbursement of treatment costs, which was addressed with relevant social welfare authorities, remained unanswered for almost 2 weeks. After long-lasting discussions with various clearing centres, the hospital agreed to operate, although it was not clear who would pay for it, since Bela does not have health insurance.

Following successful surgery, MdM Germany was informed by the Office for Migration and Housing that all surgery costs will be covered. A social facility for homeless people took responsibility for the aftercare and another welfare organisation paid for it.

Fig 21. Data from social consultations includes each individual once. Figure excludes 14,167 records of individuals without self-perceived physical health and 2,080 records of individuals missing data for housing situation. In total, 14,485 records were excluded (64.8%; 14,485/22,365).

FIGURE 22. Self-perceived psychological health; by ETHOS housing situation



39.0% of roofless individuals recorded their physical health as either “very bad” or “bad” (414/1,061) compared to 22.5% of individuals living in a personal flat or house (760/3,375). 40.7% of roofless individuals recorded their psychological health as either “very bad” or “bad” (430/1,056) compared to 19.2% of individuals living in a personal flat or house (637/3,317).

52.9% (1,027/1,943) of the diagnoses of roofless people, 59.2% (2,549/4,305) of people living in insecure housing and only 25.8% (864/3,345) of the diagnoses of people living in a personal flat or house with adequate living were chronic.⁴⁷

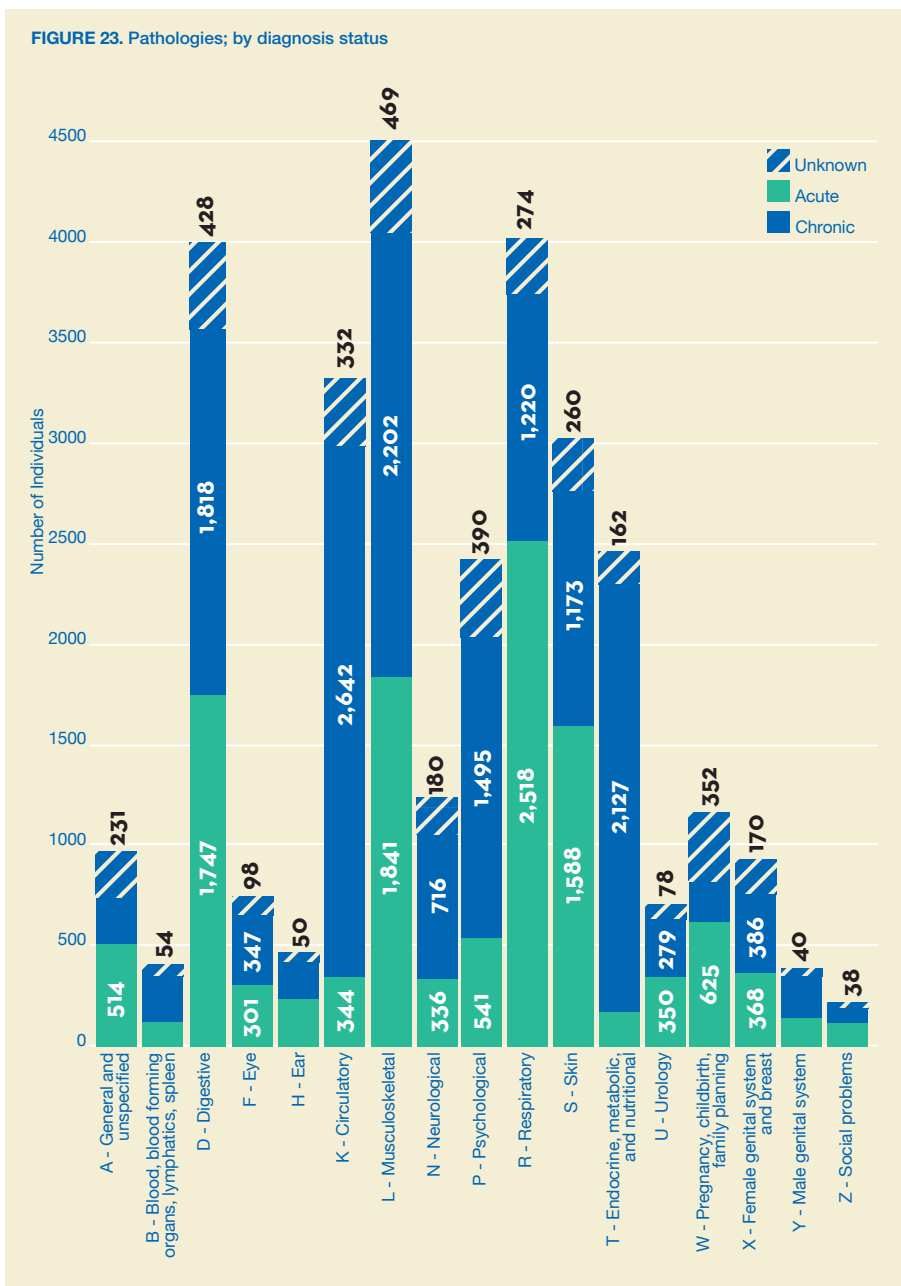
Fig 22. Data from social consultations includes each individual once. Figure excludes 14,286 records of individuals without self-perceived psychological health and 2,080 records of individuals with missing data for housing situation. In total, 14,599 records were excluded (65.3%; 14,599/22,365).

47. Data from linked medical and social consultations includes each individual once. In total, 5,494 records were excluded (12.9%; 5,494/42,749).

HEALTH CONDITIONS AND STATUS

In this chapter, we cover the health conditions and pathologies diagnosed by a clinician, and the self-perceived health status reported by individuals visiting the Mdm programmes in the seven countries.

COMMON PATHOLOGIES



NAME: TAIMUR
COUNTRY: SWEDEN

Taimur, 18, is from Afghanistan, and living in Sweden as an asylum seeker. As a result of two accidents that took place at a workplace in Iran, he has chronic back pain since approximately 3 years ago and he says that the pain sometimes is unbearable and makes him unable to move. When travelling to Sweden from Iran, Taimur says that the journey was uncertain, demanding, and difficult.

Taimur has been in contact with healthcare providers for his back pain on several occasions. Once he came to the health centre but there was no interpreter and Taimur was sent home without a referral and only a lighter examination. After being in contact with Mdm Sweden Taimur received a referral to a health centre where he got to see a doctor. He was given some exercises to do, but he has not received any further information and he has not been given a new appointment with the doctor. He has also been denied further measures, such as X-rays.

According to Taimur, there is no difference between the care that he was granted before he turned 18 and now that he is officially an adult. He states that he has never had a good reception in the healthcare system and he claims that if he had been Swedish he would have received help by now.

As a consequence of the medical staffs' lack of understanding and willingness to help, Taimur says: "Why should I even go there [the health centre] if all they will do is to send me home?" He says he has lost all confidence in the healthcare system.

Fig 23. Data from pathology dataset. Multiple pathologies may be recorded for each individual. Figure excludes records with missing International Classification of Primary Care (ICPC) chapter variable (4.8%; 1,917/ 39,751) and missing acute or chronic variable (12.9%; 5,494/39,751). In total, 8,793 records were excluded (22.1%; 8,793/39,751).

Figure 23 shows the total number of diagnosed pathologies reported (not individuals). These figures exclude records with missing International Classification of Primary Care (ICPC) chapter variable (4.8%; 1,917/39,751). Overall, the highest proportion of pathologies reported were musculoskeletal (13.8%; 5,476/39,751), respiratory (12.6%; 4,991/39,751), digestive (12.4%; 4,946/39,751), circulatory (9.8%; 3,913/39,751), skin (9.6%; 3,808/39,751), and psychological (7.7%; 3,058/39,751). Almost 60.0% of patients (59.8%; 10,843/18,145) did not know about their diagnosis prior to migration.⁴⁸

ACUTE PATHOLOGIES

Of those pathologies that had a diagnosis status, 38.3% were acute (11,857/30,958). Overall, the highest proportion of acute pathologies were respiratory (21.2%; 2,518/11,857), followed by musculoskeletal (15.5%; 1,841/11,857), digestive (14.7%; 1,747/11,857), skin (13.4%; 1,588/11,857). Pregnancy, childbirth, and family planning accounted for 5.3% of the consultations (625/11,857).

Figure 24 shows the healthcare coverage of individuals with acute, chronic, and unknown pathologies. Of those with an acute pathology, 78.5% had no coverage (2,331/2,970) and a further 16.0% had emergency coverage only (474/2,970). This data needs to be considered carefully as the definition of chronic may be interpreted differently by different data collectors and in different countries.

CHRONIC PATHOLOGIES

Of those pathologies that had a diagnosis status, 50.1% were chronic (15,495/30,958). Overall, the highest proportion of chronic pathologies were circulatory (17.1%; 2,642/15,495) followed by musculoskeletal (14.2%; 2,202/15,495), endocrine, metabolic, and nutritional (13.8%; 2,127/15,495), digestive (11.7%; 1,818/15,495), and psychological (9.6%; 1,495/15,495). Of those with a chronic pathology, 77.0% had no coverage (3,479/4,516) and a further 16.9% had emergency coverage only (764/4,516), whereas 3.2% had full coverage (145/4,516). This data needs to be considered carefully as the definition of chronic may be interpreted differently by different data collectors and in different countries.

NAME: JADE
COUNTRY: UNITED KINGDOM

Jade is from the Caribbean, and after she was widowed she came to live in London with her daughter Sally, who is a British citizen. In 2016, Jade was diagnosed with cancer. A specialist and another clinician advised her that she was too sick to fly home and that the need for chemotherapy was “urgent”.

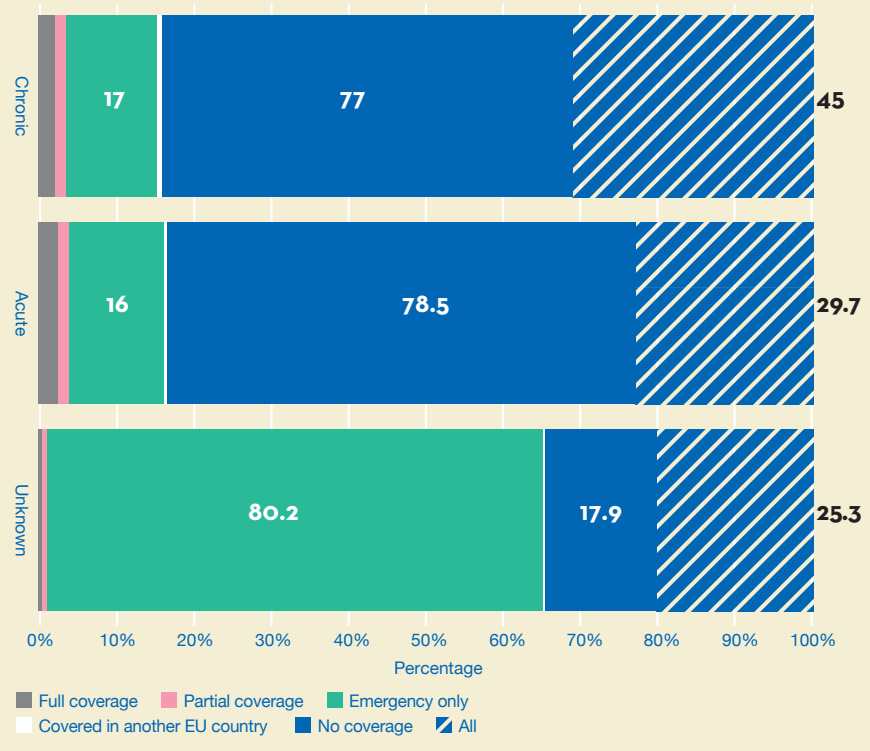
Despite this, the hospital demanded a five-figure sum before treatment could commence. Sally, being a

care worker, could not pay for her mother’s treatment all in one go.

When Jade and Sally came to MdM, Jade had been discharged from the hospital and was not receiving palliative care. She was at home and often in pain. MdM supported Sally to challenge the hospital’s decision to refuse the healthcare that Jade so desperately needed.

Jade died in early 2018.

FIGURE 24. Diagnosis status; by healthcare coverage



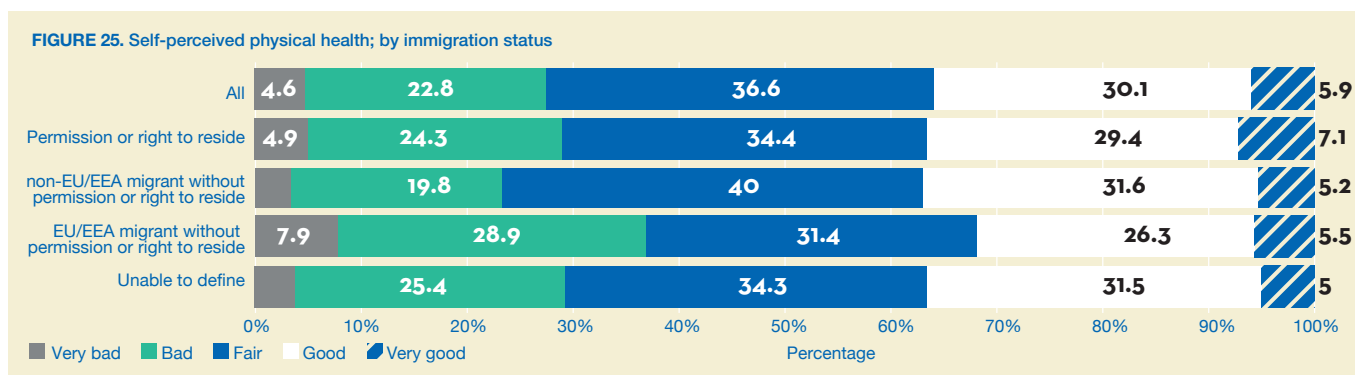
NAME: JOHN
COUNTRY: LUXEMBOURG

“I went to Médecins du Monde Luxembourg because I needed batteries for my hearing device”, explains John, in his early thirties and deaf from both ears since the age of 6. One of his hearing devices has been broken for a long time. The other has no battery anymore. Today, his two hearing devices have been changed. “For me, it is like a person who does not see colours and then one day, that person sees them ... it is a life changer!” rejoices John with a big smile. “I am going to be able to talk with others and become a social man.”

48. Data from pathology dataset where it is possible that an individual may have multiple diagnoses or consultations. Knowledge before was calculated as a composite variable with varying levels of missing data, from 70.2% (30,004/42,749) to higher.

Fig 24. Data from linked medical and social consultations includes each individual once. Figure excludes individuals without health coverage recorded (16.3%; 2,517/15,476) and those missing acute or chronic variable (calculated as a composite variable with varying levels of missing data from 82.9% [12,816/15,476] to 63.9% [9,881/15,476]).

SELF-PERCEIVED HEALTH STATUS



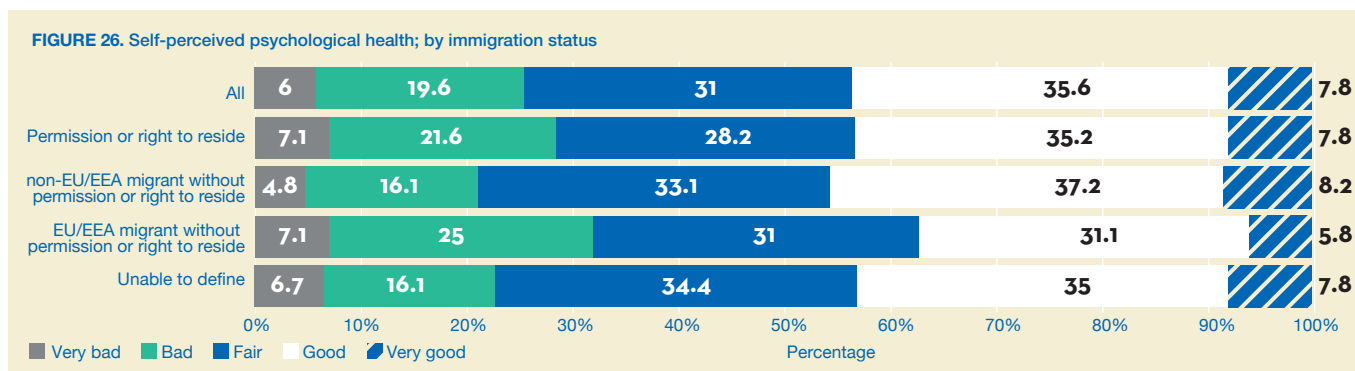
Most people who responded to the question on how they rated their physical health said it was “good” or “very good” (36.4%; 2,986/8,198). However, over half (63.6%, 5,212/8,198) did not perceive their physical health as “good” or “very good”, with 22.5% of people reporting “bad” physical health (1,841/8,198) and a further 4.5% reporting “very bad” physical health (368/8,198).⁴⁹

Figure 25 shows self-perceived physical health of those with a right or permission to reside in comparison to non-EU/EEA migrants without a right or permission to reside and EU/EEA migrants without

a right or permission to reside. Although there is not much variation across the groups, EU/EEA migrants reported the highest levels of poor physical health with 36.8% perceiving their physical health as “bad” or “very bad” (351/955).

Data on self-perceived health collected from this population can be compared with self-perceived health data collected by EU member states from the general population and held by Eurostat.^{50, 51} The comparison shows that, in the Mdm population, a higher percentage of people rated their health as “bad” or “very bad” (26.9%) in comparison to the general

population (8.3% in 2017 and 8.6% in 2018) and a smaller percentage of people reported their health as “good” or “very good” (36.4%) in comparison to the EU (EU-28) general population (69.7% in 2017 and 68.3% in 2018). This pattern is also reflected at EU member state level. In each of the seven countries, the percentage of people seen by Mdm rating their health as “bad” or “very bad” is higher than the general population and the percentage of this population rating their health as “good” or “very good” is lower. It should be noted that the Eurostat data does not include data from those aged under 16 years.



While two-fifths of the respondents perceived their psychological health as “good” or “very good” (43.5%; 3,516/8,079), over half of respondents did not perceive their psychological health as “good” or “very good” (56.5%; 4,563/8,079), with 19.4% reporting “bad” (1,571/8,079) and 6.0% reporting “very bad” psychological health

(484/8,079).⁵² Nationals had a higher proportion of “bad” or “very bad” self-perceived psychological health (43.5%; 128/294) compared to non-EU/EEA migrants (23.7%, 1,408/5,949) and EU/EEA migrants (28.5%, 505/1,769).⁵³

Figure 26 shows self-perceived psychological health of those with a right or permission to reside in comparison

to non-EU/EEA migrants without a right or permission to reside and EU/EEA migrants without a right or permission to reside. Although there is not much variation across the groups, EU/EEA migrants reported the highest levels of poor psychological health with 32.1% perceiving their psychological health as “bad” or “very bad” (304/948).

49. Data from social consultations includes each individual once. Figure excludes data missing for self-perceived physical health (63.3%; 14,167/22,365). Note: self-perceived health data is not collected in Belgium.

50. The European Commission/Eurostat. (n.d). *Self perceived health by age, sex and labour status*. Retrieved 7 October 2019, from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_01.

51. The European Commission/Eurostat. (2017). *General health*. Luxembourg: The European Commission/Eurostat. Retrieved 2 October 2019, from https://ec.europa.eu/eurostat/documents/1012329/8655367/PERSONAL+DATA_Health.pdf/0a942278-dd03-47f6-9af6-3f3000f678ce.

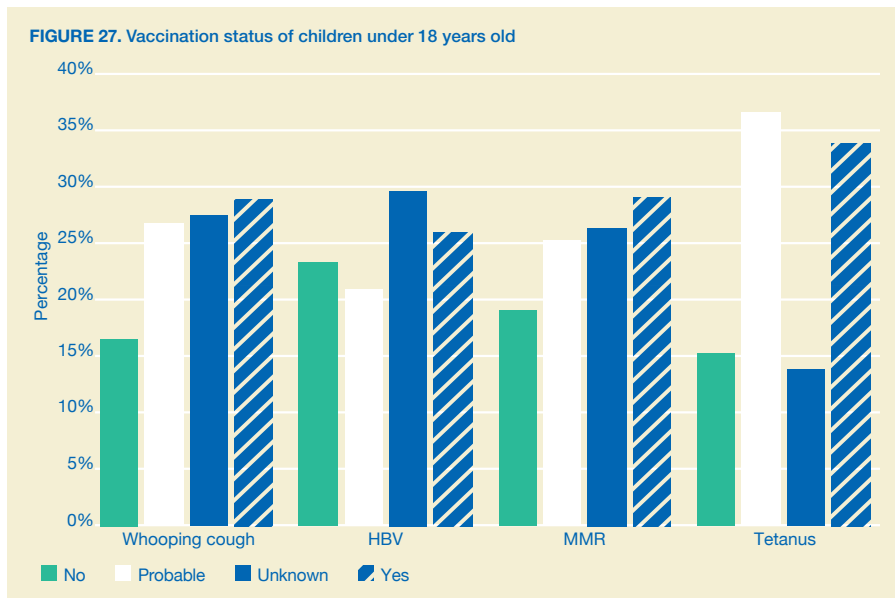
52. Data from social consultations includes each individual once. Figure excludes data missing for self-perceived psychological health (63.9%; 14,286/22,365). Note: self-perceived health data is not collected in Belgium.

53. Data from social consultations includes each individual once. Figure excludes data missing for self-perceived psychological health (63.9%; 14,286/22,365) and nationality (229 records). Note: self-perceived health data is not collected in Belgium.

Fig 25. Data from social consultations includes each individual once. Figure excludes 14,167 records of individuals without self-perceived physical health and 4,736 records of individuals without immigration status. In total, 14,574 records were excluded (65.2%; 14,574/22,365).

Fig 26. Data from social consultations includes each individual once. Figure excludes records of individuals without self-perceived psychological health (63.8%; 14,286/22,365) and individuals without immigration status (21.2%; 4,736/22,365). In total, 14,676 records were excluded (65.6%; 14,676/22,365).

CHILDHOOD VACCINATION



Of respondents, 34.0% of children had received a vaccination for tetanus (142/418), as had 29.0% for whooping cough (98/338), 29.2% for measles, mumps, and rubella (MMR) (104/356), and 26.6% for hepatitis B vaccination (HBV) (90/338). 52.9% of the children seen had either not received the vaccination for HBV or their vaccination status was unknown (182/344). Similarly, 45.5% had not received the vaccination

for MMR or their vaccination status was unknown (162/356), 44.1% had not received the vaccination for whooping cough or their vaccination status was unknown (149/338), and 29.2% had not received the vaccination for tetanus or their vaccination status was unknown (122/418). However, these results need to be interpreted with caution due to high levels of missing data across the four vaccination types.

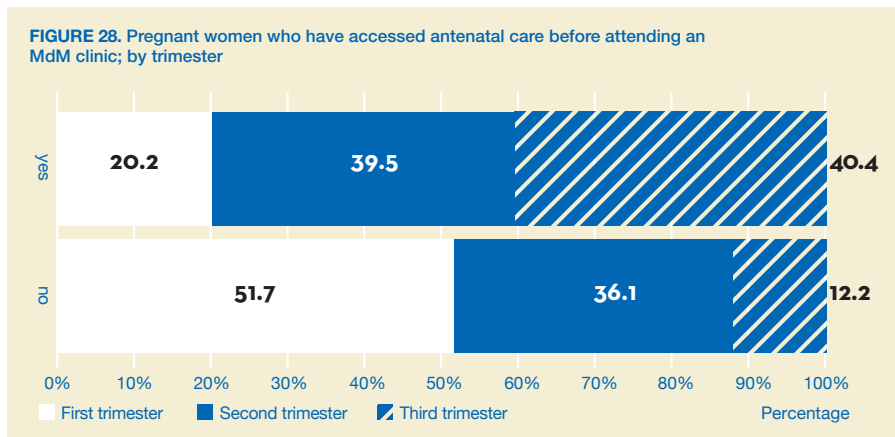
NAME: BAHIRI
COUNTRY: SWEDEN

Bahiri, 17, is from Afghanistan, and is living in Sweden as an asylum seeker. Bahiri was operated in Iran 3 and a half years ago due to a motorcycle accident where he injured his shoulder, but is still experiencing pain. Medical staff in Sweden have examined his shoulder and arrived at the conclusion that the surgery in Iran was poorly executed. On top of this, Bahiri is in a poor mental state, which has been attributed to the long wait in the asylum process and he has on several occasions harmed himself by cutting his arms.

For over a year, Bahiri has tried to receive help at different healthcare facilities by different doctors, where he has been able to attain examinations, but then been denied treatment for the pain in his shoulder. "I have tried for over a year but nothing happens!" Bahiri explains that every doctor has argued that he does not have a residency permit and that due to this, he cannot have surgery.

He has been provided with information from his lawyer about his rights to healthcare being the same as every child in Sweden. He remains hesitant to whether this is true since he himself has been denied surgery due to his lack of a residency permit. "If all children have the same rights, then why do I not receive treatment?"

MATERNITY CARE



10.4% of women seen in MdM clinics that had a medical and social consultation were pregnant (639/6,116).⁵⁴ The majority of pregnant women were in their first trimester of pregnancy (41.3%; 142/344); however, just over one-fifth were in their third trimester (21.5%;

74/344). When asked if accessing antenatal care, over three-fifths of pregnant women who responded had not accessed antenatal care prior to visiting an MdM programme (66.9%; 230/344) and 32.3% had not accessed antenatal care and were in their second

or third trimester of pregnancy (111/344). 45.6% (276/605) of pregnant women also reported living in insecure housing and another 15.0% reported being roofless (91/605).⁵⁵

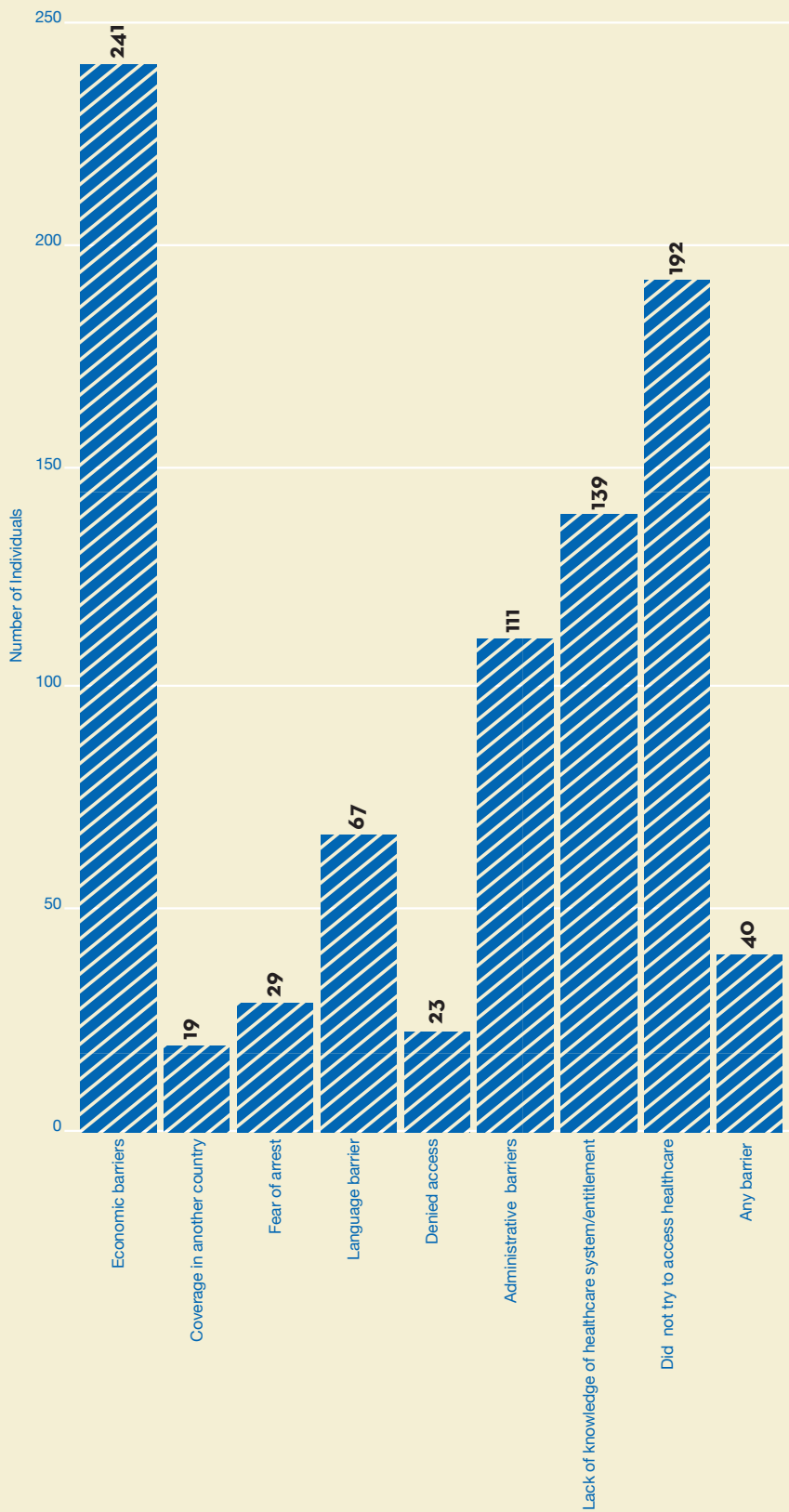
54. Data from linked medical and social consultations includes each individual once. Figure does not include missing data on pregnancy status (42.9%; 2,622/6,116) and sex (0.5%; 81/15,476).

55. Data from linked medical and social consultations includes each individual once. Figure does not include missing data on sex (0.5%; 81/15,476), pregnancy status (42.9%; 2,622/6,116), and housing status (8.8%; 540/6,116).

Fig 27. Data from medical and social consultations includes each individual once. Figure excludes 264 records missing age data. Missing data on vaccinations is quite high: 75.2% (1,024/1,362) for whooping cough; 73.9% (1,006/1,362) for MMR; 74.7% (1,018/1,362) for HBV; and 69.3% (944/1,362) for tetanus.

Fig 28. Data from linked medical and social consultations includes each individual once. Figure excludes missing data on sex (0.5%; 81/15,476), antenatal care (15.2%; 97/639), and trimester (46.2%; 295/639).

FIGURE 29. Barriers to healthcare experienced; by pregnant women



NAME: MAGDA
COUNTRY: UNITED KINGDOM

Magda is a 4-months pregnant refused asylum seeker who comes to MdM because her antenatal appointments have been suspended by the hospital. She has been told that she needs to pay £300 upfront for the first appointment and a further £5,000 for the whole maternity package to continue with the care. As a result, Magda has missed several antenatal appointments and has begun to suffer from panic attacks.

Figure 29 shows the barriers pregnant women face when accessing healthcare. 465 pregnant women reported one or more barriers. Of all reported barriers, “economic barriers” were most

commonly reported (27.9%; 241/865) followed by “did not try to access healthcare” (22.2%; 192/865), and “lack of knowledge of healthcare system/entitlement” (16.1%; 139/865).



MdM Germany: a medical consultation (once per week) taken beside the mobile clinic in Munich at the main train station. Copyright: Laura Schweizer/Ärzte der Welt

DISCUSSION

THE STATE OF UNIVERSAL HEALTHCARE COVERAGE IN EUROPE

UHC is meant to ensure access to healthcare for everyone, yet this report provides evidence that European governments are failing to provide the level of healthcare coverage committed to in the UN 2030 Agenda for Sustainable Development.⁵⁶ It provides a picture of the state of UHC in Europe and the large gaps in access to healthcare that currently exists.

Furthermore, it gives us insight into who is excluded from healthcare coverage. Firstly, it shows that large numbers of migrants – including refugees and people seeking asylum – are excluded from health systems. In all seven countries, a large proportion of individuals were non-EU/EEA migrants, suggesting all of these countries do not provide sufficient access to healthcare for this group. The SDGs outcomes document is clear that the commitment to “leave no one behind” includes people who have migrated and that a citizen-only approach is not acceptable:

We emphasize the responsibilities of all State ... to respect, protect and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status.⁵⁷

However, this report shows that, in the context of UHC in Europe, migrants and refugees are indeed left behind. The presence of asylum seekers also suggests that EU member states are not meeting the EU Directive 2013/33/EU, which requires all EU member states to ensure asylum seekers “receive the necessary healthcare which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders”.⁵⁸

The presence of EU/EEA migrants in MdM programmes also raises questions about the extent to which EU member states are meeting the healthcare needs of EU citizens living in their territory and observing Article 16 of the Social Pillar. Higher levels of EU/EEA migrants aged under 15 seeking care from MdM clinics shows that EU children are slipping through the gaps of European health systems. One of the mechanisms causing EU/EEA migrants to lose their entitlement to access to health services is Directive 2004/38/EC,⁵⁹ which removes the right of residence from EU migrants who are not employed or self-employed unless they can evidence both health insurance and sufficient resources to support themselves. This means that EU/EEA migrant workers who become unemployed, or those who do seasonal work and are in between jobs, lose their right to equal access to health services (as well as their right to remain in the country) and find themselves excluded from national health coverage schemes. This has been accompanied by a number of steps taken by European governments in recent years to limit EU migrants’ access to public services,⁶⁰ increasing levels of homelessness, and compounding the impact of unemployment.⁶¹

The report also shows variation in access to healthcare for EU/EEA migrants from country to country.⁶² Very low levels of EU/EEA migrants were observed in the MdM programmes in the United Kingdom and Sweden, where as in Germany and Luxembourg around half of people were EU/EEA migrants (59.7% and 45.6% respectively). This variation could reflect the prevalence of non-legal barriers to healthcare (as shown in Figure 14) faced by EU/EEA migrants in different countries, or the

legal rights of EU/EEA migrants without a right or permission to reside or finally the location of MdM programmes (for example, in areas of high EU migration).

The presence of nationals in the data also shows that European health systems are failing their own citizens.

The report further shows that governments are not providing access to a sufficient range of services to achieve universal coverage. The UN resolution on UHC is clear that UHC does not simply equate to emergency care, but includes “promotive, preventive, curative and rehabilitative basic health services needed and essential, safe, affordable, effective and quality medicines” and the SDG indicator 3.8.1. defines essential health services as including “reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases” services.⁶³ Yet, 6.1% of respondents had “emergency only coverage” and 3.7% had “partial coverage”. Although the precise definition of an “emergency” healthcare service will vary from country to country, it is usually restrictive, including only short-term medical interventions and does not include ongoing management of a medical condition or chronic pathologies – which are prevalent in this population (46.1% of pathologies were chronic). Similarly, the presence of pregnant women, particularly those in their second or third trimester without access to antenatal care, and unvaccinated children in the data set indicates that these levels of coverage are not ensuring an adequate level of maternal or preventive services to constitute UHC.

56. United Nations General Assembly. (2015). *Resolution 70/1. Transforming our world: the 2030 Agenda for Sustainable Development*. Resolution A/RES/70/1. Paragraph 19. New York, NY: United Nations. Retrieved 14 October 2019, from <https://undocs.org/A/RES/70/1>.

57. *ibid.*

58. European Parliament, Council of the European Union. (2013). Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection. *Official Journal of the European Union*, L180, 96–116. Retrieved 14 October 2019, from <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32013L0033>.

59. European Parliament, Council of the European Union. (2004). Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004. *Official Journal of the European Union*, L158, 77–123. Retrieved 14 October 2019, from <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:158:0077:0123:en:PDF>.

60. Homeless Link. (2017). *Timeline of changes to EEA rights: resource for homelessness services*. London, UK: Homeless Link. Retrieved 12 October 2019, from https://www.homeless.org.uk/sites/default/files/site-attachments/Timeline%20of%20legislative%20changes%20on%20EEA%20rights_0.pdf.

61. Downie, M., (ed.), Pritchard, B., Sanders, B., Reid, B., Hancock, C., Devlin, C. et al. (2018). *Everybody in: how to end homelessness in Great Britain*. London, UK: Crisis. pp. 336–370. Retrieved 14 October 2019, from https://www.crisis.org.uk/media/239951/everybody_in_how_to_end_homelessness_in_great_britain_2018.pdf; Jones, D. (2017, 20 December). Homeless EU migrants have already borne the brunt of Brexit Britain. *The Guardian*. Retrieved 10 October 2019, from <https://www.theguardian.com/housing-network/2017/dec/20/brexit-bonfire-legal-protection-homeless-eu-migrants>; Trust for London. (2019). *Rough sleepers in London*. London's poverty profile.

Retrieved 10 October 2019, from <https://www.trustforlondon.org.uk/data/rough-sleepers-london/>; Mattsson, P. (2019, 17 February). Antalet utsatta EU-migranter har inte minskat. *SVT Nyheter*. Retrieved 13 October 2019, from <https://www.svt.se/nyheter/inrikes/antalet-utsatta-eu-medborgare-har-inte-minskat>; and Wohnen. (2019). *Zahl der Wohnungslosen: BAG Wohnungslosenhilfe: 650.000 Menschen in 2017 ohne Wohnung*. Retrieved 15 October 2019, from http://www.bagw.de/de/themen/zahl_der_wohnungslosen/index.html.

62. For a comprehensive summary of the legal situation in European countries, see MdM legal report.

EXCLUSION OF VULNERABLE GROUPS IN HEALTHCARE SERVICES AND LIMITATIONS OF HEALTH REPORTING

In 2012, governments committed to achieving UHC “with a special emphasis on the poor, vulnerable and marginalized segments of the population” in the UN Resolution on Global Health and Foreign Policy⁶⁴ and, 3 years later, the UN 2030 Agenda for Sustainable Development pledged to put the most marginalised and disempowered at its centre and ensure no one is left behind. This report provides evidence that those excluded from health systems includes the most vulnerable people in Europe: children, including babies and very young children under 5 years and unaccompanied children; pregnant women; homeless people without any shelter; undocumented migrants; and the elderly. These groups closely match the “left behind” groups identified in the SDG outcomes document: “... all children, youth, persons with disabilities (of whom more than 80% live in poverty), people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants”.⁶⁵

The report raises grave and urgent questions about the welfare and health of vulnerable children across Europe. The Convention on the Rights of the Child, which explicitly protects the rights of all children “irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status”, commits governments to “recognize 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”.⁶⁶ But the fact that children – including proportionately higher levels of EU/EEA migrant children – were seeking healthcare from MdM programmes, and not the national health system, shows European governments are failing to provide them with adequate access to healthcare services.

There is growing concern about the plight of the increasing numbers of unaccompanied children – who are at particular risk of neglect, trafficking, abuse, and sexual exploitation and known to have increased healthcare needs – in Europe.⁶⁷ The presence of unaccompanied children in the data supports the concerns that European states are failing to adequately protect and meet the health and welfare needs of these highly vulnerable children. Equally concerning is the evidence that the highest levels of rooflessness were observed in children: almost a third of individuals aged 15–19 were roofless.

The report also highlights the limitations of existing mechanisms to record and monitor access to healthcare services. The “no one left behind” approach of the SDGs recognises that “left behind” groups are usually, not just economically, socially, and politically excluded and disconnected from societal institutions, but also not counted in official data therefore, invisible in the development of policies and programmes. The Social Scoreboard is an example of this. Intended to measure EU member

states’ performance with regards to the principles under the European Pillar of Social Rights, the 2017 Social Scoreboard data showed that 1.7% of the EU population 16+ reported unmet healthcare needs.⁶⁸ However, the Social Scoreboard only collects data from people over 16 years and residing in a private household, meaning all children under 16 and the broad range of people not living in a private residence are not represented in these statistics, which includes, but is not limited to, people who are roofless, those in short-term accommodation (homeless hostels, temporary accommodation, women’s shelters or refugee accommodation, asylum reception centres or migrant workers accommodation), people in health or penal institutions or residential care for elderly people, those living in unconventional or non-residential dwellings (mobile homes, slums or squats), and people with insecure accommodation (living with family or friends or in accommodation without a tenancy). This report shows what a significant omission this is. The data shows there are children within EU borders with inadequate access to healthcare. Similarly, it illustrates the multiple and complex obstacles homeless people face accessing healthcare.⁶⁹ By extension, the omission of the aforementioned groups means their needs are seldom considered in policymaking. Capturing them in this report, provides an opportunity for policymakers to address their healthcare needs.

63. United Nations General Assembly. (2015). Resolution 70/1. *Transforming our world: the 2030 Agenda for Sustainable Development*. Resolution A/RES/70/1. Paragraph 19. New York, NY: United Nations. Retrieved 14 October 2019, from <https://undocs.org/A/RES/70/1>.

64. United Nations General Assembly. (2013). Resolution 67/81. *Global health and foreign policy*. Resolution A/RES/67/81. New York, NY: United Nations. Retrieved 10 October 2019, from https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/81.

65. United Nations General Assembly. (2015). Resolution 70/1. *Transforming our world: the 2030 Agenda for Sustainable Development*. Resolution A/RES/70/1. Paragraph 23. New York, NY: United Nations. Retrieved 14 October 2019, from <https://undocs.org/A/RES/70/1..>

66. United Nations. (n,d). *Convention on the rights of the child*. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with Article 49. Geneva: Office of the High Commissioner for Human Rights. Retrieved 23 October 2019, from <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>.

67. Council of Europe. (2019). *Inadequate protection of unaccompanied children in Greece and France*. Newsletter – March 2019. Retrieved 10 October 2019, from https://www.coe.int/en/web/special-representative-secretary-general-migration-refugees/newsletter-march-2019/-/asset_publisher/cVKOAoroBOTI/content/inadequate-protection-of-unaccompanied-children-in-greece-and-france?_101_INSTANCE_cVKOAoroBOTI_viewMode=view/.

68. The European Commission/Eurostat. (n,d). *European Pillar of Social Rights: social scoreboard indicators*. Retrieved 1 October 2019, from <https://ec.europa.eu/eurostat/web/european-pillar-of-social-rights/indicators/social-scoreboard-indicators>.

69. ETHOS definition: Homelessness consists of housing situations ranging from inadequate housing, insecure housing to houselessness, and finally to rooflessness.

HOMELESSNESS AND HEALTH

In seeking to look at the relationship between housing, access to healthcare services and health, this study found, as has been shown in many previous studies, a relationship between health and housing, with those in more insecure housing reporting worse physical and psychological health. It also found evidence that people experiencing homelessness had lower levels of healthcare coverage and a higher proportion of people with insecure housing with coverage for emergency care only. “Insecure housing” covers those living in conventional accommodation, but without legal rights – for example, people in accommodation

for formerly roofless people, those temporarily living with family or friends, occupation of dwelling with no legal tenancy – and therefore, without paperwork to evidence residency. The relationship between insecure housing and limited healthcare coverage may reflect the fact that accessing services often requires housing-related paperwork – such as proof of address or proof of tenancy – which those in insecure housing are unlikely to have. The link between housing paperwork and healthcare access highlights how the Social Scoreboard’s failure to include those not in private households is a significant omission when looking at

access to healthcare services.

The large proportion of people in precarious housing⁷⁰ situations within the data set (78.5% of respondents) indicates that national health policies fail to include and address the needs of people experiencing homelessness. Although there is an important role health services can play in responding to the needs of homeless people and ensuring homeless people can access them, to achieve UHC and SDG 3, a holistic approach that looks beyond healthcare services and includes housing, as well as finance, employment, and education, must be taken.⁷¹

HEALTHCARE NEEDS OF AN EXCLUDED POPULATION

HEALTH STATUS

Routinely excluded from official data sets, little is known about the health status and healthcare needs of people unable to access mainstream healthcare services, allowing myths and stereotypes around high prevalence of infectious disease to prevail. A systematic review and meta-analysis on mortality rates in migrants by the UCL-Lancet Commission on Migration and Health found a mortality advantage of international migrants in high income countries (except for infectious disease and external causes), but also pointed to the need for improved data collection and reporting in migrant health research. The UCL-Lancet Commission found evidence that in countries with a functioning public health system, individual migrants have an increased personal risk of dying from an infectious disease, but do not spread these infections – contrary to popular myths.⁷² This data provides insight into the prevalence of pathologies in this population; top pathologies such as:

musculoskeletal; respiratory; digestive; circulatory; skin; and psychological.

The data on self-perceived health, which is recognised as a reliable indicator of objective health status and predictor of morbidity⁷³ is particularly useful in populations with little access to health services and diagnosis. A comparison of this self-perceived health data with Eurostat data on self-perceived health collected by the general populations shows that, in this population, a smaller percentage of people reported their health as “good” or “very good” in comparison to the EU (EU-28) general population and a higher percentage of people rated their health as “bad” or “very bad” in comparison to the general population, and this pattern is also reflected at EU member state level. This suggests that this population have worse overall health than the general population and supports outcomes of previous studies, where excluded populations, including migrants, generally report worse self-perceived health than the baseline populations.⁷⁴

LATE PRESENTATION AND ACUTE HEALTH NEEDS

Public and policy debates on UHC often raise the question whether restricted access to healthcare ultimately result in a higher cost to and burden on health services as people present at health services later and with more advanced and complex conditions. Economic modelling, which looked at hypertension and prenatal care in three EU member states, found that providing regular preventive care to undocumented migrants, as opposed to providing only emergency care, is cost-saving for healthcare systems.^{75,76} This report suggests that this population are presenting late to healthcare services: a third of pregnant women had not accessed antenatal care and were in the second or third trimester of pregnancy, and 6.1% of respondents had “emergency only” coverage, meaning they had no option but presenting when health issues had turned acute.

70. Precarious housing cover all types of housing that is not a private flat or house.

71. World Health Organization. (2019). *Healthy, prosperous lives for all: the European Health Equity Status Report*. Copenhagen: WHO Regional Office for Europe. Licence: CC BY-NC-SA 3.0 IGO.

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PUBLIC HEALTH

One of the key arguments for including everyone in health systems is to strengthen public health, ensuring health protection and promotion programmes have maximum reach and impact, and herd immunity is achieved. Concerns about low vaccination uptake and decreasing levels of herd immunity levels have risen in recent years with the resurgence of measles and other vaccine-preventable diseases.⁷⁷ This report provides evidence of unvaccinated children within this population. Because of the sample size and levels of missing data, it is not possible to draw population level conclusions about these vaccination levels; however, the data does suggest vaccination levels are well below the recommended standards by WHO.⁷⁸ Compared to the 2017 Observatory Report⁷⁹ the levels of vaccination are now even lower, which could lead to serious public health threats when herd immunity is weakened.

The issue of unvaccinated children can be linked to restrictive approach to healthcare entitlement for excluded populations. European countries often

take a narrow, communicable disease focused approach to those outside of mainstream health systems, only providing access to communicable disease screening and vaccination programmes. This approach fails to address the range of factors that prevent and deter excluded people from approaching healthcare services. It fails to understand that, for people to feel safe, able and motivated to engage with healthcare services they need to view the service as useful and that their most pressing healthcare needs will be met, rather than subjected to – often stigmatising – screening and vaccination programmes.

SEXUAL AND REPRODUCTIVE HEALTH

Sexual and Reproductive Health and Rights (SRHR) are a vital precondition for gender equality and non-discrimination. Represented as one of the SDG targets, SRHR are at the core of sustainable development. To ensure UHC and the principle of leaving no one behind, the specific needs of women and girls must be included within an essential package of service.

Despite progress in recent years to decrease maternal mortality, the rates of preventable deaths are still unacceptably high. In 2017, 810 women died every day from preventable causes related to pregnancy and childbirth.⁸⁰ The Lancet Commission on Migration and Health's review of pregnancies in Europe showed migrant populations had an increased risk of perinatal mortality, preterm birth, low birth weight, and congenital malformations.⁸¹

Antenatal care is essential for reducing the risk of complications during pregnancy and birth. WHO estimate perinatal deaths can be reduced by up to 8 per 1,000 births when a minimum of eight antenatal appointments are completed during pregnancy compared to only four visits and recommend first antenatal appointment in the first 12 weeks.⁸² Yet our data shows that over three-fifths of pregnant women who responded had not accessed antenatal care prior to visiting an MdM programme (66.9%) and 32.3% had not accessed antenatal care and were in their second or third trimester of pregnancy, which is beyond the WHO recommended stage for antenatal care.

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METHODOLOGY AND LIMITATIONS

The purpose of this report is to undertake common data collection process in order to generate robust data, analysed, and validated by an epidemiologist. In total, 29,359 people attended the MdM programmes in seven countries in Europe (Belgium, France, Germany, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018. In these countries, MdM conducted a total of 71,094 consultations (42,178 medical consultations and 28,916 social consultations).

DATA SOURCE

Both quantitative data and testimonies for this report were taken from face-to-face consultations at 14 MdM health centres (from Belgium, France, Germany, Luxembourg, Sweden, Switzerland, and the United Kingdom) by volunteer doctors, nurses, and support workers. Data were collected throughout 2017 and 2018 consisting of two core parts – social and medical consultations. Social consultations focused on social determinants of health such as housing status, health access, and health coverage. Medical consultations focused on issues such as medical history, current health status, pregnancy, and vaccination status. Within medical consultations, specific diagnoses were recorded using the ICPC-2 (International Classification of Primary Care – second edition) pathology classification system. However, diagnoses from Germany in 2018 were recorded using ICD-10 (International Classification of Diseases – 10th version) pathology classification system. Most of these ICD-10 diagnoses were converted into ICPC-2, yet it was not possible to convert all codes.

In all countries except France, 100.0% of the individuals who were surveyed for the observatory social or medical data collection have been included in the report. The data from MdM France excludes individuals who had their first social consultations earlier than 2017, but returned for either a social and/or medical consultation during 2017 or 2018. This data does not include any consultations with specialists.

Individuals may have had multiple face-to-face social or medical consultations. We analysed data using one social consultation record and one medical consultation record per individual. The first consultation record was selected for an individual. If an individual had more than one consultation on the same day or a consultation date was not recorded, the record that contained the most completed data was selected. An algorithm was used to score and identify the records with the most completed demographic data and key points of study. Where an individual had multiple records on the same day and if they had equal levels of completion, one was randomly selected.

There are two exceptions to this rule. First, as the data used in Figure 2 (in section “Who We Saw”) provides an overview of all consultations by country in 2017 and 2018, all data are included and therefore, Figure 2 contains duplicate records for individuals. Second, pathology data consisted of all pathologies recorded for each person from all their medical consultations – there was no exclusion or selection process and as a result, individuals may appear in this dataset more than once, dependant on how many pathologies were reported.

STATISTICS

Before analysing the data, all variables were standardised such that the answers to questions were consistent in type across the MdM health centres. For example, immigration status as provided according to each country’s status was equated to a set of statuses as defined by the International Observatory. Country of origin was used to classify individuals into nationals, EU/EEA migrants, and non-EU/EEA migrants. Data are presented throughout the Observatory Report as either simple counts or crude percentages – no weighting of percentages was performed.

LIMITATIONS

The data used in this 2019 Observatory Report were collected as part of the MdM health centre operations and as a result many items presented contained high levels of missing data. This has been reported routinely in the figure notes and highlighted in the report in situations where missing data may be particularly important to consider, as it is likely to bias comparisons between groups. It is also important to note that some variables were not collected by all countries and so underlying data for each figure is not necessarily representative of all included MdM health centres. The individuals attending consultations at the MdM health centres were not a random sample. The results should be considered to describe the issues of excluded populations seen by MdM, but not as representative of excluded populations more generally within each partner country. However, the individuals seen in the MdM health centres include some of the most vulnerable and marginalised within society who are not included in a majority of routine and vital statistics systems. Therefore, this report is an important source of information on some of the most excluded individuals of society. Classification of individuals into nationals, EU/EEA migrants, and non-EU/EEA migrants by country or origin has limitations as country or origin does not necessarily equate to nationality or citizenship. It does not take into consideration the possibility of dual nationality.



MdM Belgium: a volunteer doctor performing a medical examination on a homeless patient in the Medibus in Brussels

CONTRIBUTORS AND ABBREVIATIONS

ABBREVIATIONS

CPAS	Public Centre for Social Action
EEA	European Economic Area
EHIS	European Health Interview Survey
EPIM	European Programme for Integration and Migration
ESF+	European Social Fund Plus
EU	European Union
EU-SILC	European Union-Statistics on Income and Living Conditions
GP	General practitioner
HBV	Hepatitis B vaccination
HIV	Human immunodeficiency virus
ICD-10	International Classification of Diseases – 10th edition
ICPC	International Classification of Primary Care
ICPC-2	International Classification of Primary Care – 2nd edition
JAF	Joint Assessment Framework
MdM	Médecins du Monde/Doctors of the World
MFF	Multiannual Financial Framework
MMR	Mumps, measles, and rubella
MRI	Magnetic resonance imaging
NEF	Network of European Foundations
OSF	Open Society Foundation
SDG	Sustainable Development Goal
SImP	Social Imbalance Procedure
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
TB	Tuberculosis
UCL	University College London
UHC	Universal Healthcare Coverage
UN	United Nations
WHO	World Health Organization

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