OBSERVATORY REPORT 2018

DEPRIVED OF THE RIGHT TO HEALTH:

Sick and without medical care in Germany

“Observatory 2018 – Deprived of the right to health” is the English abridged version of a comprehensive report published in German in 2018. This report can be downloaded free of charge at www.aerztederwelt.org.

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Note: The opinions expressed in this report reflect the opinions of Ärzte der Welt and do not necessarily represent those of the EPIM, NEF or their Partner Foundations, the Medical Center of the University of Munich (LMU), the SKala initiative and the cooperation partners of Ärzte der Welt. The responsibility for the information and views presented in this report is solely with Ärzte der Welt. Ärzte der Welt assumes no responsibility for how the information may be used by third parties.

Ärzte der Welt

The humanitarian organisation Médecins du Monde was founded in France in 1980. Today, 15 branches on 3 continents make up an independent international network that is providing medical care to vulnerable people at home and abroad.

We are politically advocating for the human right to affordable medical care to be put into practice. Ärzte der Welt carries out about 340 health projects in 75 countries around the world. Founded in 2000, Ärzte der Welt e.V. is the German branch of the network.

Domestic programme

As part of the domestic programme, we offer medical treatment and social counselling. Our projects’ long-term aim is to (re)integrate all patients into standard medical care.

Projects belonging to the domestic programme

open.med München: Medical drop-in centre and outreach medical care for people living in particularly precarious circumstances

MedMobil Stuttgart: Outreach medical care in collaboration with Ambulante Hilfe Stuttgart e.V.

Migrantenmedizin westend: Medical drop-in centre in Hamburg in collaboration with hoffnungsorte hamburg/Verein Stadtmission Hamburg

open.med Berlin: Medical drop-in centre in Berlin in collaboration with Medizin Hilft e.V.

INTRODUCTION: HEALTH CARE FOR ALL

"Every person has the right to the highest attainable standard of physical and mental health," the International Covenant on Economic, Social and Cultural Rights by the United Nations stipulates. Legally binding in Germany since 1976, this covenant means that Germany is obliged to make the necessary health services available without discrimination to all people living in the country. This report shows, however, that there are still many people in Germany without sufficient health coverage and who do not receive the medical care they need. It is without question that Germany has a highly developed health care system capable of providing high-quality health services. But these are very expensive and the costs can hardly be covered privately – those without health insurance are simply denied access.

The situation is made all the harder in that the current political debate on migration in Germany is increasingly about separation: legislation envisages a considerable rollback in asylum seekers' access to health services and a tightening of the conditions under which someone may avoid deportation on medical grounds. This massively limits the right to non-discriminatory access to required health care.

Projects run by Ärzte der Welt in Hamburg, Stuttgart, Munich and Berlin ensure that people who have been denied these rights receive medical treatment and suitable counselling.

The report provides a scientific evaluation of data on our patients collected at the drop-in centres in Munich, Hamburg and Berlin between January and December 2017. The data provides an overview of social demographics, life circumstances, barriers encountered and state of health. The statistical data analysis was conducted in close collaboration with the Division of Infectious Diseases & Tropical Medicine at the Medical Center of the University of Munich.

The analysis helps to better understand the needs of the target groups and their problems as well as to tailor what we offer to them accordingly. Moreover, the data serves as the basis for our advocacy and communications work. The data will be made available to political decision-makers, economic and health activists and other associations and welfare organisations so they can help provide better access to medical care for all people living in Germany. The groups considered in the report are barely represented in nationwide statistical surveys on medical care, because they are often unavailable to the makers of these studies, for example because they have no registered address or because of language barriers. The data provided here therefore is a trove of information that is unique in the German health care landscape.

Those without sufficient care

Migrants from EU member states

➤ For a temporary stay in Germany, the European health insurance card (EHIC) should ensure treatment. But often patients do not have an EHIC or it is refused by health care practices.

➤ If the stay exceeds six months, health insurance is mandatory. However, many cannot afford the payments or the health insurance companies refuse to admit them.

➤ Since the so-called exclusion of benefits law came into effect in 2016, unemployed EU citizens who have resided in Germany for less than five years are virtually excluded from support: Within a two-year period, they may receive what are known as bridging benefits for a maximum of one month (including limited health care provision for acute and pain conditions). What is more, they have – even in emergencies – no right to be reimbursed costs for doctors' visits, hospital stays or medications.

People with ongoing asylum procedures or who live in Germany under a suspension of deportation

➤ In the case of acute and pain conditions, and of pregnancy and childbirth, there is the right for the first 15 months to reimbursement of costs for limited medical services. Additional medical care, for instance to treat various chronic conditions, must be applied for on a case by case basis, which often takes a long time.

Undocumented migrants

➤ People who are not in possession of an official residence permit have a legal right to limited care. With the exception of emergency treatment and giving birth in a hospital, however, the social service agencies are obliged to notify the immigration authorities before any costs are covered, which poses the risk of deportation to the patient.

People without health insurance or those with overdue contributions

➤ Uninsured people have no claim to cost coverage. If contributions are overdue, the individual has the right only to limited care. Children of uninsured parents are also affected in that they have no access to medical care.

METHOD:
GETTING THE DATA

Data collection

All data was collected in the course of the regular opening hours in the drop-in centres, with the priority being the treatment of the patients. Data was gathered based on the annually updated questionnaire used by the European Network to reduce vulnerabilities in health, which goes into compiling the European Observatory Report, published every year since 2006.

On their first visit, patients were invited to take part in an initial counselling session, which served mainly as a means of taking a social anamnesis. The social data was therefore gathered only once. Medical care and counselling were documented throughout the treatment period (medical history, current medical situation, tests performed, diagnoses made and medications prescribed) by a team of volunteers. Data was gathered with the aid of interpreters, if needed, and entered into a database under pseudonyms via the allocation of sequential patient numbers.

Data evaluation

Following data cleansing and plausibility checks, the datasets were exported in Excel and transferred to Stata statistical software (Version StataSE 14). Due to the purely descriptive nature of this report as well as specific methodology, a statistical analysis of correlations is omitted here. What is included are merely the direct frequencies and frequencies differentiated by subgroups as appropriate.

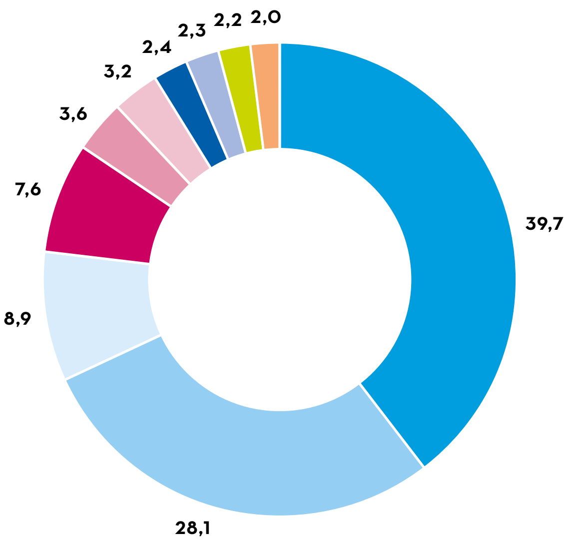
Data quality

Patients were not randomly selected. Instead, each was invited to an initial meeting and could decide whether to take part and which questions to answer. Some datasets were not completely filled out, sometimes it was necessary to combine data because of a very small number of cases or the vast diversity of certain criteria.

THE PATIENTS:
ANALYSIS RESULTS IN DETAIL

In 2017, the domestic programme run by Ärzte der Welt counselled and treated 2,300 patients in 7,270 consultations. At the three drop-in centres in Berlin, Hamburg and Munich, 1,096 people were prepared to provide data to be used in scientific evaluation.

PATIENT ORIGIN BY COUNTRY IN %



Gender: The majority of patients were female (52.4 %).

Age: The age spectrum of patients ranged from 0 to 90 years. The average age was 36.7 years. Children and adolescents under 20 years of age made up 18.7 % of the patients; 9.8 % were under 5 years of age. A further 6.6 % were over 65 years of age.

Origin: Patients came from 88 different countries (see graphic). The most common country of origin was Bulgaria, followed by Romania and Germany. Expressed as the following three groups, we see that: 619 (56.5 %) patients were EU citizens (excluding Germany), 390 were from other countries, hereafter referred to as third-country nationals (35.6 %), and 83 were German citizens (7.6 %).

INITIAL MEETING: Of the 1,096 people who were treated and counselled, 786 (71.7 %) presented for the first time in 2017. More detailed presentation of the current needs dynamic is based, unless otherwise indicated, on this group.

SOCIETY:
WHEN LIVING CONDITIONS CAUSE ILLNESS

There is a wide range of political-legal, socioeconomic and psychosocial factors that can adversely affect health. These include poverty, precarious living conditions, an uncertain residency status and social isolation.

Socioeconomic factors

Of the patients who presented for the first time at the drop-in centres during the observation period, 96.3 % lived below the poverty line; 13.8 % were roofless; 14.6 % lived in hostels; 1.7 % camped; 53.5 % lived with friends or family; 1.0 % slept at work; and only 15.5 % reported that they lived in their own or rented accommodation.

Of the homeless patients, noticeably many (70.8 %) were EU citizens.

CASE STUDY: KRISTINA K., 59, BULGARIAN

Kristina K. was employed as a cleaner in the low-income bracket. She claimed no benefits, although she knew she was entitled to them. She wanted to make her living on her own, but funds did not stretch to health insurance. Kristina K. lived in dilapidated housing and used a gas heater in the winter. One cold night, the heater exploded, which left Kristina K. badly burned. She was brought to a city hospital as an emergency. For the ambulance service she later received a bill for 700 euros, which she was unable to pay. While in hospital, she was initially placed in an artificially induced coma and first operations were carried out. Fearing the costs she would incur, Kristina K. left the hospital as soon as she was able to, despite her state of ill health. She urgently required another operation on her eye as well as compression garments including a face mask. She was refused both because she was uninsured and the resultant gap in cost coverage.

Kristina K. at first came to the drop-in centre, because she could not afford the medication she was prescribed. In addition to providing medication and regular physical therapy, the team managed to establish contact with a volunteer specialist from another charity. The specialist carried out the eye surgery free of charge. Without this operation, the patient might have gone blind. Although Kristina K. is still limited by her injuries, she has managed to find a job through which she is insured. With the insurance she received full treatment as part of the statutory system.

Political-legal factors

The legal reality for people who do not have regular or secure residency status is that they are largely prevented from participating in political and social life. Studies show a direct correlation between social involvement and physical and psychological health.

Among the patients from other EU countries, 40.0 % had been living in Germany for less than three months; 8.1 % of EU citizens had been living in Germany for over three months, had sufficient financial means and approved residency in Germany. Patients who had been living in Germany for over three months and had insufficient financial means totalled 51.9 %. Under certain circumstances, this group may lose the right to remain in the country.

The three largest groups of patients from third-country nations represented those without official residency status (35.0 %), those with ongoing asylum proceedings (21.6 %), and those with a short-term visa (17.2 %).

Psychosocial factors

Psychosocial factors such as the absence of social contact and the feeling of loneliness contribute to a high morbidity and mortality rate across age groups. 51.4% of patients reported that, when confronted with problems, they had a person to contact “never” (15.6%) or only “sometimes” (35.8%); 48.6% reported that this was the case “often” (30.1%) or “very often” (18.5%).

People without regular residency are particularly highly affected by social isolation; 58.6 % reported never or only sometimes having a person to contact, if needed. Furthermore, 53.5 % reported they they moved around less or far less freely for fear of deportation.

BARRIERS:
WHAT IS PREVENTING ACCESS TO HEALTH CARE

Insurance status

Access to Germany's regular health care system primarily depends on an individual's insurance status. EU citizens in possession of an EHIC card or asylum seekers for instance have limited insurance coverage. Those without coverage are uninsured German citizens, EU citizens who can neither present proof of health insurance in Germany or in their home country nor an EHIC card and de facto those without regular residency status.

INSURANCE STATUS BY NATIONALITY GROUPS

	EU	Germany	Third-country nations	Total
No insurance coverage	76.1 %	50.0 %	57.5 %	66.1 %
Limited insurance coverage	9.9 %	37.9 %	12.7 %	13.2 %
Statutory or private insuranc	2.9 %	10.3 %	23.0 %	12.2 %

Costs

For 40.8 % of patients, a doctor's visit was too expensive, for 31.3 % medication was too expensive.

Bureaucracy and ignorance

For 22.1 %, administrative problems represented a barrier to gaining access to medical care; 20.1 % admitted knowing too little about the health care system.

Language

Only 16.5 % of patients cited language as an immediate barrier. However, 72.7 % of patients needed linguistic assistance at the initial interview.

Abnegation and discrimination

At the time of interview, 51.0 % of respondents had not sought medical care in the preceding 12 months despite having been ill.

Patients also reported having been discriminated against by health care providers: in total, 17.7 %. It is noteworthy that 29.2 % of homeless patients felt they had been discriminated against.

DIAGNOSES:
WHY TREATMENT IS NECESSARY

HEALTH STATUS

In the projects run by Ärzte der Welt, the health status of patients is ascertained through the patients' own estimation (subjective health) and through the medical opinion and diagnoses of doctors. The subjective health assessment provides important information for describing the condition of individuals and population groups. At the first consultation, 33.0 % of patients reported their general health status to be "very poor" (5.1 %) or "poor" (27.9 %), 38.4 % as "satisfactory", 28.7 % as "good" (23.1 %) or "excellent" (5.6 %).

People in a particularly precarious living situation on average had a worse projected health status than the general population: for instance, 47.2 % of homeless patients estimated their general health to be"poor" (40.6 %) or "very poor" (6.6 %). Of the patients without regular residency status, 44.3 % reported their general health to be "poor" (35.4 %) or "very poor" (8.9 %).

Diagnoses and conditions

More than half of the diagnoses made could be attributed to the following five diagnosis groups: "Circulatory" (17.8 %), "Endocrine, metabolic and nutritional" (10.91 %), "Musculoskeletal" (10.29 %), "Pregnancy, child-bearing, family planning" (9.32 %) and "Psychological" (9.15 %).

For 32.3 % of patients at the first consultation, the need for treatment was seen as urgent. Of all diagnoses made, 56.4 % were for chronic conditions. Today, chronic conditions count among the most common and most relevant health problems in terms of the health care economy. They affect quality of life, ability to work and mortality.

Mother and child health

Pregnancy, childbirth and the first years of a child's life are associated with significant health risks. With high quality health care before, during and after childbirth, these risks can be minimised or even avoided.

Pregnant women: The WHO recommends that at least eight check-ups should be carried out during pregnancy. Of the 393 female patients making their first visit to the drop-in centres, 88 were pregnant (22.4 %), 15.9 % of those under 18 years of age. EU citizens made up 60.2 % and third-country nationals 39.8 %.

Prior to their visit to a drop-in centre, 64.8 % of the women had not had a prenatal examination. Precarious living conditions also have a negative effect on pregnancy: 96.5 % of the pregnant women were living below the poverty line, 8.2 % were affected by homelessness, 12.5 % did not have a regular residency status.

Children under five: Signatories to the United Nations "Convention on the Rights of the Child" are obliged to "ensure that all children receive the necessary medical attention and health care". This includes medical care in the event of an accident, checkups, and immunisations. Of the 1.096 patients, 205 were children and adolescents under the age of 20 (18.7 %), 107 under the age of five (9.8 %). EU citizens made up 39.8 %, 54.8 % were third-country nationals and 5.4 % were German.

Those without insurance coverage totalled 68.8 %, 7.5 % had limited coverage. Only 15.1 % of children under five had regular coverage. Apart from the "general and non-specific" diagnosis group (64.6 %), which includes preventative care such as milestone examinations and inoculations, most of the diagnoses were of the following four groups: "respiratory" (13.97 %), "digestive system" (7.86 %), "skin" (6.11 %) and "circulatory" (1.75 %). Of the diagnoses made for children under five years of age, 63.8 % were for acute and 4.98 % for chronic conditions.

WHAT IS TO BE DONE?

CONSEQUENCES OF DENYING THE RIGHT TO HEALTH CARE FOR THE INDIVIDUAL AND SOCIETY

Health is a dynamic process that depends on several factors. These include biographical factors as well as social, legal and political ones. This report shows that precarious living conditions can also impair health. At the same time, people who live under such conditions often have no or very limited access to medical care. This means that illnesses remain untreated and can lead to acute, life-threatening emergencies. In particular when chronic conditions go untreated or are not treated early enough, and people go without preventative care, the negative effects go beyond harm to the individual. The health care system is also put under increased financial strain.

In Germany, legislation and administrative regulations are becoming increasing restrictive. More and more, volunteer doctors and civil society organisations are doing the work of the state. But the primary care they offer is not the same as adequate outpatient diagnostics and treatment. If the barriers to access were removed, this would mean lower costs for the health care system. What is more, people in good health have more resources at their disposal, for instance to positively shape their living and working situation.

Political action is needed

Ärzte der Welt e.V. campaigns for the German government to be more effective in meeting its human rights obligation to ensure all people living in Germany receive access to adequate health care free of discrimination. To achieve this goal, Ärzte der Welt has worked up a comprehensive catalogue of short-term and structural measures. These are mainly concerned with the health care system and the law in Germany and can be viewed in the full version of this report.

Recommendations on EU level have also been made in order to improve health care of all people living within the EU. These include a simplification of administrative processes associated with the EHIC card and clarification of the EU-wide legal situation for people without health insurance. The European Pillar of Social Rights proclaimed in 2017 contains important elements that should be further implemented by policy-makers at EU institutions. In line with the recommendations made by the European Commission in 2017, there is a need for European regulations that ensure access to social security and the "right to timely, quality and affordable health care and treatment".

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