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Veronika Bilger, Christina Hollomey, Chantal Wyssmüller, Denise Efionayi-Mäder

Health Care for Undocumented Migrants in Switzerland

Policies – People – Practices

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Preface

Undocumented migrants gain increasing attention in Europe as a vulnerable group that is exposed to high health risks and challenges public health. In general, undocumented migrants face considerable barriers in accessing health care services. Health of undocumented migrants is highly at risk due to difficult living and working conditions often characterised by uncertainty, exploitation, and dependency. Moreover, national regulations often severely restrict access to health care for undocumented migrants. At the same time, the right to health care has been recognized as human right by various international instruments ratified by European Countries (PICUM 2007; Pace 2007). This opens a paradox for health care providers: if they give care, they may act against legal and financial regulations, if they don't give care they violate human rights and exclude the most vulnerable. However, there is little confirmed and comparative knowledge on policies and practices regarding undocumented migrants' healthcare access in Europe. The EU project 'Health care in NowHereLand – Improving Services for Undocumented Migrants in the EU' coordinated by the Danube University Krems in Austria tried to close this gap by collecting empirical data on three levels:

- Policies in EU 27 on national level
- Practices of health care for undocumented migrants on regional and local level
- Strategies of undocumented migrants to access health care based on the experiences of NGOs and other advocacy groups

In this context, the Swiss Federal Office of Public Health had an explicit interest to include Switzerland into the EU-wide comparison. Integrating the case of Switzerland into the EU comparison creates synergy effects on two levels: First, due to its highly federal structure Switzerland faces similar challenges than the EU, in particular regarding tensions between efforts to harmonise local and regional practices and large cantonal (CH) or national (EU) autonomy. Secondly, including Switzerland into the EU comparison also allows for expanding the perspective on identifying possible 'good practices' of policies and practices dealing with health care access of undocumented migrants.

The Federal Office of Public Health thus in 2008 commissioned a study on 'Access to Health Care for Undocumented Migrants in Switzerland', which was performed in close collaboration with the EU project NowHereLand. The Swiss study was conducted by the International Centre for Migration Policy Development (ICMPD) together with the Swiss Forum for Migration and Population Studies (SFM) at the University of Neuchâtel and the Trummer & Novak-Zezula OG in Vienna. Following the design of the EU project, this publication provides a detailed overview on the actual state of knowledge on the health care situation of undocumented migrants in Switzerland with regard to three levels: policies and regulations, practices of health care provision, health care needs and strategies of undocumented migrants in Switzerland, and performed an assessment of selected practice models. The Swiss study thus aims to promote the exchange of knowledge and experiences between Switzerland and the EU Member States on policies and practices that deal with the right to health care for undocumented migrants. The results of the European and the Swiss project – national and comparative policy and people reports, as well as a compilation of practices in the EU 27 and Switzerland ('Practice Database') are available at the NowHereLand website: <http://www.nowhereland.info>.



Health Care in

NOWHERELAND

*improving services for
undocumented migrants in the EU*

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List of Acronyms

AFK	<i>Ambulatorium für Folter- und Kriegsopfer</i>
AHBB	<i>Aidshilfe beider Basel</i>
AHS	<i>Aids-Hilfe Schweiz</i>
AIDS	Acquired immunodeficiency syndrome
APiS	<i>Aidsprävention im Sexgewerbe</i>
Cantons	Aargau AG, Appenzell Ausserrhoden AR, Appenzell Innerrhoden AI, Basel-Land BL, Basel-Stadt BS, Bern BE, Fribourg FR, Genève GE, Glarus GL, Graubünden GR, Jura JU, Luzern LU, Neuchâtel NE, Nidwalden NW, Obwalden OW, Sankt Gallen SG, Schaffhausen SH, Schwyz SZ, Solothurn SO, Thurgau TG, Ticino TI, Uri UR, Wallis VS, Vaud VD, Zug ZG, Zürich ZH
CHF	Swiss Francs
CHUV	<i>Centre Hospitalier Universitaire Vaudois</i>
CSI	<i>Centre de Santé Infirmier</i>
CSM	<i>Centre Santé Migrants</i>
DMC	<i>Département de médecine communautaire et de premier recours</i>
DG Sanco	Directorate General for Health and Consumer Affairs
EU	European Union
FdP	<i>Association Fleur de Pavé</i>
FG	Federal Government
FOM / BFM	Federal Office for Migration / <i>Bundesamt für Migration</i>
FOPH / BAG	Federal Office of Public Health / <i>Bundesamt für Gesundheit</i>
FPP	<i>Fonds de patients précarisés</i>
FTE	Full time employee(s)
GP	General practitioner
HEKS/EPER	<i>Hilfswerk evangelische Kirchen Schweiz/Entraide protestante suisse</i>
HIV	Human immunodeficiency virus
HPH	Network of Health promoting Hospitals
HUG	<i>Hôpitaux Universitaires de Genève</i>
ICMPD	International Centre for Migration Policy Development
LHI / KVG	Law on Health Insurance / <i>Krankenversicherungsgesetz</i>
M.A.	Master of Arts
MAS	Master of Advanced Studies
MdM	<i>Médecins du Monde</i>
MeBiF	<i>Medizinische Beratung für illegalisierte Frauen</i>
MFH	Migrant Friendly Hospitals
MsF	<i>Médecins sans Frontières</i>
NEE	<i>Nichteintretensentscheid</i> : Application for asylum is dismissed as being invalid
NGO	Non-governmental organisation(s)

NPO	Non-profit organisation(s)
PEL	<i>Association Point d'Eau Lausanne</i>
PMU	<i>Policlinique médicale universitaire</i>
PSM	<i>Programme Santé Migrations</i>
PTSD	Post-traumatic stress disorder
RSA	<i>Réseau de Soins Asile</i>
RSM	<i>Réseau Santé Migrations</i>
SFC / BV	Swiss Federal Constitution / <i>Bundesverfassung</i>
SFM	Swiss Forum for Migration and Population Studies, University of Neuchâtel
SPAZ	<i>Sans-Papiers Anlaufstelle Zürich</i>
SRC / SRK	Swiss Red Cross / <i>Schweizerisches Rotes Kreuz</i>
SRC ZH	Zurich section of the Swiss Red Cross
SVA	<i>Sozialversicherungsanstalt</i>
TB	Tuberculosis
UDM	Undocumented migrant(s)
UMSCO	<i>Unité mobile de soins communautaires</i>
UPV	<i>Unité des populations vulnérables</i>
USSI	<i>Ufficio del Sostegno Sociale e Inserimento</i>
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Glossary

Annual excess (<i>Jahresfranchise</i>)	When sickness incurs health costs, a person taking out mandatory health insurance has to pay, in addition to their monthly insurance premium, all fees up to the sum of their chosen annual excess (CHF 300 – 2500 (€ 230 – 1,925) for adults).
Asylum application*	An application made by a national of a third-party country or by a stateless person which can be interpreted, under the Geneva Convention, as a request for international protection by Switzerland or by an EU Member State.
Asylum seeker	National of a third-party country or stateless person who has – at some point - applied for asylum in Switzerland or in an EU Member State.
Basic health care (<i>medizinische Grundversorgung</i>)	Based on the Federal Constitution of the Swiss Confederation (Article 12) all persons are entitled to 'assistance when in need', including all 'essential resources to lead a dignified human existence'. The Federal Tribunal in its jurisdiction refers to 'basic medical care' (<i>medizinische Grundversorgung</i>). Experts confirm that the right to assistance also applies to non-emergency cases (see Bilger and Hollomey in this volume).
Emergency aid (<i>Nothilfe</i>)	Persons whose asylum application has been deemed inadmissible (see <i>Nichteintretensentscheid</i>) or has been rejected are entitled to emergency aid (<i>Nothilfe</i>) as specified in Article 12 of the Swiss Federal Constitution. The provision of such aid is regulated by cantonal law and may be requested from the canton which the asylum seeker has been assigned to.
<i>Nichteintretensentscheid</i> (NEE)	Dismissal of an asylum application 'without entering into substance'; http://www.admin.ch/ch/e/rs/1/142.31.en.pdf
Patient's contribution (<i>Selbstbehalt</i>)	Once an insured patient's chosen annual excess (see above) has been reached, the health insurer pays 'all' subsequent treatment costs for the patient/client. The patient/client still, however, contributes to the cost of their treatment as they are obliged to pay the 'patient's contribution' of 10% of treatment costs up to, and including, a maximum sum of CHF 700.00 (€ 540).
Refugee*	A national of a third-party country or a stateless person as defined in Article 1A of the Geneva Convention and, as such, authorised to reside in the territory of an EU Member State and to whom Article 12 (Exclusion) of directive 2004/83/EC does not apply.
Rejected (or 'refused') asylum seeker	Person whose asylum application has been rejected.

For terms marked with * see EMN Glossary:

<http://emn.sarenet.es/Downloads/prepareShowFiles.do;jsessionid=1623A2E22F0D9111443EAE63036B8DEA?directoryID=117> (last accessed: 17 July 2011)

POLICIES:

The Legal and Policy Framework on Access to Health Care for Undocumented Migrants in Switzerland

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1 Introduction

Switzerland is a confederation of 26 cantons and 2,740 municipalities comprising four officially recognised linguistic groups (German, French, Italian and Rhaeto-Romanic). Switzerland has 7.7 million inhabitants and one of the largest shares of foreigners in Europe.

Surrounded by EU Member States (except for Liechtenstein) the Federal State of Switzerland is not a Member State of the European Union but has joined the Schengen Area on 12 December 2008.

The Swiss political system is highly federalised, operates on a consociational basis and puts strong emphasis on direct democracy, cantonal autonomy and cantons' participation in all phases of political will. The system of consociational democracy promotes the balanced representation of various interests and the emphasis on direct democracy entails that a great number of actors are involved in the consultation process preceding law amendments. Political decision making is thus characterized by a search for compromise between different positions represented by the cantons, political parties, interest groups, trade unions, expert commissions, and NGOs (D'Amato 2010). This highly decentralised system has resulted in lengthy decision-making processes, and an often complex distribution of powers between the federal state, the cantons, and municipalities (D'Amato/Gerber/Kamm 2005, 59f; Baumann/ Stremlow/ Strohmeier 2006).

The federal level is represented by the Swiss Parliament (consisting of the National Council² and the Council of States³) and by the Swiss Government (the Swiss Federal Council⁴). Federal level policy making includes the areas of civil and penal legislation, international politics, national defence, and social security (e.g. social insurances) and increasingly deals with issues such as health, immigration and integration. Other areas are mainly regulated on the cantonal level such as culture, education, direct taxation, and social welfare benefits (Baumann/ Stremlow/ Strohmeier 2006; Mahnig/Wimmer 2003).⁵ In addition, in several areas as e.g. the health system, the role of private enterprises has been encouraged for supporting the government and the cantons in fulfilling their duties. While the Federal Government issues outline laws in its areas of competence, these are executed by the largely financially autonomous cantons and municipalities (FOM 2009b, 24), which enjoy great freedom with regard to the implementation of federal regulations.

Concerning immigration, granting residence permits, implementing integration and law enforcement measures is mainly the cantons' responsibility, while Swiss asylum policy is coordinated on the federal level. The Aliens Police operates exclusively under cantonal immigration authority (D'Amato 2010, 113). In the area of social security the cantonal authorities implement federal social insurance laws and monitor the obligation to 'basic health insurance'.

² *Nationalrat*, representing the people.

³ *Ständerat*, representing the cantons.

⁴ The Swiss Federal Council is elected by the parliament on a four-years-basis.

⁵ *Federal Constitution of the Swiss Confederation*, Article 3, and Article 44 (1)

This distribution of powers has resulted in a variety of different cantonal regulations and practices regarding access to basic social rights particularly for undocumented immigrants (see Ruspini 2009, Achermann/Efionayi-Mäder 2003).

2 The General Migration Context

After the Second World War, the Swiss immigration policy was mostly oriented towards temporary labour immigration channelled through a so-called 'rotation model'. Until 1991, Switzerland implemented a seasonal-worker scheme (*Saisonnier-Statut*) based on the recruitment of unskilled and semi-skilled foreign workers of which most originated from Spain, Italy, Portugal, Turkey, and the former Yugoslavia.⁶ Under this scheme, immigrants were not entitled to family reunification and could only obtain the right to long-term residence in the country after several consecutive working-seasons (Laubenthal 2007b, 119).

The 1990s finally marked the gradual abandonment of the seasonal-worker scheme. The economic downturn, increasing unemployment rates and a significant increase in asylum seekers, particularly from former Yugoslavia, created a climate of public unrest (Riaño 2010). In this context and in the aim to formulate an immigration policy that would comply with European Union policy, Switzerland introduced the so-called 'three-circle' policy in 1991. This model divided foreigners into three groups: the inner circle included nationals of the European Union and EFTA countries which would enjoy first immigration priority, followed by citizens from the USA, Canada, Australia, and New Zealand as represented in the second circle, and finally the third circle including all other nationalities who were allowed immigration only in exceptional cases (Federal Council, 1991; FOR 2004, 23; D'Amato/Gerber/Kamm 2005).

Consequently, this policy created precarious situations for several groups of foreigners now classified under the third circle. A significant number of former seasonal workers, who had not yet obtained the right to long-term residence, could no more renew their permit and were denied consolidation of their residence status. Seasonal workers from former Yugoslavia, now part of the third circle, were particularly affected, as many were not able to return due to the war in former Yugoslavia, but remained in the country unlawfully or applied for asylum (Ruspini 2009). In 1996 this concerned more than 20,000 seasonal workers from former Yugoslavia (Leuenberger and Maillard 1999, 79 as quoted by Laubenthal 2007b, 120). At the same time, despite the above mentioned restrictions, an increasing number of foreigners had managed to qualify for a long-term residence status at that time. Thus, family reunion constituted a main mode of immigration to Switzerland throughout the 1990s (FOS 2009d).

As an effect of the abolition of the seasonal workers status and the ongoing labour market crisis, the foreign net migration rate almost decreased to zero in 1996 and 1997 (see Figure 1 below). In 1998 a 'dual system' of recruiting foreign labour was introduced, which improved the rights of EU and EFTA immigrants, while at the same time also allowed for the entry of skilled immigrants from third countries (Riaño/Wastl-Walter 2006, 10). Following this, from 1998 to 2007 family reunification and high-skilled labour migration were the quantitatively most important immigration schemes to Switzerland (see FOS 2008a: 21).

⁶ Efionayi, D.; J.M. Niederberger, and Ph. Wanner (2005) 'Switzerland Faces Common European Challenges'. Available at: <http://www.migrationinformation.org/USfocus/display.cfm?ID=284> (last accessed: 17 July 2011).

Regarding the current immigration policy, as regulated under the Agreement on the Free Movement of Persons (FZA) between Switzerland and the European Union, citizens of EU Member States and the area of the European Free Trade Association (EFTA) enjoy free movement since 2002, if they can demonstrate sufficient income and a health insurance.⁷ In 2007, immigration from the EU-27 and EFTA countries accounted for almost 70% of total net migration (FOS 2008a). Moreover, nationals of EU and EFTA countries are granted priority admission to the Swiss labour market. Only a limited number of management level employees, specialists and other qualified employees are admitted from third countries, as these foreigners remain subject to the Federal Act on Foreign Nationals (AuG) and its regulatory statutes, particularly the Decree on Admittance, Residence and Employment (VZAE).⁸ Third country nationals may be granted a residence permit in Switzerland only for the purpose of professional labour and in the course of family reunification.

2.1 Total Population and Migrant Population

Switzerland has 7.7 million inhabitants and one of the largest shares of foreigners in Europe. In 2008, the share of foreigners in the total resident population amounted to 21.7% (FOS 2009). The cantons with the highest share of foreign resident population are Geneva (38.4%), Basel-city (31.3%), Vaud (30%), Tessin (25.9%), and Zurich (24.1%) (FOS 2008a).

Noteworthy, throughout the 1990's the number of female immigrants exceeded that of male persons (see Figure 1). This trend can be attributed to an increase of immigration from new regions of origin, such as Latin America and Southeast Asia, for which the share of female migrants is particularly high (FOR 2004: 29). Although their share is decreasing since 1991, the majority of Swiss immigrants still origins from European states. In 2007, half of all foreign residents originated from Germany, Portugal, France, Serbia and Montenegro, and Italy (FOS 2008: 24) and the majority of the foreign resident population (70.8%) was in working age (between 20 and 64 years) (FOS 2008: 17).

TABLE 2.1 Immigration of Foreign Nationals* to Switzerland by Reason of Immigration, 2000-2009

	2000	2002	2004	2006	2008	2009
Occupation	21 108	30 871	34 120	41 056	78 537	60 543
Family reunion	38 110	43 209	38 836	37 601	48 985	43 617
Training and qualification	10 480	14 022	13 003	13 623	15 636	15 289
Recognised refugees	1 465	1 184	1 007	1 339	1 868	2 000
Other	2 098	6 227	4 201	3 838	5 834	4 486
Total	73 261	94 667	90 310	96 553	149 674	124 933

Note: *) Including short term permits for more than 12 months and status change in asylum process.

Source: BFS-ZAR (Zentrales Ausländerregister):

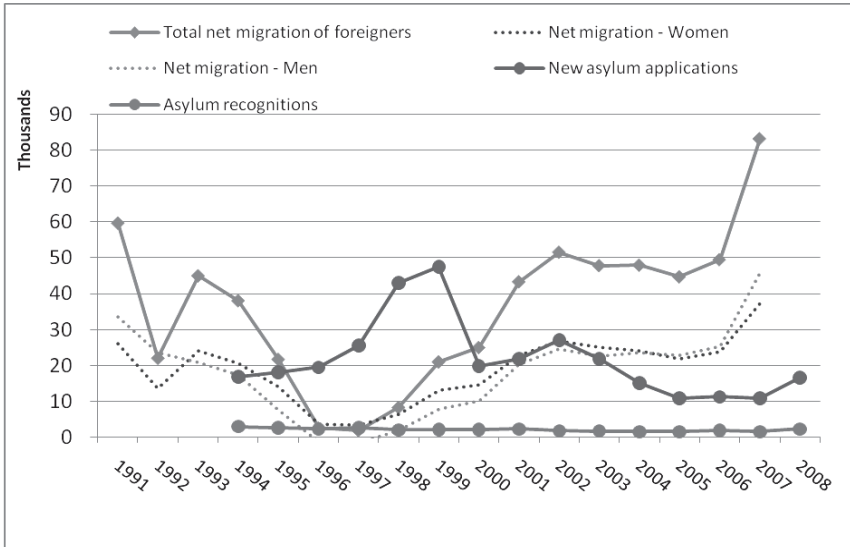
⁷ Immigration for the purpose of work for citizens of the EU 15 is no more subject to quotas since 1st June 2007 (Integrationsbüro EDA/EVD 2002).

⁸ *Verordnung über Zulassung, Aufenthalt und Erwerbstätigkeit (VZAE)*, in force since 1.1.2008.

<http://www.bfs.admin.ch/bfs/portal/de/index/themen/01/07/blank/data/01.Document.88349.xls>
(last accessed: 17 July 2011).

Apart from the above mentioned changes in the general immigration policy, the 1990s were characterised by increasing asylum related immigration. In 1991 and 1999 the number of asylum applications peaked with over 40,000 new applications (see Figure 1 below), and the number of persons in pending proceedings reached a maximum of 104,739 persons in 1999 (FOM 2009a). In response to rising asylum applications and an increasing number of persons who, after a negative decision did not leave the country or could not be returned for various reasons, regulations on asylum were increasingly restricted (Achermann 2009, 94).

FIGURE 2.1 Foreign Net Migration by Gender, Asylum Applications and Recognitions in Switzerland, 1991-2008



Sources: FOS (2008c); FOM (2009a), Asylstatistiken, Zemis

Note: The number on foreign net migration excludes persons with a short-term permit (permit L; < 12 months), and asylum seekers (permit F or N).⁹

2.2 Estimated Number of Undocumented Migrants

The extent of persons unlawfully residing in Switzerland can only be estimated. The most recent estimate is provided by a study conducted on behalf of the Federal Office for Migration in 2005, which refers to 80,000 – 100,000 undocumented migrants i.e. persons residing in Switzerland without valid residence documents for an unspecified

⁹ For the different residence permits, see the website of the Federal Office for Migration: http://www.bfm.admin.ch/bfm/en/home/themen/aufenthalt/nicht_eu_efta.html (last accessed: 17 July 2011).

period of time (Gfs.bern 2005: 58).¹⁰ The study concludes that the larger part of the unlawfully resident population in Switzerland consists of former seasonal-workers from third-countries who could not renew their residence permit after the introduction of the 'three-circle' policy in the 1990s but remained in the country. A report on 'illegal migration', published by the former Office for Migration (IMES) in 2004, estimated the number of persons staying *and/or* working irregularly in Switzerland between 50,000 and 300,000 persons (IMES 2004, 10; see also Kaeser 2009, 53). For the year 2008 the Federal Office for Migration refers to 5,302 persons who were stopped when crossing the border illegally, 1,247 foreigners were detected for irregular employment. (FOS 2009d).

Another group is composed by unsuccessful asylum seekers. In 2003, the actual abode of 10,300 asylum seekers was not known (*verschwundene Asylsuchende*) to enforcement authorities. It was concluded that these persons may have either left the country without documentation or may have remained in the country undetected after a negative decision on their asylum application (IMES 2004, 4). Since 2003 this number has decreased to 2,776 asylum seekers whose abode was unknown in 2008 (FOS 2009d).

Furthermore, according to data from the special programme *Humanitarian Action 2000* an estimated number of 15,000 non-removable (including persons without any residence status) and long term resident asylum seekers were granted humanitarian residence (Ruspini 2009, 98). Between 2001 and 2008, 3,694 applications for a residence permit for unlawfully staying migrants in *acute individual hardship* were lodged by the cantons, out of which 2,123 persons received a positive answer (Federal Office for Migration quoted by Ruspini 2009, 97).¹¹

2.3 Categories of Undocumented Migrants

The new Swiss Federal Act on Foreign Nationals (AuG), which came into force in 1 January 2008, prohibits unlawful entry, exit, residence or work in the country (article 116 AUG) as well as the promotion of these activities through third parties (article 115 AUG). The scope of this legislation de facto only refers to third country nationals (persons from non-EU or non-EFTA states).

In the Swiss context persons residing in Switzerland without valid residence documents for an unspecified period of time are referred to as *sans-papiers*.

Under the current immigration regime, the following pathways of becoming undocumented can be distinguished in Switzerland:

- Persons who unlawfully entered Swiss territory;
- Persons who legally enter Swiss territory but remain in the country after the validity of their visa/residence permit has expired ('Overstayers');

¹⁰ The estimate was based on a questionnaire answered by the cantonal immigration authorities and refers to summer 2004.

¹¹ See also Schweizerische Flüchtlingshilfe (2007) Statistische Angaben zur Härtefallregelung im Asylbereich, available at: <http://www.fluechtlingshilfe.ch/news/medienmitteilungen/haertefallregelung-muss-gerechter-werden/statistische-angaben-zur-haertefallregelung-im-asylbereich/?searchterm=H%C3%A4rtefallregelung> (last accessed: 17 July 2011).

- Persons who, after legal amendments or changes in their socioeconomic position (e.g. after loss of job or early divorce in the case of family reunion/marriage migration etc.), cannot renew their residence permit but remain in the country;
- Unsuccessful asylum seekers who 'disappear' during their asylum procedure, receive a negative decision or whose application was dismissed without entering into substance (*Nichteintretentscheid*, NEE) and who should thus leave the country within a set time-limit but remain in the country or cannot be removed for technical or other reasons (see IMES 2004, Achermann/Chiementi 2006; Federal Office for Refugees 2004: 14).

3 Policies Regarding Undocumented Migrants

3.1 Debates on Undocumented Migrants

The issue of irregular migration became a new focus of Swiss public and political discourse on immigration during the 1990s when asylum figures were exceptionally high (see D'Amato/Gerber/Kamm 2005). In the beginning of the 1990s a major political debate on 'illegal migration' sparked off from two popular initiatives (*Volksinitiative*) launched by the Swiss Democratic Party claiming 'for a reasonable asylum policy' and the Swiss Peoples Party demanding increased efforts 'against illegal immigration'. Both initiatives stipulated that asylum applications of persons who had entered the country unlawfully should no more be considered. However, the first initiative was declared invalid by Swiss parliament¹² while the second initiative was rejected by the Swiss population¹³. In the same period the Federal Council granted provisional admission to 13,000 persons from Bosnia during war in former Yugoslavia. Not only Bosnian war refugees benefitted from this measure but also illegally resident persons from former Yugoslavia who were affected by general immigration restrictions in the 1990s, such as former seasonal workers, persons who had overstayed their permit and unsuccessful asylum seekers (see Skenderovic/D'Amato 2008, 187f).

Already from the beginning of their implementation, immigration restrictions as introduced with the three-circle model were widely criticised as being racially discriminative by assessing immigrants exclusively on the basis of their nationality. In this context, at the end of the 1990s first initiatives were launched to 'urge the Swiss government to revise immigration policies, to stop cultural and gender discrimination, and to devise measures that helped improve the precarious situation of many foreigners' (Riaño/Wastl-Walter 2006, 10). After the three-circle model showed its effects and an increasing number of former seasonal workers became undocumented, a broad range of actors from the asylum and antiracism movement, industry, Swiss trade unions and other interest groups initiated a pro-regularization protest. Cantons which were faced with the fact that a number of former temporary workers who could no longer renew their seasonal work permits, but, at the same time, could also not return to their home country and thus remained undocumented, showed sympathies with this mobilisation. In Switzerland cantonal administrations are responsible for carrying out expulsions, have

¹² See: *„Eidgenössische Volksinitiative „für eine vernünftige Asylpolitik“*, available at: <http://www.admin.ch/ch/d/pore/vi/vis223.html> (last accessed: 17 July 2011).

¹³ See: *„Eidgenössische Volksinitiative „gegen die illegale Einwanderung“*, available at: <http://www.admin.ch/ch/d/pore/vi/vis238.html> (last accessed: 17 July 2011).

powers in issuing residence permits and play an important role in supporting regularisation claims (Laubenthal 2007b). When in 1996, for example, the federal authorities rejected the initiative of the canton of Vaud to grant residence to former seasonal-workers, Vaud decided though not to pursue with forced return, but instead renewed the permits of about 200 former seasonal workers and finally regularised their stay in 2000 (FOR 2004, 15). Similarly, when a group of former seasonal-workers from Kosovo formed the alliance *En quatre ans on prend racine* to protest against the expulsion of 3,000 former seasonal workers and demanded the right to stay, the canton Vaud urged the federal authorities to 'evaluate the migrants' claims generously' and effected the granting of residence permits to those who had lived more than eight years in the canton (Laubenthal 2007b, 120-121; FOR 2004, 15).

This mobilisation, which had started in the French-speaking cantons, soon developed into a nation-wide pro-regularisation movement which was supported by a wide range of actors and cantonal administrations and initiated a parliamentary debate on improving the rights of undocumented migrants in Switzerland.

3.2 Regularization Practice, its Logic and Target Groups

The Federal State of Switzerland rejects regularization on principal grounds (See Ruspini 2009, 99). However with regard to the asylum policy, since December 2001 federal law allows cantons to apply a hardship provision to unlawfully staying persons in a situation of 'acute individual hardship' (*schwerwiegender persönlicher Härtefall*) if return is not feasible or not reasonable; since January 2008 the cantons may also apply this provision to rejected asylum seekers.¹⁴ If and how cantons interpret and apply the provision of 'acute individual hardship' varies considerably between the cantons. Between 2001 and 2008, 2,123 persons received a positive answer under this provision (Federal Office for Migration quoted by Ruspini 2009, 97). Until 2004 90% of all applications were forwarded mainly by the canton of Geneva, Vaud, Fribourg and Neuchâtel, and by Bern (FOR 2004, 42), while other cantons have not applied this provision at all.¹⁵

Agreeing on the limitations of this provision, already in 2002 members of the National Council and representatives of human rights, solidarity and trade union organisations, as well as the *Sans-papier* movement, founded the 'Platform for a round table on sans-papiers' to discuss the agenda on this specific group or persons beyond the regulation on 'acute individual hardship'. In addition, access of undocumented migrants to health care was given priority on the political agenda of the Federal Office of Public Health, which explicitly refers to the situation of undocumented migrants in its second national *Strategy Migration and Health 2008-2013*. In this framework, the Office commissioned a *national platform on health care for sans-papiers*¹⁶ which aimed at enabling exchange of different health care experiences of organisations and persons working with undocumented migrants.

¹⁴ The criteria considered are: duration of stay, state of integration, health status, existing familial relations in Switzerland and the country of origin, school enrolment of children, or status of employment.

¹⁵ See also Schweizerische Flüchtlingshilfe (2007) Statistische Angaben zur Härtefallregelung im Asylbereich, available at: <http://www.fluechtlingshilfe.ch/news/medienmitteilungen/haertefallregelung-muss-gerechter-werden/statistische-angaben-zur-haertefallregelung-im-asylbereich/?searchterm=H%C3%A4rtefallregelung> (last accessed: 17 July 2011).

¹⁶ <http://www.sante-sans-papiers.ch/> (last accessed: 17 July 2011).

3.3 Access to Basic Social Rights: Accommodation, Labour, Social Security and Education

Undocumented immigrants in Switzerland in principle enjoy several economic and social rights which are made explicit under title II 'Fundamental Rights, Citizenship and Social Goals' (Article 41) of the Federal Constitution of the Swiss Confederation and other specific legal provisions. These rights include labour rights, access to social insurances including health insurance, access to education (compulsory school attendance) and to emergency aid (i.e. food, shelter, urgent medical treatment).

However, undocumented migrants face a number of practical obstacles when accessing fundamental rights as a direct consequence of their (lacking) immigration status:

Housing

In regard to housing for example renting implies registration at the competent cantonal authority¹⁷. Thus, avoiding the risk of being identified, undocumented migrants primarily arrange for accommodation informally.

Education

In the area of education school attendance is compulsory in Switzerland for the first nine years of education. In March 1991 the former Federal Office for Aliens Affairs (IMES) issued a circular on 'school enrolment of foreign children without valid residence permit' by which the cantons were summoned to generously handle the issue of undocumented children in school (IMES 2004, 28). There is consensus among all cantons to support undocumented children's school attendance (Efionayi-Mäder/Cattacin 2001, 14). A report by the Swiss Refugee Aid pointed to problems in the canton of Bern, which restricted access of undocumented children to primary school (Trummer 2008, 7). In particular, children of rejected asylum seekers and persons with NEE receiving state emergency aid (*Nothilfe*) were affected. While it seems that these problems have been resolved in Bern, the situation is still problematic in the canton of Tessin (Efionayi-Mäder 2010, 62). Regarding secondary education, there is no right for undocumented teenagers to enter an apprenticeship; a respective motion was rejected by the Political Institutions Committee in October 2010.¹⁸

Work

Concerning labour rights, Swiss labour law entitles all persons in a de facto employment relationship¹⁹ to minimal labour standards. This includes the right to a salary, paid vacation, reasonable period of notice, paid sick leave, access to the full range of social security benefits i.e. retirement, invalidity, obligatory accident insurance as well as old-age, survivors and invalidity insurance (UNIA 2007). However, as labour courts have to report the unlawful residence of a claimant to the Federal Office for Migration, in practice undocumented migrants can hardly realise their rights without risking detection (Achermann/Chiementi 2006, 31). Undocumented migrants may receive benefits if they legalize their stay or return to their country of origin (see Efionayi-Mäder/Schönenberger/Ilka 2010). Although in some cantons the share of undocumented migrants in registered employment is estimated to be comparatively high (such as in

¹⁷ See VZAE, art. 18

¹⁸ See *„Jugendliche Papierlose sollen kein Recht auf eine Berufslehre erhalten“*. Available at: <http://www.parlament.ch/d/mmm/2010/Seiten/mmm-spk-n-2010-10-22.aspx> (last accessed: 17 July 2011).

¹⁹ An employment relationship is defined as work for a private person or a company for wage, even if only verbally agreed.

Geneva), the majority of undocumented migrants is assumed to work in unregistered jobs (e.g. women working in private households) and thus, even if formally entitled, face difficulties in receiving benefits related to accident insurance or other forms of social security benefits (Achermann/Chiementi 2006, 31f).

Help in situation of distress (art. 12, Constitution)

Resulting from the unwritten fundamental right to the minimum subsistence recognised by the Federal Tribunal in 1995, the right to obtain help in situations of distress is explicitly rooted in article 12 of the Federal Constitution and guarantees to persons in situations of distress 'the right to be helped and assisted and to receive the essential resources to lead a dignified human existence'.²⁰ Article 12 of the Federal Constitution also enshrines the right to receive 'basic' health care, irrespective of one's nationality, residence or insurance status. Accordingly, undocumented migrants have the right to access and benefit from health care services (to a lesser extent than those provided by the Federal Health Insurance Law) even without insurance coverage.

TABLE 3.1 Overview on Access to Basic Social Rights for Undocumented Migrants in Switzerland

Type of right	Access	Conditions	Identified obstacles to access rights
Housing	NO	Renting requires registration at the cantonal authority	n.a.
Education	YES	9 years compulsory education	Cantonal legislation partly lacking
Labour rights	YES	Labour rights according to tax and social security requirements irrespective of residence status	Enforcement of right may result in detection
Social security	YES	Right to be insured with old-age, sickness, survivors and invalidity, and unemployment insurance for all employed persons	Actual claiming of benefits (unemployment, old-age, and invalidity) possible only with legal residence status, or when returned to the country of origin.
		Obligatory health insurance for all persons residing in Switzerland for more than 3 months; allows access to basic health care	High costs; different practices of health insurers; different cantonal practices regarding implementation and monitoring
Basic subsistence	YES	Essential resources to persons in distress, including 'basic' health care irrespective of residence or insurance status according to article 12 of the Federal Constitution	n.a.

²⁰ Article 12 of the Federal Constitution of the Swiss Confederation, available at: <http://www.admin.ch/ch/e/rs/101/a41.html> (last accessed: 17 July 2011).

4 Main Characteristics of the Health System

4.1 Main Characteristics of the Swiss Welfare Regime

The welfare regime of the Federal State of Switzerland developed from a system commonly referred to as 'residual' or 'liberal' (Armingeon 2001, Bonoli 2004), in which the market acts as service provider. In this logic, public obligation enters only where private initiative fails (Esping-Anderson 1990: 26-27 and 41-44). This explains the important role that private actors (i.e. competing health insurance companies) play also in the current Swiss health system.

Following demographic and socio-economic changes during the 1990s reforms aimed at reducing the costs that social security payments invoke to the Federal State, the cantons and the municipalities, but also at increasing social security coverage of new risk groups. Thus, in 1996 health insurance was made mandatory for the entire resident population. At the same time targeted subsidies for persons in need were introduced, while global state subsidies were abandoned (principle of 'social accuracy' - *Soziale Treffsicherheit*) (Obinger 1998, Bonoli 2004).

In order to understand the dynamics and results of the reforms over the last decades one has to take into consideration that Swiss welfare is strongly influenced by the macro-institutional context of power fragmentation and its main features of direct democracy and federalism. Combined, those two factors have resulted in large regional variations and seemingly insurmountable barriers to nation-wide reform (Crivelli et al. 2007). Social welfare support still is to a large extent a cantonal and municipal task, as financing and executive liability is delegated to the 26 cantons.

Generally, Swiss social security system encompasses five areas: old-age, survivors' and invalidity insurance; protection against the consequences of illness and accidents; income compensation allowances in case of military service and in case of maternity; unemployment insurance; family allowances.²¹ The Swiss three-pillar pension system is composed by a compulsory insurance for all persons domiciled or engaged in paid employment in Switzerland, mandatory occupational benefits and voluntary individual provident measures.²² The 1st and 2nd pillars are financed by contributions from employers and employees, as well as – for 1st pillar - subsidies by the confederation and, partly by cantons.²³

Apart from the social insurances regulated on federal level, the cantons support persons whose basic needs are not covered by social insurances through social assistance (*Sozialhilfe*) or emergency aid (*Nothilfe*) that contain financial and/or in-kind benefits and are regulated on cantonal level. In any case, as there is no nationally uniform regulation

²¹ See: Federal Social Insurance Office, Switzerland: <http://www.bsv.admin.ch/themen/ueberblick/00003/index.html?lang=en> (last accessed: 17 July 2011).

²² Swiss social security system covers five main areas: old-age, survivors' and invalidity insurance; sickness and accident insurance; income compensation allowance in case of maternity or military service; unemployment insurance; and family allowances. ('Social security in Switzerland', <http://www.bsv.admin.ch/themen/ueberblick/00003/index.html?lang=en> (last accessed: 17 July 2011).

²³ Supplementary benefits to 1st pillar.

for social welfare benefits, entitlements and provision practices differ across the cantons.²⁴

4.2 The Health System in Switzerland

The basic principle of 'federalism' guiding Switzerland's political system also applies to the Swiss health care system which is a decentralised system in which many actors are involved. With the changes of the statutory health insurance in 1996, the regulatory powers of the federal government over the health system have considerably increased and have fundamentally affected the structures for financing and delivering health care on the cantonal level (European Observatory 2000). On the federal level, the public health agenda falls under the competence of the Federal Department of Home Affairs (EDI) under which the Swiss Federal Office of Public Health (FOPH) is responsible for developing national health policies and strategies as well as for monitoring their implementation on the cantonal level.

The 26 cantons are responsible for the implementation of federal laws, regulation of health matters (e.g. monitoring the implementation of insurance obligation), provision of health care (e.g. admission of providers, hospital planning, subsidising organisations etc.), disease prevention and health education (European Observatory 2000). They may delegate parts of their responsibility to the municipalities (e.g. support to particular groups of persons such as elderly persons, pregnant women and mothers or children in schools). Thus, cantonal policies decisively influence the extent to which persons are able to access health care at their place of residence. However, little is known about cantonal practices regarding undocumented migrants' access to health care and health insurance (see 'Practices of Insurers' below).

Obligatory Basic Health Insurance

As Switzerland applies a global health insurance scheme that is obligatory for all persons residing in Switzerland longer than three months the scheme also includes undocumented migrants. Statutory basic health insurance is offered by a number of health insurance funds and private insurance companies which comply with the requirements of the health insurance law. Monitored by the Federal Office of Public Health, all registered insurance companies offering basic coverage must be non-profit.²⁵ Residents have free choice among insurers, who are in turn obliged to accept all applicants for the basic package of benefits. Individual insurance contributions can only vary by age²⁶ group and regionally (see Obinger 1998: 39). Apart from the obligatory basic health insurance, employers must register their employees with occupational accident insurance, which also covers non-work related accidents. As already mentioned above, the right to work-related social security is not based on having a work permit, but on the existence of a factual employment relationship.

²⁴ See *Schweizerische Konferenz für Sozialhilfe (SKOS)*, <http://www.skos.ch/de> (last accessed: 17 July 2011).

²⁵ Supplemental coverage may be for-profit. Thus, often insurance companies offer both compulsory and supplementary insurance policies.

²⁶ Children up to the age of 18 have to pay only half of the monthly insurance premiums. See also chapter 'Costs for Care' below.

4.3 Financing, Services and Providers

The Swiss health system is mainly financed by individual contributions (66.8%: including insurance contributions and patient co-payments, as well as employees' contributions), state subsidies (26.8%) and employers contributions (6.4%) (FOS 2009c, 23).

Main health providers for medical care are office-based general practitioners (GPs), public hospitals or private clinics. Basic insurance covers both, treatment by general practitioners and specialist care. Patients generally are free to choose any GP who would refer them to specialists, if needed, but may also make use of specialists in an ambulatory care setting (European Observatory 2000, 43).

Services Provided Within the Mainstream System

Basic health insurance covers 'services provided in the event of sickness or an accident (diagnosis, treatment, medical care) and maternity care' (see AVS/AI 2009). The basic set of benefits that equally applies to all insured persons thus includes:

- primary care,
- secondary care (both outpatient and inpatient care),
- pre-natal and post-natal care including nursing counselling and birth,
- reproductive care including abortion within the first three months of pregnancy,
- psychotherapy if prescribed by a GP,
- preventive measures (e.g. mammography for certain risk groups, gynaecological preventive check-up every three years, screening for babies and children, basic vaccinations for children and elderly persons),
- prescribed medical rehabilitation measures.

Dental treatment is as a principle not covered by basic health insurance.

4.4 Basis of Entitlement

The basis of entitlement to health care is the mandatory health insurance for all persons residing in Switzerland. As a principle, insurance companies are obliged to accept everyone. Cantons have to ensure that all persons residing on their territory are covered by basic health insurance.

All persons gainfully employed may claim appropriate treatment for the consequences of an accident and occupational diseases under related insurance schemes.

Persons without basic health insurance are entitled to 'basic' health care on the basis of article 12 of the Federal Swiss Constitution (see also 'Access to Different Types of Health Care').

4.5 Special Requirements for Migrants

Following the obligatory basic health insurance, effective since 1996, everyone residing in Switzerland has the right and the duty to take out basic health insurance, if not covered by health insurance in another EU or EFTA country (except for Romania and Bulgaria) or a country Switzerland has concluded bilateral social security agreements

with. Asylum seekers are registered with the basic health insurance during their asylum procedure.

5 Health Care for Undocumented Migrants

5.1 Relevant Laws and Regulations

Based on the Federal Constitution of the Swiss Confederation (article 12 and 41) every person residing in Switzerland is granted access to basic health care. Article 12 of the Constitution – the ‘right to assistance when in need’²⁷ – defines the minimum level of assistance necessary for survival and for leading a life in human dignity. This right cannot be restricted and applies to every person irrespective of residence or insurance status. Moreover, the federal state and the cantons are obliged by virtue of article 41b of the Federal Constitution (‘Social Objectives’) to ensure that ‘everyone has access to the health care that they require’.²⁸ Article 12 does not define the particular services or benefits to be allocated in order to ensure the right to assistance when in need, but the cantons and municipalities are responsible to transpose article 12 into their respective bodies of law, which may well exceed the absolute minimum threshold set in article 12. Moreover, health care providers who refuse to offer assistance in case of emergency are punishable under criminal law.²⁹ This is also supported in a statement by the Swiss National Advisory Commission on Biomedical Ethics who emphasizes that health professionals have a ‘moral duty’ to provide medical assistance to persons in distress, irrespective of their residence status and irrespective of any political regulations.³⁰

With regard to health care, the main instrument to transpose article 12 of the Federal Constitution is the Public Health Insurance Law. Undocumented migrants, as any person present in Switzerland for more than 3 months³¹ have the obligation and the right to contract a health insurance. The Public Health Insurance Law makes no distinction in regard to the residence status of the person staying in Switzerland. Undocumented migrants under the statutory health insurance have access to basic health care. Under the Public Health Insurance Law, insurance companies offering compulsory health insurance are obliged to accept all applicants for the basic package of benefits irrespective of individual risk related to e.g. gender, solvency, or residence status (see Obinger 1998: 39). In addition, according to Swiss accident insurance Law (*Bundesgesetz über die Unfallversicherung*) all persons gainfully employed in Switzerland must be insured by their employers against risk of accident and occupational disease. This obligation also applies to undocumented migrants in an employment relationship.³²

²⁷ Federal Constitution of the Swiss Confederation of 18 April 1999 (Status as of 17 May 2009), available at: <http://www.admin.ch/org/polit/00083/index.html?lang=en> (last accessed: 17 July 2011); Article 12: ‘Right to assistance when Persons in need and unable to provide for themselves have the right to assistance and care, and to the financial means required for a decent standard of living.’

²⁸ Article 41b of the Federal Constitution of the Swiss Confederation.

²⁹ Article 128 Swiss Penal Code

³⁰ Swiss National Advisory Commission on Biomedical Ethics (*Nationale Ethikkommission im Bereich Humanmedizin*), Stellungnahme Nr.8/2005 ‘Medizinische Betreuung ist Pflicht’.

³¹ Exceptions are listed in article 2ss of the Ordinance on health insurance of 27 June 1995, available at: http://www.admin.ch/ch/f/rs/c832_102.html (last accessed: 17 July 2011).

³² This includes: home workers; apprentices; trainees and voluntary workers; persons working in workshops for apprentices and the disabled; household staff; cleaning staff employed in private households (see: AVS/AI 2009, 75).

In order to register with an insurance company to take out basic health insurance, applicants have to provide their full name, date of birth, a contact address and a bank or post account (bank account holder must not necessarily be the person insured). In case the applicant's residence is not formally registered, the actual domicile is to be considered as place of residence. In December 2002 the Federal Social Insurance Office issued an order by which insurance companies are encouraged – under the threat of sanctions - to equally accept applicants without legal residence status.³³ In the same month, the Federal Social Insurance Office and the Federal Office of Public Health, in a communication to the cantonal governments, reiterated cantonal responsibility towards monitoring the insurance obligation and ensuring basic health care for all residents, also undocumented migrants.³⁴ Moreover, in 2005 the Swiss Federal Court³⁵ ruled that insurance companies also have to admit persons retroactively, i.e. after serious illness or a hospital sojourn, if the person has been a resident in Switzerland at the time of treatment.

In March 2010, a motion by a representative of the Swiss Peoples Party (SVP) has opened a debate on the right of undocumented migrants to health insurance. The motion claimed for excluding undocumented migrants from basic health insurance by questioning whether the idea of solidarity of the social health insurance was not unduly strained and by pointing to the fact that health insurance coverage conflicts with the duty of the state to control immigration. The Federal Council rejected the motion by clarifying that access to high quality care for the entire population represents a major social progress that should not be restricted.³⁶ Moreover, access to basic health care is a fundamental right protected by the Swiss Federal Constitution, and cannot be denied to any person on Swiss territory.

5.2 Access to Different Types of Health Care

As Switzerland applies mandatory health insurance undocumented migrants are entitled to the basic set of benefits included in the insurance package, that is offered to all persons resident in the country including out- and inpatient medical treatment, prescribed medication, care for pregnancy and birth, as well as treatment in case of accident. However, evidence shows that not all undocumented migrants may be able to take out health insurance in practice.

On the basis of the Federal Constitution of the Swiss Confederation (Article 12) all persons are entitled to 'assistance when in need', including all 'essential resources to lead a dignified human existence'. As there is no exact definition, the scope of health care under this provision is subject to interpretation and debate on whether health care should be provided only in emergency cases (i.e. life-threatening situations) or beyond. The Federal Tribunal in its jurisdiction refers to 'basic medical care' (medizinische

³³ Federal Social Insurance Office (2002) 'Versicherungspflicht der Sans-papiers', Order to the KVG Insurance Companies from 19th December 2002. FSIO: Bern. Available at: http://www.sg.ch/home/gesundheit/formulare_merkblaetter/krankenversicherung.Par.0006.DownloadListPar.0013.FileRef.tmp/SansPapiers_Kreisschreiben_Bund.pdf (last accessed: 17 July 2011).

³⁴ Federal Social Insurance Office/ Federal Office of Public Health (2002) 'Sans-papiers: Krankenversicherung und Zugang zur Gesundheitsversorgung', Communication from 23rd December 2002 to the cantonal governments. FSIO/FOPH: Bern.

³⁵ Eidgenössisches Versicherungsgericht, Sozialversicherungsabteilung des Bundesgerichts, Prozess (T 7)K 34/04, Urteil vom 2. August 2005, <http://www.bger.ch/index/jurisdiction/jurisdiction-inherit-template/jurisdiction-recht/jurisdiction-recht-urteile2000.htm> (last accessed: 17 July 2011).

³⁶ Motion by Alexander Kuprecht: „Aufhebung der KVG-Grundversicherungspflicht für Sans-Papiers“ of 18.3.2010. Available at: http://www.parlament.ch/D/Suche/Seiten/geschaeftte.aspx?gesch_id=20103203 (last accessed: 17 July 2011).

Grundversorgung).³⁷ This is also supported by the FOPH, who clearly states that 'assistance when in need' is to be interpreted much broader than emergency help and thus, health care provided should go beyond mere emergency care.³⁸ Furthermore, experts such as Kiener and von Büren (2007, 13f) confirm that the right to assistance also applies to non-emergency cases. In practice, the type of services provided depends on the individual patient and has to be assessed by the health staff in charge on a case-by-case basis (see also Efonyai-Mäder et al. 2010, 65).

Furthermore, interpretation and implementation of article 12 in regard to health care varies across cantons and municipalities. In this context, several cantons for example, have established the right to 'necessary' health care in their cantonal constitutions (Miccoli 2006, 34).³⁹ In December 2001 the Advisory Board of Medical Ethics of the University Hospital of Geneva recommended that also undocumented migrants should be entitled to receive 'basic' medical care, in emergency and non-emergency cases irrespective their insurance status. Based on this recommendation, in Geneva all patients have the right to all 'vital' care and to all health care necessary to protect public health and to lead a life in human dignity.⁴⁰

Summarizing, every person resident in Switzerland, irrespective of residence and insurance status, has the right to 'basic' health care. The cantons and municipalities are free to regulate this condition in their respective legislation, as long as they keep the minimum threshold as defined in article 12 of the Swiss Federal Constitution. Finally, health professionals have to decide on a case-by-case basis on the adequate treatment provided to a patient in need.

5.3 Costs for Care

Costs for Care in the Mainstream System

Regarding coverage of cost for undocumented migrants who take out basic health insurance, the same rules apply as for any insured persons.

Every person registered with obligatory health insurance has to cover:

- A monthly per capita insurance premium, which can vary significantly depending on the canton of residence and service. In 2009 the average premium ranged between 230 CHF in the canton Nidwalden and 420 CHF in the canton Basel-city.⁴¹ For children up to the age of 18 premiums ranged between 56 CHF in Nidwalden and 101 CHF in Basel.
- An annual excess (*Jahresfranchise*) in the amount of 300 CHF per adult person. The insured person may choose a higher excess rate, ranging between 500 and 2,500 CHF, in order to reduce the monthly premiums. Minors are exempted from

³⁷ See Decision by the Federal Tribunal, Reference No. 2P 318/2004, of 18 March 2005.

³⁸ Interview with expert at the FOPH, 1.4.2011.

³⁹ E.g. Appenzell Ausserrhoden, Berne, Neuchâtel, Tessin.

⁴⁰ Conseil d'Ethique Clinique, recommendations concerning 'Prise en charge clinique de patients requérants d'asile frappés d'une décision de Non Entrée en Matière (NEM), et attribués à un autre canton que Genève', Geneva on 15 October 2007.

⁴¹ Kantonale Durchschnittsprämien 2009/2010 der oblig. Krankenpflegeversicherung (mit Unfall), FOPH, Bern. Last update: September 2009; available at: http://www.bag.admin.ch/themen/krankenversicherung/00261/index.html?lang=de/webgrab_path (last accessed: 17 July 2011), <http://www.praemien.admin.ch/2010/index.php> (last accessed: 17 July 2011).

obligatory excess payments (but parents may opt for an excess in order to reduce monthly premiums). Once an insured patient's chosen annual excess has been consumed, the health insurer starts to pay all subsequent health care bills for the client.

- In addition to the annual excess, the client provides a 'patient's contribution' of 10% of care costs up to an annual maximum sum of 700 CHF for adults and 350 CHF for children and teenagers (see FOPH 2009). There is no patient contribution for costs related to pregnancy and birth.⁴²

The cost monitoring of the Federal Office of Public Health shows, that the average total monthly costs for basic health insurance between January and July 2010 amounted to 272 CHF (gross) per person.⁴³

According to the health insurance law⁴⁴ persons living in a 'modest economic situation' may be granted a reduction of the monthly premiums. This regulation also applies to everyone, included to undocumented migrants.

In order to ensure access to health care, cantons can indeed grant subsidies to persons on low incomes which may amount to 100% for people living in social exclusion (Médecins Du Monde 2009, 36). In many cantons however, the reduction only covers a (small) part of the premium for adults.⁴⁵

Furthermore, the conditions on which reduced monthly premiums are granted to persons in need vary across cantons.⁴⁶ Some cantons, such as Geneva and Neuchatel, require applicants to produce an income and tax statement on the basis of which the neediness is evaluated (see also Achermann 2003, 10). Consequently, in some cantons persons who do not pay taxes do not have access to reduced monthly premiums and may thus not be able to take out basic health insurance at all. However, a systematic analysis of the conditions on which premium reductions are granted to undocumented migrants is still missing.

Costs for Care Outside the Mainstream System

Persons not covered by health insurance have to bear the full costs of the treatment, with the exception of emergency care. According to a study on health care provided to undocumented migrants in Switzerland published in 2006 this may involve between 50 and 100 CHF per consultation with a general practitioner (Achermann/Chiementi 2006, 150). Furthermore the authors report that undocumented migrants were asked to pay a deposit between 4,000 CHF and 20,000 CHF in the event of giving birth⁴⁷ (Achermann/Chiementi 2006, 152). Based on consultancy work with sex workers, the *Aids-Hilfe Schweiz* reports that persons without insurance have to pay a deposit of approximately 500 CHF if they need hospitalization (Aids-Hilfe Schweiz 2009, 6).

⁴² See also 'Informationen zur Krankenversicherung für Sans-Papiers in der Schweiz', available at: http://www.redcross.ch/data/dossier/24/redcross_dossier_24_28_de.pdf (last accessed: 17 July 2011).

⁴³ Monitoring der Krankenversicherungs-Kostenentwicklung (II. Quartal 2010), available at: http://www.bag.admin.ch/kmt/index.html?webgrab_path=aHR0cDovL3d3dy5iYWctYW53LmFkbWluLmNoL2t1di9rb3N0ZW5tb25pdG9yaW5nX2xpdmUva21fZGUucGhwP21vZD0wJmIkMT0wJmxhbmc9ZGUmbmF2PVVdyOSZtYXA9YWJz&lang=de (last accessed: 17 July 2011).

⁴⁴ article 65 (1) KVG

⁴⁵ The premium reduction for minors covers the whole premium.

⁴⁶ www.gdk-cds.ch (last accessed: 17 July 2011).

⁴⁷ This shows also that giving birth may not necessarily be dealt with under the framework of 'emergency care'

Following this information, medical treatment beyond emergency treatment most likely is unaffordable for the majority of undocumented migrants who are not insured.

Despite the cantonal responsibility for guaranteeing basic health care to all persons resident on the canton's territory, there is no uniform procedure for covering treatment costs for undocumented migrants without health insurance, but practices vary between health providers and cantons.⁴⁸

Generally, costs for treatment for undocumented migrants may be covered by:

- the insurance company, if health insurance was taken out (also for treatment that dates back up to three months);
- the employer's accident insurance, if the patient had an accident at or outside the workplace
- the canton or the municipality from their solidarity and social funds;
- the health providing organisation (some hospitals have installed a specific fund for the purpose of covering the treatment costs for non-insured persons).
- the patients themselves. In this case payment may be effected in special payment arrangements to be negotiated with the health provider, or with the help of non-governmental organisations (Achermann/Efionayi-Mäder 2003, 80; Nationale Plattform Gesundheitsversorgung für Sans-Papiers).

5.4 Specific Entitlements

Undocumented Children: Health in School

Undocumented children are subject to the same restrictions as undocumented adults. However, school children have access to some health care services through the school system. As the first nine years of education are mandatory for all children living in Switzerland, this is also compulsory for undocumented children. School doctors and paediatricians indeed perform basic medical and preventive check-ups, provide free of charge vaccination as well dental screening in all schools. Any other treatment outside of school has to be organized by the parents (Médecins du Monde 2009, 37). Nevertheless, like other Swiss institutions also the school system is federalised, and thus differences in the implementation of school children's rights can be observed. In Geneva, for instance, school children are required to take out health insurance by cantonal law. In this context, the cantonal authorities in cooperation with child-care organisations cover basic health insurance for children in need (Achermann 2003, 9).⁴⁹ In 2002, 1,522 children without legal residency were registered at the cantonal insurance authority in the health insurance system (Achermann 2003, 9).

⁴⁸ See Request No. 09.3484 from Bea Heim to the Swiss Federal Council from 28.5.2009 '*Postulat: Sans-Papiers. Krankenversicherung und Zugang zur Gesundheitsversorgung*'. Available at: http://www.parlament.ch/D/Suche/Seiten/geschaefte.aspx?gesch_id=20093484 (last accessed: 17 July 2011).

⁴⁹ Achermann, C. (2003). '*Krankenversicherung für Sans-Papiers: Die aktuelle Situation in Recht und Praxis*.' Asyl 3/03: 8-11.

5.5 Regional and Local Variations

Outline laws issued by the Federal Government are executed by the 26 cantons (FOM 2009b, 24). Thus, as has become apparent throughout this report, the implementation of the respective laws greatly varies across the cantons which results in strong regional and local variations as regards access to health care for undocumented migrants (e.g. costs for health insurance, general cantonal approach towards UDM). Some cantons are known to follow a more liberal approach as regards matters of immigration and social welfare, while others are more restrictive. This is also reflected by the regulations and implementations of state emergency aid, as well as the monitoring of the insurance obligation by the cantons. However, very little is still known on respective cantonal practices in detail.

5.6 Obstacles to Implementation

*Cantonal Practices*⁵⁰

Conflicting interests of immigration law enforcement and public health care principles may be best illustrated in the area of emergency aid (*Nothilfe*). Persons whose asylum application was rejected or not admitted (NEE) are entitled to receive emergency aid (*Nothilfe*) until they have left the country.⁵¹ Under the responsibility of the cantonal administrations emergency aid and the respective services covered (e.g. food, shelter, health care) are regulated differently in each of the 26 cantons. The health service costs for persons receiving emergency aid are to be covered by the cantonal authorities (see Efonayi-Mäder et al. 2010, 66). Following legal amendments in 2004 and 2008 which restricted basic support for unsuccessful asylum seekers to emergency aid (formerly access to social assistance benefits and automatic basic health insurance coverage), several cantons started deregistering this group of persons from basic health insurance while other cantons continued covering health insurance at least for particular groups, such as persons whose return cannot be enforced, persons with serious illnesses resulting in extraordinary high treatment costs, or for specific risk groups (e.g. long-term recipients of emergency aid, persons with chronic diseases, families with children) (see Appendix; Achermann 2009; Trummer 2008).⁵² In cantons where this group of persons is not (automatically) covered with health insurance anymore recipients of emergency aid may request medical treatment at the competent authority: either the social service office or the immigration authority, which decide whether the requested treatment needs to be provided or not. Empirical evidence shows that access to the necessary treatment in these cases is not always guaranteed because the responsible civil servants usually lack the necessary medical expertise in order to assess the urgency of a treatment (Achermann 2009).

⁵⁰ In July 2011, an amendment to the Public Health Insurance Law regulated that emergency aid recipients have to be obligatorily covered by basic health insurance by the cantons until they have left the country. Costs are covered by the cantons. If there is evidence that a person is no more residing in Switzerland, the payment of insurance premiums is suspended to avoid lengthy cost recovery procedures (see: Verordnung über die Krankenversicherung (KVV), Änderung vom 6. Juli 2011, available at: <http://www.bag.admin.ch/themen/krankenversicherung/06368/index.html>, (last accessed: 17 July 2011).

⁵¹ According to the Federal Office for Migration in 2008 a total of 4,308 persons received a negative asylum decision or their application was found to be inadmissible. Out of this group, 56% had applied for emergency aid thereafter (FOM 2009c, 3)

⁵² Gautier, Dinu (2008). Asyl und Gesundheit. Illegale dürfen erblinden. WOZ. Ressort Schweiz. 06.03.2008

This practice contradicts the obligation of cantons to ensure basic health insurance coverage of the entire population present on their territory. Moreover, according to the FOPH limiting medical assistance to emergency care for some categories of persons goes against the constitutionally guaranteed right to equal treatment (article 8 Federal Constitution) and to basic health care (article 12 Federal Constitution).

Practices of Insurers

Still little is known about the compliance of insurance companies with their obligation to accept undocumented migrants. In this regard, following a request to the Swiss Federal Council on the insurance situation and access to health care of undocumented migrants,⁵³ the Federal Office for Public Health commissioned a study to analyse the practices of insurance companies towards undocumented migrants, which is expected to be finalised in the course of 2011.

5.7 Obligation to Report

Health personnel (in hospitals and ambulatory services) are bound to professional secrecy. As regulated in article 321 Swiss Criminal Code, they are not allowed to report any personal information including the residence status of a patient to any third party (Davet 2008). According to Article 84ff KVG also insurance companies are not allowed to pass on any data on the residence status of their clients.

Responding to complaints about non-compliance of the insurers, the Federal Insurance Office in December 2002 ordered the insurance companies that no personal data of undocumented clients is to be processed to third parties.

5.8 Providers and Actors

Generally, in Switzerland three main categories of health providers for undocumented migrants can be distinguished:

- 1) Services which are integrated into public hospitals,
- 2) Low-threshold medical or social drop-in centres run by non-profit or non-governmental organizations, and
- 3) Publicly (co-)financed services offering specialised care on specific health topics and targeting specific risk groups.

Civil society actors are certainly important actors promoting health care access for undocumented migrants. Some cantons have established cooperation with NGOs or established specific dedicated services that facilitate access of undocumented migrants to health care. These services are unequally distributed between the cantons, but also within a canton (e.g. between city and countryside). A detailed description of the providers and actors involved in providing health care for undocumented migrants in Switzerland is provided by Chantal Wyssmüller and Denise Efonyi-Mäder later in this

⁵³ Response to a Request No. 09.3484 from Bea Heim to the Swiss Federal Council of 2.9.2009 'Postulat: Sans-Papiers. Krankenversicherung und Zugang zur Gesundheitsversorgung'. Available at: http://www.parlament.ch/D/Suche/Seiten/geschaefte.aspx?gesch_id=20093484 (last accessed: 17 July 2011).

volume. Moreover, a detailed list of health care practices can be found in the database of the NowHereLand project.⁵⁴

6 Conclusions

The right to health care for every person living in Switzerland is protected by federal legislation defining the obligation and the right to take out basic health insurance. Apart from this, also persons without basic health insurance coverage have the right to 'basic' health care by virtue of article 12 of the Constitution of the Swiss Federation. Moreover, several policy documents issued by the federal government and directed towards the cantonal administrations and insurance companies specifically deal with access to basic health insurance for undocumented migrants. Thus, undocumented migrants have the right to health care through basic health insurance. However, in practice access of undocumented migrants to health insurance proves to be highly complex and remains a matter to investigate. One of the main obstacles to realise the right to basic health insurance can be identified in the financing of insurance premiums and treatment contributions. Although persons in a 'modest economic situation' have a right to apply for reduced insurance premiums, complex administrative procedures and requirements can easily result in difficulties in effectively implementing the given regulation. Moreover, the large autonomy of the cantons in monitoring the health insurance obligation, as well as in regulating matters of minimum social and health care support, result in cantonal variations as regards health care coverage for undocumented migrants. Furthermore, only little is known on the actual practices of insurance companies to accept undocumented migrants. Although undocumented migrants in Switzerland are granted a right to health care to the same conditions as Swiss nationals, undocumented migrants face considerable difficulties to realise this right, depending on their economic situation, their place of residence, as well as their administrative status.

⁵⁴ http://www.nowhereland.info/?i_ca_id=416 (last accessed: 17 July 2011).

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Appendix

APPENDIX 1 Health Insurance (HI) Coverage for Recipients of Emergency Aid in the 26 Swiss Cantons

Name of canton	Competent authority for emergency aid	HI for all recipient of emergency aid	HI for specific groups
AG	Cantonal social service	Yes	Recipients must be officially registered in a municipality
AR	Migration department	No	Rejected asylum seekers
AI	Department for Aliens Affairs	No	HI only for constant recipients of emergency aid
BL	Cantonal social services	Yes	
BS	Cantonal social service	No	HI only if treatment costs exceed CHF 1,000
BE	Migration department	No	HI only for persons residing in a municipality
FR	Cantonal social service	Yes	HI for persons resident more than 3 months
GE	Cantonal population office/asylum department	No	HI only for rejected asylum seekers; not for persons with NEE
GL	Cantonal social service	Yes	
GR	Aliens police	No	
JU	Aliens police	No	
LU	Cantonal social service	Yes	
NE	Migration department	Yes ¹	
NW	Asylum department	Yes	
OW	Migration department	Yes	
SG	Municipalities	No	Regulations depend on municipality
SH	Cantonal social service	No	
SZ	Aliens police	No	HI only for constant recipients of emergency aid
SO	Department for social security and asylum	No	
TG	Migration department	No	HI only in exceptional cases
TI	Cantonal social service	No	HI for families with children
UR	Municipalities	Yes	
VS	Population and migration office	No	
VD	Aliens police	Yes ²	
ZG	Migration department	Yes	
ZH	Migration department	No	

Source: Trummer 2008, Bolliger/Féraud 2010

Notes: The *Schweizer Flüchtlingshilfe* is going to publish an update to the 2008 report by Muriel Trummer, which was not publicly available by the time of writing this report. However, according to a draft version which was provided to the authors of this study, the report does not contain any changes with regard to the data presented in the table.

¹ Regarding Neuchâtel the two sources referred to in this table show contradictory information. While Trummer (2008) refers to the response to a survey in which the cantonal authority confirmed that recipients of emergency aid are covered by health insurance, Bolliger and Féraud (2010) state that undocumented migrants are only partially registered with basic health insurance in the canton of Neuchâtel.

² Regarding Vaud the two sources referred to in this table show contradictory information. While Trummer (2008) refers to the response to a survey in which the cantonal authority confirmed that recipients of emergency aid are NOT covered by health insurance, Bolliger and Féraud (2010, 30) state that this group of persons is registered with basic health insurance.

PEOPLE & PRACTICES:

Undocumented Migrants' Needs and Strategies to Access Health Care in Switzerland & Practices of Health Care Provision

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1 Introduction

An estimated 1 to 4% of the overall population of Europe are undocumented migrants (UDM) (see Bilger and Hollomey in this volume; Clandestino-Project 2010; 2009), living in a 'NowHereLand', where they face potentially precarious and health-threatening living conditions. NowHereLand is a paradoxical place: inhabitants are officially invisible, yet remain part of social reality, and health care providers have to deal with them and with the conflicting demands of immigration control, of the basic human right for health care, and of the simple desire to help.

Health care organisations and professionals face a dilemma: if they provide care, they may, under some circumstances, be contravening legal and financial regulations, if they do not provide care they are violating the Hippocratic Oath, human rights and excluding the most vulnerable.⁵⁶ Furthermore, the issue of legal status confronts UDM with their *own* dilemma, as demanding access to health care may threaten their position by rendering them visible to 'the system' and leading to imprisonment and/or deportation.

This paradox cannot be resolved on the level of practice alone, but has to be worked out by diverse actors and organisations, particularly those operating on the policy level. Non-governmental organisations (NGO), for example, play an important role in assuming the management of health care provision by providing resources and bridging the gaps between policy frameworks and people's needs.

1.1 The Swiss Context

Like other European countries, Switzerland can only estimate the numbers of undocumented migrants living within its borders. A survey of employers suggested a number between 70,000 and 180,000 persons living undocumented in the country (Piguet and Losa 2002). Another study on behalf of the Swiss Federal Office for Migration (FOM) suggested that, in the summer of 2004, between 80,000 and 100,000 UDM lived in Switzerland (Longchamp et al. 2005). However, these estimates must be interpreted with caution: an accurate count of the numbers of UDM living in a country or region is almost impossible.

While the profile of UDM in Switzerland is largely unknown, some points of convergence across different studies do exist: a majority appear to be female and employed. Their sectors of activity are mainly: private households (including care for children or the elderly), catering and the hotel business, construction, agriculture, the sex industry, cleaning and various casual jobs (Piguet and Losa 2002).

However, as different routes to becoming undocumented exist, UDM clearly do not constitute a homogenous group but, rather, encompass people with very different migration histories and socio-economic backgrounds (see Bilger and Hollomey in this volume). Moreover, the UDM population in Switzerland is highly fluid.

The legal framework, mainly the Public Health Insurance Law (*Krankenversicherungsgesetz*), which obliges all persons residing in Switzerland for more than three months to be covered by health insurance (see Bilger and Hollomey in this volume), is considered as a reference point throughout this report. However this does not mean that the legitimacy of this ruling must be left unquestioned. Several actors, politicians and UDMs contest this arrangement, even though it is meant to protect UDM (amongst other) should they need medical care.

⁵⁶ Concerning this concept see 2.2.3

1.2 Structure of the Present Report

In the remainder of this contribution, the methodology applied for surveying existing health care services for UDM in Switzerland and for data collection concerning their health care needs and strategies will be briefly described. The second chapter will deal with UDM's health needs and the strategies they apply in order to access care (People-Module), while in chapter 3 we will give an overview of the services surveyed, classified on the basis of organisational characteristics (Practices-Module). Chapter 4 will summarize some observations and trends relating to health care services for UDM in Switzerland and draw some conclusions.

1.3 Approach and Methods: Switzerland

Surveying Health Care Services

In order to collect (written) data on the health care services for UDM which is provided in the different participating countries, a questionnaire was created within the Practices-Module of the *NowHereLand-Project* (cf. www.nowhereland.info/?i_ca_id=406). To ensure comparability, we used this questionnaire for data collection in Switzerland. A few adaptations in terminology were permitted, however, and we also added some response options which seemed appropriate with respect to the local context.⁵⁷ Furthermore, the Swiss version of the questionnaire was translated and made available in the two principal national languages, German and French (for the Swiss version cf. **Error! Reference source not found.**).

The survey aimed, in particular, to collect information about services through which access to health care for UDM is assured or at least facilitated. We were interested in collecting data on several effective approaches or models in different regions of the country. For obvious reasons, we chose not to focus on health care institutions and services which are not active in the development and implementation of practical measures of health care provision for UDM, or which attach no particular importance to guaranteeing access for this population group.

As specified by those responsible for the *NowHereLand-Project's* Practices-Module, very broad information on the study – accompanied by an invitation to complete the attached questionnaire and return it via e-mail or post – was distributed in mid-September 2009 using an e-mail distribution list provided by the *Network of Health promoting Hospitals Switzerland (HPH)*.⁵⁸ It reached about 400 people including staff of health-care and health-care related institutions throughout the country, and members of the *Migrant Friendly Hospitals (MFH)* section of HPH⁵⁹ who, in particular, were thought to have developed interesting practices. Such a broad informative measure was chosen in order to be sure not to miss a service, although we knew that the large majority of the targeted audience did not fulfil the criteria necessary for participation in the survey.

⁵⁷ For example, the question of health insurance affiliation of UDM is a crucial one given the structure of the Swiss health care system. Therefore, in the Swiss version of the questionnaire, we gave respondents the possibility to tell us whether they help UDM to take out health insurance.

⁵⁸ See <http://www.healthhospitals.ch/> (last accessed: 17 July 2011).

⁵⁹ See <http://www.healthhospitals.ch/de/mfh-sektion-mfhsektion-331/ziele-mfh-mfhsektion-312.html> (last accessed: 17 July 2011).

Another key target of the questionnaire was member institutions of the *National Platform for Health care for Sans-Papiers in Switzerland*⁶⁰, a platform coordinated by the Swiss Red Cross (SRC). These institutions, many emanating from NGO initiatives and located in different cantons, are all – as their membership of the aforementioned platform suggests – committed to facilitating access to health care for UDM (cf. National Platform for Health care for Sans-Papiers in Switzerland). Hence, positive responses and relevant data were expected from these institutions.

Furthermore, the questionnaire was distributed to local branches of *Aids-Hilfe Schweiz (AHS)*. AHS is the nationwide umbrella organisation representing non-profit organisations (NPO) active in HIV/AIDS prevention and counselling across the country.⁶¹

Finally, the questionnaire was also sent to a number of institutions which had attracted our attention, either due to the data we had already collected, or to information gleaned from internet research or the relevant literature.

By the end of November 2009 twenty completed questionnaires had been returned to the research team.⁶² This seems to be a very limited number, but is less so when compared internationally. These surveyed data were completed by data collected through telephone interviews, conducted with representatives either of the institutions surveyed or of other health care services⁶³ or with informants contacted in the framework of the *NowHereLand* People-Module (see below and chapter 2).

The totality of the collected data enables us to describe in detail, in chapter 3, eighteen health care services for UDM, and to outline the basic functioning of a number of additional services. The services described are distributed across three linguistic regions and ten different cantons - in rural areas and some smaller towns no similar practices exist⁶⁴. In most other cantons, no such services exist or existed at the time of the survey. Virtually all services affiliated to the SRC platform – and therefore particularly relevant to our purposes – answered our questions. This is not surprising since these services specialise in providing care, and/or facilitating access to health care, for UDM. In the opinion of staff, the survey touched upon a salient issue and therefore they had a particular interest in presenting their activities - activities which they consider necessary. Thus, motivation to participate was high, even if it sometimes required considerable effort from the staff to provide (some of) the data requested (see below).

The response rate for services contacted via the HPH distribution list was significantly lower. Again, this was to be expected, firstly since many recipients are not health care providers at all. Secondly, since many of them, although staff members of health care institutions, probably did not consider the survey of a priority to their work, either because they did not see their institution as a health care provider for UDM, or because they did not have the

⁶⁰ This platform encompasses services specialised in health care provision and counselling for UDMs in Switzerland (see http://redcross.ch/info/dossier/dossier-de.php?dossier_id=24) (last accessed: 17 July 2011).

⁶¹ See <http://www.aids.ch/d/index.php> (last accessed: 17 July 2011).

⁶² Not all proved useful, six having been completed by services which cannot be considered UDM health care providers.

⁶³ Although the questionnaire had been adapted as far as possible to the Swiss context, as the questions asked and the response options specified were not always easy to interpret without ambiguity by Swiss health care providers, we suggested to potential respondents that we call them in order to collect information by phone. Several chose this option, and in these cases the questionnaires were filled in or completed by the research team on the basis of the information provided by the respondents.

⁶⁴ * GE, VD, FR, NE, BE; AG/SO, BS, ZH, TI. A new information desk is currently being set up in Luzern. [Abbreviations - see glossary.]

necessary knowledge and data – or, perhaps, the necessary time – to complete the questionnaire⁶⁵.

Concerning the local AHS branches contacted, while a small number did return a completed questionnaire, it soon became clear that these branches do not, in most cases, provide health care services to UDM, but exclusively prevention and counselling services. Despite this decision to exclude purely prevention- and counselling services from the survey, we will nevertheless, in the following, repeatedly refer to the important role they play, in many places, in reaching the target group and in connecting sick UDM to local health care providers disposed to treat them.

The report describes and categorises a number of selected services who chose to answer our questions. These services are, indisputably, those most specialised in receiving this particular population group and – of these services – it could be argued that it was the more professionalized providers which had the ability and resources to respond to our survey.

One challenge we faced concerned the quality of data collected. To complete the questionnaire, informants needed to possess certain statistical data about their service and its recent performance, yet such data were not available to all of the services contacted: some barely, if at all, collect statistical data about their clients and/or the variety and quantity of services they provide. Others do, but not systematically, and – even where data *are* collected – it is not guaranteed that service providers will, for example, ask clients about their legal status as many consider strict anonymity to be crucial to the functioning of their services. Thus, virtually none of our informants was in a position to provide the exact data required by the questionnaire. We encouraged recipients, however, to answer as many of the questions as possible, and to submit the questionnaire even when it was incomplete, explaining, in their own words and to the best of their abilities, what their activities are and which data were available to them.

As a result, data received were highly heterogeneous. The information which services had collected about their clients not only differs in content (one service but not another, for example, enquires about nationality), but also in the categories drawn up for the characterisation of clientele (age categories, for example, differ significantly). Thus, we must keep in mind that data can often not be directly cross compared.

Collecting Data on Health Care Needs and Strategies

In order to be able to present, in the following chapter (2), up to date information and research findings with regard to the general-, and specifically the health-, situation of UDM in Switzerland as well as to their health care needs and strategies, we combined several types of sources.

Firstly, we reviewed the recent scientific literature, whether published or not (see references), and relevant websites.

Then, as we were, for the purposes of data collection for the Practices-Module (see above), in contact with services providing health- and/or social care to UDM in different regions of the country, we collected relevant information from these parties. In addition, as specified by the *NowHereLand-Project*, we conducted semi-structured telephone interviews (focused on this topic) with six specialised informants who are regularly in touch with UDM, among them

⁶⁵ Among the recipients were members of both medical and administrative staff of certain health care institutions. Yet in large hospitals, for example, medical staff might not (or only in a very limited sense) deal with administrative proceedings, and therefore would generally know little about the legal status of patients, while administrative staff, although aware of the administrative procedures necessary for patients without health insurance, might be unable to describe precisely the medical services provided to UDM by the institution concerned.

representatives of NGO active in the field of health care and social counselling as well as health care professionals (a list of interviewees is available upon request). We thereby followed the general approach of the NowHereLand (NHL) project, which tried to collect information on undocumented migrants' health care needs and strategies via providers who were interviewed as experts. In the course of each interview, we systematically asked our interlocutors to describe some concrete cases of UDM who have sought help from their service, this in order to illustrate their statements and to enable us to provide a few vivid 'stories/testimonies' of individuals belonging to the studied group. Last but not least, we interviewed two UDM seeking care with an NGO in the Canton of Neuchâtel. Additionally, we were able to draw on data collected in 2007/8 in the framework of another research project in which SFM was involved (Sanchez-Mazas et al. forthcoming), namely fifteen interviews conducted with UDM who had been assigned NEE status.

The data collected cannot, of course, be considered representative of all UDM in Switzerland. Those who have both the knowledge and the means necessary to take out health insurance and live in a place in which they do not encounter any administrative obstacles to accessing mainstream care are especially likely to remain unidentified (as UDM) by doctors and nurses. This is why the present report does not treat such cases as a central theme and focuses rather on less favourable constellations and specialised services.

In addition, the methodological approach chosen emphasizes the health care providers' perspective. Care providers frequently face administrative and financial difficulties in their work, which may be reflected in a rather problem-driven perspective on the topic, though we tried to take into account resources and opportunities alongside risks and threats in terms of the access to health care for UDM.

When reading about the various health disorders and needs described in the following, we therefore need to keep in mind that there are UDM – and probably not a small number – who are generally healthy, particularly as most seem to be relatively young and possess a good constitution. Nevertheless, the following chapter gives a valuable insight into the spectrum of health care needs occurring in this group and the diverse strategies which UDM apply in order to access care.

2 Undocumented Migrants' Health Needs and Health-Care Access Strategies⁶⁶

2.1 Profiles of Undocumented Migrants Seeking Health Care

Switzerland's UDM population is not static, but in constant flux. Based on the data we collected, we can simply give, in the following, an overview of certain profiles or characteristics of UDM who have been in touch with our informants.⁶⁷ In doing so, we can provide an approximate idea of the diversity of Switzerland's UDM population and the variety of situations in which these individuals live.

UDM not only differ from each other in terms of gender, age and country of origin, but also – equally importantly – in terms of their integration into the labour market, living and housing conditions, integration into social and family networks etc. These properties in turn sometimes vary considerably, not least depending on the 'categories' of UDM – or rather the

⁶⁶ This chapter is equivalent to other contributing countries' 'People's module' reports.

⁶⁷ People active in health care or social counselling in different regions of the country.

routes by which individuals have become UDM – mentioned in chapter 0 (unlawful entry, 'overstay', non-renewal of a residence permit, unsuccessful asylum application).

According to our informants, most UDM with whom they have been in contact are fairly young, between 20 and 40 years of age. In several regional and institutional contexts, a majority of UDM seeking health care are women, which can partly be due to frequently observed gender- and age-specific needs in the realms of sexual and reproductive health (most notably needs relating to pregnancy). In particular, a high number of undocumented women from Latin America or the Caribbean, but also from Sub-Saharan Africa (e.g. Cameroon and Nigeria), eastern Europe or Asia, seek care at the surveyed health care services in western Switzerland (Geneva, Lausanne and Fribourg) as well as in Zurich and Basel. Men seeking health care are often of Balkan origin or – unsuccessful asylum seekers in particular – from North or Sub-Saharan Africa.

While in urban centres the UDM clientele of health care services consists predominantly of women, more men tend to seek help from services in smaller towns, and rural areas have predominantly a male clientele; we assume that some of them are employed in the primary sector.

The majority of UDM clientele at health care services have already spent a long time in Switzerland, on average between one and three years according to a recent internal survey carried out by the SRC. Some, however, have been living in the country for up to fifteen or twenty years. Others have arrived only recently, such as female sex workers, who in particular are often highly mobile.

With regard to employment, undocumented women seeking health care tend, more often than men, to be earning. Many such women work in (several) households, others in the sex industry. Men frequently work in construction, for removals firms, in farming and such like. Even though some have been earning a living in Switzerland for several years and are even able to support a family here, many UDM, even if they have the possibility of working, often can only rely on an irregular income.

Unsuccessful asylum seekers in many cases can hardly find employment at all and usually do not work regularly. This subgroup of UDM is dominated by men, many from Africa (Maghreb and Sub-Saharan Africa), others from eastern Europe, Turkey or (Central) Asia (Iran, Iraq, Afghanistan and Mongolia).

Undocumented former asylum seekers are mostly single, but our informants have also seen couples or families with (young) children. Sometimes they are separated by the authorities because one partner, usually the man, is arrested and incarcerated for some time.

While it is rather unusual that service providers come into contact with the children of UDM, our informants know of many women who have children in their country of origin and who make these children's education possible by earning money abroad.

According to our informants and Winizki (2009), a significant number of UDM seeking health care in Zurich are relatively well educated, most seeming to have attended school for ten to twelve years at least, some having academic degrees. Similar observations were made elsewhere.

English or French/German/Italian speaking UDM have an advantage in communicating with health care providers. As staff of specialised health care services often also speak Spanish or Portuguese, UDM speaking these languages can – in many cases – also communicate in their mother tongue. For UDM who speak none of these languages, communication with Swiss health care staff and mutual comprehension can both be problematic unless interlocutors can call on an interpreter.

2.2 Health Care Needs

As previously mentioned, we must keep in mind that the factors affecting UDM's health, the resources which are available to them and their health problems and health care needs can vary considerably according to their profile and individual situations.

Factors Affecting Undocumented Migrants' Health

Despite the above caveat, we can say that the main factor affecting UDM's health is generally their – for the most part – poor living conditions and the distress caused by the insecurity of their irregular status, as well as (most notably in the case of rejected asylum seekers or those whose claims are deemed invalid) – their lack of future prospects.

Our informants report, supported by the literature consulted,⁶⁸ that UDM attending their services are, generally speaking, not in a condition of well-being. Virtually all seem to suffer, more or less intensely, from mental and/or physical distress, due to the precariousness, on multiple levels, which characterises their daily lives.

The fear of denunciation, arrest, deportation and an insecure future weighs on them. Non-admitted asylum seekers and those whose applications have been deemed invalid, in particular, suffer from a total lack of perspective on their life once their 'migration plan' has failed. These factors then combine with others, first and foremost with the daily struggle for survival which many UDM endure: they have – if at all – insecure employment, unsteady income and, if they can work, they are in fear of losing their job. A further factor that must be added – and which is, of course, related to those already mentioned – is the, in most cases, unfavourable housing conditions (frequently changing and – often – shared, single-room accommodation; lack of privacy) in which many UDM live.

UDM who have made an unsuccessful application for asylum and who apply for emergency aid are housed in collective emergency accommodation or spend nights in emergency overnight drop-ins, which they have to leave the following morning. Moreover, it is not uncommon that they are periodically arrested and incarcerated. They are entitled to basic health care, which means that, in the case of dental problems for example, teeth may be extracted even when a more commonly used treatment would be appropriate. This can, in turn, engender further health problems.

For UDM in stable employment, overall life situation tends to be less precarious. Some, however, face work-related factors that can affect their health: many work in physically and/or psychically demanding conditions (extremely variable working hours, etc.), and often in dangerous jobs with a high risk of accident.

Further factors which can indirectly affect UDM's health, such as lack of health literacy or of knowledge regarding the functioning of many aspects of life in Switzerland, tend to make them dependant on their employers, landlords or other acquaintances⁶⁹. Particularly women, but sometimes also men – are sometimes exposed to physical violence. In their contacts with the authorities or institutions of the host society they often feel discriminated against. Due to their specific situation and living conditions many UDM with poor health suffer from isolation, a feeling of shame and sometimes loss of self-esteem. In addition, they often feel

⁶⁸ When mentioning the literature in general we usually refer to these authors: Achermann (2006), Achermann and Chimienti (2006), Chimienti and Achermann (2007), Faucher et al. (2009), Gross (2009), Hunkeler and Müller (2004), Induni (2009), Lanz (2006), Pohl (2005), Sanchez-Mazas et al. (forthcoming), Schwager (2006), SRK (2006), Tolsdorf (2008), Traber (2008), Winizki (2009), Witzig and Berner (2006).

⁶⁹ By 'acquaintances' we mean friends, family members or other relatively trustworthy persons who know about the UDM's situation (or who will not, it is thought, change their attitude should they discover it) and who tend help the UDM in everyday life either for money or for free.

responsible for family members in their country of origin and compelled to support these family members financially, even when they can hardly make a living themselves.

Generally, the life situations of many UDM are characterised by deprivation and a lack of vital resources (see chapter 'Resources'). Such situations must be considered harmful if not actually pathogenic – negative effects on health are not only immediate but can also make themselves felt years later. The specific life situations of UDM along with the resulting mental stresses and strains can, moreover, bring to the fore health-damaging behaviours such as excessively hard work, unhealthy diet, substance abuse or self-harm.

Furthermore, UDM active in sex work (mostly female) often take risks with regard to their sexual health and to sexually transmittable diseases, on the one hand because of lack of knowledge or means of protection, on the other because they are pressurised into doing so by their clients.

All the above health-influencing factors can lead to various health problems which will be described in the next sub-chapter.

Common Health Problems

According to our informants and the available literature, UDM are affected by a wide range of health problems. To a large extent they **suffer from the same illnesses as the general population**: seasonal illnesses such as colds or influenza; headaches or digestive disorders; contusions and such like; childhood diseases, etc.

Nevertheless, it is observed that some problems and diseases are more frequent in UDM than in other population groups, such as, for example, certain **infectious or sexually transmittable diseases** like Tuberculosis (TB) or HIV. Informants agree that this is a highly relevant issue for Public Health. With regard to (latent) TB, a recent study has demonstrated that prevalence is high among UDM (Bodenmann et al. 2009), and it is also assumed that many UDM are highly exposed to the risk of TB due to their precarious living conditions, as they are, for example, constantly changing accommodation and often sharing a room with (many) others.

Mental health problems are also common, and this is true to an even larger extent of asylum seekers whose applications have been rejected or deemed invalid (NEE) (Goguikian Ratcliff and Strasser 2009 ; Sanchez-Mazas et al., forthcoming), many of whom suffer psychically due to their specific legal and life situation. Three dimensions seem to be of particular relevance in this context: a) the uncertain issue of legal situation already present during the procedure characteristic of all asylum seekers who are awaiting a decision (appeal, re-examination of their application, etc.), b) the fear of being discovered or deported when living 'undocumented', and c) distress linked to traumatic experiences related to persecution and flight. Mental stress is often expressed through insomnia, apathy or psychosomatic symptoms such as headaches, digestive problems or diffuse pains. To relieve suffering, some UDM take medication (pain killers, tranquilizers, etc.), some also begin to consume alcohol or tobacco products (provided they can procure them). This in turn can lead to addiction or further health problems. Some UDM develop heavy depressions, personality disorders or other kinds of serious conditions, others suffer from post-traumatic stress disorder (PTSD). According to observations, for some this may even lead to the expression of suicidal thoughts.

Somatic problems are often work-related (accidents, musculoskeletal problems, backaches, allergies). Many of our informants also mentioned dental care as a major need of UDM as of other underprivileged population groups. Other somatic symptoms frequently described by UDM seeking help from our informants are gastrointestinal troubles, ophthalmological problems and respiratory or skin diseases.

Some UDM also suffer from chronic diseases – besides HIV, diabetes, for example, was repeatedly mentioned by the health care providers interviewed.

Female UDM's need for aid in the fields of sexual and reproductive health also seems to be widespread. Besides pregnancies and births requiring assistance, it is not rare that female UDM suffer from gynaecological problems of some kind. Two studies carried out at the University Hospital of Geneva (Wolff et al. 2005 ; Wolff et al. 2008) showed that, among undocumented, uninsured pregnant women attending a free antenatal facility during 2002/3 and 2005/6 respectively, a high proportion had unintended pregnancies mostly caused by a lack of contraception. The authors of these studies identified, as did several of our informants, this high proportion of unintended pregnancies as a major health issue and recommended improved access to preventative measures for UDM. Unintended pregnancies combined with difficult living conditions lead to a high number of abortions, as observed in one of the studies mentioned (Wolff et al. 2008) and by several of our informants.

Our informants also indicated that UDM often do not properly recover from their illnesses as their life situation forces them to keep working even in a state of ill health, which may lead to chronic health problems.

Particularly Vulnerable Groups

Compared to the general population, UDM must generally be seen as vulnerable with regard to health and health care due to their lack of legal residence status and their often poor living conditions including related mental stress (see above).

The multiple theories of human vulnerability and social vulnerability in particular which exist across different disciplines cannot be discussed in detail in this report (see Thomas 2010). The terms refer to individuals as well as to groups. Most authors agree that rather than simple social vulnerability this is a process which leads to social exclusion in economic, professional and relational terms. Risks linked to this process may in turn lead to physical and psychological fragility or vulnerability which is often understood as the counterpart of resilience and other individual resources. A technocratic understanding of the term in policy or by advocacy organisations sometimes leads to a moral and psychological approach to social or legal problems, stigmatising 'vulnerable' groups and justifying patronising protection measures and control policies. However, our conception of vulnerable groups and individuals refers to *social vulnerability* understood as an exclusionary process induced by the legal situation and living conditions which UDM in many cases face. These different interpretations of vulnerability have to be kept in mind when reading this section, which is based on the points of view of the organizations interviewed. Our informants identified several subgroups of UDM as particularly vulnerable, based on a combination of characteristics known to be risk factors with regard to health. The combination of these factors often accompanies an accumulation of health risks.

One of the subgroups to which most of the health care professionals interviewed have pointed is that of **unsuccessful asylum seekers**, whose living conditions are in general especially adverse and who often lack meaningful future prospects. These people are generally **without a permanent home** and **lacking in any financial means**, as many of them – having arrived quite recently and being unfamiliar with life in the host country – have difficulties in finding work and cannot rely on a supportive social network. Many of them feel stigmatised as 'abusers' of the asylum law and tend to hide their NEE status, preferring being considered as 'common' UDM.

If they choose to apply for emergency state aid, they are provided with minimal assistance in terms of nutrition/hygiene (mostly vouchers amounting to 8-12 CHF (€ 6-9)/day redeemable in supermarkets), housing (in collective emergency accommodation or overnight drop-ins)

and medical emergency care, defined by cantonal laws and regulations and implemented by the authorities of the canton to which they have been assigned. The procedures for the application and delivery of emergency aid – if the canton has established such procedures at all – are seen as inscrutable, degrading and altogether pathogenic, not only by many UDM concerned but also by the health professionals consulted as well as the authors of the available scientific literature (Sanchez-Mazas et al. forthcoming) (Bolliger and Féraud 2010).

Unsuccessful asylum seekers who have not applied for emergency aid usually rely entirely on aid from relatives, friends, associations or individuals.

Generally speaking, **UDM** who, for various reasons, cannot work, that is to say people **without an income** and **without an occupation** that can absorb them and give meaning to their lives, are more vulnerable with regard to health problems and general well-being than people who have the opportunity to work, a point made both by our informants and in the relevant literature (Achermann and Chimienti 2006).

Undocumented female **sex workers** are repeatedly mentioned as another vulnerable subgroup, as they are exposed to high risks with regard to sexual and reproductive health and to exploitation, abuse and/or violence. Particularly in danger of being abused and exposed to violence are women from non-EU countries who hope to legalise their stay through marriage to a Swiss citizen⁷⁰.

People **suffering from chronic diseases** must also generally be seen as particularly vulnerable, as are, for instance, UDM who are HIV-positive. If they perceive that, in their country of origin, they would not have access to appropriate therapies, they fear deportation doubly, not only in itself, but also because they believe it would lead to therapy rupture.

Families, i.e. UDM with children to care for, and primarily **single women**, are also regarded as particularly vulnerable. **Unaccompanied undocumented minors** represent another vulnerable category.

Representatives from NGO as well as UDM with NEE status who were interviewed in another study (Sanchez-Mazas et al. forthcoming) consider discrimination – notably due to skin colour – to be an issue in everyday life and in the health sector. Those concerned are primarily UDM from Sub-Saharan Africa.

Resources

Vulnerability with regard to health can also be a consequence of a lack of individual or structural resources. In contrast, the availability of certain resources can affect health and health related behaviour positively.

According to our informants and the relevant literature,⁷¹ resources supportive of good health on an **individual level** – not only for UDM but for people in general – include the following:

- to dispose of a basically sound physical and mental constitution, which is – in fact – the case for most young migrant workers who only rarely contact our informants;
- to have a job, i.e. to have a (regular) income, making possible a certain financial independence, and to be occupied in a meaningful activity;
- to have future prospects and to be active in realizing or improving those prospects;

⁷⁰ A legislative change, which came into force on 01.01.2011 forbids UDM in Switzerland to marry.

⁷¹ See Achermann and Chimienti (2006), Gross, Witzig and Berner (2006).

- to be able to support their family in their country of origin or in Switzerland, which confers a feeling of satisfaction;
- to have family/relatives or friends living legally in Switzerland, giving material and/or mental support and facilitating access to health care;
- to participate in social relations in order to obtain information and to establish supportive contacts (religious communities, compatriots' organisations, private initiatives such as 'lunch tables' (free lunches), etc.);
- to be highly educated and therefore better placed to rapidly familiarize themselves with the new environment;
- to believe strongly in God and/or in their own strength and ability to realize their projects (Hagan 2008).

While some of the abovementioned resources are related to the individual profile of migrants, others tend to be more situation centred and to develop over time: local language skills, a feeling of security and confidence as well as knowledge of the health system and the general context (the rights of UDM and access to those rights). In this respect, 'overstayers' tend to have a better starting point than newcomers, but each situation is different and the support of a social network may be more important than individual factors.

On a **structural level**, facilitators with regard to UDM's health and to the accessibility of health care vary considerably according to the local context. They depend, among other things, on prevailing beliefs and opinions as well as attitudes and behaviours towards immigrants in local society, on the existence, accessibility and quality of local health care and counselling for UDM, on how regulations concerning health insurance affiliation of UDM are implemented on a local level (procedures to apply for cantonal subsidies, for example) or on cantonal regulations relating to the supply of emergency aid and the way in which these regulations are implemented. Generally speaking, health-supportive structural resources are more present in urban areas and in the western parts of the country than in rural zones and in the northern, central and eastern regions of Switzerland (see chapter 3). The more individual resources UDM dispose of, and the more they are – on an individual basis – combined with structural resources, the better is their state of health and health related behaviour (Traber 2008).

2.3 Perceptions of Health

Although health issues, including the prevention of disorders, are rarely considered a priority in the life of a UDM, our informants and the available scientific literature indicate that many are well aware that all their projects depend, to a large extent, on their good health. It is not unusual for UDM in contact with the informants or interviewed themselves in the context of another research project to report that, from time to time, they wonder what would happen if they had an accident or became seriously ill, and that they therefore avoid health risks whenever possible. This observation may be partially related to a more commonly 'female'⁷² attitude to health, as most informants cited in the literature and clients of our interviewees are female.

However, as UDM may fear that seeking health care could lead to a high risk of discovery of their irregular residence status and, hence, deportation, they tend to avoid contact with the health system for as long as possible. Prevention and screening as well as health care is

⁷² There is some empirical evidence that women are less prone to risk-taking than men, which is related to gender differences in risk perception (e.g. Harris et al. 2006).

therefore postponed as long as UDM feel (relatively) healthy. In other words, health is not an urgent concern in everyday life, and the migrants give priority to assuring their living (work and housing) and their various life projects (savings, support of family members, etc.). Even if some UDM know of ways in which to protect their health (healthy food, preventive controls, etc.), their living conditions and the fear of detection generally preclude the adoption of health-supportive behaviours or recourse to preventative health care.

Once, however, health problems do occur, the topic rapidly becomes one of major importance for the UDM concerned. In such a case, regaining their health and functional capabilities is their first preoccupation in order to 'save' the project for which they have, until now, suffered significant adversity. Most UDM in this situation do not only think of themselves, but also of their relatives in their country of origin, who – they know – depend on them and on their good health. But as fear of discovery, financial concerns and, in many cases, a lack of information about their rights and about available services prevent them from seeking health care, they usually try to combat symptoms on their own at first by applying certain strategies (see below).

All our informants, as well as the literature consulted, agree that UDM show a clear tendency to delay care. In 2008, the medical drop-in centre *Meditrina* in Zurich (see chapter 3) systematically recorded the time lag between the onset of symptoms and the patient's appearing for a first consultation, and it was observed that UDM wait significantly longer than legal residents before seeking care (Gross 2009). As a consequence, UDM's health troubles have often, by this point, developed into serious problems which require urgent and often costly treatment.

Interestingly, a contrasting tendency relating to care-seeking is observed in UDM who have applied for emergency aid. According to our informants, these people are usually aware of their (minimal) rights and attempt to assert them, though some cantons do not promote systematic health insurance affiliation.

As regards UDM's conception of health in general, and the perception of mental health problems in particular, based on information from our sources we can say that many UDM understand health in a holistic way, comprising financial, social and mental well-being (see Gross 2009). Usually they are well aware of the negative influence that their life situation can, and does, have on their mental condition and, thereby, on their health in general. Some of the UDM interviewed, mainly unsuccessful asylum seekers, rightly perceive symptoms such as a certain apathy and general indisposition, often accompanied by insomnia and headaches, as being psycho-somatic, and associate them with their specific life situation here and now, declaring that they did not have major health problems before coming to Switzerland. Some interpret the clearly perceived changes in their general disposition as a substantial change in their personality which they deplore and which also frightens them. Considering this, it is not astonishing that UDM, according to our informants, hardly ever self-report their health status as 'good'. However this appreciation reflects the sample of UDM who are most likely to be in contact with the experts interviewed in this study.

As in the general population, many UDM, particularly males, seem to feel ashamed of their mental ill-health and either do not speak of their problems at all or highlight only the somatic aspects of them. Women, according to the specialists consulted, tend to express feelings of depression more openly. Some UDM try to alleviate mental suffering by resorting to alcohol, medication or drugs.

The collected data suggest, moreover, that female UDM of reproductive age feel the need for periodical gynaecological control even when they feel generally healthy. Another phenomenon observed by our informants is that some UDM, when they become parents for the first time during their stay in Switzerland, try to take more care of their health than they did before.

2.4 Perception of Health Care Accessibility and Access Strategies

(Perceived) Access Barriers

In the preceding chapter, we stated that many UDM, as long as they feel relatively healthy, tend to avoid thinking that they may need health care one day. Once they effectively suffer from ill health, many try to delay care for as long as possible, even if it is actually very important to them to recover rapidly.

As observed by our informants and stated in the literature consulted, several factors effectively prevent UDM from seeking health care and making use of appropriate services, even when those services would, in theory, be available to them. This is related to:

- a) the way in which UDM perceive information on their rights to access health care, i.e. how well informed they are with regard to their rights and to the services available to them;
- b) the way in which they evaluate the risk that gaining access to health care could result in the discovery of their irregular status or in the obstruction of a future regularisation of that status.

According to the information we have collected, many UDM tend to maintain a low profile and to avoid attracting public attention in their daily life. In particular, they try to avoid contact with authorities of any kind, for fear of being detected and reported to the police and immigration authorities. Before having been informed of the fact by NGO representatives, few know that, in Switzerland, even UDM have a right to health care and health insurance, and that insurance companies as well as health care providers must guarantee strict confidentiality; that is to say that not only do insurers and providers have no obligation to provide information to immigration authorities, such provision is forbidden.⁷³

Moreover, even when UDM have been informed about these rights and regulations, this knowledge does not immediately create actual trust. This is comprehensible, as most of them know of incidents in which UDM have been arrested in connection with accessing health insurance or care. While such incidents may today be rare, they sometimes still occur. Therefore, while health care providers generally respect their obligations and, thanks to information provided by federal authorities and NGO, many health insurance companies and services responsible for health insurance subsidies cooperate to facilitate access to care for UDM (at least in certain local contexts), NGO in most regions are not yet in a position even to broadly guarantee that the rules are followed by every single stakeholder within the local system. In short, regional and local differences in terms of access to health care persist, and are even tending to increase.

Another major fear felt by UDM when considering making use of health care services is related to finances. They are usually convinced that they will be billed for the care they receive and, as they cannot afford this, that they will hence be reported to immigration authorities at the latest when they fail to pay the bill. In reality, UDM have the right – and are even legally obliged – to be insured, which means that basic health care is covered by the respective health insurance company except for the excess (*Jahresfranchise*) and the patient's contribution (*Selbstbehalt*)⁷⁴ (see Bilger and Hollomey in this volume). However, to

⁷³ Health care staff are bound to professional secrecy and, as set out in article 321 of the Swiss Criminal Code, are not allowed to report any personal information including the residence status of a patient to any third party. This applies also to the staff of insurance companies as outlined in article 84ff of the Law on Health Insurance (LHI) (see Bilger and Hollomey 2010, Davet (2008)).

⁷⁴ Once a patient's chosen excess has been reached, the health insurer begins to pay all subsequent health care bills for the patient/client. The patient/client still, however, continues to contribute to the cost of their own care as

be insured they have to pay monthly premiums, which can indeed be difficult given their often meagre financial resources. In some local contexts, notably where no functioning procedures have yet been established to accord UDM cantonal subsidies for health insurance, monthly premiums effectively often amount to sums that many are unable to pay. As a consequence of non-payment, they run the risk of being subjected to debt collection, a prospect which is not only frightening to the UDM concerned, but is considered by many of our NGO informants as a high risk to run, be it with regard to discovery, or be it in view of a potential future regularisation of their stay.

Provided a UDM has been informed of their rights with regard to health and decided to trust Swiss health care and insurance providers, he or she still must, in order to effectively have access to care:

- a) know how the local health care system functions, in other words how they can concretely access health insurance and where they are supposed to seek, and find, appropriate care with regard to their specific health problem; and
- b) effectively dispose of the financial resources necessary for the payment of insurance premiums, and, where care is provided, of the excess (*Jahresfranchise*) and the patient's contribution.

In many cases, neither of these conditions are fulfilled, and while NGO and, in some contexts, health care providers and public authorities, endeavour to reach UDM and to inform them concerning the functioning of the health care system and assist them in accessing adequate care, the second condition is even more difficult to fulfil. Lack of financial resources seems to be, for many UDM, a very effective barrier to their accessing health care in Switzerland. Very few seem to have health insurance (Bisegger and Stuker 2009 ; Gross 2009), and many depend on alternative structures and ways of accessing care (see chapter 3).

Strategies Applied Where Health Care is Required

As the aforementioned factors (fear of discovery, lack of financial resources and information) prevent many UDM from (immediately) seeking professional care when they fall ill, they first try to combat symptoms on their own, using homespun remedies,⁷⁵ or seek help from friends or relatives. UDM even sometimes ask someone in their country of origin to send a specific medicine to them rather than purchasing it at a Swiss chemist, where it would be more expensive. For persistent illnesses, buying medicine at a chemist seems to be a rather common strategy (Winizki 2009) – apparently, fear of discovery is lower with regard to retail chemists than to other health care professionals, and costs can be kept under control. There are, however, also potential dangers related to this strategy: it seems not uncommon that UDM consume medication in an unregulated manner (Fulliquet 2009), which can, itself, have harmful consequences. Another UDM strategy for accessing care seems to be to either seek out preferably anonymous health centres, or the general practitioner (GP) of relatives or friends residing stably in Switzerland, to present themselves as a tourist, and to pay cash for the treatment received (Winizki 2009).

As illustrated above, many UDM tend not to seek professional health care unless they perceive their health situation as being so alarming that they are prepared to run the perceived risks which accompany the act of seeking care (to miss work and maybe lose their

they are obliged to pay the 'patient's contribution' of 10% of all care costs up to, and including, a maximum sum of CHF 700.00 (€ 540).

⁷⁵ We have already mentioned that some UDM attempt to reduce symptoms and suffering by consuming addictive substances.

job, to be discovered, to have to pay high costs for treatment or to be unable to pay and subsequently exposed to debt collection). For this reason and because many do not have a family doctor, it is rather common that UDM's first contact with care providers in Switzerland is at an emergency department of a public hospital because – while often unaware of alternative, facilitated ways for them to access care – they are usually confident that they will get emergency care in a hospital, albeit at the price of discovery.

It also occurs that a UDM patient, for fear of being discovered when presenting him- or herself at a hospital or for fear of having to pay high costs, uses the name and insurance card of a relative or a colleague to access care. This is not unproblematic however, as the physicians interviewed point out that it can lead to (dangerous) medical malpractice if the medical history of the card-holder does not match that of the actual patient in question. Another way for UDM to access health care, or at least acquire medicines, is to have a friend or acquaintance with health insurance consult a physician and pretend to have the same health problems as the UDM concerned. The medicines prescribed are then passed on to the UDM.

An undocumented young woman had been working in a private household in a Swiss city, caring for the children, when one day she happened to see on TV a brief presentation of an NPO service facilitating access to health care for UDM in the city in which she lived. When she decided, soon after, that she needed a gynaecological check-up, she was glad to know that there seemed to be a way for her to access care without taking too many risks. She enquired about the location of the service, a drop-in in the city centre, and as the people who had informed her seemed trustworthy decided to consult the NPO nurse. Since then, she has given birth to a son and both of them have taken out health insurance. The baby's father being a Swiss National and recognizing the child as his, the woman's stay will probably soon be regularized. (Interview)

People considered trustworthy by a UDM are a very important element in access to health care. It is to them that UDM usually turn first when they need help or want to know more about a service which they have heard or read of via the media or in a leaflet. Such 'acquaintances' can be from the same country of origin as the UDM, speak the same language and have lived in Switzerland for a longer period, sometimes working in the same sector as the UDM concerned. They can also be co-members of a religious community to which the UDM belongs, or representatives of civil society⁷⁶ groups, or even employers. Disposing of a certain knowledge and know-how with regard to the health care system and often also holding a residence permit or even Swiss citizenship, they can advise or represent the UDM when it comes to dealing with health care or insurance providers.

Often working together with acquaintances and applying a low-threshold, outreach approach, NGO or charitable institutions⁷⁷ targeting UDM and aiming to facilitate their access to health care are most likely to gain the confidence of the target group and mediate between them and regular health care providers (see chapter 3). Once UDM have accessed these services, they generally build up confidence and use the services again and again in case of illness, no longer delaying care as they would have done before.

⁷⁶ By this term we refer to various forms of collective action and (semi-)organised groups other than the government, e.g. trade unions, NGO, charitable organisations, religious organisations, community-based organisations and civic movements or advocacy groups.

⁷⁷ In Geneva and Lausanne there are specific services which target vulnerable groups (including UDM), services integrated into public hospitals (see chapter 3). They also apply a low-threshold- and – in Geneva – an outreach approach, and have hence managed to gain the confidence of UDM patients.

Interviews with experts and migrants as well as available data show that many UDM are well disposed to contribute to the payment of health care costs within their means. Some of those with a regular income are even prepared to take out health insurance, although it is, for most, quite difficult to predict if their income will continue to be sufficient to do so and health insurance affiliation hence remains a considerable risk from their perspective. Willingness to take out health insurance is usually higher in those local contexts where cantonal subsidies cover to a large extent premiums (e.g. in Fribourg). Among those insured it is observed, in some cases, that knowing that they are insured can be an important relief and reassurance for them. On the other hand, however, and particularly in cantons where UDM cannot, in practice, apply for subsidies, health insurance affiliation would represent 'one more' stress factor and is therefore not a viable option, as observed by our interviewees.

Finally, for UDM suffering from health problems, taking the decision to leave the country and to seek care elsewhere or to go back to their country of origin can also be an option, even if, according to our data as well as to the relevant literature, it seems to be extremely rare that UDM effectively leave the country when they are ill.

Rejected Asylum Seekers and Persons with NEE Status

A contrasting tendency relating to perception of care and care seeking strategies is observed with respect to rejected asylum seekers or those with NEE status who have applied for emergency state aid and are, therefore, known to the authorities. Unlike other UDM, they more often try to assert their rights, knowing that they have nothing to lose by making their whereabouts known. In their case, seeking health care can be associated with expectation rather than with fear: they sometimes hope that being considered ill and therefore vulnerable might improve their living conditions, and that – for example - they will be allowed better accommodation, or that a medical certificate could avert or at least delay their deportation. The same can apply to pregnant women, who can come to perceive their pregnancy – even if it was unintended – as an opportunity to regularise their situation (if the father of the child is a Swiss citizen, for instance), or hope that they would at least not be deported while raising a young child.

At the same time, some of those who apply for emergency aid judge the way they are treated by the authorities, and sometimes also by health care providers, as degrading and discriminatory⁷⁸ which, in itself, can further negatively influence their health. In fact, according to recent research dealing with this new category of UDM (Sanchez-Mazas et al. forthcoming), although those who apply for emergency aid are usually provided health care if they present injuries or health disorders that are immediately 'visible'. They are sometimes distrusted and not (promptly) cared for when their disorders are not immediately obvious, as is – for instance – the case with ailments relating to mental distress.

A rejected asylum seeker consulted an NPO-service in a Swiss city. Staff initiated medical examinations and the woman was finally diagnosed with breast cancer. As she had delayed seeking care, the cancer had advanced considerably and the patient needed drastic therapy and an operation. The NPO affiliated her to a health insurance provider and paid her premiums and treatment costs, continuing to do so even after the cancer therapy was terminated. The woman is currently suffering psychically, has lost her jobs and accommodation, and does not have any support from relatives or friends. Despite this, she says that she cannot, and does not want to go back to her country of origin. (NPO interview)

⁷⁸ Some UDM interviewees, based on their personal experiences, were convinced that they were not given the same quality of care as others because of their status as unsuccessful asylum seekers.

Some of these rejected asylum-seekers, i.e. persons whose whereabouts are known by the authorities, also reported that they had better access to health care when they were in prison (Sanchez-Mazas et al. forthcoming) or when they presented themselves in a canton different to the one they had been assigned to. The aforementioned research (Sanchez-Mazas et al. forthcoming) also pointed to the phenomenon of former asylum seekers sometimes preferring not to apply for emergency aid in order to escape the stigma adherent to refused asylum seekers and 'emergency aid applicants', and hoping for better access to quality health care outside the emergency aid system (NGO initiatives, see chapter 3).

2.5 Final Remarks

Roughly speaking three UDM profiles can be distinguished: a) the typical undocumented worker is a young to middle-aged South American female b) the rejected or dismissed asylum seeker is a young male from the Balkans, Africa or Asia c) any third country national having lost his or her right to stay in Switzerland. Recent studies show that the UDM population has become more diverse in terms of age (children born and grown up in Switzerland, aging groups), duration of residence (increasing proportion of long-stay persons), and migration background (work-, family- or flight-related migration) (Efonayi-Mäder et al. 2010).

It is difficult to draw any overall conclusions concerning the situation and strategies of UDM in Switzerland regarding access to health care, mainly because their situations and strategies vary according to:

- Migration trajectories and de facto integration (into the labour market, social groups, families, etc.) of the persons concerned;
- Immigration status ('overstayers', rejected asylum seekers, unauthorized immigrants, etc.);
- Places of residence with a specific institutional and NPO context and political opportunity structure; and last but not least
- Collected data only permitting an approximate idea of the UDM population in Switzerland and the variety of situations in which they live.

Given the legal framework of access to health care in Switzerland, under the most favourable conditions UDM in need of treatment may immediately enjoy full access to health care as would any other citizen. This holds true for those who have both the necessary knowledge and the means to take out health insurance and who live in a place where they do not encounter any administrative obstacles to such an affiliation. As many of the patients concerned are likely to remain unidentified (as UDM) by doctors and nurses, it is virtually impossible to estimate the scope of the phenomenon.

This is also the reason why the present report does not treat such cases of mainstream care as a central theme and focuses rather on less favourable constellations. In a comparative approach, we should however consider the potential of this situation and bear in mind that major policy changes in this regard could bring this currently unnoticed category to the fore.

While health insurance affiliation is a necessary, though not sufficient, precondition to accessing regular health care, evidence shows that the majority of UDM have no health insurance. Major obstacles to insurance affiliation are connected to a lack of information and, most importantly, insufficient financial means, as premiums represent a considerable proportion of income, subsidies may not be available and non-payment may result in the risk of denunciation. Exceptions can be found, where specific municipal or cantonal

administrations have taken the initiative to systematically insure selected categories of undocumented migrants, such as children and rejected asylum seekers in Geneva, rejected or dismissed (NEE) asylum seekers in the Canton of Vaud, and new born children in Zurich, Geneva and other cities.

As a general rule, most UDM avoid seeking care for various reasons (e.g. lack of information on their right to health care, lack of financial means, fear of being denounced, ...) and tend therefore only to seek help when they are seriously ill. UDM who have lived in the country for a longer period of time, are more likely to have developed social networks and usually know of low-threshold health services, which are now accessible in many cities and offer basic and inexpensive care. The situation becomes more complicated when long-term or expensive treatment is required, but often viable solutions with costs shared between patients, services and NGO can be negotiated. In contrast, newcomers or isolated individuals tend not to know their rights and fear any contact with services they perceive as 'official'; in these cases outreach work is the only way of establishing mutual trust as a basis for a consultation.

The health-care seeking strategies of rejected or dismissed asylum seekers who benefit from emergency aid is different, because they are anyway already known to the authorities and their removal or repatriation cannot be enforced for technical or other reasons and they thus do not fear denunciation. Most of them live in particularly precarious conditions, which frequently cause health – psychological or physical – disorders in the long term.

3 Practices: A Survey on Health Care Provision for Undocumented Migrants in Switzerland

3.1 Overview of the Services Surveyed

As described in section 0, the practices presented in the following were surveyed between September and December 2009. Hence, unless otherwise specified, this description of their services refers to the situation as it was at the time of response (see NHL Practices database⁷⁹).

On the basis of organisational characteristics and adhering largely, to the classification made within the European *NowHereLand-Project*, the Swiss services surveyed can be categorised as follows:

- **Type 1:** Services which are integrated into public hospitals and which provide a wide range of medical/health services also accessible to UDM.
- **Type 2:** Low-threshold medical or social drop-in centres run by NPO which facilitate access to health care for UDM and for other marginalized patients by referring them to health professionals or institutions who are members of a network which offers free or low-cost health care. Thus, the NPO coordinate these health care networks and function mainly as 'door openers'⁸⁰ to (further) medical care. In case of minor health issues however, the NPO, mostly represented by a nurse (in some cases assisted by a GP), provides nursing or primary care as well as (non-prescription) medication.
- **Type 3:** Publicly (co-)financed services offering specialised care in specific health fields and targeting specific risk groups. These can be prevention and counselling services in the areas of sexual and reproductive health and/or sexually transmitted diseases targeting mainly sex workers, or victim assistance services, or services offering counselling and therapy in the mental health field.

In the following, the services surveyed as examples of each of these three types will be presented in detail, descriptions each following the same structure. First, we make a short note on the characteristics and particularities of the service concerned in comparison with other models. This is followed by a brief description of the service in terms of its historical, conceptual and organisational properties (origins/initiators, target population, services provided, staff involved and service financing). Then, information is given about its UDM clientele and the way access to health care is facilitated (the characteristics and management of health insurance and financial issues for this clientele). The final dimension presented concerns success factors for the service as perceived by those responsible for its operation.

The information presented here is – unless otherwise specified – based on self-description, i.e. on information provided by the person or persons responsible for the service in question (data collected by questionnaire or by telephone interview, completed by information available on the service's website or found in the documentation/literature).

⁷⁹ http://www.nowhereland.info/?i_ca_id=370 (last accessed: 17 July 2011).

⁸⁰ 'Door opener' is defined herein as a service which facilitates access to (further specific) health care providers.

3.2 Services Integrated into Public Hospitals

Within this first type, three services were surveyed. They are all located in the western French-speaking part of the country, specifically in the cantons of Vaud and Geneva.

Important note to the reader: the following text boxes contain a presentation of the practices surveyed illustrating different types of services. The content of the boxes is structured identically to the extent that information is available. It is not necessary to read all the presentations in order to follow and understand this chapter's analysis as presented in the main body of the text.

Hôpitaux Universitaires de Genève (HUG), Unité mobile de soins communautaires (UMSCO)⁸¹

HUG-UMSCO is a health care provision model for marginalized groups which is institutionalized and integrated into mainstream public health care. The procedure and the criteria for the financing of care are transparent. Health care for the marginalized, including many UDM, is to a large extent financed by public means. Geneva is the canton that deploys the most financial means for ensuring access to health care for UDM.

Origins/Initiators: The *Unité mobile de soins communautaires* (UMSCO) is a specialised unit within the outpatient clinic (*Département de médecine communautaire et de premier recours* - DMC) of the University Hospital of the Canton of Geneva (HUG). It provides primary (itinerant) health care to marginalized groups and aims to integrate them into the regular health care system. The service was initiated during 1996/97 by the cantonal public health department with the aim of guaranteeing access to health care for the entire population as stipulated by the federal law on health insurance which came into effect in 1996. The initiators thus acted for political, humanitarian and institutional reasons. The management of health care for marginalized people needed to be coordinated on a local level. Further, there was an institutional interest in conducting research into the specific needs of the targeted population and in training staff in caring for these people.

Targeted population groups: Those targeted generally speaking live in precarious situations and therefore have limited access to health care. Among them are migrants with or without legal status, vulnerable groups such as pregnant women, the homeless, sex workers etc. The service primarily targets people with the aforementioned profile living in the city and Canton of Geneva.

Services provided and staff/professionals involved: UMSCO's mission comprises four axes:

- facilitate access to health care for people in precarious situations;
- coordinate health- and social care services and promote integration into existing health care and social networks;
- support and further train nurses and other members of the social and health care network in exercising their profession;
- conduct research into topics related to precariousness (cf. <http://umsco.hug-ge.ch>).

To accomplish this mission, the service employs six nurses, eight physicians (GPs and one psychiatrist) as well as two social workers, corresponding to ten full time employees (FTE). Representing the first element of a double gate-keeping model, staff provide nursing services⁸² free of charge in a drop-in setting and pursue an outreach approach (that is to say nurses are 'mobile', i.e. they regularly visit the places in Geneva in which homeless and marginalized people are given shelter). If necessary, nurses refer patients to a GP in the outpatient clinic who assumes the role of the second gate-keeper to specialised care. Access to the latter is guaranteed by a network of specialised health care professionals – many of them working within different departments of HUG, others in their own practice (dentists, psychotherapists, gynaecologists, etc.). In addition, social consultations are provided by UMSCO, consisting of a socio-economic assessment of the patient's situation and the taking on of various of the patient's administrative tasks. UMSCO is also closely linked to, and collaborates with, many

⁸¹ Sources: Questionnaire ; <http://umsco.hug-ge.ch> (last accessed: 17 July 2011); Wolff (2004, 2006).

⁸² That is to say nurses are active in general care, prevention and health education, establish a supportive relationship with the patient, assess the patient globally and orient him, or her, to other services according to his or her needs.

different social- and other services within the city of Geneva and is a member of the cantonal-communal *platform against exclusion* which coordinates different services for the marginalized on a local level.

Staff, although mostly Swiss or French nationals, speak the language of the majority of clients (Spanish), and for other languages involve interpreters/cultural mediators in service provision when necessary. Multilingual information material is also available and staff are trained on an ongoing basis in giving care to vulnerable people.

Financing the service: Within its mission as a cantonal public hospital, HUG employs UMSCO staff and ensures the functioning of this specific unit. UMSCO facilities are made available by the Social Services Department of the city of Geneva.

UDM-Clientele: The people responsible for the service estimate that UDM account for 80-90% of the clientele. In 2008, around 3,000 UDM clients were recorded for consultation. Numbers had been increasing during the three previous years. Main nationalities within the UDM client group are currently Bolivian (23%), Brazilian (21%) and Moroccan (7%). The majority are women (59.8%) and most are aged between 36 and 60 (56%) or between 18 and 35 (34%). It is assumed that UDM clients mostly come to hear of the service through word-of-mouth, but also via the media, government agencies, health care providers, NGO and outreach work. No documents are required to access the service, but it is appreciated if clients are able to show an identity paper or card.

Management of UDM's health insurance affiliation: UDM clients are informed about their right to health insurance and are also concretely supported in concluding a contract if they wish to do so.

Financing care and UDM's contribution to costs: HUG covers the costs of assessment and of the care prescribed and provided by UMSCO staff. If costs for medical services exceed CHF 4,000 (€ 3,080), the situation, and the need for care, is further assessed by a group of (external) experts.

Thanks to the association *Pharmacies du Cœur*, medication that has been returned to Geneva pharmacies is available free in two city pharmacies upon presentation of a prescription from an UMSCO physician. Another source of medication is free samples offered by the pharmaceutical industry. If the medicine needed is not available for free, the UMSCO physician can access a fund managed by the DMC. Often the patient contributes to the costs of such medicine.

While, depending on circumstances and evaluated against assessment criteria, patients are required to contribute to financing their treatment, access to health care always has priority over financial considerations. Since 2000, the general management of HUG has allocated, to UMSCO, a fund designated for medical care, diagnostics or therapeutics for the benefit of UMSCO target groups (*Fonds de patients précarisés*, FPP). This fund is intended to contribute to the financing of hospitalisation or outpatient care which is not of vital importance and which is provided outside the DMC.

In order to guarantee maximum transparency, the head of the DMC has created a committee charged with elaborating criteria for allocating the finances of the fund, with reviewing individual cases if and when difficult ethical, medical and social predicaments present themselves, and with making recommendations to the people responsible for the DMC. Among the qualification criteria necessary for FFP financing is the condition of precariousness, meaning that the patient has no health insurance and is unable to take out health insurance as he/she is unable to pay the premiums and has no access to other human resources which may help him or her to do so. The decision whether or not to finance service provision by means of the FFP is further instructed by defined medical, social and economic criteria.

Some patients without health insurance are able to pay entirely or partly for the treatment received. Clients unable to pay (entirely) and not fulfilling the criteria for FFP financing can be helped to find private funding.

Self-assessed factors of success:⁸³ As main factors of success the respondents indicate the development of specific competences in giving care to vulnerable groups; ongoing research into, and training in, these matters; adaptation to demand; the fact that the providers have gained the confidence of migrant communities; cultural adaptation and the application of a bio-psycho-social approach.

⁸³ These factors were identified by our informants and communicated through the questionnaire.

Hôpitaux Universitaires de Genève (HUG), Programme Santé Migrations (PSM)⁸⁴

HUG-PSM is designed for, and specialised in, giving care to people enrolled in the asylum application procedure. Staff members are familiar with, and regularly trained in, matters related to asylum and related administrative and legal questions. The cantonal authorities and the direction of HUG have therefore decided that unsuccessful asylum seekers, entitled to emergency aid until they have left the country, could – in case of need – be best cared for at HUG-PSM rather than at HUG-UMSCO.

Origins/Initiators: The *Centre Santé Migrants* (CSM) was created in 1993 on the initiative of the Geneva Red Cross and became affiliated to the *Département de médecine communautaire et de premier recours* (DMC) of the University Hospital of the Canton of Geneva in 1999. In 2002, the CSM participated in the creation of the *Réseau de Soins Asile* (RSA). Today, the CSM is a centre for ambulatory care intended principally for asylum seekers aged 16 and over, assigned by the federal immigration authority to the Canton of Geneva. Care, however, is also provided to other migrants in precarious situations, among them people whose asylum applications have been dismissed as invalid (NEE) or whose asylum applications have been rejected, and who are entitled to emergency aid according to the Swiss Federal Constitution (Art. 12). Thus, the service is mandated by the Canton of Geneva to deliver health care to this specific category of the UDM population, namely those persons issuing from the asylum-seeking procedure entitled to emergency aid from the canton.

Targeted population groups: Those targeted are mainly asylum seekers, but also former asylum seekers who are entitled to emergency aid from the canton.

Services provided and staff/professionals involved: CSM provides ambulatory care to its clientele, applying a multidisciplinary approach which integrates the intercultural and psychosocial dimensions characteristic of care for migrant patients.

In three *Points Santé Migrants*, situated at the principal reception centres for asylum seekers in the canton, nurses (8.5 FTE) receive asylum seekers and carry out an initial assessment of their condition before assigning a GP (member of the Réseau de Soins Asile - RSA) to each. At regular intervals they provide the asylum-seekers with basic health care in a drop-in setting and assure continuous care (chronic health disorders and mother-and-child care). If necessary, they refer patients to their designated GP. Furthermore, the nurses coordinate medical and social interventions for each individual and participate in health promotion and preventative projects (HIV, contraception, tooth decay prevention, healthy nutrition promotion, etc.). In the Centre Santé Migrants (CSM) in Charmilles, a drop-in setting, nurses carry out Hepatitis B screening and administer standard vaccinations. They also provide consultations and basic health care to UDM who are entitled to emergency aid from the canton. The medical staff of CSM – GPs and one psychiatrist corresponding to 5.5 FTE – ensure primary and mental-health care consultations for asylum seekers and UDM entitled to emergency aid (after initial assessment by a nurse). They can – as part of their job – benefit from specific further education in the field of migrant health. Administrative staff are engaged in receiving patients and organising consultations. Furthermore, the CSM team collaborates with cultural interpreters/mediators, trained by the Geneva Red Cross, in interpreting in the medical domain. All staff members are trained on an ongoing basis in the management of specific migration-related problems and related administrative and legal questions.

Financing the service: As part of its mission as a public hospital, HUG ensures the functioning of this specific service and CSM staff are hence employed by HUG.

UDM-Clientele: UDM entitled to emergency aid account for an estimated 20% of the CSM clientele. The number of UDM treated in 2008 was not recorded, but the service's directors estimate that around 1,000 consultations with medical staff and around 800 consultations with nurses took place. The trend over the last three years is one of increase. Predominant nationalities within the group of UDM clients are currently (estimated to be): Nigerian (c. 60%), Guinean (c. 30%) and eastern European (c. 10%). It is estimated that the great majority of UDM clients are male (90%) and between 18 and 35 years of age (90%). According to those responsible for the CSM, UDM come to hear of the service mainly through word-of-mouth, government agencies and other health care providers. No documents are required to access the service, but UDM clients need to show that they have, at one point, been enrolled in the asylum-seeking procedure. If they cannot or do not do so, they are referred to UMSCO (see above). Our informants indicate that, although CSM is only mandated to deliver care to UDM issuing from the asylum-seeking procedure and resident in the Canton of Geneva, it is quite common for NEE or rejected asylum seekers from other cantons to seek help at the CSM. The CSM team does not withhold much-needed care from such people but points out that some cantons apparently do not assume their responsibilities in this respect.

⁸⁴ Sources: Questionnaire and http://migrantcare.hug-ge.ch/soins_migrants/CSM_activites.html (last accessed: 17 July 2011).

Management of UDM's health insurance affiliation: CSM staff provide information regarding the possibilities of taking out health insurance, but not concrete support in concluding an insurance contract.

Financing care and UDM's contribution to costs: Health care costs for UDM entitled to emergency aid are covered by the Canton of Geneva. Rejected asylum seekers are systematically affiliated to health insurance providers by cantonal authorities. Non-admitted asylum seekers (NEE) are affiliated to health insurance providers if they can show a medical certificate (Trummer 2008).

Self-assessed factors of success: A main factor of success, according to our informants, is that the service is perceived by UDM as independent from asylum- and police authorities, but that it nevertheless is in contact, and cooperates efficiently, with the different relevant stakeholders including cantonal authorities in charge of emergency aid.

Policlinique Médicale Universitaire (PMU) Lausanne, Unité des Populations Vulnérables (UPV) and Centre de Santé Infirmier (CSI)⁸⁵

PMU Lausanne is another model of care provision to marginalized groups integrated into mainstream public health care. As distinguished from HUG in Geneva (see above), PMU works in a private-public-partnership with NPO. While UMSCO in Geneva follows an outreach approach, PMU services are not 'mobile', and thus work in cooperation, to some extent, with non- or semi-governmental, low-threshold structures such as the association *Point d'Eau Lausanne* (PEL) or *Fleur de Pavé* (FdP) (see below).

Origins/Initiators: The *Policlinique Médicale Universitaire* (PMU) of Lausanne was created as a 'legally regulated institution' in 1957. Its mission consists of providing basic and emergency health care to everyone living in Lausanne and the Canton of Vaud, including people living in a state of precariousness. Since 2002, the PMU has been located near the *Centre Hospitalier Universitaire Vaudois* (CHUV) – the cantonal university hospital – with which it collaborates closely. PMU runs a unit specialized in caring for vulnerable groups (*Unité des Populations Vulnérables* -UPV). It provides primary health care and functions as a door opener to a wide range of health care services for its patients, regardless of their legal status. Since 2001, the services of PMU-UPV have also been frequently used by UDM.

The *Centre de Santé Infirmier* (CSI) – the core of a double gate-keeping system⁸⁶ for asylum seekers – has since 2006 been located in the same buildings as the PMU and placed under the same medical direction as UPV. This centre's mission is to assess the health of asylum seekers as well as non-admitted or rejected asylum seekers entitled to emergency aid from the Canton of Vaud, and to provide and organise all care necessary. Since 2008, PMU has been a member of the WHO network *Health Promoting Hospitals* (HPH) and its section *Migrant Friendly Hospitals* (MFH). It has developed, and is further developing, its competences in providing care for vulnerable migrant groups, on a clinical level as well as on the levels of research, training and of 'public health actions'.

Targeted population groups: The targets of PMU-UPV are all kinds of vulnerable groups residing in the Canton of Vaud, regardless of their legal status. PMU-CSI especially target asylum seekers and UDM issuing from the asylum procedure.

Services provided and staff/professionals involved: PMU is an institution for ambulatory care, consisting of a number of professionals⁸⁷ and services specialised in different medical fields as well as in health promotion. Thus, a wide range of health care, preventive care and health promotion services are provided, including surgical services in the case of emergency. Multilingual information material is available (in the principal languages of the patients) in addition to – where needed – qualified interpreters or cultural mediators. Staff members are trained on an ongoing basis with regard to trans-cultural competences and giving care to vulnerable people. PMU is continually striving towards improving the service provision criteria established by MFH. In delivering care to

⁸⁵ Sources : Questionnaire ; http://www.polimed.ch/pmu_home/pmu_qui_sommes.htm (last accessed: 17 July 2011); *Le Grand Conseil du Canton de Vaud* (1957) ; *Conseil d'Etat du Canton de Vaud* (2006) ; Puig et al. (2009).

⁸⁶ The initial assessment is made by a nurse who, if necessary, refers patients to a GP who – in turn – refers them to further specialised care if needed.

⁸⁷ Nurses, midwives, GPs and a wide range of medical specialists such as psychiatrists, dentists, paediatricians, gynaecologists, obstetricians, etc.

UDM, PMU closely collaborates with *Point d'Eau Lausanne (PEL)*, a low-threshold dispensary chemist located in the city centre of Lausanne and operated by a civil society association (see below).

Financing the service: The Canton of Vaud contributes considerably to the financing of PMU's services as the latter is legally recognised institution. The clinic also benefits from federal and municipal subsidies. Other sources of finance are donations and legacies and funds obtained for research projects.

UDM-Clientele: A significant proportion of the PMU-UPV/CSI clientele consists of asylum seekers. UDM, however, only accounted for about 1 to 2% of the clientele in 2008, an estimated figure since legal status is not recorded for all patients. While the CSI registered 2,800 patients (asylum seekers, people with NEE status or rejected asylum seekers), 650 of those registered were either UDM or people whose legal status was unknown and who did not have health insurance. The trend over the last three years seems to be one of stability. Based on estimates, the UDM group was split equally on gender lines, the main countries of origin being in Latin America, Sub-Saharan Africa and eastern Europe. About 60% of CSI patients were male, frequently coming from Sub-Saharan Africa, North Africa and the Balkans.

UDM mainly hear of the possibility of receiving care at PMU through word-of-mouth, sometimes via the media, government agencies, other health care providers or NGO. Our informants point to the fact that many of the UDM they welcomed issued from the asylum procedure and despite having been assigned to certain (often German speaking) cantons showed up at PMU, in French speaking Lausanne, because they could not receive (adequate) care in their 'own' canton.

Management of UDM's health insurance affiliation: Patients without health insurance are informed of how the system functions and helped in concluding a contract.

Financing care and UDM's contribution to costs: A committee (*groupe référence*) has been created to discuss cases in which patients in need of costly treatment are not covered by health insurance. PMU aims for cost sharing with the patient wherever applicable. The patient's socioeconomic situation is systematically assessed and taken into consideration when fixing the terms of such arrangements. It is possible for the patient to pay the agreed amount in instalments over a certain period of time. If the patient is unable to pay, the committee seeks a financial solution in collaboration with the public authorities.

Self-assessed factors of success: Our informants mention, on the one hand, the fact that PMU manages to inspire trust in its clients, and on the other the solid partnerships which have been established with the relevant public authorities. Globally, according to those responsible, access to emergency health care is guaranteed and easy at PMU, and – further – access to non-emergency health care is not refused even if clients do not dispose of an appropriate legal status or necessary financial means.

While information on the abovementioned services is readily available in some cantons, in others only limited documentation concerning practices in public hospitals exists. The hospitals contacted either let us know that they extremely rarely – if at all – came (knowingly⁸⁸) into contact with UDM, or that they preferred not to publish details of their practices. As we learnt from our informants, in several cities where NPO initiatives exist (see below, description of Type 2), public hospital services (and in one case a privately run hospital) have in recent years been persuaded by NPO to cooperate with them – in some manner – so that the latter can now provide facilitated access to hospital care and also function as door opener in this respect (on a local level). In Bern for instance, the drop-in health centre for UDM run by the Swiss Red Cross (SRC) since 2007 has concluded an agreement with a local private hospital (also managed by SRC) to create a fund from which costs resulting from the treatment of insolvent UDM without health insurance can be met.

In Zurich, those responsible for the *Meditrina* project (initiated by *Médecins sans Frontières* - MSF) were successful in negotiating with the city's public hospitals and the cantonal university hospital for the application of a lower tariff⁸⁹ for the provision of hospital care to a

⁸⁸ Some hospital representatives indicated that patients sometimes give false names and/or present someone else's health insurance card when seeking treatment at the outpatient clinic. This means that, in some cases, administrative staff and health care professionals are not – or at least not immediately – aware that they are dealing with UDM.

⁸⁹ Originally it was stipulated that people without health insurance would be charged 'tourist tariffs', which are considerably higher than those charged for patients covered by health insurance.

UDM. This agreement also provides for the possibility of payment by instalments. While, in many cases, the NPO involved in the *Meditrina* project still have to cover a considerable portion of the hospital treatment costs for UDM or to find an alternative financing solution, these agreements at least facilitate their task.

In some cantons (such as Bern, Basel, Aargau, Solothurn or Ticino), public hospitals seem to provide care to uninsured UDM and either bear the costs of the treatment themselves, share it with civil society groups or charitable foundations, or bill, or are reimbursed by, the cantonal social services department. Where cantons have established clear procedures regarding emergency aid provision for those entitled, public hospitals are either instructed to bear the costs of service provision to a UDM or to bill, or be reimbursed by, the cantonal authority responsible for emergency aid delivery (usually the cantonal Social Services Department).

To illustrate this point, we will examine the procedures established at *Inselspital* – Bern University Hospital (*Patientenmanagement Inselspital* 2009). There, health care professionals are not necessarily aware of the legal status of their patients during treatment. Neither are administrative staff in charge of patient management who only need to know if the patient is insured or not⁹⁰. If the patient is not insured and cannot guarantee even partial payment by paying a deposit, the question becomes one of whether they need emergency care or – if not – whether they reside in the Canton of Bern. If either point is true, the hospital is compelled to provide care⁹¹. In such situations, the patient – after receiving care – is informed of the workings of the procedure by means of a leaflet produced by the SRC initiative *National Platform for Health care for UDM in Switzerland* (National Platform for Health care for Sans-Papiers in Switzerland) and is then reported to the cantonal Social Welfare Service (*Amt für Sozialversicherung und Stiftungsaufsicht* - ASVS). According to the patient management service of *Inselspital*, the ASVS staff is bound to uphold confidentiality and is trained in managing such cases. The ASVS then asks the patient to conclude or reactivate a health insurance contract, or itself contacts a health insurance company in order to conclude a contract on behalf of the patient in question. In very rare cases of extreme hardship health insurance premiums can be covered by funds generated by the social service of *Inselspital*.

3.3 NPO Initiatives

By far the majority of the services surveyed can be attributed to this category, that is to say NPO initiatives aiming to facilitate access to health care for UDM and others with care access difficulties.⁹²

The common rationale of these initiatives is to establish and operate a local low-threshold contact point or drop-in centre which serves as a door opener for medical care (and often for social or legal counselling too). In most cases, the NPO managing the contact point coordinates a local network of health care professionals and institutions disposed to deliver care to patients belonging to the target group, while respecting and taking into account the particular legal and socio-economic situation of these people.

⁹⁰ Unsuccessful asylum seekers who are entitled to emergency relief from the Canton of Bern need to show a special attestation (*Nothilfebescheinigung*). On the basis of this document, the hospital can then bill cantonal authorities for health care costs. In the case of high costs, the latter affiliate the patient to a health insurance company.

⁹¹ If the patient does not need emergency care and/or does not reside in the Canton of Bern, they are referred to a health care provider in their canton of domicile or their country of origin.

⁹² As mentioned in sub-chapter 1.5, institutions or projects of this kind had a particular interest in presenting their activities – motivation to participate was certainly particularly high in their sector.

Based on (slight) differences regarding the services provided by NPO and the organisational structure of the service provider, we can distinguish four sub-categories. These mainly vary according to the type of social and/or health care provided by the NPO in question.

In the following, these four subtypes and the services which illustrate each will be presented, beginning with NPO which function as door opener towards health care rather than providing it themselves, and ending with those which provide even specialized health care to UDM.

The Outreach Approach

The **first subtype** is characterized by a clear **outreach approach** and the fact that it grew from **prevention work**: The staff (often nurses and key mediators⁹³) of the projects/institutions concerned, although primarily aiming to carry out preventative outreach work, function simultaneously as door openers to primary health care. To illustrate this point, two examples follow.

The type of service illustrated by the two NPO described under this subtype is characterized by its low-threshold, outreach approach which facilitates the establishment of a first contact with targeted persons belonging to specific risk groups, regardless of residential status. However, the NPO are mainly active in prevention and health promotion and cannot be seen as health-, but rather social care, providers, although they function as door openers towards health care services with which they have established close cooperation.

Fleur de Pavé (FdP) Lausanne, Projet Permanences Blanches⁹⁴

Origins/Initiators: The association *Fleur de Pavé (FdP)* was created in 1996 out of the concern of its initiators, shared by representatives of the city of Lausanne, for the needs of female drug addicts who prostitute themselves. Today, FdP is dedicated to the prevention of sexually transmissible infections and addressing the dangers associated with prostitution with regard to female sex workers in the Canton of Vaud.

Targeted population groups: Female sex workers (and those considered female) in the Canton of Vaud, regardless of their legal status.

Services provided and staff/professionals involved: Two female collaborators of FdP (one with personal experience of prostitution) tour the streets of Lausanne (sites where prostitution occurs) in a camping van, five nights a week from 10 p.m. to 2 a.m. The service consists of serving hot drinks and counselling sex workers on the prevention of sexually transmissible diseases and the risks associated with drug consumption and sex work. Protective materials are distributed as are sterile syringes. Every Wednesday, a nurse from *Médecins du Monde (MdM)* accompanies the bus in order to receive sex workers, in small groups of five, to discuss health related questions with them and to orient them towards the existing local socio-medical network⁹⁵ (project *Permanences Blanches*). FdP's activities also include visits to establishments accommodating prostitution in Vaud as well as the operation of a drop-in centre in Lausanne (open 3 days a week), where sex workers are received and listened to, and where they are accompanied with regard to administrative proceedings and provided with information regarding their rights. For example, where appropriate, clients are accompanied to their first appointment with a lawyer, or to the centre for victim aid, or to the hospital for an abortion.

⁹³ By 'key mediator' we refer to people who often have a migrant background themselves, and who therefore speak the languages of specific migrant groups and are often more successful in reaching 'newcomers' and in gaining their trust. As they are also familiar with the host society, they are sometimes able to mediate between a (newly arrived) migrant/UDM and people/institutions of the host society.

⁹⁴ Sources: Telephone interview with the director of FdP on 26 October 2009, http://www.fleurdepave.ch/index.php?option=com_content&view=article&id=32&Itemid=41 (last accessed: 17 July 2011).

A very similar project is *Permanences Volantes* implemented by HEKS/EPER in the city of Geneva, see <http://www.heks.ch/fr/suisse/secretariat-romand/permanences-volantes/> (last accessed: 17 July 2011).

⁹⁵ Recipients are primarily *Point d'Eau Lausanne* (PEL, see below), PMU-UPV (see above) as well as a local network of organisations active in HIV/AIDS prevention, care and counselling.

Financing the service: The association's sources of finance are the public authorities of the city of Lausanne, other municipalities in the region, the cantonal public health service as well as charitable foundations.

UDM-Clientele: Approximately two thirds of the clientele are migrants, but as information about legal status is not systematically collected⁹⁶ the exact number of UDM clients cannot be determined. In total, FdP recorded 10,827 client contacts in 2008. Client contact totals have been increasing in recent years. UDM clients currently come predominantly from Brazil and Cameroon, some from Nigeria or from eastern Europe (Romania, Bulgaria). Some have been living in Switzerland for years, others arrived only recently. Thanks to word of mouth, the latter access the services of FdP quite rapidly.

Management of UDM's health insurance affiliation: FdP collaborates closely with *Point d'Eau* Lausanne (PEL, see below) to assist clients in health insurance matters. Concretely, the FdP office often serves as an administrative address for correspondence between a health insurance company and a UDM client.

Financing care and UDMs' contribution to costs: While, in collaboration with PEL, health insurance affiliation of UDM is aimed for where health care needs incur high costs, FdP hasn't the financial means to assist clients in paying their monthly premiums. As a result, UDM clients are often exposed to debt collection after having been unable to pay their premiums or excess. In individual cases, FdP staff try to activate their network to raise funds, but this generally results in only small amounts of money being raised to help UDM pay their debts.

Aidshilfe beider Basel (AHBB), Projekt APIS PLUS⁹⁷

Origins/Initiators: The association *Aidshilfe beider Basel* (AHBB) was created in 1985. It is a regional branch and member of *Aidshilfe Schweiz* (AHS), an umbrella organisation representing organisations active in the HIV/AIDS domain in Switzerland. AHBB's activities range from implementing – in collaboration with local partners – HIV prevention projects aimed at different target groups (people at high risk as well as the general population) to offering individual consultations and legal, financial and/or social support to people touched by HIV/AIDS.

Targeted population groups: The activities of AHBB target different groups: the general population; schoolchildren/students; professionals; institutions; practising homosexuals; sex workers; people with a migration background. In the framework of a project called APIS (*Aidsprävention im Sexgewerbe*), AHBB targets female sex workers from Africa, Asia, eastern Europe and Latin America.

Services provided and staff/professionals involved: Within the APIS project, five mediators with different cultural and linguistic backgrounds deliver the prevention message to compatriot sex workers by making regular visits to their workplaces. They also hand out prevention materials and function as people of trust and first contact in case of health or social problems, referring sex workers in need to the appropriate social services. The project coordinator is responsible for the supervision and training of the mediators and works together with local institutions and authorities as well as similar services/projects nationwide.

Within the APIS project, APIS PLUS is an additional offer inspired by the fact that female sex workers often have no health insurance and, therefore, do not easily access health care. The project offers them assistance in accessing medical care in a rapid and uncomplicated manner by accompanying the women concerned to a GP or gynaecologist who collaborates with AHBB. These health care professionals are multilingual and competent in the specific health care problems and needs of sex workers. If necessary, an interpreter is provided.

Financing the service: AHBB finances its activities through donations made by the cantons of Basel-Stadt and Basel-Land and several municipalities as well as through the help of church-related or private donors. With regard to APIS PLUS, the two cantons of Basel have – as yet – not been disposed to finance such additional services and AHBB is, hence, reliant on other donors to ensure the project's continuation.

UDM-Clientele: Among the target population of APIS PLUS (female sex workers without health insurance) many are certainly UDM, but as data on legal status is not collected the exact number is unknown. Many women come from Brazil and Latin America in general, others from Bulgaria, several from Africa. They are typically a highly changeable group, many only staying for a short time before moving on to another country.

Management of UDM's health insurance affiliation: As the beneficiaries of APIS PLUS generally do not stay in the country for long, health insurance is normally not deemed necessary.

⁹⁶ Staff members only ask about legal status if this information is necessary to accompany/advise a client adequately.

⁹⁷ Sources: Telephone interviews with the manager of AHBB and a project collaborator on 22 and 26 October 2009; <http://www.ahbb.ch/> (last accessed: 17 July 2011).

Financing of health care and UDM's contribution to costs: Services provided by the two medical professionals are paid for by the project APIS PLUS, except laboratory tests which are billed to patients at a reduced tariff.

Both these models of outreach-based, low-threshold 'door opening' to health care for UDM developed out of publicly subsidised prevention programmes or projects organised by specialised NPO addressing specific target groups such as sex workers, homosexuals, drug addicts or other people at risk of contracting specific (infectious) diseases. As they do not usually specifically target UDM and are not concerned by the legal status of their clients, they cannot know if they actually come in contact with UDM, and – if so – with how many. All over the country, a great number of such prevention activities are implemented on a local level by numerous organisations, often by the regional branches of *Aidshilfe Schweiz (AHS)*, but also by many other organizations.⁹⁸ These activities are often publicly recognised and supported. Although their primary missions are disease prevention and health promotion, it is likely that some of them have also developed procedures and local collaboration partnerships in order to facilitate access to health care for clients without health insurance (among them probably UDM) with whom they come into contact, as is the case of the two projects described here (see – for example – the description of *Meditrina* in Zurich, below, in which the cantonal AHS branch is involved).

The Low-Threshold Contact Point

The **second subtype** within this category consists of a **low-threshold contact point** especially targeting UDM or people with precarious legal status, operated by civil society organizations and **offering general social and legal advice** to people concerned. As health care needs are frequently of relevance to UDM clients, such advisers have developed some competences in this field and become door openers to primary health care by, on the one hand, referring clients to a local network of health care professionals disposed to deliver care to UDM at reduced tariffs where necessary, and on the other by negotiating and administering health insurance affiliation for UDM and applications for cantonal subsidies (contacts with insurance companies and public authorities). The *Anlaufstelle für Sans-Papiers Basel* and the project *Salute nell'Ombra*, implemented by the NPO *Antenna May Day* in Lugano, illustrate the functioning of this subtype.

⁹⁸ To give just a few examples: in Fribourg, the association *FriSanté* (see below) implements the prevention project *Grisélidis* aimed at sex workers and dependent drug users, and the *Fondation Tremplin*, in cooperation with AHS, operates the *centre Empreinte*, where confidential counselling is provided to people concerned by infectious diseases (<http://www.tremplin.ch/fr/empreinte/index.php>). Furthermore, the AHS branch *Valais romand*, in cooperation with the *Ligue valaisanne contre les maladies pulmonaires* (Valais canton's respiratory illness association), is similarly active in the prevention of infectious diseases (<http://www.sida-vs.ch/>). The same applies to the activities of *aids hilfe bern* (<http://www.aids-be.ch/>) or to the prevention project *Primis* implemented by *Aiuto Aids Ticino* (in collaboration with *Antenna May Day*, see below), to the *Fachstelle für Aids- und Sexualfragen* operated by the *Verein Aidshilfe St.Gallen – Appenzell* (<http://www.aids-ai.ch/>) or to the prevention and health promotion project *Maria Magdalena* which targets female sex workers and is financed and implemented by the Public Health department of the Canton of St. Gallen (http://www.sg.ch/home/gesundheitsvorsorge/Maria_Magdalena.html).

Anlaufstelle für Sans-Papiers Basel⁹⁹

As those described under subtype 1, this kind of service cannot be considered health-, but rather social care, provision for UDM. That is to say it does not employ any health care professionals and does not dispense medicine. But it does counsel and concretely (administratively) help UDM to access health care and insurance. Unlike the NPO contained in subtype 1 whose target groups were defined according to specific health risks this service targets UDM specifically. Its services in health care matters did not originate in its core activities, but rather developed in the course of time because the people responsible for the service realized that they would answer a specific need of their target group. This service can be considered as an example of good practice since it succeeds in integrating a high proportion of beneficiaries into mainstream care, through health insurance affiliation and thanks to positive collaboration with social services which enables insurance premiums to be subsidized.

Origins/Initiators: This contact point for UDM (*Anlaufstelle für Sans-Papiers*), founded in 2001, was the first service of its type in the German speaking part of Switzerland. It resulted from a political movement: at that point in time, for the first time in Switzerland, UDM (together with their supporters) raised their public profile and claimed residence and working permits. The contact point was created to provide consultancy for, and empowerment of, UDM, for supporting their efforts with regard to self-help and unionisation (see the Union of workers without residence permit, below), as well as for maintaining positive public relations. Concerning health care, in 2001 a local network of health care professionals ready to deliver care to UDM for free, or to apply reduced tariffs, already existed. This network had been established by the *Solidaritätsnetz Region Basel*, another civil society group active in the region. The *Anlaufstelle* was able to assume coordination of this network and refer UDM with health care needs to these professionals.

Targeted population groups: Target groups are specifically UDM and those in touch with them.

Services provided and staff/professionals involved: Staff give advice about rights and opportunities for UDM regarding the following topics: residence permits and related legalisation; difficulties with the police; health care and insurance¹⁰⁰; labour legislation; exploitation in the workplace; the situation of children; courses in the German language; leisure time activities. A multilingual information leaflet is distributed. In addition, the *Anlaufstelle* can arrange the affiliation of interested UDM to the *Union of workers without residence permit* or a mentoring relationship with a Swiss citizen.

Financing the service: The *Anlaufstelle* is an association financed by membership fees and donations.

UDM-Clientele: Clients of the *Anlaufstelle* are UDM or those in touch with them. Traditionally, the UDM clientele of the *Anlaufstelle* primarily consists of people who did not enter the country in an asylum context¹⁰¹. In 2008, there were 205 initial consultations and over 1,000 consultations in total. About 10% of the initial consultations concerned families with children. There were more women than men seeking help. Half of the clients originally came from Latin America or Sub-Saharan Africa, others from the Balkans (Kosovo, Macedonia).

Management of UDM's health insurance affiliation: Although in some cases the consultants still work together with health professionals of the long-established network, nowadays the *Anlaufstelle's* strategy¹⁰² for facilitating access to health care is to maximise UDM's affiliation to health insurance and thereby integrate them

⁹⁹ Sources: Telephone-interviews with the director of the *Anlaufstelle* on 29 September 2009 and 5 February 2010; Annual Report 2008 of the *Verein Anlaufstelle für Sans-Papiers Basel*; <http://www.sans-papiers.ch/site/index.php?id=38> (last accessed: 17 July 2011).

¹⁰⁰ As, in recent years, consultations over health related issues represented a large and increasing percentage of the total number of consultations (about 20% in 2008 and 40% in 2009), it was decided that this domain should be taken over by a specialised institution and team. Thus, since 1.11.2009, the NGO HEKS/EPER has been operating the *HEKS Gesundheitsberatung für Sans-Papiers*. This new service gives advice on health care and insurance to UDM living in the city and outskirts of Basel. It is located in an office near the *Anlaufstelle* and is provided by two professionals employed by HEKS/EPER, a project director (0.2 FTE) and a psychologist who counsels the clients (0.4 FTE).

¹⁰¹ Non-admitted or rejected asylum seekers are more frequently in touch with the association *Solidaritätsnetz Region Basel*, although in recent times the *Anlaufstelle* has seen more and more of these clients, too. If they call on emergency relief from the Canton of Basel-Stadt they are, in the case of health problems, referred to one specific general practitioner in Basel with whom the social services have made an agreement (see below chapter 3.4)

¹⁰² Since November 2009 this is also the strategy of the newly established service *HEKS Gesundheitsberatung für Sans-Papiers*.

into the regular health care system. With regard to the Canton of Basel-Stadt, this procedure has proven to be rather successful. According to the people responsible, in about 90% of cases UDM can be affiliated to health insurance and receive subsidies which enable them to pay their monthly premiums – provided they have a wage. On this point, positive collaboration with the social services and the cantonal service for social security contributions (*Amt für Sozialbeiträge*) has been established. With the latter, the *Anlaufstelle* has informally agreed that its confirmation of a UDM's residence in the Canton of Basel-Stadt is sufficient basis for applying for subsidies. Under these conditions, the monthly insurance premium for a UDM amounts to roughly CHF 100 (€ 77), which most of the UDM with a regular income seem to be in a position to pay. The health insurance company concerned also seems to be quite happy with this practice, as they have become aware that 90% of insured UDM pay their premiums on time (which is not the case of the general population). In the case of the other 10% however, i.e. UDM who are not able to ensure the payment of monthly premiums, the situation is less satisfying: although the canton has made a general arrangement with health insurance companies stating that the latter still have to cover the costs of care if the patient has not paid their premiums, the problem remains, from the UDM's standpoint, that they will be exposed to debt collection, which in turn can be a disadvantage if they should ever get the chance to regularise their status, e.g. by marriage. Another problem is that, even when staff of the *Anlaufstelle* have applied for subsidies for a UDM, several months can pass before the subsidies are actually paid – meanwhile the UDM has to pay the full amount of the premiums which he or she often cannot afford.

Financing care and UDM's contribution to costs: UDM who cannot or do not wish to take out health insurance are still referred to the health professionals of the aforementioned network, or – in the case of an emergency – to the university hospital or the cantonal hospitals in Basel. The costs of the care subsequently provided will be written off by the service providers. In individual cases the *Anlaufstelle* can help UDM with small amounts of money by accessing an 'emergency fund' (*Notfonds*).

Similar contact points providing general counselling to UDM exist in Zurich (*Sans-Papiers Anlaufstelle Zürich* - SPAZ¹⁰³) and Bern (*Berner Beratungsstelle für Sans-Papiers*¹⁰⁴). Regarding health related questions, they work closely with the respective projects implemented in these cities (*Meditrina* by SRC in Zurich and *Gesundheitsversorgung für Sans-Papiers* by SRC in Bern-Wabern, see below).

Based on a rather similar concept but traditionally more health-oriented is the service described below, located in the southern, Italian speaking part of Switzerland.

Antenna May Day Lugano, Progetto Salute nell'ombra¹⁰⁵

Like the *Anlaufstelle* in Basel described above, this project does not provide health care on site, but functions as a door opener towards local health care providers. Nevertheless, it seems that *Antenna May Day* is developing its services towards becoming a reference centre and coordinating service with regard to the health care needs of UDM in the Canton of Ticino. In this role it functions as a contact point for governmental and non-governmental stakeholders.

Origins/Initiators: *Antenna May Day* is an NPO service located in the city of Lugano. It aims to – from a perspective of disease prevention and health promotion – facilitate access to the existing socio-medical services for migrants living in the Canton of Ticino, especially for those with precarious legal status. It was created in 1996 and its activities consist mainly of informing, counselling and orienting clients with respect to socio-medical questions, as well as informing and counselling socio-medical staff with regard to the rights and problems of migrants in precarious situations. Moreover, the service is active in health promotion and works together with local partners in prevention projects aimed at sex workers¹⁰⁶.

¹⁰³ <http://www.sans-papiers.ch/site/index.php?id=36> (last accessed: 17 July 2011).

¹⁰⁴ <http://www.sans-papiers-contact.ch/> (last accessed: 17 July 2011).

¹⁰⁵ Sources: Questionnaire; telephone interview with the project coordinator on 23 October 2009; *Antenna May Day* (2009) ; <http://www.sos-ti.ch/mayday.html> (last accessed: 17 July 2011).

¹⁰⁶ For example, *May Day* collaborates with *Aiuto Aids Ticino* on the project *Primis*, which follows an approach similar to the one described above under subtype 1.

By 2008, research by *Médecins sans Frontières (MSF)* had made it clear that, in the Canton of Ticino, it was impossible for UDM (not least non-admitted or rejected asylum seekers) to access health care except in an emergency. Consequently, since 2008, *May Day* has been operating a project called *Salute nell'ombra* which facilitates access to primary health care for UDM and people with precarious legal status by coordinating a network of health professionals who deliver care free of charge. An important initial step of the project was to inform and sensitize the diverse stakeholders in the general health care and social system of the Canton of Ticino regarding the situation and fundamental rights of UDM.

Targeted population groups: In the framework of *Salute nell'ombra*, target groups are primarily UDM but also migrants with precarious legal status living in the Canton of Ticino.

Services provided and staff/professionals involved: The project employs two social workers¹⁰⁷ who, according to their clients' needs, orient them towards health care services organised in a network covering different regions of the Canton of Ticino.¹⁰⁸ The private members of this network treat UDM in need free of charge; a pharmacy provides low-cost medicine. Multilingual information material is available, and – if needed – the project also provides for interpreters/mediators who accompany clients to see health care professionals. *May Day* staff also orient clients towards local social services and offer social counselling and support.

Financing the service: The project *Salute nell'ombra* is financed by *Antenna May Day*. At the time of response, it was expected to continue for a period of three years (2008-2010). Private carers within the medical network volunteer; some additional costs arising from free provision of care (acquisition of medicine, laboratory costs) are covered by the cantonal service for social assistance and integration (*Ufficio del Sostegno Sociale e Inserimento - USSI*) according to an arrangement made between *May Day* and USSI.

UDM-Clientele: During the project's first year of implementation (2008), twenty consultations with UDM clients were recorded.¹⁰⁹ UDM accounted for around 85% of the clientele. The demographics of UDM clients can only be estimated: around 40% were from Africa and another 40% from Latin America. A clear majority (roughly 80%) were between 18 and 35 years of age and around 20% were between 36 and 60. Approximately two thirds were male. Clients come to hear of the service through word-of-mouth, media, government agencies, health care providers and NGO. They do not need to show any documents to access the service.

Management of UDM's health insurance affiliation: Staff give information about health insurance and help clients to conclude an insurance contract. However, there have actually been very few situations in which UDM have been advised to affiliate to a health insurer. In most cases, the assessment of the clients' financial resources did not lead to affiliation since they would have been unable to pay their monthly premiums. A demand for cantonal subsidies has never been made, but according to information currently available to the project coordinator, such a demand seems unlikely to succeed. In one case where a UDM client was covered by health insurance, *May Day* took the role of mediator between the client and the health insurance company (postal address for correspondence, verification of reimbursements, etc.)

Financing care and UDM's contribution to costs: Private members of the medical network provide care free of charge; a pharmacy provides low-cost medicine. The public network-members (hospitals, socio-psychiatric service) who provide care in the framework of emergency aid are reimbursed by the cantonal Service for Social Assistance and Integration (USSI) or by health insurance companies.¹¹⁰

Self-assessed factors of success: The project coordinator indicates that her service is a member of a wide network of socio-sanitary and judicial services which have a long experience of dealing with migrants (refugees/asylum seekers, foreigners with or without precarious legal status). Collaboration with several services active in the field of migration – with the result that the project can benefit from their experiences and use synergies – is seen as an example of good practice, and as the project can make use of health professionals providing their services free of charge and without 'asking questions' it really has something substantial to offer its clients.

¹⁰⁷ Corresponding to 0.4 FTE.

¹⁰⁸ The network consists of five private GPs, a dental service, a pharmacy, as well as the socio-psychiatric service and the public hospitals of the Canton of Ticino.

¹⁰⁹ Taking into account the numbers for 2009 (until September), an increasing trend can be observed.

¹¹⁰ Depending on cost forecasts on a case-by-case basis, USSI concludes a health insurance contract for a UDM entitled to emergency relief and pays the monthly premiums.

Drop-In Centres

The **third**, and currently most frequent, **subtype** within NPO initiatives comprises the **operation of a drop-in centre** where one or several **nurses provide primary care** and **refer clients to other health professionals** if further care is necessary. In some cases, the drop-in also offers facilities for personal hygiene, doing laundry or meeting other people and targets deprived, socially marginalised people in general, not specifically UDM even if they represent a considerable proportion of the clientele. In other cases, however, the drop-ins were established with the precise goal of targeting UDM and facilitating their access to health care. The five practices surveyed within this sub-category are described in the following.

Point d'Eau Lausanne (PEL)¹¹¹

A particular feature of this service is that it primarily addresses people who have no health insurance. Thus, it is explicitly designed to be complementary to the mainstream health care system.

Origins/Initiators: The association *Point d'Eau Lausanne* (PEL) was founded in 1999 by different church-related actors: the *Service hospitalier de l'Ordre de Malte en Suisse*, the *Commanderie suisse de l'Ordre de St-Jean*, the *Pastorale de la Rue*, Caritas Vaud, the *Centre Social Protestant* and the *Armée du Salut*, in collaboration with the *Policlinique Médicale Universitaire* (PMU, see above). In its rooms, located in the city centre of Lausanne, it provides facilities for personal hygiene and laundry as well as free consultations with a nurse and other low-cost medical and paramedical services for people living in precariousness. Initiated on humanitarian grounds by the aforementioned civil society groups, it also immediately gained the support of the city of Lausanne.

Targeted population groups: PEL targets people living in precariousness (short or long term) and not covered by health insurance, regardless of legal status, residing in the city of Lausanne and surrounding areas.

Services provided and staff/professionals involved: Besides hygiene and laundry facilities, certain medical and paramedical services are provided free of charge or at a low price:

- Nurses receive clients (on appointment) for free of charge consultations. These consultations are dedicated to screening, prevention, health preservation and promotion.

- About ten medical professionals (GPs and some specialists) volunteer to provide regular consultations¹¹² at PEL's facility free of charge.

- About 40 specialists located in the city and surrounding areas of Lausanne accept patients who are referred to them by PEL¹¹³. Clients can also be sent to the medical outpatient department (PMU) of the University Hospital of Lausanne if necessary.

Other services offered on-site and free of charge or at a low price are osteopathy, massage and podiatry.

In addition, the PEL-coordinator and a social worker give information and advice – for example regarding health insurance affiliation – and orient clients toward the appropriate social structures within the city of Lausanne and its surrounding areas.

PEL employs ten people in total, amounting to four fulltime positions: administrative staff (including the coordinator), a social worker, four nurses and a dental hygienist with her assistants. They are supervised and trained on an ongoing basis. The medical/paramedical network involved in service provision consists of several

¹¹¹ Sources: Questionnaire; telephone interview with a nurse employed by PEL on 16 October 2009; <http://www.pointdeau-lausanne.ch/accueil.html> (last accessed: 17 July 2011).

¹¹² Consultations with a GP take place once a week, with a dentist ten days per month, with an orthopaedist, gynaecologist and psychotherapist either once every two weeks or once a month respectively.

¹¹³ They treat either one client per month free of charge or they apply a reduced tariff (CHF 10 or CHF 15 (€7.70 or € 11.50) per consultation).

volunteering health professionals¹¹⁴. The majority of staff members involved are Swiss nationals (some with migration backgrounds), others are from Italy, Brazil, Uruguay and Chile. In addition, PEL can count on about 100 volunteers who receive clients during the opening hours of the centre and orient them towards appropriate services¹¹⁵. Clients do not need to show any documents to access the services. No feedback mechanism has been established as yet.

Financing the service: Services provided by the association are financed to a large extent by a subsidy from the city of Lausanne (CHF 500,000 (€ 385,000) per year), also by donations and membership fees, and last – but by no means least – by the financial contributions of clients themselves.

UDM-Clientele: With regard to nursing services, 2,840 consultations took place in 2008. UDM accounted for 90% of these consultations. The numbers of UDM clients were stable over the last three years. Main countries/regions of origin of clients in 2008 were Latin America (53%), Sub-Saharan Africa (19%) and Europe (eastern Europe and Spain) (14%). The vast majority of clients are between 20 and 50 years old, 70% are female. UDM clients are able to access the service thanks to word of mouth, low-threshold structures and outreach work.

Management of UDM's health insurance affiliation: PEL staff members inform clients of their right to health insurance, but do not systematically recommend affiliation nor assist in concluding a contract. Affiliation is initiated if considerable health care costs are envisaged (e.g. surgical interventions).

Financing care and UDM's contribution to costs: PEL services are available at the following 'social tariffs': CHF 5 (€ 3.85) for a (para)medical consultation, surgical intervention, taking of a blood sample or an electrocardiogram; CHF 2 (€ 1.50) for a urine test, an injection or dressing; between CHF 2 (€ 1.50) and CHF 5 (€ 3.85) for medication; CHF 40/hour (€ 31/hour) for consultations with the dental hygienist. The network's specialists either treat one client per month free of charge or apply a reduced tariff (CHF 10 or CHF 15 (€7.70 or €11.50) per consultation). If costly health care interventions are necessary, PEL staff refer clients to PMU where a solution for financing has to be found (see above, PMU).

Self-assessed factors of success: According to our informants, the fact that services are provided at a low price is a major factor of success. Moreover, they mention that PEL is a warm and homely place which inspires people with trust and which is easily accessible.

FriSanté Fribourg, Espace de soins et d'orientation¹¹⁶

A particularity of this practice is that the services provided by *FriSanté* were initiated by MsF Switzerland who had been operating the centre for roughly two years before handing it over to a local association. Today, the services are well established and also supported and co-financed by governmental bodies, even if they still rely significantly on volunteers.

Origins/Initiators: In 2003, after having assessed needs, *Médecins sans Frontières* (MsF) initiated a project in the city of Fribourg with the objective of facilitating access to health care for deprived people. After a year, the operation of the drop-in centre – where a nurse receives and orients clients twice a week – was transferred from MsF to the association *FriSanté*, which has been responsible for organising the service ever since. Today, the association is financially supported by the cantonal public health authorities. At present, it operates two programmes: *FriSanté Espace de soins et d'orientation* (described here) and *Grisélidis*, a prevention and health promotion initiative targeted at sex workers and dependent drug users¹¹⁷.

Targeted population groups: The services provided by *FriSanté Espace de soins et d'orientation* were originally conceptualized to specifically target UDM, but are actually available to all people with no, or limited, access to health care, regardless of legal status, living in the city and region of Fribourg.

¹¹⁴ Eight general practitioners, an orthopaedist, a gynaecologist, a psychotherapist, a dentist, three masseurs, a podiatrist and several students in osteopathy.

¹¹⁵ PEL's direction estimates approximately 50 hours of voluntary work per week are carried out by professionals and non-professionals.

¹¹⁶ Sources: Questionnaire; telephone interview with the coordinator of *FriSanté* on 15 October 2009; *FriSanté-Grisélidis* (2009).

¹¹⁷ A programme subsidised by AHS, similar to the ones described above under subtype one.

Services provided and staff/professionals involved: In its drop-in centre in Fribourg (open twice a week), *FriSanté* provides anonymous consultations with a nurse¹¹⁸ as well as information and consultations about the health care system and patients' rights. Clients are assessed and referred to the appropriate services within the local social and medical network and the general health care system. Information material in different languages is provided and interpreters placed at the patients' disposal if necessary. *FriSanté* employs an administrative coordinator, a nurse and an interpreter, corresponding to two FTE. Staff – predominantly of Swiss origin – are trained on an ongoing basis. The health-related network coordinated by *FriSanté* consists of (volunteering) medical professionals (GPs, dentists, psychiatrists, gynaecologists and a paediatrician) as well as nurses, midwives and psychotherapists. The *FriSanté* team is also active in advocacy for UDM's health and social care concerns. If necessary, limited financial or other material support is provided for people in need.

Financing the service: The association finances its activities by membership fees, donations and subsidies from the cantonal public health authority (*Santé publique de l'état de Fribourg*), the *Loterie Romande*¹¹⁹ as well as a local charitable foundation. Members of the health care network charge (uninsured) patients according to patients' financial resources. Members of the association's steering committee as well as other volunteers spent, in 2008, more than 1,000 hours volunteering for *FriSanté* and thereby contributed considerably to its service provision.

UDM-Clientele: In 2008, about 85% of the clientele were UDM¹²⁰. This number had been increasing over the previous three years. Currently, most of the clients are estimated to be from Cameroon (30%), Mongolia (20%) and Turkey (10%). Most clients are female (66%) and between 36 and 60 years of age (60%). UDM clients come to hear about the service by word to mouth, through the media or through other health care providers. They do not need to show any documents to access the services and anonymity is strictly guaranteed.

Management of UDM's health insurance affiliation: Clients are informed about their right to health insurance and assisted in concluding a contract if they wish to do so. *FriSanté* has established a cooperative relationship with one specific health insurance company, and has developed competencies regarding the proceedings necessary to obtain cantonal health insurance subsidies for UDM. In the Canton of Fribourg, the subsidies accorded reduce monthly health insurance premiums substantially, so that UDM with a regular income are in general able to pay them.

Financing care and UDM's contribution to costs: Whenever possible, *FriSanté* aims at concluding a health insurance contract for UDM clients. If necessary, *FriSanté* provides limited financial or other material support for patients in need.

Self-assessed factors of success: As principal factors of success the respondents mention the good reputation of their team, their coordinated and individual responses to the needs of clients, their active listening competences. Another important factor, according to our informants, is that *FriSanté's* health care and prevention services are accessible to everyone regardless of legal status. Moreover, a crucial factor is the existence and effective performance of a large network of health professionals disposed to give care to these patients, so that all UDM seeking care can effectively be treated.

*Dispensaire des rues Neuchâtel*¹²¹

This service is an example of a private initiative made on humanitarian grounds, relying solely on donations and, to a large extent, on volunteers. It aims to provide concrete and straightforward assistance to people in need rather than to be active in political lobbying and advocacy for specific groups or for more equitable access to mainstream health care.

Origins/Initiators: Originating from a private initiative inspired on humanitarian grounds, the association *Dispensaire de Neuchâtel* has been, since 2000, operating a *Dispensaire des rues*, i.e. a drop-in space – in the

¹¹⁸ The services provided by the nurse comprise screenings and infectious disease control (prevention) as well as psychological support.

¹¹⁹ The *Loterie Romande* is an 'association of public utility' which organises and runs lotteries in the French speaking cantons of Switzerland. Proceeds are used, by the *Loterie Romande*, to provide financial support to civil society groups, namely in the fields of culture, sport and social welfare (see <http://www2.loterie.ch/loro/index.php>).

¹²⁰ Of 655 consultations in total, around 557 concerned UDM.

¹²¹ Sources: Questionnaire; telephone interview with the coordinator of the *Dispensaire des rues* on 14 October 2009; <http://www.dispensairedesrues.org/disp/index.php> (last accessed: 17 July 2011).

city centre of Neuchâtel – where facilities for personal hygiene and laundry as well as free consultations with a nurse and orientation towards a local health and social network are provided for people living in precariousness. The association is not subsidised by public authorities but relies solely on donations.

Targeted population groups: Those targeted are people with limited access to health care for financial reasons, regardless of legal status, residing in the city and outskirts of Neuchâtel.

Services provided and staff/professionals involved: The *Dispensaire des rues*, open on three afternoons per week, provides, in localities owned by the association, rooms for sanitation (shower and laundry facilities), services such as hairdressing, pedicure and osteopathy as well as consultations with a nurse or – if necessary – with a GP or a dentist. The health care professionals to whom clients are referred¹²² apply reduced tariffs for the consultations. Staff members of the *Dispensaire des rues* also refer clients to social professionals or institutions depending on their needs. At the same time, the *Dispensaire des rues* conceives of itself as a place where marginalized people are listened to and where they can meet other people and experience sociability. With respect to health promotion and disease prevention, staff members give advice relating to influenza, HIV and health-related behaviours in general. They do not work with trained interpreters, but staff speak different languages and multilingual documentation is available. The majority of staff receiving the clients at the centre are volunteers¹²³, i.e. they are not (necessarily) trained professionals¹²⁴. For nursing consultations, three trained nurses are employed by the association, though only equivalent to 0.2 full time employees. Nurses dispose of a basic dispensary and can – after having consulted a medical professional – deliver some kinds of medicine (generic products).

Financing the service: The association finances the activities of the *Dispensaire des rues* using the assets of a legacy as well as donations and membership fees. The service is not subsidised by the public authorities. To be able to assure the services described above, the association relies heavily on the help of volunteering staff. Medical professionals within the network provide care at reduced tariffs, taking into account the financial means of the patients.

UDM-Clientele: The clientele of the *Dispensaire des rues* is diverse: Along with some Swiss citizens whose access to specific health care services¹²⁵ is limited due to a lack of financial resources, there are migrants with legal status (asylum seekers or others) and also UDM. The latter currently account for around 10% of the clientele¹²⁶. Numbers have been increasing since 2006. Demographics of UDM clients (origins, age, gender, etc.) have not been recorded. UDM do not need to show identity papers to access the services. They come to hear about the *Dispensaire des rues* mainly by word to mouth, sometimes through other social institutions with which they come into contact or via the media.

Management of UDM's health insurance affiliation: Staff of the *Dispensaire des rues* give information about opportunities for health insurance affiliation, but UDM clients often do not chose this option (due – for example – to financial reasons or to fear).

Financing care and UDM's contribution to costs: In exceptional cases, the association can – in a very limited manner – contribute to the payment of certain of their clients' health care costs. If a client needs optical aids, for instance, costs are usually shared between the attending ophthalmologist, the client and the association *Dispensaire de Neuchâtel*.

Self-assessed factors of success: As success factors of the service the coordinating nurse mentions her and her (voluntary) team's efforts to create, coordinate and maintain a network of professionals and institutions disposed to give advice and care to people in need, and their efforts to orient their clients towards these professionals. As another key factor for success she notes the activities carried out to advertise the service among the targeted population and thus the success of word-of-mouth 'advertising'. Moreover, the number of people who are disposed to volunteer for service provision is an important resource.

¹²² The medical network consists of a dentist, a general practitioner, a dermatologist and a gynaecologist as well as a local family planning centre.

¹²³ There are roughly 20 people of diverse origin, spending – on average – 18 hours per week volunteering for the *Dispensaire des rues*.

¹²⁴ However, the association encourages volunteering staff to undertake further training and annually proposes a special training event. Nevertheless, the consultants' competences are limited, for instance when it comes to helping people with serious mental health problems.

¹²⁵ For example dental care which is not covered by basic Swiss health insurance.

¹²⁶ About 50 UDM clients were registered in 2007.

Réseau Santé Migrations (RSM) La Chaux-de-Fonds¹²⁷

This service exists largely due to the financial commitment of the two NGO involved and the volunteering of network members. As it is located in a rural area, as clients are not numerous, and as cases requiring costly health care have been extremely rare until now, this approach may function well. In an urban context where client numbers are higher and expensive health care is needed more frequently, it would probably be more difficult to create and maintain a network of volunteering professionals and facilitating access to hospital care would also become a necessity.

Origins/Initiators: The project *Réseau Santé Migrations* (RSM) was initiated in 2007 by the collaboration of two NGO: *Médecins du Monde* (MdM) *Suisse* and HEKS/EPER, organisations both active and competent in the fields of health care and migration respectively. The project comprises the establishment and operation of a contact point for UDM in La Chaux-de-Fonds (Canton of Neuchâtel), where nursing consultations and social support is provided. Access to further medical care is facilitated by the coordination of a network of health professionals prepared to deliver free care to UDM on humanitarian and public health grounds. An M.A. research project had previously assessed the need for such a service in the region concerned (parts of the cantons of Neuchâtel, Jura and Bern).

Targeted population groups: The original target group was intended to be UDM without health insurance cover. In fact, however, services are now extended to any person with limited access to health care.

Services provided and staff/professionals involved: Twice a week, a nurse employed by MdM receives clients in a drop-in setting in La Chaux-de-Fonds. She assesses their health and social situation and, if necessary, organises further medical care within an established network of around 30 health care professionals¹²⁸ offering free care to RSM clients. In addition to the above services, a social worker employed by HEKS/EPER provides social counselling and support. Multilingual information material and interpreters/mediators are available if needed. The project is coordinated by two administrative project directors, one employed by each of the two NGO involved. In total, staff employed are equivalent to 0.9 FTE, while members of the medical network volunteer.

Financing the service: The services provided by RSM are financed by MdM and HEKS/EPER, with contributions from the city of La Chaux-de-Fonds, the *Loterie Romande* and a charitable foundation.

UDM-Clientele: In 2008, 31 UDM clients were recorded, accounting for around 75% of the total RSM clientele. Since the beginning of the project in 2007, client numbers have been increasing. Principal nationalities of UDM clients were (estimated percentages for 2008): Cameroonian (15%), Turkish (12%) and Algerian (9%). The vast majority of UDM clients were between 20 and 45 years old, 60% were male. UDM come to hear of the RSM services through word-of-mouth, leaflets, media, government agencies, health care providers, NGO and outreach work. They do not need to show any documents to access the service and anonymity is strictly guaranteed.

Management of UDM's health insurance affiliation: Clients are systematically informed concerning their right to health insurance. If they wish to conclude a contract, the social worker will arrange it for them and apply for appropriate cantonal subsidies. It is, however, rare that UDM clients can afford to pay monthly health insurance premiums, and – in such cases – they are not advised to take out health insurance. Clients are, however, advised and helped to do so where pregnancy/childbirth or other costly health care interventions are envisaged.

Financing care and UDM's contribution to costs: Members of the medical network bear the costs of care delivered to RSM clients. Health insurance affiliation is recommended when it is probable that the UDM concerned will be able to pay the monthly premiums. If costly health care interventions are required, clients are assisted in taking out health insurance.

Self-assessed factors of success: Our respondents mention the wide range of health care professionals collaborating in the network and the effectiveness of their collaboration, as well as the network of local associations and institutions which direct UDM to the service. The upstream gate keeper function of the service (nurse), the combination of social and health counselling and a favourable political and institutional context for such a service in the region (high acceptance and tolerance levels) are considered further success factors.

¹²⁷ Sources: Questionnaire; telephone interview with the project manager of *Médecins du Monde* (MdM) on 12 October 2009; <http://www.medecinsdumonde.ch/reseau-sante-migrations-fr69.html> (last accessed: 17 July 2011) and <http://www.heks.ch/fr/suisse/secretariat-romand/reseau-sante-migrations/> (last accessed: 17 July 2011). An evaluation of the RSM was carried out in collaboration with the SFM in 2009 (the report is available upon request).

¹²⁸ GPs, dentists, paediatricians, psychiatrists, psychotherapists, midwives, etc.

Spagat Aargau-Solothurn¹²⁹

As this service has only recently been created, it has potential for further development. Notably, the local-level lobbying/advocacy carried out by the project may produce further improvements with regard to access to health care for UDM living in the region.

Origins/Initiators: The project *Spagat* was initiated in 2008 by HEKS/EPER, an NGO whose overall goal is to contribute to humane living conditions for all. The concept of this project was guided by already existing initiatives from other parts of the country (namely RSM La Chaux-de-Fonds, see above). *Spagat* particularly targets UDM living in the cantons of Aargau and Solothurn and aims to:

- inform them of their rights and support them in asserting these rights;
- facilitate access to health care;
- improve their living conditions by providing health promotion activities and social counselling, by increasing their autonomy and by sensitizing authorities, and the general public, with regard to their situation.

Targeted population groups: The project targets UDM living in the cantons of Aargau and Solothurn.

Services provided and staff/professionals involved: Twice a week, nursing services and clinical assessment are provided by a nurse (trained in nursing sciences) in a drop-in setting. If necessary, further health care is organised within a network of independent health care professionals or within the mainstream health care system. In the fields of health promotion and disease prevention the nurse provides information about genital diseases, makes condoms available, explains the risks of tooth-decay to families, etc. She also suggests relaxation exercises in order to help clients cope with stress.

Continuously trained staff – i.e. the nurse and a social worker, assisted on-demand by interpreters of diverse origins¹³⁰ – also offer social counselling and support, including information about health insurance and help in concluding a contract, information about school enrolment or training opportunities for young people, the arrangement of contacts with social institutions or the accompanying of clients on visits to health care providers or public authorities. Multilingual information material is available. If necessary, limited financial support is provided for people in need (purchasing of train tickets and medicines). In addition, staff members are active in advocacy for the resolution of UDM's health and social care concerns.

Financing the service: The project is financed by HEKS/EPER, a relief organisation which finances its activities in Switzerland, and abroad, by grants and donations from private individuals, as well as from churches, diverse organisations and public authorities.

UDM-Clientele: Although the project targets UDM specifically, those involved in the asylum application process are also allowed access. From the project's inception in November 2008 until October 2009, 50 UDM consulted the service (increasing trend) and accounted for 67% of the total clientele.

The main nationalities of clients¹³¹ were Iranian, Iraqi, Ethiopian, Mongolian (6.5% of each), followed by Afghan, Cameroonian, Romanian and Thai (4.5% of each). There were some individual clients from several other countries of origin. An estimated 20% of the total clientele were under 17 years of age while the majority (nearly 80%) were between 36 and 60. About one third of the clientele were female, 55% male and 12% were families (estimated percentages).

Clients come to hear of the service through word-of-mouth, leaflets, media, government agencies, health care providers, NGO or migrant associations. They do not need to show any documents to access the service; consultations are strictly anonymous.

Management of UDM's health insurance affiliation: UDM clients are systematically given information about their right to health insurance and helped in concluding a contract if they decide to do so. Most UDM clients cannot, however, afford health insurance premiums and therefore are unwilling to take out health insurance unless their health care requirements are likely to incur high costs. It has not yet been possible for the *Spagat* team to negotiate a practicable procedure enabling it to apply for cantonal subsidies on its UDM clients' behalf¹³².

¹²⁹ Sources: Questionnaire; telephone interview with the nurse working for *Spagat* on 12 October 2009; <http://www.heks.ch/de/schweiz/regionalstelle-aargausolothurn/spagat-sans-papiers-anlaufstelle/> (last accessed: 17 July 2011).

¹³⁰ Staff employed are equivalent to 0.75 FTE.

¹³¹ Numbers refer to the total clientele, i.e. UDM and asylum seekers.

¹³² Currently, the authorities still ask for an (official) residence certificate of the canton.

Financing care and UDM's contribution to costs: Staff have, as yet, encountered few cases of high-cost medical care delivered to UDM. The few cases encountered which did generate considerable costs were dealt with in the framework of emergency aid, i.e. paid for by cantonal authorities. In one particular case, the *Spagat* team approached a charitable foundation for help in financing a surgical intervention.

Self-assessed factors of success: The respondents mention their networking activities and the regular feedback they provide to network members, which members appreciate greatly. Their work and lobbying for the concerns of the clients are also seen as a success factor. Another strong point mentioned is the concurrent offer of social and health counselling.

The **fourth subtype** of NPO initiative differs only slightly from the third in that, at the drop-in centre operated by an NPO, not only is nursing care provided – the nurse functioning as gate-keeper and door opener to further (primary) care – but **general practitioners or even certain specialists are also present, employed by the NPO** to provide primary or specialised care to UDM on site where necessary. The NPO, in this case, functions as door opener mainly towards (other types of) specialised care as well as towards hospital care rather than towards general care. This subtype is, here, illustrated by two of the surveyed practices: *Meditrina* in Zurich and *Gesundheitsversorgung für Sans-Papiers* in Bern-Wabern.

***Meditrina* Zurich¹³³**

In recent years, in *Meditrina*, a valuable service which facilitates access to health care for UDM has been established in Zurich. Informative work by NGO has obliged local authorities and health care providers to become more and more aware of the existing need and to recognize that practicable local solutions must be found with regard to health care for UDM. Compared to Geneva or Lausanne, however, public authorities in Zurich leave the lead to NGO which subsequently try to convince public health care providers to cooperate in this matter. Municipal authorities and care providers, especially, cooperate increasingly (more than do the cantonal authorities) but, unlike in Geneva or Lausanne, public service providers prefer not to highlight their cooperation with *Meditrina* in public.

Origins/Initiators: In 2006, the NGO *Médecins sans Frontières* (MsF) initiated the project *Meditrina* after having assessed the need for such a service in the city and outskirts of Zurich.¹³⁴ The project aimed at providing (ambulatory) primary health care and facilitating access to general health care for UDM. Over four years, the project team has established and operated a drop-in centre located in a central district of the city of Zurich, where a nurse and GP receive and assess clients with regard to their health problems and, if necessary, refer them to specialist care providers participating in an available network, or to public hospitals, respectively. During the first two years, client numbers were not as high as expected, and MsF considered abandoning the project. But after certain measures were taken – outreach work was intensified and the target group was opened up to include those who cannot easily make use of regular services – the number of consultations increased considerably within three months and the project work can now continue. On January 1 2010 the project was taken over by the Zurich section of the Swiss Red Cross (SRC ZH) and moved to another locality in Zurich. The concept and the activities of *Meditrina* remain broadly the same as those initiated by the MsF team.

Targeted population groups: Target clients are those with no or limited access to health care, regardless of legal status, living in the city and Canton of Zurich.

Services provided and staff/professionals involved:¹³⁵ SRC ZH employs a GP as well as a nurse/midwife also trained in International Health (MAS). This interdisciplinary and multilingual team receives clients three days a

¹³³ Sources: Questionnaire; telephone interviews with the coordinator and the nurse on 18 September and 3 December 2009; Gross (2009); www.srk-zuerich.ch/meditrina (last accessed: 17 July 2011).

¹³⁴ MsF already had some experience of implementing a similar project in Fribourg, see above.

¹³⁵ When the project was surveyed in autumn 2009, it was still operated by MsF. Therefore, the information presented here was provided by MsF project managers and describes the state of affairs under MsF management. Much of the future situation under SRC ZH sponsorship was, however, already known to staff and, according to the nurse who worked both for MsF and now for SRC ZH, the concept and the activities of *Meditrina* remain widely the same. See also the updated project website of SRC ZH for information regarding

week in a drop-in setting and assesses them with regard to their health problems. If necessary, professional interpreters can be called upon. Services provided by *Meditrina* staff include basic medical and emergency care as well as diagnostics, (partial) woman and child care, as well as screening and infectious disease control (Tuberculosis, HIV VCT¹³⁶) and psychological support. If necessary, over-the-counter medicines are dispensed. Initial consultations with *Meditrina* are free of charge. If further or specialised care is necessary, staff can refer patients either to one of over fifty primary and specialist care providers participating in a network¹³⁷, where they will receive care at a reduced cost, or to a public hospital¹³⁸. *Meditrina* also provides information regarding the health care and insurance system, and refers UDM to local social counselling services which can advise clients with respect to their situation. If necessary, financial support is provided for people in need.

Financing the service: The services provided by the *Meditrina* team are financed by SRC ZH¹³⁹, along with other services in the field of migration and asylum. SRC ZH is an NGO financed by private and institutional donations and legacies.

UDM-Clientele: *Meditrina* recorded a total of 1,187 consultations (unique or multiple) in 2008. 248 new UDM clients were recorded, representing roughly half of the new clientele¹⁴⁰. This is not counting new clients with NEE status or unclear legal status. If they are included, the percentage of new clients which can be classed as UDM rises to approximately 60% of the total. Statistics established by *Meditrina* staff do not express the geographic origin, age and gender of UDM clients, but rather of the new clientele in general. In 2008, half of new clients were from Latin America, 10% from Sub-Saharan Africa and 9% from Europe. The majority of clients (roughly 60%) were between 16 and 40 years of age, around 30% were between 41 and 60. Most were women (58%). We can, thus, describe the typical UDM client at *Meditrina* as a female Latin American under the age of 40. Recently, however, there has been an increasing number of rejected asylum seekers or people with NEE status (mostly males) who have not applied for emergency aid.

UDM become aware of the service mainly through word-of-mouth and outreach work, but also by means of information material (leaflets and a website), the media, or through health care providers or NGO. They do not need to show any documents to access the service and anonymity and confidentiality are strictly guaranteed. An estimated 70-80% of the clientele live in the city of Zurich, the rest either in the canton of Zurich or elsewhere¹⁴¹.

Management of UDM's health insurance affiliation: *Meditrina* staff give information and counselling related to health insurance affiliation and support clients in concluding a contract. They choose insurance companies primarily according to premium costs, but have also gained experience in knowing which companies will be disposed to cooperate. Usually, the postal address of *Meditrina* is given to the company as the residential address of the UDM. With regard to application for cantonal subsidies, *Meditrina* staff work closely with the *Sans-Papiers Anlaufstelle Zürich* (SPAZ) where staff have negotiated – with the legal section of the municipal Public Health Department of Zurich and the cantonal social security service (*Sozialversicherungsanstalt - SVA*) – manageable methods of obtaining cantonal subsidies for UDM living in the city of Zurich. Generally, to decide whether insurance affiliation is advantageous or not, *Meditrina* staff estimate treatment costs and compare them with available financial resources on a case by case basis¹⁴².

Financing care and UDM's contribution to costs: Initial consultations with *Meditrina* are free of charge. For a consultation with network members, patients are charged CHF 50 (€ 38.50). Whenever costly treatment is foreseen, *Meditrina* staff will try to affiliate the patient to a health insurance scheme. They also give advice and

Meditrina's current activities: <http://www.srk-zuerich.ch/srk/lch-suche-Hilfe/fuer-Migrantinnen/Meditrina/index.php> (last accessed: 17 July 2011).

¹³⁶ VCT = Voluntary Counselling and Testing.

¹³⁷ Among them laboratories, pharmacies and specialised counselling or therapeutic services, e.g. *Zürcher Aidshilfe, Lungenliga, Gynäkologische Sprechstunde der städtischen Gesundheitsdienste*.

¹³⁸ Approximately 20% of clients are referred to network members.

¹³⁹ Between 2006 and 2009 by *Médecins sans Frontières* (MsF).

¹⁴⁰ Along with 579 people who had consulted *Meditrina* before, there were 503 new clients, i.e. people who consulted for the first time in 2008.

¹⁴¹ Interlocutors from eastern or central parts of Switzerland where access to health care for UDM is particularly difficult and no facilitating services exist as yet (see below) told us that, time and again, UDM with whom they were in contact had come to know of *Meditrina* and planned to use the services provided in Zurich. In the absence of a similar service in Luzern, for instance, local church-related organisations or social services seem to systematically refer UDM to *Meditrina*, sometimes even paying their train ticket to Zurich.

¹⁴² According to SPAZ estimates, very few UDM in the Canton of Zurich are actually insured (less than 1%). Those insured are mostly pregnant women and many of them are close to a regularisation of their status through marriage.

support in fund-raising for the payment of health insurance premiums, or – if insurance affiliation is not possible – for the payment of medical costs. Certain special conditions regarding billing in the case of uninsured patients have been negotiated with the public hospitals in the city of Zurich, with the result that hospitalisation has become at least a little more affordable for the UDM concerned (or rather the people or organisations paying for them). In the case of Tuberculosis treatment for which patients were not able to pay, *Meditrina* and the Zurich Lung League (*Lungenliga Zürich*) have so far shared the costs. In the case of – more expensive – HIV/AIDS treatment, however, it remains unclear who will bear the costs in the future¹⁴³.

Self-assessed factors of success: Our informants mention the availability of a large network of health professionals who provide a wide range of different care services applying reduced tariffs (specialist, general, paramedical, pharmacies, etc.). Other success factors are considered to be: the relationship of trust between the provider and the clients, favoured by the independence and reputation of the founding organisation (MsF); the guaranteed strict discretion; the transcultural competences of staff; outreach work by multilingual staff (some with the same origins as the clients); the availability of, and work with, intercultural interpreters; good accessibility and adequate location; efforts in publicity and lobbying. In the eyes of respondents, it is also key that the target group is not limited exclusively to UDM.

The second service surveyed in this fourth subtype is located in Bern and is also operated by SRC. Compared to *Meditrina*, the drop-in service in Bern differs in that there is not only a GP present, but also a psychiatrist on site who can assess and, if necessary, treat UDM clients. Moreover, the service is embedded in a specialised multidisciplinary centre, also operated by SRC, where ambulatory therapies are provided to patients traumatised after having experienced war or torture.

Gesundheitsversorgung für Sans-Papiers Bern-Wabern¹⁴⁴

This SRC service, in comparison to others, possesses relatively comfortable financial resources to facilitate access to quality health care for UDM. Its cooperation with an SRC hospital may discharge public hospitals from providing care to UDM. The fact that the service is embedded within the well-established therapy centre for war and torture victims enables optimal use of synergies, although its location near the building which houses the Swiss Federal Office for Migration (FOM) might raise the access threshold for UDM wishing to use the service.

Origins/Initiators: Since 2007 the Swiss Red Cross (SRC), a powerful NGO active in health as well as migration issues in Switzerland, has been operating this drop-in centre located in Bern-Wabern, near the therapy centre for war and torture victims (*Ambulatorium für Folter-und Kriegsofper* - AFK¹⁴⁵) also operated by SRC. Prior to this, from 2001 onwards, the non-profit association *MeBif* (*Medizinische Beratung für illegalisierte Frauen*) had provided medical counselling to female UDM and referred them to medical professionals active in Bern and its outskirts who treated these women free of charge or at reduced tariffs. The *Berner Beratungsstelle für Sans-Papiers*, newly created in 2005, as well as the SRC medical drop-in presented below, both inherited this network of professionals. They now conjointly account for facilitating access to health care for UDM living in Bern and surrounding areas.

Targeted population groups: The target group are specifically UDM (people with NEE status or rejected asylum seekers included) living in the city of Bern and surrounding areas.

Services provided and staff/professionals involved: *SRC Gesundheitsversorgung für Sans-Papiers* employs a nurse responsible for the direction of the service. She receives clients at the drop-in three days a week (or on appointment), assesses their state of health, gives basic medical care and/or information and counselling about health issues and disease prevention¹⁴⁶ as well as about the health care and insurance systems. If necessary,

¹⁴³ Until now, the *Zürcher Aidshilfe* has participated in paying the costs on a case by case basis.

¹⁴⁴ Sources: Questionnaire; telephone interview with the director of the service on 17 September 2009; <http://www.redcross.ch/activities/integration/news/news-de.php?newsid=721&archive=0> (last accessed: 17 July 2011).

¹⁴⁵ AFK is a multidisciplinary centre where ambulatory therapies are provided to patients traumatised after having experienced war or torture.

¹⁴⁶ With regard to nutrition and oral hygiene, gynaecological controls, screening for Tuberculosis and HIV testing.

she refers clients to the GP or the psychiatrist on site, both employed by *SRC Gesundheitsversorgung für Sans-Papiers*, or to the multidisciplinary team of the nearby AFK centre. Furthermore, if necessary, clients can be referred to members of an external network of health professionals (dentists, gynaecologists, midwives, psychotherapists, etc.) who treat them free of charge or at reduced tariffs¹⁴⁷. Last but not least, treatment within the regular health care system can be organised by *SRC Gesundheitsversorgung für Sans-Papiers*.

Staff, i.e. the nurse, the two medical professionals as well as an administrative assistant¹⁴⁸ (all with a migration background themselves) are trained on an ongoing basis (super- and intervision) and apply a case management approach. They also give psychological and administrative support (for example with regard to affiliation to health insurance services) or orient clients towards the region's appropriate social services (*Berner Beratungsstelle für Sans-Papiers*, other social counselling centres, church-related services, etc.) Multilingual information material and interpreters/mediators are available if required.

Financing the service: Costs for the services provided in the drop-in centre are covered by SRC, an NGO financed by private and institutional donations and legacies.

UDM-Clientele: The clientele consists exclusively of UDM. The number of clients has been increasing continually since the project began. In 2008, 70 UDM clients were recorded. From January to September 2009 there have already been more than twice as many UDM consulting *SRC Gesundheitsversorgung für Sans-Papiers* as throughout the previous year. In 2008, most clients came from Africa (50%) – women mainly from western Africa, men from the Maghreb – and from non-EU Europe (20%), Asia (20%) or Latin America (10%). The vast majority were between 18 and 35 years of age (nearly 60%) or between 35 and 60 (roughly 30%). There were as many male as female clients.

It is presumed that UDM hear about the service mainly by word of mouth, but also through the media, NGO, social services and through outreach work. Clients do not need to show any documents to access the service.

Management of UDM's health insurance affiliation: Staff give information and advice with regard to health insurance affiliation and support clients in concluding a contract if they wish to do so.

Financing care and UDM's contribution to costs: The health care professionals within the network provide initial consultations to UDM free of charge. Further consultations or treatments are billed and paid for either (partly) by the patients themselves or by the SRC, where a special fund has been created for such purposes. If patients do not, and cannot, have health insurance, *SRC Gesundheitsversorgung für Sans-Papiers* can help them by accessing this fund.

Self-assessed factors of success: Our informant mentions the availability of financial resources to guarantee access to quality care; trained staff with transcultural and other requisite competences; the fact that psychiatric care is also provided on site; the low-threshold, interdisciplinary approach of the service; the fact that individuals are helped on a long term basis (case management; relationship of trust). Furthermore, in her view, the fact that the service targets UDM specifically is another strength of the approach, as staff members gain experience in assessing the specific positions of UDM and become genuine specialists in caring for them.

3.4 (Semi-) Governmental, Health Topic-Specific or Risk Group-Oriented Services

Among the services surveyed, three differ from those already described in that they are neither integrated into public hospitals nor do they fit into the model of drop-in centres established and operated by NPO. They are services which are completely, or to a great extent, **mandated by public authorities to offer specialised care regarding specific health topics**, and this often by **targeting specific risk groups**. This means that these services are actually part of the mainstream health care system.

The three services surveyed and presented in the following are active in prevention and counselling in the area of sexual and reproductive health and sexually transmitted diseases (targeting mainly sex workers), in victim assistance and in counselling and therapy in the

¹⁴⁷ Among the members of this network there is also a SRC hospital disposed to bear a part of the costs for health care provided to uninsured UDM.

¹⁴⁸ In total, staff employed correspond to 1.6 FTE.

field of mental health. They do **not specifically target UDM**, which generally account for a rather small percentage of their clientele. However, more or less frequently, they do come into contact with clients lacking legal status and have developed some experience in dealing with these situations. That is why they decided to fill in our questionnaire, which in turn has allowed us to further broaden the spectrum of health care practices for UDM in Switzerland presented here. It can be assumed that there are, throughout the country, more such institutions which, operating within the regular health care system, also occasionally treat UDM.

Gynäkologische Sprechstunde der städtischen Gesundheitsdienste Zurich¹⁴⁹

Ambulatory health care for marginalized groups is, in Zurich, organised by the municipal health service which operates special institutions to this end, such as the *Ambulatorium Kanonengasse* with its gynaecological consultations presented above. These services were mainly developed to serve drug addicts, but have adapted their offer to current needs and began to collaborate with *Meditrina* a few years ago.

Origins/Initiators: The municipal health services (*Städtische Gesundheitsdienste*) are a public institution operated by the city of Zurich. They are assigned different public health tasks, such as ensuring health insurance coverage of the resident population, providing inpatient treatment of addictive disorders as well as basic medical care accessible to all, or implementing HIV prevention measures. Originally, the gynaecological consultations (*Gynäkologische Sprechstunde*) offered by the *Städtische Gesundheitsdienste* were intended to provide health care and implement prevention measures with regard to HIV – and sexually transmitted diseases generally speaking – within a specific group of underserved women, particularly female sex workers and/or women with addictive disorders. More recently though, those responsible have become aware of an unmet medical need concerning some particularly vulnerable groups of sex workers. Therefore, since 2003, the services have also been accessible to female migrants or tourists lacking social support.

Targeted population groups: Those targeted are primarily medically underserved women active in sex work and/or touched by addictive disorders, regardless of legal status, living in the city of Zurich.

Services provided and staff/professionals involved: The service provides – in a walk-in clinic open three days a week – general gynaecological as well as prenatal care and is also active in the prevention of HIV, hepatitis and other sexually transmissible infections¹⁵⁰. Where necessary, treatment of addiction is also provided. In cases of mental health needs, clients can be referred to psychiatric care providers, and, in cases of a need for hospital care, to the municipal city hospitals and the (cantonal) University Hospital of Zurich. The service is also active in health promotion (counselling) and provides social and legal support (for example information and counselling related to health insurance affiliation or to the initiation of custodial measures). Information material, in different languages, is available, as are interpreters if required. If necessary, financial support is also provided to facilitate access to care. Professionals employed and involved in service provision correspond to approximately 4.4 FTE¹⁵¹.

Financing the service: The municipal health services (*Städtische Gesundheitsdienste*) are a public institution financed by the city of Zurich.

UDM Clientele: It is estimated that between June 2003 and June 2008 UDM accounted for around half of the clientele of the *Gynäkologische Sprechstunde*. During this period, an estimated 470 UDM clients made use of the service (increasing trend). These women originally came from Latin America or the Caribbean (c. 35%), eastern Europe (c. 27%), Africa or Asia. The vast majority (93%) are aged between 18 and 60. They come to hear about the service mainly through word-of-mouth, partner NPO and outreach work.¹⁵² Clients do not need to show any documents to access the services.

¹⁴⁹ Sources: Questionnaire; telephone interview with the director on 18 November 2009; http://www.stadt-zuerich.ch/gud/de/index/gesundheit/medizinische_versorgung/gyni.html (last accessed: 17 July 2011), Wuschek (2009).

¹⁵⁰ Among the preventative services provided are: infectious disease control (tests and screenings), vaccinations, gynaecological control, family planning and advice on methods of contraception, etc.

¹⁵¹ Administrative staff 0.2; nurses 2.8; general practitioners around 0.1; gynaecologists 1.0; social workers 0.2.

¹⁵² A principal partner is *Meditrina* (see above): The *Gynäkologische Sprechstunde* is a member of the *Meditrina* health care network and is seen, by *Meditrina* staff, as complementary to the services provided. A large part

Management of UDM's health insurance affiliation: UDM clients are informed and counselled with regard to health insurance affiliation. In some cases, i.e. mainly when they are pregnant, they are further supported in concluding a contract.

Financing of health care and UDM's contribution to costs: Care provided to UDM clients and sex workers is predominantly paid for by the clients themselves (Wuschek 2009).

Self-assessed factors of success: Main success factors appear to be: the accessibility of the service; the linguistic competences of the staff; discretion/anonymity; confidence building; provision of high quality health care and prevention. Good practices of the service are considered to be: target-group specific and adequate high-quality health care and prevention measures; individual-centred treatment; a qualified and personally committed team; continuity within the staff; transparent information; effective process-oriented action and collaboration with partners.

Fondation Profa Vaud, Programme Migration&Intimité (M&I)¹⁵³

This institution, as part of mainstream health care provision, has decided to open up its services to reach all parts of the population, including migrants, and regardless of legal status, and has taken appropriate related measures by implementing a special programme entitled *Migration & Intimité*.

Origins/Initiators: In 1966, the *Ligue vaudoise Pro Familia*, assisted by public authorities, created a socio-medical centre in Lausanne where family planning and marriage counselling were to be offered. In 1969, the section 'sex education for young people' (*éducation sexuelle de la jeunesse*) was added to the centre. Since 1984, the centre has been independent from *Pro Familia* and been organised as a private foundation (*Profa*) recognised by public authorities for its public utility and mandated by them to offer services and counselling in the extended field of sexual and reproductive health, thus complementing existing state run services.

Targeted population groups: The target group are those living in the Canton of Vaud, in need of services/consultation in the fields of sexual and reproductive health, regardless of their legal status.

Services provided and staff/professionals involved: The different sections of *Profa* located across the canton provide services aimed at improving the quality of the affective, relational and sexual life of the population and promoting respect for the integrity of the individual. Concretely, these services consist of information and counselling in the fields of prevention and health promotion (vaccinations and screenings), but also crisis intervention or health care where necessary, marriage counselling/sexology, family-planning consultations, perinatal counselling, sex education and victim assistance. In cooperation with *Point fixe-prévention SIDA* (the local branch of AHS) and other local partners, the *Profa* family-planning service implements the program *Migration & Intimité (M&I)* with the objective of preventing unwanted pregnancies and sexually transmissible infections in migrants (regardless of their legal status) from Latin America and Sub-Saharan Africa. The programme, carried out in collaboration with associations or representatives of different migrant communities, includes the promotion of sexual health. Multilingual information materials and interpreters/mediators are available if needed. The staff (35.0 FTE), trained on an ongoing basis, consists of ten administrative professionals, eight GPs, twelve midwives, sixteen social workers specialised in victim assistance or perinatal counselling and ten consultants specialising in matters of sexual and reproductive health. Most are Swiss nationals (95%); others are from African, Arabic or Latin American countries or from the Balkans.

Financing the service: The public utility of *Profa's* services is recognised by the public authorities. The foundation is mandated by the Public Health Service of the Canton of Vaud to carry out specific tasks in the fields of marriage counselling, family planning, perinatal counselling, sex education and victim assistance.

UDM-Clientele: No precise statistical information is available with regard to the number of the service's UDM clients. Those responsible for the service estimate that 2 to 5% of the clientele are UDM, and that these mostly use the victim assistance services or perinatal and family planning counselling (where clients are usually women aged between 18 and 60). Clients come to hear of the service through word of mouth, leaflets, the media, government agencies, health care providers, professionals from social institutions or, when victim assistance is concerned, through the police. They do not need to show any documents to access the services.

(64%) of its UDM clients have been assigned to the *Sprechstunde* by *Meditrina* staff (Gross 2009). Another important partner for the coordination of outreach work is *Isla Victoria*, a contact point for female sex workers operated by the *Zürcher Stadtmission*.

¹⁵³ Sources: Questionnaire; telephone interview with the Director on 12 October 2009; <http://www.profa.org/FondationProfa/FondProfa.htm> (last accessed: 17 July 2011).

Management of UDM's health insurance affiliation: *Profa* staff provide uninsured clients with information about their right to, and options regarding, health insurance affiliation, but do not support them further in the conclusion of a contract.

Financing care and UDM's contribution to costs: The services are provided free of charge or at affordable tariffs.

Self-assessed factors of success: Respondents mention the guaranteed strict confidentiality of their services; the fact that they are free of charge or affordable; individualized reception and counselling of clients as well as the multilingual staff. The implementation of the programme *Migration & Intimité* – which enables the promotion of sexual health in collaboration with different associations or representatives of different migrant communities in several parts of the canton – is regarded as a model of good practice.

***Fondation de Nant, soins psychiatriques dans le secteur de l'Est vaudois*¹⁵⁴**

As with *Profa* described above, the *Fondation de Nant* is an institution within the mainstream health care system that has decided to become more migrant-friendly and has taken appropriate measures to do so, bearing the additional costs generated thereby.

Origins/Initiators: The *Fondation de Nant* was founded as a private initiative in 1943. Since 1961 it has assumed a public role on behalf of Vaud cantonal authorities. Today it organises mental health-care services for the general population in the eastern part of the Canton of Vaud. Since only recently (June 2009) it also disposes of a special deployment in transcultural psychiatry, called *Dispositif de psychiatrie transculturelle*. This programme issued from the organisational objective to improve knowledge and specific staff-member competences with relation to migration (knowledge about migration policy and its local implementation, about the authorities involved, about special health care networks that exist for migrant groups, etc.). The development of this programme was facilitated, indeed triggered, by initial funding in the framework of the *Migrant friendly hospitals* (MFH) project. Another motivating factor was the will to implement professional ethical standards.

Targeted population groups: The overall target group of the *Fondation de Nant* is members of the general population with mental health problems in the eastern part of the Canton of Vaud, regardless of legal status. No services are provided specifically to UDM, but staff have gained experience in working with migrants and, since June 2009, a special programme – *Dispositif de psychiatrie transculturelle* – has been implemented, with the objective of enhancing appropriate care for the migrant clientele.

Services provided and staff/professionals involved: The different services of the *Fondation de Nant* provide psychiatric care (including emergency, ambulatory and hospital care), treatment for addiction and occasional psychological support. Thanks to the programme *Dispositif de psychiatrie transculturelle*, for the coordination of which a psychiatrist and a social worker (1.1 FTE) are responsible, staff (nurses, psychiatrists, psychotherapists, social workers as well as administrative staff) are trained specifically and on an ongoing basis in caring for, and coordinating care for, migrants. Multilingual information materials and interpreters/mediators are available if required. For health care delivery, the services cooperate closely with the outpatient department of the University Hospital of Lausanne (PMU, see above).

Financing of the service: The *Fondation de Nant* is mandated and financed by the Canton of Vaud to organise mental health-care services for the general population in the eastern part of the canton. The costs of the programme *Dispositif de psychiatrie transculturelle*, however, are born by the foundation, and no supplementary resources are allocated to it by the canton.

UDM-Clientele: UDM account for an estimated 0.3% (7 persons) of the clientele. No precise statistics are available, but those responsible estimate that, in 2008, around seven UDM patients – mostly women originating from Kosovo or Africa (Ethiopia) – called on the service. Patients mostly come to hear of the services provided by the *Fondation de Nant* through other health care providers. No documents have to be shown to access the services except for by unsuccessful asylum seekers who need to show a special voucher obtained from the cantonal health agency for asylum seekers. Access is facilitated by providing outreach services and maintaining flexible opening hours.

Management of UDM's health insurance affiliation: When clients without health insurance need long term treatment, information and counselling regarding the conclusion of a health insurance contract is provided.

¹⁵⁴ Sources: Questionnaire; telephone interview with the director of the *Dispositif de psychiatrie transculturelle* on 19 November 2009.

Financing care and UDM's contribution to costs: In the case of some migrant patients, a finance partner is the cantonal agency for social insurance and housing (*service des assurances sociales et de l'hébergement*). For occasional accommodation and support of people in need, the services collaborate with the charitable institutions of various religious communities.

Self-assessed factors of success: Respondents point to the establishment of a transverse specialised deployment which guarantees the development of specific competences in the field of migration and translational care, as well as to the fact that there is a pool of intercultural mediators/interpreters at staff's disposal.

3.5 Health Care within the Framework of Emergency Aid Provision in Other Contexts

While most UDM seek medical care near the place they live, dismissed or rejected asylum seekers are in principle only granted support – housing, food, medical aid – in the canton of assignation (for details of the regulations concerning emergency aid - see the the policy report's chapter concerning 'Unsuccessful asylum seekers'). However, practices regarding the provision of (minimal) health care under emergency aid, vary considerably between cantons, as a report issued in December 2008 by the umbrella organisation of NGO active in the field of migration in Switzerland shows (Trummer 2008).

To illustrate this point, in the following, we briefly describe how medical care is provided to UDM within the framework of emergency aid in the Canton of Basel-Stadt. A general practitioner operating a surgery in Basel has informed us of the health care services he provides UDM entitled to emergency aid in this canton, on behalf of the cantonal social welfare authorities.

GP's surgery (*Praxis für Allgemeinmedizin*) in Basel

Origins/Initiators: Some time prior to new regulations regarding NEE coming into force in April 2004, our informant, a GP with a surgery in the city of Basel, was approached by the cantonal social welfare office and asked if he was interested in receiving UDM whose asylum application had not been admitted and who were suffering from health problems, and in assessing their health and treating them, if necessary, within the framework of emergency aid. He accepted this proposal and a contract was established between the surgery and the cantonal social welfare service, and – ever since – he has been assessing and treating UDM within the framework of emergency aid.

Targeted population groups: The surgery is basically open to the general population living in the city and outskirts of Basel. In addition, it is mandated by the social welfare service of the Canton of Basel-Stadt to assess and treat UDM within the framework of emergency aid. Moreover, the surgery is a member of the network coordinated by the *Anlaufstelle für Sans-Papiers Basel* (see above).

Services provided and staff/professionals involved: The GP, assisted by his administrative staff, provides general primary health care services and refers patients to specialised care providers where necessary.

Financing the service: The surgery invoices insured clients. In the case of uninsured clients, treated within the framework of emergency aid, the surgery invoices the cantonal social welfare office.

UDM-Clientele: At the time of information collection, the GP had averaged around ten medical consultations per week with UDM patients entitled to emergency aid from the Canton of Basel-Stadt. He saw roughly one new client per week. These patients mainly originate from Africa, most of them – currently - from Eritrea and Nigeria. The majority are young men between 18 and 30 years of age.

Management of UDM's health insurance affiliation, financing of health care: Consultation and treatment costs within the framework of emergency aid are charged to the cantonal social welfare office. In the case of high health care costs, the cantonal social welfare service will affiliate the UDM to a health insurer with which it has made an appropriate arrangement.

Our informant considers his cooperation with the social welfare office to be basically good. The fact, however, that a social worker (and not a health care professional) initially has to assess a UDM's health and to decide whether he or she is allowed a medical consultation is – in this GP's opinion – clearly unsatisfactory. Not only might UDM be denied required care, but the GP concerned also regularly receives UDM patients announced as an emergency who – in reality – suffer from a relatively trifling ailment. This state of affairs hinders the effective functioning of his surgery. Another difficulty he mentions is the fact that professional interpreters are not provided for (neither by health insurance nor by the social welfare office), with the result that he often treats patients without an interpreter, hence complicating communication and hindering mutual understanding and, therefore, the quality of care.

Some cantons have specific regulations (e.g. PSM in GE, or UPV in VD) regarding health insurance for rejected or dismissed asylum seekers, while others explicitly dismiss any kind of 'special' service for particular categories of UDM (ZH). Experts observe that these differences are likely to induce internal movements heading to the cantons in which health care services are accessible. In some cases, health providers were asked to identify rejected asylum seekers assigned to other cantons; this challenges the principle of confidentiality with regard to immigration status.

3.6 Final Observations

The level and modalities of health care provision accessible to UDM are extremely variable between cantons and cities - probably less due to a particular profile of the UDM population concerned in a given place than to prevailing 'political opportunity structures'¹⁵⁵. Most of the specialised facilities we surveyed were set up during the last 15 years. In many cases, the initiative originated in the private sector and targeted vulnerable populations in general, before focusing primarily – though not always only – on UDM. Meanwhile several NPO projects or services were able to gain (limited) public support and to establish codified procedures for collaboration with the mainstream health care sector.

In Lausanne and Geneva however, the two biggest towns in the French speaking part of the country, the impetus came from the public sector (university hospitals CHUV and HUG) and was closely linked to community-care development, research activities and training. Both services are based on a double gate-keeping, nurse-to-GP-to-specialised-care, system. In the case of Geneva, a specific service (for UDM and other marginalised groups) was set up, with its own budget and several outreach branches to guarantee low-threshold access. The transfer to mainstream services, if needed, is assured and financial procedures exist. In the CHUV model the service providing care is integrated into the university department (PMU) which targets a larger migrant population. The setting is slightly more complex, as it is based on a private-public-partnership with NPO who guarantee low-threshold access and provide simple care before transfer to the hospital service. This model shares costs between public and private sectors and seems in practice to exert a stronger incentive to health insurance affiliation than does a structure which is entirely subsidized.

So far, hardly any similar public initiatives have unfolded in the German speaking part of Switzerland; the policymaking climate, with regard to the concept of the state's role, and party politics, are probably not unrelated to this state of affairs. While modes of cooperation between public and private hospitals do exist, they are rarely made public and formalised,

¹⁵⁵ The term refers to a particular configuration of institutional or civil society arrangements and prevailing patterns in political power.

which is an obstacle in terms of trust-building and certainty (predictability of decisions) for NGO as well as for the UDM concerned.

NGO regularly addressed a dilemma they face with regard to recommending their clients to take out basic health insurance: NGO declared that for undocumented migrants health insurance is often not a feasible option if they lack the financial resources to pay the monthly insurance premiums. Moreover, NGO cannot entirely guarantee to their clients that the data of undocumented clients given to health insurers will not be transferred to immigration authorities, especially if a client is not able to pay their premiums. Such fears are founded, since the regulation of data exchange between 'social insurance' providers and migration authorities ('population services') are extremely complex and might easily lead to misinterpretations to the detriment of undocumented migrants.

Documentation about the functioning and the strategies of NPO or institutions providing services to undocumented migrants is only partially available (see NHL practice database - http://www.nowhereland.info/?i_ca_id=370). It is known that contact points providing general counseling or medical care to UDM collaborate with hospitals and GPs' networks on a more or less continuous basis in German-speaking Swiss cities as well as in (smaller) cities of the French-speaking part of the country. Many of these centers or information desks have undergone various organizational changes and are still developing. New regulations concerning emergency aid (since 2004 and 2008) have also had an impact on existing offers and modes of collaboration, which once again vary between cantons. Some local authorities have deliberately opted for a uniform approach in terms of access to health care, treating all UDM in an identical manner; others have created specific structures and rules for particular groups (depending on the migration background or duration of stay). Meanwhile, several cantons demand, as standard, the affiliation to health insurance contracts for all beneficiaries of emergency aid, others only deciding on a case by case basis. In the same vein, some cities have seen specialised NGO help desks set up for rejected asylum seekers, while elsewhere existing ones have extended their offer to this category of the population.

With regard to this constantly changing and sparsely documented 'landscape' of centers for medical counseling and care, sometimes also for prevention, it seems impossible at this stage to propose a more thorough typology of existing services. Future developments and strategies will also depend on various decisions to be taken regarding UDM access to mainstream care. They concern, amongst others, questions linked to a functioning access to health insurance and premium subsidization, and to the regulations controlling data exchange between different administrative bodies.

4 Trends and Conclusions

While the general legal framework concerning access to health care for UDM has remained largely unchanged during the last decade (Bilger and Hollomey in this volume), multiple and varying developments have taken place with regard to practices. This makes it difficult to work out a common denominator of the changes and the current situation. However a few general observations can be made.

Over the past decade, the UDM population has become more diverse in terms of socio-demographic profile, migration background and duration of residence. Therefore life conditions vary widely, which makes it difficult to draw overall conclusions on their situation and health behaviour. As in most other countries, it can be observed that many UDM avoid seeking care, unless they are seriously ill, because they lack information, necessary financial means and fear administrative difficulties or denunciation. Only a minority of an unknown number has health insurance and accesses mainstream care. Depending on the institutional context, health-care-seeking strategies of rejected or dismissed asylum seekers who benefit from emergency aid may be different, because they are known to the authorities, especially if they do not fear denunciation. Moreover most of them live in particularly precarious conditions, which frequently cause health – psychological or physical – disorders in the long term.

In most of the bigger cities, outpatient clinics or information desks which mediate access to voluntary health care networks, were set up during the past 10 years. Most of them are run by civil society NPO and are sometimes subsidised by local authorities or cantons. The only two services which are integrated into public university hospitals were set up during the nineties in Geneva and Lausanne and both have undergone several organisational changes since. While the Geneva UMSCO follows an outreach approach, the PMU in Lausanne is not 'mobile', but works in a private-public-partnership with NPO who cater for vulnerable migrants. Like most of the outpatient clinics surveyed these services are based on a double gate-keeping, nurse-to-GP-to-specialised-care, system.

Many existing facilities offer treatment for a variety of health problems, including gynaecological and dental problems, and assure an ever larger geographic coverage, which - considering the limited freedom of movement of UDM - is an important advance. Emergency care and simple secondary treatment are, in general, available but the situation remains complicated when expensive or long term care is required especially if the patient has not taken out health insurance. In these cases, access to appropriate care often depends on the initiative of individual staff such as physicians, staff in medical institutions, or NGO staff.

There is some evidence that, on the whole, health personnel, even in mainstream institutions, are better informed about the situation and entitlements of UDM than they were a decade ago. Training and information campaigns among care- or social service providers have contributed to raising awareness about the rights of undocumented migrants and related procedures not only among professionals, but also among other population groups including UDM themselves. In this context, federal and local authorities as well as NPO have certainly played an important role in providing information and mediating access to health care provided by the mainstream system or by UDM-specific services. In spite of this development the deficit in information remains, in many cases, considerable and a need for the continuous updating of knowledge will - since the administrative framework and complexity of some procedures involve constant changes - certainly persist. Furthermore, there are also significant differences in awareness between medical services in Swiss regions.

Another relatively recent trend, at least in the German-speaking part of Switzerland towards promoting access of undocumented migrants to health insurance can be observed especially among NGO: apart from directly and pragmatically responding to the health needs of undocumented migrants, many of them actively encourage UDM to, and assist them in, taking out health insurance to cover basic health care. In this respect, the *Anlaufstelle für Sans-Papiers Basel* is an interesting case of a versatile facility which has contributed to integrating a high proportion of beneficiaries into mainstream care through health insurance affiliation. Newborn or school children are, meanwhile, almost systematically insured in several cities, and premium subsidies – which cover the whole insurance premium for children – are generally granted, while a patient's contribution of 10% remains to be paid for the care provision (up to a maximum of CHF 350(€ 270)). NPO have also helped to develop procedures to facilitate access to premium reductions for adults. At the same time, and following initial reluctance, some cantons have decided to affiliate UDM receiving emergency aid to health insurance (Sutter 2011). However, there is no exact data on the number or proportion of adult UDM who have taken out health insurance.

While possessing health insurance without doubt facilitates access not only to primary treatment but also to specialised- and hospital care in general, there are some obstacles which prevent undocumented migrants from taking out health insurance. These obstacles primarily relate to the financing of the insurance costs. Apart from the monthly insurance premiums, additional costs (to the amount of the annual excess and the patients' 10% contribution) frequently exceed patients' means. In some cases, it has been observed that, paradoxically, UDM prefer for financial reasons to see care providers outside the mainstream system, a trend that has also been observed for persons in precarious living conditions in general. Indeed, assisting the uninsured is given priority by some local NPO initiatives. In this context, one may consider that a guarantee of mandatory health insurance protection can only be ensured by a functioning subsidization of premiums (Winizki 2009). While alternative ways of financing care provision systems such as by establishing a particular fund dedicated to financing health care for persons without health insurance may, upon initial examination, seem to be a more direct way forward, they are susceptible to creating new problems and involving additional costs. However, the creation and establishment of 'parallel structures' for care are still being debated among policy-makers.

Aside from these general challenges, guaranteeing access to mainstream preventative medicine and health care for UDM involves, without doubt, various dilemmas inherent in the dissociation of the protection of social rights irrespective of residence status on the one hand, and migration control issues on the other. While these challenges have so far been met with different local responses which are not always widely known and advertised, they need to be addressed in a more comprehensive manner in the longer term. Although certainly not perfect, providing universal access to mainstream medical care via basic health insurance is certainly a major asset of the 'Swiss system' and one which constitutes a flexible approach integrating proven local solutions into the national framework of social insurance provision.

As stated earlier, the UDM population has become more diverse in terms of age (children born and raised in Switzerland, aging groups), duration of residence (increasing proportion of long-stay cases) and migration background. Many of these migrants will remain in Switzerland and (continue to) participate as members of its workforce while others will return to their country of origin or move on to another country. In all cases, securing social rights and maximising these people's capabilities and their control over their own lives is not only in the interests of the persons in question, but remains a concern for society as a whole. Reducing inequalities in the field of health by guaranteeing access to care for all residents, is not only vital for the economy and the upholding of humanitarian values, but is a

question of fairness and – moreover - a key strategy in the perspective of sustainable human development in society (Marmot 2010).

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Appendix

Appendix 1 Swiss Questionnaire (German Version)



Gesundheitsleistungen für undokumentierte Migrant-inn- en in der EU und der Schweiz

FRAGEBOGEN ZUR ERHEBUNG VON ANGEBOTEN UND LEISTUNGSERBRINGERN

Irreguläre Zuwanderung und der Aufenthalt von undokumentierten MigrantInnen (UDM) – oft auch „Sans Papiers“ genannt – stellt für die Gesundheitssysteme in ganz Europa eine spezifische Herausforderung dar. Die EU (EC-DG SANCO) finanziert darum die Durchführung des Projektes *NowHereLand – Improving Services for Undocumented Migrants in Europe*, dessen Gesamtkoordination von der Donau-Universität Krems (Österreich) gewährleistet wird (vgl. beigelegter Projektbeschreibung oder www.nowhereland.info).

Die Schweiz wird durch eine vom Bundesamt für Gesundheit (BAG) finanzierte Studie an das EU-Projekt angebunden. Diese Studie wird vom Schweizerischen Forum für Migrations- und Bevölkerungsstudien (SFM) der Universität Neuchâtel in Zusammenarbeit mit dem International Centre for Migration Policy Development (ICMPD) Wien durchgeführt. Möglichst viele Organisationen/Einrichtungen, die in der Schweiz Gesundheitsversorgungsleistungen für UDM erbringen (öffentliche Institutionen aber auch z.B. NGOs, Ärztlennetzwerke u.ä.), sollen erfasst und deren Leistungsangebot beschrieben werden. Diese Informationen werden anschliessend in einer Online-Datenbank der Öffentlichkeit zugänglich gemacht. Ausserdem sollen für jedes Land – auch für die Schweiz – einige „contextualized good practice“-Modelle identifiziert und präsentiert werden.

Wir bitten Sie als Einrichtung/Organisation, die Gesundheitsleistungen für UDM in der Schweiz erbringt, diesen Fragebogen auszufüllen. Sie leisten damit einen wichtigen Beitrag zur Erfassung von zugänglichen Angeboten zur Gesundheitsversorgung in Europa und tragen zur Entwicklung eines wertvollen Instruments bei, das Zusammenarbeit und gegenseitigen Austausch unterstützt. Ihre Organisation und die spezifischen Angebote für UDM werden via Online-Datenbank für die Öffentlichkeit sicht- und nutzbar gemacht.

Erläuterungen zum Fragebogen für Schweizer Leistungserbringer:

Da der Fragebogen für Adressaten in ganz Europa entwickelt wurde, finden sich darin auch Begrifflichkeiten, die in der Schweiz nicht geläufig sind oder Einrichtungen bezeichnen, die hierzulande nicht in dieser Form existieren. Wir haben uns bemüht, die Terminologie soweit wie möglich anzupassen, falls Sie aber bei gewissen Fragen trotzdem Mühe haben, Ihre Institution bzw. Ihr Vorgehen anhand der vorgegebenen Antworten zu beschreiben, nutzen Sie bitte die Möglichkeit, ihre Angaben unter „Anderes/Sonstiges“ auszuführen.

Der Begriff „**Undokumentierte MigrantInnen' (UDM)**, wie er hier verwendet wird, bezieht sich auf Personen aus Drittstaaten (Nicht-EU-Staaten), die über keine Aufenthaltsberechtigung in der Schweiz verfügen („Sans Papiers“). In diese Kategorie fallen z.B. jene Personen, deren Asylgesuch abgelehnt worden ist (inkl. Personen mit Nichtintretensentscheid NEE) wie auch Personen, die Ihre Aufenthaltsbewilligung verloren oder gegen die Visavorschriften verstoßen haben.

Die im Fragebogen gemachten Angaben werden nach Auswertung durch das Forschungsteam in der Datenbank auf der Website www.nowhereland.info öffentlich zugänglich sein. **Sollten Sie eine anonyme Darstellung wünschen, ersuchen wir Sie, das Feld „Kontaktdaten vertraulich behandeln“ anzukreuzen bzw. einzelne Fragen nicht zu beantworten.**

[...]

KONTAKTINFORMATIONEN

Kontaktdaten vertraulich behandeln

Name der Kontaktperson:

Funktion:

Adresse:

E-Mail – Adresse:

Website:

Telefon (inklusive Landesvorwahl):

Fax (inklusive Landesvorwahl):

Voller Name der Organisation/Einrichtung:

Kürzel der Organisation/Einrichtung:

INFORMATIONEN ÜBER DIE ORGANISATION/EINRICHTUNG, DIE GESUNDHEITSVERSORGUNG FÜR UDM ANBIETET

0.1 Art der Organisation/Einrichtung: (mehrere Antworten möglich)

0.1.1 Öffentliche/staatliche Einrichtung

0.1.2 Nichtstaatliche Organisation (NGO, Non-Governmental Organisation)

0.1.3 Nicht gewinnorientierte Organisation (NPO Non-Profit Organisation)

0.1.4 Gewinnorientierte Organisation

0.1.5 Karitative Einrichtung/Hilfswerk

0.1.6 Sonstige (bitte ausführen):

0.2 Art des Gesundheitsversorgungsanbieters:(Mehrfachnennungen möglich)

0.2.1 Einrichtung der Primärversorgung (z.B. Praxen für Allgemeinmedizin, Notfallstationen/Permanences)

0.2.2 Spital, stationäre Einrichtung

0.2.3 Spezialisierte Versorgungseinrichtung außerhalb des Spitals (z.B. niedergelassene FachärztInnen)

0.2.4 Ambulante Einrichtung (z.B. Ambulatorium, Gesundheitszentrum)

0.2.5 Einrichtung speziell für UDM im öffentlichen Gesundheitssystem

0.2.6 Einrichtung speziell für UDM außerhalb des öffentlichen Gesundheitssystems

0.2.7 Gemeindeggesundheitszentrum

0.2.8 Einrichtung zur Gesundheitsförderung und Vorsorge

0.2.9 Ärztenetzwerk

0.2.10 Sonstige (bitte spezifizieren):

0.3 Die Aktivitäten der Organisation umfassen folgendes Einzugsgebiet:

0.3.1 Land:

0.3.2 Region:

0.3.3 Stadt/Gemeinde:

0.3.4 Sonstige (bitte angeben):

0.4 Gründungsdatum der Organisation (MM.JJJJ):

1. Bitte nennen und beschreiben Sie Ihre drei Hauptpartner (Organisationen/Einrichtungen), die Sie bei der Umsetzung der Gesundheitsversorgungsleistung für UDM auf lokaler, nationaler und/oder internationaler Ebene unterstützen:

	Name des Partners/Organisation	Name des Partners/Organisation	Name des Partners/Organisation
Art: (mehrere Antworten möglich)	<input type="checkbox"/> Öffentlich/staatlich <input type="checkbox"/> Nichtstaatlich <input type="checkbox"/> Nicht gewinnorientiert <input type="checkbox"/> Gewinnorientiert <input type="checkbox"/> Karitativ <input type="checkbox"/> Sonstige (bitte ausführen):	<input type="checkbox"/> Öffentlich/staatlich <input type="checkbox"/> Nichtstaatlich <input type="checkbox"/> Nicht gewinnorientiert <input type="checkbox"/> Gewinnorientiert <input type="checkbox"/> Karitativ <input type="checkbox"/> Sonstige (bitte ausführen):	<input type="checkbox"/> Öffentlich/staatlich <input type="checkbox"/> Nichtstaatlich <input type="checkbox"/> Nicht gewinnorientiert <input type="checkbox"/> Gewinnorientiert <input type="checkbox"/> Karitativ <input type="checkbox"/> Sonstige (bitte ausführen):
Formeller Vertrag:	<input type="checkbox"/> Ja <input type="checkbox"/> Nein	<input type="checkbox"/> Ja <input type="checkbox"/> Nein	<input type="checkbox"/> Ja <input type="checkbox"/> Nein

Zweck/Ziel der Zusammenarbeit:	<input type="checkbox"/> Lobbying	<input type="checkbox"/> Lobbying	<input type="checkbox"/> Lobbying
	<input type="checkbox"/> Informationsaustausch	<input type="checkbox"/> Informationsaustausch	<input type="checkbox"/> Informationsaustausch
	<input type="checkbox"/> Gesundheitsversorgung	<input type="checkbox"/> Gesundheitsversorgung	<input type="checkbox"/> Gesundheitsversorgung
	<input type="checkbox"/> Finanzierung	<input type="checkbox"/> Finanzierung	<input type="checkbox"/> Finanzierung
	<input type="checkbox"/> Sonstige (bitte ausführen):	<input type="checkbox"/> Sonstige (bitte ausführen):	<input type="checkbox"/> Sonstige (bitte ausführen):

2. Wer war der Hauptinitiator der Gesundheitsversorgungsleistungen für UDM (bitte ausführen)?

2.1 Öffentliche/staatliche Behörde

- lokale
- regionale
- nationale

2.2 Religiöse Organisation

2.3 Zivilgesellschaftlicher Akteur

2.4 Unabhängiger Gesundheitsversorgungsanbieter

2.5 MigrantInnenverein/-organisation

2.6 Sonstige:

3. Seit wann bietet Ihre Organisation/Ihr Projekt Versorgungsleistungen für UDM an (MM.JJJJ)?

4. Was war der Grund/die Motivation, diese Versorgungsleistungen anzubieten? (bitte Zutreffendes ankreuzen, Mehrfachnennung möglich)

4.1 Politische Motivation/Gründe (bitte ausführen):

4.2 Humanitäre Motivation/Gründe (bitte ausführen):

4.3 Institutionelle Motivation/Gründe (z.B. Verbesserung der Qualität und Effizienz) (bitte ausführen):

4.4 Sonstige (bitte ausführen):

5. Nennen Sie bitte weitere Zielgruppen Ihrer Gesundheitsversorgungsleistung. (Mehrere Antworten möglich)

5.1 (Speziell) Asylsuchende/Flüchtlinge

5.2 Allgemein MigrantInnen mit regulärem Aufenthaltsstatus

5.3 Vulnerable Gruppen (ungeachtet des rechtlichen Status)

 5.3.1 Schwangere

 5.3.2 Kinder

 5.3.3 Personen mit schweren Infektionskrankheiten (z.B. Tuberkulose, HIV/Aids)

 5.3.4 Obdachlose

 5.3.5 SexarbeiterInnen/Prostituierte

 5.3.6 Sonstige (bitte spezifizieren):

6. Bitte nennen oder schätzen Sie den Prozentanteil der UDM von allen Personen, die Ihre Gesundheitsversorgungsleistung nutzen: %

erhoben geschätzt

7. Wie viele UDM erhielten im letzten Jahr (2008) Gesundheitsversorgungsleistungen von Ihrer Organisation?

7.1 1 Dokumentierte Anzahl:

7.1 2 Bei fehlenden Aufzeichnungen nehmen Sie bitte eine Schätzung vor:

7.2 Tendenz der Anzahl während der letzten 3 Jahre:

 7.2.1 steigend

 7.2.2 gleich bleibend

 7.2.3 sinkend

8. Beschreiben Sie bitte die drei am häufigsten vorkommenden Nationalitäten innerhalb der Gruppe der UDM, die Ihre Gesundheitsversorgungsleistung während der letzten 12 Monate (oder einer anderen zu spezifizierenden Erhebungsperiode) in Anspruch genommen haben (bitte geben Sie Prozente für die jeweiligen Kategorien an):

8.1 Herkunft: die drei am häufigsten vorkommenden Nationalitäten

8.1.1 %

8.1.2 %

8.1.3 %

erhoben geschätzt

Wenn nicht bezogen auf die letzten 12 Monate, bitte Bezugsperiode spezifizieren:

8.2 Alter:

0-17:	18-35:	36-60:	over 60:
-------	--------	--------	----------

%	%	%	%
<input type="checkbox"/> erhoben	<input type="checkbox"/> geschätzt		
Wenn nicht bezogen auf die letzten 12 Monate, bitte Bezugsperiode spezifizieren:			
8.3 Geschlecht			
Weiblich:	%		
Männlich:	%		
<input type="checkbox"/> erhoben	<input type="checkbox"/> geschätzt		
Wenn nicht bezogen auf die letzten 12 Monate, bitte Bezugsperiode spezifizieren:			

9. Benötigen UDM irgendwelche Dokumente, um Ihre Gesundheitsversorgungsleistung in Anspruch nehmen zu können?

9.1 <input type="checkbox"/> Krankenversicherungskarte
9.2 <input type="checkbox"/> Keine Dokumente erforderlich
9.3 <input type="checkbox"/> Spezielle 'Gesundheitskarte' (bitte ausführen):
9.4 <input type="checkbox"/> Sonstige (bitte ausführen):

10. Welche Dienstleistungen bieten Sie UDM? (mehrere Antworten möglich)

	Im Rahmen der Regelversorgung:	Im Rahmen eines (Pilot-)Projektes (Angabe der Projektdauer):
10.1 Präventive Versorgung:	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.1.1 Impfungen	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.1.2 Screenings	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.1.3 Kontrolle infektiöser Erkrankungen	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.1.4 Sonstige (bitte ausführen):	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.2 Gesundheitsförderung und Information	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.2.1 Anwaltschaft/Interessenvertretung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.2.2 Information/Beratung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.2.3 Sonstige (bitte ausführen):	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.3 Psychische Gesundheitsversorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.3.1 Psychiatrische Behandlung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.3.2 Psychologische Unterstützung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.3.3 Suchtbehandlung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.3.4 Sonstige (bitte ausführen):	<input type="checkbox"/>	<input type="checkbox"/> Dauer:

10.4 Soziale Unterstützung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.4.1 Information/Beratung bezüglich Krankenversicherung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.4.2 Unterstützung bei Abschluss einer Krankenversicherung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.4.3 Finanzielle Unterstützung für Zugang zu Gesundheitsversorgungsleistungen	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.4.4 Sonstige materielle Unterstützung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.4.5 Anderes (bitte ausführen):	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5 Medizinische Versorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.1 Zahnmedizinische Versorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.2 Notfallversorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.3 Allgemeinmedizinische Versorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.4 Pädiatrische Versorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.5 Mutter-Kind-Versorgung	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.6 Diagnostische Leistungen	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.7 Chirurgische Leistungen	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.8 Arbeitsmedizin	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.9 Alternativmedizin	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.5.10 Sonstige (bitte ausführen):	<input type="checkbox"/>	<input type="checkbox"/> Dauer:
10.6 Sonstige (bitte ausführen):	<input type="checkbox"/>	<input type="checkbox"/> Dauer:

11. Welches sind in Bezug auf die Gesundheitsversorgung die am häufigsten vorkommenden Bedürfnisse der UDM, die Ihre Einrichtung aufsuchen?

<p>Bedürfnisse im Zusammenhang mit:</p> <p>11.1 <input type="checkbox"/> Arbeitsbedingten Erkrankungen oder Unfällen</p> <p>11.2 <input type="checkbox"/> Infektiösen Erkrankungen (z.B. Tuberkulose, ...)</p> <p>11.3 <input type="checkbox"/> Sexuell übertragbaren Erkrankungen und HIV</p> <p>11.4 <input type="checkbox"/> Psychischer Gesundheit</p> <p>11.5 <input type="checkbox"/> Sexueller und reproduktiver Gesundheit</p> <p>11.6 <input type="checkbox"/> Sonstigem (bitte ausführen):</p> <p>Angaben beruhen auf: <input type="checkbox"/> Erhebung/Statistik <input type="checkbox"/> Schätzung</p>

12. Unterstützen Sie UDM beim Zugang zum Gesundheitssystem?

12.1 <input type="checkbox"/> Ja, nämlich durch:	12.2 <input type="checkbox"/> Nein
12.1.1 <input type="checkbox"/> Dolmetschdienste 12.1.2 <input type="checkbox"/> Interkulturelle Mediation 12.1.3 <input type="checkbox"/> Mehrsprachiges Informationsmaterial 12.1.4 <input type="checkbox"/> Mobile Versorgung (z.B. aufsuchende Betreuung) 12.1.5 <input type="checkbox"/> Flexible Öffnungszeiten 12.1.6 <input type="checkbox"/> MitarbeiterInnentraining (bitte ausführen): 12.1.7 <input type="checkbox"/> Information/Beratung/Unterstützung im Hinblick auf den Abschluss einer Krankenversicherung 12.1.8 <input type="checkbox"/> Sonstiges (bitte ausführen):	

13. Welche Faktoren sind für den Erfolg Ihres Leistungsangebots für UDM ausschlaggebend:

14. Lassen Sie Ihre Dienstleistungen von Ihren UDM-KlientInnen systematisch/regelmässig beurteilen? Wenn ja, bitte führen Sie aus, wie Sie die Meinung/das Feedback der KlientInnen einholen:

14.1 <input type="checkbox"/> Ja (bitte Vorgehen kurz ausführen):	14.2 <input type="checkbox"/> Nein
.....	

15. Bitte beschreiben Sie kurz, was im Rahmen ihrer Leistungserbringung für UDM besonders gut funktioniert bzw. sie als besonders erfolgreichen Ansatz betrachten (Zielgruppenausrichtung, bestimmte Leistungen, Zusammenarbeit u.ä.m.)

16. MitarbeiterInnen, die an der Leistungserbringung für UDM beteiligt sind:

16.1 Welches Fachpersonal ist an den Dienstleistungen für UDM beteiligt? Bitte geben Sie auch die Anzahl der jeweiligen MitarbeiterInnen an:

	Anzahl der Angestellten	Anzahl der Ehrenamtlichen
16.1.1 <input type="checkbox"/> Administratives Personal		
16.1.2 <input type="checkbox"/> AllgemeinmedizinerInnen		
16.1.3 <input type="checkbox"/> Pflegepersonal		
16.1.4 <input type="checkbox"/> PsychiaterInnen		
16.1.5 <input type="checkbox"/> ZahnärztInnen		
16.1.6 <input type="checkbox"/> KinderärztInnen		

16.1.7	<input type="checkbox"/> GynäkologInnen		
16.1.8	<input type="checkbox"/> GeburtshelferInnen		
16.1.9	<input type="checkbox"/> Hebammen		
16.1.10	<input type="checkbox"/> PsychotherapeutInnen		
16.1.11	<input type="checkbox"/> Interkulturelle MediatorInnen		
16.1.12	<input type="checkbox"/> SozialarbeiterInnen		
16.1.13	<input type="checkbox"/> DolmetscherInnen		
16.1.14	<input type="checkbox"/> Sonstige (bitte ausführen):		

16.2 Bitte geben Sie das Arbeitspensum aller Angestellten in Vollzeitstellen an (Beispiel: Drei Mitarbeitende mit 50%-Pensum und eine/r mit 100%-Pensum ergibt 2,5 Vollzeitstellen):

.....

16.3 Bitte geben Sie die Gesamtzahl der ehrenamtlich geleisteten Arbeitsstunden pro Woche an:

.....
 Angabe beruht auf: Erhebung/Statistik Schätzung

16.4 Welche Nationalitäten/Herkunftsländer sind bei Ihren MitarbeiterInnen am häufigsten vertreten? (bitte geben Sie für die Kategorien auch Prozente an):

16.4.1	%
16.4.2	%
16.4.3	%
16.4.4	%
16.4.5	%

Angabe beruht auf: Erhebung/Statistik Schätzung

17. Wie haben die von Ihrer Einrichtung versorgten UDM von Ihrer Dienstleistung erfahren? (Mehrere Antworten möglich)


17.1	<input type="checkbox"/> Mund-zu-Mund – Propaganda
17.2	<input type="checkbox"/> Medien (öffentliche Kampagnen etc.)
17.3	<input type="checkbox"/> Behörden
17.4	<input type="checkbox"/> Gesundheitsversorgungsanbieter
17.5	<input type="checkbox"/> NGOs
17.6	<input type="checkbox"/> Infolge aufsuchender Arbeit (outreach work)
17.7	<input type="checkbox"/> Weiß nicht
17.8	<input type="checkbox"/> Sonstige (bitte ausführen):

Angaben beruhen auf: Erhebung/Statistik Schätzung

18. Haben Sie weitere Bemerkungen?

18.1 Ja (bitte ausführen):

18.2 Nein



Undocumented migrants' access to health care is shaped by two conflicting policy priorities: the right to healthcare which constitutes a basic human right, and immigration regulations that aim to control the residence of all foreigners in a country. This publication addresses the way Switzerland deals with this particular issue on three levels: policies and regulations on access to healthcare for undocumented migrants, practices of service providers, as well as individual migrants' strategies to access health care. Given the high degree of federalism that characterizes the Swiss political landscape, the case of Switzerland is also informative for related developments and discussions at the EU level.

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