

Health care provision for illegal migrants: may health policy make a difference?

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Illegal migrants in Europe are, generally, only entitled to emergency care and services for children and pregnant women. In 2002 legal changes in Spain made accessible medical cards and free medical care for illegal migrants in similar terms than the legal migrants or the Spanish population. We interviewed 380 migrants to assess whether there were differences on health services utilization by legal status. We did not find differences in the utilization of health services when ill between legal and illegal migrants. However, a significantly lower utilization of health services was associated with less education (RP = 0.4; 95% CI: 0.2–0.9).

Keywords: Access to health care, Equatorian migrants, health services utilization, illegal migrants, Spain

Introduction

National health systems of European societies have been under pressure in recent years to respond to two parallel issues: tackling health care needs of increasingly multicultural and multiethnic societies and providing health care to persons who are not legally entitled to receive it, namely illegal migrants. Legal migrants are entitled to use health services in equal terms than the host country population, but in spite of their poorer health they do not always use health services accordingly.^{1,2} Nonetheless, health care for illegal immigrants is an issue of even greater concern and debate in Europe and elsewhere.^{3,4} Illegal migrants are, generally speaking, not entitled to receive public health care, being exceptions to this rule emergency care and services for children and pregnant women.⁵ Unsurprisingly, utilization of health services in cases of need appears to be lower in illegal than in legal migrants.^{6,7} Lack of access to health services in cases of need may be questioned on the basis of ethical as well as public health grounds.⁵ It is unclear, however, whether improving access to health care increase utilization in illegal migrants, as lower utilization of health services might still occur in illegal migrants as a result of fear, discrimination or poor integration in the host country. In 2002 legal changes in Spain made feasible for illegal immigrants to receive medical cards and free medical care in equal terms than the legal migrants. The objective of this study was to assess whether sick legal and illegal migrants are now using health services with similar frequency irrespective of their legal status. This article is a follow-up of a previous work conducted in Madrid in 1997 using similar methodology.⁷

Methods

A cross-sectional study was conducted in a District of the City of Madrid targeting Equatorian migrants, older than 15 years of age, who had lived in Spain for more than 3 months and resided in the study District. Madrid host about one-third of

the migrants in Spain, and Equatorians are currently the largest national group of migrants in Spain. Intercept interviews were conducted during the first semester of 2005, from early in the morning to late at night. Eligible subjects were approached in the streets and health services and their immediate surroundings were specifically excluded as potential places for recruitment. Two trained surveyors conducted data collection. In total, 380 Equatorian migrants were interviewed. Persons who reported having ever been ill in Spain were asked whether they sought medical care for their last episode of illness. Administrative legal status was ascertained by one open question: ‘what is your current administrative status in Spain?’ Illegal status was defined as a person who did not have a valid residency permit. Analyses were conducted in SPSS.

Results

In total, 226 persons reported having ever been ill in Spain, and 86% had used medical services the last time they were ill. No differences were observed in the utilization of health services between legal or illegal migrants in the univariate analyses (table 1). There were no differences in the utilization of health services between legal or illegal migrants when stratified by sex, education, living conditions, problems with health services or self-perceived health status (table 2). However, 12 or more years of schooling, having University education, having lived in Spain for five or more years, and having a stable contract as compared to a temporal or no work contract, were all associated with higher utilization of health services (table 1). In the multivariate analyses, having completed primary education or less was associated with lower utilization of health services (RP = 0.4; 95% CI: 0.2–0.9).

Discussion

We did not find significant differences in the utilization of health services between legal and illegal Equatorian migrants. Our study suggests that once legal barriers to access health services are removed others issues (such as education level, fear to lose once job, or job instability, among others) may become more relevant, as has been reported for Dutch first generation migrants.⁸ Although utilization of health services was fairly common in both groups, and were used by 82% of the sick illegal migrants in this study, difficulties to use health services were also reported by about one-quarter of interviewees, ranging from administrative issues to discrimination or denial

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Table 1 Utilization of health services by migrants who had ever been sick in Spain, the last time they reported being ill

	The last time ill				Prevalence rates
	Sought medical care		Did not seek medical care		
Sex					
Male	84	(85)	15	(15)	1.0 (0.9 – 1.1)
Female	111	(87)	16	(16)	
Administrative status					
Legal	108	(90)	12	(10)	1.1 (1.0 – 1.2)
Illegal	87	(82)	19	(18)	
Education					
University studies	31	(97)	1	(3)	1
Secondary school	76	(89)	9	(11)	0.9 (0.8 – 1.0)
Primary or no schooling	87	(81)	21	(19)	0.8 (0.7 – 0.9)
Years of schooling					
<12 years	82	(82)	18	(18)	0.9 (0.8 – 1.0)
12 or more	109	(89)	13	(11)	
Lives with family					
Yes	158	(85)	27	(15)	1.0 (0.8 – 1.1)
No	33	(89)	4	(11)	
Self perceived health status					
Regular	85	(87)	13	(13)	1.0 (0.9 – 1.1)
Good	106	(86)	18	(14)	
Problems with health services					
Yes	49	(88)	7	(12)	0.9 (0.4 – 2.3)
No	145	(88)	19	(12)	
Ever denied medical care					
Yes	11	(85)	2	(15)	0.8 (0.2 – 3.6)
No	180	(88)	25	(12)	
Years living in Spain					
>5 years	147	(84)	28	(16)	0.9(0.8 – 0.99)
	44	(94)	3	(6)	
Type of contract					
Fixed contract	27	(100)	0	(0)	1
Temporal	49	(86)	8	(14)	0.86 (0.77 – 0.95)
Eventual	78	(80)	19	(20)	0.80 (0.73 – 0.89)

The first category of each variable has always been used as the reference category in the calculation of the prevalence rates.

Table 2 Care seeking practice in health services by migrants who had ever been sick in Spain the last time they reported being ill by legal status

	The last time ill				Prevalence rates
	Sought medical care		Did not seek medical care		
	Legal <i>n</i>	Illegal <i>n</i>	Legal <i>n</i>	Illegal <i>n</i>	
Sex					
Male	51	33	6	9	2.3 (0.8 – 7.1)
Female	57	54	6	10	1.8 (0.6 – 5.1)
Education					
University studies or secondary education	68	39	5	5	1.7 (0.5 – 6.4)
Primary or no schooling	49	48	7	11	1.7 (0.6 – 4.5)
Years of schooling					
<12 years	36	46	7	11	1.2 (0.4 – 3.5)
12 or more	69	40	5	8	2.8 (0.8 – 9)
Lives with family					
Yes	90	68	10	17	2.6 (1 – 5.2)
No	15	18	2	2	0.8 (0.1 – 6.6)
Self perceived health status					
Regular or poor	43	42	5	8	1.6 (0.5 – 5.4)
Good	62	44	7	11	2.2 (0.8 – 6.1)
Problems with health services					
Yes	28	21	3	4	1.8 (0.4 – 8.8)
No	76	65	9	12	1.6 (0.6 – 3.9)
Ever denied medical care					
Yes	6	4	1	1	1.5 (0.1 – 31)
No	98	80	11	15	1.7 (0.7 – 3.8)
Years living in Spain					
<5 years	66	84	9	19	1.7 (0.7 – 3.9)
>5 years	42	3	3	0	1 (0.9 – 1.1)
Type of contract					
Fixed or eventual contract	71	11	8	1	0.8 (0.1 – 7.1)
No contract	37	76	4	18	2.2 (0.7 – 6.9)

of medical assistance, but no differences were found in those reports between the two groups.

Migrants were asked about their legal status in the streets and concerns may be raised about the validity of their answers. Pilot studies conducted in 2004 showed that answers were reliable and consistent and that migrants had no special difficulties with these items. The fact that more than 40% of the sample declared that they were illegal is also consistent with the estimations that were made at the time of the survey about the magnitude of illegal migration in Madrid. The main limitations of our study are possible differential recall by legal and illegal migrants, the cross-sectional design and possible selection bias in the selection of the sample of migrants. Differential recall of illnesses might have occurred if illegal migrants tended to recall only more severe episodes of illness, but there were no differences in the causes of illness reported in the two groups. The cross-sectional design might have induced some misclassification as legal status was ascertained at the time of the interview and it might have been different when the illness occurred. However, the utilization of health services is sufficiently high to exclude that this bias, if present, might be important in this case. Finally, people who spent more time on the street looking for a job or just walking were more likely to have been selected. However, it is unlikely that those differences might account for the similarities in the utilization of health services that we find in the study.

Practically all migrants (except two) knew that they were entitled to medical cards, and all (except six) had medical cards. We did not specifically ask about how they knew about the new legislation. However, when asked about their knowledge of NGOs or local migrant associations only 53% had ever visited one, and only 51% could recall the name of at least one NGO or association. Therefore, we may speculate that friends, other migrants or peers might have been the most likely sources of information.

A study conducted in Madrid in the late 90s, using similar instruments and methodology found that illegal migrants were using significantly less health services than legal ones.⁷ Providing access to medical cards does not guarantee utilization of health services and it cannot be concluded that barriers have been eliminated through those legal changes, as has been clearly shown in other studies.⁸ Nonetheless, the finding that illegal migrants use health services when ill with similar frequency than other migrants is encouraging, as it suggests that significantly positive improvements can be made once legal barriers are removed, and therefore, public health policies may have a positive impact in reducing health inequalities.

Our study design does not allow us to know whether all health care that might have been needed was indeed used by either group of migrants. Further research is needed to address whether health services are similarly used in severe as well as in less severe cases of illness, by legal and illegal migrants, or whether, in fact, there is an underutilization of health services in some specific illnesses, such as mental diseases in illegal migrants.

Our study also raise a relevant policy research question: why was that legislation approved in Spain? Or, what factors made possible the legal changes that guaranteed access to medical care for illegal migrants? We may speculate that a partial answer may be found in the social mobilization and political

climate created around that issue by NGOs, opposition parties and Unions. But why that may have happened in Spain, a country where work migration is a relatively new phenomenon, and not in other European countries undoubtedly deserves further attention.

What this paper adds

This study suggests that when access is provided and is available for all migrants having illegal status may not be an additional limiting factor to health services utilization in cases of need.

Policy implications

Policy changes that remove barriers to health services and improve health care access for illegal migrants may be effective to increase health care utilization by illegal migrants.

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Key points

- providing access to medical cards for illegal migrants in similar terms than legal ones removes barriers to the utilization of health services in cases of need
- once administrative barriers to health care access are removed working status or level of education become the main limiting factor to health care utilization in cases of need
- policy decision may have a short term positive impact in the utilization of health services of underserved migrant populations

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