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Illegality as risk factor: A survey of unauthorized migrant patients in a Berlin clinic

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ABSTRACT

Unauthorized migrants face health disadvantages in many receiving nations. However, few studies have explored precisely how the condition of "illegality" influences illness experiences, medical treatment, and convalescence. This article presents a case study from Germany (2004–2006 and 2008), where unauthorized migrants face limited access to health care and the threat of deportation results in avoidance of services and treatment delays. This is confounded by unique laws which essentially criminalize health care workers for aiding migrants. This article provides a snapshot of 183 patients who attended a Berlin clinic that functions as the single largest source of medical assistance for unauthorized persons in Germany. The demographic information sketches a picture of labor migrants with a mean age of approximately 29 years. More women than men presented at this clinic, a result of its ability to successfully arrange prenatal care and delivery as well as a reflection of local labor markets. The diversity of countries of origin ($n = 55$) is surprising, underscoring the utility of using illegal status as a unifying variable to highlight migrants' shared position in the global economy and the resulting barriers to basic medical services. Patients presented with a range of illnesses typical for their age group. However, the effects of illegal status resulted in four areas of disparities: 1) limits to the overall quality and quantity of care for mothers and infants; 2) delayed presentation and difficulties accessing a regular supply of medication for patients with chronic illnesses; 3) difficulties in accessing immediate medical attention for unpredictable injuries and other acute health concerns; and 4) a lack of mental health care options for generalized stress and anxiety affecting health. In Germany, an incoherent policy environment contributes to inadequate services and treatment delays. Solutions must address these legal ambiguities, which represent a primary barrier to equity in a nation with otherwise universal health coverage.

Introduction

Unauthorized migration is increasingly a low-cost, flexible, but vulnerable source of reserve labor for many wealthy nations. In much of Western Europe, unauthorized migration has provoked tensions between universal health care models for those entitled to well-established social welfare systems and humanitarian concerns of providing basic medical services for all residents, whether they are "legal" or not. Defined as "illegality" (Chavez, 2007; De Genova, 2002) or "undocumentedness" (McGuire & Georges, 2003), uncertain legal status represents an additional, seldom studied variable impacting health, illness, and convalescence.

The condition of illegality is an expression of juridical status and social relation to the state (De Genova, 2002; Inda, 2006; Ngai, 2004). In contemporary Germany, as in many other nations, illegality is produced via labor market demands and results in shifting practices of inclusion and exclusion. Although the term "undocumented" is commonly used, especially in the United States, the term "unauthorized" is utilized in this article. Typically, migrants have some form of documentation, but use them in unauthorized ways – such as overstaying tourist, student, or border-crossing visas, or taking on employment without a work permit (Heyman, Nuñez-Mchiri, & Talavera, 2009). This term is especially appropriate in the German context, where the vast majority of individuals enters the country legally but overstays visas, resulting in illegal residency status. This description is also useful because it can be extended to two specific subgroups in the German context: 1) asylum seekers whose claims have been denied but who remain in the country, as well as 2) individuals arriving from the new European Union (EU) member states who are technically legal residents but who fall under transitional restrictions on labor migration. In Germany, individuals lacking residency or work permits are not included in the comprehensive social health insurance system. While mandatory, the system rests on employment status (since it is partially funded through employer contributions) or eligibility for state welfare resources. For those working illegally or overstaying a visa, evidence for neither can be mustered.

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This article explores how illegality influences experiences of health, illness, and convalescence using a study of a Berlin clinic that treats primarily unauthorized migrant patients. It constitutes the single largest source of medical aid for such migrants in Germany, serving many of the city's estimated 100,000 unauthorized migrants (Gross, 2005) with more than 3000 visits per year. In Germany, while limited access to medical care is technically guaranteed to unauthorized migrants, a complex web of laws makes the provision of care difficult and certainly inadequate. Furthermore, migrants avoid public facilities because they will be questioned about insurance coverage, which will inevitably expose their unauthorized status and may lead to deportation. As there are no systematic studies of unauthorized migrants in Germany, this study is an initial attempt to document their health needs and service utilization.

This article reports on the results of 183 case studies of unauthorized patients collected during the participant observation phase of the larger study. Basic demographic information is presented and followed by a discussion of four themes which highlight the impact of illegality on health: 1) limits to the overall quality and quantity of care for mothers and infants; 2) the difficulties associated with accessing a regular supply of medication for chronic illnesses; 3) the unpredictable nature of injuries and other acute health concerns requiring immediate medical attention; and 4) generalized stress, anxiety, and depression affecting health that has led some patients and physicians to refer to an "illegal syndrome." These discussions are drawn from case examples gathered during the participant observation phase and supplemented with interviews to highlight how the condition of illegality influenced experiences of medical treatment and convalescence.

Background

"Illegality" as health risk

Epidemiological data on unauthorized populations in any host nation are scarce. Attempts to infer morbidity patterns by examining legal migrants' health patterns result in complex and contradictory data, depending on indices, location, and population. Some studies conclude that migrants have lower overall morbidity rates compared to host country counterparts; this is often explained by the healthy migrant effect – a selection bias which occurs when only relatively healthy young people migrate (see Wingate & Alexander, 2006 for a discussion). This pattern of general health, however, is confounded by poorer access to services, adverse effects of acculturation, and social and environmental factors that increase susceptibility to illness. The impact of these factors increases considerably if the person is unauthorized. Indeed, inferences from legally residing migrant populations are insufficient, because migrant illegality represents a variable with separate but largely unexplored effects.

Several features unite unauthorized migrants with illegal (or uncertain) status, all of which have distinct impacts on health. Specific structural constraints include lack of health insurance, low income levels, limited host country language skills, lower education, lack of access to transportation, frequently shifting accommodation and work, a limited number of health care facilities, fear of authorities, and laws that bar migrants' use of services and programs (Arcury & Quandt, 2007). However, these should not be viewed as discrete barriers but as "webs" that create more complex challenges than individual obstacles alone (Heyman et al., 2009). Among European Union nations, Germany is often characterized as having the most restrictive laws regarding medical care for illegal migrants. It has been faulted for its particularly shortsighted utilitarian approach, which allows only emergency treatment justified by a desire to protect the health of the host population (Romero-Ortuño, 2004). However, even in nations where policies have created the conditions for comprehensive health care coverage of unauthorized persons, such as Spain, illegal status remains significantly associated with low utilization of health services (Torres & Sanz, 2000).

In addition to structural factors, the stress of living in fear and insecurity contributes to illness, operating alongside discrimination and the synergistic effects of class and racism. Studies on the effects of stigma and discrimination on health have focused primarily on minority groups within a single society (Stuber, Meyer, & Link, 2008), but many of these insights can be applied to the uncertain juridico-legal status of unauthorized migrants. McGuire and Georges (2003) comment that the concept of allostatic load, defined as the accumulation of biological risk associated with persistent hyperarousal, is applicable to the lives of migrants without legal status. The prolonged biological stress associated with "undocumentedness," they argue, exacerbates health risks in tandem with other variables such as accessibility, affordability, and willingness to seek care.

Complex access issues for unauthorized migrants in contemporary Germany

Although much of the literature has focused on processes in the United States, migration has become an increasingly significant issue throughout Europe. Several features make Germany intriguing as a case study. Since the 1990s, unauthorized migrants have increasingly filled gaps in the German labor market. Political pressures following reunification, along with border militarization in the wake of EU expansion, resulted in restrictions on legal entry. At the same time, neoliberal reforms in the labor market, a rapidly aging population, and low reproductive rates have resulted in high demand for unauthorized workers in particular sectors of the economy such as construction, domestic work, and agriculture (Alt & Bommes, 2006). However, soaring unemployment in recent years has made immigration unpopular, with political parties negatively predisposed to assuring the rights of migrant workers, including access to health care services in a nation with a traditionally universal system of coverage.

Unique to Germany is a complex set of laws under which medical professionals can face criminal charges for treating unauthorized persons. Germany's Residence Act (*Aufenthaltsgesetz*) contains two sections that impact medical assistance. Section 87 is known as the "Denunciation Law" and mandates that persons residing in Germany illegally be reported to the authorities if they seek services at public facilities. This initiates the deportation process, and is one of the primary reasons unauthorized persons avoid hospital emergency rooms (Médecins du Monde, 2007). Section 96 of the same act states that "assisting" unauthorized persons is a crime punishable with a fine or imprisonment up to five years. While the law was designed to deter trafficking, physicians – in theory – can be held liable if they "assist" unauthorized patients by facilitating their continued presence in the country (as can landlords, clergy, or taxi drivers).

To complicate matters, unauthorized persons are covered under the same laws that provide emergency medical aid to asylum seekers applying for refugee status (Gross, 2005). However, as Section 87 of the Residence Act requires that they be subsequently reported to the authorities if they access these rights, they are *de facto* not available to them. While hospitals are entitled to reimbursement by the state for providing services to uninsured persons, the patient's illegal status comes to light when the request is submitted. Thus, any serious illness spells the possibility of deportation. To summarize,

> By 'illegalising' undocumented migrants, criminalizing assistance to them and requiring their 'denunciation' by all governmental and public institutions, the German government has created a web of laws that effectively exclude undocumented migrants from claiming their human rights, including their right to health (Scott, 2004: 25).

Methods

Setting: the Migrant Clinic

Despite this web of laws, local efforts ensure that some level of medical aid is available. Across Europe, nonprofit and nongovernmental organizations have responded to migrants' health needs by establishing networks of referral or by creating low-cost or free clinics (PICUM, 2002). Data were collected at one such organization, the Berlin Migrant Clinic (a pseudonym), as part of an ethnographic study on unauthorized migration and medical aid in Germany from 2004 to 2006 and supplemented by follow-up fieldwork in 2008. This clinic provides free or low-cost medical care for the uninsured. Since Germany embraces a universal health care system, services are aimed primarily at unauthorized migrants, the main group left without coverage. The "Clinic" – a term chosen for the sake of brevity – is actually more akin to a general practice office with expanded features. It functions as the first point of contact for patients with a wide variety of issues, including surgical and dental complaints which would be atypical in a regular general practice. About one-third of cases are treated in-house, while more complex illnesses are referred to specialists participating in an informal network. The Clinic operates three days a week and runs entirely from donated equipment and medications, volunteer staff, and specialists willing to forego compensation. Opened in 2001, by 2004 it drew upon a network of 105 physicians, seven hospitals, two laboratories, one medical supply store, two opticians, three pharmacies, five lawyers, and one physical therapist.

Studying unauthorized populations: methodological issues

Unauthorized migrants are a "hidden" population for whom a representative study is impossible to construct, since the very basic demographics are not understood. Determining sampling adequacy is made exponentially more difficult by this population's heterogeneity. Migrants are not captured in official statistics, and may be reluctant to participate in a research study because of the stigmatized or illegal nature of their activities. Walter, Bourgois, Loinaz, and Schillinger (2002) further emphasize the general difficulty in accessing this population because of mistrust in official institutions, making them less likely to respond candidly to formal surveys. They recommend ethnographic methods built around participant observation to enable a deeper analysis of experience.

Ethnography is a multifaceted, holistic, and systematic data gathering method that includes interviewing, participant observation, and complementary activities such as surveys and archival research. Using ethnographic field methods in the study of hidden populations has the potential of "limiting the artificiality of group definitions by grounding research parameters within the context of actually observed behaviors; insider understandings…; [and] self-reported identities of the target group (Singer, 1999: 172)." In addition, ethnography allows the researcher to gain access to locations and activities that might otherwise be closed for surveys, and encourages long-term commitment to a field site which aids in capturing longitudinal change. While it does not permit the calculation of incidence and prevalence rates, it does allow in-depth investigation of the various factors influencing health inequalities.

Methods in this study

This study utilized ethnographic methods including over six months of participant observation at the Clinic and 61 semi-structured interviews with unauthorized migrants, physicians, organization staff, and local experts on migration. Complementary data sources included documentation of a 2005 physicians' conference focused on medical issues for unauthorized migrants and systematic collection of media coverage and legislative debates. All data collection methods and protocols were approved by the University of Arizona Institutional Review Board. Additional results of the qualitative data have been published elsewhere (e.g., Castañeda, 2007, 2008a, 2008b).

This article focuses on the 183 case studies of patients collected during the participant observation phase of research at the Clinic. Overall, a total of 204 case studies were collected. These included smaller groups of legal migrants, tourists, and German citizens trying to locate medical aid for a wide variety of reasons; however, those individuals have been excluded in the analysis presented here in order to explore issues unique to unauthorized migrants. This sample represents a patron population (Singer, 1999), accessed through a specific location. Since 69.3% of these patients returned for multiple visits, each "case" represents not a single visit but a single patient who may have made multiple visits. The sample consists of patients observed at the Clinic independent of criteria such as day of the week, age, gender, language spoken, or type of illness. In fact, the author was the only assistant for approximately three months during the summer of 2005, so that this study captured every patient during that particular time frame. Patients were informed of the purpose of the project and provided verbal consent to the researcher's presence. Audio recording was excluded in the project design due to the sensitive nature of the activities being observed: "illegal" immigration, medicine operating in a gray legal area, and for reasons of patient privacy. In addition, note-taking during a clinical consultation would have been inappropriate. Therefore, extensive notes were typed up at the end of each shift, facilitated by short notations made during the course of the day. Although the Clinic kept patient records (often anonymized or using pseudonyms), these were not accessed as a form of data.

In addition to qualitative fieldnotes resulting from observations, data were gathered on age, gender, nationality, number of visits, and reason for visiting the Clinic. For the purposes of analysis, the 55 countries of origin were later reorganized into seven categories. Similarly, reasons for visiting the Clinic were organized into 15 general categories. When patients arrived with more than one complaint, the primary reason for the visit was selected. It should be noted that this method, chosen because it was also utilized in the Clinic's internal record-keeping, necessarily results in an under-reporting of health concerns. Clinic staff provided "baseline" information from the previous four years (2001–2004), representing 7300 total patient visits. These data were used to compare information from the six-month study period.

The 183 observations from the Clinic were analysed using SPSS (Version 16.0). Statistical tests included 1) chi-square tests analysing gender, region of origin, and reason for visiting the Clinic; 2) Mann–Whitney *U*-tests analysing age and number of visits by gender; and 3) Kruskal–Wallis tests analysing age by region of origin and number of visits by region of origin and by reason for visiting the Clinic. All qualitative data were analysed using ATLAS Ti software (Version 5.0). This created a database holding all files related to the project (interview transcripts and fieldnotes), which could be coded and then sorted for easy retrieval of a particular theme. Although recruitment for interviews was conducted separately, in some cases, participants who were interviewed were also part of the sample observed at the Clinic. This allowed for

interviews to supplement statistical data by offering a more in-depth understanding of individual migrants' everyday lives. These segments from interview transcripts appear here as illustrative quotes.

Results

Patient characteristics

The sample of 183 patients collected during this study can be considered "typical" in that it mirrored the existing statistics provided based on the Migrant Clinic's own internal record-keeping. While the patients who sought assistance at the Clinic were a heterogeneous group, it is possible to point to some key patterns (Table 1).

Age

Most of the patients fell between 18 and 50 years of age (77%). The range was just a few days old to 75 years, with a mean of 29.34 years. A Mann–Whitney test revealed no significant difference in age between males and females ($p = 0.266$), and a Kruskal–Wallis test showed no significant differences in age between regions of origin ($p = 0.077$).

Gender

Females accounted for 59.6% of all patients and males 40.4%. This is similar to the ratio for the previously measured periods (58–42% for 2001–2004) and a chi-square analysis indicated a significant difference ($p = 0.025$). This was an initially unexpected finding, since reports generally cite more male migrants in Germany, suggesting that women account for anywhere from one quarter to one-third of the total (e.g., Lutz, 2001; Schönwälder, Vogel, & Sciortino, 2004). However, in recent years the Migrant Clinic has begun to "specialize" in prenatal care, as discussed below. It is also noteworthy that Berlin has a substantial labor market for women working in domestic sectors such as care of the elderly, child care, and cleaning homes and businesses, as well as strong migrant representation in the city's sex work industries. These factors may help explain the higher proportion of female patients.

Table 1
Demographic features of a sample of unauthorized migrant patients ($n = 183$) visiting the clinic during the study period.

	%	*n*
Gender		
Female	59.6	109
Male	40.4	74
Age in years		
<18	14.8	27
18–30	36.6	67
31–50	38.8	71
>50	9.8	18
Region of origin		
Post-socialist Europe, new EU	24.6	45
Latin America	19.7	36
Asia	16.4	30
Sub-Saharan Africa	15.3	28
Post-socialist Europe, non-EU	12.0	22
Middle East	8.7	16
North America	3.3	6
Number of visits		
1	30.6	56
2–5	50.8	93
6–10	16.9	31
>10	1.6	3

Countries of origin

Fifty-five countries of origin were present in this sample. As noted earlier, these were grouped into seven broadly conceptualized categories. These included (with countries listed in order of frequency): post-socialist nations that have joined the EU since 2004 (Poland, Romania, Lithuania, Estonia, Bulgaria, Latvia, Slovenia); post-socialist, non-EU nations (Croatia, Serbia–Montenegro, Kosovo, Russia, Ukraine, Moldova, Bosnia, Georgia, Macedonia, Belarus); Asia (Vietnam, Mongolia, China, Korea, Japan, Indonesia, Philippines, India); Middle East (Algeria, Lebanon, Syria, Turkey, Israel, Palestine, Jordan); Sub-Saharan Africa (Ghana, Guinea, Benin, Cameroon, Nigeria, Sudan, Liberia, Mozambique, South Africa, Equatorial Guinea); Latin America (Ecuador, Peru, Brazil, Bolivia, Cuba, Argentina, Columbia, Honduras, Mexico, Dominican Republic, Chile); and North America (USA and Canada).

Grouping nationalities result in many analytical limitations, since it cannot reflect the diverse circumstances that produce migration flows from particular regions. For example, in this study individuals from Vietnam, Cuba, and Mozambique often drew upon existing labor migration ties between socialist "brother nations" and the former German Democratic Republic (East Germany). However, here they are all located in different categories, namely Asia, Latin America, and Sub-Saharan Africa, respectively.

These groupings – only one of many potential ways to categorize sending nations – are thus defined primarily by geography but also emphasize meaningful distinctions between types of EU member states. Different forms of inclusion – specifically, the presence or absence of a work visa – are important factors when considering the large numbers of individuals arriving from post-socialist European nations. The 2004 and 2007 European Union enlargements extended membership to twelve nations and essentially legalized the residency status of citizens of those states; however, most were not provided labor permits. Thus, as EU citizens they are now able to travel freely and claim residency in Germany, but must continue to work illegally because they do not have proper work permits. As a result, they are not enrolled in health insurance plans in Germany, and are usually no longer participating in the health insurance schemes of their home countries.

The largest group utilizing the Clinic was migrants from post-socialist European countries (36.6%). Of these, 67.2% percent are from states that have recently joined the European Union. Other groups that are well-represented are migrants from Latin America (19.7%), Asia (16.4%), and Sub-Saharan Africa (15.3%). There was a relationship between country of origin and gender ($p = 0.048$). Specifically, a disproportionate number of individuals from Asia (25/30) and from Sub-Saharan Africa (19/28) were female.

Number of visits

The Clinic had varied levels of contact with patients. In many cases, they came in only once for a "quick fix," or returned a year or two later when a different concern threatened their health. Others returned on a regular basis for treatment of a chronic condition. The staff was acutely aware that patients could disappear because of deportation at any time, and were often unsurprised – though not unconcerned – when a patient failed to return for follow-up. In the study sample, 69.4% (127/183) were return patients who had been to the Clinic on at least one occasion in the past. Patient number of visits ranged from one to thirty-two, with a mean of 3.4 visits per person. No significant relationships were found between the number of visits and gender, region of origin, or reason for attending.

Types of illnesses

Several distinct patterns emerged regarding types of illness in relationship to gender, region of origin, and age. The single most

Table 2
Reasons for clinic visits recorded during the study period (sample of 183 unauthorized migrant patients).

	%	*n*
Prenatal care	27.9	51
Chronic illness	13.1	24
Dental	7.6	14
Pediatrics	8.7	16
Acute illness	6.6	12
Injury	6.6	12
Infection	6.0	11
Dermatology	5.5	10
Gynecology	4.4	8
Surgery	5.0	9
Orthopedic	2.7	5
ENT	2.2	4
Urology	1.6	3
Mental health issues	1.6	3
Ophthalmology	0.5	1

common reason for visiting the Clinic was prenatal care, representing about 27.9% of all visits, followed by chronic illness (13.1%), pediatrics (8.7%), dental issues (7.6%), acute illness (6.6%), and injuries (6.6%). Men were more likely to seek care for injuries, dental issues, and acute illnesses (such as gastrointestinal infections or tonsillitis). Pregnancy was the single most frequent reason migrant women sought care at the Clinic. When those seeking prenatal care were excluded, chronic illnesses became the primary reason for women's visits to the Clinic, accounting for roughly one quarter of all complaints. The following sections draw upon observations in the Clinic and interviews with individuals to discuss four broad illness scenarios which highlight the impact of illegality on health (Table 2).

Maternal child health: limits to the overall quality and quantity of care?

Pregnancy is a precarious time for unauthorized women because of the need to interact with the health care system and state offices, which heightens their visibility and subsequent deportability. It requires extra resources for medical care and hospital delivery, and parenthood results in loss of work time and lack of mobility. Prenatal care takes on an especially important role in this particular location, representing up to 27.9% of visits and 46.8% of all women's visits. Chi-square testing for independence between reason for attending and region of origin proved to be significant ($p = 0.001$). The main pattern was region of origin and prenatal care. Migrants from Vietnam made up over 31% of patients attending the Clinic for prenatal care; this also represents 84% of all individuals from Vietnam. The second largest group seeking prenatal care services (21%) were women from Sub-Saharan Africa, especially from Ghana. These rates are especially notable when compared to their overall representation at the Clinic during the measured time period (Table 3).

Several possible explanations for this disproportionate representation emerged during the study. First, interviews indicated that referrals through existing social networks channeled women to the Clinic as a trusted source of care. A 30-year-old woman, Thi Hang, explained that, "There are many Vietnamese in Berlin but we all know each other…[W]hen I became pregnant, I came here because that is where my cousin went and also two girlfriends. They are very nice here." Second, in contrast to migrants from nations in closer proximity, such as Poland, these women are unable to return home for delivery. Because children born in Germany do not automatically become citizens, there is little benefit in giving birth here rather than the home country. However, for unauthorized women from Vietnam or Ghana, distance and difficulties associated with re-entering the country made this an improbable scenario. Finally, ethnonational conceptualizations of race in contemporary Germany make it less likely for nonwhite migrants to "pass" as tourists during hospital delivery. This is an example of the heightened visibility of bodies and movements, especially of nonwhite foreigners, which plays a role in everyday experiences of illegality.

Most pregnant women did not appear at the Clinic until their final trimester. Many also did not return to learn the results of tests provided during the initial visit, including blood typing, Rh factor, hepatitis B and HIV status, and screening for anemia and gestational diabetes. A lack of access to important preventive measures for unauthorized pregnant women has been noted in other settings (Wolff et al., 2005). The Clinic partners with other organizations by providing complementary aspects of prenatal care, including laboratory testing and arranging delivery at a local hospital. In this way, patients are able to receive discounted rates; however, expenses are almost never fully paid, and payment plans are often arranged.

The Clinic also sees a number of infants for well-baby examinations and vaccinations. These are the only truly preventive exams performed by the Clinic, and are highly structured by German medical convention with results recorded in a small yellow booklet (called the *Kinderuntersuchungsheft* or "children's examination booklet"). In all cases observed in this study, the children were unauthorized or awaiting clarification of legal status because of paternity issues or paperwork delays. Paternity is a critical factor, since Germany has retained a primarily descent-based system of citizenship. Children born in the country do not automatically become citizens, but if one of the parents is German, the child is eligible for German (or dual) citizenship (see also Castañeda, 2008a). For all intents and purposes, the *Kinderuntersuchungsheft* provided them with their first form of legal documentation.

In some ways, the medical treatment that unauthorized children received varied little from formal standards of care. Many physicians interviewed prioritized the health of the next generation. As one commented, "Children are helpless about their situation and shouldn't have to suffer because of the parents' decisions to move here. We just try to give them a better start in life than their parents have had." However, at the same time, some aspects of care were noticeably different. A look at the *Kinderuntersuchungsheft* often revealed that not all required developmental tests had been completed in a timely fashion. This was evidence that they had

Table 3
Features of a subsample of unauthorized migrant women seeking prenatal care ($n = 51$).

	%	*n*
Age in years		
18–20	5.9	3
21–30	58.8	30
31–40	35.3	18
Region of origin		
Asia	37.3	19
Sub-Saharan Africa	23.5	12
Post-socialist Europe, new EU	17.6	9
Post-socialist Europe, non-EU	7.8	4
Latin America	5.9	3
Middle East	5.9	3
North America	2.0	1
Number of prenatal visits		
1	31.4	16
2–5	56.9	29
6–10	7.8	4
10–15	3.9	2

been released from the hospital earlier than the typical newborn because of cost issues, either on their own accord or by the hospital that had donated a bed. It also illustrates that the family had not been able to follow-up with a pediatrician during the postpartum period due to lack of insurance. While this is not medically problematic as long as mother and child are healthy, it is indicative of a different standard of care.

When an examination at the Clinic yielded cause for concern, children were referred to specialists. One child was sent to a pediatric orthopedist to monitor hip development, and another to a neurologist for a suspected tumor. However, if a serious medical concern was to be identified, there was no guarantee that it could be treated. For instance, it took over two years of negotiating with various hospitals and specialists to arrange rehabilitative surgery for a disabled four-year-old boy. Emil had suffered an accident in his home country which left his right arm paralyzed. While his condition was easily correctable through surgery, his family had an uncertain legal status and no health care coverage. In 2007, the surgery was finally performed and financed using donated funds and volunteer physicians.

Chronic illness and access to medication

According to the Clinic physicians, patients who arrive are "sicker" on average than in a normal practice and often delay seeking medical treatment. In the meantime, they use over-the-counter, herbal, and homeopathic preparations acquired from the pharmacy or from friends. Prophylactic or therapeutic antibiotic use appeared to be high, based on observation and interviews. Patients often brought along packaging to show what they had been taking. Some medicines available only by prescription are more readily available in migrants' homelands and neighboring countries.

Chronic illness represents the second largest group of health concerns in this sample. Patients typically did not arrive until symptoms became acute, and medication availability and affordability was an important barrier. For example, Mirjana, a 35-year-old Romani woman, arrived at the Clinic one Friday morning. A Type 1 diabetic, Mirjana had not taken any insulin for two days because she could not afford it. She said she felt "just awful" and complained of headaches and fatigue. When asked where she usually obtained her medication, she explained that a local physician provided her with a prescription. Although she had grown up in West Germany, she had lost her residency status after returning to her Serbian homeland for a year. Since her return, she had been living in the country illegally. Her blood sugar was tested, and she was given a ten-day supply of insulin and asked to return for follow-up.

A lack of regular health care can have severe consequences for persons with a chronic illness requiring a consistent source of medication and monitoring, such as diabetes. Mirjana had enjoyed full health care coverage for most of her life in Germany, but lost this coverage along with her residency permit when she left the country for more than six months. In recent years and under normal circumstances, she had been able to use a prescription from a private physician and pay for her insulin entirely out-of-pocket. However, when money was short, she had no recourse but to stop taking her insulin. Her high glucose levels indicated that she had been very close to a diabetic coma when she decided to seek out the aid of the Clinic. Had she lapsed into a coma and been taken to an emergency room, she would have faced certain deportation upon recovery. Mirjana never returned for her follow-up appointment.

The utterly unpredictable and absolutely urgent

Other types of illnesses with particular significance for unauthorized persons are those which require immediate medical attention. These issues cannot be handled in a lay setting or with over-the-counter products, and are urgent enough to seek care regardless of fear of apprehension.

Consider the following example. Misha, a 25-year-old man from the Ukraine, first came to the Migrant Clinic in 2004 following an incident at the construction site where he worked. At the time, he had a wound that required over 20 stitches to his abdomen, and though it was very serious, his recovery was complete. One afternoon Misha arrived with his 19-year-old colleague Yuriy, who appeared to have broken his wrist. Misha translated, as Yuriy spoke very little German. He slipped going down some stairs, Misha said, breaking his fall with his right hand. The physician unwound the bandage Yuriy had wrapped around his wrist. It was very blue and swollen, and Yuriy winced as the physician probed the area, gently twisting and pulling. It needed to be X-rayed, but certainly appeared to be fractured. The physician asked Misha, "Is he here legally, illegally, a tourist, what?" Misha turned and asked Yuriy, then translated back, "He says he is here not legally, but not illegally." "Is he working here in Germany?" "No," Misha said. "Not even under the table?" "No." "Should I believe that?" "What do you mean? I, I don't understand the question." Misha tried to look genuinely confused, but a small smile showed that he had failed. The physician chuckled, and then went back to her desk to arrange an X-ray.

Migrants like Misha and Yuriy must avoid emergency rooms because they will be questioned about insurance coverage, which will inevitably expose them as "illegals." Having health insurance is taken for granted in a nation with a universal system, so that people like Misha and Yuriy cannot simply walk into the nearest emergency room without attracting a great deal of attention. While they may hesitate to seek out treatment for something even as serious as a broken wrist, they eventually must locate a trusted source of care.

Many labor migrants work in conditions in which they are likely to encounter on-the-job injuries. In another example, two construction workers were sharing a single rickety ladder while painting an interior hall. When it broke under their weight, both fell 5 m and broke their ankles. The foreman, rather than be queried about health and workers' compensation insurances at the local hospital emergency room, brought the men to the Clinic. As at least one of the men needed surgical intervention in addition to a cast, the doctors attempted to locate a surgeon willing to donate services – with little success. In this case, there were two options: find a physician willing to donate services, or skip the surgery and hope the cast alone would provide enough stability for the complex fracture. Neither one of these options represents medical best practices and thus highlights the unequal medical care individuals receive in these kinds of settings.

Another fairly common complaint during the study was abscesses. These are noteworthy because they can happen in healthy young people, do not target any particular risk group, and require lancing and drainage or excision to alleviate pain and infection. This means that they are both utterly unpredictable and absolutely urgent, which can be a nightmare for someone living illegally. In the following excerpt, Rosa, a 19-year-old woman for Ecuador, tells her story:

> "At first I thought the pain was coming from my backpack, like it was banging against that area. I wear it every day while I'm traveling around the city to my different jobs, cleaning houses. And since you don't really look back there, you can't see what it is. So I ignored it. But then one morning it just hurt so much I couldn't stand it. I couldn't go to work, I couldn't even walk, nothing. I lay in bed, and that hurt. I tried to sit up, but that hurt worse. I couldn't move. Really! None of the pain medicines worked. So then my stepmother told me to come here and get it checked. I had to have two people carry me here!"

When she arrived at the Clinic, Rosa was referred for immediate outpatient surgery for a pilonidal abscess (an infected cyst on the coccyx). It also required intensive follow-up, since the drained wound must be packed and dressings changed regularly for up to eight weeks. During the study period, there was an average of two such abscess cases per month in otherwise healthy young adults.

"Illegal syndrome": stress, anxiety, and depression

Finally, while it was generally accepted among staff and patients alike that life as an "illegal" resulted in mental and emotional stress, few cases of mental health concerns were recorded in the Clinic statistics. These conditions are almost certainly underrepresented in the data presented here as well. However, a number of "stress narratives" arose during consultations, in which patients would detail the difficult circumstances in their lives and reflected on how they directly impacted a current health problem.

Anna is a home health care worker from Romania who came to Berlin when she was 19. As she explained in 2006, "I have lived in Berlin for 13 years illegally." She entered Germany legally on a visa, but had no residency or work permit. By 2007, when Romania joined the European Union, she was considered a legal resident; however, when I spoke with her in Summer 2008, she remained without a work permit and was still working "under the table." Anna had been coming to the Clinic for several years, mostly for various somatic symptoms she herself said were provoked by "anxiety," including psoriasis, back pain, and other complaints. She said,

> "The psoriasis is stress-related, I know that. It gets worse when I'm having problems. And it started, of course, after Selim [boyfriend who brought her to Germany] left me and I was stuck without a visa and the police were looking for me. [Then] some time ago I had episodes where I had this lump in my throat, like I couldn't swallow. I went to the Clinic and they sent me to another doctor, a throat specialist. He did all sorts of tests, but he couldn't find anything! It has happened a few times since then. It is like I have something stuck in my throat (*Klosgefühl*). It is also stress-related. One of the doctors said these things are not uncommon, she calls it the 'illegal syndrome' [laughs]."

Such stress-related health concerns have begun to warrant their own description as a "syndrome," as shown in this example. This was also confirmed in some of my interviews with physicians, along with observations at the Clinic. It was not uncommon for patients to arrive with nonspecific health complaints that the physician could not diagnose by physical examination, such as general pain, malaise, or stomach-aches. Often, the physicians could provide no more than a sympathetic ear and over-the-counter medications such as antacids.

Finally, it is not unusual for refugees to seek aid at the Clinic. Some divulge that they are in the process of formally applying for asylum, in which case the staff recommends that they seek care through the state. However, services are very limited, permitting only emergency care and pain relief – issues which are defined subjectively and have been at the center of debates over access to medical care in recent years. Many refugees report being denied medical attention when they go through the proper channels, typically administrators at their assigned asylum homes. In other cases, former refugees whose asylum claims have been denied or revoked sought treatment at the Clinic.

Zarima and her husband are a married couple from Kosovo in their late 50s. Along with two children, they had come to Germany as refugees in the 1990s and were given temporary asylum. They were ordered to return to Kosovo shortly after the conflict ended, but decided to stay in Germany since their former home and livelihood had been destroyed. They now lived entirely dependant on one of their sons, who is a university student and able to secure housing for them in his name. However, they have no real income and remain sequestered in their apartment most of the time. The couple attended the Clinic on a regular basis with a multitude of complaints – the husband with high blood pressure and dermatological problems, the wife with headaches, anxiety, and depression. On one visit, Zarima complained of "high blood pressure when I get angry," and cried as she mentioned thoughts of suicide.

In these situations, there is often little recourse for physicians besides providing medication. The treatment of refugees is complex and requires substantial resources. In this particular situation, as in many others, the physician referred Zarima to an organization that provides aid to refugees facing mental health trauma, including the scars of torture. These organizations offer therapy at a reduced rate, although treatment can be difficult due to the lack of a stable environment, irregular work schedules, or lack of transportation (Brzank, Gross, & Stahl, 2002). It is difficult to locate a therapist who is linguistically capable and aware of cultural factors influencing treatment, as most therapists refuse to work using a translator. Most importantly, however, nonprofit organizations providing mental health services for refugees rely at least partially on state funding. As a result, they are required to screen patients for eligibility. As she no longer held refugee status and now resided in the country "illegally," it was highly unlikely that Zarima would be considered for mental health services, despite her long and documented history of depression.

Discussion

Effects of "illegality" on health

The data presented here stem from the largest single source of medical aid for unauthorized persons in Germany and provide a glimpse into patient background, types of illnesses, and major issues encountered during the study period. While the information sketches a picture of labor migrants at the height of their working years, other variables were less predictable. The diversity of countries of origin is particularly surprising. Among the 183 patients, 55 countries of origin were identified. The heterogeneity of migrants in this setting suggests the importance of using illegal status as a unique variable in place of or in addition to other markers. The fact that patients come from such widely divergent corners of the globe underscores their similar position in global economy and shared lack of rights – defined here as access to medical services – in contemporary German society. This suggests an independent impact of "illegality" or "undocumentedness" on health, illness, and convalescence. However, at the same time, it is important to attend to the historical and geopolitical connections that drive migrants to Germany. These include lingering migration networks forged decades ago during guestworker programs as well as current relationships with nations at the outer borders of the European Union.

Each of the illness scenarios discussed here exemplifies illegality as a health risk and reflects specific disparities in care. For example, there is generally recourse for pregnant women and their infants, even when the larger sociopolitical environment does not favor aid to unauthorized migrants. However, there are limits to the overall quality and quantity of care, evidenced by late presentation in the final trimester, a lack of follow-up for important test results, and earlier release following delivery. Children are viewed as particularly worthy of quality care; however there remain limitations in the treatment of serious conditions, such as those requiring expensive surgery. Unauthorized migrants also face barriers to obtain a steady supply of medication. As a result, chronic illnesses

may be treated only once they are in an acute stage, as evidenced by Mirjana's brush with a diabetic coma. At the same time, medication is often the only recourse for physicians struggling to treat nonspecific complaints related to generalized stress (the "illegal syndrome") and mental health concerns. The need for mental health services cannot be fulfilled by existing organizations that must exclude migrants because of their illegal status. Finally, young, otherwise healthy adults may face a range of unpredictable illnesses that require immediate medical attention. These include injuries due to accidents, such as Yuryi's broken wrist, and abscesses that require urgent treatment to relieve pain and infection. These are significant because they inevitably expose the unauthorized status of patients and potentially lead to deportation. In each of the cases presented here, access disparities extended beyond simple lack of health insurance and reflect treatment delays and avoidance because of illegal status.

During this study's conception, it was assumed that only the most marginal individuals, such as recent migrants without adequate social ties, would seek out the services of the Clinic. However, it appears that on some level, a semi-formalized system of care has emerged, based on word-of-mouth referrals, high numbers of returning patients, and growing families needing primary care. At the same time, it is also true that patients seek care infrequently, once an illness has progressed to an acute stage (in the case of pregnancy, the last trimester), and experience several barriers to convalescence. Patients faced a range of illnesses typical for their age group and not particularly distinct from the host population. Overall, the most notable disparity is the lack of access for fairly common health concerns, including inadequate preventive care and follow-up. This confirms reports from neighboring countries that suggest a similar spectrum of illnesses as well as reliance upon low-cost, necessarily substandard care by volunteer physicians and hospitals (Braun, Brzank, & Würflinger, 2003, Médecins du Monde, 2007; PICUM, 2002; Verbruggen, 2001).

Limitations

This study should be viewed as a starting point for further investigations and has several limitations. Because it is impossible to establish the extent to which Clinic patients are statistically representative of the whole population of unauthorized migrants in the area served, no conclusions can be drawn about the incidence or prevalence of health problems. Because this study relied upon a patron population in a particular setting, it may not reflect the full range of potential patients. Some may not seek out these services because they are able to draw upon other networks in times of illness. For instance, while the vast majority of Berlin's large, well-established Turkish communities are legal residents, there are local Turkish physicians who may be willing to see compatriots who are not.

Policy implications

Romero-Ortuño (2004) has argued that unauthorized migrants should be afforded publicly funded health care, as the situation is simply "inadmissible" from a human rights perspective. This is especially poignant in nations with otherwise universal coverage, and given that unauthorized migrants have been shown to demand fewer health care resources than other residents. In Germany, a number of solutions have been proposed to ensure access to medical care, such as a dedicated set of public funds to compensate physicians. However, there remain different opinions about how to finance it, and some have argued that it would result in a parallel health care system with differential treatment and chronic underfunding (Braun et al., 2003). In other words, there is no guarantee that it would be any different from the current reliance upon nongovernmental organizations and charity clinics, especially given political reluctance to alter the policy environment.

Overall, the situation in Germany is one in which certain minimal rights to health care are technically available, but unauthorized migrants are not assured access to these rights. While emergency medical aid is guaranteed through one set of laws, other policies require that migrants be subsequently reported to the authorities if they access treatment. Similarly, physicians and hospitals are already entitled to reimbursement for providing services to uninsured persons, but another law states that "assisting" unauthorized persons is a crime. These paradoxes may create the illusion that steps have been taken to discourage further unauthorized migration and punish offenders. However, this incoherent policy environment contributes to inadequate medical care and fosters short-term remedies without additional resource commitment. Over the long term, this represents reliance upon improvisational strategies rather than dedicated political commitment to ensuring adequate medical care.

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