Social Inclusion and Access to Basic Services of Third-Country Nationals (AccessIN)

Working Paper on the role of interactions between medical staff and migrant patients in determining access to services

AccessIN Deliverable D4.5 (Work Package 4)

This publication was funded by the European Union's Asylum, Migration and Integration Fund. The content of this publication represents the views of the author only and is his/her sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

Introduction

This working paper explores access and provision of healthcare to non-EU migrants through the narratives of medical staff and migrant patients. Access, non-access, and quality of provision can be conceptualized through a border studies framework. In particular, this follows from a 'processual shift' in border studies (Brambilla, 2015), which recognizes that borders proliferate within the formal demarcations of nation states; and that these 'internal borders' are enacted through institutional procedures, relationships, and a variety of actors, most notably street-level bureaucrats. In the case of healthcare, these processes are multifaceted and multi-scalar, with different levels of governance and municipalities often implementing varying, and sometimes conflicting policies (Bendixsen and Näre, 2024). For migrants, healthcare access is bordered not only by formal 'top-down' regulations but also by a diverse array of actors, including doctors, nurses, civil society organizations, local authorities, and migrants themselves, underpinning the institutional and social construction of the border (Paasi, 1998; Villa, 2000). To explore this healthcare border, this working paper examines the narratives of healthcare workers and non-EU migrants across cities in Belgium and Germany, two key migrant receiving countries, within which interviews were conducted as part of the AccessIN project.

Sites and Interviewees

The study design used a comparative approach to include perspectives from both healthcare providers and migrants. We focused on large, diverse migrant-receiving cities and smaller (nearby) towns in both countries - German interviews took place in Frankfurt, Offenbach, and Marburg, while Belgian interviews were primarily in Brussels, with some in Liège. In total, 107 interviews were conducted with healthcare workers and third-country migrants in Germany and Belgium. This included 26 healthcare workers (14 in Germany, 12 in Belgium) and 81 non-EU migrants equally divided between the two countries.

The interview sample reflected a diverse set of professional settings (from the healthcare worker interviewees) and immigration journeys (from the migrant interviewees). The healthcare professionals came from a variety of organizations, including public health institutions and various NGOs, resulting in a multidisciplinary sample. Participants included directors, managers, coordinators, doctors, nurses, social workers, psychologists, psychotherapists, and socio-legal advisors, predominantly female (20 women, 6 men). The migrant sample was diverse in age and background, with an average age of 37 years (ranging from 21 to 74) and a slight female majority (60%). Migrants arrived through various pathways such as student visas, work permits, marriage, and irregular means, with some gaining legal status post-arrival. Most had been in Europe for less than five years, though the range extended from two months in Belgium to 35 years in Germany.

Participants originated from South America, Central America, the Caribbean (Trinidad), the Middle East (Iran, Iraq, Syria), North Africa (Morocco, Algeria), Sub-Saharan Africa (notably Ghana, Cameroon), Malaysia, and Ukraine, highlighting the diverse migrant populations in Belgium and Germany. Interviews were conducted in English, French, German, and Spanish. The data was coded and analyzed inductively to explore healthcare access challenges and

experiences for migrants in accessing and using public healthcare. This also allowed us to determine the services available to migrants in each site, as well as the key local actors.

Local Healthcare for Migrants

The Belgian Cities

Local actors in Belgium have established a robust support network for migrants. This involves NGOs, government agencies, and other organizations. Brussels, as a central hub for refugee processing, hosts many of these services, including immigration and arrival centers, making it a focal point for NGO efforts. One key facility is the Hub Humanitaire ("the Hub"), created in response to the 2015 migration crisis. The Hub operates as a day center, offering a range of services such as medical and mental health care, hygiene facilities, food, clothing, and social, administrative, and legal assistance, particularly for minors and family reunifications. Today, it assists migrants from 104 different nationalities, with many from Eritrea, Afghanistan, Burundi, and Ethiopia. The Hub is managed by Médecins du Monde, the Belgian Red Cross, Médecins Sans Frontières, SOS Jeunes-Quartier Libre AMO, and the Citizen Platform BE Refugees, allowing each organization to specialize while coordinating efforts.

Médecins Sans Frontières Belgium (MSF) plays a significant role in healthcare, especially mental health services, for migrants. It is recognized by migrants in Brussels due to its international presence (along migration routes). MSF initially targeted migrants heading to the UK but has since expanded to include asylum seekers affected by Belgium's reception crisis. In 2022, MSF set up a temporary clinic, conducting 2,500 consultations in three months. During COVID, MSF ran a vaccination campaign that further aimed to integrate migrants into the mainstream healthcare system.

The NGO network in Belgium works collaboratively to provide comprehensive support. MSF focuses on psychological support, notably utilizing intercultural mediators to improve communication. The Red Cross runs emergency shelters and clinics offering various medical services, including specialized consultations and dental care. SAMU Social supports unaccompanied minors and homeless migrants. Additional specialized clinics address HIV and tuberculosis, while a Refugee Medical Point caters to uninsured migrants. The Citizen Platform, which began as a grassroots initiative, now offers extensive shelter and support services. Saint-Pierre Hospital is known for accepting migrants despite the financial burden, enhancing the network of healthcare services available to migrants.

The German Cities

In Germany, migrants can access care beyond emergency treatment through a network of services and organizations that includes clinics, health authorities, and NGOs. Services range from general medical services to specialized consultations like dental and physiotherapy. The Frankfurt Health Department is a key player in this effort. They run Humanitarian Consultation Hours in partnership with organizations like Maisha, which supports African women. This program offers weekly pediatric and gynecological services, as well as biweekly general

medical consultations, addressing a broad range of health issues including high blood pressure, diabetes, pregnancy care, HIV testing, and female genital mutilation (FGM). Since 2021, the department has also operated a Clearing House that provides personal counseling to help migrants navigate the healthcare system, clarify their insurance status, and overcome language barriers, all while ensuring confidentiality. The Health Department also runs an outpatient childbirth program for women, covering costs through installment plans and alternative funding. Hospitals in the area provide protected consultation hours, midwifery services, at-home postnatal care, and a 'baby pilot' program to assist with parental allowance applications.

The Caritas Association runs the Elizabeth Street Outpatient Clinic, which offers medical, dental, and physiotherapy services to uninsured and homeless individuals. With twelve permanent staff members and over thirty volunteers, the clinic operates on weekdays and conducts outreach using an ambulance bus. More than half of the patients have irregular or temporary legal status. Malteser Medicine for People without Health Insurance in Frankfurt and Offenbach provides care for both acute and chronic conditions, supplies medications, and offers social counseling. They rely heavily on volunteers, which helps alleviate migrants' fears about data sharing with authorities. Their services cater to migrants from various regions, including Iraq, Afghanistan, Turkey, the Caribbean, South America, and Syria. Numerous other initiatives and organizations exist, including the Crisis Intervention Center for Boys, Young Men, and Transgender People in Sex Work, and Fatra, which offer a range of services specifically targeted to their user population as well as helping migrants to integrate.

Narratives of Migrants

Belgium

Interviews with migrants in Belgium have unveiled a complex set of obstacles in accessing healthcare, highlighting the diverse nature of these issues. A major factor is immigration or legal status. Those without regular status in particular are especially disadvantaged, as the lack of official papers severely restricts their ability to join health insurance plans or receive subsidized services. These individuals frequently have to pay upfront for specialized medical treatments, with only partial reimbursements from insurance. This financial burden is worsened by the challenges of opening bank accounts, which are complicated by residency status and banks' hesitance to serve temporary residents. This impacts their employment income, ability to pay for services, and sense of belonging. It also adds precarity, with one respondent for instance sharing a story of workplace harassment, which then led her seek out medical support for mental distress:

"…around 4 in the afternoon she said to me, 'And don't you dare go on sick leave because if you do, you won't come back to this office, you won't return to this job, because I will make your life impossible, and I'll even have your papers taken away'. One interviewee described exclusion as making them feel invisible:

> "We have no rights to anything. That's why I say that we do not exist…"

The financial strain can be substantial, as demonstrated by one interviewee who had to pay nearly seven thousand euros for childbirth due to a lack of insurance coverage. One interviewee

noted that she had been misinformed about the costs associated with her medical stay by hospital staff:

> "I got to the hospital, and the first thing they ask is for your document and your mutual insurance. I remember, even in my pain, the doctor asked what insurance I had, and I said Partenamut. He asked if I wanted a private room or shared. I asked, 'What's the difference?' He said, 'There is none because you have good insurance.' So I chose private…. When I got the bill, it was 6,000 euros. My mutual insurance covered half, so I had to pay 3,000 euros. That's a lot when you only earn 1,500 to 1,800 euros a month and have to pay 900 euros for rent."

The fear of being turned away due to irregular status can further deter migrants from seeking medical care, as expressed by another interviewee:

> "I don't know… what if I show up at the doctor's office, and suddenly he tells me, sorry, I can't treat you because you are illegal."

Navigating the healthcare system involves numerous administrative challenges. Upon arrival, migrants often lack information and guidance, making it difficult to understand and access their rights and services. The process of renewing status or understanding the different regulations across various communes is particularly challenging. The inconsistency in urgent medical aid support and unclear healthcare entitlements add to the difficulty. Social assistants are available, particularly for those under support of Fedasil, the Belgian asylum agency, but their quality varies. The presence of support staff can increase pressure and stress for migrants, who worry about miscommunication or being judged:

> "There is the one who asks questions, then there is the translator, and then there is another person taking notes. There are like three people there. I mean… the pressure one has there not to make a mistake [is great]."

Cultural differences and discrimination based on appearance or nationality adversely affect migrants' experiences in the healthcare system. Being labeled as non-European or receiving unequal treatment can create a hostile environment, discouraging them from seeking medical care. Many interviewees felt discriminated against based on their looks or origin. Language barriers significantly impede their sense of belonging and access to healthcare. One interviewee found language to be a bigger obstacle than lacking documents, as it hampers understanding of the process and options. Miscommunication in medical settings can also affect other areas, such as financial difficulties. One interviewee believed their financial problems could have been lessened if they spoke the language:

> "When you don't know French, when you're a foreigner, when no one tells you, you're not always aware that you have the right to split it and pay in installments."

Besides this, many interviewees noted perceiving discrimination generally that transcends their healthcare experiences to include other aspects of their life. Others noted that co-ethnic medical staff displayed hostility. This is exemplified by one Spanish-speaking migrant who faced hostility from a Spanish-speaking nurse who insisted that communication occurred in French, despite the interviewee not being able to speak French fluently:

> "So [the nurse] entered and said, 'speak,' so my friend and I spoke in Spanish. Then she said, 'Oh, you speak Spanish,' and I said, 'Oh yes, how nice, it makes me happy to hear

someone speak Spanish.' And she replied, 'Oh yes, that's nice, but you need to speak to me in French.' Imagine the look on my face. She said, 'Speak to me in French.' And my friend replied, 'Oh, you speak Spanish, so why?' She said, 'That's superiority,' and left because she had to do an exam. She said, 'You're in the country where you need to speak French, not Spanish.' I told her that I speak French when I need to, but if I'm talking with someone who speaks Spanish, I speak Spanish. That superiority is so horrible. I said, 'If you don't want to treat me because I don't want to speak French, then I will leave and ask for another appointment.' She didn't want to treat me unless I spoke French."

Housing is closely tied to health and presents additional challenges for migrants. Securing rental accommodation is difficult for those on social assistance or without stable jobs. Irregular migrants noted that landlords often prefer tenants with steady employment over those reliant on social assistance. The stress of migration, especially the asylum process, can lead to mental health issues that are often under-recognized and poorly addressed, compounding existing trauma from their migration journey. Access to psychological support services is limited, even for native Belgians, and is further restricted by the same barriers: legal status, financial constraints, language difficulties, and cultural misunderstandings. Moreover, the interviewees mentioned long wait times for specialized services.

Germany

Similar to the situation in Belgium, nearly all interviewees in Germany identified the language barrier as a major challenge. This barrier caused misunderstandings, perceptions of inadequate care, and feelings of being ignored or disrespected by healthcare providers. Many found medical terminology particularly difficult to understand and frequently needed to ask for clarifications or translations. Some resorted to using Google Translate or relying on bilingual acquaintances, while others tried to find English-speaking doctors but often with limited success. The lack of fluency in German also led to fear and pressure, with one interviewee stating:

"If you don't speak German, you're nobody; and life becomes very difficult."

Navigating the German healthcare system was also challenging due to its perceived complexity and bureaucracy. Interviewees struggled with paperwork and communication with insurance companies. Most had to navigate the system without structured guidance, relying instead on family, internet searches, chance encounters, or medical necessity. Many found adapting to a new system difficult, especially understanding the intricacies of the German insurance system, such as specific coverage and additional insurance for treatments like dental care, as well as data protection laws. Some, for instance, chose to return to North Africa and Latin America for treatment despite having coverage in Germany.

Cost was another barrier, particularly for those without insurance or with private insurance, and especially for irregular migrants. Some had to pay in installments or rely on family contributions. Finding doctors who accepted their insurance was also difficult for those without statutory insurance. One interviewee highlighted their lack of insurance and the hope of not falling ill, stating:

> “I have to get through the system and then make my own insurance, so I'm hoping and staying careful so that nothing happens to me.”

Many interviewees reported difficulties in finding doctors accepting new patients, especially during the COVID-19 pandemic. This was even more challenging when seeking specialists and gynecological care. Long wait times for appointments and extended waits in doctors' offices despite having appointments were common frustrations, compounded by their uncertainty with the system. Personal advocacy or assistance from family and friends was often necessary to understand the healthcare system, find doctors, and deal with insurance issues.

Lastly, cultural differences in medical practices and perceived discrimination were also mentioned. Some interviewees felt their concerns were not taken seriously or that they received different treatment due to their nationality. There were instances where migrants felt disrespected for not speaking German and believed they faced discrimination based on the visibility of their religion, affecting their interactions with healthcare providers. Many characterized the care as lacking warmth and thoroughness compared to their expectations from their countries of origin. This evidences the importance of actors throughout the healthcare experience. For example, one interviewee explicitly considered nurses and secretaries to be ‘gatekeepers’:

> "I´ve gone to a couple of [GPs] where they treat people very poorly. Especially I want to emphasize on the fact that all the places I went to which were bad it wasn´t the doctor who was bad it wasn´t the nurses who were bad. It´s the people at the entrance you know the gatekeepers actually who don´t treat people nicely."

Narratives of Healthcare Providers

Belgium

In Belgium, healthcare professionals with whom we spoke highlighted numerous challenges in providing services to migrants, many of which arise from a complex and sometimes hostile administrative and political processes. The asylum process is particularly complicated, with processing times varying based on the migrant's country of origin, leading to unequal access to services. The Belgian government has been criticized and faced legal actions for insufficient asylum support, indicating systemic issues in addressing migrant needs. Most interviewees noted that the Belgian government dismisses the humanitarian concerns of migrants, unlike local governments, which work with NGOs through more open and reciprocal relationships.

NGO interviewees noted a public fatigue surrounding migration that was attributed to negative media portrayals of migration. Interviewees felt there was a lack of positive discourse on migration, with little discussion about regular migration or the development of safe, legal pathways for migrants. Many discussed a worsening “reception crisis” in the Belgian asylum system. Additionally, Fedasil, the federal agency for asylum seekers, refuses to assist irregular migrants, referring them instead to NGOs. One interviewee suggested that the Belgian government deliberately exhausts NGO resources to worsen conditions and deter future migrants, with one interviewee saying:

> “They [the Belgian Government] believe that the NGOs can cover the gap they left, which is, if I can add, absolutely absurd because the means we have, whether financial

> or human resources, are not comparable to those of the state. It seems really that there is… a deliberate policy to create marginalization in order to deter people from coming to Belgium."

Mental health issues are a major challenge for migrants in Brussels, especially those who see their stay as temporary while aiming for other destinations (notably the UK). These migrants may carry trauma from their home countries and journeys, which is often worsened by the conditions in Belgium. Although public health received significant funding during the COVID pandemic, mental health remains underfunded and less visible. Staff feel overwhelmed by the reception crisis and institutional violence.

The mainstream medical system receives mixed descriptions from our migrant sample; some say the general medical system works well, while others find it overburdened. There is a shortage of primary care physicians and registering for emergency aid (AMU) is cumbersome, especially without regular status or stable housing. This process varies by municipality, with smaller ones being less equipped. Many migrants lack knowledge about the Belgian healthcare system, leading 25-30% to bypass primary care for emergency services. For non-urgent care, hospitals often check legal status and turn away irregular migrants to avoid treating uninsured patients. This shifts the burden to NGOs, who must advocate for migrants and maintain contacts with accommodating hospitals. Irregular migrants struggle to access specialized services, such as women's health, and frequent changes in residence complicate medical care access further.

Germany

Interviews in Germany, like those in Belgium, revealed numerous factors affecting healthcare access for migrants. A primary challenge is the language barrier between NGOs, authorities, health insurance companies, and diverse migrant groups. While interpreters are available for common languages, obtaining interpretation for less common languages is difficult. The bureaucratic nature of the German healthcare system, with forms and processes predominantly in German, further disenfranchises non-German-speaking migrants. Even proficient German speakers can find the system overwhelming, and migrant women facing domestic violence are particularly vulnerable due to these linguistic barriers.

Another significant obstacle is the lack of intercultural understanding among authorities, such as health insurance companies and job centers, which impacts the efficacy of migrant support. The healthcare system provides basic care but often struggles with complex medical needs like surgeries or ongoing treatments. Migrants fear seeking healthcare outside designated humanitarian consultation hours due to potential legal repercussions, including deportation. Cultural differences in illness perception and treatment expectations, especially regarding mental health, add to the challenges. Discrimination within the healthcare system further compounds issues like irregular status or substance addiction, which can preclude access to some clinics.

Organizations assisting migrants face structural challenges, including limited resources, reduced staffing, and inadequate space, hindering their ability to meet high demand. Migrants' expectations for immediate assistance often clash with the reality of available services, which

may require multiple appointments, particularly for time-consuming processes like legal case opinions or involving an interpreter.

Medical training

Professionals criticized the lack of sensitivity toward migrants' conditions and culture within healthcare settings. From the perspective of NGOs that catered to migrants, there was a feeling that mainstream healthcare providers resist specialized training, due to a belief that migrants experience similar health issues as the general population. Especially in the context of interconnected service delivery, as occurs in the Hub in Brussels, this reflected a fundamental lack of understanding of how intersectional vulnerabilities, such as homelessness, relate to medical outcomes. Similarly, workers expressed a need for specialized training based on migrants' legal statuses – especially in Brussels where a significant portion of Belgium's precarious migrants are still in transit. The impacts of this are particularly felt in mental care, where despite migration-related trauma being common amongst many precarious migrants, training is described as Eurocentric, and where psychotherapists are not routinely trained to work with translators or mediators.

Nevertheless, legal, emotional, and cultural sensitivity training are being provided on the ground. In Belgium, Médecins du Monde has deployed training to twenty general practitioners across three medical centers, ultimately aiming to open the border to mental health treatment for migrants within the mainstream system. MSF trains cultural mediators, including in identifying gender-based violence and mental health. In Frankfurt, social and legal counselors are typically trained in social law and participate in pertinent webinars, and an intercultural communal health initiative exists to facilitate intercultural mediation. The City of Frankfurt offered intercultural competency training, but this was disrupted due to the Coronavirus pandemic. Generally, however, there was a desire for training to be more fully integrated into mainstream medical curricula.

Conclusion

The narratives of migrants and healthcare providers shared by our interviewees reveal a persistent dichotomy between the inclusive principles of healthcare treaties and the practical outcomes of healthcare infrastructure on the ground. Migrants frequently face perceived discrimination, financial barriers, and administrative hurdles that relate to, but also exacerbate, precarity related to their migration status. The psychological toll of navigating a foreign healthcare system, compounded by pre-existing trauma and socio-economic instability, further alienates migrants from seeking timely, adequate, and safe or comfortable medical care. The stories of perceived discrimination and exclusion shared with us illustrate the systemic difficulties of accessing healthcare for migrants.

Healthcare providers, on the other hand, grapple with the limitations of political will, mainstream training, and resources. The lack of intercultural competence and specialized knowledge about migrant health issues among mainstream healthcare workers reflects a broader misalignment between migrant needs and the public health system. The reliance on NGOs is highly successful, notably in Frankfurt where this has strong municipal integration

and backing but is perceived as unsustainable in the long run in Brussels, where it is seen by some of our interviewees for example as a means of 'filling the gap' left by hostile political attitudes towards service provision for migrants, and a more general instrumentalization of migration policies in the local arena. This highlights the pertinence of the notion of a healthcare border, as set of legal, administrative, interpersonal, and cultural barriers that migrants, workers, and auxiliary workers must navigate to ensure healthcare access and suitable provision.

This study highlights the need for deeper investigation of the healthcare landscape from the ground-up, so as to ensure equitable and inclusive healthcare access and provision. As the findings of this working paper point to, the access of migrants to healthcare being multifaceted and linking to intersectional vulnerabilities related to migration, this requires a concerted effort from a variety of stakeholders, including local and national policymakers, healthcare providers, and civil society organizations.

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