Policies on Health Care for Undocumented Migrants in EU27

Country Report

Malta

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Preface

Undocumented migrants have gained increasing attention in the EU as a vulnerable group which is exposed to high health risks and which poses a challenge to public health. In general, undocumented migrants face considerable barriers in accessing services. The health of undocumented migrants is at great risk due to difficult living and working conditions, often characterised by uncertainty, exploitation and dependency. National regulations often severely restrict access to healthcare for undocumented migrants. At the same time, the right to healthcare has been recognised as a human right by various international instruments ratified by various European Countries (PICUM 2007; Pace 2007). This presents a paradox for healthcare providers; if they provide care, they may act against legal and financial regulations; if they don’t provide care, they violate human rights and exclude the most vulnerable persons. This paradox cannot be resolved at a practical level, but must be managed such that neither human rights nor national regulations are violated.

The EU Project, “Health Care in NowHereland”, works on the issue of improving healthcare services for undocumented migrants. Experts within research and the field identify and assess contextualised models of good practice within healthcare for undocumented migrants. This builds upon compilations of

- policies in the EU 27 at national level
- practices of healthcare for undocumented migrants at regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

As per its title, the project introduces the image of an invisible territory of NowHereland which is part of the European presence, “here and now”. How healthcare is organised in NowHereland, which policy frameworks influence healthcare provision and who the people are that live and act in this NowHereland are the central questions raised.

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**Healthcare in NowHereland: Improving services for undocumented migrants in the EU**

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*Partners:*

- Centre for Health and Migration at the Danube University, Krems (AT) (main coordinator)
- Platform for International Cooperation on Undocumented Migrants (BE)
- Azienda Unità Sanitaria Locale di Reggio Emilia (IT)
- Centre for Research and Studies in Sociology (PT)
- Malmö Institute for Studies of Migration, Diversity and Welfare (SE)
- University of Brighton (UK)
Introduction

This report is written within the framework of the research project, NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU, and one of its work packages. The focus of this work package – policy compilation – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.¹

The term used in this project is thus, “undocumented migrants”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.²

The General Migration Context

Malta became a member of the European Union in 2004 and joined the Schengen area in 2007. Malta is situated on the border of the Schengen area.

¹ Information regarding the project and all 27 Country Reports can be found at http://www.nowhereland.info/. Here, an Introduction can also be found which outlines the theoretical framework and method as well as a clustering of the states.

² For the report at hand, the person to acknowledge is: Marika Podda Connor, Head of Migrant Health Unit, Department of Primary Health, Malta and the president of the European Transcultural Nursing Association (ETNA).
In 2005, Malta had a net-immigration of 2,057 migrants, mainly originating from Great Britain, Italy and Germany (Reichel and Kraler 2009:95). Malta started experiencing irregular migration from the 1990s. Since 2001, so-called “boat people” started arriving. Currently, Malta is seemingly an accidental destination for migrants departing by boat from the North African coast and is mostly sought to be avoided (Munro 2009). In general, Malta does not conceive itself as being a country of immigration and immigration is generally viewed as exceptional (Reichel and Kraler 2009:95).

Over the last few years, Malta has dealt with inflows of migrants seeking asylum and arriving by boat. A majority of these are believed to have headed for Italy and are often intercepted at sea en route to Italy (Reichel and Kraler 2009:95). Many asylum seekers are rejected and subsequently deported. However, there are also groups of rejected asylum seekers who cannot be deported, who are initially detained in centres and after a period of 18 months are released to so-called open centres (ibid.:96). In terms of this policy, irregular immigrants are placed in closed centres upon arrival. They remain in closed reception centres until their identity is established and their application for asylum processed, for up to a maximum of eighteen months. They are released from closed centres, which then, in collaboration with NGOs, provide accommodation in open centres (Ministries of Justice and Home Affairs and Family and Social Solidarity).

Over the last ten years, Malta has received 12,131 immigrants ("boat people"), of whom 13% were women and children. In 2008, a total of 2,775 irregular migrants arrived in Malta. All 84 boats in which they had arrived had departed for Europe from Libyan shores. Also, the 2008 arrivals exceeded the Maltese birth rate. In 2008, the persons arriving by boat consisted of: 1,443 from Somalia, 338 from Nigeria, 187 from Mali, 159 from Ivory Coast and 192 from Eritrea (Munro 2009).

Since 2000, 7,852 cases, of a possible 8,463, were heard by the authorities. Of these, 212 were given status, 4,013 were given subsidiary status and 7 temporary status. 3,557 cases

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3 Detention is regulated in the Maltese Immigration Act (Laws of Malta, 1970, Chapter 217)6. This Act also sets out the rules for granting different types of residence (Schlenzka 2007). Berlin Institute of Comparative Social Research. 2007.

were rejected and 172 withdrawn (the rest remain in progress). Some were taken up by other EU countries (1%) or the US (4%) (Munro 2009).5

**Total Population and Migrant Population**

By 1 January 2010, the population in Malta was 416,333 (Eurostat)6. In 2008, the foreign-born population was 15,000 (Eurostat 94/2009). Of these, 4,100 were citizens of the United Kingdom, 900 of India and 800 were citizens of Serbia (ibid.). In the 2005 population census the number of non-nationals was 12,112, of whom 4,713 were British citizens. Other salient origins are Italy and Germany (Reichel and Kraler 2009:95).

**Estimated Number of Undocumented Migrants**

There is no data available regarding the number of undocumented migrants in Malta, but these are estimated to be comparatively low. (Baldwin-Edwards & Kraler 2009:41). In November 2008, the number of persons at detention centres (2,000 persons) and open centres (2,400 persons) exceeded the maximum capacity of the centres. In addition, the number of persons living in the community (not at centres) was 1,400 (Calleya and Lutterbeck 2008; Jesuit Refugee Service Malta 2009).

**Categories of Undocumented Migrants**

In Malta, asylum has a role in "producing" undocumented migrants (Baldwin-Edwards & Kraler 2009:41). Many asylum seekers are rejected and subsequently deported. As previously stated, groups of rejected asylum seekers who cannot be deported are initially detained in centres and after a period of 18 months are released to so called open centres (Reichel and Kraler 2009:95).

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Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups
Malta has never launched a regularisation program (Reichel and Kraler 2009:95). The humanitarian permit, granted to asylum applicants and rejected asylum seekers alike, is a temporary regularisation mechanism. It is usually issued for a period of 1 year, and if no specific reasons for non-prolongation exist, is usually renewed after expiry (ibid.).

Internal Control: Accommodation, Labour, Social Security and Education
Accommodation is not covered.

As regards employment and the related social security, persons living in the community and in open accommodation centres do receive unemployment benefits and those granted refugee status receive social benefits. The estimated number of those registered for employment is about 1 200, while the estimated number of those in employment is about 500. The estimated number in 'unofficial' employment is about 650 (depending on the tourism season) (Calleya and Lutterbeck 2008).

The right to education in Malta can be considered to be implicit, as there is no impediment to the enrolment of children who do not have legal residency status in the country (European Commission 2004:33).

Main Characteristics of the Health System

Financing, Services and Providers
The Maltese welfare system consists of state social security, financed through national insurance payments. The National Insurance Scheme is funded by the government, employers and employees and provides welfare benefits, sickness benefits and pensions, which are thus contribution-based. All contributors and their dependants are covered. In addition, a social assistance scheme exists to cover the unemployed. (Muscat 1999). However, health care is funded by government and financed through general taxes (78 %), and pooled at national level (Thomson et al. 2009). The Maltese health care system operates by means of an integrated health service that is organised at the national level. Although the public system provides broad coverage, many people use private sector services as a means of bypassing waiting lists for public sector care. Private sector services are mainly financed by out-of-pocket payments although supplementary private health insurance is beginning to play more of a role. However, it tends to focus on elective surgery and medical treatment overseas (ibid.:170). Collectively, 78% of health care is financed by taxes and 20 % by out-of-pocket payments. Private health insurance plays a minor supplementary role, but the trend is increasing (2%) (ibid.). As the contribution is
mandatory, opting out of the system is prohibited. The state system covers all Maltese citizens, irrespective of income or ability to pay, as all persons covered by the National Insurance Act of 1956 are eligible for free health care. The Ministry of Health is responsible for providing health care coverage to beneficiaries (Muscat 1999).

The health system covers all residents for a wide range of benefits, largely provided free of charge at the point of delivery. The services covered by the state health care system are a highly comprehensive package of health care benefits with only a few items excluded. At primary care level, the package includes GP consultations, home visits, minor treatment, community nursing and preventive programmes including immunisation and screening. At hospitals, diagnostic and therapeutic specialist interventions at outpatient clinics and inpatient hospital wards are covered. Emergency care is offered at the one main hospital. In addition, treatment abroad, in the United Kingdom, is also provided for by the government in cases requiring highly specialized care which is not available in Malta (Muscat 1999:25). Cost sharing applies to optical and dental care and to outpatient prescription pharmaceuticals, with exemptions for people with low incomes (“pink card” holders), people with chronic illnesses and some other categories (prisoners, members of religious orders, some police and military personnel, and so forth). This means that access to some services free-of-charge is coupled with a “pink card” issued under the Social Security Act after means testing. Furthermore, there is a “yellow card” issued in terms of the same act, which entitles persons with specific chronic conditions to free medicine. The National Insurance Scheme also covers pensions and unemployment benefits.  

The state health care system follows the integrated model, with public hospitals being owned by the state. Hospital care forms the main focus of the state health care system. There are also private hospitals, run as private for-profit organisations. There are no longer any acute care hospitals owned by voluntary organisations such as the church. Primary health care is provided by the state health service and by private general practitioners. These two systems of general practice function independently of one another. General practitioners (GPs) in public service are allowed to carry out private practice. The state primary health care system covers general practice, community care, immunisation and the school health service. Patients are free to choose primary care doctors but must be referred to specialist care (Muscat 1999:39). In private health care, consumer choice is virtually unlimited, both for primary and specialist care, as there is no gatekeeper function. At private hospitals and clinics, the patient pays out-of-pocket to supplement reimbursements from voluntary insurance schemes (ibid.).

**Basis of Entitlement**

Entitlement is based on citizenship (Muscat 1999:29) but in practice legal residency is required.

Special Requirements for Migrants

Legally resident foreigners are entitled to the same care as nationals. Temporary visitors from EU member states have direct access to health care from publicly funded health care services upon presentation of an EHIC (European Health Insurance Card) together with an identification document. EU citizens are advised that an original EHIC is required when using public health care facilities. If the relevant forms are not presented, health care bills must be paid in full prior to leaving the health care facility. Furthermore, the government of Malta is not responsible in any way for any treatment or care given to EU citizens in private hospitals or health centres or by practitioners of any sort in their private capacity.  

There is one bilateral agreement in place, relating to citizens of the United Kingdom and Northern Ireland who are exempted from the production of a valid EHIC when they call at a public hospital or government health care centre to be given emergency medical care (see footnote 1).

Care for asylum seekers is regulated by the Refugees Act of 1 October 2001 (part 3, 10 (1)) and these persons are entitled to “receive state medical care and services”. In terms of Subsidiary Legislation (Article 11(4) of the Subsidiary Legislation 420.06 on Reception of Asylum Seekers (Minimum Standards) Regulations of 22 November 2005), wherever possible, asylum seekers are expected to contribute to health care costs.

Difference Sensitivity

There are some adaptive structures to migrants in health care in Malta. One example is health education sessions that are given to migrants through the Migrant Health Unit in the Primary Health Department. Other examples include projects run by The Organisation for the Integration and Welfare of Asylum Seekers (OIWAS,) and other non governmental organisations (COPE Project). OIWAS is financed by the European Refugee Fund II, which has also run projects aimed at asylum seekers and topics relating to personal hygiene, dental hygiene, nutrition and environmental sanitation. Furthermore, translated material is being prepared by the Migrant Health Unit (Primary Health Department) in cooperation with non governmental organisations and Cultural Awareness Training Seminars for Health Professionals was organised in Primary Health in 2008 and are planned to target health professionals in both secondary and tertiary care (Questionnaire Malta).

http://docs.justice.gov.mt/lom/Legislation/English/SubLeg/420/06.pdf (20-01-2010).
Health Care for Undocumented Migrants

Relevant Laws and Regulations

There is no specific legislation with respect to health care for undocumented migrants in Malta. However, at the beginning of 2005, the Maltese Government published its policy, "Irregular Immigrants, Refugees and Integration, Policy Document". This document lays down a number of principles, and with respect to health care states that, “People in detention shall be entitled to free state medical care and services”. This means that health care for undocumented migrants must be understood in the context of the Maltese authorities’ policy of systematically detaining all irregular immigrants (including asylum-seekers).

Access to Different Types of Health Care

Malta has been criticised for its policy of detention, inter alia by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). In the CPT report, health care is also dealt with and concern is expressed as the detention itself has damaging effects on physical and psychological health. Also, in the report the CPT calls upon the Maltese authorities to take immediate measures to ensure the daily presence of trained nurses in the holding centres, since a lack of trained staff and visits by medical doctors have previously been noted (Council of Europe 2007, see also HUMA Network 2009).

Access to health care is not dealt with in the policy document and is thus open to interpretation. In practice, it is understood to be a free health service, with the same coverage applying as with a Maltese citizen holding a “pink card” (Questionnaire Malta).

Costs of Care

The health care is free of charge as it is paid for by the state. Furthermore, occasionally a non governmental organisation offers to pay for treatment or services which the migrant cannot afford, such as dental treatment, the provision of spectacles, etc (Questionnaire Malta).

Specific Entitlements

In terms of the policy document, particular attention is to be given to those irregular immigrants who are considered to be more vulnerable, namely unaccompanied minors,

12 "Irregular Immigrants, Refugees and Integration", Policy Document, Ministry for Justice and Home Affairs and Ministry for the Family and Social Solidarity.  


persons with disability, families and pregnant women (Policy document, page 13). As regards pregnant women, this involves family planning information, participation in programmes to prepare for motherhood, and antenatal and postnatal classes (in the appropriate language) (ibid: 21). As regards children, it is stated that they shall not be kept in closed centres but accommodated in homes for minors. They are eligible to receive the assistance, care and services to which local children are entitled (ibid.).

There are no specified entitlements involving specific (contagious) diseases as they are included in the equivalent “pink card” coverage, whilst HIV screening and treatment is included. However, as regards health care in open centres, there is a reference to contagious diseases, which states that in case of suspected infectious conditions, the Centre shall have the right to refer residents to the competent authorities for medical investigations, advice and treatment in the best interest of the resident concerned as well as that of other residents and the community at large (ibid.:24).

**Regional and Local Variations**

In Malta there cannot be said to exist regional and local variations with respect to the entitlement to health care for undocumented migrants. The competence to make decisions involving entitlements and the delivery of care are found at the national level. Generally, the Maltese health care system is highly centralized and regulated (Muscat 1999:19).

**Obstacles to Implementation**

Not covered.

**Obligation to Report**

In Malta, there is no obligation on health care staff to report a patient to authorities such as the police (HUMA Network 2009).

**Providers and Actors**

**Providers of Health Care**

Providers of health care can be found among hospitals in general, the emergency units and among general practitioners in the mainstream system. Furthermore, there are non governmental international organisations active in Malta (Médecins Sans Frontières)\(^\text{15}\).

It is worth noting that the providers are facing new challenges with respect to entitlement issues, language barriers and cultural issues (Questionnaire Malta).

\(^{15}\) [http://www.msf.org](http://www.msf.org)
Advocacy Groups and Campaigns on Rights

In Malta there have been information campaigns regarding the right to health care for undocumented migrants conducted by non-governmental organisations as well as by the mainstream system (Questionnaire Malta).

Political Agenda

In Malta there is an ongoing debate dealing with undocumented migrants in general as well as rejected asylum seekers. Irregular migration is one of the major issues discussed and a cause of major concern to the authorities (Reichel and Kraler 2009:95). Malta has been calling for support and “burden-sharing” from other EU countries as it has become an increasingly pressing humanitarian challenge (Calleya and Lutterbeck 2008).

International Contacts

Médecins sans Frontières are active in Malta.

Bibliography


European Council (2007). Report to the Maltese Government on the Visit to Malta Carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 15 to 21 June 2005.  


