Between Law and Reality: A Comparison on Access to Health Care for Undocumented Migrants in France, Italy and Switzerland

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ABSTRACT:

Undocumented migrants often suffer from poor living conditions and face many challenges in receiving access to health care. Reacting to this, France, Italy and Switzerland implemented different provisions aimed at granting access to the national health system for undocumented migrants living in the country. These systems differ significantly depending on the type of national health care system, the financing method and whether or not a separate scheme for undocumented migrants exists. This article analyses the laws and practices in these countries in light of the human rights principle of accessibility, and its elements of non-discrimination, physical accessibility, economic affordability, and information accessibility. Through this comparative analysis, the article evaluates the impact of different solutions on the respect of the human right to health care, identifies the main obstacles to the effective implementation of the principle of accessibility, and proposes policy recommendations for the full implementation of the right to health care. The article concludes in favour of the adoption of a human-rights approach in order to bridge the gap between law and reality.

A menudo, los migrantes indocumentados se enfrentan a malas condiciones de vida y a diversos desafíos que limitan su acceso a la atención médica. Para resolver este problema, Francia, Italia y Suiza han adoptado diferentes disposiciones legales destinadas a permitir acceso al sistema nacional de salud para migrantes indocumentados que viven en el país. Estos sistemas cambian considerablemente según el tipo de sistema nacional de salud, el método de financiación y si está previsto un sistema alternativo para los migrantes indocumentados. El objetivo de este artículo es

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realizar un análisis comparativo, bajo un enfoque de derechos humanos, sobre las disposiciones legales y las practicas reales, a la luz del principio de accesibilidad y de los elementos de no discriminación, accesibilidad física, económica y de las informaciones. A través de este análisis comparativo, el artículo evalúa el impacto de diferentes soluciones referente al respeto hacia el derecho humano sobre cuidado de la salud; identifica los principales obstáculos para la efectiva implementación del principio de accesibilidad, y propone recomendaciones políticas para la plena implementación del cuidado de la salud. El artículo concluye en favor de la adopción de un enfoque de derechos humanos para disminuir paulatinamente la brecha entre derecho y realidad.

1. INTRODUCTION

The recent increase in the influx of migrants in the European Union, and the consequential increase of the number of migrants in an irregular situation, has been accompanied by growing concerns regarding the respect of their human rights, as well as claims of financial and demographic overburden of national social security systems. On the one hand, Norman in the Lancet contends that “access to health care throughout European countries is increasingly being used as a weapon in immigration control”, and that the European countries “[make] a farce of the UN conventions that they have all ratified.”¹ On the other hand, immigration is accused of being at the roots of the lowering of wages and of the “destabilization of our society and its balances.”²

Undocumented migrants are particularly vulnerable to human rights violations, and often suffer from the consequences of poor and precarious living conditions which entails a negative impact on their health situation. Despite what has been called the “healthy migrant effect,”³ meaning that usually international journeys are undertaken by the healthiest and youngest share of the population, the level of health care in the country of destination is often negatively affected by factors including the lack of preventive health care in the country of origin, experiences of violence

during the journey and their housing and working conditions in the country of destination.\textsuperscript{4} With regard to the latter, the majors factors of vulnerability include unheated and overcrowded accommodation\textsuperscript{5}, non-respect of the labor standards on occupational safety and health and consequent high incidence of work accidents, feeling of precariousness and instability and, lastly, the impossibility or unwillingness to refer to the national health care system, which will be object of analysis in the following paragraphs.\textsuperscript{6} Many undocumented migrants suffer from mental issues, in particular the Chronic and Multiple Stress Syndrome (so-called Ulysses syndrome)\textsuperscript{7} and other forms of anxiety and depression connected to the sense of precariousness and the fear of being

\textsuperscript{4} Amet Suess et al., The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context, 24 EUR. J. OF PUB. HEALTH 712, 717 (2014).

\textsuperscript{5} As underlined by the theory of “interdependence of rights”, different social rights have a strong influence on each other, which can be either positive or negative in different situations. For instance, when the right to housing and to decent living conditions, including safe and drinkable water, is not respected, this can have a negative impact on the right to health care. See Luca Bicotcchi & Michele LeVoy, UNDOCUMENTED CHILDREN IN EUROPE: INVISIBLE VICTIMS OF IMMIGRATION RESTRICTIONS, 9, 66-69 (PICUM, 2009).


\textsuperscript{7} PICUM, Workpackage No. 6, supra note 6, at 3-4.
deported, as well as chronic and infectious diseases and dental problems. Additionally, many undocumented migrants work in the informal economy, and are thus often excluded from basic social rights including sickness benefit. Moreover, their unstable legal position leads to the fear of losing their job in case of prolonged absence, and further limits their possibility to see a doctor or spend time at home to recover from illness. Lastly, *Médecins du Monde* (Doctors of the World) remarked how the European economic crisis further endangered undocumented migrants’ health conditions, as it generated a vicious circle in which worsened living conditions led to higher needs in terms of health care, whose higher costs could not be sustained by the migrants due to the impaired economic situation.

While achieving certainty on the number is a close-to-impossible mission, recent official estimates fluctuate between five and eight million and two to four million of undocumented migrants in Europe. According to Article 5 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, “undocumented migrants” are those who do not comply with the national legislation and international agreements concerning the entrance, stay and employment in the host State. Depending on the national legislation, they may become so because they enter a country irregularly, or because they remain in the country after the expiration of their visa or after their asylum application has been refused. While undocumented

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9 PICUM, *Workpackage No. 6, supra* note 6, at 4.
migrants vary broadly with regard to age, country of origin, social and economic integration, living conditions and genders, a large portion are between 20 and 40 years old, and live in poor housing conditions, having insecure and instable economic resources.¹⁴

This article aims to analyze the possible responses to the problem of ensuring access to health care for undocumented migrants in Europe, through the comparative study of the French, Italian and Swiss systems, which provide undocumented migrants with access to health care beyond emergency. The selection of the countries has been guided by the twofold purpose of assessing solutions from a broad spectrum of different health care systems and comparing the obstacles arising in countries whose legal frameworks recognize to a wide extent the right to health care for undocumented migrants. While the Italian health care system is based on universal coverage and is financed through universal taxation, the French and Swiss systems are mainly insurance-based. In Switzerland, undocumented migrants can register with the national health insurance under the same conditions as citizens, upon payment of the insurance fees, while in Italy and France migrants have access to treatments free of charge through a separate channel distinct from the one available for the rest of the population. Despite these differences, common challenges hinder effective access to health care for migrants in an irregular situation, and in all these countries undocumented migrants’ human right to health care is not fully respected.

Firstly, the article will analyze the international human rights framework on the right to health care, and its application to undocumented migrants. In particular, it will focus on the General Comment No. 14 of the Committee on Economic, Social and Cultural Rights, which sets the principles of availability, accessibility, acceptability and quality. Secondly, it will examine how undocumented migrants’ right to health care is addressed at the European level, under instruments adopted by both the European Union and the Council of Europe, and it will present a brief review of the literature available on the right to health care for undocumented migrants in Europe. Thirdly, the national legal frameworks in France, Italy and Switzerland will be presented, with the purpose of comparing different solutions in terms of levels of entitlement, financing system and means of

implementation. Lastly, these laws, as well as their practical implementation, will be analyzed in the light of the human rights principle of accessibility, and its sub-elements of non-discrimination, physical accessibility, economic affordability, and information accessibility.

Through this comparative analysis, the article aims at evaluating the impact of different solutions on the respect of the human rights to health care, and at identifying the main obstacles to the effective implementation of the principle of accessibility. In conclusion, four main policy recommendations are suggested: the adoption of legal provisions granting access to health care to undocumented migrants and implemented equally and effectively throughout the nation; the creation of a safe environment in which migrants can access public services without fearing identification or deportation; the economic affordability of the system, which includes the adoption of measures granting fees reductions for those in need, and the promotion of information and awareness campaigns among health personnel, immigration authorities and migrants themselves.

2. THE HUMAN RIGHT TO HEALTH CARE AND THE PRINCIPLES OF AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY

Enshrined in several binding and non-binding international instruments, access to health care is a fundamental human right to which every person is entitled independent of his or her

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15 The Convention on the Rights of the Child (CRC) grants all children “the enjoyment of the highest attainable standard of health.” Convention on the Rights of the Child, art. 24, November 20, 1989, 1577 U.N.T.S. 3; The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) prohibit any form of discrimination in any field including health care with regard to gender. Convention on the Elimination of All Forms of Discrimination against Women, art. 12, December 18, 1979, 1249 U.N.T.S. 13; The International Convention on the Elimination of All Forms of Racial Discrimination (CERD) prohibit any form of discrimination in any field of public life including health care with regard to race, color, descent, or national or ethnic origin. International Convention on the Elimination of All Forms of Racial Discrimination, art. 5, December 21, 1965, 660 U.N.T.S. 195; With specific regard to migrants’ rights, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) affirms the right for all migrants, included undocumented ones, to receive health care “urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned.” International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, art. 28, December 18, 1990, 220 U.N.T.S. 3; Lastly, within the framework of the International Labour Organization, whose Preamble to its Constitution includes the protection of “the interests of workers when employed in countries other than their own”, the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) includes undocumented migrants in its of application, granting equality of treatment in respect of social
administrative status. According to Article 25 of the Universal Declaration of Human Rights, “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care […].” On a similar tone, article 12 of the International Covenant on Economic, Social and Cultural Rights imposes on its State parties (166 as of January 2018 including all the European Union member States and Switzerland) the duty to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

The International Covenant on Economic, Social and Cultural Rights lays down the obligation of the State members to respect, protect and fulfill the human right to health care, which includes the negative obligation to not interfere with enjoyment of this right, the positive obligation of preventing any interference from third parties, and the positive obligation to adopt appropriated legislative, administrative, financial and social measures to fully realize this right. In its General Comment No. 14 on the Right to the Highest Attainable Standard of Health (Art. 12), the Committee on Economic, Social and Cultural Rights elaborated four “interrelated and essential elements” which compose the right to health care. These elements are its availability, accessibility, acceptability and quality. Firstly, the element of availability refers to the physical presence of the health care facilities, goods and services in sufficient quantity, including “the underlying determinants of health, such as safe and potable drinking water and adequate sanitation security rights (including health care) arising out of past employment in the receiving country. Convention No. 143 Migrant Workers (Supplementary Provisions), art. 9(1), General Conference of the International Labour Organization, 60th Sess., adopted June 24, 1975 (ratified by 23 countries).

20 General Comment No. 14, supra note 19, at ¶ 12.
facilities, access to drinking water and adequate sanitation.”21 Secondly, the *accessibility* of the service refers to the respect of the principle of non-discrimination of all persons within the jurisdiction of the State, and includes four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility. Thirdly, the *acceptability* of the service refers to the respect of medical ethics and of the culture of the beneficiaries, as well as the principle of confidentiality. Lastly, the *quality* of the facilities and services mean that “goods and services must also be scientifically and medically appropriate,”22 and includes medical skills and adequate sanitation. According to the Committee, the application of these elements is dependent on the particular conditions implemented by each State, and, due to their intercorrelation, the full right of health care can be attained only upon fulfilment of all of these criteria.

The elements of *availability, acceptability* and *quality* mainly refer to the general health system implemented at the State level, which needs to be organized and financed adequately in order to ensure that facilities, goods and services are sufficiently available, ethically appropriate and of high quality standards. The fulfilment of these criteria generally refers to the financial means and the structure of the national services, and thus affects migrants and non-migrants on an equal level. On the opposite, the criterion of *accessibility* explicitly includes the respect of the principle of non-discrimination, and therefore refers to the equal treatment of all persons within the jurisdiction of the State, and the fulfilment of the obligation to refrain “from denying or limiting equal access for all persons, including […] asylum-seekers and illegal immigrants, to preventive, curative and palliative health services.”23 Hence, in this article the level of access to health care for undocumented migrants as compared to documented migrants and national citizens will be analyzed in the light of the principle of accessibility, and in particular through the lenses of its sub-elements of non-discrimination, physical accessibility, economic accessibility and information accessibility.

3. THE RIGHT TO HEALTH CARE FOR UNDOCUMENTED MIGRANTS IN EUROPE: VAGUE EUROPEAN STANDARDS AND VARIEGATED NATIONAL SOLUTIONS

The Charter of Fundamental Rights of the European Union, which became legally binding following the ratification of the Treaty of Lisbon, in 2009, states that “[e]veryone has the right of

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21 General Comment No. 14, *supra* note 19, at ¶ 12(a).
22 General Comment No. 14, *supra* note 19, at ¶ 12(d).
23 General Comment No. 14, *supra* note 19, at ¶ 34.
access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.”

With regard to undocumented migrants, the European Parliament resolution of 8 March 2011 on Reducing Health Inequalities in the EU recommends that States ensure equitable access to health care for “most vulnerable groups, including undocumented migrants,” and “assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation.” The resolution further acknowledges the impact of socio-economic inequalities on effective access to health-care, and calls on States to “press ahead with their efforts … on the basis of the universal values of human dignity, freedom, equality and solidarity.” Despite the importance of these steps, there has been hitherto no European Directive establishing minimum rights standards for undocumented migrants, except as regards the situation of undocumented migrants who have been identified by the authorities and who are either in detention centers or have been granted a leave of seven to thirty days prior to voluntary departure. In only those situations, the Return Directive grants the right to emergency health care and essential treatment of illnesses, and requires the States to take into consideration the particular causes of vulnerability. The insufficient commitment, or lack of political will, to undertake effective measures enhancing undocumented migrants’ rights is demonstrated by a recent Communication of the European Commission, which commented on the lack of ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families among the European Union countries affirming that “[t]he insufficient distinction

24 Consolidated Version of the Treaty on European Union art. 6(1), May 9, 2008, 2008 O.J. (C 115) 19. (emphasis added).
26 Id. at ¶ 4.
in the Convention between the economic and social rights of regular and irregular migrant workers is not in line with national and EU policies, and has therefore become a fundamental obstacle.\textsuperscript{28}

Under the framework of the Council of Europe, the Resolution 1509 (2006) on Human Rights of Irregular Migrants has gone beyond the right to emergency health care, encouraging states to “seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly.”\textsuperscript{29}

Moreover, Article 13 of the European Social Charter requires that the States ensure that affordable assistance and health care is provided to \textit{all destitute persons},\textsuperscript{30} and that should ensure equal treatment between their nationals and nationals of other state parties.\textsuperscript{31} Even though this last provision refers only to documented migrants, the European Committee for Social Rights stated that any denial of emergency care to migrants, including those in an irregular situation, should be considered contrary to Article 13(4) of the Charter.\textsuperscript{32} Lastly, in 2011, the Committee of Ministers of the Council of Europe adopted a Recommendation on mobility, migration and access to health care,\textsuperscript{33} based, among others, on the contributions of international NGOs working with undocumented migrants and explicitly affirming the need to pay special attention to the entitlement to health services of migrants in an irregular situation.\textsuperscript{34}


\textsuperscript{30} See \textit{Id.} at Art. 13(1) & (3). (emphasis added)

\textsuperscript{31} See \textit{Id.} at Art. 13(4).


\textsuperscript{34} \textit{Id.} at art. 8(d). In particular, this Recommendation sets policy guidelines on the collection of migration health data, on the provision of adequate entitlements, and on the organization of accessible, high-quality services. Among the measures recommended to the States, particularly relevant in the framework on access to health care for undocumented migrants, is the prohibition of requesting health care providers to inform the migration authorities, as well as the promotion
At the national level, European Union member states adopted, in the last decades of the 20th century, a series of measures conferring a diverse range of rights to undocumented migrants, varying from ensuring access to emergency care upon payment of full costs to granting access free of charge to primary and secondary treatments. These different policies have been object of different comparative analyses since 2000, and in particular from 2009 onwards, which aimed to classify the countries in different categories according to the level of access to health care to which undocumented migrants are entitled. Between 2009 and 2012 alone, 27 comparative studies were written on this topic, evidencing great differences among European countries.

These studies highlight that all European countries grant undocumented migrants access to emergency health care; however, in some countries the payment of the full costs of the treatment is imposed on the migrants themselves, who normally cannot afford them. Moreover, the concept of emergency is often not exhaustively defined, which leads to risk of discretionary interpretations or inequality among regions or municipalities. Besides emergency care, the level of access to health care has been analyzed by asking three technical questions: which subcategories of undocumented migrants are covered, which type of services are included and who pays for the

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35 After the second world war, the migration flow in Europe was characterized by the orientation towards the labour market needs, which led to the idea of “selecting” healthy workers who would contribute to the national economy for a limited period before returning to the home country, and to the total absence of integration policies. Following the economic crisis in the 1970s, raising unemployment, the prolonged stay of many migrants entered through short-term programs, as well as the arrival of families or the birth of children in the host countries, lead to a different framework in which need for integration programs and the inclusion in the health system became quickly evident. P. Bollini, Health for Immigrants and Refugees in the 1990s: A Comparative Study in Seven Receiving Countries, 6 INNOVATION: THE EUROPEAN J. OF SOCIAL SCI. RES. 101, 101-10 (1993); S. Cattacin, et al., Politique de migration et politique de santé en Europe. Des normes aux pratiques.7 (Geneva, Eris, 2009).


37 Suess et al., supra note 4, at 821-22.


39 PICUM, Workpackage No. 6, supra note. 6, at 8; PICUM, Access to Health Care for Undocumented Migrants in Europe 8 (Brussels, PICUM, 2007).
services. In order to provide an answer, different factors should be taken into consideration: the financing system, the coverage envisaged by the national health care system, the level of cost-sharing and the basis of entitlement. Accordingly, European countries have been classified in three clusters: countries where there is no access to health care, countries granting minimum access to health care, and countries granting full access to health care for undocumented migrants. These three cluster, as suggested by PICUM, reflect different levels of interrelation between migration policies and health policies: in the first group, there is a strict connection between access to health and migration policies, and therefore access to health care is severely limited for those who do not comply with immigration rules; in the second, there is a certain link between the level of social intervention and the administrative status of the individual, which leads to different degrees of differentiation between nationals and non-nationals; lastly, in the third one there is complete independence of migration and health policies, as human right values are considered to have autonomy with respect to migration policy.

The three countries which will be analyzed in this article, France, Italy and Switzerland, have been almost unanimously included in the cluster granting the highest access to health care for undocumented migrants, and where therefore migration and health policies have a quite strong degree of autonomy. Moreover, these three countries are representative of the widest spectrum of answers to the three technical questions presented above, as the Italian system is tax-based and aims at universal coverage, the French system collects contributions through the local government and Switzerland operates through privatized and canton-based social insurance funds. The following section will study in more detail the national systems of these three countries, analyzing the conditions of entitlement, the services included and the financing provisions.

42 Cattacin et al., supra note 35, at 10.
43 According to Cuadra’s study, there is no direct relation between the financing system adopted by a state and the different level of degree of access to health care. The author suggests, as an alternative explanation, that one of the reasons for which some European countries grant a higher level of health protection for undocumented migrants can be the relationship between the welfare state and the labor market economy, and the relationship between formal and informal economy. Cuadra, supra note 41, at 268-70.
4. THE NATIONAL LEGISLATIVE FRAMEWORK: ENTITLEMENTS, COSTS AND CONDITIONS

4.1. FRANCE

In France, the Preamble of the 1948 Constitution, integrated by the 1958 Constitution, grants to everyone the protection of health (Elle garantit à tous, notamment à l'enfant, à la mère et aux vieux travailleurs, la protection de la santé). Historically, the principle of universal health coverage has been first introduced in 1999 through Law 641 of 1999, which instituted the CMU (Couverture Maladie Universelle) and aimed to ensure higher levels of protection for those people with lower incomes (Article 1). At the same time of the entrance into force of the CMU, in 2000, a separate system, the so-called State Medical Assistance (Aide Médicale de l’Etat, AME) was created for undocumented migrants.

Since January 2016, the Health Coverage (Couverture Maladie Universelle, CMU) was reformed into the Universal Health Protection (Protection Universelle Maladie, PUMA), with the aim of simplifying the access procedure and the registration conditions. Nonetheless, two separate systems still apply to documented and undocumented migrants, granting entitlement to different levels of treatment and care. As a consequence, on the one hand, every migrant regularly

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44 1958 CONSTITUTION, Preamble (Fr.).
45 1947 CONSTITUTION, Art. 11 (Fr.).
47 The CMU was divided in “basic coverage” and “complementary coverage,” which addressed the most economically vulnerable groups of the population ensuring fees reduction and financial coverage of additional treatments (i.e. dental and ophthalmologist care). While the “basic coverage” is now completely abolished, the “complementary coverage” continues applying upon the same income conditions.
49 Historically, French social security system did not discriminate based on nationality or migration status, until in 1993 “Loi Pasqua” introduced the requirement of a regular permit in order to register with medical insurance. This reform, which introduced for the first time in France a limit to the principle of universal access to health care, has been validated by a decision of the Constitutional Court, which stated that "les étrangers qui résident et travaillent régulièrement sur le territoire français et ceux qui ne satisfont pas aux mêmes conditions de
and permanently residing in the country (“résidant de manière stable et régulière”\textsuperscript{50}) has access to the general French health care system through PUMA, while, on the other hand, AME applies to undocumented migrants, providing them with basic access to healthcare services.

In order to register with AME, a migrant must prove his or her identity, the continuous residence in France for more than three months consecutively, and that his or her income lies below a fixed threshold.\textsuperscript{51} However, the minimum residence condition does not apply to children, who should have access to AME from the first day of arrival.\textsuperscript{52} As remarked in many critiques, AME beneficiaries are entitled to a partially different set of treatment as compared to PUMA beneficiaries, and the gap between the two systems has been further increased by the financial reform in 2010.\textsuperscript{53} Moreover, beneficiaries of AME are excluded from “Carte Vitale”, which allows for reimbursement of medicines’ costs.\textsuperscript{54} Another difference between the two systems regard the source of financing, as PUMA is funded through state-collected contributions, while AME relies on budgetary credits, which makes it vulnerable to fluctuating governmental politics reflected in

\textsuperscript{50} CODE DE LA SÉCURITÉ SOCIALE [SOCIAL SECURITY CODE], art. L111-1, 380-1 (Fr.).
\textsuperscript{54} Maille & Touiller, supra note 53, at 31.
ever-changing circulars and reforms. Once issued, AME is valid for one year, after which it can be renewed upon re-presentation of all the necessary documentation.

Lastly, undocumented migrants who are not eligible or not registered to AME have the right to urgent and basic health care, through the healthcare access department (Permanence d’accès aux Soins de Santé, PASS), which include treatment in life-threatening situations and when the absence of care would lead to serious and lasting health deterioration, care for avoiding the spread of a disease, maternity and birth-related care, abortions and children care. For this purpose, a special fund has been introduced in 2004 (Fonds de Soins d’Urgence), which is paid to the hospitals by the state on a case by case basis, upon evidence of urgency and of lack of any other coverage.

4.2. ITALY

The Italian health system is based on the principle of universal coverage, as foreseen by Article 32 of the Constitution which states that every individual has the right to health care. Registration to an insurance is not required, and the system is financed through general taxation as well as moderating fees (“ticket”). While the regions have competence with regard to the

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57 CODE DE L’ACTION SOCIALE ET DES FAMILLES [CODE OF SOCIAL ACTION AND OF THE FAMILIES], art. L254-1-L254-2 (Fr.).
organization of the health care system, minimum essential levels are established at the state level,\textsuperscript{59} and include the principle of equality between nationals and non-nationals.\textsuperscript{60}

Migrants’ entitlement to health care was notably extended for the first time with the reform of the migration framework in 1998, and in particular law 40 of 1998, the so-called “Turco-Napolitano” and the Unified Text on Migration.\textsuperscript{61} In particular, these laws granted to all migrants on the territory of Italy the right to receive urgent, essential and continuing care, both outpatient and inpatient, including preventive medicine programs to safeguard individual and collective health, pregnancy and maternity protection, protection of minors, mandatory vaccinations and prevention, diagnosis and treatment of infectious diseases, going much beyond the previous limitation to emergency care.\textsuperscript{62} While different systems apply to regular migrants based on their origin and their length of stay in the country, migrants in an irregular situation have access to these treatments through the “Foreigner Temporary Present” code (STP), which is issued free of charge by the hospital administration or the local health administration (ASL).\textsuperscript{63} The code can be issued any time, either at the moment when the treatment is given or before, and is valid for six months, after which it can be renewed.\textsuperscript{64} In order to receive the code, the undocumented migrants must fill a form with his own information, but does not need to show a proof of identity.\textsuperscript{65} At the time of provision of the treatment, undocumented migrants can fill in another form to request the “destitution status” (“\textit{stato di indigenza}”), which testifies to their situation of poverty and exempts them from paying the “\textit{ticket}” at the same conditions of citizens.\textsuperscript{66} In this case, the costs of urgent

\begin{itemize}
\item \textsuperscript{59} Art. 117(2) Costituzione [Cost.] (It.).
\item \textsuperscript{60} \textit{Accordo Stato - Regioni del 2013} [Agreement State-Regions of 2013] G.U. n. 32, 7 febbraio 2013 - Suppl. Ordinario note 9 (It.).
\item \textsuperscript{61} Legge 12 marzo 1998, n. 40, G.U. Mar. 12, 1998, n.59, Supplemento ordinario, n. 40 (It.);
\item \textsuperscript{62} Law 1998 No. 40, \textit{supra} note 62, at Art. 33(3); T.U. Immigrazione, \textit{supra} note 62, at Art. 35(5).
\item \textsuperscript{63} Decreto Presidente della Republica 31 agosto 1999, G.U. Nov. 3, 1999, n.258, Supplemento Ordinario n. 190, Art. 43 (It.);
\item \textsuperscript{64} Circular of the Ministry of Health No. 5 of 24 March 2000 (Circular 2000 No. 5) G.U. n. 126 del 1 Giugno 2000, section 2 (It.).
\item \textsuperscript{65} \textit{Id.} at §2.
\item \textsuperscript{66} In this case, the hospital will issue a code “X01” which is valid only for the single treatment and must be issued again each time. This code is valid nonetheless only for urgent and essential
\end{itemize}
and essential care are covered by the Ministry of Interior, while the costs of preventive care and care for public health reasons are covered by the National Health Fund. Nonetheless, while the STP code is renewable, the declaration of destitution must be requested again every six months. Some kinds of treatment (including emergency care, basic essential care, ambulatory urgent treatment with direct access, maternity care and care for children and elderly as well as outpatient treatment of contagious and chronic diseases) are always exempted from payments.

The extension of the treatments to which undocumented migrants are entitled has been the object of numerous decisions of the Constitutional Court and the Court of Cassation, which unanimously reaffirmed that the level of care goes beyond emergency care and should include all treatments necessary for the life of the person, and that the “essential core” of the right to health enshrined in Article 32 of the Constitution is an inviolable right to which every person is entitled independent of his or her migration status. Nonetheless, differently than migrants in a regular situation, undocumented migrants cannot register with the National Health System (Sistema Sanitario Nazionale, SSN), and thus do not have access to a General Practitioner, which is necessary to access secondary and specialist ambulatory care, home visit and specialized exams.

4.3. SWITZERLAND

According to the Swiss Federal Constitution, the Confederation and the Cantons share responsibility to ensure that everyone has access to health care, and the Cantons have the duty of

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67 T.U. Immigrazione, supra note 62, at Art. 35(6), 43(4), 43(5); Circular 2000 No. 5, supra note 65, at section II.

68 Circular 2000 No. 5, supra note. 65, at section II.


72 CONSTITUTION FÉDÉRALE [CST] [CONSTITUTION] Apr. 18, 1999, art. 41(b) (Switz.).
providing assistance to people in need who reside in their territory.\textsuperscript{73} Based on a strict interpretation of the principle of subsidiarity, enshrined in Article 3 of the Constitution, the Confederation can take general decisions on medical insurance, while the competence to organize health care and prevention lies within the Cantons.\textsuperscript{74} As a consequence, each Canton in Switzerland has the right to establish a different health care system, which leads, potentially, to 26 different systems.\textsuperscript{75} Traditionally, the Swiss health system has been shaped by the predominance of a free market ideology ("liberal" or "residual" approach\textsuperscript{76}) and by a high level of decentralization and federalism, both factors which until very recently limited the impact of any State-led intervention.\textsuperscript{77}

In 1996, this trend was partially reversed when the Federal Law on Health Insurance (\textit{Loi fédérale sur l’assurance maladie} - LAMal) introduced for the first time the principle of compulsory registration to an insurance company.\textsuperscript{78} According to Article 3 of said law, every person residing in Switzerland has the right and the obligation to register with a health insurance, with the sole requirement of having resided in the country for more than three months, with no further condition of nationality or regular status. In order to address the frequent, yet illegal, practices of restrictive interpretation of the law, the Federal Office of Social Insurances (Office Fédérale des assurances sociales, OFAS) issued a directive of in 2002\textsuperscript{79} reaffirming the equal application of this principle to undocumented migrants.

\textsuperscript{73} \textit{Id.} at art. 115.
\textsuperscript{74} Cattacin et al., \textit{supra} note 35, at 89.
\textsuperscript{75} W. Achtermann, C.Berset, \textit{Les Politiques suisses de santé, Potentiel pour une politique nationale} 30 (Berne, Office fédéral de la santé publique, 2006).
\textsuperscript{78} This change can be reconducted to three factors: the diffusion of HIV/AIDS and the increasing problems of drug-addiction which led to the need of a national strategy to increase prevention, the increase in the number of precarious jobs which did not allow to finance insurance affiliation, and the new WHO strategy of “health for all”. See Cattacin et al., \textit{supra} note 37, at 89.
\textsuperscript{79} \textit{Directive: Affiliation des sans-papiers} [Directive on the registration of undocumented migrants] Circulaire 02/10, December 19, 2002 (Switz.).
Under the current system, while every person is responsible for registering with an insurance company, they have the duty to accept them, and the Cantons must ensure that every person residing in their territory is covered by a health insurance.80 Additionally, undocumented migrants in gainful employment are also embraced by the scope of application of the Swiss accident insurance Law (Loi fédérale sur l’assurance-accidents - LAA), according to which every person employed in the Swiss territory shall be insured against risks of accident and work injuries.81 Compared to France and Italy, the provision of health care in Switzerland is highly privatized, and financed mainly through individual contributions paid directly to the private insurance companies, which cover 62 % of the total cost, while the rest is funded by the state (32%) and the employers (7%).82

The conditions to register for a health insurance are the same for documented and undocumented migrants, and include the provision of the full name and birth information, a valid address and a bank account number (which can also be provided by someone else), as well as the payment of monthly insurance premiums and annual fees.83 The basic health insurance covers exams, treatments and care given at home, in hospitals or medical establishments, maternity and childhood care, abortion, preventive measures, as well as psychotherapy and rehabilitation when prescribed by a doctor.84 In case of destitution, Article 65 LAMal foresees an exception to the payment of insurance premiums and fees, providing the possibility to grant a fee reduction to applicants whose income falls below a certain threshold.85 Nonetheless, the competence to decide the criteria of eligibility lies within the Cantons themselves, which have adopted very different

80 Ordonnance sur l’assurance-maladie [Ruling on Health Insurance] [hereinafter OAMal] RS 832.102, June 27, 1995 (as amended), art. 1 (Switz.); Loi fédérale sur l’assurance-maladie [Federal Law on Health Insurance] [hereinafter LAMal] RS 832.10, March 18, 1994 (as amended), Art. 6 (Switz.); Tribunal fédérale [TF] [Federal Court] Judgment, Dec. 24, 2002, K28/01 (Switz.).
83 Bilger & Hollomey, supra note 77, at 25.
84 LAMal, supra note 80, at Art. 24-31; Rs 832.112.31 Ordonnance du DFI du 29 septembre 1995 sur les prestations de soins obligatoires en cas de maladie (OPAS) [Rs 832.112.31 Order of Sept. 29, 1995 on benefits in compulsory health insurance in the event of illness (OPAS), RS 832.112.31, September 29, 1995 (Switz.).
85 LAMal, supra note 80, at Art. 65.
standards regarding undocumented migrants’ access to this provision, as it will be analyzed in the following section.

Lastly, asylum seekers whose application has been rejected have access to the emergency aid (Aid d’urgence), according to Article 12 of the Swiss Constitution which states that “Quiconque est dans une situation de détresse et n’est pas en mesure de subvenir à son entretien a le droit d’être aidé et assisté et de recevoir les moyens indispensables pour mener une existence conforme à la dignité humaine”\(^\text{86}\) While the responsibility to implement this provision again lies within the Cantons,\(^\text{87}\) the core of these services “ne peut être restreinte sous peine de réduire des individus à la mendicité ou à des situations de dénuement peu compatibles avec la dignité humaine et les valeurs de la Constitution fédérale,”\(^\text{88}\) and should include, at least, minimum accommodation, food, and emergency medical care.\(^\text{89}\)

5. FROM LAW TO PRACTICE: AN ANALYSIS OF THE MAIN OBSTACLES AND CHALLENGES IN THE LIGHT OF THE HUMAN RIGHTS PRINCIPLE OF ACCESSIBILITY

As mentioned above, in its General Comment No. 14 the Committee on Economic, Social and Cultural Rights established four elements which, together, constitute the human right to health, and on which attainment depends the full realization of this right. These elements are the availability of health care facilities, goods and services, their accessibility, their acceptability, which refers to ethical and cultural components of the service, and their quality. While the elements of availability, acceptability and quality generally refer to the national health system implemented in a country, and are not migrant-specific, this section will focus on the criteria of accessibility,

\(^{86}\) “Every person who is in a situation of destitution and is unable to support him or herself has the right to be helped and assisted and to receive the necessary means to live a life in conformity with human dignity.” (emphasis added) CONSTITUTION FÉDÉRALE (SWITZ.), supra note 72, at Art. 12.

\(^{87}\) Federal Constitution of the Swiss Confederation, supra note 72, at Art. 115.

\(^{88}\) “Cannot be restricted, on pain of reducing individuals to beggary or situations of destitution not compatible with the human dignity and values of the Federal Constitution” Tribunal fédérale [TF] [Federal Court] Mar. 18, 2005, 22 ATF 131 I 166 [Switz.].

\(^{89}\) Conférence suisse des directeurs/-trices cantonaux des affaires sociales (CDAS), Recommandations relatives à l’aide d’urgence destinée aux personnes te-neues de quitter le pays [Recommendations regarding emergency aid for persons who have to leave the country] (Berne, March 3, 2007) (Switz.)

which requires that “[h]ealth facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party”, and can thus be used to analyze the level of access to health care for undocumented migrants. In particular, the legal and practical context in France, Italy and Switzerland will be analyzed in light of the four complementary dimensions which together constitute the principle of accessibility: non-discrimination, physical accessibility, economic accessibility and information accessibility.

5.1. NON-DISCRIMINATION

The principle of non-discrimination means that “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”90 Hence, the respect of this principle shall not only be measured in terms of primary legal provisions but shall also be assessed through the analysis of regulations and practices implemented in the country. Indeed, problems linked to conflicting or unclear interpretations of the law, burdensome administrative practices and misapplications of the legal framework have been observed in all three countries object of analysis in this article, which result in discriminatory practices between migrants in a regular and irregular situation.

5.1.1. France

As analyzed above, the current legislation in France maintains a two-stream system, providing differentiated access to health care for documented and undocumented migrants. This distinction has been strongly criticized by many organizations,91 as the claim of “universal coverage” is intrinsically contradicted by the creation of two pathways and by the gap in the set of treatments to which the beneficiaries are entitled. Moreover, two main points of concern have been

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90 General Comment No. 14, supra note 19, at ¶ 12(b).
raised with regard to the ambiguity of the legal framework, the former in relation to the conditions to access PUMA and the latter regarding the documentation required to register with AME.

As concerns the first one, a certain level of ambiguity persists with regard to the definition of the criteria of “stable and regular residence,” which draws a distinction between documented migrants entitled to PUMA and undocumented migrants who only have access to AME. Indeed, a decision of the Constitutional Council (Conseil Constitutionnel) in 1993 stated that undocumented migrants have the right to remain registered with the general health system for one year after the loss of the residence permit. A subsequent Ministerial Circular of 2000 regarding the CMU system, confirmed the application of this rule to the so-called “complementary coverage,” which remains unchanged under the latest reform. Nonetheless, some concerns on this point have been raised as the current phrasing of the Social Security Code mentions the loss of residence status as one of the causes of interruption of health coverage, apparently contradicting the Constitutional Council decision. At present, the State Council (Conseil d’Etat) shall issue a Decree regulating the criteria of stable and regular residence, thus leaving a door open for the possibility of legal endorsement of the right to remain insured for one year.

With regard to the second point, undocumented migrants face serious difficulties in providing the documentation required in order to register with AME, in particular as concerns the necessity to demonstrate continuous residence in France for more than three months and to provide information regarding their economic resources for the previous twelve months. Indeed, whereas these documents are not available, a Circular issued in 2000 imposes the obligation for the Health Centers to accept in substitution a sworn declaration together with other elements of substantive information which should allow a control a posteriori. Nonetheless, in 2004 a letter

92 Conseil constitutionnel N. 93-325 (Fr.), supra note 49, at ¶ 118.
93 See Id.; Maille & Touiller, supra note 53, at 29.
94 Code de l'action sociale et des familles [Code of Social Action and of the Families], art. L161-15-1 (Fr.).
95 Id. at Art. L111-2-3.
96 Secours Catholique Caritas France, supra note 91.
97 This can be proved, for instance, by presenting the expired visa, the asylum rejection notification, school registration, bills or a document signed by a recognized organization.
98 Convention AME 2000, supra note 50, at art. 5.
of the National Health Insurance Fund (Caisse Nationale de l'Assurance Maladie) excluded the possibility of proving the three months of residence in the country via sworn declaration only, whereas this is not accompanied by relevant evidence. As regards the practical implementation of this provision, “Doctors Without Borders” and PICUM report that, in most situations, applications based on sworn declarations are not accepted, with only few exceptions when the undocumented migrant’s request is supported by well-known non-governmental organizations. Moreover, some Health Centers require undocumented migrants to prove residence in France for each of the three months of residence, even though this practice has been declared unlawful by a circular of the National Health Insurance Fund.

Lastly, a further point of concern is the unjustified practice of refusing AME applications of migrants who could not prove to be in an irregular situation, or whose position could be theoretically regularized; a practice often encouraged by informal internal directives.

To conclude, in many situations the excessive and often unlawful bureaucratic burden imposed on undocumented migrants induces them to abandon the procedure, and generates further lack of trust in the health system. Moreover, this practice is an additional factor of discrimination among undocumented migrants themselves, as uneven conditions are applied in different centers, depending on the geographical location or the varying number of requests.

5.1.2. Italy

Similar to France, in Italy undocumented migrants access the health system through a separate channel, namely the registration via the “temporary present foreigner” code (STP), and cannot register with the National Health System. The main consequence of this distinction is that

doit être accompagnée, dans toute la mesure du possible, des justificatifs de ressources et les demandeurs doivent être vivement encouragés à les fournir dès le dépôt du dossier […]. Néanmoins, si la production de pièces justificatives, s’agissant des ressources, doit être fortement encouragée, son défaut ne peut faire obstacle à l’attribution du droit. Le demandeur atteste alors sur l’honneur l’exactitude des informations portées sur le formulaire."  

undocumented migrants cannot register with a General Practitioner, and thus cannot be prescribed specialist, ambulatory and home visits. Hence, migrants in an irregular situation are excluded from a broad area of secondary care, which risks to seriously endanger the continuity of treatment, and introduces a disparity between documented and undocumented migrants.

Furthermore, as reported by different NGOs working with undocumented migrants’ access to health care, the national legal framework is not implemented uniformly in different regions and hospitals, principally because of the high level of decentralization in the organization of the health system. Most notably, it appears that the legal framework is usually interpreted more restrictively in small cities and rural areas, where the presence of civil society organizations is less strong and where the structures are often ill-suited to welcome undocumented migrants. Nonetheless, different challenges also affect urbanized areas: in Lombardia, one of the most industrialized regions, the regional law prohibits private providers operating within the national health service (ospedali convenzionati) from prescribing exams and medical visits to patients who do not hold a regular residence permit. This situation creates a contradictory legal situation according to which on the one hand, private providers are responsible, under the regional law, to provide health care to every person in the territory, while on the other hand they are prevented from ensuring continuative care and follow ups to a part of the population. Lastly, it has been reported that some public hospitals in the area refuse to issue the STP code, and do not grant access to secondary care to undocumented migrants.

5.1.3. Switzerland

As analyzed above, in Switzerland the Cantons maintain a high level of discretion with regard to the implementation of the principle of universal access to health insurance. Consequently, undocumented migrants have uneven levels of entitlement according to the geographical area where they reside. The main points of divergence are the different organization of the insurance

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105 *Id.*
107 *Id.*
system, most notably as regards the conditions to access fees reductions, and the different structure of emergency aid (Aid d’urgence).

As regards the first point, insurances are regulated very differently in the Cantons, in particular as regards their price, the treatments included beyond the basic insurance\footnote{LAMal, supra note 80, at Art. 24-31; OPAS, supra note 84.} and the conditions for subsidies. Most notably, while the national legal framework provides for the possibility to grant a fee reduction for applicants whose income falls below a certain threshold,\footnote{LAMal, supra note 80, at Art. 65.} each Canton can impose different qualifying conditions. The high level of discretion results in a widespread practice of requiring documentation which is usually not available for migrants in an irregular situation, such as proof of regular residence in the territory, a valid ID or the last tax declaration, all conditions which represent an indirect form of discrimination against the undocumented.\footnote{According to the 2014 report of the the Plate-forme nationale pour les soins médicaux aux sans-papiers, created in 2006 by office federal de la santé publique (OFSP), undocumented migrants have access to cost reduction programs in the province of Fribourg, Berne, Bale-Ville, Vaud (upon presentation of a valid ID), Zurich (but only in the city of Zurich and Winterhur) and Geneva (but only for undocumented minors). Plate-forme nationale pour les soins de santé aux sans-papiers, supra note 8, at 18-19.} Furthermore, according to the national law the cantons are also responsible of ensuring that every person residing on their territory is covered by a social insurance. Nevertheless, this control is often carried out by comparing the insurance data with the demographic data, a method which automatically excludes all undocumented migrants who are not inscribed in the registers of the population.\footnote{Wyssmüller & Efionayi-Mäder, supra note 14, at 38, 42.} Moreover, the uneven implementation of this obligation frequently leads to discrimination on the part of insurers against undocumented migrants, who are often illegitimately refused registration under the pretext of unlawful bureaucratic burdens.\footnote{See Id.}

As regards the second point mentioned above, namely the services included in the Emergency Aid (Aid d’urgence), Cantonal legislations also vary to a great extent, with regard to both the level of services and the conditions of access. In particular, only 11 Cantons followed the recommendation of the Commission Fédérale pour les questions de Migration (CFM)\footnote{D. Efionayi- Mäder, S. Schoenenberger, & I. Steiner, Visage des sans-papiers en Suisse – évolution 2000-2010, 67-68 (Berne-Wabern, Commission fédérale pour les questions de migration, 2010); Conférence des directeurs et directrices des affaires sociales (CDAS),} to register...
the recipients of Emergency aid with a health insurance, while the others require undocumented migrants to request each specific medical treatment from the competent authority\textsuperscript{114}, which can be either the social services unit or the immigration authority depending on the Canton. In particular, if the latter authority is deemed responsible, there is a risk that access to necessary and urgent treatments is refused because the immigration authorities may not always have the medical expertise necessary for identifying situations of emergency.

5.2. **Physical Accessibility**

Physical accessibility means that “health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS.”\textsuperscript{115} As concerns undocumented migrants, the element of “safe physical reach” acquires particular relevance in those situations in which accessing health structures would entail the risk of being identified by the migration authorities and of consequentially being expelled.

Indeed, the fear of being reported to the authorities and being expelled from the country appears to be one of the main reasons because of which undocumented migrants do not access public health services, as reported by several civil society organizations operating in the sector.\textsuperscript{116} For this reason, in order to analyze the physical accessibility of the right to health, it is equally important to analyze both the legal provisions and the level of risk perceived by the migrant population, as the latter is often increased by limited knowledge of the law, word of mouth, different levels of ambiguity in the legal framework and the general climate of fear in which undocumented migrants often live.

5.2.1. **France**

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\textsuperscript{115} General Comment No. 14, \textit{supra} note 19, at ¶ 12(b).

\textsuperscript{116} PICUM, \textit{Workpackage No. 6}, \textit{supra} note 6, at 6.
In France, medical personnel are bound by professional secret not to report any information which has been discovered in the exercise of their profession, except in cases of contagious disease. While this provision is legally binding, and prevails over the obligation to report crimes according to Article 40(2) of the Code of Criminal Procedure, undocumented migrants’ safe access to health care is seriously endangered by the risk of being arrested inside the hospitals, as permitted by in Ministerial Circular of 2006. However, the abolishement of the crime of illegal stay in the country in 2012 raises a valid question on the enduring applicability of the Ministerial provision, which explicitly refers to the previous criminal law framework. Furthermore, in 2009 Le Figaro reported some cases of social security agents illegitimately reporting undocumented migrants who were applying to AME to the police. All these factors contributed to the raise of the perceived risk of being detected while referring to the health system; consequently, many NGOs observe that fear of deportation remains one of the main causes for undocumented migrants not to access public hospitals.

5.2.2. Italy


118 Anas, Avis technique Préconisations pour les professionnels soumis au secret et confrontés à des révélations ou constats d’infractions Fondements légaux et déontologiques pour maintenir des pratiques efficaces de travail social, 9, 24-28 (September 2011), http://www.anas.fr/attachment/297864/.

119 Ministère de la Justice, Circulaire relative à aux conditions de l’interpellation d’un étranger en situation irrégulière, garde à vue de l’étranger en situation irrégulière, réponses pénales [Circular concerning the conditions of arrest of an alien in an irregular situation, custody of a foreigner in an irregular situation, criminal responses], CRIM 2006 05 E1/21-02-2006 NOR : JUSD0630020C, Feb. 21, 2006 (Fr.).


122 Doctors Without Borders (France), supra note 55, at 45, 58.
Traditionally, the Italian Unified Text on migration (Testo Unico sull’immigrazione) included the explicit prohibition for health institutions and professionals to report the irregular situation of their patients to the authorities.\textsuperscript{123} However, this provision has been partially contradicted by the introduction, in 2009, of the crime of irregular entrance and stay in the country, which entailed that every public official and public service officer (including doctors) were subject to the obligation to report it to the police.\textsuperscript{124} Following this reform, despite the limited number of actual reports to the police, many NGOs recorded a steep decrease in access to public hospitals, allegedly linked to undocumented migrants’ increased fear of being reported and to the ambiguity of the legal situation.\textsuperscript{125} A few months later, a Circular of the Ministry of Interior solved the inconsistency affirming the overriding nature of the prohibition to report.\textsuperscript{126} However, the uncertainties generated by the conflicting laws has contributed to the fact that migrants in an irregular situation continue to have very little trust in the health care system.\textsuperscript{127} Lastly, another point of concern regards the provision of a temporary visa for pregnant women, which regularizes their situation for the time being but automatically leads to increased risks of being identified and reported after the expiration of the document.\textsuperscript{128}

5.2.3. Switzerland

In Switzerland, undocumented migrants can face a judicial civil procedure as a consequence of non-payment of the insurance premiums or of the impossibility to pay for the cost of medical assistance received outside the insurance coverage.\textsuperscript{129} Despite being a civil proceeding, the debt-collecting procedure can entail the risk of relevant information being transmitted to the

\textsuperscript{123} Legge 12 marzo 1998, supra note 61, at Art. 33(5).
\textsuperscript{125} For instance, Save the Children (Italy) reports situations in which the police controlled the archives of the hospitals, and some cases of reporting of undocumented patients to the immigration authorities. F. Severino & M. Bonati, Migranti e salute: tra diritto (alle cure) e reato (di clandestinità), 25 R&P 50, 57 (2010), www.simmweb.it/fileadmin/documenti/Simm_x_news/2010/4-2010_R_P.pdf.
\textsuperscript{126} Ministero dell’Interno, Circolare del Ministero dell’Interno n. 12 del 27 novembre 2009 [Circular of the Ministry of the Interior No. 12, November 27, 2009], Prot. N. 780/A7 (It.).
\textsuperscript{128} Severino, Bonati, supra note 125, at 57-58.
\textsuperscript{129} Plate-forme nationale pour les soins de santé aux sans-papiers, supra note 8, at 20.
Cantonal authority, thus increasing undocumented migrants’ risk of being identified. As a consequence, this risk often deters migrants from registering with a health insurance and even from accessing public hospitals in situations of emergency, and increases the recourse to hazardous homespun remedies. Moreover, similarly to France and Italy, there have been reports of arrests of undocumented migrants who were accessing health insurance or medical care, which further contributes to a climate of fear and lack of trust among undocumented migrants in public services.

5.3. Economic Accessibility

Economic accessibility, or affordability, means that “health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, must be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.”

5.3.1. France

In France, registration with AME is provided free of costs to all undocumented migrants able to prove that their income level is below a certain threshold, which is established on an annual basis and dependent on the dimension of the household. Upon registration, the beneficiary has access to all treatments included in AME free of charge. Nonetheless and as mentioned above, beneficiaries of AME do not receive the “Carte Vitale,” necessary for reimbursement of medicines’ cost, and must therefore sustain the burden of these expenses. Moreover, undocumented migrants not registered with AME have access to emergency health care via PASS, which provides for a set of urgent and basic treatments free of charge.

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130 Wyssmüller & Efionayi-Mäder, supra note 14, at 22-23.
131 Id. at 21.
132 General Comment No. 14, supra note 19, at ¶ 12(b).
133 In 2017, this sum was fixed to 8,723 € for one person. www.service-public.fr/particuliers/vosdroits/F3079 (law visited March 11, 2018).
134 Maille & Touiller, supra note 53, at 31.
5.3.2. **Italy**

In Italy, undocumented migrants are subject to the payment of the so-called “ticket” at the same conditions as documented migrants and nationals. Nonetheless, at the moment of registration of the “temporary present foreigner” code (STP) they can apply for the “destitution status” filling a designated form. In this case, the hospitals can issue the X01 code, which exempts migrants from payment of the ticket. However, some associations reported situations in which destitute undocumented migrants have been required to pay the “ticket”, which can sometimes have prohibitive costs.

5.3.3. **Switzerland**

The high cost of health care is particularly problematic in Switzerland, where undocumented migrants who cannot access fee reduction have to pay substantial monthly premiums (which, in 2013, amounted to almost 400 CHF), yearly allowances and 10% of the costs of treatments as out-of-pocket payment. Indeed, the exorbitant costs of registration has been identified as one of the principal reasons explaining the very low level of health coverage among undocumented migrants in Switzerland. In this regard, a recent study indicated that 14.5% of the persons interviewed in Geneva in 2011 were prevented from accessing a doctor for financial reasons. A further worrisome consequence of the steep costs is that many undocumented migrants either try to register with the health insurance only once they are already very sick, thus being subject to much higher fees, or choose cheaper insurances with higher franchises, which can lead to heavier financial burdens in case they need to be hospitalized.

Lastly, undocumented migrants not registered with a medical insurance are responsible of paying the full costs of all the treatments they are subjected to. Besides exposing them to risk of

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136 See supra note 66.
138 Plate-forme nationale pour les soins de santé aux sans-papiers, supra note 8, at 7.
140 H. Wolff et al., *Health care renunciation for economic reasons in Switzerland*, SWISS MED. WKLY., 2011; 141:w13165; Plate-forme nationale pour les soins de santé aux sans-papiers, *supra* note 8, at 16.
being subject to judicial procedures in case of non-payment, this has particularly negative consequences on their health conditions as it severely endangers the continuity of the cure.

5.4. Information Accessibility

Lastly, information accessibility includes “the right to seek, receive and impart information and ideas concerning health issues.” As regards this element, very similar issues have been identified in the three countries despite the notable differences in the legal systems. Indeed, limited access to information on the health system and on the conditions for entitlement both on the side of patients and on the side of medical personnel represents one of the major obstacles to the full enjoyment of the right to health. In particular, two studies conducted among health professionals across Europe underlined the difficulties resulting from language barriers, lack of familiarity with the health care services, cultural differences and different understandings of illness and treatments. Most notably, communication proves to be a major problem, especially due to the limited availability of interpretation services. Lastly, it has been reported that in some situations undocumented migrants’ lack of awareness on the right to receive health care leads to the misuse of insurance cards from relatives or friends in a regular position, even when they would be entitled to be insured themselves, which can entail serious problems for understanding the medical history records of the patient.

5.4.1 France

In France, PICUM reports a low level on information on the conditions to access AME and in particularly as regards the complaint procedures in case of unjustified refusal of registration. Moreover, the healthcare access departments (PASS), which are in charge of facilitating access to the health care system and providing information on migrants’ rights, are distributed unevenly among the departments, and there is little available information on their location. A troublesome

142 General Comment No. 14 supra note 19, at ¶12(b).
145 PICUM, Workpackage No. 6, supra note. 6 at 7.
146 See Id.; PICUM, Health Care in NowHereLand, Improving services for undocumented migrants in the EU, 25 (Draft Book Manuscript, Vienna, December 2010).
147 Id.
consequence of the lack of information on the right to health care is that many undocumented migrants resort to private doctors, who often charge them disproportionate fees.\textsuperscript{148} Lastly, it has been shown that the general climate of fear and suspicion has a negative influence on both undocumented migrants’ and healthcare providers’ perception about deservingness, which leads at the same time to reduced access to health services and to more restrictive interpretations of the legal provisions.\textsuperscript{149}

5.4.2. Italy

With regard to Italy, a report of Doctors Without Borders on agricultural workers in Southern Italy highlighted that 63\% of the people interviewed affirmed not to have accessed the health system for lack of information.\textsuperscript{150} Moreover, the lack of awareness of the functioning of the health system leads to the widespread over-utilization of the Emergency Department (\textit{Pronto Soccorso}) in cases which lack urgency; with results of further backlogs and delays in the provision of care and treatments.\textsuperscript{151}

5.4.3. Switzerland

On a similar tone, in Switzerland the lack of information on how to access the health care system has been identified as a major obstacle for undocumented migrants, together with the financial reasons analyzed above. Most notably, this problem is exacerbated by the fact that undocumented migrants are not easily identifiable and live very dispersed, which increases the difficulties in outreaching undocumented migrants with prevention and information campaigns.\textsuperscript{152}

6. DIFFERENT SYSTEMS, SIMILAR OBSTACLES: A COMPARISON OF THE FRENCH, ITALIAN AND SWISS HEALTH CARE SYSTEMS AND THEIR IMPACT ON THE RIGHT TO HEALTH CARE.

\textsuperscript{148} Id.
\textsuperscript{149} S. Larchanché, \textit{Intangible obstacles: Health implications of stigmatization, structural violence, and fear among undocumented immigrants in France}, 74 SOCIAL SCIENCE AND MEDICINE 858, 858-63 (2012).
\textsuperscript{151} Id. at 9.
\textsuperscript{152} Wyssmüller & Efionayi-Mäder, \textit{supra} note 14, at 25-26; Wolff et al., \textit{supra} note 6, at 2152-53.
Throughout Chapters 4 and 5, the national legal frameworks and their practical implementation have been analyzed in the light of the human rights principle of accessibility, and its four sub-elements of non-discrimination, physical accessibility, economic accessibility and information accessibility. The results of the analysis are summarized in Figure 1, which shows that, despite the different measures implemented in the three States, many common challenges persist. The main obstacles which came to light relate to the clashes between law and practice, uneven implementation of the law, administrative burdens, fear of deportation, and information accessibility.

The three elements analyzed in the table are the type of system, the existence of a separate channel for undocumented migrants and the financial structure adopted. As regards the first one, Italy applies the principle of universal coverage, granting access to health care to every person in the territory and not requesting registration to an insurance. In France, nationals, documented migrants and those in an irregular situation must register with an insurance (either through PUMA or AME system), which is public and organized at the national level. In Switzerland, undocumented migrants have the right and the obligation to register to a health insurance. However, the insurance system is privatized, and subject to different regulations in each Canton. As concerns the second point, Switzerland is the only country which does not have a separate channel for undocumented migrants, while in Italy undocumented migrants cannot register with the National Health System and in France they access health care through a specific scheme, AME. Lastly, the financial provisions differ notably between the three countries. In France, AME is financed by government budget, and the undocumented migrants are not required to pay any fee at the moment of registration. In Italy, the system is financed through general taxation, but undocumented migrants can be required to pay a moderating fee (“ticket”) at the same conditions as nationals. In Switzerland, every person is subject to the payment of high insurance premiums, and the conditions to access fees reductions vary notably among the Cantons, often excluding undocumented migrants from their scope of application.

The impact of these differences on the principle of accessibility are diverse. On the one hand, the distinction between tax-based and insurance based systems does not appear to have a big impact on the effectiveness of the right to health care, as all countries face similar problems as regards the principle of non-discrimination, physical accessibility and information accessibility. However, the institution of a separate system for undocumented migrants, which grants access
only to a limited set of treatments, can have a discriminatory impact. In particular, the exclusion from the national health system is problematic in the case of Italy, where undocumented migrants cannot access specialized care. In France, the differences between PUMA and AME are less acute, but still lead to different levels of entitlement as regards some kinds of treatment and the reimbursement of medicines’ costs. In Switzerland, documented and undocumented migrants can register with private health insurances under the same conditions, and the level of treatment to which they are entitled depends solely on the type of insurance chosen and the consequent amount of the premiums.

Nonetheless, the mere provision of equal treatment is not a sufficient condition for granting access to health care, when this is not accompanied by economic affordability. This element appears particularly problematic in the case of Switzerland, where undocumented migrants face serious economic constraints which practically annihilate the right to health care. Accordingly, free access to health care, or, subordinately, the existence of a subsidizing mechanism, is essential for the fulfilment of the principle of accessibility, as the right “on paper” loses its meaning when excessive financial burden makes access impossible for most of the undocumented population.

Albeit these differences, all countries also face similar obstacles as regards the elements of non-discrimination, physical accessibility and information accessibility. Most notably, the most recurrent problems regarding the element of non-discrimination consist in the lack of full legal entitlement to the same treatments as documented migrants, illegitimate administrative practices conflicting with the legal framework and discretionary and uneven application of national standards at the regional or cantonal level. As concerns physical accessibility, fear of deportation represents a serious obstacle as many undocumented migrants prefer not to make use of the public services due to fear of being identified and reported to migration authorities. As analyzed above, the perceived risk is often higher than the real risk: nonetheless, reports of contradictory practices and unclear legal provisions, as well as, in the case of Switzerland, the risk of being subject to a civil debt-collecting procedure, further reduce the trust in the system. As a consequence, undocumented migrants often postpone the decision to resort to public hospitals until situations of stark emergency, or prefer to turn to homespun remedies which can have dangerous side-effects on their health. Lastly, limited rights-awareness on the side of both undocumented migrants and health care providers has a strong negative impact on the element of information accessibility. Most notably, lack of information often regards both the legal entitlement, the practical steps
necessary to access health care and the judicial means to implement this right, and is further jeopardized by the difficulties in outreaching migrants in an irregular situation. These obstacles, which seriously endanger the effective accessibility of health care, appear not to be significantly influenced by the differences in the health care systems analyzed above.

7. CONCLUSIONS AND POLICY RECOMMENDATIONS

This article has analyzed the French, Italian and Swiss health care systems in the light of the human right principle of accessibility, with the aim of comparing and assessing the effectiveness of different legal and administrative measures in granting access to health care for undocumented migrants. The comparison evidenced remarkable differences with regard to the different health care systems implemented in the countries, in particular in relation to the type of national health care system, the existence of a separate scheme for undocumented migrants and the financing method. Nonetheless, the analysis of such systems under the principle of accessibility shows very similar problems as concerns the implementation of this right. In particular, France, Italy, and Switzerland face comparable obstacles regarding the respect of the principle of non-discrimination, of physical accessibility and of information accessibility. Economic accessibility represents an exception, as the Swiss system stands out for its high insurance costs and the impossibility of accessing reductions fees in some Cantons, which seriously jeopardize the effectiveness of the right to health care. Consequently, this study demonstrates that the gap between the theoretical recognition of the human right to health care and its fulfilment in practice is not solely attributable to the differences between national health care systems, as most of the barriers to the principle of accessibility are present in all the countries analyzed.

The apparent inconsistency between the right to health care “on paper” and its lack of effectiveness in practice can be overcome through the adoption of the human-rights approach as discussed above, and in particular by giving relevance to the different components of the principle of accessibility. Consequently, four main policy recommendations can be drawn from the comparative analysis of these three different legal systems and their practical implementation. Firstly, states should ensure that consistent provisions ensuring undocumented migrants’ right to health care are enshrined in the national framework and are implemented equally and effectively throughout the nation. In particular, this should be achieved through the revision of the relevant legal and administrative instruments in order to ensure congruency and lack of ambiguity, the
creation of national minimum standards concerning both access to health care and financial affordability, and the institution of effective and accessible judiciary remedies and internal controls. Secondly, the creation of a safe environment in which access to health care is independent from migration control goals represents an essential step to ensure that undocumented migrants can effectively access public structures free from fear of identification and deportation. Thirdly, states should ensure the economic affordability of the health care system, through the adoption of measures granting fees reductions for those in need, and should regard both primary and secondary treatments as well as the necessary medicaments, as a key element to ensure that services are accessible to those in need. Lastly, information campaigns should be organized amongst health personnel, immigration authorities and migrant communities in order to ensure awareness on the right to health care and on the procedures to access it.
<table>
<thead>
<tr>
<th>Country</th>
<th>Type of system</th>
<th>Separate system for undocumented migrants</th>
<th>Financing structure</th>
<th>Accessibility</th>
<th>Physical accessibility (fear of deportation)</th>
<th>Economic accessibility</th>
<th>Information accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>insurance based (national level)</td>
<td>Yes (AME)</td>
<td>Government budget</td>
<td>Problematic (two-stream system leading to entitlement to different sets of treatments, legal uncertainties and conflicting practices)</td>
<td>Problematic (no obligation to report, but possibility of police interpellation in the hospital and high perceived risk)</td>
<td>Yes (but no reimbursement of medicines’ costs)</td>
<td>Problematic</td>
</tr>
<tr>
<td>Italy</td>
<td>Universal coverage</td>
<td>Yes (STP code)</td>
<td>Taxes</td>
<td>Problematic (no access to General Practitioner, conflicting practices)</td>
<td>Problematic (no obligation to report but high perceived risk)</td>
<td>Yes (upon application for the)</td>
<td>Problematic</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Insurance based (private insurances)</td>
<td>No</td>
<td>Insurance premiums</td>
<td>Problematic (no obligation to report but possibility of being subject to debt-collecting procedures and high perceived risk)</td>
<td>Problematic, depends on Cantons</td>
<td>Problematic</td>
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interpretation, regional differences)  “destitution status”)