PARALLEL REPORT TO THE CESCR

ON THE RIGHT TO HEALTH FOR NON-NATIONALS

On the 6th Periodic Report of the : Federal Republic of Germany on the implementation of the International Covenant on Economic, Social and Cultural Rights

Prepared for the Committee on Economic, Social and Cultural Rights, 64th session

Submitted July 2018

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INTRODUCTION

The Federal Republic of Germany has signed numerous international treaties that recognize a guaranteed right to health and non-discriminatory access to healthcare for all.

Overall, Germany has a highly developed healthcare system. Healthcare is, however, expensive and most people cannot afford to pay for their health care out-of-pocket. The majority of the population is covered by statutory or private health insurance; some groups receive coverage through the social services department. Not to be covered by one of these mechanisms means in effect not to have access to affordable healthcare.

In the 6th Periodic Report to the committee on Economic, Social and Cultural rights, the German government states: “People in Germany can rely on a high-quality system of medical care.”

Several groups of people in Germany are, however, by law or in practice excluded from effective coverage mechanisms and, thus, do not have adequate and non-discriminatory access to health care. To reduce need, civil society and welfare organizations provide health care and social services for many of those excluded from health coverage in Germany.[1]

More than 30 civil society organizations submitted a list of issues to the CESCR in 2017 highlighting the barriers to healthcare for non-nationals in Germany. In its list of issues in relation to the 6th Periodic report of Germany, the CESCR asks:

"Please provide information on the specific efforts made by the State party to ensure that the citizens of EU member states who do not benefit from the European Convention on Social and Medical Assistance, asylum-seekers and migrants without regular status have access to adequate and affordable healthcare services. In particular, please indicate the measures taken or envisaged to ensure that migrants without regular status access healthcare services without having their status reported to immigration authorities in accordance with Section 87(2) of the Resident Act."

While the belief in a functioning social security and health care system is generally high in Germany, civil society and welfare organizations as well as researchers are increasingly pinpointing the fact that many people remain excluded. A broad coalition of 25 civil society and welfare organizations (including Deutsche AIDS Hilfe, Amnesty International, Diakonie Deutschland, Paritätischer Gesamtverband, medico international, Médecins du Monde/Doctors of the World) thus joined up for a rally for the right to health at the Brandenburg Gate in Berlin on March 20th, 2018, which was covered in various media reports.[2] 15 organizations also co-signed a letter to minister of health Jens Spahn in May 2018 on universal health care coverage in Germany[3].

The following information on limitations in access for EU citizens, asylum seekers and undocumented migrants is based on the data collection of civil society and welfare organizations, official statistics and research results.

While this report focuses on three groups of non-nationals, it has to be highlighted that many Germans also do not have access to health insurance coverage and that many other migrants face barriers as well. Besides legal and financial restrictions depicted below, language barriers limit access for many migrants: Interpretation services essential for an adequate communication between non-German-speaking patients and health care professionals are not covered by the statutory health insurance.

While specific policy proposals for the sub-groups are explicated in each chapter, the following recommendations for German government are overarching:

- Develop a federal strategy and an action plan to ensure non-discriminatory access to healthcare
- Revise any existing legal restrictions that limit equal access for all persons to preventive, curative and palliative health care.
- Monitor inequalities in health and healthcare access.
- Ensure sufficient availability and financing of translation services needed for adequate communication between patients and healthcare professionals.

EU CITIZENS

In 2016, 4,275 million citizens from other countries of the European Union lived in Germany, most of them coming from Poland (783.061), Italy (611.379) and Romania (533.539).[4] While the majority is insured through a regular job or through a working family member, people without regular employment face serious difficulties in accessing healthcare coverage and other social protection. Those who cannot provide proof that they have been insured in their country of origin are usually not accepted as members by the health insurance companies.

a) Legal developments and status quo

A new law passed in December 2016 has worsened the situation of several groups of EU citizens. In the year before, German social courts had ruled in several cases that EU citizens should receive social services after a 6-months residency in Germany. Countering these rulings, the law of 22.12.2016[5] excludes EU migrants from social protection services, including basic health care coverage, if they have been regular residents of Germany for less than five years, have no right of residence or their right of residence results solely from the purpose of finding work or from Article 10 of the EU Regulation No. 492/2011[6]. For these groups, only so-called "bridging benefits" are provided for a maximum of one month and only once within two years. These benefits include basic health services required for the treatment of acute illnesses and pain. After receiving these reduced benefits for one month, the affected groups of EU migrants have no entitlement to the coverage of any – even emergency – health care services within the next 23 months in Germany. Hospitals and other providers are thus reluctant to offer care which is not refunded.

Beyond access to health care, the law seriously impedes the living conditions of many EU citizens, because the newly excluded groups do not have access to homeless shelters, domestic assault shelters or other social welfare services. It pushes people into precarious working and living conditions.

The law thus presents a retrogression compared to the previous situation.

b) Scope of the problem

There is no official statistic on access to social services, including health care, by EU migrants in Germany. The lack of accurate statistics on access and non-access to healthcare is not in line with core obligations outlined in General comment 14[7] of the right to health which requires that adequate statistics are collected by national states to monitor inequalities in health and healthcare access.

The following data from social counselling and health service providers can show that unemployed EU citizens are among the main groups depending on voluntary structures for basic health care.

Eight organizations offering medical care for homeless people without access to the regular health system in Berlin have collected data on the nationality of their clients. Of 4978 homeless clients in 2016, 2295 (46,1%) were from other countries of the EU.[8]

The Malteser Order is offering healthcare for people without health insurance in 19 cities throughout Germany and has collected basic data on its patient profiles. In 2017, of more than 6000 patients without health insurance coming to the clinics for medical care, about half came from EU countries.

In the federal state of North Rhine-Westphalia, so-called "clearing houses" for people without health insurance were established as a pilot in five cities to provide advice and support on (re-)integration into the health insurance system. Of the 3797 contacts between May and December 2017, 82% were with EU citizens.

The German section of Médecins du Monde/Doctors of the World is offering health care for people with restricted or no access to the healthcare system in four cities in Germany. Overall, more than 2000 patients came to the clinics in 2017. EU citizens, mostly from Romania and Bulgaria, constituted the biggest group among the 1215 new clients in 2017. They are more often than other patients affected by homelessness and face the most complex bureaucratic regulations.

Table 1: Characteristics of new clients with EU citizenship (except Germans) in 2017 in MdM clinics

Clinic location	Male		Female		Under 18		Homeless		No healthcare coverage		Total
	Abs.	%	Abs.	%	Abs	%	Abs.	%	Abs.	%	
Munich	107	54	90	46	19	9,6	72	36	157	80	197
Berlin	23	65	13	35	20	56,7	1	2,7	34	94	36
Hamburg	66	38	107	62	29	17	17	10	130	75	173
Stuttgart	120	62	73	38	29	15	148	77	137	71	193
Total	316	53	283	47	97	16	238	40	458	76	599

Individual consequences

When EU citizens without health insurance go to a doctor or clinic, they will be asked to either sign that they will cover the cost individually or to provide proof that the social service department will. For many, signing the payment commitment means that they become heavily indebted. In cases of emergency, the hospitals will treat a person, but discharge them early without the necessary follow-up treatment.

In order to receive the "bridging benefits", the person has to fill out an application form. In many districts this involves the obligatory statement that the person plans to leave the country. In addition to the legal restrictions in access, discrimination, language barriers and lack of knowledge of the administrative procedures on both sides further impede access to healthcare.

> Mr. C. is a 47-year-old EU citizen without income, living on the streets in Germany. He lived in North-America for 27 years, where he worked as a bar manager. He came to Germany in 2016. He does not have a health insurance in Europe and has lost proof of his insurance in North-America. In November 2017 he came to the Médecins du Monde/Doctors of the World clinic because he suffered serious vision impairments and had been rejected in other doctor's offices. MdM arranged an appointment with an ophthalmologist and a radiologist, who both agreed to treat him without reimbursement. In February 2018, the MRT showed a life-threatening brain tumor which required immediate surgery. However, the hospital wanted proof that the costs would be covered, either by Mr. C. himself or by the social service department. In March 2018, MdM contacted the responsible social service department, describing the acute need for surgery and requesting coverage of hospital costs. However, for two weeks there was no answer from the social service department. Only after MdM announced to use legal measures the social service department agreed to take over the cost. The surgery was successful and Mr. C. regained his vision.

c) Reactions

The exclusion of some EU citizens from social services, including healthcare, with the new law of December 2016 has led to critical reactions from many stakeholders.

- In the public hearing of the parliamentary committee on Labor and Social Affairs of the German Bundestag, two major welfare organizations (*Diakonie Deutschland* and *Paritätischer Gesamtverband*) have criticized the law for hindering integration, pushing people into precarious working conditions and for not being in conformity with the constitution.[9]
- The *Neue Richtervereinigung*, an association of judges and state attorneys, has criticized the new law for excluding EU citizens, including those that are legally residing in Germany from social services. It has highlighted that the law is primarily affecting Roma from Bulgaria and Romania. The association has also pointed to the fact that

people will accept harsh working conditions if losing their job means losing any kind of social security and stated: “the regulation creates a group of modern slaves”. [10]

- 37 welfare and civil society organizations have signed a letter to the Federal minister of Labor and Social Affairs, Hubertus Heil, describing the consequences of excluding EU citizens from healthcare and requesting a change in the regulation to the effect that access to basic health care is provided to EU citizens residing in Germany.[11]
- Die Linke, an opposition party in the German Bundestag, has filed a parliamentary inquiry on the exclusion of EU citizens from healthcare in Germany (18/13430).[12] The government reacted, writing inter alia that in individual cases healthcare can be covered if special circumstances exist. There is, however, no entitlement to this and individual case decisions often take long. The German government was not able to provide numbers of how many people are affected by the new regulation. Also, it referred to the possibility of those affected to receive healthcare in their countries of origin.[13]

d) Recommendations

The signatories ask the Committee to call upon the government of Germany to

- Revise the current legislation in order to enable access to adequate health care coverage for EU citizens without discrimination
- Provide “clearing houses” for people without healthcare coverage on options for (re-) integration into the healthcare system.

ASYLUM SEEKERS

a) Legal developments and status quo

For the first 15 months of their stay in Germany, the entitlement of asylum seekers to healthcare is by law restricted to acute and painful conditions (Act on Benefits for Asylum Applicants, ABAA section 4(1)) and can be extended to other essential healthcare services (§6 ABAA) only by often complicated and lengthy individual case decisions. There is, however, no explicit catalogue defining what these essential healthcare services include, and there is no entitlement to receive the optimal level of care needed[14]. No legal restrictions exist for healthcare services related to pregnancy and childbirth (ABAA section 4(2)), vaccinations and medically required preventive services (ABAA §4(1)), e.g. related to preventive check-up examinations for children. Unaccompanied minors fall under Social Code Book VIII, which grants full access to health care, while children in asylum-seeking families fall under the restrictions of the ABAA. Depending on their place of residence, asylum seekers need to obtain a voucher to access healthcare. Some, but not all, states have introduced an electronic health card (EHC) for asylum seekers, and only the EHCs in the smallest federal states (Bremen and Hamburg) reduce the entitlement restrictions[15].

While the state party considers the level of healthcare granted under the ABAA as "appropriate" in its 6th Periodic Report (p. 10), the restricted entitlements are considerably lower than the catalogue of minimum services of the statutory health insurance[16] which the law defines as sufficient, adequate and according to the scientific state of the art.

After 15 months (ABAA section 2), asylum seekers may be granted full access to healthcare services equivalent to the level provided to the general population in need of welfare services under Social Code Book XII. The full entitlement to healthcare services, however, can be withdrawn or denied if asylum seekers themselves extended their stay "unlawfully" (ABAA section 2). The legal practice regards an unlawful extension of the duration of stay as given when asylum seekers report a false nationality, do not mention having had another nationality, do not provide (accurate) information on their identity or ethnicity, or are repeated applicants for asylum and have re-immigrated[17]. Further reasons to deny regular access to healthcare services are if an asylum application has been filed to avoid deportation and if the asylum application was rejected and the person has an immediate obligation to leave the country[18]. The withdrawal or denial of full entitlements to health care is thus, as also noted by the scientific department of the German Parliament, a mechanism to impose "sanctions" during the asylum procedure[19].

The period of time during which asylum seekers are entitled to limited healthcare has been substantially reduced in March 2015 from 48 to 15 months. However, this period of time is arbitrarily chosen, is not based on individual need, and is still longer than in the years 1994-1996 when the period was 12 months[20]. Before the introduction of the ABAA, no such restrictions existed for asylum seekers based on their residence status[21]. Compared to the pre-1990s and the period between 1994 and1996, the current legal situation constitutes a retrogression.

With the introduction of the new Asylum Law (*Asylgesetz*), which came into force on 20th October 2015, authorities are allowed to retain asylum seekers up-to 6 months in state-level reception centers before transferring them to accommodation centers in districts and communes (section 47 Asylum Law)[22]. The maximum duration of stay in reception centers was 3 months before this reform. Furthermore, asylum seekers from presumed "safe countries of origin" (currently: Albania, Bosnia and Herzegovina, Ghana, Kosovo, Macedonia, Montenegro, Senegal and Serbia[23]) are now obliged to remain in reception centers during the whole asylum procedure, or in case of a rejected application until they voluntarily return or are deported[24]. Their entitlements to healthcare may remain restricted throughout if their asylum application is regarded as unjustified by the authorities.

According to Article 21 of the European Union Directive 2013/33/EU, Germany is obliged to ensure that the special needs of vulnerable asylum seekers, i.e. "minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation" [25]must be identified upon reception and addressed. As a conclusion and in order to effectively implement this obligation, EU Members States must lay down their own procedures to identify them[26]. The recent human rights report by the German Institute of Human Rights shows that the situation in German reception centres does not comply with the EU directive requirements as no standard procedure is in place to identify special needs[27]. Even if special needs are identified, it is not guaranteed that these can be addressed adequately based on individual need due to the restrictions of the ABAA[28]. In other words: special needs do not automatically entitle asylum seekers to needed healthcare services under section 6 of the ABAA, as case decisions are still made based on residence status and the presumed probability of a justified and successful asylum application.

b) Scope of the problem

Germany has received 1.4 million first-time asylum applications between January 2015 and April 2018[29]. According to the latest figures of the Statistics of the ABAA (which lag behind the statistics of asylum applications), a total of 728,239 asylum seekers were subject to the ABAA at the end of the year 2016. Of these, 23,617 were obliged to immediately leave the country due to a negative decision on their application. A total of 567,401 individuals were entitled to services according to sections 4 and 6 ABAA, and a total of 160,838 asylum seekers were granted full access to health services according to the Social Code Book XII at the end of the year 2016[30]). This relates to a ratio of 3.5, i.e. on each asylum seeker with full entitlements to healthcare services, there were in average 3.5 asylum seekers with restricted entitlements to such services.

The average duration of an asylum procedure according to data of the Federal Office for Migration and Refugees as of June 2017 was 11.7 months, with substantial variation between countries of origin, ranging from 7.8 months for Syrians to 17.2 months for applicants from the Democratic Republic of Kongo[31]. An average of 4.5 months may additionally pass between

entering the country and until a formal application for asylum can be submitted[32]. Furthermore, with the increase of on-site decisions in reception centers, asylum seekers increasingly appeal against negative decisions on their application and enter lengthy lawsuits. At the end of September 2017, about 273,000 lawsuits were filed against negative decisions. Of these, 44% were successful in showing that the accelerated decisions were inappropriate[33].

No accurate statistics exist on the number of asylum seekers with special needs, and there is no data on the number of negative case decisions taken by local authorities on healthcare applications for asylum seekers during the first 15 months of their stay. Non-access to healthcare thus remains widely hidden, but is reported from the daily experience of healthcare professionals in the field[34]. The lack of accurate statistics on access and non-access to healthcare is not in line with core obligations outlined in General comment 14[35] of the right to health (Article 12 of the International Covenant on Economic, Social and Cultural Rights, ICESCR), which requires that states collect adequate statistics to monitor inequalities in health and healthcare access[36].

c) Individual consequences

The legal regulations have substantial consequences for asylum seekers' access to health care. Especially those with special needs and chronic conditions are likely to suffer from the restrictive regulations, resulting in lengthy bureaucratic procedures for decisions on case-based applications and on whether access is granted to necessary diagnostic measures or medical treatment. The legal restrictions clearly violate the principle of non-discrimination operationalized in General Comment 14 on the right to health (enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights, ICESCR), which declares that states should "[..] refrain 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; [and]abstain from enforcing discriminatory practices as a State policy [..]"[37]

The voucher model of accessing healthcare, which is still practiced in many federal states despite the effective and appropriate EHC model[38], violates the principle of non-discrimination in physical access to care. The heterogeneous implementation of the EHC leads to inequalities in access to health care among asylum seekers depending on their allocated place of residence, thus making non-discriminatory physical access to health care a matter of chance[39]. Despite the improved legal situation that allows states and communes to introduce EHCs, many communes and states decided not do so because some sickness funds request higher administrative costs than for the regular population in need of welfare services. The legal framework thus proves as insufficient to effectively foster a nation-wide introduction of EHCs[40]. Amendments are needed to ensure that sickness funds do not request higher administrative costs than for the general population receiving welfare services under section 264 of the Social Code Book V[41].

Empirical studies adjusting for age-, sex- and/or morbidity-related differences in need show that asylum seekers falling under legal restrictions have a higher rate of avoidable hospitalizations,

i.e. hospitalization that could be avoided through good outpatient care or prevention[42], emergency service use[43] as well as lower rates of utilization of primary care and outpatient services[44]. Furthermore, asylum seekers with chronic conditions are more likely to receive fewer prescriptions in age-/sex- and morbidity-matched samples with regularly insured patients, providing robust evidence for under-provision of services at the same level of need[45]. This pattern of care leads to higher healthcare expenditures compared to regularly insured patients[46]. A quasi-experimental study over a period of two decades (1994-2013) shows that healthcare expenditures among asylum seekers with regular entitlements to healthcare are about 40% lower than those for asylum seekers with restricted entitlements[47], refuting the unproven assumption that restrictions on healthcare services lead to cost-savings.

Furthermore, the legal restrictions have been criticized as they are in conflict with the therapeutic freedom of physicians[48]. They also undermine the regulations of the EU directive, as special needs - even if identified – are likely to remain unaddressed under a restrictive interpretation of the ABAA, which is subject to interpretation by local authorities who are not medically trained.

> A 30 years old male patient from Togo suffered from voiding difficulties after an appendicitis surgery 2013 in Togo. In 2016, the situation of the patient, who was in Italy at the time, aggravated leading to acute urine retention with necessity for emergency treatment in form of a suprapubic catheterization. Since then, the patient suffered from recurrent complicated urinary tract infections had to undergo multiple antibiotic treatments by a physician in a German reception center. The patient was additionally examined by urology specialists. A recommended further procedure (an urodynamic test) was rejected by government administration, as the patient had received a negative notification on the asylum claim in the meantime. The patient appealed against the rejection of the asylum claim, but remained with the suprapubic catheter without further follow-up. The root cause of the voiding difficulties remained unclear and the patient was left with symptomatic treatment for the recurrent infections and with a high risk of developing septicemia in the future.

In summary, the regulations of the ABAA link access to essential healthcare services to residence status, country of origin and the (presumed) outcome of the asylum procedure. As such, the Act is an instrument of migration policy aimed at deterrence of migrants, and does not qualify as instrument of health policy.

d) Reactions

The legal practice of restricting access to health care for asylum seekers has been criticized by different stakeholders:

- The German Federal Physicians Chamber (Bundesärztekammer) has repeatedly criticized the restrictions in access to health care for asylum seekers, e.g. in the German Parliament in 2016[49] and in their annual resolution[50].

- In 2016, two opposition parties ("Die Linke" and „B90/Die Grünen") submitted parliamentary requests on the improvement of healthcare for asylum seekers[51]
- In 2014, several civil society and welfare organizations formed a coalition against the restrictions of the ABAA[52]
- The German Platform Global Health, consisting of researchers, civil society organizations and labor unions has positioned itself against the restrictions in access for asylum seekers[53].

e) Recommendations

The signatories ask the Committee to call upon the government of Germany to

- Remove the restrictions to healthcare under section 4 ABAA and ensure that access to essential healthcare services under section 6 ABAA is based on medical need alone, i.e. not influenced by residence status, country of origin and/or the (presumed) outcome of the asylum procedure
- Ensure and prove compliance with the EU Directive 2013/33/EU with respect to addressing the special needs of vulnerable asylum seekers
- Ensure that the voucher system is abolished and EHCs are effectively introduced nation-wide
- Ensure adequate coverage of healthcare expenditures at national level or (at minimum) at federal state-level to ensure sufficient risk pooling and sharing of financial responsibilities
- In the meantime, collect and report data on number and reasons for rejected healthcare applications disaggregated by age, sex and residence status on a regular basis to ensure monitoring of the impact of the legal regulations on access to healthcare

UNDOCUMENTED MIGRANTS

a) Legal developments and status quo

Undocumented immigrants in Germany by law have the same – restricted - access to healthcare as asylum seekers, which is restricted to acute illnesses and pain and prenatal care (section 4(1), Act on Benefits for Asylum Applicants, ABAA).

In practice, however, undocumented persons cannot even make use of this restricted entitlement without putting themselves at the risk of deportation, because applying for the coverage of the costs for non-emergency care involves sharing personal information with state officials. In order to access health care, patients need to apply at the local social welfare authority for a healthcare voucher. These officials, however, are obliged to report to the police or immigration authorities if someone cannot provide a valid residence permit (section 87 residence act). This de facto prevents outpatient care.

In the case of a medical emergency, treatment can be granted without a prior application for a healthcare voucher. The hospital is retroactively reimbursed for its costs by the social welfare office (section 6a ABAA).

To allow for treatment in case of emergencies, an administrative regulation was introduced in 2009 (General Administrative Regulation to the Residence Act, GMBL No. 42-61 of 30.10.2009) extending the protection of personal patient information beyond medical personnel to administrative staff in hospitals and employees in social offices. No information about the person may be reported to the immigration authorities or the police in the case of an emergency. However, the definition of a medical emergency varies greatly depending on the federal state or municipality. In addition, not many people are familiar with the regulation.

Unfortunately, the hospitals' claims for cost reimbursement often fail. As a result, hospital administrators oftentimes put pressure on patients and their families to pay for the treatment themselves.

A major hurdle in the process of receiving reimbursement for emergency care is the so-called "means test" carried out by the welfare offices. This "means test" requires the patient to provide a large number of documents, such as copies of passports, bank statements, and/or rental agreements. Providing these documents is often very difficult for people without legal residence status. In addition, this process puts a high administrative burden on the hospital, the social welfare offices, and the immigration authorities, because it requires specialist knowledge. The experience of many NGOs shows that claiming benefits is cumbersome and time consuming.

b) Scope of the problem

According to data of the Police Criminal Statistic of the Federal Criminal Office (Polizeiliche Kriminalitätsstatistik – PKS (Vogel, 2015)), for the year 2014, an estimated 180,000 to 520,000 undocumented immigrants were staying in Germany.

More recent estimates are currently unavailable, due to bureaucratic problems with the registration of asylum seekers. Therefore, data for 2015 and the following years is corrupted by the numbers of yet unregistered asylum seekers. A further increase of undocumented persons in Germany can be assumed due to the latest tightening of asylum laws and the high numbers of asylum seekers in the years 2015-2016.

Much of the existing information about access to healthcare for undocumented persons comes from humanitarian organizations. These organizations work parallel to the national healthcare system to provide undocumented persons with at least partial healthcare – in most cases free of charge. The German section of Médecins du Monde/Doctors of the World offers health care for people with restricted or no access to the healthcare system. Overall, more than 2000 patients came to the clinics in 2017. Of the 879 new patients in Hamburg, Berlin and Munich in 2017, 16% did not have a legal status.

c) Individual consequences

Undocumented persons can access health benefits only in case of emergency and with great difficulty. The legal situations puts undocumented persons in a situation where, if they are sick, they have to choose between remaining untreated or seeking treatment and thereby exposing their undocumented resident status, risking deportation.

Other factors also hinder access to health care. Uncertainty of where the needed treatment can be found and language barriers are further reasons why medical assistance is either sought too late or not at all. In the case of long-term and chronic conditions, medical treatment does often not take place at all. Oftentimes, undocumented persons do not have the time to allow their medical condition to heal adequately because of their precarious working conditions.

> Mrs. Petra A is a 63 years old Serbian who has lived in Germany for more than 10 years. She applied for asylum in Germany in the 1990s. Asylum was refused and she was deported back to Serbia. With no means to support herself, no help from social agencies in Serbia and all of her family and friends in Germany (with residence permits), she decided to return. Mrs. A. is considered a 'VISA overstayer' and will not be granted a residence permit because neither she nor her family can guarantee to pay for her food, rent, and health insurance. Mrs. A is chronically ill with hypertension, gastritis, multiple recurrent otolaryngological problems, arthrosis of both knees, and chronical bronchitis. Accessing healthcare according to the ABAA would require her to contact state officials, who would likely report her to the police or immigration authorities, which would put her at risk for deportation. Due to her undocumented status, she depends on medical support by local humanitarian organizations. She receives medication there and smaller examinations can be made, both funded by donations. She repeatedly had to get inpatient emergency care and was given a bill, which is why she is in debt to the hospital.

While civil society and humanitarian organizations offer access to healthcare for undocumented migrants in many cities, they depend on donations and volunteer work and cannot ensure full realization of the human right to healthcare.

d) Reactions

The humanitarian issue of 'unrestricted access to health care for undocumented persons' has been raised by German civil society and welfare organizations for years (since 1993).

A *National Working Group on Health/Illegality (*Bundesarbeitsgruppe Gesundheit/Illegalität (BAG) was established in March 2006. This group brings together experts from science, medicine, religious groups, welfare organizations, municipalities, and NGOs. The BAG advocates for non-discriminatory access to healthcare for undocumented persons, including the full scope of benefits according to the Benefits of Services Catalogue of statutory health insurance (Social Security Statute Book, Book V [SGB V]).

As early as ten years ago, the BAG stressed the urgent need for action. In 2007, it published the report "Undocumented women, men and children in Germany – Their Right to Health" in cooperation with the German Institute for Human Rights, describing the problem and possible solutions.[54] Recent publications of the BAG include the paper "Health Care for Undocumented Persons 2017" and a collection of individual patient stories ("Fallsammlung Krank und ohne Papiere 2018")[55]. The BAG continuously advocates in the German parliament and the Federal ministries and also engages in public relations and media work.

In February 2017, the CESCR gave a statement (E/C.12/2017/1) referring to the restrictions of the right to health due to the duty to report:

> "In its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee recalled that States parties have a duty to respect the right to health by ensuring that all persons, including migrants, have equal access to preventive, curative and palliative health services, regardless of their legal status and documentation (para. 34). The Committee is aware that migrants face specific obstacles in this regard, as documentation may be required from those seeking access to health care. Migrants, particularly those who do not speak the language of the host country, may not be aware of their entitlements. Migrants in an irregular situation may also fear being detained for deportation, particularly in countries where public officials have a duty to report on irregular migrants. In addition to ensuring access to health care without discrimination, strict walls should exist between health-care personnel and law enforcement authorities, and adequate information should be made available in the languages commonly spoken by migrants in the host country, in order to ensure that such situations do not result in migrants avoiding seeking and obtaining health care."

e) Recommendations

In recent years, some changes have taken place improving undocumented persons' possibility to take advantage of their right to social participation. In some regions of Germany, "anonymous healthcare vouchers" have been introduced. In this model, the voucher is provided from an

organization that does not have the duty to report while the costs are covered by the social welfare department.

From the perspective of the *National Working Group on Health/Illegality*, however, a nationwide solution is needed, ensuring comprehensive medical care for undocumented persons. Without legal readjustment and abolition of federal restrictions at the national level, regional interventions can only be attempts to counterbalance these deficiencies. It is the state party's responsibility to ensure access to healthcare. Proposals include:

- The abolition of the obligation to report for social service departments (section 87 of the residence act). The obligation to report has already been abolished for all institutions in the education sector to fulfil the right to education. The obligation to report hinders access to healthcare.
- The abolition of restrictions in the Asylum Seekers' Benefits Act. This act reduces access to healthcare to the treatment of acute illnesses and pain as well as prenatal care.

[1]Civil society organizations that provide support and/or health services for people without or with limited access to health care include: Ärzte der Welt e.V./Doctors of the World Germany (in Berlin, Hamburg, Stuttgart and Munich), Malteser Medizin für Menschen ohne Krankenversicherung (in Arnstadt, Augsburg, Berlin, Darmstadt, Duisburg, Erfurt, Euskirchen, Frankfurt, Fulda, Hamburg, Hannover, Köln, Mannheim, München, Münster, Oldenburg, Osnabrück, Siegen, Stuttgart), Medibüros/Medinetze (among others in Berlin, Bielefeld, Bonn, Dresden, Essen, Heidelberg, Koblenz, Lübeck, Mainz, Ulm, Würzburg), Armut und Gesundheit e.V. (Mainz)

[2] See media reports and flyer in annex 2.

[3] See letter to ministry of health in annex 3

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[5] Gesetz zur Regelung von Ansprüchen ausländischer Personen in der Grundsicherung für Arbeitssuchende nach dem Zweiten Buch Sozialgesetzbuch und in der Sozialhilfe nach dem Zwölften Buch Sozialgesetzbuch, 22.12.2016. Bundesgesetzblatt Jahrgang 2016, Teil I Nr. 65, issued on December 28th, 2016 https://www.bgbl.de/xaver/bgbl/start.xav?start=%2F%2F*%5B%40attr_id%3D%27bgbl116s3155.pdf%27%5D#__bgbl__%2F%2F*%5B%40attr_id%3D%27bgbl116s3155.pdf%27%5D__1529917570871

[6] Regulation (EU) No 492/2011 of the European Parliament and of the Council of 5 April 2011 on freedom of movement for workers within the Union Text with EEA relevance. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32011R0492

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[11] Please find the letter to the minister of work and social affairs in annex 4

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ANNEX 1

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ANNEX 2

Rally on the Human Right to Health, March 20th 2018 – Flyer

English translation:

Health – a human right
Hundreds of thousands in Germany are barred from adequate medical services. This is a scandal! We call on the government to ensure access to health care for all people living in Germany.

Rally
Access to health care for all!
March 20, 6:30 p.m.
At Brandenburger Tor (west side)

Access to adequate and high-quality health care is a human right. Germany is obliged by international law to protect, respect and implement this right. It's a scandal that, despite of this obligation, many people in this country have no or only limited access to medical care. Among those affected are

- asylum seekers
- persons without regular residence status
- persons without health insurance or with insurance contribution debts
- EU citizens in precarious working conditions or seeking employment

Besides legal hurdles, languages barriers and discrimination prevent access to adequate medical services.

We call on the German government to take immediate measures to remove discriminating barriers and ensure access to health care for all.

Press reactions

tagesschau.de: https://bit.ly/2I1unAK

Berliner Zeitung: https://bit.ly/2G3JusA

rbb zibb: https://bit.ly/2GgGpZv

Presseportal.de: https://bit.ly/2pB8Yr2 und https://bit.ly/2GhyB9X

Heilpraxis.net: https://bit.ly/2G3V0Ed

Solinger Tageblatt: https://bit.ly/2DOAVjx und https://bit.ly/2pbLxDV

Lokalkompass.de: https://bit.ly/2G0qfEk

Domradio: https://bit.ly/2IOlDiy

rbb Inforadio: https://bit.ly/2FZ2JHY

Remscheider Generalanzeiger: https://bit.ly/2pEbqMX

RP online: https://bit.ly/2GeqlHX

Berliner Morgenpost: https://bit.ly/2ugml4l

RS-aktuell: https://bit.ly/2INU8p1

Nachrichten-heute: https://bit.ly/2pvUyIY

Firmenpresse.de: https://bit.ly/2DP3ltE

Gateo.de: https://bit.ly/2pyQVB0

Kölncityvisits.de: https://bit.ly/2DOZ2OQ und https://bit.ly/2DPfUoW

Ärzte Zeitung online: https://bit.ly/2FXo4kN

Junge Welt: https://bit.ly/2pyF7Pi

Europe Online Magazine: https://bit.ly/2Gifqgo

Neues Deutschland: https://bit.ly/2FXxg8Y

Hier-Luebeck.de: https://bit.ly/2HXfkrv

Freeletter.de: https://bit.ly/2INF76C

Zm-online: https://bit.ly/2pz9u8c

Pharmazeutische Zeitung online: https://bit.ly/2Ilij8B

rbb Radioeins: https://bit.ly/2G9YcS5

rbb Inforadio: https://bit.ly/2HYHRNu

An
Herrn Bundesminister Jens Spahn
Bundesgesundheitsministerium
11055 Berlin

Berlin, den 30. Mai 2018

Sehr geehrter Herr Bundesminister Spahn,

Am 20. März fand in Berlin eine Kundgebung mit dem Titel „Gesundheit ist ein Menschenrecht – Zugang zu Gesundheitsversorgung für Alle“ am Brandenburger Tor in Berlin statt. Ein breites Bündnis von 22 zivilgesellschaftlichen Organisationen und Wohlfahrtsverbänden hat mit dieser Aktion Aufmerksamkeit dafür geschaffen, dass hunderttausende Menschen in Deutschland keinen oder nur eingeschränkten Zugang zu Gesundheitsversorgung haben.

Tagesschau.de (www.tagesschau.de/inland/krankenversicherung-105.html) der WDR, RTL und rbb berichteten anlässlich der Kundgebung über das Thema.

Täglich kommen Frauen, Männer und Kinder in zivilgesellschaftliche, oft ehrenamtlich betriebene Anlaufstellen in ganz Deutschland, um notwendige medizinische Versorgung zu erhalten, die sie auf anderem Wege nicht bekommen können.

Betroffen sind Asylsuchende, die in den ersten 15 Monaten nur einen eingeschränkten Anspruch auf Gesundheitsversorgung haben. Dieser liegt unter dem Niveau der gesetzlichen Krankenkassen. Auf die Behandlung chronischer Krankheiten besteht beispielsweise kein Anspruch. Dabei ist der Leistungskatalog der Gesetzlichen Krankenversicherung bereits so definiert, dass das medizinisch Notwendige nicht überschritten werden darf. Auch wenn in Einzelfällen die Behandlung oftmals durchgesetzt werden kann: Bewusst wird hier vom Gesetzgeber der Anspruch unter das medizinisch Notwendige gesenkt.

Menschen ohne Papiere und ihre Kinder haben den gleichen eingeschränkten Anspruch wie Asylsuchende. Vor einem Arztbesuch müssten sie jedoch zum Sozialamt, um einen Krankenschein zu beantragen. Das Sozialamt ist verpflichtet, eine Person bei der Ausländerbehörde zu melden, wenn sie keinen rechtmäßigen Aufenthalt nachweisen kann. Damit droht eine Abschiebung. Arztbesuche werden daher vermieden, bis die Krankheit zu einem Notfall wird, der im Krankenhaus behandelt werden muss. Dies führt zu unnötigem Leiden und oftmals zu Chronifizierungen.

Für viele Menschen mit geringem Einkommen, insbesondere für Selbständige, sind hohe Krankenversicherungsbeiträge eine finanzielle Belastung. Wenn sie Beitragsschulden haben, bekommen sie bis zur kompletten Rückzahlung nur eingeschränkte Versicherungsleistungen.

Zunehmend kommen auch Menschen aus anderen Ländern der EU in die Anlaufstellen. Rechtliche Einschränkungen, administrative Hürden und mangelnde Information bei Gesundheitspersonal und Patient(inn)en führen dazu, dass prekär beschäftigte oder erwerbslose EU-Bürgerinnen und –Bürger und ihre Kinder häufig keine Möglichkeit haben, die medizinische Hilfe in Anspruch zu nehmen, die sie brauchen.

Diskriminierungen durch Gesundheitspersonal und Sprachbarrieren behindern darüber hinaus den Zugang.

Es sind zivilgesellschaftliche und humanitäre Organisationen, die sich gezwungen sehen, wenigstens eine medizinische Basisversorgung und Beratung für diese Menschen anzubieten. Der Staat kommt seiner völkerrechtlich bindenden Verpflichtung nicht nach, den Zugang zu Gesundheitsversorgung für alle Menschen im Land diskriminierungsfrei zu sichern (Art. 12 des UN-Sozialpakts). Entsprechend hat der UN-Ausschuss für wirtschaftliche, soziale und kulturelle Rechte im Oktober 2017 eine diesbezügliche Rückfrage an die Bundesregierung gestellt (E/C.12/DEUQ/6).

Mit diesem Schreiben fordern wir Sie auf, gemeinsam mit anderen Bundesressorts und im Austausch mit zivilgesellschaftlichen Organisationen, eine Strategie zu entwickeln, damit alle in Deutschland lebenden Menschen Zugang zu Gesundheitsversorgung bekommen.

Es existieren – z.T. bereits seit vielen Jahren – konkrete Vorschläge für Gesetzesänderungen. Dazu gehören:

- Eine Ausnahme von der Übermittlungspflicht für Sozialämter, damit Menschen ohne Papiere nicht bei der Ausländerbehörde gemeldet werden müssen, wenn sie ihren gesetzlich verbrieften Anspruch geltend machen und einen Krankenschein bekommen möchten.
- Ausweitung des Leistungsumfangs für alle in Deutschland lebenden Menschen auf das Niveau der Gesetzlichen Krankenversicherung.
- Abschaffung des Gesetzes, das seit Anfang 2017 erwerbslose EU-Bürger und Bürgerinnen unter bestimmten Bedingungen komplett vom Leistungsbezug ausschließt.
- Senkung des Mindestbeitragssatzes zur GKV für Selbständige

Zu einer umfassenden Strategie der Bundesregierung gehört außerdem die Sicherstellung und Finanzierung von Sprachmittlung für Arztbesuche sowie die Bereitstellung von verständlichen Informationen für Patientinnen und Patienten und Gesundheitspersonal.

Die Sicherung einer bedarfsgerechten Gesundheitsversorgung für alle ist genuine Aufgabe des Staates und darf nicht in den Händen ehrenamtlich tätiger, spendenfinanzierter Organisationen liegen.

Wir bitten Sie zeitnah um ein Gespräch, um Ihnen die Problematik und die aus unserer Sicht notwendigen Maßnahmen vorzustellen.

Mit herzlichem Dank im Voraus und freundlichen Grüßen

François de Keersmaeker,
Direktor
Ärzte der Welt e.V.

Prof. Dr. Gerhard Trabert,
1. Vorsitzender
Armut und Gesundheit in Deutschland e.V.

Maria Kayem,
Bundeskoordination für Medizin und Menschenrechte,
Bundesvertretung der Medizinstudierenden in Deutschland e.V.

Elise Bittenbinder,
Vorsitzende,
Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer

Prof. Dr. Ulrike Kostka,
Caritasdirektorin und Vorstandsvorsitzende
Caritasverband für das Erzbistum Berlin e.V.

Silke Klumb,
Geschäftsführerin
Deutsche AIDS Hilfe

Maria Loheide,
Vorstand Sozialpolitik,
Diakonie Deutschland

Andrea Käthner-Isemeyer,
Leiterin Abteilung Soziales
Humanistischer Verband Berlin-Brandenburg KdöR

Carlotta Conrad,
Vorstandsmitglied
IPPNW – Internationale Ärzte für die Verhütung des Atomkriegs – Ärzte in sozialer Verantwortung e.V.

Medibüro Berlin - Netzwerk für das Recht auf Gesundheitsversorgung aller Migrant*innen

Dr. Claudia Tamm,
Vorsitzende
MediNetz Koblenz e.V.

Jonathan Sauer,
Vorstandsmitglied
Medinetz Mainz e.V.

Medinetz Ulm e.V.

Dr. Pia Skarabis-Querfeld,
Vorstandsvorsitzende
Medizin Hilft e.V.

Walter Münzenberger,
Geschäftsführer
Ökumenische Fördergemeinschaft Ludwigshafen GmbH – STREET DOC –

Ulrich Neugebauer,
Leiter der Kältehilfe
Stadtmission Berlin

Kontaktperson:
Dr. Johanna Offe, Referentin für Grundsatzfragen
Ärzte der Welt e.V. - Stresemannstraße 72 - 10963 Berlin
johanna.offe@aerztederwelt.org


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MediNetz Bielefeld
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Menschen ohne Krankenversicherungsschutz


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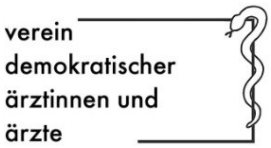
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Pharmazie
in sozialer
Verantwortung
VdPP


westend
hoffnungsorte
hamburg

Herr Bundesminister
Hubertus Heil
Bundesministerium für Arbeit und Soziales
Wilhelmstraße 49
10117 Berlin

Berlin, den 17. April 2018

Sehr geehrter Herr Bundesminister Heil,

wir, Vertreter/-innen von über 30 zivilgesellschaftlichen Organisationen, Beratungseinrichtungen und Wohlfahrtsverbänden, sind besorgt über die Auswirkungen, die das von Ihrem Ministerium verantwortete Leistungsausschlussgesetz auf die gesundheitliche Situation von Unionsbürger/-innen in Deutschland hat.

In den zum Teil ehrenamtlich betriebenen Anlauf- und Beratungsstellen sehen wir seit vielen Jahren Menschen aus Ländern der EU, die keinen oder erschwerten Zugang zu notwendiger medizinischer Versorgung haben. Der Zugang zur gesetzlichen und zur privaten Krankenversicherung ist für nicht erwerbstätige Unionsbürger/-innen erschwert bis unmöglich. Viele Menschen suchen aufgrund finanzieller, administrativer oder sprachlicher Hürden erst sehr spät medizinische Hilfe. Krankheiten werden dadurch häufiger chronisch und führen zu Notfällen.

Das „Gesetz zur Regelung von Ansprüchen ausländischer Personen in der Grundsicherung für Arbeitssuchende nach dem Zweiten Buch Sozialgesetzbuch und in der Sozialhilfe nach dem Zwölften Buch Sozialgesetzbuch“ vom 22.12.2016 verschärft diese Situation erheblich, indem es bestimmte Gruppen von Unionsbürger/-innen von allen Sozialleistungen ausschließt. Selbst dringend benötigte medizinische Versorgung muss nur bis zur Ausreise, maximal für einen Monat und einmalig innerhalb von zwei Jahren gewährt werden.

Der Zugang zu angemessener gesundheitlicher Versorgung ist Teil der grundrechtlich geschützten Menschenwürde. Die Bundesregierung ist mit der Unterzeichnung des UN-Sozialpakts verpflichtet, den Zugang zu erschwinglicher und qualitativ hochwertiger medizinischer Versorgung für jeden Menschen, der in Deutschland lebt, unabhängig z.B. von Aufenthaltsstatus oder Nationalität, zu sichern und zu gewähren.

Bei der Verweigerung von Sozialleistungen wird davon ausgegangen, dass die Betroffenen in ihre Herkunftsländer zurückkehren. In der Gesetzesbegründung aus Ihrem Ministerium heißt es: „Es ist davon auszugehen, dass die Regelung des Leistungsausschlusses im SGB XII eine Lenkungswirkung entfalten wird“. Die Freizügigkeit von Unionsbürger(inne)n ist ein wesentliches Merkmal der europäischen Einigung. Die Verweigerung von Sozialleistungen, inklusive notwendiger medizinischer Versorgung, darf nicht dazu genutzt werden, Menschen zur Ausreise zu bewegen. Sie ist unserer Erfahrung nach diesbezüglich auch wirkungslos.

Wir sehen bereits jetzt erste negative Auswirkungen des Ausschlusses von Unionsbürger(inne)n von Sozialleistungen. Männer, Frauen und Kinder bekommen nicht die Behandlung, die sie benötigen und werden frühzeitig aus dem Krankenhaus entlassen, wenn das Sozialamt die Kosten nicht übernimmt.

Durch das Gesetz wird die Verantwortung für die Sicherstellung der Gesundheit an das Krankenhauspersonal und an oft mit Ehrenamtlichen arbeitende Beratungs- und Versorgungseinrichtungen abgeschoben. Unsere Anlaufstellen können die Lücken in der Versorgung, die durch das Gesetz geschaffen wurden, nicht schließen. Es ist nicht die Aufgabe von Wohlfahrtsverbänden und zivilgesellschaftlichen Organisationen, staatlicherseits bewusst geschaffene Menschenrechtsverletzungen aufzufangen.

Wir appellieren an Sie, sehr geehrter Herr Minister, die menschenrechtliche Verpflichtung der Bundesregierung ernst zu nehmen und den Zugang zu Gesundheitsversorgung auch für Unionsbürger/-innen sicherzustellen. Wir bitten zeitnah um ein Gespräch mit Ihnen, um Ihnen auf der Grundlage unserer Erfahrungen in der Praxis die aus unserer Sicht notwendigen Maßnahmen vorzustellen.

Mit herzlichem Dank im Voraus und freundlichen Grüßen

François de Keersmaeker, Direktor
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Erster Vorsitzender
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Der Paritätische Gesamtverband

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Claudius Voigt,
Gemeinnützige Gesellschaft zur
Unterstützung Asylsuchender e.V.
(GGUA Flüchtlingshilfe)

Gesundheitsladen,
Caritasverband Worms e.V.

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Forschung, Dokumentation, Bildung
und Beratung e.V.

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Katholische Bundesarbeitsgemeinschaft
Wohnungslosenhilfe

Ludwig Mittermeier, Vorstand
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München e.V. (KMFV)

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Leiterin Ambulanz der
Berliner Stadtmission

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Netzwerk für das Recht auf Gesundheitsversorgung aller Migrant*innen

Medibüro Lübeck

Medinetz Aachen e.V.

MediNetz Bielefeld - Medizinische
Flüchtlingshilfe für Menschen ohne
Krankenversicherungsschutz

MediNetz Bonn e.V. – Medizinische
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Medinetz Hannover e.V.

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MediNetz Koblenz e.V.

Medinetz Leipzig e.V.

Medinetz Mainz e.V.

MediNetz Rhein-Neckar e.V.

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MediNetz Ulm e.V.

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und Dr. Arndt Dohmen, Vorstandsmitglied
REFUDOCS FREIBURG e.V.

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