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Right of access to health care for undocumented migrants in EU: a comparative study of national policies

Carin Björngren Cuadra

Faculty of Health and Society, Malmö University, Malmö, Sweden

Correspondence: Carin Björngren Cuadra, Faculty of Health and Society, Malmö University, 205 06 Malmö, Sweden, tel: +46 (0)40 66 57 964, fax: +46 (0)40 66 58 100, e-mail: carin.cuadra@mah.se

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Background: The aim of this article is to characterize policies regarding the right of access to health care for undocumented migrants in the 27 Member States of the European Union and to identify the extent to which these entitlements are congruent with human rights standards. **Methods:** The study is based on a questionnaire sent to experts, non-governmental organizations and authorities in the Member States between April and December 2009, as well as on available reports and official websites. Primary sources were also consulted as regards legislation. **Results:** Right of access to health care differs considerably between Member States. States can be grouped into 3 clusters: in 5 countries undocumented migrants have the right to access care that is more extensive than emergency care; in 12 countries they can only access emergency care and in 10 countries not even emergency care can be accessed. These variations are independent of the system of financing or the numbers of undocumented migrants present. Rather, they seem to relate to the intersection between practices of control of migration, the main types of undocumented migrants present and the basic norms of the welfare state—the 'moral economy' of the work society. **Conclusion:** International obligations articulated in human rights standards are not fully met in the majority of Member States. A more complete understanding of the differing policies might be obtained by considering the relationship between the formal and informal economy, as well as the role of human rights standards within the current 'moral economy'.

Keywords: access, European Union, health-care policy, human rights, moral economy, undocumented migrants

Introduction

In the EU context, the term 'undocumented migrants' refers to third-country nationals without a valid permit authorizing them to reside in the EU Member States. This includes those who have been unsuccessful in asylum procedures (rejected asylum seekers) or who have violated the terms of their visas ('overstayers'), as well as those who have entered the country illegally. The type of entry (i.e. legal vs. illegal border crossing) is thus not considered to be relevant in defining the concept. According to recent estimates, there are between 1.8 and 3.9 million undocumented migrants in the fifteen core Member States.[1] Approximately 1% of the entire population in the European Union and on an average 10% of the foreign-born population is undocumented.[2] The problematic nature of undocumented migrants' access to health care has recently gained attention in public discourse as well as in research.[3–5]

An important point of reference concerning access to health care is provided by standards outlined in the human rights framework. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms the right of everyone to enjoy the highest attainable standard of physical and mental health.[6] Other binding treaties incorporating the right to health include the International Convention of the Rights of the Child (CRC), the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Constitution of WHO, the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion and the Bangkok Charter for Health Promotion in a Globalised World.[7] The Committee on Economic, Social and Cultural Rights, which monitors and interprets ICESCR, advised that states are 'under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including [...] asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; [...]' (para. 34).[8] Hence, from a human rights perspective, health care clearly involves primary, secondary as well as preventive care. The Council of Europe has addressed the situation of undocumented migrants in a resolution of the Parliamentary Assembly. 'Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants', Article 13.2 declares that as a minimum right, emergency care should be available for irregular migrants.[9] States should also 'seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly'.

Although these international and European instruments imply a uniform approach, policies regulating undocumented migrants' entitlement to health care differ widely between EU Member States. In this article, policy is understood as 'a standard that sets out a goal to be reached'.[10] This broad understanding is chosen in order to be applicable both to countries in which legal norms are in place, and countries which have not explicitly regulated these issues.

The extent to which a health-care system is accessible to individuals has to do with the system's financial characteristics.[11] To begin with, health-care systems can be differentiated according to their financing systems, which may involve public financing (such as tax and social insurance contributions), private health insurance or out-of-pocket payments. In this way, we can differentiate Member States with (i) mainly tax based and (ii) mainly social insurance-based systems.[12] A further differentiation can be made in terms of whether taxes are collected centrally (Ireland, Malta, Portugal and UK) or locally (Cyprus, Denmark, Finland, Italy, Spain and Sweden). In social insurance-based systems contributions can be collected by central government (Belgium, Bulgaria, Estonia, France, Hungary, Latvia, The Netherlands, Poland, Romania and Luxembourg) or directly by health insurance funds (Austria, the Czech Republic, Germany, Greece, Lithuania, Slovakia and Slovenia). Parallel to the collective system of financing, some Member States (e.g. Bulgaria, Greece, Cyprus

and Latvia) rely most heavily on individual out-of-pocket payments.[12]

Entitlement to health care within a particular system is related to the current basic norms and institutions of the welfare state and the individualized rights of access to service.[13] However, another consideration in the case of undocumented migrants is the way in which migration, regular as well as irregular, is dealt with. The latter question has direct relevance to migrants' entitlements in general,[14] as well as to the pathways into irregularity in each national context and the question of whether or not the presence of undocumented migrants is acknowledged.[15]

In order to discuss undocumented migrants' entitlements, the notion of 'right' needs further clarification. The right to health, as understood in this article, involves a notion of accessibility in line with the UN Committee on Economic, Social and Cultural Rights in its comments on implementing ICESCR.[8] This committee proposes that the right to health entails being able to receive care which is available, accessible, acceptable and of good quality. 'Accessibility' is further broken down into four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility. 'Accessibility' is thus understood as an essential element of 'right'.[8] In this article, we are mainly concerned with the issue of 'economic' accessibility. Consequently, the level of co-payment and affordability for patients is the central issue when comparing policies on entitlement. Characteristics such as cost-sharing arrangements ('out-of-pocket payments'), which may undermine accessibility for people at risk of exclusion are of special interest.[16]

Against this background, we would not regard care which an undocumented migrant has a right to access, but only in return for payment of the full cost, as being 'accessible'—since in most cases such care will not be affordable. This form of financially conditioned right is not consistent with the notion of right embodied in the human rights framework. Nevertheless, it is reasonable to regard a moderate fee, commensurate with that paid by other patients, as not seriously impairing accessibility.

When discussing access to health care for undocumented migrants it is relevant to note that empirical studies have shown that such migrants often experience a fear of being reported to police or immigration authorities by health workers or administrative staff, and that this anxiety constitutes a barrier to seeking care.[17–19] To the extent that 'denunciation' is governed by explicit rules (either requiring it or forbidding it), these rules can be considered as part of a country's policy on health care for undocumented migrants. However, this topic will not be pursued further here because an explicit obligation to denounce is only found in two of the 27 Member States: Lithuania and (in certain circumstances) Sweden. (Policy in Germany was changed in September 2009). Rules 'prohibiting' denunciation are often indirect; the practice can, for example, be forbidden on the grounds of laws regulating the confidentiality of the medical encounter and the protection of privacy.

However, the anxiety migrants experience may not have much to do with the regulations that exist on paper. This issue provides a good illustration of the 'implementation gaps' that may exist in this field. Health workers or administrators may choose to report migrants to the authorities when they are not supposed to do so—or keep quiet about them in spite of an obligation to report them. If the latter only occurs incidentally, it does not really remove the barrier to access for the migrant, because he or she cannot know in advance whether it is safe to seek medical help.[17–19]

Such 'implementation gaps' can also arise with regard to the basic question of entitlement to free or subsidized care. In a negative direction, staff may refuse access because they do not know the rules or do not agree with them. (No Hippocratic Oath exists for receptionists and administrative staff.) In a positive direction, there are many examples of individuals or institutions offering a' window of opportunity' to undocumented migrants in spite of regulations, which are supposed to exclude them from care. From this perspective, a clarification of legislation could paradoxically imply stricter access, 'the closing of the window of opportunity'.

The intricate relationship between policy and practice cannot be further investigated in this article. Our aim is far more limited: it is to characterize and compares policies regarding entitlement to health care for undocumented migrants. A clustering of the 27 Member States based on the collected data will be offered. An additional aim is to identify the extent to which undocumented migrants' entitlement to health care in EU27 is congruent with human rights standards.

Methods

An initial methodological question is how to differentiate qualitatively the amount of care undocumented migrants are entitled to. For this purpose the Council of Europe's notion of 'minimum right' was found useful.[9] Centred on this concept, entitlement to health care can be clearly categorized in three levels: (i) less than minimum rights, (ii) minimum rights and (iii) more than minimum rights.

A first phase of this research involved 'desk research' in order to identify relevant indicators to describe and compare policies. This stage involved locating relevant sources including published literature, research reports and 'grey literature' such as reports from government departments and non-governmental organizations. Sources covering health systems and/or with special focus on undocumented migrants, as well as those relating to migration at European Union and country level, were explored. Once the indicators had been identified a questionnaire (in English) was formulated, which was intended to guide expert interviews covering five topics: welfare system, health-care system, policies regarding undocumented migrants, health care for undocumented migrants and context of migration.

The validity and reliability of this questionnaire was tested by asking several researchers to fill it in in a number of different countries, as well as researchers engaged in a separate overview of policies. The questionnaire had both closed and open questions and space was provided to allow for additional remarks. It was sent by e-mail to one identified expert (preferably a researcher) in each Member State during April–December 2009. The experts were recruited from research networks in the field of migration and health (e.g. the COST HOME network and MIGHEALTHNET), and from non-governmental organizations advocating for undocumented migrants. Occasionally a contacted person provided a new contact.[20] To cover Romania and Hungary, research assistants (fluent in the respective languages), were appointed to obtain data from authorities because of the difficulty of finding suitable contacts. For some countries, the most knowledgeable contacts identified consisted of ministries and embassies. This was the case of Estonia, Ireland, Latvia, Slovak Republic, UK and partly in the case of Germany. Before distribution the questionnaire was partly filled in by the author using information acquired from 'desk research'. This provided a check on the information already acquired, which was important because realities on the ground are constantly changing. Frequent correspondence was required to probe for clarifications as well as sources. Statistical information (volume of migration, numbers of undocumented migrants, etc.) was obtained from official websites (national authorities) and from secondary sources which are specified in the Country Reports.[20]

Results

On the basis of the findings, it was possible to group Member States in three clusters based on the level of entitlement of

(adult) undocumented migrants to health care. Each cluster was further subdivided according to the method of financing of the health system.

Cluster 1: less than minimum rights

In the first cluster, we find Member States in which entitlement is restricted to an extent that makes even emergency care inaccessible for undocumented migrants as it is not affordable. This cluster also includes Member States offering health care only within detention centres. Ten Member States can be found to be applying this level of rights. The classification only refers to policies on paper, and because of the 'implementation gaps' mentioned above it is possible that a better level of care is sometimes provided in practice; however, such exceptions are arbitrary and not predictable from the patients' perspective (table 1).

Cluster 2: minimum rights

In the second cluster, we find Member States in which undocumented migrants are entitled to emergency care, or care specified in terms such as 'immediate' or 'urgent'. In some cases, there is a moderate fee. From the patients' perspective, the provision of care is predictable, as the rules do not allow health-care staff to exercise their discretion as to who will or will not receive care. Included in this cluster are also the Member States, where health care of a more extensive kind might be accessed under certain unpredictable circumstances (e.g. at the discretion of the professional involved), or in return for payment of the full cost. Twelve Member States were found to be applying this level of rights (table 2).

Cluster 3: more than minimum rights

In the third cluster, we find Member States in which entitlement to health care includes services beyond emergency care, in particular primary and secondary care. The relevant provisions are laid down in legislation which explicitly refers to undocumented migrants. Entitlement is associated with administrative procedures which may, in practice, impair access to care to a certain extent. Collectively, five Member States can be found to be applying this level of rights (table 3).

Table 1 Member States in which undocumented migrants have less than minimum rights of access health care

Right of access	Member States	
	Tax	Insurance
May access emergency care for an unclear cost	Finland Ireland	
May access emergency care in return for payment of the full cost	Sweden	Austria[a] Bulgaria Czech Republic[b] Latvia
Right to access emergency care, provided they are affiliated to insurance, via employment or privately		Luxembourg[c]
State medical care and services free of charge within the framework of detention centres	Malta	Romania

a: Applies to first aid, in case of emergency, at federal hospitals. As the hospitals are obliged to pay the costs if the patient turns out to be unable to pay (or not identified) and if the possibility for a patient to get a considerate dept is not stressed, it might be interpreted as a minimum right
b: Alternatively, on upon purchasing a private insurance
c: Undocumented migrants might also fall inside the system, depending on their level of income and can access primary care as well as specialist care provided they are insured by way of employment

Table 2 Member States in which undocumented migrants have minimum rights of access health care

Right of access	Member States	
	Tax	Insurance
Right to access emergency care free of charge.		Germany Hungary[a]
Right to access emergency care free of charge. May in principle access primary and secondary care in return for payment of the full cost.	Cyprus Denmark U K[b]	Estonia Lithuania Poland[c] Slovak Republic Slovenia[d]
Right to access 'urgent medical aid' (AMU). Involves an administrative procedure by social services centres (CPAS/OSMW) to verify irregular stay and 'destitution'.		Belgium[e]
Right to access emergency care in case of life-threatening conditions at emergency units.		Greece

a: May in principle access primary care with private practitioners in return of payment of the full cost
b: Applies to Accident and Emergency departments. May in principle access primary care (if accepted to register by a GP) and secondary care for payment of the full cost or are exempted (determined on a case by case basis)
c: If affiliated to insurance, rejected asylum seekers or 'overstayers' of visas may access primary and secondary care for free
d: May access primary and secondary care in the Health Centres for Persons without Health Insurance
e: The term 'urgent medical aid' might imply both preventive and curative care such as examinations, operations, childbirth, physiotherapy, medications, tests, exams, etc.

Table 3 Member States in which undocumented migrants have more than minimum rights of access health care

Right of access	Member States	
	Tax	Insurance
Right to access health care free of charge. Access involves an administrative procedure.	Italy	Netherlands[a]
Right to access healthcare for no, or a moderate, fee. Access involves an administrative procedure and is subject to a prerequisite involving the period of stay.	Portugal Spain	France

a: Care is defined in terms of 'directly accessible' and 'not directly accessible' services and free of charge. The latter form requires a referral to a provider with a contract to deal with UDM. The service provider is only reimbursed if attempts to recover the costs from the patient have failed; moreover, for most services reimbursement only covers 80% of the cost.

Discussion

While the results of this study are highly interesting, they also have to be interpreted with some caution. As already mentioned, the situation in many countries is not static, so that some information may already be out of date. Another qualification is that the clustering is based on policies regarding adults. If children were included, a different clustering would result. Finally, we must repeat again that the study was concerned with policies and did not attempt to investigate the way these policies are implemented in day-to-day practice. It is known from previous reports[5,18,19] that many of the problems that undocumented migrants experience have just as much to do with implementation than with the laws governing entitlement. Nevertheless, implementation can only be improved when policies are in place that can be implemented.

It is clear that there are wide differences in the entitlement to health care for undocumented migrants in the EU27. In 10 Member States, the right of access to health care is less than the minimum standard outlined by the Council of Europe. In 12 Member States, there is access to emergency care, thus meeting this minimum standard. However, according to the interpretation of the ICESCR given by the UN Committee on Economic, Social and Cultural Rights, access to emergency care falls far short of the full scope of the right to health. There are, therefore, 22 Member States whose policies do not conform to the right to health specified by the UN. Even among the five Member States offering access to a broader range of care, weaknesses in the design and implementation of policies have been signalled which in practice tend to undermine their effectiveness.

A second observation is that the variations observed do not seem to be associated with the system of financing (mainly tax based or insurance based). There is no relation between the financing system and the levels of care to which undocumented migrants are entitled. Intuitively it might also be expected that strong, well-established welfare states will grant more complete entitlements than newer welfare states. However, comparing Sweden on the one hand with Portugal and Spain on the other shows that the opposite is also found.

What, then, do the Member States in each cluster have in common? Can any patterns be identified? In order to approach this topic, at least tentatively, it may be worth considering some issues relating to migration. The volume and nature of irregular migration, as well as the approach to irregular migration embodied in practices of regularization, might offer some clues. Regularization is a 'state procedure by which third country nationals who are illegally residing, or who are otherwise in breach of national immigration rules, in their current country of residence are granted legal status.'[15]

As regard the volume of irregular migration, it is interesting to note that all the Member States found in the third cluster have high (Italy, Spain and Portugal) or medium (France and The Netherlands) proportions of undocumented migrants in a European comparative perspective.[15] In the second cluster, some countries have high proportions (Belgium, Cyprus, Germany, Greece, Hungary and UK), whereas others have low (Denmark, Lithuania, Poland, Slovak Republic, Slovenia) or medium (Estonia) proportions. In the most restrictive cluster, countries with low (Bulgaria, Finland, Ireland, Latvia, Malta, Romania) or medium (Austria and Sweden) rates are found, while the magnitude in Luxembourg is unclear. However, we also find a Member States with high numbers in the restrictive cluster (Czech Republic).[15] From this, we can conclude that the volume of irregular migration is a poor predictor of policies on access to health care.

We can also consider the nature of irregular migration, i.e. the types of irregularity most often found. Countries in the third cluster mainly harbour undocumented migrants whose pathway into irregularity is related to the (informal) working market, while countries in which the undocumented migrants are largely 'produced' by the asylum system (rejected asylum seekers)[15] tend to be found in the more restrictive clusters. Also The Netherlands with its relatively large numbers of rejected asylum seekers fit this pattern as the largest group of undocumented migrants consists of labour migrants.[17]

A last observation concerns the differing practices of regularization, which generally tend to relate to Members States' policies of external or internal control of migration.[21] 'External' controls focus on the borders and entry points of a country, while 'internal' control is based on administrative measures, in particular restricted access to welfare benefits and public resources.[22] The very fact that undocumented migrants do not have the required permits and documentation make them prime targets of internal control. Based on the findings from the REGINE study on regularizations in Europe,[15] it seems as if most countries in cluster three rely on regularization practices (France, Italy, Spain and Portugal). However, The Netherlands only use regularization on humanitarian grounds (i.e. in relation to the asylum system). Among the countries found in the middle cluster, we find only one relying on regularization programmes (Greece), new Member States using small scale regularization (Estonia, Hungary, Lithuania, Poland and Slovak Republic) or not at all (Cyprus and Slovenia). In this cluster, we also find the UK using regularization very sparingly, while Belgium and Denmark uses regularization on humanitarian grounds and Germany is ideologically opposed to it, yet allows it to a slight extent in practice. In the most restrictive cluster, we find countries that are ideologically opposed (Austria), new non-regularizing Member States (Bulgaria, Czech Republic, Latvia, Malta and Romania), countries that only use regularization on humanitarian grounds (Finland, Luxembourg and Sweden) and countries that use only small scale regularization (Ireland).[15] It seems reasonable to claim that the overall impression with regard to regularization is that countries with more restrictive policies on health-care entitlement also tend to rely on internal control of migration, or at least do not rely on regularization practices.

Do further patterns emerge if relationships to the logic of social policies are explored? The basic norms and institutions of the welfare state involve redistribution over the individual's life course. The aim is security, i.e. managing risks (such as sickness, disability and old age) to which the organization of work leaves the individual exposed.[23] Health care is to be understood as an activity of risk-management, one of the core fields of social policy.[13] Redistribution is underpinned by the collectively shared moral assumptions that define the rules of reciprocity and determine the criteria for inclusion and exclusion in the system of social care and security.[23] The basic collective norms and obligations, characterized as the 'moral economy' of the society,[24] concern as well which risks should be covered and who are eligible and what are legitimate practices.[23]

The current moral economy is that of a 'work society'. This notion expresses the fact that it is above all the social organization of work that structures welfare state interventions and norms of reciprocity.[23] Such issues go far beyond the scope of this article. However, they suggest that the relation between the labour market and irregular migration may be pivotal to health-care policies. Hence, to fully understand the differing policy approaches regarding undocumented migrants it may be fruitful to consider the theoretical discussion on the welfare state and its relationship to, and role within the market economy and labour market. In particular, the relationship between the formal and informal economy within the context of the 'moral economy' may shed some light to the situation of the undocumented migrants. Furthermore, the role of human rights standards within the current moral economy deserves to be considered when pondering, not least from a public health perspective, the question of why rejected asylum seekers so often seem to be excluded from the norms of reciprocity maintained in the EU27. As regard policy makers, a salient question would be to cite Doomernik and Jandl; 'How fare can states go in the implementation of their control, particularly in terms of human rights for migrants and refugees?'[21]

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Key points

- The article groups the differing levels of right of access to health care for undocumented migrants in the EU 27 in three clusters.
- Ten Member States do not even grant access to emergency care; 12 grant access to emergency care, while 5 grant access to more extensive care.
- The obligations as regards health care outlined by the human rights standards are met only partially, or not at all, in the majority of Member States.
- Differences do not seem to relate to system of financing or volume of irregular migration, but rather to categories of undocumented migrants and strategies for controlling migration.
- European health policy makers should consider the role of human rights standards within the basic norms and institutions of the welfare state in relation to the issue of irregular migration.

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