Health, Migration and Return

A HANDBOOK FOR A MULTIDISCIPLINARY APPROACH

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edited by

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PREFACE

The North is being increasingly confronted with a new phenomenon of migration: the so-called 'health tourism' of irregular migrants. One can already recognize a tendency among would-be migrants who either overstay their visas, or arrive under the pretext of being asylum-seekers, to come to the North with the intention of receiving medical treatment, in particular complicated surgery or other expensive forms of treatment, which they cannot get in their countries of origin, certainly not free of charge. Moreover, many others use 'illness' as a pretext or a reason for not being returned, or to obtain leave of stay.

In this respect one needs to take into account that public health services in most Western European and North American countries are already overloaded as a consequence of modern medical developments, but also in view of the general increase in the percentage of old people among the population. In many countries there are long waiting lists for non-urgent operations and contributions to health systems have to be constantly increased in order to cover the extensive costs of modern medical treatment.

The countries concerned are in a dilemma. Even if they understand from a humanitarian point of view the need for medical treatment requested by irregular migrants or for example rejectees, they are under legal and moral pressure to give priority to and to respect the interests and rights of those persons who contribute directly or indirectly to the national health service. The situation is even more complicated in respect of diseases which require permanent treatment such as kidney dialysis or medication for AIDS. The aliens concerned, however, may consider a return to their countries of origin to be inhuman and incompatible with their right to life, if they cannot receive such treatment at home.

The health protection and medical treatment of irregular migrants (including rejectees) is no doubt a very complex issue touching upon legal, medical, ethical, social, financial and humanitarian aspects, which as an issue has hitherto been neglected and which requires a multi- and interdisciplinary approach. The seminar organized in Noordwijkerhout in September 2000, and of which this Handbook is the direct result, was a first, but important step in this direction. This Handbook is, therefore, particularly welcome as it could and should trigger a wider debate on this important issue.

Winter 2001 DR. WILLIBALD PAHR

ACKNOWLEDGEMENTS

This Handbook is the outcome of a fairly long and complicated process which resulted in an expert meeting in which representatives from IOM, ICMH, WHO, ECtHR, Academia, the Executive as well as the medical and legal professions participated, all of whom à titre personnel, in order to launch a multidisciplinary debate on the difficult and sensitive issue of health and return.

The September 2000 Noordwijkerhout meeting was organized by the T.M.C. Asser Institute in close co-operation with the Netherlands IND, the Netherlands Chapter of the Society for International Development – as part of consultative sessions within their international and multidisciplinary project on the future of asylum and migration – and the Röling Foundation. All these organizations deserve proper thanks.

This Handbook is the direct result of the above expert meeting and is meant to provide the necessary material for what promises to be a lengthy debate. Lengthy, as it concerns efforts to cross bridges, to cover gaps, and to ensure communication between disciplines which are not used to meeting, not to mention debating, as they, from time to time, speak completely different languages. Lengthy also, because it involves emotions, ethics and difficult choices.

The Handbook, therefore, is a tool in an important and precious process, and the editor is thankful to the IND for having made the funds available for its publication. Thanks are also due to the excellent and expeditious English language editor Peter Morris, to Charles O. Pannenborg, Jacques de Milliano and Frans Bouwen who all gave invaluable advise, to Willibald Pahr, who once again proved to be an excellent chair and sparring partner, as well as to Ms Sabrina van Miltenburg who greatly assisted in the difficult process of creating a solid structure for this Handbook. Moreover, all the other participants and authors involved are owed thanks for their various contributions.

This Handbook is dedicated to Diederik, Katrien and Sebastiaan who, it is hoped, will not need to roam this world in search of adequate health services. After all, it is about the fish and not about the water. And then again, it may be about the water and not about the fish.

TABLE OF CONTENTS

INTRODUCTION

Peter J. van Krieken

if services have to be provided to all,
then not all services can be provided[1]

GOOD CASES MAKE BAD LAW

This Handbook is about the search for norms. Norms which are needed to solve often intrinsic problems. Of course, when confronted with an emotional, individualized drama, we all tend to look and act the Samaritan, and try and find the ideal solution. If an individual is in need we try to assist, but we often forget that good cases make bad law. And exceptions, particularly in a world of eager lawyers, often do make the law. So the question remains what to do in cases where we know we can help one individual, but would be forced to withdraw if that one individual would be followed by hundreds or thousands of others: charity has its limits, singular acts may have multiple consequences.

The main issue to be addressed in the context of this Handbook is in how far communities which have reached a certain level of economic and social development are obliged to share the fruits of that development with members of a different community.

The issue boils down to the question in how far solidarity amounts to egalitarianism, or, in other words, whether the better off are obliged to share, and/or whether this sharing is without limits, without borders. This issue of 'sharing' has ethical and economic aspects, as it includes elements of (re-)allocation, mechanisms of correction and inklings of correctness. Moreover, the differences between solidarity and charity also need to be emphasized as the latter is a one-way affair, whereas the former includes mutuality, an almost contractual relationship.

Since their inception, virtually all societies have agreed on mechanisms to draw limits to the freedom of man to act according to his very own will: issues like life (thou shall not kill), property (thou shall not steal) and health (washing hands, eating habits, and, maybe, even circumcision) were already subject to rules and regulations of individuals or groups living together in a community. These rules and regulations, although very sympathetic and considerate, were not

[1] WHO Report 2000, p. xiv.

P.J. van Krieken (Ed.), Health, Migration and Return

necessarily based on humanitarianism, but rather on utilitarian, pragmatic needs, mainly based on survival instincts. In order to be effective, and to avoid the legitimacy of the imposed rules, such 'laws' were normally not agreed upon by men, but rather adopted, accepted as 'divine law'.

Ever since, societies have continued to draw lines and to find balances, ensuring survival and workable relationships. 'Law' in fact is nothing more and nothing less than the result of millennium-long efforts to redress what became to be conceived as 'ills', to help the balance shift towards favouring the weak, the poor, the less lucky. This idea can be translated into economic competition, behaviour in traffic, and so on. Law, in short, is a correction mechanism.

One of the corrections, which may be needed to be introduced, relates to the differences in health care, to the inequalities in, on the one hand, providing and, on the other, assuring access to care and cure. It is indeed fully justified to try and address the issue of why in certain regions individuals have a life expectancy of merely 45 years, whereas in others this amounts to over 80. Indeed, in a world that becomes more and more interrelated, we have agreed to a common working towards the improvement of the state of individuals and communities 'through international assistance and co-operation, especially economic and technical.'[2] Yet, whatever the efforts, a truly egalitarian world will and should never be accomplished as it would deny everything for which human beings are unique. There are differences between brothers and sisters, between families, between groups in a community, between communities and, indeed, between countries. It would amount to nothing other than flippancy to deny such differences.

The question nevertheless needs to be answered what to do with the problem of a member from a less fortunate community seeking individual assistance in a more fortunate community. And indeed the world community has agreed that if such an individual were to face persecution were he to be returned to his country of origin, asylum should be granted.

The concept of asylum, however, has been restricted to only very few characteristics. The persecution concerned should be related to race, religion, nationality (i.e. ethnic group), membership of a particular social group or political opinion.[3] This indeed means that – coupled with the very fact that there is as such no right to migration – seeking assistance, support and/or protection for reasons not related to the ones enumerated above, shall not necessarily result in access to other communities and thereby access to the services normally offered in such a community.

The above betrays a human rights approach, and most observers tend to base their contemplation on the issue at stake in this Handbook on indeed that angle. However, as will be shown, on the basis of human rights alone, no solutions can

[2] International Covenant on Economic, Social and Cultural Rights, 1966, Art. 2.1.

[3] See e.g. Universal Declaration of Human Rights (1948), Art. 14.1; Convention Relating to the Status of Refugees (1951), Artt. 1A2 and 33.1.

be found to what is basically a very complex issue, with inroads into various disciplines. A broader approach is needed.

MEMBERS V. NON-MEMBERS?

The above discussions of course deal with developments within societies, among the members of those societies concerned. This becomes the more apparent when modern society is compared with a 'mutual insurance system' which indeed could be considered part and parcel of the post-WWII welfare system. Calculations and budgets, education plans and the planning of fte are all based on a more or less closed system, in which the population of the society concerned are both the decision makers and the potential beneficiaries.

With the surge of migratory movements it becomes obvious that new challenges deserve new answers: are the newcomers automatically included in the 'mutual insurance system', have they immediately become co-decision makers, and are they to be considered fellow beneficiaries, and if so, under which conditions? In those cases the health system as a whole needs to provide additional services and needs to be prepared to do so, both financially and relative to manpower.

In the case of temporary migration (business, students, temporary labour), the financial aspects may be dealt with by the newcomers insuring themselves locally, or through their existing insurances based in the country of origin.

In the case of refugees and others in need of protection (e.g. victims of an ongoing war) the situation may be different. The stakes differ as well for the prospects for temporariness and the financial resources. It may after all concern new, permanent members of the society to which they fled. Most societies either call in help from the outside (e.g. NGOs, like MSF, in the case of developing countries), or allocate additional funds to cater for the medical needs of the newcomers. However, in general the obligations and responsibilities towards refugees have been fairly well defined and indicate that this category should have access on a similar footing as the inhabitants of the country of asylum.

It becomes slightly more complicated in the case of asylum seekers, i.e. persons whose access to the society has not yet been decided upon. It is generally believed that this category should enjoy access to health services, at least to emergency treatment, PHC, MCH et. al.

The stakes rise and the debate becomes more blurred when it concerns 'rejectees', i.e. the category of persons whose application has been rejected upon due process of law. And finally, the web threatens to become intangible, when those 'rejectees' (or, for that matter, newly arrived persons) apply for a residence permit **solely** on health grounds, on the differences between health services in the country of origin and the country where residence is being sought.

The latter group (rejectees) is of some concern. Societies hesitate to take a stand: feelings of sympathy and humanitarianism come into conflict with economic ground rules and the principles of the 'mutual insurance' system. Can access to someone else's system be enforced. And what would a de facto open door policy mean? This is the one topic on which a variance of reactions can and should be expected, reactions which are often dictated by the discipline or intellectual background of the person reacting: the philosopher vs. the politician, the legal expert vs. the economist?

UTILITARIAN V. HUMANITARIAN?

Most nephrologists keep a sharp eye on the issue of kidney transplantation as well as on the availability of dialysis. In some countries patients with renal problems are not necessarily referred to dialysis (not to mention: transplantation) if they have reached the age of, say, 60. In other countries the link between diabetes and renal problems is not sufficiently emphasised, whereby neglecting diabetes may have tremendous consequences. In yet other countries the availability of dialysis is limited because of financial constraints: dialysis after all costs roughly E 50,000 per year per patient, which means that shortages may be possible, again, depending on expectations, concerning referrals and available funds. The issue becomes even more apparent in the case of newly arrived refugees, asylum seekers or rejectees desperately in need of transplantations or dialysis: how is society to react?

An initial reaction tends to be humanitarian, often based on emotion, or emotion translated into moralistic stands or e.g. human rights law. Another one could be utilitarian, whereby results can be reached which need not differ from action based on a humanitarian approach. When it comes to health, this can be illustrated as follows: to ensure health to all, or at least to as many persons as is feasible, may be looked upon from a rights angle, but at the same time, investment in health pays off, as productivity will not be hindered by sick leave, thereby ensuring both a greater economic output, and a greater number of consumers who do not need to use their money for health services.

THE TEACUP STORY

As the story goes, the falling of, say, a teacup from the table on to the floor, with a thousand small pieces of crockery spread all over, normally results in a variety of reactions. It may be shock or sheer pleasure, anger or disinterest. Moreover, the scientist will be interested in the speed of the cup falling, and the chemical composition resulting in the thousand small pieces; the businessman will be interested in selling new cups (and a vacuum cleaner at the same time!), the

lawyer focuses on litigation, damages and the possibility of suing the offender. Someone with a theological background may wonder what the meaning of the fall might have been, and whether this incident had been predestined.

A variety of reactions, as a result of a variety of angles, a variety of disciplines. The same would appear to be true in the case of the difficult question in how far would-be migrants should be admitted or rather turned away. The question becomes more complicated when the would-be migrant turns out to be suffering from an illness. The question whether someone could or should be returned to the country of origin whilst fully aware of the fact that the person is sick and that the health services in the country of origin are significantly below the ones in the country where residence is being sought is hence a difficult one, and deserves to be dealt with in a multidisciplinary manner.

It would appear that the issue has various dimensions, various angles from which to approach the issue: ethics, medicine, theories of justice, economics and legal norms. The following examples relating to society's approach and attitude towards health in general may bring the issue somewhat to light:

– Most societies have, when it comes to the allocation of the national budget, 'fights' as to whether to spend funds on education, infrastructure or e.g. health.

– Within the health budget the allocation (or: rationing) of funds will by itself generate intensive debate on how to spend the funds available. A classical dilemma may be found in the use of health-educational funds (10 barefoot physicians or rather one cardio-vascular specialist) or the health-related utility funds (one sophisticated operation theatre or rather 10 primary health care units).

– Also in developed countries there is often the following heated debate: should the money go to cancerresearch or rather to even more bypasses or, maybe, plastic surgery. Moreover, many deliberations deal with 'national health services' and the issue of insurance and the non-insured.

– The decisions as to which drugs/medicines are to be part of the insurance system are hotly contested, sometimes ending up in the courts.

This in fact shows that the debate as to who is entitled to enjoy the health services that are made available to the population at large is of great relevance.

STRUCTURE

The Structure of this Handbook is hence as follows:

1) Attention needs to be paid to the issue of the right to health. Are there differences between civil, political and social rights? What does the right to health contain, what does it mean, and how should it be interpreted? Does it have a cross-border impact, and what legal texts are available? In this Chapter One the full text of the General Comment on this topic as issued by the Committee under the Covenant on Economic, Social and Cultural Rights has, of course, been fully included.

2) The General Comment on health refers to the WHO Essential Drugs List. That would mean that the medical profession and health economists should be considered of relevance to the discussion on health and return. And that is why Chapter Two deals with health per se, and the standard-setting in this realm in particular. The WHO report 2000 has been scrutinized, and is believed to be of use for all the disciplines involved, a survey of the various diseases has been provided, as well as the relevant opinion of Jeffrey Sachs, the Harvard-based uttermost expert and visionary in this field. The Essential Drugs List has of course been included, together with an expert opinion on the relevance of this list. Finally, an old hand has given some insight into the 'inclusion' issues in daily practice in the Third World: it proves that each and every society, each and every community, in view of the very fact that more is possible on the technical level than financially having to draw a line, has to make decisions as to what services can be feasibly provided. It is hoped that acronyms like DALE and QALY will become familiar in non-health economics as well. Only very few appreciate that also in developed countries there is a limit to the medical services which can be made available, as recent debates on the availability of anti-cholesterol drugs have shown: drugs which have a tremendous positive impact, but which are simply considered to be far too costly.

3) The Third Chapter deals with probably the most important question of this Handbook: when and how is a society obliged to say 'yes' to an application submitted by a relative outsider, and when could or should a community say 'no' in spite of the emotional aspects involved. This aspect is probably crucial to the debate at stake, and it is hence remarkable that the experts, some from academia, others from 'the field', appear to agree on the possibilities in this very field. In fact, and this has been duly reproduced in the 'Noordwijkerhout First Steps', a community may indeed say 'no' to a request for social services submitted by someone who is neither a member of that community nor has financially contributed to the insurance system involved.

4) Chapter Four takes us back to the Human Rights debate, this time on the right to migration (quod non), the obligation to return if an application for whatever residence permit has been rejected upon due process of law, the status of foreigners both those lawfully residing and those unlawfully residing, as well as the need to take the health issue into the realm of the general migration debate. Legal texts have been provided from a great variety of sources, and, of course, the two relevant General Comments on this subject as issued by the Human Rights Committee, the committee under the 1966 Covenant on Civil and Political Rights have been duly included as they provide a true insight into the state of thinking on this subject.

5) Health and Migration have a variety of links and relationships, which is the subject of Chapter Five. Health can be a hindrance to migration, particularly in the case of formal migration under which certificates confirming good health are a prerequisite in order to be allowed to immigrate. This check has two aims: the

country of immigration would rather not be forced to see its new arrivals becoming a burden on the social security level, and secondly to prevent certain diseases from spreading among the population of the country of immigration. Within this realm it is of relevance to note that new findings appear to indicate that screening no longer prevents the illnesses and diseases from entering other countries: new mobility patterns underline that diseases that until recently were believed to have either been eradicated (TB) or limited to the Third World (Malaria) have now become part and parcel of GP practices.

Similarly, health conditions may prevent would-be passengers from boarding a plane. It is a recognized practice that passengers with an infectious disease are not allowed to travel. ICAO and/or IATA rules clearly confirm this practice, and it is not difficult to subscribe to its usefulness and logic.

Yet, health may be the exact reason for travelling as the search for a better cure and/or care may indulge migratory movements. Health gaps are now being considered as one of the determinants for such movements, not only within countries but increasingly cross-border.

In this respect the question needs to be asked whether indeed the health services in the country of arrival have a greater chance to cure the patient than services, albeit on a different level, in the country of origin. It is argued that in a great many cases, in particular where it concerns Post Traumatic Stress Disorders or Syndromes, cure may be more readily brought about in the country of origin as the home environment, the presence of peers, being among persons who have had similar traumatic experiences, and also because of the availability of traditional healing practices may be of paramount importance (apart from language and other cultural aspects).

Finally, this chapter also deals with the impact of population mobility on health in general terms, as well with the health aspects of return in the immigration context, aspects which are central to the debate.

6) With the above in mind: the WHO norms, the ethics involved, the various relationships between health and migration, as well as the human rights debates on the right to health and the right to migration, it is a logical next step to focus on legal practice. Chapter Six deals *in extenso* with the case law of the Strasbourg-based European Court of Human Rights. In no less than seven cases (both the Court and the Commission) health aspects have played a role. Introductions to the relevance of Strasbourg case law have been provided and due attention has been paid to the cases themselves, of great importance to all involved in this debate, as it clearly shows that the legal profession (in this case the Strasbourg judges) appears to have embarked on drawing lines, on setting landmarks which are principled, realistic and pragmatic.

Yet, as is shown in the final chapter, the actual practice on the ground does not yet fully use the parameters as provided by the Strasbourg institutions. Most executive bodies, most decision makers use yardsticks which are not necessarily in conformity with would be logic as regards to what not only Strasbourg

indicates, but also with what the other disciplines would indicate (the medical profession, the health economists, the experts on ethics).

Hence the need for information gathering, the exchange of information, the creation of data-banks, but above all the need for looking over the fences surrounding one's own discipline.

SCYLLA AND CHARIBDIS

The Russian composer Dmitri Smirnov, born in 1948 in Minsk (now Belarus), and living in St. Albans near London, recently completed his 'Between Scylla and Charibdis' . He explains that for him these Monsters represent Morality, Politics, Philosophy and 'other dangers in our lives'.

The question, of course, needs to be asked in how far morality, politics and philosophy may be considered 'dangers in our lives': these fields of thoughts and study can after all assist us in tackling difficult questions, dilemmas or paradoxes, similarly as multidisciplinary approaches may have added value. However, it may at the same time be obvious that the mere invitation of these Scyllas and Charibdes may create unwanted complications: the philosopher may wholeheartedly disagree with the politician or the moralist, the legal expert may not wish to know what an economist might submit on a certain subject, and the surgeon turns around once the philosopher starts to speak.

Yet, in order to find solutions to the intrinsically difficult issue of health, migration and return, a unilateral approach, based on legal principles or, say, health economics alone, is bound to fail. Only a combined effort may yield some results, and this indeed involves a multidisciplinary, holistic approach. The Noordwijkerhout expert meeting was proof of such a starting point. This Handbook is not meant to provide definitive answers, nor does it claim to be complete. Its only aim is to trigger debate, and to provide the material on which such a debate could, or maybe should, be based.

MULTIDISCIPLINARY EXPERT MEETING

'The Noordwijkerhout First Steps'

1) There is a relationship between health and international population mobility (migration); it requires particular attention, study and analysis.
Such analysis has to take into account the necessity of a comprehensive migration policy including not only all different forms of migration (regular and irregular as well as refugee flows), but also the health element.

2) It is ethically defensible to give priority on health matters to members of one's own community. This could be argued from a communitarian ethical perspective (as opposed to the universal/liberal perspective),
and from a consequences-oriented approach (as opposed to the ethics of principles). Of relevance is also the impact of proximity.

3) Most national health systems are not based as such on ('real') solidarity but rather on common proper interests, resulting in a mutual insurance model, i.e. a closed system.
Attention should be paid to the shape of the present system that already now appears to be overloaded (e.g. waiting lists). Therefore this system may absorb a few irregular (non-funded) cases but not too many.

4) There is a difference between solidarity and charity. The latter makes recipients dependent and includes the notion of providing handouts to those who in principle have no right to it. Solidarity indicates that there is an element of sharing and reciprocity and contains notions of duty, responsibility and rights/real claims.
Charity for an individual may result in the breakdown of solidarity for an entire group.
The state needs to take its political responsibility seriously so that the General Practitioner can exercise his/her own responsibility, thereby avoiding existing tensions in this field.

5) Global responsibilities towards attaining social and economic rights exist and deserve to be emphasized. As to the issue of adequate health care, it could be submitted that it is acceptable to focus on improving general health conditions in a third country at the cost of denying care/cure to a third country national.

P.J. van Krieken (Ed.), Health, Migration and Return

In view of the limited means available there is a need for a balance between public and individual interests. This could be linked to communitarian ethics, consequence ethics and the argument of cost effectiveness.
Moreover, in certain countries expensive individual cure/care interventions are budgeted development expenses. As such these funds are unwisely spent from a development point of view as they cure/care (for) an individual but do not contribute to development.

6) All societies are free to decide what health services should or, as the case may be, are being made available and at what cost, albeit within the parameters set by e.g. the ICESCR, General Comment no. 14 in particular.
Obligations, if any, do not prevent differences between various health systems.
Health needs are contextually determined.
This includes responsibility for making choices on national drugs lists, treatment protocols and other medical services, e.g. on the basis of cost effectiveness (cost/benefit analysis).

7) There is a need to emphasize that even in so-called affluent societies there are limits to the level of health services available.

8) International norms (PHC, basic health services, essential drugs list) can be determined with regard to a country's obligation/responsibility. Intention, good allocation of resources, and progress within given means are some of the criteria involved, as well as (a) access, (b) selection, (c) affordability, (d) sustainable financing, and (e) delivery systems.
There are no absolute standards of health care services.

9) Migrants, in particular forced migrants (refugees, IDPs, etc.), are particularly vulnerable to mental illnesses (e.g. PTSD and PTSS). These diseases can be more effectively prevented and treated in their region/country of origin.

10) The indivisibility of first and of second generation human rights deserves to be stressed. However, there are differences e.g. the supervision mechanisms.
It is not to be excluded that in due time a Special Rapporteur on the right to health will be appointed under the auspices of the (UN) Commission on Human Rights.

11) Provisions of the European Convention on Human Rights (ECHR), in particular article 3 and to some extent articles 2, 8 and 14 are of relevance for the protection of health for migrants. The Court's Jurisdiction (e.g. D v. UK) and the Commission Decisions on Admissibility (Karara v. Finland and SCC v. Sweden) are equally relevant.

12) The ICESCR Art. 12 in conjunction with General Comment no. 14 can be considered the main determinants in the context of health and migration. The General Comment has laid down minimum obligations and refers to [systematic] violations (which may have an - in particular political – cross-border impact). The 'State' referred to in para. 39 of this GC is the State of origin, and not the State of destination (which also follows from the Human Rights Committee's General Comment 27 on freedom of movement).

13) Finally, it has to be noted that there are special regulations concerning the protection of health for certain categories of migrants such as refugees or foreign workers and that first aid in cases of emergency should not be refused.