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Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective

Veronika Flegar ^{1,*}, María Dalli ^{2,*} and Brigit Toebes ^{3,*}

¹ Department of Constitutional Law, Administrative Law and Public Administration, University of Groningen, Groningen 9712 CP, The Netherlands

² Human Rights Institute, University of Valencia, València 46022, Spain

³ Department of International Law, University of Groningen, Groningen 9712 CP, The Netherlands

* Correspondence: v.l.b.flegar@rug.nl (V.F.); maria.a.dalli@uv.es (M.D.); b.c.a.toebes@rug.nl (B.T.); Tel.: +31-50-363-7105 (V.F.)

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Abstract: The present study analyzes the preventive health care provisions for nationals and undocumented migrants in Germany, the Netherlands and Spain in light of four indicators derived from the United Nations Committee on Economic, Social and Cultural Rights' General Comment 14 (GC 14). These indicators are (i) immunization; (ii) education and information; (iii) regular screening programs; and (iv) the promotion of the underlying determinants of health. It aims to answer the question of what preventive health care services for undocumented migrants are provided for in Germany, the Netherlands and Spain and how this should be evaluated from a human rights perspective. The study reveals that the access to preventive health care for undocumented migrants is largely insufficient in all three countries but most extensive in the Netherlands and least extensive in Germany. The paper concludes that a human rights-based approach to health law and policy can help to refine and concretize the individual rights and state obligations for the preventive health care of undocumented migrants. While the human rights framework is still insufficiently clear in some respects, the research concedes the added value of a rights-based approach as an evaluation tool, advocacy framework and moral principle to keep in mind when adopting or evaluating state policies in the health sector.

Keywords: preventive health care; undocumented migrants; right to health; human rights indicators; underlying determinants of health

1. Background

International human rights law (IHRL) is gaining momentum as an innovative approach for conceptualizing the rights and obligations of states in the context of health¹. However, previous authors have argued that IHRL contains an inherent paradox, namely, the fact that “rights are conferred on persons as human beings; yet IHRL assumes that the universal subject enjoys some degree of membership in the nation-state” ([3], p. 345). This emphasis on membership can result in the denial of

¹ See, for instance, [1–3].

rights to non-members. This is also depicted by the difficulties surrounding the granting of social rights to undocumented migrants. Particularly the access to health care has been suggested to constitute a controversial issue that is not easily resolved ([3], p. 345). The present study therefore focuses on the access to preventive health care of undocumented migrants in Germany, the Netherlands and Spain in order to highlight what a human rights perspective might be able to contribute despite its inherent controversy.

Undocumented migrants are not a homogeneous group but come from many different cultural backgrounds and have become undocumented for a variety of reasons. The countries of origin of undocumented migrants are different in each receiving country: In some countries the undocumented migrant population largely originates from one cultural background, whereas in other countries undocumented migrants belong to a variety of different ethnic groups [4]. The reasons for becoming undocumented are similarly diverse and include entering the country illegally, overstaying a visa, having an asylum request rejected or being born to undocumented parents [2]. In 2010, estimates on undocumented migrants worldwide figured around 10%–15% of the 214 million international migrants [5]. More recent numbers are hard to acquire, as migration estimates are usually based on (ten-year interval) national censuses, and undocumented migrants are especially hard to record due to the very nature of their undocumented status [6].

As the undocumented migrant population is very diverse, the provision of health care to this group also varies across the different Member States of the European Union (EU). Previous research suggests that, while undocumented migrants only receive emergency care in countries like Spain, other countries, such as Germany, allow limited access to primary and secondary care, whereas again other countries, including the Netherlands, provide for more extensive health services for undocumented migrants [7]. Besides such legislative differences on the access to health care for undocumented migrants, restrictive policies and practical issues pose additional obstacles for undocumented migrants to actually use the health services offered. According to Scheppers *et al.*, such barriers can potentially be identified at the “patient level”, the “provider level” and the “system level”, and include a large number of different issues such as language difficulties (patient), medical procedures and practices (provider) and intake procedures (system) [8]. This results in many undocumented migrants living beyond the reach of medical care, regardless of any legal entitlements.

Such impediments are even higher when it comes to preventive health care, as undocumented migrants often lack the necessary information and are scared of being discovered ([9], p. 6). The latter poses a particularly high threshold for preventive health care, as such care is often not seen as vital for survival in the short-term and therefore not worth the risk of potentially being detected. As undocumented migrants are primarily worried about short-term survival, their general state of health is usually not a principal concern to them. Hence, undocumented migrants mostly only try to access the health care system when they feel severely ill ([9], p. 6). This situation can easily lead to a deterioration of their health, which is why preventive health care would be all the more important ([9], p. 5). Literature in the medical field sees preventive health care to include “primary (lifestyle counselling and immunizations), secondary (early detection of subclinical disease by screening or case finding to prevent disability), and tertiary (minimizing disability and handicap from established disease)” measures [10]. Focusing on preventive health care is particularly relevant, as the main health concerns of undocumented migrants consist of mental health problems, infectious and sexually transmitted diseases, and reproductive health, all of which could easily be diminished through effective preventive measures ([9], p. 2).

Research on access to preventive health care for undocumented migrants is largely nonexistent. Hence, the present study aims to shed light on the issue of access to preventive health care for undocumented migrants with a specific focus on Germany, the Netherlands and Spain. The three countries under investigation are particularly insightful to compare because, while all three are high income countries and Member States of the EU, they vary in the number of undocumented migrants they receive, their health care system and the health care provided to undocumented migrants:

Estimates in Germany are between 500,000 and 1 million undocumented migrants [11], while these estimates figure between 60.000 and 133.000 undocumented migrants in the Netherlands [12], and around 624.883 in Spain². While the German and Dutch systems are insurance-based, the Spanish system is tax-based. As outlined above, previous research reveals that access to health care for undocumented migrants varies across these three countries, being most extensive in the Netherlands and most restrictive in Spain [7].

Analyzing these differences from a human rights perspective seems particularly revealing for the question of how the right to health functions in a practical context as well as for the advantages and disadvantages of a human rights-based approach to health care regulation. The main questions this study aims to answer are thus the following: What preventive health care services for undocumented migrants are provided for in Germany, the Netherlands and Spain, and how should these be evaluated from a human rights perspective?

2. Methodology

The study is exclusively based on desk research conducted from July to December 2015. We first embarked upon a literature review in order to identify the relevant reports and peer-reviewed studies on access to health care of undocumented migrants. This review revealed that insufficient attention has hitherto been paid to preventive health care in this context.

Hence, we identified relevant international human rights treaties and authoritative explanatory documents on the right to health that could shed light on the state obligations with regard to preventive health care. Based on this, we concluded that the International Covenant on Economic, Social and Cultural Rights (ICESCR) is the most relevant treaty on this matter, and General Comment 14 (GC 14) of the treaty body monitoring its compliance, the Committee on Economic, Social and Cultural Rights (CESCR), is most broadly applicable. We therefore conducted a doctrinal analysis of CESCR GC 14 for a systematic review of what preventive health care means under international human rights law. This analysis revealed four essential indicators of a right to preventive health care: (i) immunization; (ii) education and information on health and behavior-related health concerns; (iii) regular screening programs and (iv) the promotion of the underlying determinants of health [14].

Subsequently, we identified the relevant national laws and policies concerning access to preventive health care in the three countries. Based on the above indicators, we conducted a comparative legal analysis of this national legislation in order to reveal the extent to which German, Dutch and Spanish legislation provide for any such preventive health care measures for nationals or undocumented migrants. We considered it necessary to analyze the laws for both nationals and undocumented migrants in order to determine more adequately what care undocumented migrants are lacking in comparison to registered residents.

In addition, we searched for reports and grey literature by governmental and non-governmental national and international bodies in order to determine the actual practice and potential private initiatives that change the outcome of what is laid down in the law with regard to the preventive health care of undocumented migrants. We then compared the entitlements of nationals with those of undocumented migrants within and between the three countries on the basis of the four indicators for a right to preventive health care. The subsequent parts of the paper are structured accordingly through first outlining national legislation, policy, practice and private initiatives in the legal analysis section before comparing and discussing the results in light of international human rights law.

The paper aims for a practical approach that focuses on the implementation and effect of national policies in light of human rights law, rather than discussing human rights law in itself. It is thus

² The number of undocumented migrants for Spain was calculated as the difference between the number of non-EU foreigners registered in the municipality and the number of non-EU foreigners with legal residence. Statistics available at [13].

aimed at applying a rights-based approach to the context of the access to preventive health care of undocumented migrants.

3. Legal Analysis

3.1. Human Rights Law Framework

In order to answer the question of what preventive health care services for undocumented migrants are provided in Germany, the Netherlands and Spain and how this should be evaluated from a human rights perspective, it is necessary to first elaborate upon what exactly this human rights perspective entails. All three countries signed and ratified several binding international human rights treaties. Since all three countries adhere to the monist system, these treaties are directly applicable and the states must abide by these international obligations. The right to health seems most relevant in this respect and is contained in a wide range of these treaties [15–18]³.

At the international level, Article 28 of the International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families states that the right to health of undocumented migrants is limited to situations of emergency [18]. However, none of the three countries investigated in this study has signed or ratified this convention. Other treaties at the international level such as the Convention on the Elimination of Discrimination against Women neither explicitly limit nor explicitly emphasize the right to health of undocumented migrants [16]⁴.

However, the Convention on the Rights of the Child recognizes the right to health of all children below the age of 18 in Article 24.

At the regional level, the European Social Charter contains extensive health rights in Articles 11 and 13. However, the extent to which they are also applicable to undocumented migrants is disputed: The appendix to the European Social Charter limits the personal scope of its rights to only include legal residents [19]⁵. While the supervisory mechanism to the European Social Charter, the European Committee of Social Rights, has expanded this personal scope to also include undocumented migrants in certain circumstances, this supervisory mechanism has hitherto not been accepted by Germany and Spain⁶.

The most authoritative provision on the right to health at the international level is Article 12 of the ICESCR. Germany, the Netherlands and Spain all signed and ratified this treaty and are therefore required to respect, protect and fulfill the right to health in legislation, policy and at the judicial level. Article 12 of the ICESCR recognizes the “right to the highest attainable standard of health” and mentions four concrete undertakings for States to realize this goal [20]. In 2000, the CESCR adopted GC 14, a non-binding but authoritative explanatory document on the right to health in Article 12 of the ICESCR⁷. This document mentions a number of important guideposts for the right to health that are frequently mentioned and applied by human rights scholars, non-governmental organizations, and increasingly also by judicial bodies and State authorities [21].

This study is based on GC 14 as the main document from which indicators that could test whether national laws are in line with international human rights law can be gathered. The choice to focus on GC 14 was made because it can be considered to be the most comprehensive document on this issue, and because other international and regional human rights documents seem more limited in the universal scope of the rights they try to protect.

³ Convention on the Rights of the Child, Article 24. Convention on the Elimination of Racial Discrimination, Article 5(e) (iv). International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families, Article 28.

⁴ Convention on the Elimination of Discrimination against Women, Article 12.

⁵ European Social Charter (revised), Article 11, Article 13, Appendix 1.

⁶ *FIDH (International Federation for Human Rights) v France* (2004), European Committee of Social Rights, para. 32.

⁷ Committee on Economic, Social and Cultural Rights. *The Right to the Highest Attainable Standard of Health*, UN General Comment No. 14 (2000), UN Doc. E/C12/200/4, 11 August 2000.

In light of this study's focus on preventive health care it is important to point out that GC 14 recognizes that the right to health is a broad human right extending not only to access to health care services but also to the underlying determinants of health, including access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information⁸. As such, the right to health has two dimensions: a right to health care services and a right to a broad set of underlying conditions for health. It has many cross-connections with the other existing human rights standards (indirectly) aimed at protecting health, including the right to education, water and sanitation, and housing.

A further important component of GC 14 concerns the identification of a set of principles that apply with respect to all health-related services: States are to guarantee the availability, accessibility, acceptability and quality of health facilities (the so-called "AAAQ")⁹. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility¹⁰. These principles also extend to the duty to provide preventive health care services.

Furthermore, GC 14 defines a set of state obligations to "respect, protect and fulfil" human rights and also describes potential violations of states in relation to a right to health¹¹. These obligations are further defined in a set of core obligations that result from the right to health, which emphasize minimum essential levels of health services that States must guarantee "at the very least"¹². These minimum core obligations were partly inspired by the World Health Organization's (WHO) Primary Health Care Strategy [22]. Paragraphs 43 and 44 of GC 14 define the core. Particularly relevant for the preventive health care of undocumented migrants seems to be paragraph 43(a), which emphasizes the access to health facilities for vulnerable groups. For the purposes of this article, it is also worth noting that the core obligations outlined in paragraph 44 explicitly refer to preventive health care: (a) to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; (b) to provide immunization against the major infectious diseases occurring in the community; (c) to take measures to prevent, treat and control epidemic and endemic diseases; and (d) to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them¹³.

Based on these core obligations and based on the various references to preventive health care throughout GC 14, four important indicators for a right to preventive health care can be identified. These indicators are (i) immunization; (ii) education and information; (iii) screening programs, and (iv) attention for the underlying determinants of health [14]. GC 14 does not give any detailed information on what specific immunization programs should be implemented but seems to primarily refer to "the community's major infectious diseases"¹⁴ and to include "other strategies of infectious disease control"¹⁵. GC 14 is more explicit on the education and information programs that states should implement under the right to health and specifies that such education should include information on "the main health problems in the community"¹⁶, "behavior-related health concerns"¹⁷, "sexual and reproductive health"¹⁸, "sexual education and information"¹⁹, and "traditional practices, domestic

⁸ General Comment 14, paras. 8 and 11. The present paper refers to the underlying determinants to health instead of to the social determinants of health in the understanding that both terms are synonymous.

⁹ General Comment 14, para. 12.

¹⁰ General Comment 14, para. 12.

¹¹ General Comment 14, paras. 33–37.

¹² General Comment 14, paras. 43–44.

¹³ General Comment 14, para. 44.

¹⁴ General Comment 14, paras. 28, 36 and 44(b).

¹⁵ General Comment 14, para. 16.

¹⁶ General Comment 14, para. 44(d).

¹⁷ General Comment 14, para. 16.

¹⁸ General Comment 14, para. 11.

¹⁹ General Comment 14, para. 34.

violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances”²⁰. GC 14 does not go into detail on what type of screening programs should be provided by states. The information on the underlying determinants of health is equally vague, but state provisions should cover at least “environmental safety, education, economic development and gender equity”²¹.

The right to health is particularly instructive for challenging the abovementioned paradox of international human rights law as being seen as universal but nevertheless not including everyone in practice. While the European level still struggles to recognize and implement that undocumented migrants have a right to access health care²², the international level, in particular GC 14, is more inclusive and forward-looking in that respect. While there are other relevant treaties and documents that might affect the right to preventive health care of undocumented migrants, the present study therefore exclusively focuses on this innovative approach in GC 14 ([2], p. 50). This innovative approach becomes apparent in GC 14’s proclamation that “States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services”²³. This is a very remarkable and far-reaching statement but the question remains whether this obligation is adhered to in the national context.

3.2. Germany

The health care system in Germany has been developed in the Bismarck tradition. As such, it is a social insurance-based public-private system. Public insurance companies are obliged to accept any person regardless of their health status. Contributions are income dependent and paid in equal parts by the employer and employee ([23], p. 65). Medical costs are almost fully reimbursed, with the exception of 1%–2% of the patient’s gross income ([23], p. 66). The Fifth Social Code (*Fünftes Sozialgesetzbuch*) lists all people obliged to be insured under public insurance [24]²⁴. In essence, this includes any German citizen or foreigner with a residence permit. Undocumented migrants are not mentioned and have thus no right to public health insurance. Private insurance companies are only accessible for higher-earning employees, civil servants and self-employed persons and membership can be denied on the basis of the individual medical situation ([23], p. 66). It is therefore also unlikely that undocumented migrants could be insured in one of the private companies.

The most essential laws laying down any preventive health care measures for nationals and legal residents are the Infection Protection Act (*Infektionsschutzgesetz*), the Fifth Social Code, and the recently passed Prevention Act (*Präventionsgesetz*).

According to Article 3 of the Infection Protection Act, the government must inform and educate the “general public” about the dangers of infectious diseases, including information about advisory and care centers. What exactly the term general public refers to is left undefined, but the text suggests that this would include anyone present on German territory—regardless of their residence status. In addition, vaccinations, passive immunoprophylaxis (injecting antibodies) or chemoprophylaxis (giving medication) must be provided [25]²⁵. The government is obliged to inform “the population” about the relevance of such vaccinations and other prophylactic measures, which again leads to assume that anyone present on the territory would fall within the scope of this obligation²⁶. However, patients are only reimbursed for such measures if they are insured under Article 4 of the Fifth Social Code, which, as outlined above, does not include undocumented migrants²⁷. Nevertheless, *Bundesländer*

²⁰ General Comment 14, para. 36.

²¹ General Comment 14, para. 16.

²² See, e.g., *FIDH v France* (2004), paras. 33 and 34.

²³ General Comment 14, para. 34.

²⁴ Fifth Social Code, Article 5.

²⁵ Infection Protection Act, Article 2(10) and 20.

²⁶ Infection Protection Act, Article 20.

²⁷ Infection Protection Act, Article 20(4).

(federal states) have the discretion to provide free vaccinations or other prophylactic measures against particular infectious diseases. In situations of an increased risk of the spread of an epidemic disease, vaccinations are mandatory for endangered parts of the population²⁸. It seems that, in the interest of public health, this would also include undocumented migrants.

The Fifth Social Code entails more detailed provisions on a number of preventive measures applicable to insured persons. As such, insured persons have a right to illness prevention, to the prevention of the deterioration of an illness and to the early detection of illnesses²⁹. Prevention should include measures to improve the general state of health and especially the health chances of socially disadvantaged persons, to inform about the relationship between working conditions and certain illnesses as well as to promote self-help groups³⁰. As indicated above, vaccinations in accordance with the Infection Protection Act also fall within the scope of this provision. Moreover, the Fifth Social Code entails detailed provisions on the preventive dental care covered for children³¹. Medical prevention also includes the obligation to provide medicine, bandages and other cures and aids necessary to diminish the risk of a deterioration of the state of health, to counteract the endangering of the healthy development of the child, to prevent illness, and to prevent the necessity of long-term care³². In addition, the following screening programs must be provided: two-yearly screening for persons above the age of 35 for early detection of illnesses, including cardiovascular and kidney problems as well as diabetes. Moreover, anyone above the age of 18 has the right to a preventive cancer screening. Insurance companies must actively invite insured persons to these screenings on a regular basis, and the invitations must include comprehensible and extensive information about the risks and usefulness of the screenings³³. The preventive screening program for children includes several healthy development screenings before the age of six and one screening after the age of ten³⁴.

On 17 July 2015, Germany passed a new law on preventive health care, the Prevention Act, which amends the Fifth Social Code. According to this law, German citizens and legal residents have the right to extensive prevention services, and insurance companies must pay particular attention to the prevention of diabetes mellitus and breast cancer, encourage a lower tobacco and alcohol consumption, and improve the healthy development of the child. Moreover, they must devote efforts towards the improvement of life skills, exercising and dietary habits, health skills, and the personal responsibility of all patients, encourage healthy aging and improve the prevention, early recognition, and sustainable treatment of depression [26]³⁵.

While the above legislation on preventive health care for nationals proves quite extensive, the situation for undocumented migrants is entirely different. Access to health care for undocumented migrants is codified in two separate laws, the Asylum Seekers Benefit Act (*Asylbewerberleistungsgesetz*, ASBA) and the Residence Act (*Aufenthaltsgesetz*, RA) [27,28]. Remarkably, the ASBA also applies to undocumented migrants if they are enforcedly deportable, even if a deportation order is no longer or not yet enforceable³⁶. However, persons are excluded if they took measures that resulted in their falling within the ASBA's scope for the sole purpose of receiving the ASBA's benefits, or if they cannot be deported due to their own fault (unless the situation makes access to the benefits undeniably necessary)³⁷.

²⁸ Infection Protection Act, Article 20(6) and (7).

²⁹ Fifth Social Code, Article 11(2) and (3).

³⁰ Fifth Social Code, Article 20.

³¹ Fifth Social Code, Article 21 and 22.

³² Fifth Social Code, Article 23(1).

³³ Fifth Social Code, Article 25.

³⁴ Fifth Social Code, Article 26.

³⁵ Prevention Act, Article 1.

³⁶ ASBA, Article 1.

³⁷ ASBA, Article 1(a).

With regard to health care measures for those who fall within the ASBA's scope, treatment of acute illness or pain must be ensured, including the provision of medicine and bandages as well as other items necessary for healing, recovery or relief. The provision of dentures is only given in urgent cases³⁸. Pregnant women are entitled to access to medical and nursery help and care, midwifery help, medicine, bandages and curative measure³⁹. Regarding prevention, the government agency responsible must ensure access to the advisable vaccinations and medically necessary screenings⁴⁰. Other measures may be provided if they are imperative to the health or livelihood of the person or necessary for the needs of children⁴¹. Asylum seekers who have stayed in Germany for more than 15 months have similar rights to preventive care as publicly insured nationals [29]⁴². No such provision exists for undocumented migrants.

The lack of access to preventive health care for undocumented migrants is aggravated by Article 6(a) of the ASBA *jo.* Article 87(2) of the RA, which introduce a reporting obligation for public authorities: Health care providers can claim their expenses for the treatment of an undocumented migrant at the social security office, which then must notify the immigration office [28]. The requirement of confidentiality effectively nullifies this provision and, if applied, allows undocumented migrants to remain anonymous. Nevertheless, most undocumented migrants are denied access to health care since they are still scared to be reported and consequently deported if they make use of health care services. This threshold is even higher for preventive health care, as the benefit of a preventive measure is highly unlikely to outweigh the risk of being detected [30]⁴³. An additional barrier is introduced by the bureaucratic hurdles that must be taken before costs are actually reimbursed [30].

Several *Bundesländer* have started initiatives to facilitate access to health care for undocumented migrants. Berlin, for instance, has introduced anonymized health insurance vouchers that allow undocumented migrants to access health care services without being reported [31]. However, it is unclear what exact measures fall within the scope of this initiative and whether it also extends to preventive measures. It is therefore left to the individual health care provider to decide what care is given.

The vaccination of undocumented children is also further regulated by the *Bundesländer*. In Berlin, for instance, the Children and Youth Health Service (*Kinder-und Jugendgesundheitsdienst*) provides preventive health care to all children, including immunization and screening programs. Undocumented migrant children can also make use of these services free of charge [30].

Similarly, private initiatives are increasingly concerned with the health care of undocumented migrants. Most notable are non-governmental organizations present in most larger cities and usually called *Medinetz*, *Medibüro* or *Medizinische Flüchtlingshilfe*⁴⁴. These organizations usually claim to "arrange medical care regardless of your residency permit or health insurance status" and bring undocumented migrants in contact with a medical professional who will treat them "if possible" free of charge [33]. Yet these non-governmental organizations try to fill the gap where it is most urgent, namely, if undocumented migrants themselves feel that they need to see a doctor [34]. As such, they do not usually provide preventive health care.

³⁸ ASBA, Article 4(1).

³⁹ ASBA, Article 4(2).

⁴⁰ ASBA, Article 4(3).

⁴¹ ASBA, Article 6(1).

⁴² ASBA, Article 2 *jo.* Twelfth Social Code, Article 47 and 52.

⁴³ According to Article 6(a) ASBA, health care providers can claim the expenses made when providing services a person falling under the ASBA at the social security office (*Sozialamt*). In accordance with Article 87(2) RA this government office then has to contact the immigration office about the irregular residence of the undocumented migrant that had been helped by the health care providers.

⁴⁴ See, for instance [32].

The *Malteser*, a large catholic medical association, runs similar contact points for sick or pregnant undocumented migrants, the so-called *Malteser Migrantenmedizin*. These contact points bring undocumented migrants in touch with a doctor or nurse who can provide an initial examination or emergency care in cases of sudden illness, injury or pregnancy [35]. Again, no mention is made of preventive health care, and it is unlikely that any such care is provided.

3.3. The Netherlands

As is the case in Germany, the Dutch health care system is rooted in the Bismarckian social insurance tradition. After twenty years of preparation, a drastic revision was introduced in 2006, establishing a single compulsory insurance scheme in which a range of private health insurers compete for insured persons ([36], p. xxii). In this new scheme, which is regulated by the Health Insurance Act (*Zorgverzekeringswet*, HIA), the government moved from directly steering the system towards safeguarding the process from a distance by controlling the quality, accessibility and affordability of care ([36], p. xxii).

Undocumented migrants have been excluded from health insurance since 1998, when the country adopted the Linkage Act (*Koppelingswet*) connecting the right to social services to administrative status. As is discussed further below, undocumented migrants are nonetheless entitled to so-called “medically necessary care.”

The most important law concerning preventive health care in the Netherlands is the Public Health Act (*Wet publieke gezondheid*, PHA). This law was adopted in 2008 with the primary aim of implementing WHO’s new International Health Regulations (2005). Based on the PHA, “public health” is the joint responsibility of government and the local municipalities [37]. At the national level, the National Institute for Public Health and the Environment (*Rijksinstituut voor Volksgezondheid en Milieu*, NIPH) plays an important coordinating role. In turn, the Dutch municipalities are responsible for disease prevention, health promotion and health protection. The PHA stipulates that the specific duties of municipalities include youth health care, environmental health, socio-medical service, periodic sanitary inspections, public health for asylum seekers, medical screening, epidemiology, health education, and community mental health ([36], pp. 143–44). The Netherlands counts 57 municipal health services (*Gemeentelijke gezondheidsdienst*, MHSs) that carry out part of these tasks for all 393 municipalities ([36], p. 143). With the adoption of the PHA, the Dutch municipalities have become responsible for the entire field of youth care. When it comes to children under the age of four, specialized child health centers (*consultatiebureaus*) are responsible for monitoring their health and for advising their parents.

The Netherlands has a National Immunization Program to protect children against infectious diseases covering vaccination against 12 potentially fatal infectious diseases [38]. The Program is carried out by a range of organizations, including the MHS, while monitored by the NIPH and financed by the government. The Screening Act (*Wet op het bevolkingsonderzoek*), which was adopted in 1992, regulates health screening for which a license is required. This law is also applicable to the national population screening program, which is carried out by NIPH. Based on this program, NIPH is responsible for directing, managing and coordinating the national population screening programs for cervical cancer, breast cancer and hereditary high cholesterol [39,40]. Eligible Dutch population groups receive this screening free of cost. When it comes to regulating lifestyle, the approach of the Dutch government is rather reticent: In a policy paper of 2011, it emphasizes the need to stimulate people’s individual responsibility for health ([41], p. 14).

As mentioned, immigrants without a residence permit cannot apply for basic health insurance in the Netherlands. However, based on Article 10(2) of the Aliens Act (*Vreemdelingenwet* 2000), they are nonetheless entitled to “medically necessary care.” Until 2009, health care providers relied on a special fund that covered such necessary services. Since that year, health care providers have no longer relied on this fund for reimbursement. Based on Article 122a of the HIA, they can now seek reimbursement for 80%–100% of the cost of care, depending on the costs concerned (for example, costs resulting from

pregnancy and childbirth are reimbursed in full)⁴⁵. This reimbursement is overseen by the National Health Care Institute (*Zorginstituut Nederland*, previously CVZ). To receive the reimbursement, health care providers must prove that they first attempted to collect the owed amount from the patient⁴⁶. In principle, therefore, undocumented migrants now pay for health services unless they cannot afford the bill.

While health care for undocumented migrants is financed outside the compulsory health insurance system, undocumented migrants are, in principle, treated in the mainstream health care system. Yet, in addition to regular care providers, there are approximately 100 NGOs in the Netherlands providing assistance to undocumented migrants, most of which receive support from local governments [41]. Most organizations, such as Doctors of the World, provide information to undocumented migrants and play a facilitating role in bringing undocumented migrants in contact with health care providers. Organizations involved in providing health care services include *Kruispost* (Amsterdam) and *Straatdokters* (Rotterdam). While these organizations can be found throughout the whole country, most care is concentrated in the large cities ([41], pp. 14–15).

As a result of the above-mentioned scheme, a wide range of services is available, in principle, to undocumented migrants in the Netherlands, covering primary, secondary and tertiary care ([2], pp. 49–60). The new scheme distinguishes between “directly accessible” (for example, GPs, midwives, dental care up to the age of 21 and acute hospital care) and “not directly accessible” services (for example, non-emergency hospital care and nursing homes)⁴⁷. While directly accessible services can be accessed on demand, “not directly accessible” services require a referral and only a limited number of specially contracted providers belong to the scheme ([41], p. 11). Human immunodeficiency virus (HIV) and hepatitis treatments are free of charge if it is proven that the patient is unable to pay the costs [42].

When it comes to preventive health care specifically, the following observations can be made. Undocumented migrant children are entitled to free vaccinations, free preventive care and check-ups at baby clinics ([41], p. 11). HIV and hepatitis screening are available to undocumented migrants provided that it is considered to be medically necessary by the health care provider ([42], p. 43). Pre-natal screening for pregnant women is also free of cost⁴⁸.

In practice, undocumented patients face some financial and practical hurdles in accessing health care. In a recent study among detained undocumented migrants, about 25% of the respondents who had sought medical help reported to have been denied care by a health care provider [43]. Another study indicated that 29% of undocumented migrants in the Netherlands did not receive the medical services they needed [44]. In relation to this, the study reported unwillingness on the part of a number of general practitioners to treat undocumented migrants, leaving the responsibility to a small group of general practitioners who were willing to carry the burden [44]. Furthermore, due to financial obstacles for health care providers (80% reimbursement for part of the treatments), the referral system from primary to secondary care is not optimal [43]. It is also reported that a lack of information about the entitlements to health care coupled with the fear of having to pay the bill constitute barriers for undocumented migrants seeking health care services [45].

When it comes to preventive health care more specifically, it can be problematic that dental care (including acute dental care) for adults over 18 years is not covered. Problems also arise in relation to the vaccination of children, as non-registered children do not receive invitations for the vaccination program. Moreover, undocumented parents are often too scared to become visible to the government, have other priorities, or move too frequently; as a result, they do not register their children for the necessary preventive health care measures. Other issues that arise in practice are the

⁴⁵ Article 122a-4 Zvw.

⁴⁶ Article 122a-3(a) Zvw.

⁴⁷ Article 122a-4-5 Zvw.

⁴⁸ Article 122a-4(a) Zvw.

fact that undocumented migrants are increasingly missing out on influenza vaccinations because the number of vaccinations available for the population as a whole is limited. Moreover, undocumented migrants are not invited for colorectal cancer screenings, and undocumented women do not receive an invitation for preventive breast cancer or cervical screenings. Many general practitioners provide other no-cost preventive measures and do not usually make a distinction between nationals and undocumented migrants in the provision of these measures. However, as soon as the treatment costs money (like physiotherapy, sport activities *etc.*), undocumented migrants are excluded⁴⁹.

3.4. Spain

The Spanish health care system evolved from the Bismarck to the Beveridge model during the course of the 20th century. Hence, the Spanish National Health Care System (NHS) provides high coverage of health care through tax-based rather than social insurance-based funding. Before 2012, undocumented migrants who were registered in a municipality were therefore entitled to universal health care. However, in 2012, the main law specifying health care provisions under the Spanish NHS, Law 16/2003 on the Cohesion and Quality of the National Health Care System (Law 16/2003), was reformed through Royal Decree-Law 16/2012 (RDL 16/2012) [46]. This introduced serious changes for the beneficiaries of the health care system: Instead of providing universal health care, the Spanish NHS now only covers persons who are insured under the social security system or who have a dependency tie to an insured person [47]. Undocumented migrants therefore do not have regular access to the health care system anymore.

Preventive health care for nationals and legally residing non-nationals is regulated in various constitutional and legal provisions. Section 43 of the Spanish Constitution specifically refers to preventive medical services through recognizing the right to health protection and subsequently stating that “[i]t is incumbent upon the public authorities to organize and watch over public health by means of preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all in this respect” [48]. Moreover, “the public authorities shall foster health education, physical education and sports”⁵⁰. The Spanish Constitution does therefore clearly recognize the importance of preventive health care in more general terms.

The General Health Care Law 14/1986 (Law 14/1986) further recognizes and specifies general preventive health services [49]. This law obliges the regional so-called Public Health Administrations to promote, for instance, sanitary education, primary health care and the prevention of the spread of diseases⁵¹. Regarding the underlying determinants of health, the law calls upon the government to improve the sanitation systems, the systems for the elimination and treatment of liquid waste and solids, the air quality control systems, the provision of water, the systems for monitoring sanitation and the environmental health in all fields of life⁵². The Public Health Administrations must also promote and improve the early detection of disabilities and reduce the occurrence of new disabilities and the intensification of pre-existing ones to a minimum⁵³.

Law 16/2003 on the Cohesion and Quality of the National Health Care System further clarifies Law 14/1986 and is more specific about the preventive health care services within the basic common packet of services, making preventive health care a part of primary health care⁵⁴. Thus, primary health care comprises activities including health promotion, sanitary education and assistance, the prevention

⁴⁹ We would like to thank Maria van den Muijsenbergh for providing this very helpful information on the practical realities of preventive health care for undocumented migrants. E-mail correspondence from 21-12-2012 on file with the authors.

⁵⁰ Spanish Constitution, 1978, Section 43.

⁵¹ General Health Care Law 14/1986, Section 18.1 and 18.2.

⁵² General Health Care Law 14/1986, Section 18.6.

⁵³ General Health Care Law 14/1986, Section 18.18.

⁵⁴ Law 16/2003.

of illness, the maintenance and recovery of health, as well as physical rehabilitation and social work⁵⁵. However, the further implementation of the laws is left to the Autonomous Communities.

In relation to the undocumented migrant population, Law 4/2000 regulates the rights of documented and undocumented foreign nationals living in Spain [50]. Before 2012, this law and Law 16/2003 regulated that foreigners without legal residence status were covered by the NHS after they had registered in a municipality. As mentioned above, since 2012, only insured persons or persons with a dependency tie to the insured have access to the Spanish NHS. Categories are tied to the social security system on the basis of either direct employment/retirement/beneficiary of unemployment benefit or through having family or dependency ties with an “insured” person (for example, children under 26 years old, partners, brothers and sisters, and other people with a tie of dependency with the “insured” person)⁵⁶. Nevertheless, the reform established that nationals, European citizens, and documented migrants still count as “insured” if their annual income is below 100,000 euro⁵⁷. Hence, undocumented migrants do not have regular access to the NHS and cannot benefit from any preventive health care.

However, there are three exceptions to the denial of access to the NHS for undocumented migrants: (1) emergency care; (2) health care to children under the age of 18; and (3) pre- and post-natal care⁵⁸. Moreover, undocumented migrants can still access the complete health care package if they can afford being insured with the NHS. In order to do so, undocumented migrants must pay 60 euro per month below the age of 65 and 157 euro per month above the age of 65 [51]. Another possibility is to subscribe to an existing private insurance plan, also available to nationals and documented migrants who prefer private health care services. While this seems a legitimate approach in theory, undocumented migrants are almost never able to pay the insurance and therefore remain outside the Spanish NHS.

At a more practical level, some Autonomous Communities have thus introduced additional measures to limit the negative effects of RDL 16/2012. The reason for this is that the new Spanish regulation could violate some of the Autonomous Communities’ competences. Furthermore, the majority of their autonomy statuses recognize the universal entitlement of the right to health [52]. While some Autonomous Communities apply RDL 16/2012 consistently, others have expanded the health care provisions to also include undocumented migrants and other persons who would otherwise not be covered by the Spanish NHS. According to Doctors of the World, there are four different approaches: (1) offering normalized access to health care for undocumented migrants (Andalusia and the Principality of Asturias); (2) “special programs” to expand assistance to undocumented migrants on the basis of certain criteria (Aragon, Canary Islands, Cantabria, Catalonia, Basque Country, Extremadura, Galicia and the Valencian Community); (3) applying RDL 16/2012 with some exceptions (Madrid, Murcia, Balearic Islands, The Rioja and Castile-Leon) and (4) strictly applying the state rule (Castile-La Mancha) ([53], p. 21). Since the regional elections in May 2015, there have been some changes in this respect, and more Autonomous Communities have expanded the access to health care for undocumented migrants. This is the case of Valencian Community, whose Decree Law 3/2015 has been recently appealed by the Spanish government before the Constitutional Court [54].

In addition to these local practices that try to mitigate the effect of RDL 16/2012, some non-governmental organizations provide preventive health care to undocumented migrants. Doctors of the World, for instance, provides health care, social care and psychological care. In 2014, the organization intervened in 12.068 instances, 58.49% of the issues were social, 36.82% sanitary and 4.69% psychological. The organization also conducts informative and educational activities on health-related issues [55].

⁵⁵ Law 16/2003, Section 12.1.

⁵⁶ RDL 16/2012, 20 April, 2012, Section 1.

⁵⁷ Law 16/2003, Section 3.3 reformed by Royal Decree-Law 16/2012.

⁵⁸ Law 16/2003, Section 3.3.

Despite such positive initiatives, there are many practical irregularities in the provision of preventive health care for undocumented migrants. Such irregularities include, for instance, the sending of invoices to undocumented children despite the fact that they are still covered under the Spanish NHS or situations in which the provision of emergency care was denied to undocumented migrants [53]. Some non-governmental organizations have created registers where they collect such incidents. In the Valencian Community, for instance, more than 1.338 incidents have been registered in three years ([56], p. 8). The prevalence of such inconsistencies with the law might be due to the difficulty of implementing the new regulation after decades of broader access to health care in the Spanish NHS.

Many international organizations of human rights have denounced these irregularities as well as the consequences of RDL 16/2012 itself. For instance, the Commissioner for Human Rights of the Council of Europe, Nils Muižnieks, has denounced the denial of health care to undocumented children after visiting Spain in June of 2013 ([57], para. 21). RDL 16/2012 has also been challenged by political parties and different Autonomous Communities; consequently, Spain is currently waiting for the verdict of the Constitutional Court regarding this matter (see Table 1).

Table 1. The access to preventive health care in Germany, the Netherlands and Spain.

Country	Germany	The Netherlands	Spain
<i>Health Care System</i>	Insurance-based, public-private: universal access to obligatory state insurance, private insurance on the basis of income and health risks, no insurance for undocumented migrants	Insurance-based, private; all registered residents are required to take out compulsory insurance	Tax-system funding, regular access for covered persons and undocumented children, possibility of paid insurance for undocumented migrants
<i>Preventive measures for nationals</i>	Infection Protection Act, Fifth Social Code, Prevention Act: extensive preventive health care measures for insured persons	PHA: extensive preventive health care for insured persons	Laws 14/1986, 16/2003: extensive preventive health care for covered persons
Non-Nationals			
<i>Legislation</i>	ASBA, RA: - advisable vaccinations and medically necessary screenings for undocumented migrants (who were, are or will be) in the deportation process - no rights for those not in the deportation process	PHA: - infants participate in the national vaccination program - screening programs available to undocumented children	Laws 4/2000, Royal Decree 16/2012: - preventive measures to children under 18 years and to insured undocumented migrants (if they can afford it) - no preventive measures to uninsured adult undocumented migrants
<i>Practice</i>	Limited access due to reporting obligation but anonymized insurance vouchers in some <i>Bundesländer</i>	Limited access for children due to practical issues. No screening programs for adults. Some preventive care provided by general practitioners on an <i>ad-hoc</i> basis but only if free from costs.	Some preventive health care services to adult undocumented migrants in some Autonomous Communities.
<i>Private initiatives</i>	<i>Medinetz, Medibüro, Medizinische Flüchtlingshilfe, Malteser Migranten Medizin</i> (usually no preventive health care)	Doctors of the World (facilitating role), <i>Kuispost</i> and <i>Straatdokers</i> (provide health care but not necessarily preventive health care)	NGOs such as Doctors of the World (includes social and psychological care)

4. Comparison

The following summarizes the results of the above country analysis and compares the national laws and practices on preventive health care for nationals and undocumented migrants in Germany, the Netherlands and Spain in light of the international human rights law framework. Special attention is paid to the indicators of preventive health care identified in GC 14: immunization, education and information, screening programs and the underlying determinants of health (see Table 2).

Table 2. Preventive health care indicators in Germany, the Netherlands and Spain.

	Germany		The Netherlands		Spain	
	Nationals	Undocumented migrants	Nationals	Undocumented migrants	Nationals	Undocumented migrants
Immunization	V	(v)	V	(v)	V	(v)
Education/ information	V	X	V	(v)	V	(v)
Screening programs	V	(v)	V	(v)	V	(v)
Underlying determinants of health	V	X	V	X	V	X

V: available, (v): largely available to children but not or only to a limited extent to adults; X: not available.

4.1. Immunization

In Germany, advisable vaccinations are available for those who are subject to deportation. However, it is unclear whether and to what extent undocumented migrants are actually informed about this possibility. Undocumented migrants not subject to deportation have no access to vaccinations unless the vaccinations are offered in the interest of public health and therefore free of charge. Undocumented children are often entitled to vaccinations at the federal level. In the Netherlands, undocumented children participate in the regular vaccination program. However, problems arise in practice due to the fact that registration is required before the vaccination can be carried out. In Spain, immunization programs are fully accessible to all children below the age of 18. However, undocumented migrants above the age of 18 cannot access vaccinations or other immunization measures. Vaccinations seem to be equally available to undocumented children in all three countries, but vaccinations of undocumented adults seem to be more problematic.

4.2. Education and Information

For as far as a desk study can reveal, there is no specific education or information about a healthy lifestyle, preventive health care, or any other measures related to preventive health care available to undocumented migrants in Germany. In the Netherlands, information is available to undocumented parents about the (healthy) development of their children. Given the reticent attitude of the Dutch government with regard to lifestyle information for the population at large, it is unlikely that any more extensive information on healthy living is available specifically to undocumented migrants. In Spain, education and information on preventive health care may be available to undocumented children if they attend school. Moreover, the Spanish Ministry of Health usually publishes general information on preventive health care on its website. Educating and informing undocumented migrants about a healthy lifestyle, their health care entitlements or about any other measures related to preventive health care seems to be an equally low priority in all three countries. However, while no targeted education or information is available to undocumented migrants in all three countries,

non-governmental organizations have in some instances taken the initiative to provide health-related information and education to undocumented migrants.

4.3. Regular Screening Programs

Screening programs in Germany are available for those under government supervision. However, in practice, this is only available to undocumented migrants who are not scared about being deported and are therefore willing to be known to the government. The exact content of which screening programs are available is undefined and the right to the “advisable” screening programs is to be defined by each federal government agency separately. Those undocumented migrants who are not subject to deportation are unable to avail themselves of any screening measures. While private initiatives attempt to limit the negative impact of restrictive government policies in this respect, no specific attention is being paid to the provision of screening programs. At a federal level, government agencies usually provide screening programs to undocumented children free of charge. In the Netherlands, screening programs are available to undocumented children but usually not to undocumented adults. Even children are often barred from accessing screening programs due to practical barriers. In Spain, screening programs are not available to adult undocumented migrants unless they can afford the insurance. However, undocumented migrant children are entitled to the same screening programs as national children. In all three countries, screening programs seem to be available to undocumented children but not to undocumented adults.

4.4. Promotion of Underlying Determinants of Health

Attention to the promotion of the underlying determinants of health is not included in the provisions of health care to undocumented migrants in any of the three countries. The lack of awareness of this aspect is discussed in more detail below.

While this might not even be the full scope of preventive measures that would be necessary for undocumented migrants preventive health care, this limited set of indicators already reveals the shortcomings of the three countries at stake in light of a human rights-based approach. The indicators reveal that all three countries have severe shortcomings in the preventive health care for undocumented migrants. While they largely pay sufficient attention to the preventive health care of nationals (although there is still improvement possible in this respect as well), preventive health care for undocumented migrants remains very limited.

5. Discussion

5.1. Limitations of the Preventive Health Care Indicators

Based on the references to preventive health care throughout GC 14, we identified four important indicators for a right to preventive health care: (i) immunization; (ii) education and information; (iii) screening programs; and (iv) attention for the underlying determinants of health ([14], p. 93). First of all, it must be acknowledged that such indicators are to some extent arbitrary: The indicators are based on the most explicit, most frequent and most consistent reference in connection of preventive health care. However, others might find that these are not the only or most important criteria by which to judge or that there are other, more implicit, possible indicators to which attention should be paid. This is an unavoidable limitation of the present analysis, as this study is merely a steppingstone for future research on preventive health care in international human rights law. A further discussion of these indicators is therefore strongly encouraged.

One additional, more conceptual, limitation that must be acknowledged is that prevention and treatment are often not strictly separate. In some cases, treatment can also be part of preventive health care, for instance, if the objective is limiting the deterioration of an existing disease. The primary and secondary measures of prevention can be implemented through taking action in accordance with the four indicators identified above. Tertiary measures, however, require active treatment and cannot be

achieved through preventive health care only. Nevertheless, these tertiary measures also form part of prevention in the public health discourse. This aspect was not further developed in the present study because it is not explicitly mentioned in GC 14 and because it seems more useful to draw a clear line between prevention and treatment in order to illustrate the impact of a human rights-based approach more clearly. It could have contributed to the realization of preventive health care if GC 14 had clarified preventive health care more clearly along the lines of the public health discourse. However, since this is not the case, the only clarification of prevention is provided by the four indicators identified in the present study.

5.2. Potentially Useful: The Underlying Determinants of Health

While the underlying determinants of health form part of the indicators, they were not referred to extensively in the present study. The reason for this is that the underlying determinants of health are a rather fluid concept that, due to its broad scope that goes way beyond the access to health care, is not easily tested against law and practice. Nevertheless, it is an important aspect that needs to be taken into account if the situation of undocumented migrants is to be evaluated and improved in accordance with the international human rights paradigm. The underlying determinants of health seem both helpful and limiting due to their broadness and can grant valuable insights on the usefulness of a human rights approach to health care. Underlying determinants have considerable influence on the health status of people. For this reason, the concept has been developed within the UN system, both by the WHO and by the CESCR. Without adequately addressing the underlying determinants of health, there will still be causes that, regardless of the quality of health care, can provoke diseases.

GC 14 refers to the underlying determinants of health as including “environmental safety, education, economic development and gender equity”⁵⁹, and also, “access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health”⁶⁰. While it can already be considered as a tremendous achievement that the underlying determinants are referred to at all in relation to the right to health, the approach of GC 14 still insufficiently explains and emphasizes the role of the underlying determinants of health ([1], p. 4).

A further clarification can be offered by a public health framework developed by the WHO that provides clear evidence of the influence of the influence of the underlying determinants of health [58]. According to Marmot and Wilkinson, the underlying determinants of health are socio-economic causes that have an influence on health, such as diet, access to potable water, housing, and work. These determinants or factors can be understood as the *causes of the causes* of the illness. An unhealthy diet, for instance, can be the cause of an augmented level of cholesterol, but the lack of economic resources to access healthy food can be the *cause of the cause* of this illness [59]. In relation to preventive health care, Whitehead confirms these inequalities as determining factors: The more deprived classes consult the doctor a greater number of times, but they use less preventive services [60]. Likewise, a 2008 report of the WHO Commission of Social Determinants of the Health underlines the fact that the conditions of daily life are the main factor that needs to improve in order to achieve health equity—the circumstances in which people are born, grow, live, work, and age [61]. The underlying determinants of health are thus clearly related to the social and economic conditions in which humans live.

The underlying determinants of health provide a potentially useful concept that can carry any discussion on the right to health to a more substantial level and contribute to a more comprehensive understanding of the national legal frameworks on health care. A human rights perspective on health rights is promising particularly because of this broader approach to health. It allows cross-reference to

⁵⁹ General Comment 14, para. 16.

⁶⁰ General Comment 14, para. 11.

other social rights in the ICESCR, such as the right to housing, food, and education, in accordance with the principle of indivisibility and interdependence of all human rights. While an in-depth comparison of this issue was beyond the scope of this research, future analysis of the underlying determinants of health in relation to the preventive health care for undocumented migrants is strongly encouraged. In relation to any legal discussion of this issue, it would also be valuable to collect data on the social conditions under which undocumented migrants live in Germany, the Netherlands and Spain in order to understand which underlying determinants of health are most promising for the prevention of illnesses of undocumented migrants.

5.3. What a Human Rights-Based Approach can Add to the Health Protection of Undocumented Migrants

The present study revealed that there is a need for further refinement of the state obligations and individual rights under the right to health. Particularly the right to preventive health care is not yet defined clearly enough in the international human rights framework. While indicators can be identified on the basis of an in-depth analysis of relevant legal documents, no explicit official legal framework on preventive health care has hitherto been established. Nevertheless, the fact that it is possible to identify indicators on preventive health care and to compare whether and to what extent national legal and policy frameworks are in line with these indicators already shows a tremendous achievement of the human rights framework. Three important advantages of a human rights-based approach to health are therefore worth pointing out: It can be seen as an evaluation tool, an advocacy framework and a moral principle.

First, the human rights-based approach can serve as an evaluation tool because it provides insights that a legal positivistic interpretation of national health law could not provide. Through making individual entitlements more concrete, the human rights-based approach becomes a tool for evaluation and critique of state practices. It reveals inequalities and serves for holding states accountable through becoming an evaluation mechanism of human rights treaty bodies in their concluding observations and complaint mechanisms. This can eventually enhance health equity for both citizens and non-citizens.

Second, the human rights-based approach can serve as an advocacy framework because, even if the justiciability of human rights in general is sometimes problematic, the present analysis has shown that the human rights framework can help to hold states accountable. Even if the indicators applied in the present study are not strictly legal means, they can still serve as an advocacy framework and provide a higher standard that we aim to achieve one day. This could even be the most essential aspect that a human rights-based approach can add, in terms of preventive health care and in more general terms.

Third, the human rights-based approach can serve as a moral principle because of its outspoken emphasis on universal human rights. As the present analysis has shown, rights are commonly denied to persons in marginalized or vulnerable situations. The emphasis of international human rights law and, in particular, of GC 14 on the universality and inalienability of human rights for all humans, regardless of their legal status, allows for far-reaching protection that can eventually also reach undocumented migrants.

6. Conclusions

The present study analyzed the preventive health care provisions for nationals and undocumented migrants in Germany, the Netherlands and Spain in light of international human rights law. Despite preventive health care being recognized as particularly important for undocumented migrants, this paper revealed severe shortcomings in the provision of preventive health care for undocumented migrants when evaluated against the indicators (i) immunization; (ii) education and information, (iii) regular screening programs, and (iv) the promotion of the underlying determinants of health.

Taking human rights seriously means that their universality and interrelatedness must be fully acknowledged. This innovative approach recognized in GC 14 is a tremendous step towards the

full realization of human rights. A rights-based approach reveals that States, in order to ensure that their national laws and policies are in line with international human rights law, should ensure the access to preventive health care for undocumented migrants in line with the four indicators identified in the present study. While one may find that preventive health care is not the most urgent aspect to focus on, or that undocumented migrants should be happy to receive any care at all, a human rights-based approach tells a different story: despite the budgetary and other considerations which may cause States to limit the human rights of particular individuals, a rights-based approach to health emphasizes that universal and interrelated human rights are the standards against which national policies should be measured. If states want to fully abide by their obligations under the right to health, these requirements should no longer remain neglected.

A rights-based approach to health can thus help to refine and concretize the individual rights and state obligations for the preventive health care of undocumented migrants. While the present analysis showed that the human rights framework is still insufficiently clear in some respects, the study clearly concedes the added value of a rights-based approach as an evaluation tool, advocacy framework and moral principle to keep in mind when adopting or evaluation state policies in the health sector.

Author Contributions: Background: Flegar, Method: Flegar: Human Rights Framework: Toebes and Flegar, Germany: Flegar, the Netherlands: Toebes, Spain: Dallí, Comparison: Flegar, Dallí, Toebes, Discussion: Flegar and Dallí, Conclusions: Flegar.

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Abbreviations

AAAQ	availability, accessibility, acceptability and quality;
ASBA	Asylum Seekers Benefit Act;
CESCR	Committee on Economic, Social and Cultural Rights;
EU	European Union;
GC 14	General Comment 14;
GHCL 14/1986	General Health Care Law 14/1986;
ICESCR	International Covenant on Economic, Social and Cultural Rights;
HIA	Health Insurance Act;
HIV	human immunodeficiency virus;
IHRL	International human rights law;
MHS	municipal health service;
NHS	National Health Care System;
NIPH	National Institute for Public Health and the Environment;
PHA	Public Health Act;
RA	Residence Act;
RDL 16/2012	Royal Decree-Law 16/2012;
UN	United Nations;
WHO	World Health Organization.

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