

2021 OBSERVATORY REPORT



**UNHEARD, UNSEEN,
AND UNTREATED:
HEALTH INEQUALITIES
IN EUROPE TODAY**

MÉDECINS DU MONDE 2021



ACKNOWLEDGEMENTS

We would like to take this opportunity to thank the service users of Médecins du Monde/Doctors of the World (Mdm) programmes for offering their time and stories to this 2021 Observatory Report.

We would also like to express our gratitude to the Mdm teams of staff and volunteers that work closely with the service users offering support and carrying out data collection and interviews.

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Front cover – *Mdm Belgium*: Jacques Brel Day Centre. Photo by Olivier Papegnies



Centralförbundet för Socialt Arbete (CSA)

This report uses the following terms: “EU/EEA migrants” to refer to citizens of European Single Market states – European Union (EU) countries, European Economic Area (EEA), Switzerland, and the United Kingdom – who are living in another EU or EEA

country, Switzerland, or the United Kingdom; “non-EU/EEA migrants” to refer to those who are not citizens of EU or EEA countries, Switzerland, or the United Kingdom; and “nationals” to refer to those who presented at a programme in their country of origin.

FOREWORDS

The European Network of Médecins du Monde/Doctors of the World (MdM) have for several years published updated Observatory Reports on the state of Universal Healthcare Coverage (UHC) in European countries. The current version, published at the end of the second year of the coronavirus disease 2019 pandemic, not only documents the continued exclusion of thousands of children, women, and men from healthcare services in seven European countries (Belgium, France, Germany, Greece, Luxembourg, Sweden, and the United Kingdom); but also reminds European societies, politicians, and health professionals – again – of the enduring discrimination against some of the most vulnerable members of our societies that, with the current pandemic has become even more salient. The 2021 Observatory Report makes an important further step by highlighting what is probably the single major determinant of all the varied modes and shades of exclusion and avoidable harm: the severe lack of attention for and interest in those who live at the margins of our European societies.

When people and their needs are unheard and unseen, their pain, suffering, and concerns will remain unattended and untreated. Inattention prevents people from enjoying the highest attainable standard of physical and mental health.

This report throws light on how the exclusion through neglect works in seven European countries, all with health systems of different kinds and structures. We have to acknowledge: independent of the type of system; independent of “Bismarck or Beveridge”; of health insurance or tax funded models, similar factors and forces drive the dynamics of exclusion. Inside health systems and services, it is the sustained disregard for responding to the social and cultural diversity of our populations, and the absence of a clear and coherent commitment to health equity that excludes and harms. The report shows language barriers still present a major obstacle, despite all the initiatives and projects that have conclusively shown the need for and feasibility of linguistic and cultural mediation in health services. The same applies to the lack of information on entitlements and access to preventive and curative healthcare, as well as to financial barriers. This is a sad diagnosis for European countries, health systems, and policies after close to two decades of talking about and promoting migrant inclusive health services.

However, the major obstacles for advancing health equity and UHC in Europe are not to be found inside health services, systems, and policies, but beyond. It is about politics, narratives, and the persistence of what is currently often called “colonial” patterns of thoughts that – in contrast to the universalist conception of human rights – are ready to accept different levels of human dignity and entitlements to fundamental rights. This report conclusively attests that the disregard for universal human rights – when “everyone” no longer means “everyone” independent of legal status, country of origin, or any other social category – has detrimental effects on the health of those most in need.

This report reaffirms the critical role of migration policies and laws in determining the health, wellbeing, and personal fate of refugees and migrants. The recommendation to review migration laws according to the duty of states to protect and fulfil the right to health is paramount. We should not permit that instead of advancing “Health in all Policies”, migration politics become the ruling force “in all policies”, including health. At the same time, this report shows that it is not only an issue of migrants, or of foreigners. The exclusion from health services is a much broader issue, and the reality of the people seeking assistance in the programmes of MdM is often much more complex than what politicians, policymakers, and the people in charge in health and social systems may assume.

Equity starts with evidence, and the particular quality of this report is to convey the dire reality and the mechanisms of neglect. I am grateful to all the active members of MdM in the seven European countries for their enormous commitment and, in particular, for doing the extra work of documenting and “bearing witness” that makes this report possible. The evidence and data from the programmes are what makes this report conceivable and gives it its particular strength. The people have to be attended and cared for, their stories have to be told, and the structures impeding their right to health have to be analysed and dismantled – this is the pathway to change.

Dr Michael Knipper
Assistant Professor for Medical History,
Anthropology, Ethics and Global Health
University Justus Liebig,
Giessen, Germany

Unseen, Unheard, and Untreated: Health Inequalities in Europe Today is a highly relevant, timely, hard-hitting report that is a wake-up call for addressing one of the most critical issues of our times. I would first like to commend and congratulate MDM and all the contributors for their excellent work emphasising that inequities in health remain a relevant priority for Europe as despite the gains made in the past decades the unfinished agenda is formidable.

From the outset, the nature of the COVID-19 pandemic indicated that “the chain of preventive measures is only as strong as its weakest link ignoring or forgetting these groups might cost them not only their lives but will undoubtedly have an impact on controlling the pandemic”. The COVID-19 pandemic has revealed that despite the underlying core values of solidarity, equity, and universality in Europe the reality is far from being true to these values. Besides gaining a better understanding of the intersectional nature of health, the enormous costs to society of disease and excess morbidity and mortality, the COVID-19 pandemic has heightened public awareness and political concerns about health including inequities. The 2021 Observatory Report has been able to capture these issues during the COVID-19 pandemic highlighting the precarious situation of those left behind with a narrative that is impossible to ignore.

“No data no progress” rings true as observed with the reporting of the Sustainable Development Goals. “No data no problem” is another side of the coin. If there is no data available, it is often assumed there is no problem and thus easier to ignore or not act upon. Though data on health inequities has become available, the data that this report provides is scarce, as it deals with those who fall between the cracks or those excluded. By providing this data through a credible and convincing narrative MDM takes the agenda one step further. The importance of filling the gaps through collecting relevant, credible data in order to raise awareness of health inequalities, gain public engagement, and political commitment, cannot be overemphasised.

The evidence generated by this report should inform policies. Some of these are clearly outlined in this report’s recommendations. The World Health Organization and the European Union declared that “no one is safe until everyone is safe”. From this report the confirmation of the large exclusion of disadvantaged groups such as migrants and ethnic minorities from national responses require immediate action in order to attain full health protection. All countries should aim to produce and use data on these hard-to-reach groups that do not feature in national statistics as without such information, serious inequalities will remain undetected and unexplained. This report’s recommendations are not a “band aid” or a quick fix in their scope and should be given due consideration. We need models for action, for ongoing engagement and integration within a framework of UHC.

The European Public Health Association (EUPHA): Migrants and Ethnic Minority Health (MIG) Section, the European Hub – Lancet Migration, and the Global Society on Migration, Ethnicity, Race and Health are all striving towards the same goal as MDM in ensuring no one is left behind. We hope our partnerships will strengthen our collective ability to overcome the barriers to progress.

Professor Bernadette Nirmal Kumar

*President EUPHA MIG Section
Co-Chair European Hub –
Lancet Migration*

*Chair Global Society on Migration,
Ethnicity, Race and Health*

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MdM Greece: a refugee girl outside
MdM Open Polyclinic in downtown Athens

EXECUTIVE SUMMARY

This 2021 Observatory Report is an observational study on the people excluded from mainstream healthcare services in Europe and provides a snapshot of the state of Universal Healthcare Coverage (UHC). The report contains data and testimonies collected at Médecins du Monde/Doctors of the World (MdM) programmes in seven European countries (Belgium, France, Germany, Greece, Luxembourg, Sweden, and the United Kingdom) between January 2019 and December 2020.

There were a total of 25,355 unique individuals attending the aforementioned MdM programmes during this period and a clear majority of the people we saw reported not having healthcare coverage. This means that despite international commitments to UHC and a dedication to the Sustainable Development Goals (SDGs), based on the seven European countries studied in this report, there are still people that lack access to healthcare. Furthermore, this report concludes that healthcare exclusion in Europe disproportionately affects people already facing vulnerabilities, such as children, undocumented migrants, homeless people, pregnant women, and the elderly.

The issues of inequalities in health have been made even more evident with the coronavirus disease 2019 (COVID-19) pandemic posing a greater risk to: women; children; migrants; older people; those living in poverty; those with pre-existing health conditions; and those who have been forcibly displaced.¹ The COVID-19 pandemic has uncovered the fragility and inadequacy of health systems worldwide, disclosed major gaps in social protection, and highlighted the importance of healthcare access for all through mainstream public healthcare.

In order for informed policymaking to be possible there is a need for data on groups excluded from healthcare. Efforts have been made in recent years to establish data collection on access to healthcare in the European Union (EU) with the introduction of the instrument known as the Social Scoreboard. The Social Scoreboard rates EU member states compliance with the principles under the Social Pillar and collects data on “self-reported unmet need for medical care”.² Yet, to be included in this data, individuals must be both over 16 years of age and part of a private household. However, between 2019–2020 less than one-fifth of the people we saw lived in a personal flat or house, meaning that the majority experienced different forms of homelessness. MdM also saw children under the age of 16 unable to access healthcare services. Both groups (people experiencing homelessness and children under 16) are excluded in the Social Scoreboard indicator measuring level of compliance with Article 16. For the development of health policies to be effective it is vital to include the most vulnerable groups in health reporting.

This report aims at capturing the health status and circumstances of people left out in health reporting and national statistics. The overwhelming majority of the people that MdM saw lived under the poverty threshold in the country they presented in and the barriers to accessing healthcare that they reported ranged from economic to lack of understanding of the healthcare system, and administrative and lingual barriers. Both mental and physical health was poor within the groups and many suffered from chronic disease.

The data presented in this report shows us that we are far from realising the pledge to first reach those who are furthest behind and therefore we continue to ask European governments and EU institutions to:

1. improve the accessibility of regular healthcare systems to include full entitlements to health for people in vulnerable situations such as homelessness, migration, and poverty, especially for children;
2. improve methods to identify barriers to health for the most vulnerable by including them in data collection; and
3. implement a rights-based approach as it is the only way we can make sure that no one is indeed left behind.

1. United Nations. (2020). *Policy brief: COVID-19 and universal health coverage*. Retrieved 10 September 2021, from https://unsdg.un.org/sites/default/files/2020-10/SG-Policy-Brief-on-Universal-Health-Coverage_English.pdf.

2. The European Commission. (2021). *European Pillar of Social Rights: social scoreboard indicators*. Retrieved 17 September 2021, from <https://ec.europa.eu/eurostat/web/european-pillar-of-social-rights/indicators/social-scoreboard-indicators>.



MdM UK: a doctor about to carry out their duties at the London clinic.
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2019/2020 IN FIGURES

WHO WE SAW:

- 25,355 unique individuals attended MdM programmes in Belgium, France, Germany, Luxembourg, Sweden, and the United Kingdom between January 2019 and December 2020. In these countries, MdM conducted a total of 45,292 consultations, comprising 22,334 medical consultations and 22,958 social consultations. In MdM programmes in Greece, only testimonies were collected.
- There were 28,254 medical and social consultations in 2019 and 16,203 medical and social consultations in 2020; that is a reduction in 12,051 consultations between 2019 and 2020 due to reduced operations in most countries as a result of the COVID-19 pandemic.
- 74.7% of all individuals seen at MdM programmes were non-EU/EEA migrants (14,159/18,962), 22.2% were EU/EEA migrants (4,210/18,962), and 3.1% were nationals (593/18,962).
- The most common country of origin was Côte d'Ivoire at 10.9% (2,068/18,962), followed by Romania at 9.6% (1,814/18,962), Bulgaria at 6.7% (1,277/18,962), Morocco at 6.2% (1,182/18,962), and Algeria at 5.8% (1,095/18,962). A total of 158 different nationalities were recorded.

DETERMINANTS OF HEALTH AND HEALTHCARE ACCESS:

- A clear majority, 78.2%, of the people we saw reported not having healthcare coverage (9,981/12,767), and only 9.2% of non-EU/EEA migrants (799/8,696) and 10.3% of EU/EEA migrants (178/1,730) reported full coverage.
- 91.6% of the people seen were living below the poverty threshold in the country they presented in (6,704/7,321).
- Almost half of individuals, 47.5%, in all MdM programmes lived in insecure housing (7,127/14,993), while one in five or 18.9% were roofless or sleeping rough (2,837/14,993). A higher proportion, 35.1%, of EU/EEA migrants were living in roofless situations (776/2,211), compared to 19.5% of non-EU/EEA migrants (1,901/9,737) or 19.6% of nationals (89/453).
- The most frequently reported barriers were "lack of knowledge of healthcare system/entitlement" at 22.5% (2,630/11,698), "administrative barriers" at 22.1% (2,582/11,698), and "did not try to access healthcare" at 17.3% (2,029/11,698).

HEALTH CONDITIONS AND STATUS:

- The most frequent pathologies were diseases of the circulatory system (20.9%; 5,217/24,917), followed by diseases of the respiratory system (12.3%; 3,077/24,917), and diseases of the musculoskeletal system and connective tissue (12.3%; 3,077/24,917).
- The highest proportion of chronic pathologies were circulatory (26.1%; 2,214/8,476) followed by musculoskeletal (12.7%; 1,077/8,476), psychological (10.9%; 925/8,476), endocrine, metabolic, and nutritional (10.5%; 886/8,476), and skin (7.0%; 597/8,476).
- The highest proportion of acute pathologies were respiratory (22.1%; 1,309/5,911), followed by circulatory (19.2%; 1,133/5,911), musculoskeletal (13.6%; 806/5,911), and skin (12.4%; 732/5,911).
- The majority of pregnant women had not accessed antenatal care prior to visiting an MdM programme (52.7%; 109/207). Around 42.9% of women who had not accessed antenatal care were in their second or third trimester of pregnancy (33/77).
- 31.0% of people who responded to both questions screening for depression (Patient Health Questionnaire-2) (508/1,641) had a score of greater than 3 and should be screened for major depressive disorder.

78.2%

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3.1%

of people visiting MdM programmes were nationals (593/18,962).



RECOMMENDATIONS

All European governments and the EU have committed to ensuring UHC³ and pledged to “leave no one behind” through the Agenda 2030 and its SDGs.⁴ This includes SDG Target 3.8: “Achieve universal health coverage, including financial risk protection ... for all” and “We pledge that no one will be left behind. ... we will endeavour to reach the furthest behind first.”⁵

“Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality.”⁶ (Article 16, European Pillar of Social Rights)

Our data shows there are both gaps in even understanding the needs and in the interventions themselves needed to reach UHC and especially those furthest behind. The following recommendations for political action can be drawn from the analysis:

PROVIDE BETTER DATA: ENSURE THAT MONITORING INSTRUMENTS PROVIDE RELEVANT INFORMATION ON EXCLUSION FROM HEALTHCARE

Unmet need for healthcare has been recognised as an important aspect of social protection by EU member states and is thus included in the Social Scoreboard monitoring their performance in relation to the European Pillar of Social Rights. However, the population base for the indicator “self-reported unmet need for medical care”, drawn from the EU Statistics on Income and Living Conditions (EU-SILC) is defined as “people living in private households above 16 years of age”. The data from this 2021 Observatory Report indicates that 82.3% of our participants do not live in private households and 8.5% are under 16 years.

The unmet healthcare needs described in this report are thus not represented in the official reporting. People living in communal housing or institutional care, undocumented people, homeless, or children under 16 years are left out. The COVID-19 pandemic has again revealed

that it is of utmost importance to know who is not reached by regular health services in order, for example, to tailor vaccine or information programmes. To create a valid evidence base for policy making, we recommend the following:

To national governments:

1. Government institutions should actively develop and employ additional methods, such as participatory qualitative research to include currently excluded groups in health reporting. Specifically, government officials need to meaningfully include service providers, civil society organisations, as well as affected communities, into the development of methods and data analysis for country assessments, as well as into the distribution of the results.

To the EU Commission:

2. Ensure that the EU-SILC and other monitoring instruments of the EU Social Pillar include information on people living in communal housing or institutional care, undocumented people, homeless, and children under 16 years.
3. Provide systematic and continuous information on the results of the monitoring and additional analyses within all tools of the European Semester cycle.
4. Based on these results, the EU Social Protection Committee should systematically and explicitly advise the member states and the EU Commission with country-specific policy recommendations targeting inequalities and exclusions in health.

REVIEW THE LAWS: ENSURE THAT THE RIGHT TO HEALTHCARE IS NOT UNDERMINED

Barriers in accessing healthcare reported by our service users clearly show that laws and policies can be a hindrance to the fulfilment of everyone's right to health. For example, undocumented migrants, or non-EU/EEA migrants without a right or permission to reside, (62% of our participants) do

not have access to healthcare in some countries because their data is shared with immigration authorities when they seek medical care (Germany and the United Kingdom) or coverage of costs. They thus avoid accessing healthcare due to fear of expulsion.

In most countries, EU/EEA migrants (22.2% of our participants) lack access to healthcare if they are unemployed and not insured in their country of origin or often have to pay unaffordable costs out-of-pocket in breach of the declaration of UHC. Some groups are only entitled to restricted healthcare services, such as asylum seekers (8.2% of our participants), in Belgium, Germany, Luxembourg, and Sweden. Preventive care and management of chronic disease, which are both often excluded from entitlements, are integral parts of UHC. Limiting the service package to acute or emergency care is against the right to health and has shown to be more costly.⁷

In the context of the COVID-19 pandemic, entitlement to free testing, treatment, and vaccination to non-citizens was often unclear or restricted.

To national governments:

5. Governments should reaffirm and fulfil the right of every human being within their jurisdiction, without distinction of any kind, to the enjoyment of the highest attainable standard of health. This includes a comprehensive people-centred approach, with an aim to leave no one behind. To do this and fulfil their obligation under the Agenda 2030 they should without delay ensure full entitlements to promotive, preventive, diagnostic, curative, rehabilitative, and palliative health services for everyone residing in the country, regardless of immigration status. Governments should take special care to ensure equitable access to sexual and reproductive health and rights, children's right to health and endeavour to reach the furthest behind first, including refugees and migrants, both EU/EEA citizens and those of other nationalities.

3. United Nations. (2019). *Political Declaration of the High-Level Meeting on Universal Health Coverage, “Universal health coverage: moving together to build a healthier world”*. New York, NY: United Nations. Retrieved 7 September 2021, from <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>.

4. United Nations. (n.d). The 17 Goals. Retrieved 15 September 2021 from <https://sdgs.un.org/goals>.

5. *ibid.*

6. The European Commission. (2021). *The European Pillar of Social Rights in 20 principles*. Retrieved 15 September 2021, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

7. Bozorgmehr K. & Razum, O. (2015). Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994–2013. *PLOS ONE*, 10(7), e0131483. Retrieved 3 October 2021, from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0131483>.

6. Governments should implement laws and practices to ensure “firewalls” between those working in the provision of social services and healthcare on the one hand and the immigration authorities on the other so that undocumented migrants can access healthcare services without fear.

To the EU Commission:

7. The EU needs to translate Article 16 of the European Pillar of Social Rights, “everyone has the right to timely access to affordable, preventive and curative health care of good quality”⁸ into concrete and ambitious policy work. The EU Commission should communicate a roadmap leading the member states to long-term efforts to achieve the principles in the pillar.
8. The Fundamental Rights Agency should systematically report to EU member states on breaches of the right to health and discrimination against people who have been denied access to healthcare. Those reports should also be included in the semester reporting cycle.

REDUCE BARRIERS: MAKE HEALTHCARE SYSTEMS MORE ACCESSIBLE

In addition to the legal framework, our data also shows that barriers within the regular healthcare system need to be addressed in order to allow wider access. An important pillar in the provision of care is to ensure that it is available, accessible, acceptable, and of high quality. However, the data shows a multitude of barriers affecting a person's ability to access healthcare:

- Language: In 40.6% of the consultations at MdM sites, an interpreter was used (5,480/13,499).
- Lack of information: Our data shows that a lack of understanding of the healthcare system is a major barrier in accessing the services that are needed (22.5%, 2,630/11,698).
- Cost: Our data shows that economic barriers, such as cost of consultation, cost of treatment, and cost of insurance are perceived as serious barriers for people to access healthcare (10.1%; 1,184/11,698).

To national governments:

9. Reduce administrative barriers to the healthcare system often experienced by people in vulnerable situations, such as homelessness or migration.
10. National healthcare systems need to provide comprehensible and targeted information on services and entitlements, for example, for migrants and homeless people.

11. National healthcare systems need to ensure sufficient availability and financing of translation services necessary for adequate communication between patients and healthcare professionals, also using technological support systems.
12. National healthcare systems should issue clear guidelines and provide training for healthcare professionals for non-discriminatory healthcare provision, including on specific vulnerabilities, healthcare needs, and existing referral services. Reporting mechanisms on perceived discrimination should be established.

13. Low threshold health services and support structures for people in vulnerable situations, such as homelessness and in migration should be set up and securely funded. Mobile clinics and outreach of healthcare professionals have proven effective to target the most excluded and to recover trust in the healthcare system. Coordination between social services and healthcare providers needs to be improved in order to provide effective follow-up treatments and housing, especially for homeless people suffering from chronic illness, drug users, mental health patients, and discharged hospital patients.

To the EU Commission:

14. Make sure that financial instruments such as the European Social Fund Plus (ESF+) are available to fund initiatives and programmes responding to the healthcare needs of those who have been excluded from healthcare. Funds must be made available to encourage innovative low threshold accessibility healthcare services throughout Europe. This is especially important when focusing on post pandemic strengthening of health systems and of cohesion between countries such as making systems for vaccination programmes available and usable for mobile populations.

CREATE HEALTHIER LIVING CONDITIONS: REDUCE HOMELESSNESS AS A MAJOR DETERMINANT FOR ILL HEALTH

The conditions under which people are born, grow, live, work, and age determine their health more than their ability to access healthcare. A health in all policies approach is thus urgently needed, in which the health consequences of policies in all sectors are systematically considered. This report shows that only 17.7% of the people we saw lived in adequate housing, and the clear majority experienced different forms of homelessness. Adequate and proper housing is not only an undeniable human right but a precondition for healthcare, regular treatment, and support. Accessing healthcare services is often dependent on housing-related paperwork, such as proof of tenancy or proof of address. Measures for affordable housing and improved conditions in shelters are thus important for improving health outcomes and reducing health inequities.

To national governments:

15. National governments in close cooperation with affected communities and civil society should ensure that there is a legal base for the right to housing, improve data on housing conditions, implement preventive measures against homelessness, and provide sufficient and adequate shelters.

To the EU Commission:

16. Innovative solutions towards integrated and coordinated social and healthcare services that take into account the specific needs of homeless people should be supported, funded, and disseminated through various financial instruments, especially the ESF+. In order to be effective, the initiatives should be low threshold, flexible, needs-based, and organised in a people-centric way (outreach and drop-in rather than appointment-based).

8. The European Commission. (2021). *The European Pillar of Social Rights in 20 principles*. Retrieved 25 September 2021, from https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.

2021 OBSERVATORY REPORT

INTRODUCTION

On January 24 2020, the first European case of the coronavirus disease 2019 (COVID-19) was reported in France. On January 30 2020, the World Health Organization (WHO) declared the first outbreak of COVID-19 a “public health emergency of international concern” and on March 11 2020, Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO, declared COVID-19 a “global pandemic”.⁹

The COVID-19 pandemic has uncovered the fragility and inadequacy of health systems worldwide, disclosed major gaps in social protection, and highlighted the importance of healthcare access for all through mainstream public healthcare. The pandemic has displayed the importance of the Sustainable Development Goals (SDGs) and the issue of Universal Healthcare Coverage (UHC)¹⁰, defined by WHO as: “all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care”.¹¹

The importance of UHC has long been recognised through the International Covenant on Economic, Social and Cultural Rights, with Article 12 stating: “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.¹² Further through the SDGs and its promise of leaving no one behind. And finally through the European Pillar of Social

Rights Article 16: “Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality.”¹³

Still, about half of the world’s population does not have full coverage of necessary health services and over 800 million people spend at least 10.0% of their household budgets to pay for healthcare. Out-of-pocket payments for healthcare undermines these international agreements and erodes health as a human right that should be attainable for all. The global COVID-19 pandemic has unmasked the wider problems connected to out-of-pocket payments for health when economic recession, created by a health emergency, causes people to lose access to healthcare when they need it the most.¹⁴

The Médecins du Monde/Doctors of the World (MdM) 2019 Observatory Report¹⁵ provided a snapshot of access to care in seven European countries between 2017–2018 and reported people being left behind without access to healthcare. The report concluded that healthcare exclusion in Europe disproportionately affects people already facing vulnerabilities.¹⁶ Further, to provide a deeper insight into what it means to be excluded from healthcare by the people behind the statistics, a complementary report: *Left Behind: Voices of People Excluded From Universal Healthcare Coverage in Europe*¹⁷ was published in 2020. This report is a compilation of human stories from people seen at MdM and the European Federation of

National Organisations Working with the Homeless (FEANTSA) member programmes between 2019–2020. The testimonials addressed barriers in access to healthcare such as lack of housing, discrimination, poverty, and distrust in public healthcare systems.

The issues of inequalities in health have been made even more evident with the COVID-19 pandemic posing a greater risk to: women; children; migrants; older people; those living in poverty; those with pre-existing health conditions; and those who have been forcibly displaced.¹⁸

In order for informed policymaking to be possible there is a need for data on groups excluded from healthcare. Since most governments rely on healthcare services to gather data and information on the health needs of the population, the health needs of those unable to access these services will inevitably be missing. As MdM’s Observatory Reports are based on data collected from people seeking healthcare outside of the regular health system, it provides a unique insight into the extent of unmet healthcare coverage needs in Europe, and the extent to which the right to health as a fundamental right is protected and promoted.

Efforts have been made in recent years to establish data collection on access to healthcare in the European Union (EU) with the introduction of the instrument known as the Social Scoreboard. The Social Scoreboard rates EU member states compliance with the principles

under the Social Pillar and collects data on “self-reported unmet need for medical care”.¹⁹ Yet, to be included in this data, individuals must be both over 16 years of age and part of a private household. Children under 16 and people living outside of a private household are consequently excluded. The omission of these populations in the EU’s data severely undermines policymakers’ ability to address unmet healthcare needs in Europe and achieve UHC. The importance of data on groups currently left behind cannot be overstated. It is fundamental for the work towards realising Agenda 2030 and the current lack of data on vulnerable groups is highlighted in the SDGs outcomes document.²⁰ In this 2021 Observatory Report, MdM are able to provide data on unmet healthcare needs that are missing from EU statistics and hence, offer a basis for informed policymaking both at EU level and for national governments.

PURPOSE

The 2021 Observatory Report is an observational study on the people excluded from mainstream healthcare services across Europe. The report contains data and testimonies collected at MdM programmes in seven European countries (Belgium, France, Germany, Greece, Luxembourg, Sweden, and the United Kingdom) between January 2019 and December 2020. The MdM programmes provide medical and non-medical services, collecting social and medical data as well as testimonies. There were a total of 25,355 unique

individuals attending the aforementioned MdM programmes during this period, excluding MdM Greece who only provided qualitative data to the report. The 2021 Observatory Report is a continuation of the work produced by the European Network to Reduce Vulnerabilities in Health,²¹ and the 2019 MdM Observatory Group.²²

This report was produced in partnership with University College London (UCL). UCL academics have the breadth and depth of expertise across the entire range of academic disciplines and a strong commitment to enhancing the lives of people around the world.

The purpose of this report is to provide policymakers at national and EU level with the robust evidence base needed to continue the strive towards UHC. By presenting quantitative data, analysed and validated by epidemiologists at UCL, on people who are excluded from mainstream healthcare services, alongside testimonies, the report provides insight into who is excluded from healthcare, their social, economic, and political circumstances, and health status.

This report will be:

1. a valuable resource for policymakers and health service providers interested in addressing health inequalities and tackling the determinants of health, providing insight into how policies and services can be designed to include those not living in private households;

2. a beneficial resource with regard to missing data on excluded populations and offers a greater understanding of the problem at hand; and
3. useful for academics interested in gaining a greater understanding of excluded populations and patient groups across Europe, and organisations and campaigners working to strengthen the right to healthcare and advocating for UHC.

STRUCTURE

This report:

- presents recommendations to the relevant institutions, national governments, and organisations to achieve UHC across Europe;
- provides an overview of the issues surrounding UHC and the global COVID-19 pandemic;
- describes who is excluded from healthcare services, including demographics, country of origin, and migrant categorisation;
- observes the socioeconomic circumstances of our participants such as living conditions and income;
- observes the issues our participants faced regarding healthcare access, including healthcare coverage and barriers to healthcare services;
- presents the diagnosed health conditions and health status reported by our participants; and
- provides an overall discussion on the key findings.

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15. Burns, R., Aldridge, R. W., Graverson, P., Miller, A. K., Bader, C., Offe, J. & Fille, F. (2019). *Left behind: the state of Universal Healthcare Coverage in Europe*. Stockholm: Médecins du Monde.

16. *ibid*.

17. Graverson, P., Bader, C., Van Limbergen, E., & Dayoub, R. (2020). *Left behind: voices of people excluded from Universal Healthcare Coverage in Europe*. Stockholm: Médecins du Monde.

18. United Nations. (2020). *Policy brief: COVID-19 and universal health coverage*. Retrieved 10 September 2021, from https://unsdg.un.org/sites/default/files/2020-10/SG-Policy-Brief-on-Universal-Health-Coverage_English.pdf.

19. The European Commission. (2021). *European Pillar of Social Rights: social scoreboard indicators*. Retrieved 17 September 2021, from <https://ec.europa.eu/eurostat/web/european-pillar-of-social-rights/indicators/social-scoreboard-indicators>.

20. United Nations General Assembly. (2015). *Resolution 70/1. Transforming our world: the 2030 Agenda for Sustainable Development*. Resolution A/RES/70/1. New York, NY: United Nations. Retrieved 12 September 2021, from <https://undocs.org/A/RES/70/1>.

21. The European Network to Reduce Vulnerabilities in Health observatory reports can be accessed from <https://mdmeuroblog.wordpress.com/resources/publications/>.

22. Burns, R., Aldridge, R. W., Graverson, P., Miller, A. K., Bader, C., Offe, J. & Fille, F. (2019). *Left behind: the state of Universal Healthcare Coverage in Europe*. Stockholm: Médecins du Monde.

PARTICIPATING PROGRAMMES

The participating MdM programmes were from the seven European countries:²³

Belgium

The MdM programmes in Antwerp and Brussels provide primary medical, psychological, and dental care, and social counselling for people without access to care as well as close partnerships with hospitals for specialised care. The objective of the programmes is to (re)integrate all patients into standard medical care facilities. MdM Belgium adjusted its services during the COVID-19 crisis, but always made sure to be accessible. It also set up several projects that worked specifically on the topic of COVID-19, such as an adapted testing team, an Outbreak Support Team, opening of a day centre for homeless people, and launched a mobile vaccination team.

France

Three MdM healthcare, advice, and referral centres (CASOs) in Bordeaux, Nice, and Saint Denis provide medical consultations as well as specialised care such as gynaecological, dental, psychological, and psychiatric consultations, ophthalmology, etc. All three MdM clinics also provide sexual and reproductive health and rights (SRHR) services. In March 2020, MdM France began adapting their reception and outreach activities to take account of the constraints imposed by COVID-19. MdM's teams adapted activities in the CASOs, setting up telephone helplines and adapting reception and care protocols to the different phases of the pandemic. But the COVID-19 pandemic caused an exceptionally sharp decline in CASO activity: in 2020, the programme in Bordeaux, Nice, and Saint Denis saw respectively 1,700 (2,464 in 2019), 1,045 (1,513 in 2019), and 2,520 (5,625 in 2019) people.

Germany

The MdM programmes in Munich, Berlin, and Hamburg offer medical treatment and social counselling. The projects' long-term aim is to (re)integrate patients into standard medical care. The MdM clinics and a medical bus in Munich provide primary care and specialised care such as paediatric, gynaecological, and psychiatric consultations, as well as consultations for chronically ill patients. The project in Hamburg is run in collaboration with the organisation *hoffnungsorte hamburg* and the project in Berlin in cooperation with *Medizin Hilft e.V.* During the pandemic, MdM Germany adapted their services to patients' needs with a focus on protecting the most vulnerable: chronically ill; homeless; and/or undocumented patients. In most MdM clinics, people who present with COVID-19 symptoms can be tested for free and from summer 2021 MdM patients were offered COVID-19 vaccination in Munich as well as in Berlin.

Greece

MdM Greece provides access to a comprehensive package of public healthcare, sexual and reproductive health (SRH), mental health, and psychosocial support services. Through an intercultural, person-centred, community-based approach, it focuses on the most vulnerable and complex cases requiring a holistic framework of medical and social interventions, including health literacy, training and empowerment of health professionals, community mobilisation, and paths to integration. During the pandemic, MdM Greece was appointed as the national partner of the Hellenic National Public Health Organization reaching out to a total of 25,643 people. Testimonies included in the present report, have been collected within the framework of "opening access to health and medicines for all" that is implemented as part of "the Active citizens fund" in Greece by MdM Greece (project promoter) and its partners GIVMED and The Press Project. The project's main objective is to advocate for access of all citizens and especially the most vulnerable to quality free health services and appropriate medication.

Luxembourg

MdM Luxembourg provides social, psychological, and medical services to people without access to healthcare through several clinics across the country. MdM Luxembourg also has a network of specialised care (dentistry, physiotherapy, etc) and intervenes since the pandemic in 2020 on shelters for homeless people and vulnerable people with serious illnesses. The medical services are strengthened by specific prevention actions, for example, the vaccination against influenza but also by streetcare with the distribution of sleeping coats. During the pandemic, MdM Luxembourg helped coordinate national large-scale testing for vulnerable and homeless people.

Sweden

The MdM clinics in Malmö and Stockholm both provide primary care for, mainly, European citizens and undocumented migrants as well as legal advice and psychosocial support. Both MdM clinics remained open and accessible during the COVID-19 pandemic with upgraded routines aimed at protecting both volunteers and visitors. At the MdM clinics, visitors went through triage and if COVID-19 symptoms were detected they were referred to the public healthcare system. Since 2021, COVID-19 vaccination is provided by the public healthcare system for MdM target populations in cooperation with the MdM clinics in Malmö and Stockholm.

United Kingdom

Doctors of the World runs a clinic in London, as well as advocacy programmes in Birmingham and Manchester, "pop up" clinics in partnership with other organisations, and a specific "Women and Children's" services. As a result of the COVID-19 pandemic, clinic services have been adapted to phone and online services and Doctors of the World has provided outreach services (including COVID-19 vaccination services) in emergency accommodation for people experiencing homelessness and for asylum seekers.

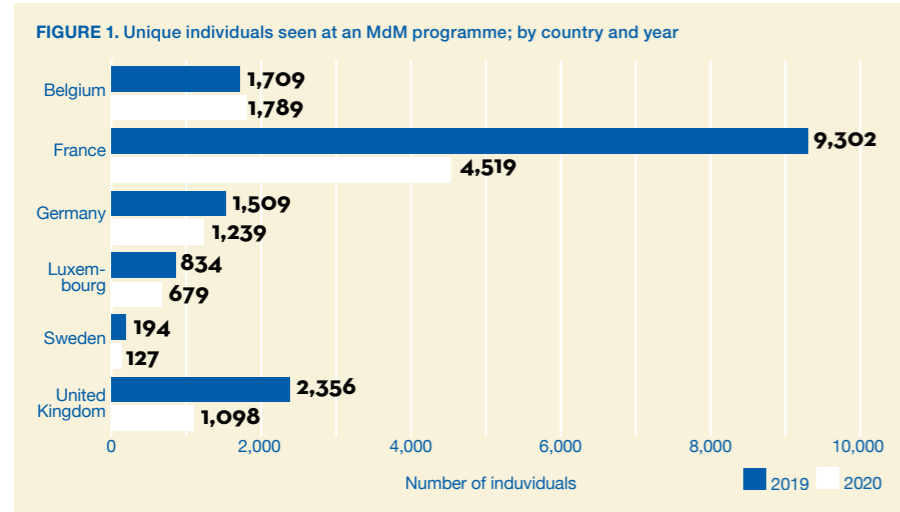
23. Note: This report does not include data from all individuals who accessed MdM programmes. See "Limitations".



MdM Luxembourg: a volunteer doctor about to perform a consultation on a homeless person beside the street.
Copyright: Laurent Antonelli.

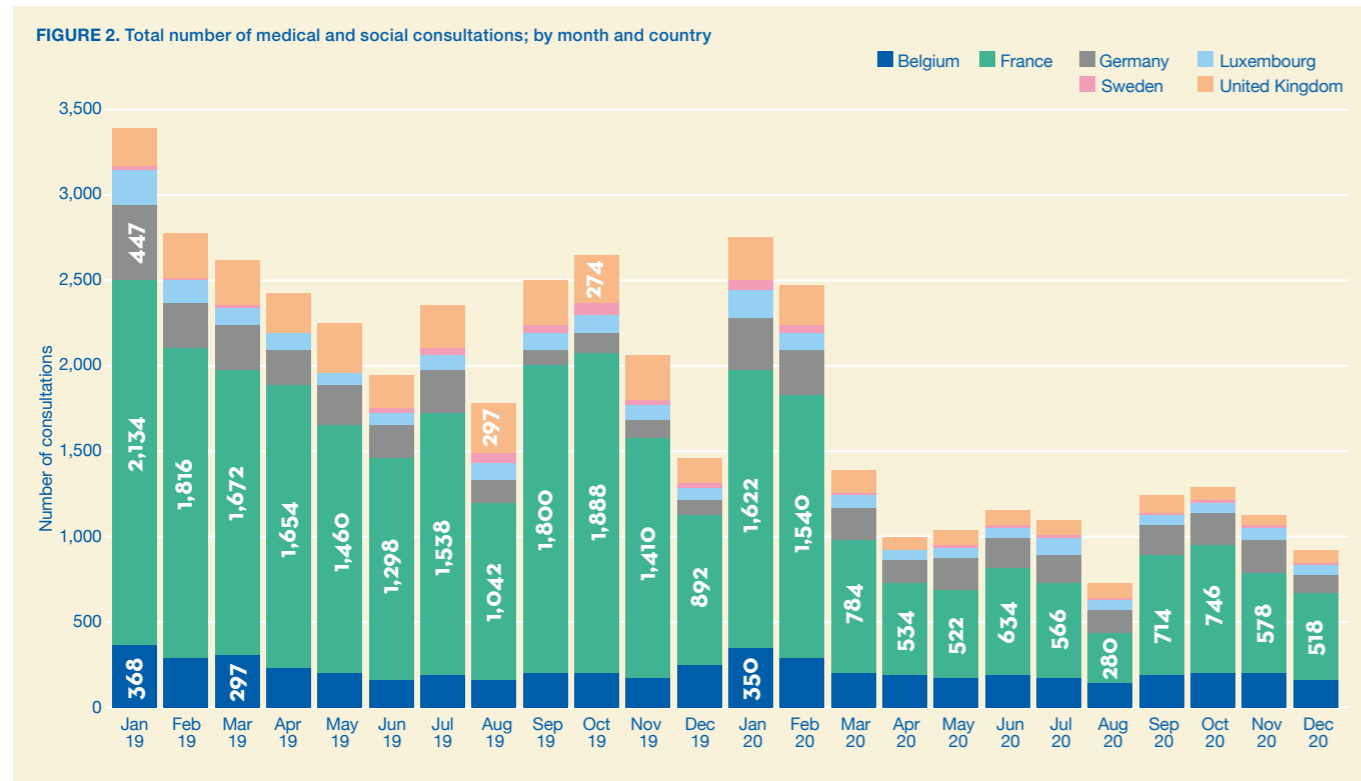
WHO WE SAW

PEOPLE SEEN



In 2019 and 2020, 25,355 unique individuals attended Mdm programmes in Belgium, France, Germany, Luxembourg, Sweden, and the United Kingdom. The greatest amount of data was collected from individuals in France (59.0%; 13,821/23,418) and the smallest amount of data was collected from individuals in Sweden (1.4%; 321/23,418). In 2019, 15,904 individuals were seen in Mdm programmes. In 2020, 9,451 individuals were seen by Mdm clinics. This reduction can be seen in every country programme except Belgium.

CONSULTATIONS



The data was collected in 45,292 consultations carried out in the Mdm programmes between January 1 2019 and December 31 2020. In total, there were 22,334 medical consultations carried out by clinicians, which focused on medical history, current health status, pregnancy, and vaccination status. There were 22,958 social consultations, which focused on addressing social determinants of health such as housing status, health access, and health

coverage. The greatest number of consultations were carried out in France (61.0%; 27,642/45,292) and the smallest number of consultations were carried out in Sweden (1.4%; 642/45,292).

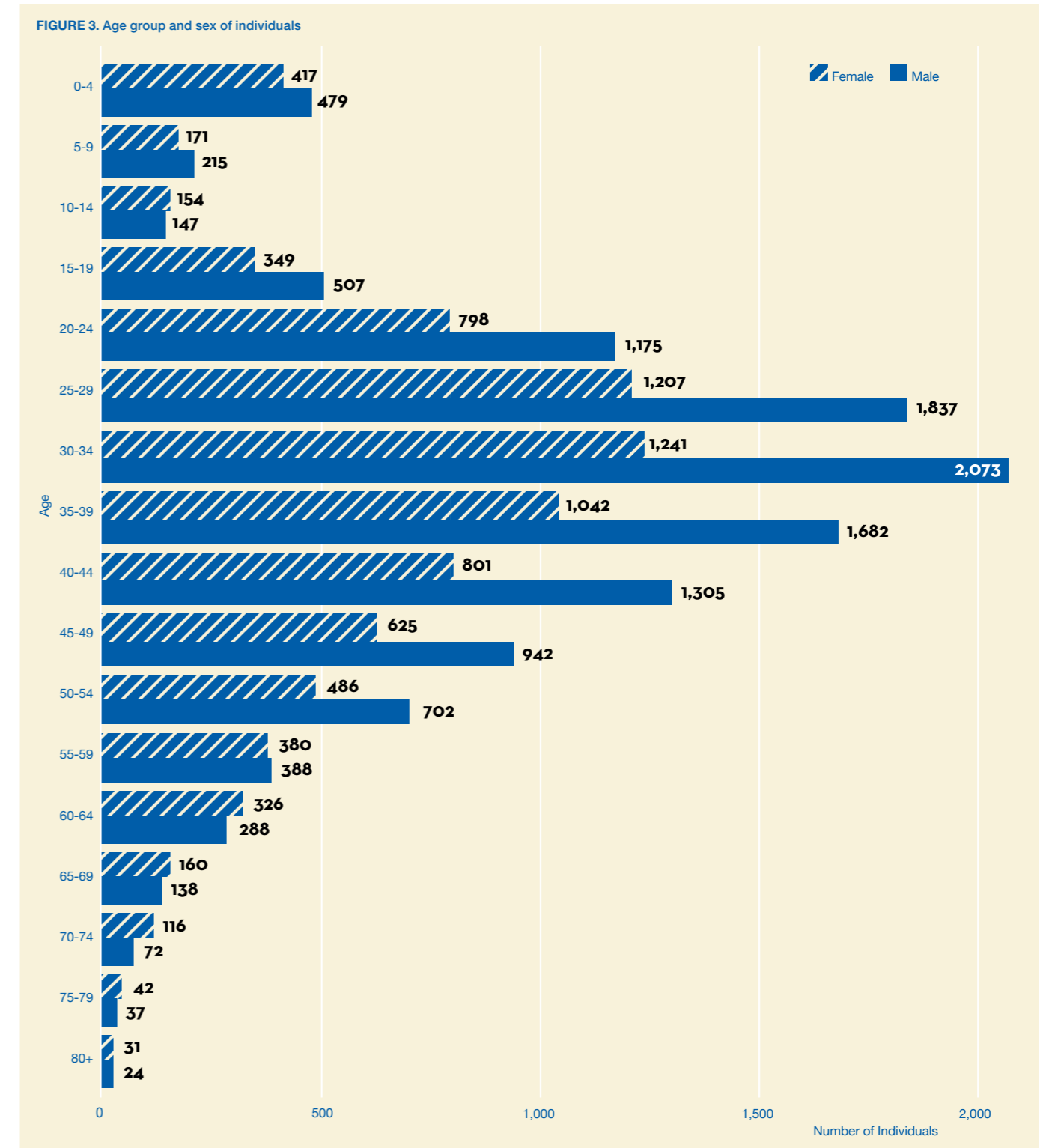
Figure 2 shows the total number of medical and social consultations by month and country. There were 28,254 medical and social consultations in 2019 and 16,203 medical and social consultations in 2020; that is a reduction in 12,051 consultations between 2019

and 2020 due to reduced operations in most countries as a result of the COVID-19 pandemic. The greatest number of consultations were carried out in January 2019 (7.5%; 3,397/45,292).

Fig 1. Data from combined social and medical consultations includes each individual once. There is no missing data in this figure.

Fig 2. Data from total of social and medical consultations (45,292). There is no missing data in this figure.

DEMOGRAPHICS



24. The questionnaire also contains "other/do not want to identify" besides "man" and "woman", but the sample size was too small to be included in the figure.

Fig 3. Data from social consultations includes each individual once. Individuals recorded as transgender (<10) were not shown. Figure excludes 2,601 records missing age, sex, or both (11.3%; 2,601/22,958).

In total, 59.1% of the people seen were men (12,270/20,747) and 40.9% were women (8,477/20,747).²⁴ The median age was 34 (interquartile range 26–44). The modal age group for men and women was the 30–34 age group. In all age groups under 60, there were more men than women, except in the 10–14 age group. In age groups over 60, there were more women than men. 1.6% of people seen were 70 years and older (322/20,357). 8.8% of the people seen

were children under 18 or aged 0–17 years (1,783/20,357). 8.5% of individuals seen were children aged 16 and under (1,728/20,357), 4.4% of all children were under 5 years (896/20,357), and 7.8% were under 15 years (1,583/20,357).

NATIONALITY

FIGURE 4. Nationalities of individuals

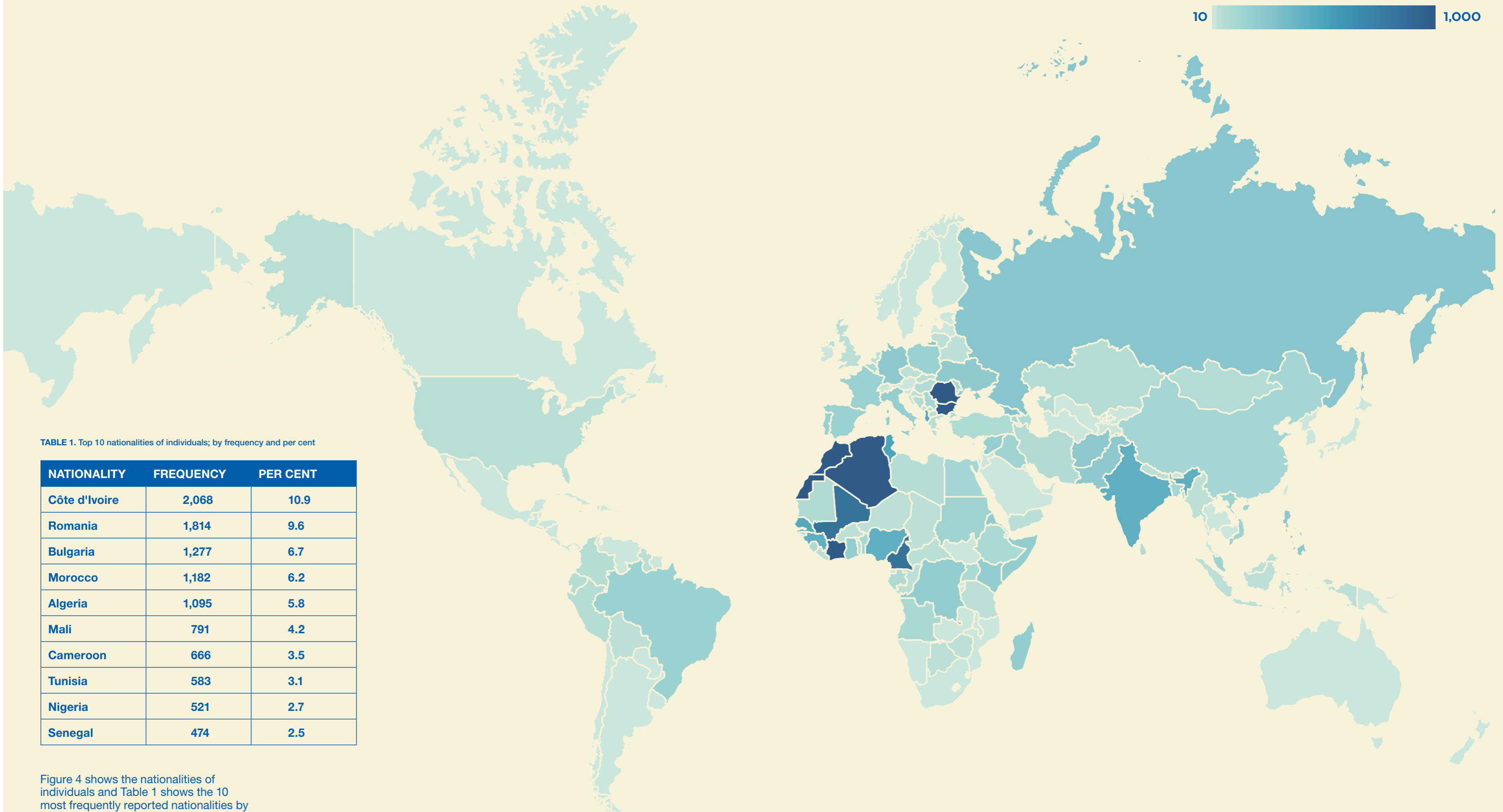


TABLE 1. Top 10 nationalities of individuals; by frequency and per cent

NATIONALITY	FREQUENCY	PER CENT
Côte d'Ivoire	2,068	10.9
Romania	1,814	9.6
Bulgaria	1,277	6.7
Morocco	1,182	6.2
Algeria	1,095	5.8
Mali	791	4.2
Cameroon	666	3.5
Tunisia	583	3.1
Nigeria	521	2.7
Senegal	474	2.5

Figure 4 shows the nationalities of individuals and Table 1 shows the 10 most frequently reported nationalities by individuals. The most common country of origin was Côte d'Ivoire at 10.9% (2,068/18,962), followed by Romania at 9.6% (1,814/18,962), Bulgaria at 6.7% (1,277/18,962), Morocco at 6.2% (1,182/18,962), and Algeria at 5.8% (1,095/18,962). A total of 158 different nationalities were recorded.

Fig 4. Data from social consultations includes each individual once. Figure excludes 3,996 records missing nationalities (17.4%; 3,996/22,958).

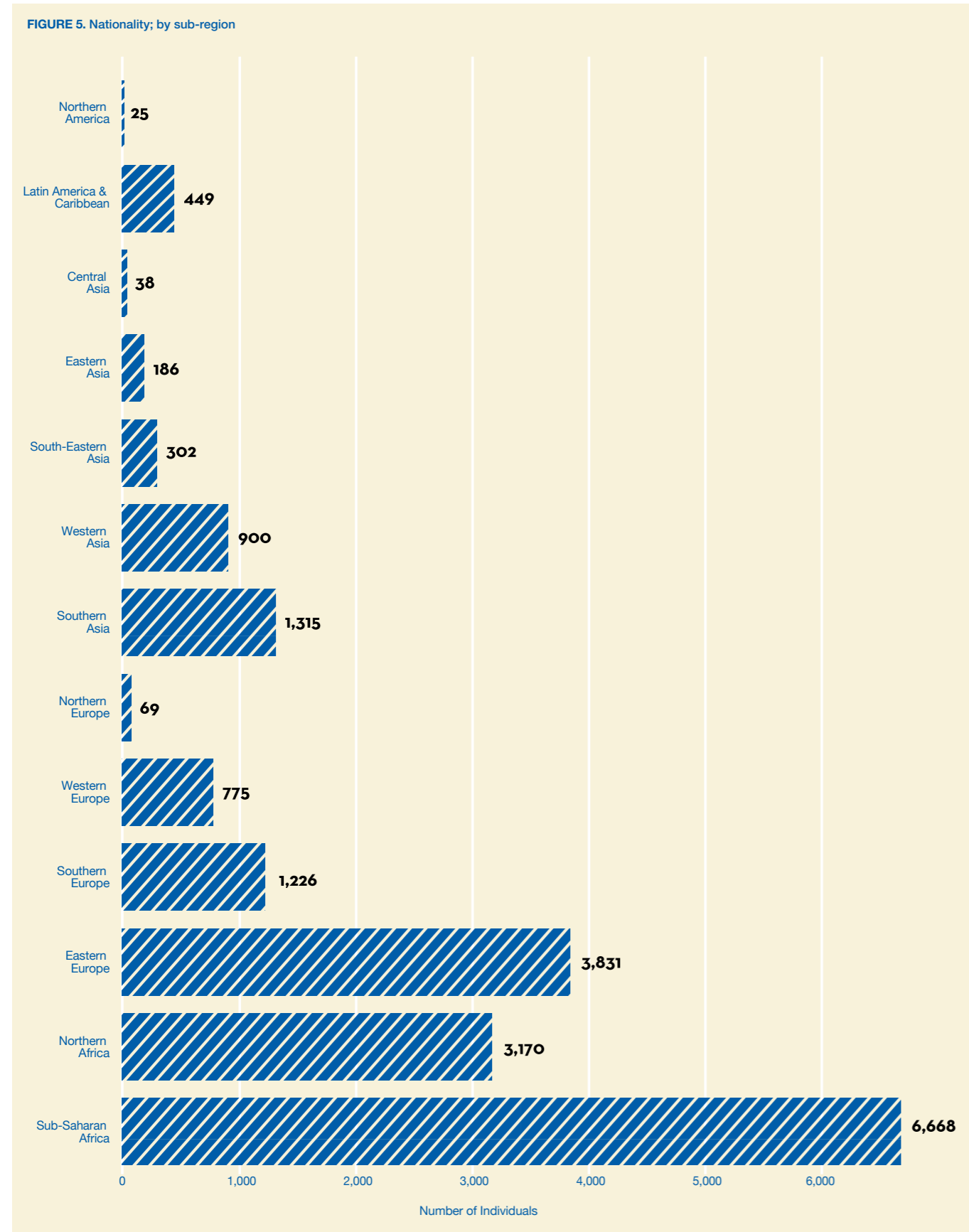
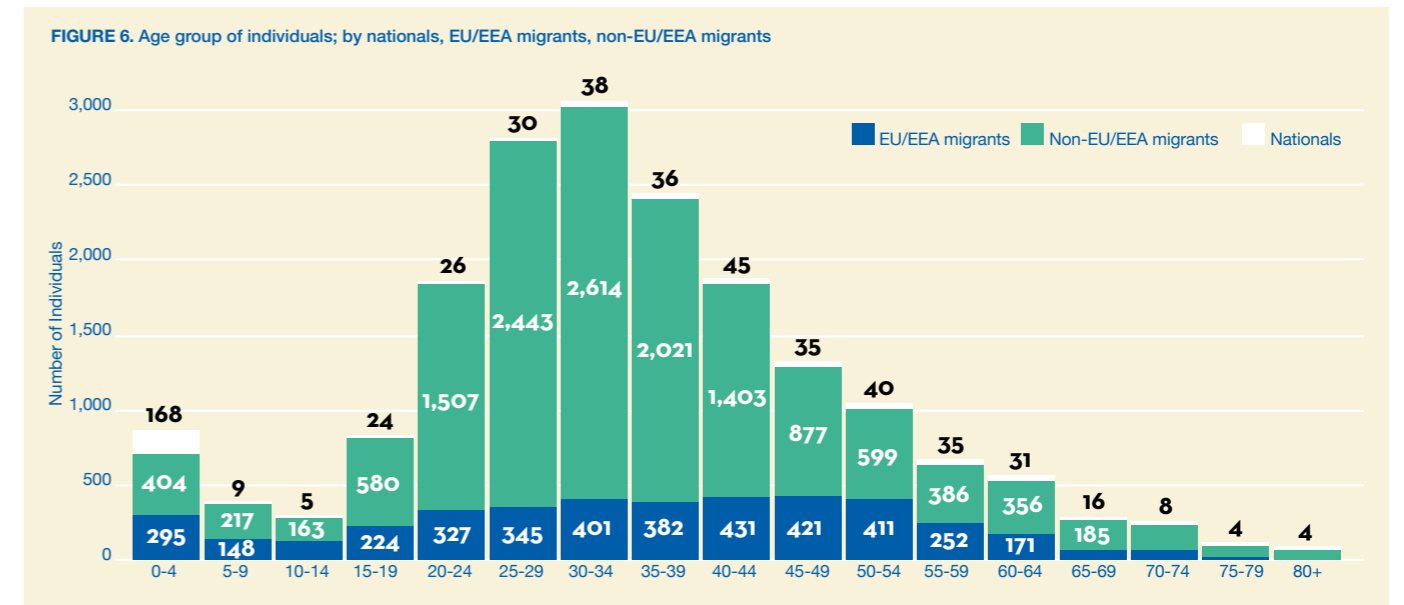


Figure 5 shows that a little more than half of the individuals seen at the MdM programmes were nationals from Africa (51.9%; 9,838/18,962), with 35.2% native of sub-Saharan Africa (6,668/18,962) and 16.7% from Northern Africa (3,170/18,962).

31.1% of individuals were from Europe (5,901/18,962) with 20.2% native of Eastern Europe (3,831/18,962). 14.5% of individuals were from Asia (2,741/18,962). Just 2.5% of individuals were from the Americas (474/18,962).

Fig 5. Data from social consultations includes each individual once. Continents with less than 10 individuals not shown (Oceania, with eight individuals). Figure excludes 3,996 records missing nationalities (17.4%; 3,996/22,958).

MIGRANT CATEGORISATION



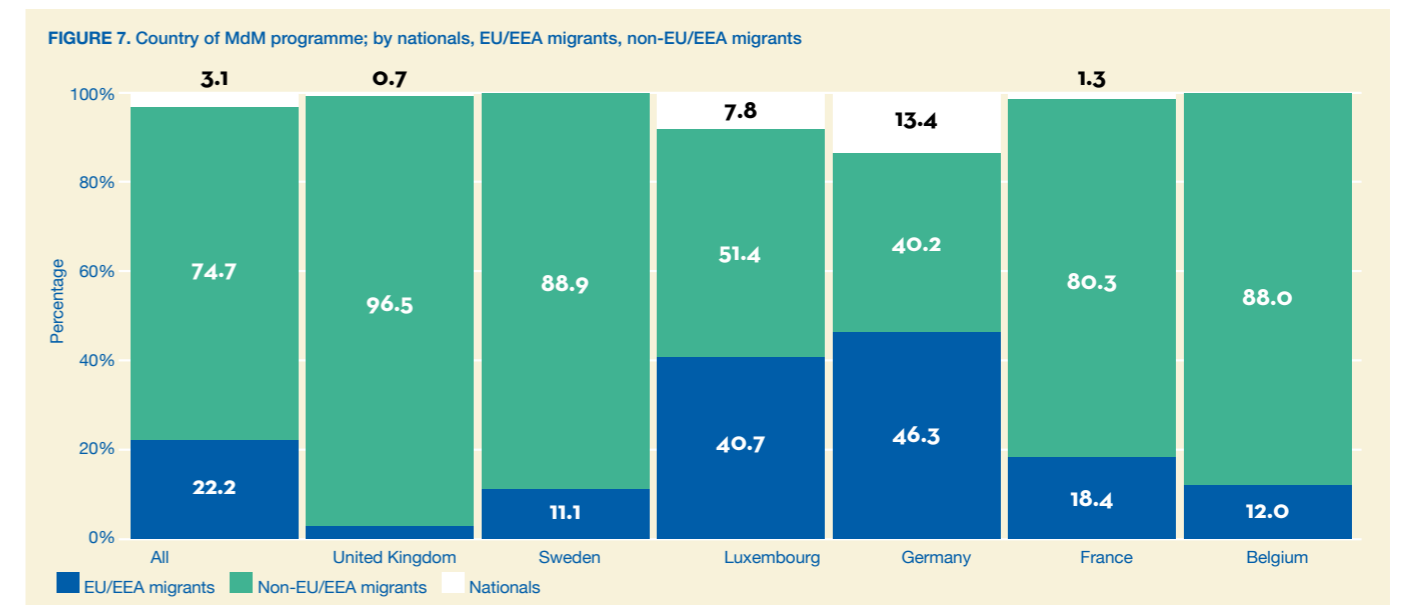
Figures 6 and 7 present the data categorised by EU/European Economic Area (EEA) migrants, non-EU/EEA migrants, and nationals.^{25, 26} Most of all individuals seen at MdM programmes were non-EU/EEA migrants (74.7%; 14,159/18,962), followed by EU/EEA migrants (22.2%; 4,210/18,962) and nationals (3.1%; 593/18,962).

Figure 6, in which data is categorised by age groups, shows that in all age groups the majority of individuals were non-EU/EEA migrants. The highest proportion of non-EU/EEA migrants was in the 30–34 age group (18.7%;

2,614/13,976). In general, the age profile of the non-EU/EEA migrants was younger than the EU/EEA migrants and national groups. The highest levels of EU/EEA migrants were observed in children in comparison to the other age groups; 34.0% of individuals in the 0–4 age group (295/867) were EU/EEA migrants as were 39.6% of the 5–9 age group (148/374) and 41.9% of the 10–14 age group (121/289). Almost a third of nationals who attended an MdM programme were under the age of 4 (30.3%, 168/554).

In Figure 7, the data is categorised by the

country of the MdM programme in which the individual was seen. The highest proportion of non-EU/EEA migrants attended programmes in the United Kingdom (96.5%; 688/713), Sweden (88.9%; 272/306), Belgium (88.0%; 1,667/1,894), and France (80.3%; 9,865/12,285). The highest level of EU/EEA migrants was observed in Germany (46.3%; 1,111/2,397) and Luxembourg (40.7%; 557/1,367). The MdM programmes saw 593 nationals in total, with the highest proportions in Germany (13.4%; 322/2,397) and Luxembourg (7.8%; 107/1,367).



25. This categorisation was calculated based on individuals' nationality in relation to the country where they had a consultation. There are limitations to this categorisation, which must be considered (for further details see the section on "Limitations").

26. This report uses the terms: "EU/EEA migrants" to refer to citizens of European Single Market states – EU countries, EEA, and Switzerland – who are living in another EU or EEA country, or Switzerland; "non-EU/EEA migrants" are those who are not citizens of EU or EEA countries, or Switzerland; and "nationals" are those who reported nationality the same as the clinic country code.

Fig 6. Data from social consultations includes each individual once. Figure excludes 4,362 records missing age, nationality, or both (19.0%; 4,362/22,958).

Fig 7. Data from social consultations includes each individual once. Figure excludes 3,996 records missing nationalities (17.4%; 3,996/22,958).

DETERMINANTS OF HEALTH AND HEALTHCARE ACCESS

There are different factors influencing the health of a person. The people we saw at MdM programmes faced a variety of barriers in access to healthcare. This chapter shows socioeconomic determinants of health as well as issues in access to healthcare.

NAME: ALICIA
COUNTRY: SWEDEN

Alicia, a 44-year-old woman from Russia, was born with cerebral palsy and as a result is in a wheelchair. She needs 24-hour assistance, but at the moment cannot afford this help. She came to MdM Sweden to seek the help of a neurologist.

Alicia has already been denied asylum three times and is now an undocumented migrant, but until recently she could still live in a home provided by the Swedish Migration Agency. The situation was very uncertain because she could be removed at any time from Sweden by the agency. During the COVID-19 pandemic some of the elderly people in the home got sick and died, which scared her. So when she met some men who promised to support her, to provide accommodation, and to help her to get documents, she agreed. Unfortunately, the moment she moved out from the home, the men changed their minds and told her they would not support her. After that she had no place to stay, because she could not return to the home she moved out of.

At the moment she shares a room together with two other men, in

an overcrowded apartment. The situation is very uncomfortable for her and the place is dirty. She cannot shower in the bathroom as it is too small for her wheelchair, so she does her hygiene in the room she shares with the two men.

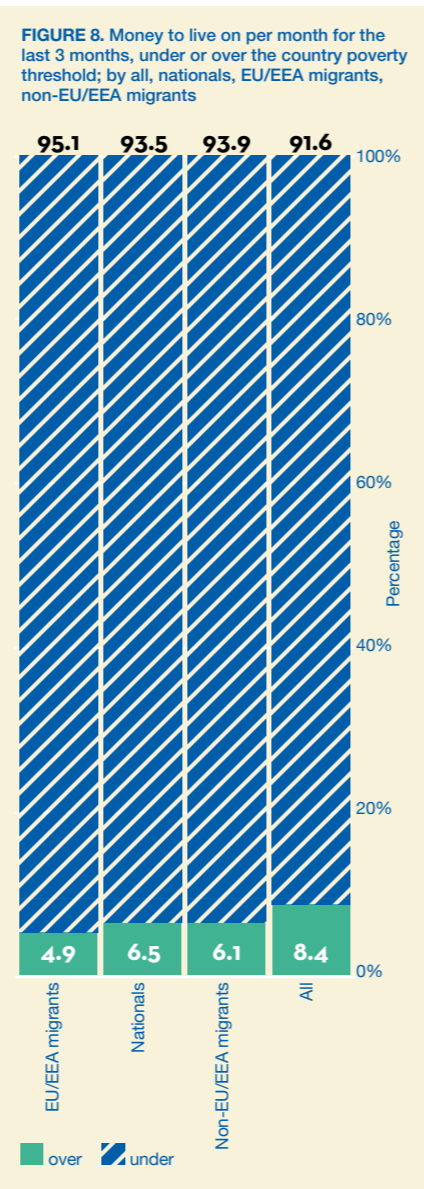
She is looking for a small apartment to have privacy and an adequate bathroom, but this is very difficult to find, especially with a wheelchair.

She was denied healthcare once by a Swedish public care provider. At the pharmacy she must pay the full price of the medicines, although she believes that she, as an undocumented migrant, has the right to subsidised care and medication, which means she should pay a maximum amount of 50 Swedish kronas. Because of that she sometimes does not get the medication she needs because it is too expensive for her. She sometimes finds herself in a position where she needs to choose between paying for medication, food, or changing diapers. Most times she chooses the latter, because her hygiene is very important to her.

SOCIOECONOMIC DETERMINANTS OF HEALTH

INCOME

When presenting at an MdM programme, the people we saw were asked about their income in relation to the poverty threshold in the country they presented in. Out of all the respondents, 91.6% (6,704/7,321) lived under the poverty threshold. This means that their income was below 60.0% of the median equivalised net income of the population in a private household and therefore were at risk of not being able to secure the minimum resources necessary for long-term physical wellbeing and to meet their basic needs (such as food, clothing, and shelter).²⁷ However, these figures should be interpreted carefully since missing data varied across the three groups.²⁸



27. Assessment of above/below the poverty threshold is based on the established poverty threshold in the country that the individual presented in. Note: 60.0% of the median equivalised net income is the median of total income of all households, after tax and other deductions that is available for spending or saving, divided by the number of household members converted into equivalised adults.

28. 62.8% of EU/EEA migrants, 77.0% of non-EU/EEA migrants, and 35.2% of nationals were missing the income variable.

Fig 8. Data from social consultations includes each individual once. Figure excludes 15,637 records missing income, nationality, or both (68.1%; 15,637/22,958).



MdM Greece: COVID-19 Response – a volunteer carrying a delivery of humanitarian aid (personal protection equipment and hygiene kits) for distribution in Victoria Square, Athens (Victoria Square is a focal point for refugees and migrants dwelling in the centre of Athens)

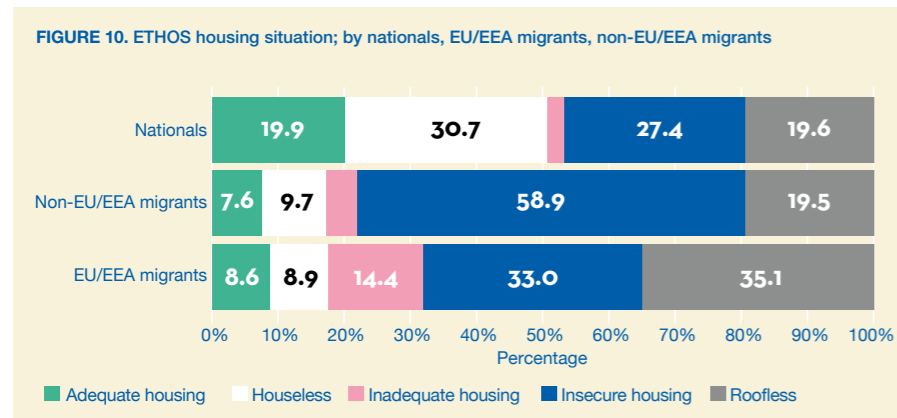
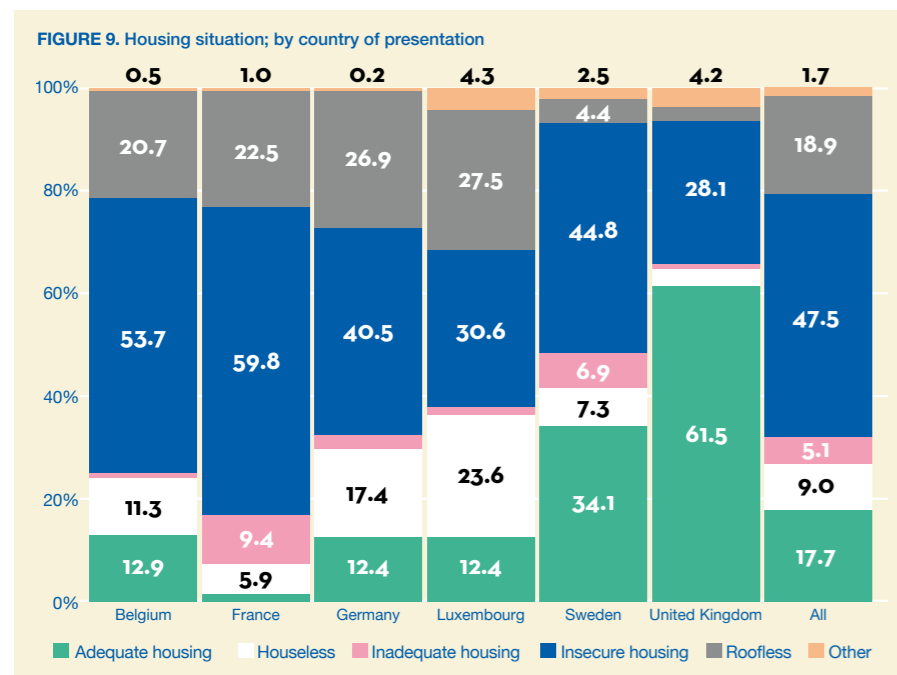
LIVING CONDITIONS

For this report, we have adopted the official European Typology of Homelessness and Housing Exclusion (ETHOS),²⁹ which covers the range of circumstances a homeless person can be living in. This includes:

- **personal flat or house** – living in a personal flat or house;
- **inadequate housing** – living in unfit or overcrowded conditions;
- **insecure housing**³⁰ – living with friends or family in conventional housing, but without secure tenancy or under threat of eviction or of violence;
- **houselessness** – living in various types of temporary shelters or institutions; and
- **rooflessness** – living on the street or emergency shelter.

Figure 9 includes 14,993 unique individuals. The United Kingdom has the highest proportion of individuals living in adequate housing (61.5%; 1,829/2,973). Luxembourg (23.6%; 259/1,098) and Germany (17.4%; 388/2,233) have the highest proportion of individuals experiencing houselessness, which means individuals are residing in an organisation, charity, or hotel for over 15 days. Similarly, Luxembourg (27.5%; 302/1,098) and Germany (26.9%; 601/2,233) have the highest proportion of individuals who were roofless.

Almost half of individuals (47.5%; 7,127/14,993) in all MdM programmes lived in insecure housing while one in five (18.9%; 2,837/14,993) were roofless or sleeping rough.



A higher proportion of EU/EEA migrants were living in roofless situations 35.1%; (776/2,211), compared to 19.5% of non-EU/EEA migrants (1,901/9,737) or 19.6% of nationals (89/453).³¹

58.9% of non-EU/EEA migrants live in insecure housing (5,731/9,737).

Almost half of nationals experienced either rooflessness (19.6%; 89/453) or houselessness (30.7%; 139/453).²⁵

**NAME: ELENA
COUNTRY: GREECE**

Elena lives in Rafina with her two sons. She has no medical insurance. She has no husband (woman-headed family). She is insulin dependent and suffers from depression. One of her two sons has been disabled following a car accident. Their only income derives from the employment of the other son.

"I cannot always pay the standard financial contribution for the specialised tests that me and my son need ... in public hospitals there are no appointments available, so the referral note expires. So, I have to call the health line time and again in order to see a doctor to re-issue/renew the referral note. And so, the process starts over ..., I receive the sugar measuring tapes free of charge from the state run hospital, but I need to make a 2-hour journey to be able to get them ... in the hospital where I had to do my son's neuropsychological tests, the level of service was really poor, so I had to find another doctor, with the specialisation I needed and there are only two individuals all over Attica with this specialisation. At the end, I had to pay 500 euros. How can I move all the time in my condition? Many times I only have 1 euro in my pocket."

29. FEANTSA. (2005). *ETHOS typology on homelessness and housing exclusion*. Retrieved 29 September 2021, from <https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion>.

30. "Insecure housing implies people living in conventional housing or accommodation but without rights or tenancy agreements to secure long-term occupation, meaning they are at risk of eviction, includes: Living with family and friends, accommodation for formerly homeless people, living under threat of eviction or violence, without tenancy or through illegal occupation of land." ETHOS, *ibid*.

31. These figures should be interpreted carefully since missing data varied across the three groups. 46.1% of EU/EEA migrants, 28.7% of non-EU/EEA migrants, and 21.2% of nationals were missing the housing variable.

Fig 9. Data from social consultations includes each individual once. Figure excludes 7,965 records missing housing situation (34.7%; 7,965/22,958). 51.0% of individuals from MdM France are missing the housing situation variable, elevating the total missing records to 34.7% for the entire cohort.

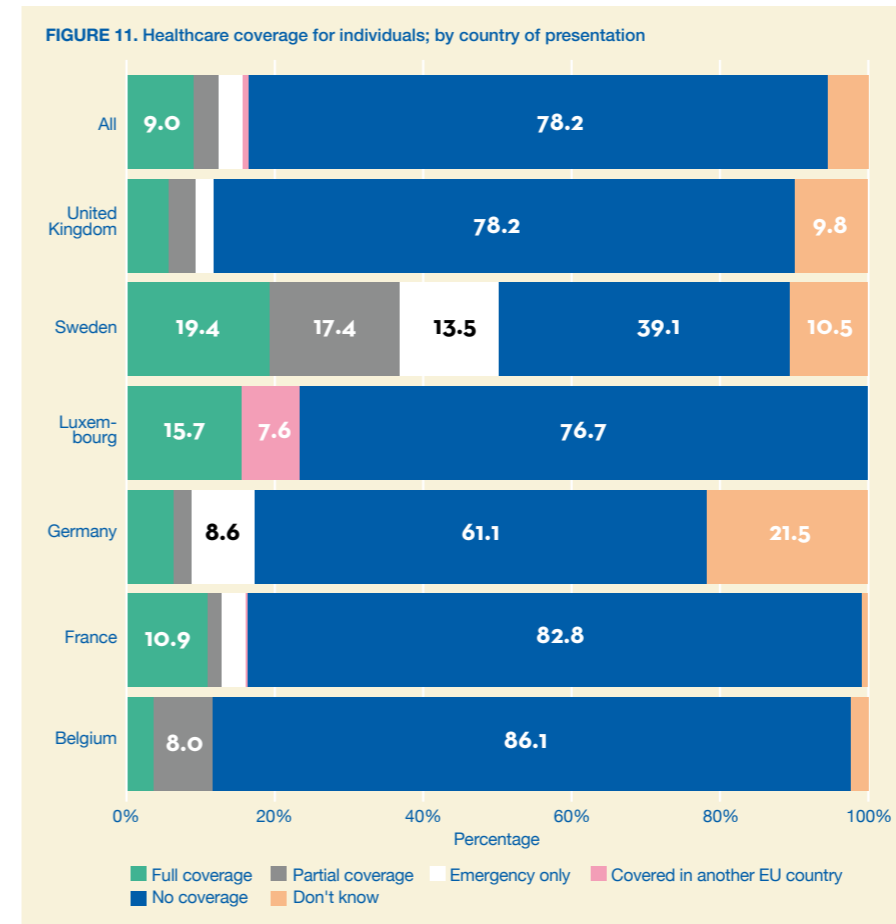
Fig 10. Data from social consultations includes each individual once. Figure excludes 10,557 records missing housing situation, nationality, or both (46.0%; 10,557/22,958). ETHOS: European Typology of Homelessness and Housing Exclusion.

HEALTHCARE ACCESS

Medical care in Europe is of a high standard, but can also be expensive. In recognition of this it is broadly accepted that healthcare must be financed either by an insurance system or a social service rather than out-of-pocket payments by individuals. All 27 EU member states have adopted

Agenda 2030 with the goal of achieving UHC to ensure "all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship".³²

HEALTHCARE COVERAGE



In total, 12,767 unique individuals responded to the question on healthcare coverage. As demonstrated in Figure 11, a majority of people reported not having healthcare coverage (78.2%; 9,981/12,767). Belgium had the highest proportion of people reporting not having healthcare coverage (86.1%; 1,526/1,773). Sweden (19.4%; 59/304) and Luxembourg (15.7%; 182/1,159) had the highest proportions of individuals reporting full healthcare coverage. Sweden had the highest proportion of individuals reporting either partial

(17.4%; 53/304) or emergency only (13.5%; 41/304) healthcare coverage. Luxembourg was the country with the highest proportion of individuals reporting healthcare covered in another EU country (7.6%; 88/1,159). Germany had the highest proportion of people who did not know their healthcare coverage status (21.5%; 331/1,536), followed by Sweden (10.5%; 32/304) and the United Kingdom (9.8%; 238/2,419). Out of all respondents 3.3% (415/12,767) reported having access to emergency care only.³³

32. World Health Organization. (2021). *Universal health coverage*. Retrieved 29 September 2021, from https://www.who.int/health-topics/universal-health-coverage#tab=tab_1.

33. These figures should be interpreted carefully since missing data varied across the groups. 59.6% of individuals from MdM France, 23.9% from MdM Germany, and 16.6% from MdM Luxembourg were missing the healthcare coverage variable. missing the healthcare coverage variable.

Fig 11. Data from social consultations includes each individual once. Figure excludes 10,191 records missing healthcare coverage (44.4%; 10,191/22,958).

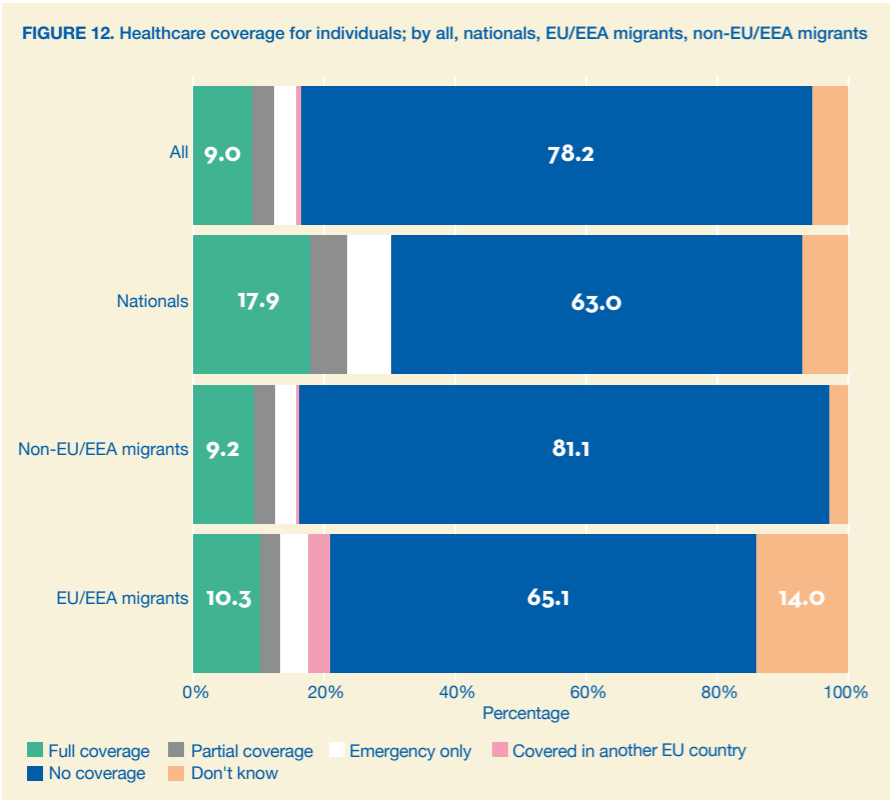
**NAME: ERICK
COUNTRY: UNITED KINGDOM**

Erick fled violence in El Salvador and claimed asylum in 2020 in the United Kingdom with his wife and 6-year-old daughter. They live in a flat provided by the Home Office. A few weeks ago, he started to feel ill with symptoms of COVID-19 and did not know where to turn for help. "We didn't know how to get food or buy medicines for the symptoms. I had thousands of questions, like what kind of things am I able to take for the continuous dry cough that I have. So, I started buying natural things my mum used to give me back in my country. The struggle to breathe is the thing that worries me the most because that is what kills you." Erick dialled the National Health Service number 111 to ask what to do when his symptoms had disappeared but he did not get the information he needed. "They told me they were going to call me again and send me guidance, but they never called back." Erick gets his information from watching the news, if he has enough airtime credit.

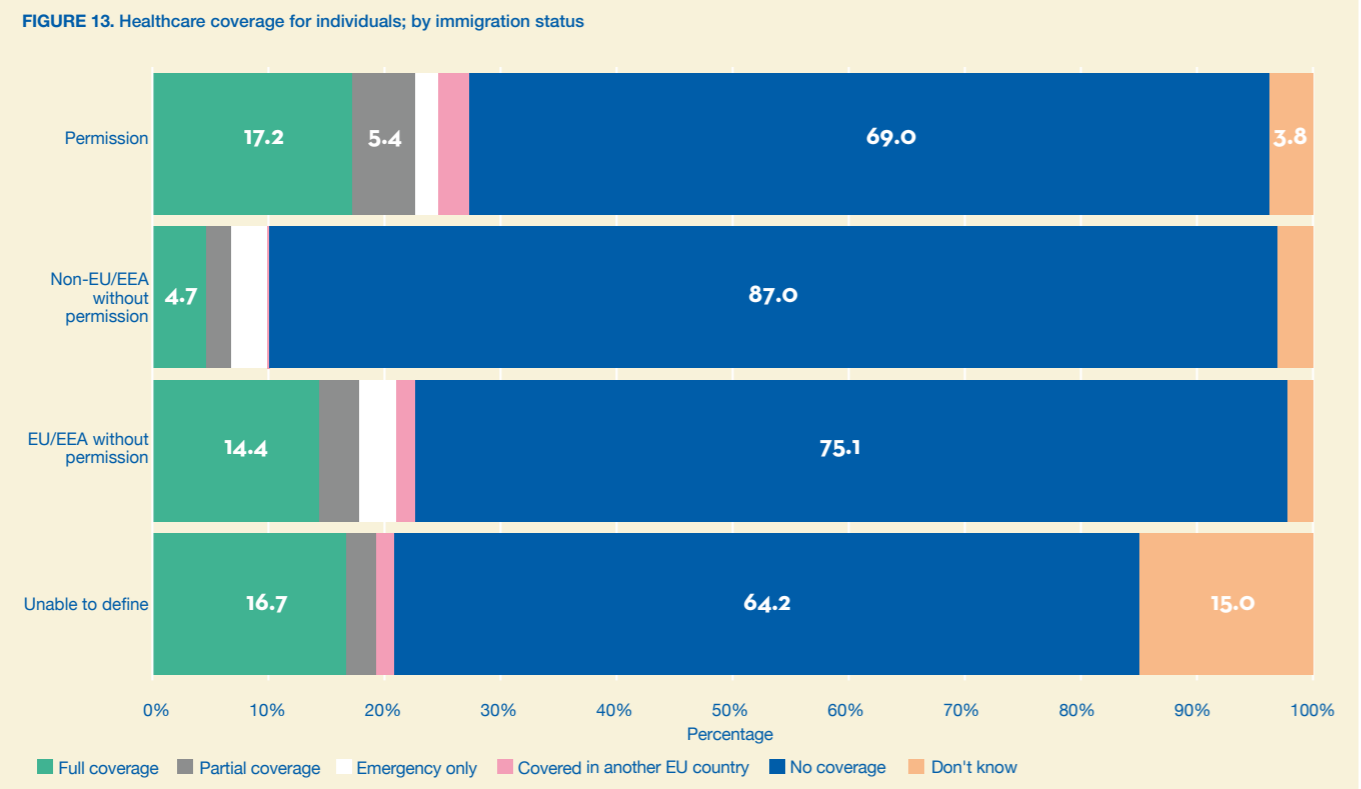
It was not the first time Erick had struggled to access healthcare. "In my area, I have two GPs [general practitioners] closer to my house. One of them refused to register me because they said I'm not from here, so they just didn't want me to be registered there because I am from another place."

Erick reports that many people in his community are encountering the same problems during COVID-19. "A lot of new asylum seekers, people who are new to the system, that came here when the lockdown was starting, they couldn't register themselves with the GPs. At some point, they are going to need access to healthcare and if you are not registered that is going to make it harder."

Erick uses his English language skills to help people in his community get access to healthcare. "Language over the phone is an issue. And that's another problem with accessing the GP. We don't have enough credit to call the GP and sometimes the call can take really long."



In Figure 12, nationals have the highest proportion of individuals reporting full healthcare coverage (17.9%; 73/408). Only 9.2% of non-EU/EEA migrants (799/8,696) and 10.3% of EU/EEA migrants (178/1,730) reported full coverage. A majority of non-EU/EEA migrants reported not having healthcare coverage (81.1%; 7,053/8,696), followed by 65.1% of EU/EEA migrants (1,126/1,730). 14.0% of EU/EEA migrants did not know if they had healthcare coverage (242/1,730).³⁴



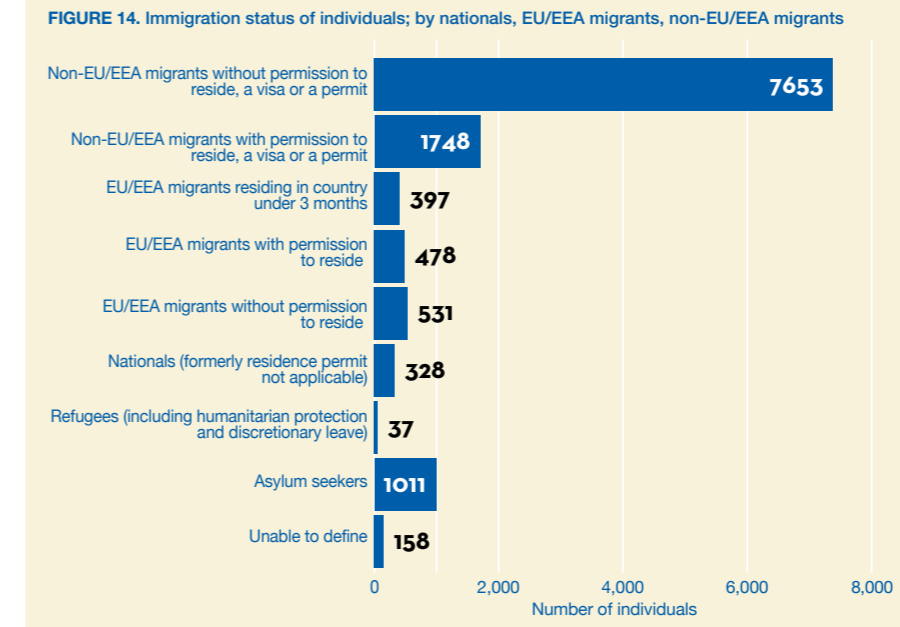
As demonstrated in Figure 13, 69.0% of individuals with permission to reside reported not having healthcare coverage (2,289/3,319). A higher proportion of EU/EEA migrants without permission to reside reported full healthcare coverage (14.4%; 45/313) compared to non-EU/EEA migrants without permission to reside (4.7%; 306/6,552).³⁵

34. These figures should be interpreted carefully since missing data varied across the groups.
35. These figures should be interpreted carefully since missing data varied across the groups.

Fig 12. Data from social consultations includes each individual once. Figure excludes 12,124 records missing healthcare coverage, nationality, or both (52.8%; 12,124/22,958). The "all" bar excludes 19,191 records just missing healthcare coverage (44.4%; 10,191/22,958).

Fig 13. Data from social consultations includes each individual once. Figure excludes 12,654 records missing healthcare coverage, immigration status, or both (55.1%; 12,654/22,958).

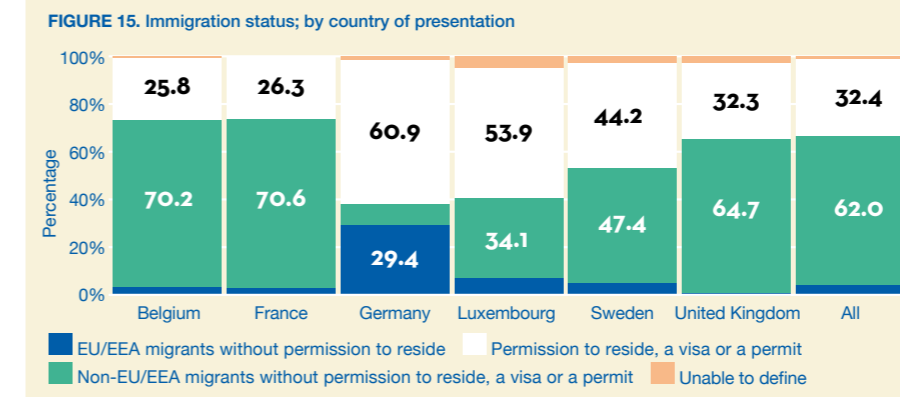
IMMIGRATION STATUS



National legislation on access to healthcare for migrants often varies and immigration status has a profound impact on people's abilities to access care. As demonstrated in Figure 14, 62.0% (7,653/12,341) of individuals were non-EU/EEA migrants without permission to reside. The term "without permission to reside" for non-EU/EEA migrants means "not fulfilling conditions for entry, stay, or residence in the country the person is living in". It includes those who enter Europe regularly on documents that have since become invalid, those who entered irregularly, and asylum seekers whose claims have been refused. 14.2% (1,748/12,341) of individuals were non-EU/EEA migrants with permission to reside and 8.2% (1,011/12,341) were asylum seekers. The smallest proportion

of individuals were refugees (0.3%; 37/12,341).³⁶

Of the people we saw, 4.3% (531/12,341) were EU/EEA migrants without permission to reside, meaning they were residing in their host country for over 3 months but were not fulfilling the requirements of the European Directive 2004/38/EC (meaning they were not either employed or self-employed or did not have sufficient resources for themselves and no health insurance as required by the European Directive 2004/38/EC).³⁷ Immigration status is complex and sometimes, in the absence of legal expertise, individuals can be uncertain or incorrect about their immigration status, especially in the case of EU migrants who are not automatically issued residence permits.



In total, 65.3% of individuals did not have permission to reside (8,184/12,341), including both non-EU/EEA and EU/EEA migrants. A third of MdM programmes attendees had permission to reside in the country they presented (32.4%; 3,999/12,341). Germany had the highest proportion of EU/EEA migrants without

permission to reside (29.4%; 187/637) and those with permission to reside (60.9%; 388/637). France and Belgium had the highest proportion of non-EU/EEA migrants without permission to reside (70.6%; 4,078/5,777 and 70.2%; 1,098/1,564, respectively).³⁸

NAME: KATARINA
COUNTRY: GERMANY

Katarina fled her home country during the ex-Yugoslavian conflict in the early nineties. By fear of being deported to Serbia, Katarina never declared her presence in Germany nor filed an application for a residence permit since she moved here. For more than 30 years, Katarina has been living undocumented in Germany, and in constant fear of being arrested and deported. She has made a living from working odd jobs, including working as a cleaner.

A few years ago, she fell down the stairs and was brought to the emergency services in an ambulance. During her hospital stay she was diagnosed with several chronic diseases requiring urgent treatment. A friend paid her hospital bill, as she could not afford to.

This was the first time Katarina consulted a doctor in more than 20 years. Before that, she was too scared to go and see a doctor. "I can't go anywhere. I don't have any documents. I don't have any valid residence permit here and I can't be asked for identification."

Now, Katarina comes to MdM Germany every 2 months for a check-up where she receives free medical care as well as the correct medication.

36. These figures should be interpreted carefully since missing data varied across the groups. 74.1% of individuals from MdM France, 58.0% from MdM Germany, and 4.0% from MdM United Kingdom were missing the immigration status variable.

37. European Parliament, Council of the European Union. (2004). Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member amending Regulation (EEC) No 1612/68. *Official Journal of the European Communities*, L158, 77-123. Retrieved 30 September 2021, from <https://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX:32004L0038>.

38. These figures should be interpreted carefully since missing data varied across the groups.

Fig 14. Data from social consultations includes each individual once. Figure excludes 4,736 records with missing immigration status (21.2%; 4,736/22,365).

Fig 15. Data from social consultations includes each individual once. Figure excludes 10,617 records missing immigration status (46.2%; 10,617/22,958). In total, 12,341 unique individuals.

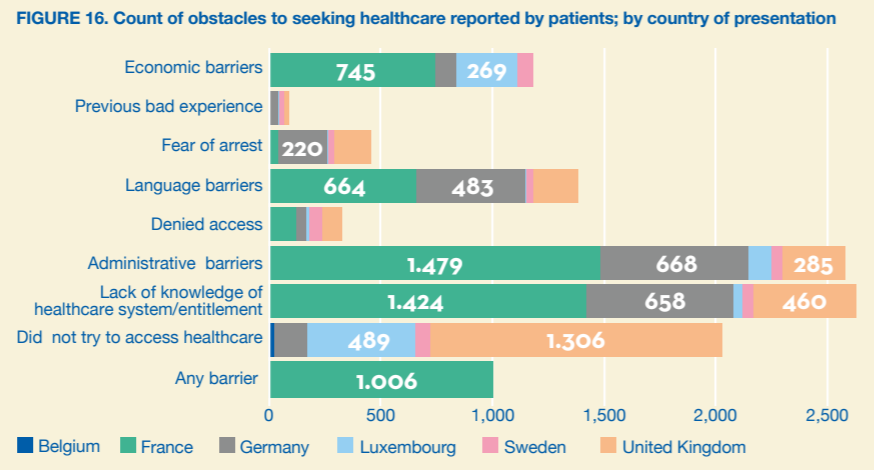
**NAME: DESPINA
COUNTRY: GREECE**

Despina is 90 years old, suffers from dementia, and mostly remains still. She has cholesterol issues, high blood pressure, incontinence, and suffers from decubitus ulcer, which she has difficulty coping with. Despina receives a pension of 500 euros and receives care from her daughter.

Her daughter also faces financial difficulties and receives a pension of around 450 euros. Her daughter is unable to adequately cover the costs due to the increased needs of her mother for daily and medical care. Their housing situation is also difficult as they both live together in a small house, which although privately owned, has suffered a lot of damage and is in a poor condition.

"I find it very difficult to pay for electricity, water, telephone, medicines, creams, diapers, and under-pads that my mother needs. These costs are not covered by the medical insurance, provided as part of our pension ... How can I take her to the hospital for her examinations and see the doctors? I want an ambulance, which although it comes, prioritises other emergencies. Doctors have not guided me or given me clear instructions for the care and rehabilitation of my mother. I feel alone and always leave the hospital with a lot of unanswered questions. I have to ask a doctor in my neighbourhood to prescribe the medication without taking any money for it because our money is not enough to pay him."

BARRIERS TO HEALTHCARE

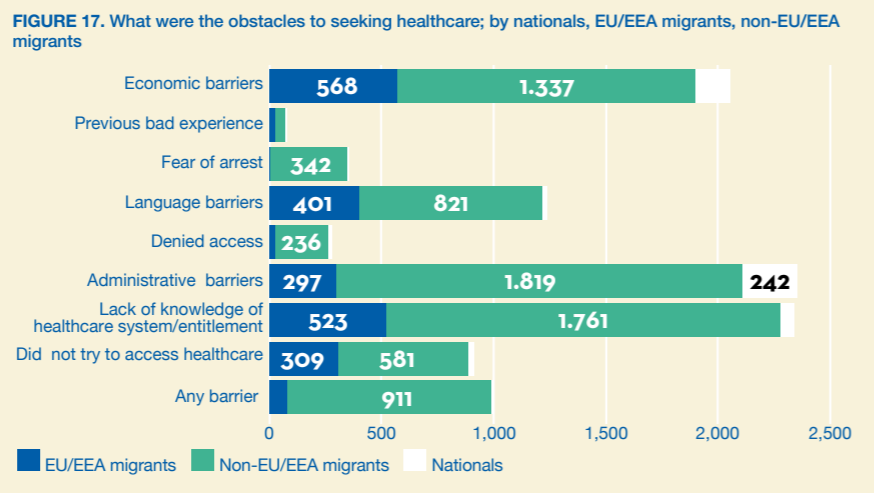


When presenting at an MdM programme, people were asked about barriers they faced when trying to access healthcare. This question allowed for multiple responses since people often face more than one barrier. Figure 16 reports the number each answer was given and should not be interpreted as individuals. The barriers stated are not expert opinions on what constitutes a barrier to health, but our participants' experiences.

In total, 11,698 barriers were recorded, with multiple responses per individual. Of the respondents, 29.9% experienced at least one barrier (6,857/22,958). The most frequently mentioned barriers were "lack of knowledge of healthcare system/entitlement" (22.5%,

2,630/11,698), "administrative barriers" (22.1%; 2,582/11,698), and "did not try to access healthcare" (17.3%; 2,029/11,698). A person that reported "did not try to access healthcare" could imply a number of barriers such as: the person had given up on trying to access care; stigma; experiences of discrimination; too far to travel; was not allowed to seek care by family members; etc, making it difficult to interpret.

64.4% of responses to "did not try to access healthcare" came from the United Kingdom (1,306/2,029), 47.8% of responses to "language barriers" came from France (664/1,388) and 34.8% of responses to "economic barriers" came from France (745/1,184).



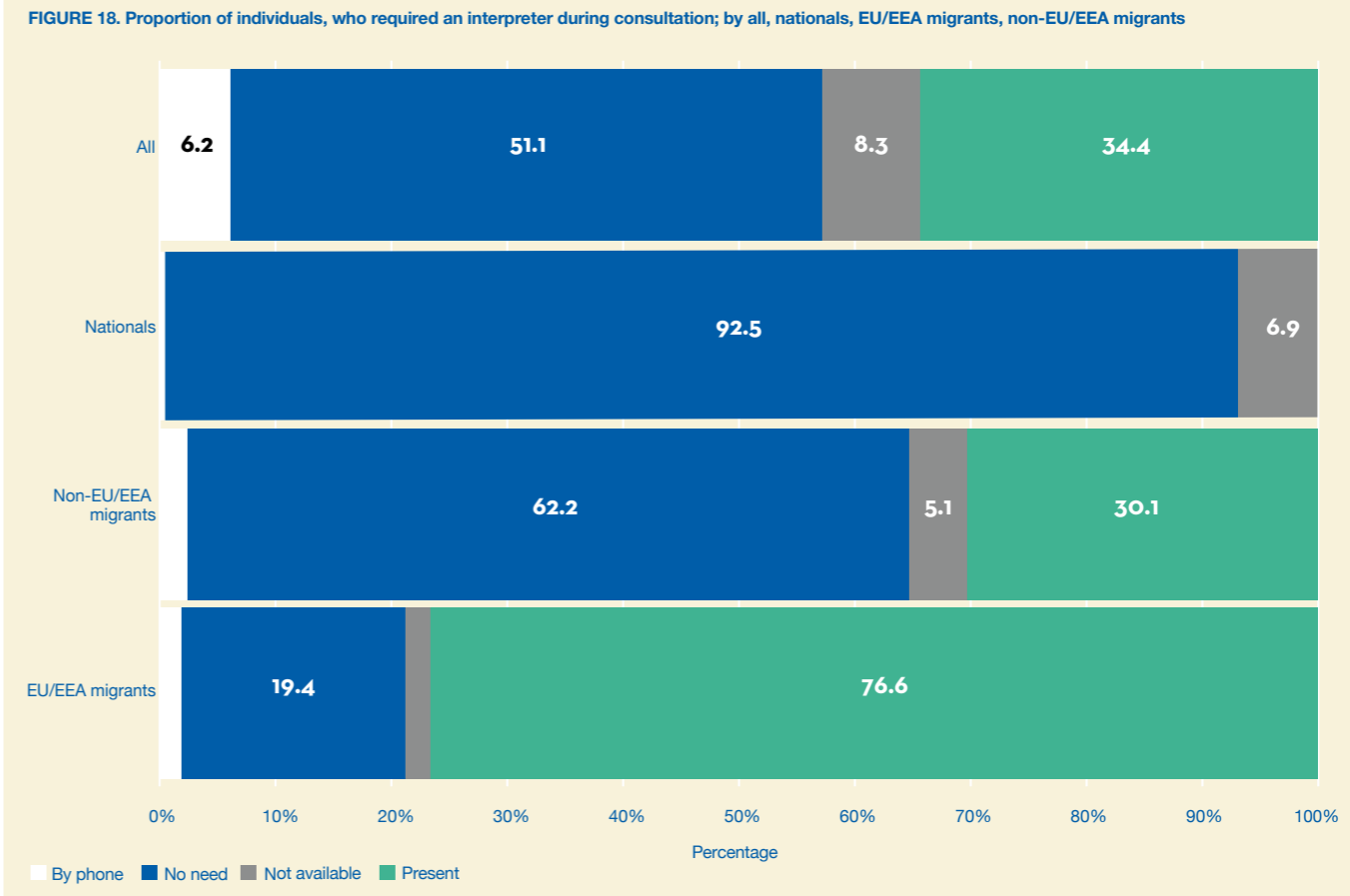
Viewed in relation to migrant status 10,609 barriers were reported. The largest barriers for EU/EEA migrants were "economic barriers" (25.5%; 568/2,231), followed by "lack of knowledge of healthcare system/entitlement" (23.4%; 523/2,231) and "language barriers" (18.0%; 401/2,231). The largest barriers for non-EU/EEA

migrants were "administrative barriers" (23.2%; 1,819/7,853) and "lack of knowledge of healthcare system/entitlement" (22.4%; 1,761/7,853). The largest barriers for nationals were "administrative barriers" (46.1%; 242/525) and "economic barriers" (29.3%; 154/525).

Fig 16. Data from social consultations includes each individual once. Multiple reasons may be recorded for each individual. Figure excludes records reporting "no difficulties". Economic barriers combine: consultation too expensive; treatment too expensive; and health insurance too expensive.

Fig 17. Data from social consultations includes each individual once. Multiple reasons may be recorded for each individual. Figure excludes records reporting "no difficulties". Economic barriers combine: consultation too expensive; treatment too expensive; and health insurance too expensive.

TRANSLATOR



As demonstrated in Figure 18, 76.6% of EU/EEA migrants (1,425/1,861) had an interpreter present compared to 30.1%

of non-EU/EEA migrants (2,678/8,887). Across all people, half of individuals had no need for an interpreter

(51.1%; 6,892/13,499) and 34.4% of individuals needed an interpreter to be present (4,639/13,499).

**NAME: SARA
COUNTRY: SWEDEN**

Sara is from Azerbaijan and has been living in Sweden as an asylum seeker since 2015. Before moving to Sweden, Sara's first child died. Sara's second child, a 9-year-old boy, is severely autistic, aggressive, unable to express himself, and needs 24-hour personal assistance.

Sara's husband is an addict and abuses her and her son. In 2015, Sara and her family applied for asylum but were rejected – Sara never attended the interview with the Migration Board or the Migration Court because her husband abused her to prevent her from attending or revealing their family relationship. After the asylum was rejected, Sara moved apart from her husband, reported him to the police, and is now in hiding with her son.

Sara does not get any support for her son, she has to feed and help him with all his hygiene. Her son attends a regular school for 2 hours a day where Sara is also present. But Sara believes that with the right help, her son could start talking and

expressing himself. She also believes the fact that no one helps her, is like mental abuse, and says it violates her and her child's human rights. "As an adult, it's easier to go without clothes and food, but this is about a child – he can't wait. I lost a healthy child and no one took responsibility for it. Now I have to fight for my second child."

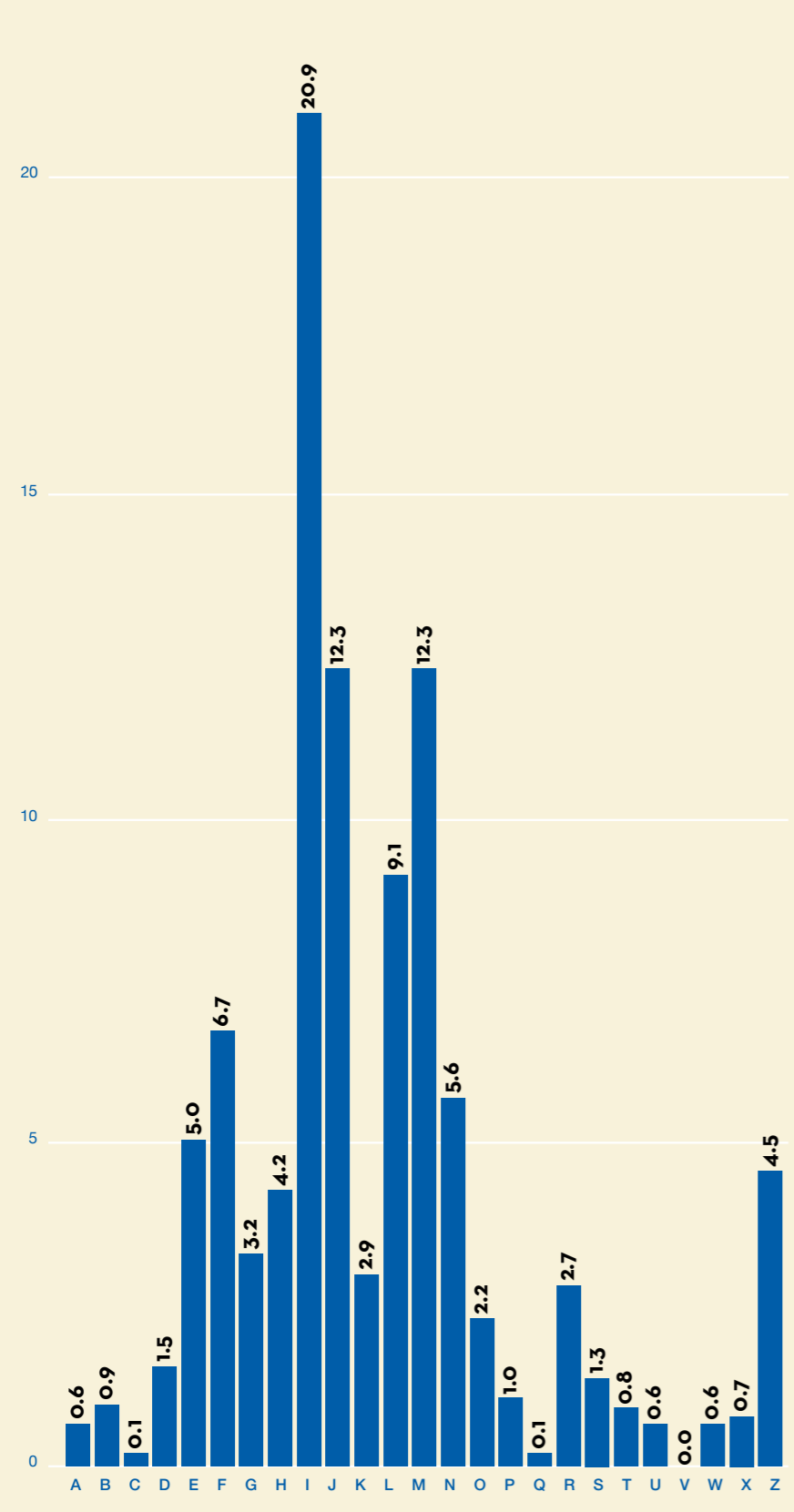
Through a friend, Sara came into contact with MdM Sweden where she now receives legal and psychosocial support, which has enabled Sara to appeal the decision of the Migration Court to the Supreme Migration Court.

Sara says she does not understand the process of appeal and does not know who to talk to. "I have to take care of my child all the time. I can't think about anything else." She has not been assigned an interpreter during conversations with the Migration Agency. The lawyer she has been in contact with in the past has only spoken to her husband and she says she feels the lawyer has prioritised his interests.

Fig 18. Data from social consultations includes each individual once. Figure excludes 5,833 records missing translator or nationality (41.2%; 5,833/19,332). Missing data from Belgium, Luxembourg, and Sweden (3,626 individuals).

HEALTH CONDITIONS AND STATUS

FIGURE 19. Diagnoses of MdM service users; by ICD-10 chapter⁴⁰



In this chapter, we cover the health conditions and pathologies diagnosed by a clinician, and the self-perceived health status reported by individuals visiting the MdM programmes in the six countries.³⁹

COMMON PATHOLOGIES

Overall, the most frequent pathologies were diseases of the circulatory system (20.9%; 5,217/24,917), followed by diseases of the respiratory system and diseases of the musculoskeletal system and connective tissue (12.3%; 3,077/24,917, respectively).

39. Greece is excluded as only testimonies were collected for MdM Greece.

40. World Health Organization. (2004). ICD-10: international statistical classification of diseases and related health problems, tenth revision, 2nd ed. Geneva: World Health Organization. Retrieved 30 October 2021, from <https://apps.who.int/iris/handle/10665/42980>.

Fig 16. Data from the pathology dataset. Multiple pathologies may be recorded for each individual. Figure excludes records with missing International Statistical Classification of Diseases and Related Health Problems–10th Revision (ICD-10) chapter variable (3.6%; 940/25,857).

TABLE 2. ICD-10 Chapters⁴¹

ICD-10 CHAPTERS

A – Certain infectious and parasitic diseases
B – Certain infectious and parasitic diseases
C – Neoplasms
D – Neoplasms and Diseases of the blood and blood-forming organs, and certain disorders involving the immune mechanism
E – Endocrine, nutritional, and metabolic diseases
F – Mental and behavioural disorders
G – Diseases of the nervous system
H – Diseases of the eye and adnexa and Diseases of the ear and mastoid process
I – Diseases of the circulatory system
J – Diseases of the respiratory system
K – Diseases of the digestive system
L – Diseases of the skin and subcutaneous tissue
M – Diseases of the musculoskeletal system and connective tissue
N – Diseases of the genitourinary system
O – Pregnancy, childbirth, and the puerperium
P – Certain conditions originating in the perinatal period
Q – Congenital malformations, deformations, and chromosomal abnormalities
R – Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified
S – Injury, poisoning, and certain other consequences of external causes
T – Injury, poisoning, and certain other consequences of external causes
U – Codes for special purposes
V – External causes of morbidity and mortality
W – External causes of morbidity and mortality
X – External causes of morbidity and mortality
Z – Factors influencing health status and contact with health services
Total (including those missing ICD-10 category)

ICD-10: International Statistical Classification of Diseases and Related Health Problems–10th Revision.⁴²

NAME: DANIELA
COUNTRY: GERMANY

Daniela is a Bulgarian citizen who had no health coverage in Bulgaria or in Germany. She moved to Germany with her family more than 8 years ago, hoping for a fresh start. But no one in her family managed to find a job or an apartment. Two years after leaving Bulgaria, her son was diagnosed with cancer and died shortly afterwards.

Ever since, Daniela has found herself homeless, sleeping on the streets, in cars, in containers, and sometimes at some acquaintances' place. She first came to open.med München in February 2012. Starting from 2018, she continued to visit open.med München because of a persistent skin condition, which ultimately spread to her entire body. For the same reason, she was sent to the emergency services in 2019 and was diagnosed with a rare skin disorder. After being discharged, open.med München provided Daniela with medical care, but to no avail.

A few months after this, Daniela

came back to open.med München, presenting with several large ulcers. The doctor on duty sent her to the dermatological emergency services. She was refused admittance despite the intensity of the pain, which made her unable to eat, drink, or have bowel movements. The open.med München team then sent her to another clinic. The diagnosis was incontrovertible. Daniela had suffered from a life-threatening chronic inflammatory disease for more than half a year and required emergency surgery.

With the support from another organisation – Caritas, MdM Germany helped Daniela to complete her applications for assistance in case of illness (§48, Social Security Code Book XII) and basic security in old age (§41 Social Security Code Book XII). Despite the medical evidence proving the emergency of her situation, all of Danielas applications were rejected, which led to her health condition worsening and ultimately to her death.

41. *ibid.*

42. Some diagnoses range from one letter to the next which means there is repetition in diagnoses. For example, A and B.

43. International Labour Organisation. (2021). *NATLEX Database of national labour, social security and related human rights legislation*. Retrieved 1 November 2021, from https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=83685.

44. *ibid.*



MdM Greece: a volunteer doctor performing a medical examination at MdM Open Polyclinic in the centre of Athens

NAME: OMAR
COUNTRY: LUXEMBOURG

Omar presented himself at MdM Luxembourg for consultation during a Wednesday. While Omar spoke, it was difficult to understand anything he said, he could move all four limbs, and he walked on his two feet by discreetly limping on his left leg. While he was trying to speak, he presented a very discrete left facial paralysis, and finally was diagnosed by MdM Luxembourg with Wernicke's (Receptive) aphasia caused by a cerebral issue, transient ischaemic attack, stroke, or tumour.

MdM Luxembourg called the emergency number 112 where Omar was urgently transferred to the night hospital and the assigned emergency room doctor was informed of the diagnosis. Dr Thill recalls: "After a vascular surgery and 1 month of hospitalisation, Omar returned to sleeping in the streets until December 1st. Since then, he has spent his evenings in a homeless shelter. Every morning, at 6.30am, he wakes up and at 8.45am, he leaves for the train station."

Since Omar left the hospital, from time to time, he still has trouble finding his words and his left leg remains weaker than his right. He is conscious that some of these symptoms will be with him for life. Since Omar has not yet fully recovered from this illness, he is hesitant to return to work. Under these conditions, since he does not work and as he does not have medical insurance, Omar cannot pay for the two indispensable medicines that were prescribed for him at the hospital. For this reason, he continues to come to MdM Luxembourg. "MdM [Luxembourg] is the only care I have. You have helped me a lot, you saved my life!"

FIGURE 20. Pathologies; by diagnosis status

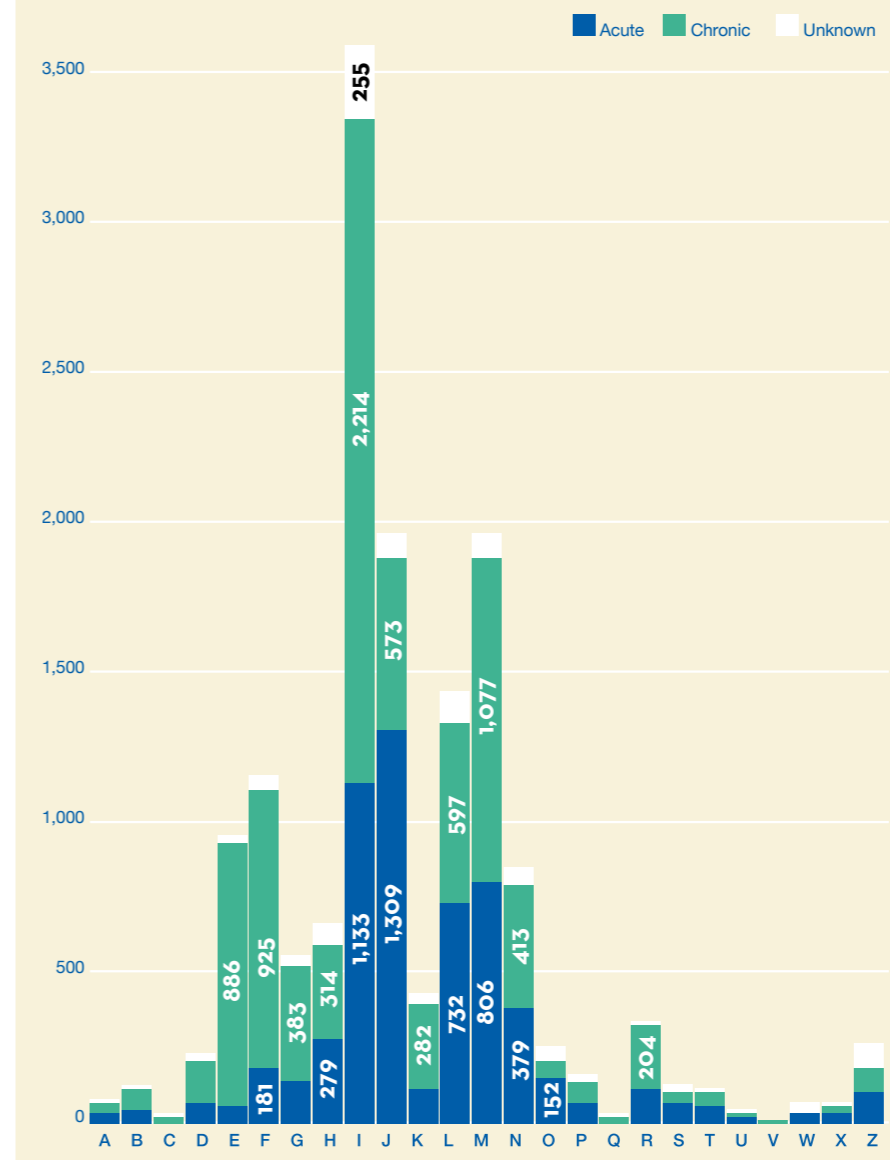


Figure 20 shows the total number of diagnosed pathologies reported (not individuals) by diagnosis status. These figures include records with unknown diagnosis status (7.1%; 1,093/15,480).

ACUTE PATHOLOGIES

Of those pathologies that had a diagnosis status, 38.2% were acute (5,911/15,480). Overall, the highest proportion of acute pathologies were respiratory (22.1%; 1,309/5,911), followed by circulatory (19.2%; 1,133/5,911), musculoskeletal (13.6%; 806/5,911), and skin (12.4%; 732/5,911). Pregnancy, childbirth, and family planning accounted for 2.6% of the consultations (152/5,911).⁴⁵

CHRONIC PATHOLOGIES

Of those pathologies that had a diagnosis status, over half were chronic (8,476/15,480). Overall, the highest proportion of chronic pathologies were circulatory (26.1%;

2,214/8,476) followed by musculoskeletal (12.7%; 1,077/8,476), psychological (10.9%; 925/8,476), endocrine, metabolic, and nutritional (10.5%; 886/8,476), and skin (7.0%; 597/8,476). This data needs to be considered carefully as the definition of chronic may be interpreted differently by different data collectors and in different countries.

In the current context, it is important to keep in mind that comorbidities, including chronic diseases, can be associated with a higher risk of developing severe forms of COVID-19.⁴⁶

Fig 20. Data from the pathology data set. Multiple pathologies may be recorded for each individual. Figure excludes 4,344 diagnoses recorded with missing status (16.8%; 4,344/25,857) as well as 6,033 diagnoses with missing ICD-10 chapter variable (23.3%; 6,033/25,857).

45. Note: Data slightly differs from the previous figure considering a small amount of it did not include both the diagnosis (ie, the ICD-10-chapter variable) and diagnosis status (ie, the acute or chronic variable).
46. Cha, S., Henry, A., Montgomery, M. P., Laws, R. L., Pham, H., Wortham, J., et al. (2021). Morbidity and mortality among adults experiencing homelessness hospitalized with COVID-19. *J Infect Dis*, 224(3), 425-430. <https://academic.oup.com/jid/article/224/3/425/6276529>.

SELF-PERCEIVED HEALTH STATUS

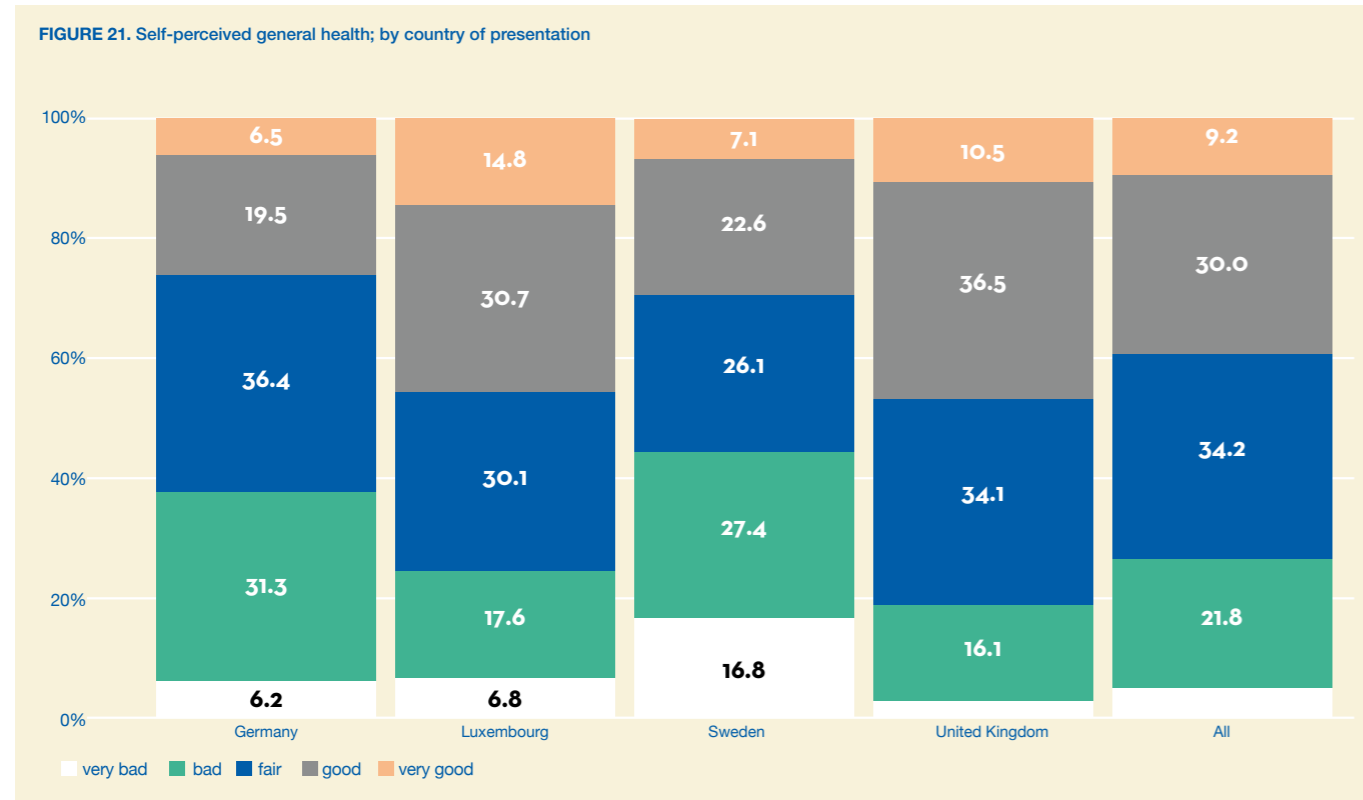


Figure 21 shows people's self-perceived general health in four countries (Germany, Luxembourg, Sweden, and the United Kingdom). Around 39.2% (1,947/4,965) of individuals who responded to the question on how they rated their physical health said it was "good" or "very good". However, over half (60.8%; 3,018/4,965) did not perceive their physical health as "good" or "very good". One in four respondents reported their general health to be "very bad" or "bad" (26.6%; 1,321/4,965), with 21.8% (1,080/4,965) of people reporting "bad" general health and a further 4.9% (241/4,965) reporting "very bad" general health. Sweden had the highest proportion of individuals reporting "very bad" general health (16.8%; 52/310).

Data collected on self-perceived general health of non-EU/EEA migrants in comparison to EU/EEA migrants and nationals shows that non-EU/EEA migrants might experience the highest levels of self-perceived poor general health with 34.6% of them perceiving their general health as "bad" or "very bad" (619/1,791), although there is not much variation across the groups.

Data on self-perceived health collected from this population can be compared with self-perceived health data collected by EU member states from the general population and held by Eurostat.⁴⁷ The comparison shows that, in the MdM population, a higher percentage of people rated their health as "bad" or

"very bad" (26.7%) in comparison to the general population (8.3% in 2017, and 8.4% in 2018 as well as in 2019⁴⁸) and a smaller percentage of people reported their health as "good" or "very good" (39.2%) in comparison to the EU (EU-28) general population (69.7% in 2017, 69.1% in 2018, and 69.2% in 2019⁴⁹). This pattern is also reflected at EU member state level. In each of the four countries, the percentage of people seen by MdM rating their health as "bad" or "very bad" is higher than the general population and the percentage of this population rating their health as "good" or "very good" is lower. It should be noted that the Eurostat data does not include data from those aged under 16 years.

NAME: CHARLES
COUNTRY: SWEDEN

Charles is from Uganda and has been in Sweden for 9 years and is still in the process of applying for asylum. Previously, in Uganda he was active in the military and spent 2 years in a Ugandan prison due to a misunderstanding with the government. Charles came to Sweden in 2012, and has not been back to Uganda or seen his family since.

Charles said he went to the hospital but they sent him to MdM Sweden instead. The reason he sought care was that he was feeling ill, suffered from headaches, and had trouble sleeping. He has spent 8 years on

the street sleeping rough and has not been able to work.

In 2019, his case was dismissed by the migration authorities. Now he has to open a new case and start from the beginning. Charles feels desperate thinking that this might take another 8 years. "Now, for me, my prison has no walls. And I don't know when it is going to end." Because of his LMA (Lagen om mottagande av asylsökande) card Charles has had the possibility to work but, since his residency permit is only for 3 months at a time, no one wants to hire him.

47. European Commission/Eurostat. (n,d). *Self perceived health by age, sex and labour status*. Retrieved 1 October 2021, from https://ec.europa.eu/eurostat/databrowser/view/HLTH_SILC_01__custom_1259498/default/table?lang=en

48. *ibid.*
49. *ibid.*

Fig 21. Data from social consultations includes each individual once. Figure excludes 2,256 records missing self-perceived general health (31.2%; 2,256/7,221). In total, 4,965 unique individuals. Missing variable from two countries: Belgium and France.

MENTAL HEALTH

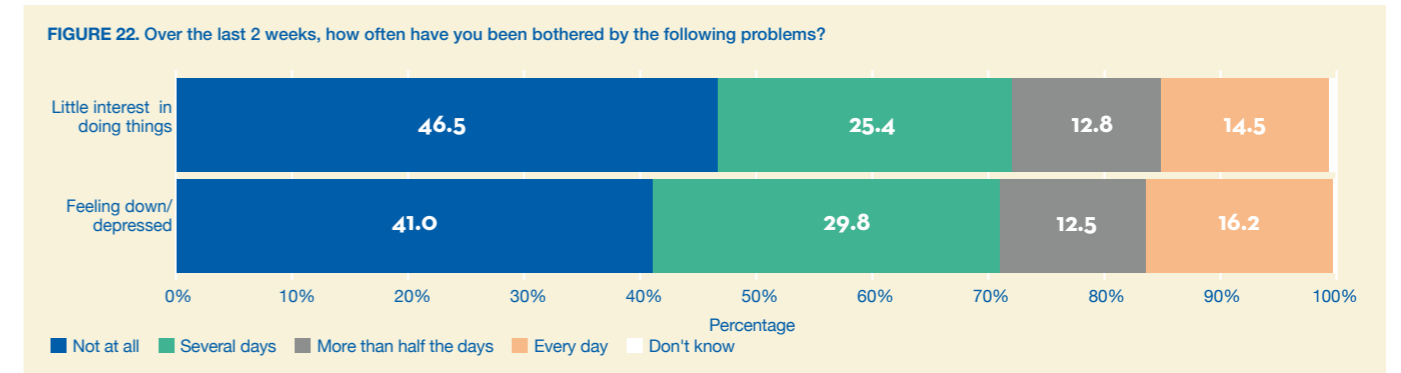


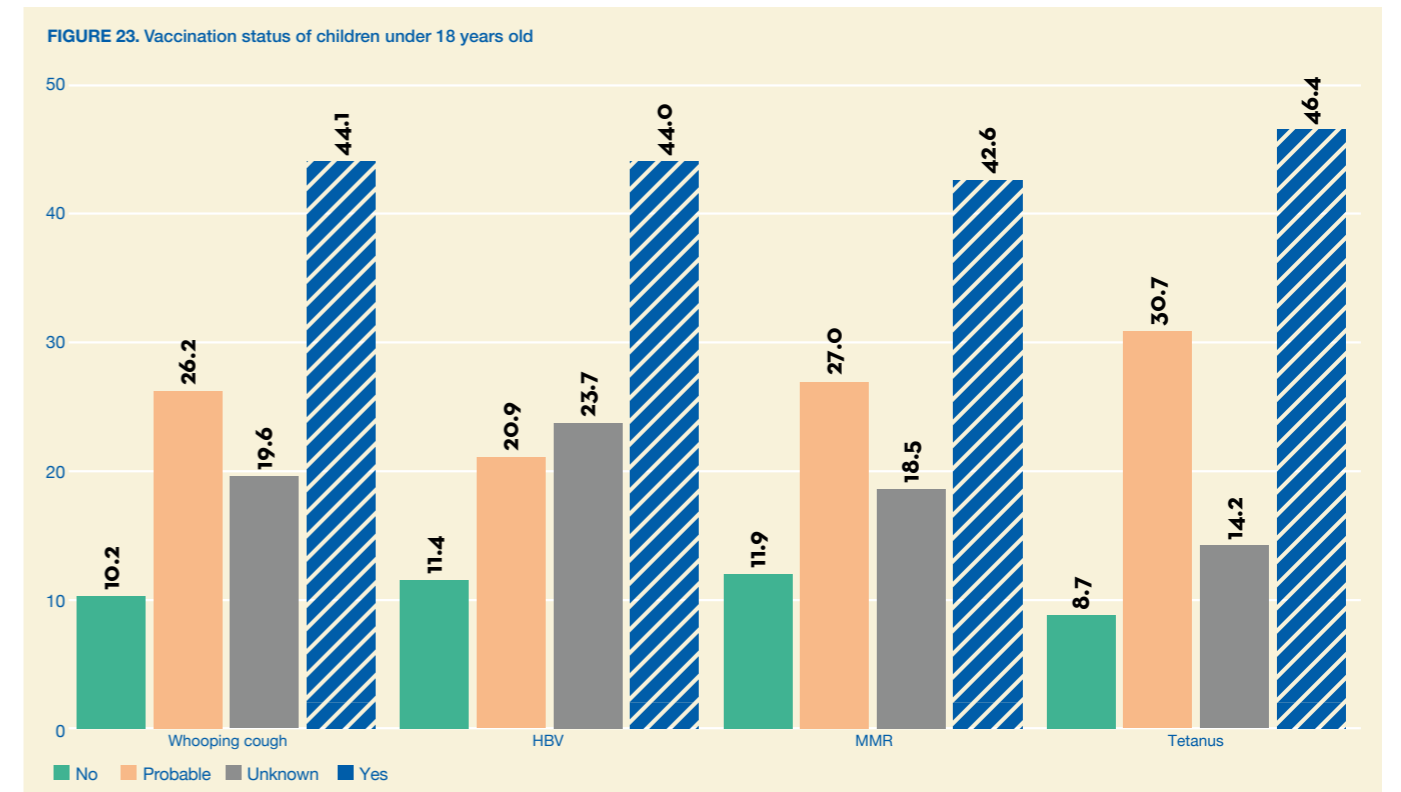
Figure 22 presents answers to the following question: Over the last 2 weeks, how often have you been bothered by the following problems: little interest in doing things and feeling down or depressed? These two questions are part of the Patient Health Questionnaire-2 (PHQ-2). A PHQ-2 score is calculated adding the score for

each question. With a PHQ-2 score of 3 or greater, major depressive disorder is likely. This tool should be seen as a screening tool.

Of those who answered the first question, 58.6% (1,028/1,754) reported that they felt down or depressed every day, more than half the days, or for several days. More than half of

individuals (52.7%; 893/1,694) reported that they had little interest in doing things for several days, more than half the days, or every day. A third of individuals who responded to both PHQ-2 questions (31.0%; 508/1,641) had a PHQ-2 score of greater than 3 and therefore, should be further screened for major depressive disorder.

CHILDHOOD VACCINATION



Of respondents, 46.4% of children had received a vaccination for tetanus (219/472), as had 44.1% for whooping cough (160/363), 44.0% for hepatitis B vaccination (HBV) (154/350), and 42.6% for measles, mumps, and rubella (MMR) (175/411). 35.1% of the children seen had either not received the vaccination for HBV or their vaccination status was unknown (123/350). Similarly, 30.4% of children reported not having had

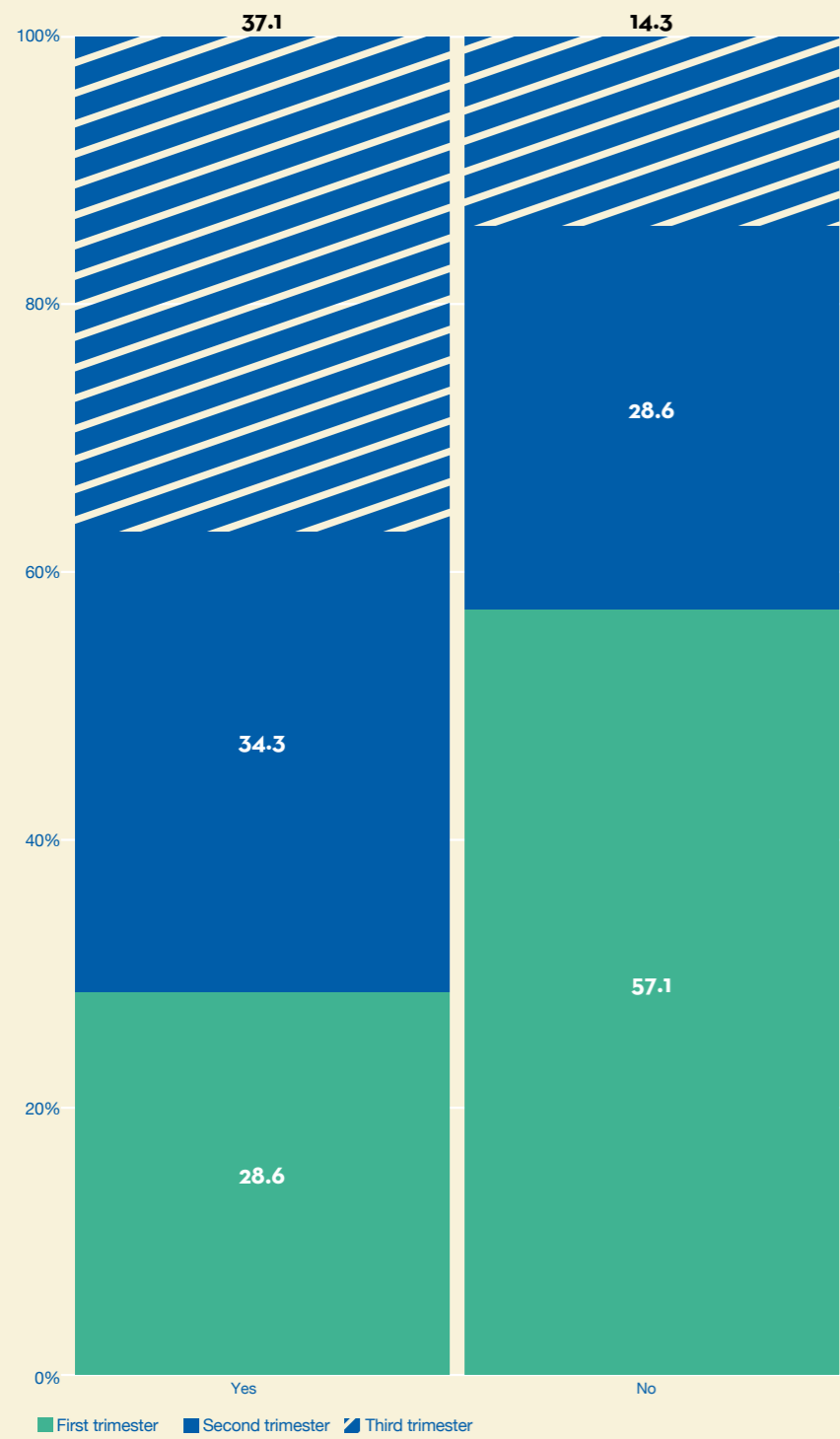
the MMR vaccine or their vaccination status was unknown (108/472). However, these results need to be interpreted with caution due to high levels of missing data across the four vaccination types.

Fig 22. Data from social consultations includes each individual once. Figure excludes 4,078 records missing information on "feeling down/depressed" (69.9%; 4,078/5,832) and excludes 4,138 records missing information on "little interest in doing things" (70.9%; 4,138/5,832). Data from three countries are missing: Belgium; France; and Luxembourg (17,126 individuals).

Fig 23. Data from medical and social consultations includes each individual once. Figure excludes 1,401 records missing age data. Missing data on vaccinations is quite high with, for instance, 80.3% (1,432/1,783) for HBV. HBV: hepatitis B vaccination; MMR: measles, mumps, and rubella.

MATERNITY CARE

FIGURE 24. Pregnant women who have accessed antenatal care before attending an MdM clinic; by trimester



NAME: SABRINA
COUNTRY: LUXEMBOURG

Sabrina, aged 33 years, is pregnant with twins and is a mother to a 2-year-old child.

“The first time I went to MdM Luxembourg, they gave me back my smile. I had been informed by social service of the possibility of a volunteer affiliation. Before then, I had not known of them. The assistants helped me associate my son with the health insurance. Up until now, 8 months later, they are the only service that has not let me down. They took me seriously and didn’t judge me. I want to thank them from the bottom of my heart.”

5.9% of all women seen in MdM clinics that had a medical and social consultation were pregnant (437/7,410). The majority of pregnant women, who were asked about their pregnancy (238 women), were in their first trimester of pregnancy (45.0%; 107/238); while 33.6% were in their second trimester (80/238). However, over one-fifth were already in their third trimester (21.4%, 51/238). When asked if they accessed antenatal care, over half of pregnant women who responded had not accessed antenatal care prior to visiting an MdM programme (52.7%, 109/207). As demonstrated in Figure 24, 42.9% of women who had not accessed antenatal care were in their second or third trimester of pregnancy (33/77).

NAME: DIMITRA
COUNTRY: GREECE

“As a mother of two, I feel quite insecure about not having a pharmacy on the island. What will I do, if my children get sick? This is every parent’s nightmare. Personally, I came here [MdM Greece] today to be informed on the vaccines that my children need to have, who will prescribe them, etc. The rural doctors should be the ones to

inform us, but they don’t. I found the courage to come to you [MdM Greece] knowing about the free medicine programme MdM Greece implements. As you can see, this place [Greek island] instead of going forward is going backwards, in 2020 the pharmacy was closed. We can’t be at the mercy of every rural doctor and of the weather anymore!”

Fig 22. Data from linked medical and social consultations includes each individual once. Figure excludes missing records on sex (7.8%; 1,562/20,060), antenatal care (52.6%; 230/437), and trimester (45.5%; 199/437).



MdM Sweden: a volunteer checking for COVID-19 symptoms at the Stockholm clinic

DISCUSSION

THE STATE OF UHC IN EUROPE

MdM views health under the more holistic prism of health and wellbeing and follows a rights-based approach acknowledging and acting upon social determinants of health such as poverty, racial discrimination, housing, working conditions, etc. This *modus operandi* reveals significant gaps and challenges in regard to access to health for people living in different geographical areas. What remains more hidden, even to date, is the problems and obstacles different people experience within the boundaries of the European continent itself as well as the reasons behind these barriers. The present report attempts to give a better insight on the profile of people excluded from healthcare in Europe today and the reasons behind their discrimination. The consequences of health inequity in terms of individual and public health are also tackled on the basis of relevant findings.

According to the principles of UHC, all people should have access to the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course: “leaving no one behind” and “caring for the furthest behind first”.⁵⁰ However inequalities prevail across the health sector in Europe today, as the present report illustrates with 25,355 unique individuals visiting MdM programmes instead of public health facilities during 2019–2020.

The results of this 2021 Observatory Report shows that out of all people visiting the MdM programmes, the percentage of non-EU/EEA migrants benefiting from the MdM programmes was 74.7%. While slightly reduced, compared to 81.6% in the 2019 Observatory Report, it nevertheless remains high, vividly illustrating the point that these populations are indeed left behind, despite political declarations on the opposite. In that sense, European

governments are not adhering to the Covenant on Economic, Social and Cultural Rights and especially the right to the highest attainable standard of health.⁵¹

At the same time, the percentage of EU/EEA migrants among MdM beneficiaries increased, reaching 22.2% in the 2021 Observatory Report as opposed to 15.9% in the 2019 Observatory Report. This implies a cross-cutting deterioration of health services in Europe today and raises questions about the extent to which European states are meeting the healthcare needs of European citizens living in their territory, thus observing Article 16 of the Social Pillar.

It is also interesting to note that, out of the total, the percentage of national patients examined by MdM was 3.1%. This indicates fractions and niches of the developed EU health systems that while advanced, they nevertheless fail to provide full health coverage, free of charge, even to their own citizens. Further evidence to this is also supported by the fact that the proportion of nationals increased between the 2019 Observatory Report and the 2021 Observatory Report from 2.5% to 3.1%.

Almost one-third of nationals who attended an MdM programme were under the age of 4 (30.3%). High levels of children were also observed among EU/EEA migrants. That is strong evidence of the need to further increase the level, accessibility, affordability, acceptance, and quality of paediatric and family healthcare services in European countries today. Moreover, it stands out as a sad confirmation that national governments do not fully comply with the letter and the spirit of the United Nations Convention on the Rights of the Child that clearly states: “State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to

ensure that no child is deprived of his or her right of access to such health care services.”⁵²

High percentages of patients with chronic diagnoses (eg, circulatory: 26.1%, musculoskeletal system and connective tissue: 12.7%, and psychological disorders: 10.9%) are evidence of complex cases that require a broader framework of health and social support. Even so, 3.3% reported having access to emergency care only, and a staggering 78.2% reported having no healthcare coverage. Patients with chronic diagnoses require the availability of needs-tailored services and this report presents evidence that governments are not providing access to a sufficient range of services to achieve well-targeted assistance and universal coverage.

COVID-19: CHALLENGE AND MOMENTUM

On top of a European environment already burdened by financial austerity, Brexit and deterrence policies in relation to refugees and migrants’ reception, the outbreak of COVID-19 has come to test our willingness and ability to deliver health for all. The pandemic threatens to undo decades of progress. It has disrupted delivery of essential health services in many countries, stretched resources to the limits, and revealed the impact of decades of underinvestment in primary care and essential public health functions.⁵³ This puts additional pressure on vulnerable population groups with unmet health needs. There can no longer be any question about the links between public health and the broader resilience of economies and societies. COVID-19 has reinforced existing evidence that investments in health have long-term returns, while underinvestment has potentially devastating large-scale global social and economic effects that could last for years. The pandemic is costing the global economy \$375 billion a month and 500 million jobs since the crisis erupted.^{54, 55}

MdM ground experience indicates that the most vulnerable populations are traditionally excluded from public national health systems due to their social, cultural, or legal status and are the ones that suffer the most during health crises.⁵⁶ Populations such as homeless, roma, asylum seekers, migrants, etc, are indeed among the groups of concern regarding COVID-19 from a public health perspective: being unable to properly follow the necessary precaution measures, they are at high risk of getting COVID-19 and also contributing to its transmission.

At the same time, COVID-19 has created a new momentum towards prioritising prevention and public health measures for UHC at all levels and striving for a robust, collaborative, global health architecture.

EXCLUSION OF VULNERABLE GROUPS IN HEALTHCARE SERVICES AND LIMITATIONS OF HEALTH REPORTING

The financial crisis, the subsequent political and solidarity “crises” erupting across different European countries in relation to migration, and the outbreak of COVID-19 have created a new level of fragmentation and exclusion and have aggravated access to healthcare for the most vulnerable: unaccompanied children; pregnant women; homeless people without any shelter; undocumented migrants; and the elderly.⁵⁷ Difficulties in accessing healthcare services have long been more common among certain population groups. In addition, new groups that were not considered vulnerable before, such as young unemployed men or young couples facing housing and job insecurity, a “newly poor” have also emerged.^{58, 59}

Within the framework of the 2021 Observatory Report, the reduction witnessed in total non-EU/EEA beneficiaries’ numbers and consultations between the 2019 Observatory Report and the 2021 Observatory Report could reflect the results of movements’ restrictions and lockdowns imposed during the year due to COVID-19 and points toward other, more worrisome developments, namely, the reinforcement of the “Europe fortress” approach, the prevalence of deterrence policies, and the malpractice of pushbacks allegedly conducted by national authorities and Frontex, a practice that directly violates the principle of “non-refoulement” as dictated by the international human rights law.⁶⁰

The report raises grave and urgent questions about the welfare and health of vulnerable children across Europe. The fact that children – including proportionately higher levels of EU/EEA migrant children – were seeking healthcare from MdM programmes, and not the national health system, shows European governments are failing to provide them with adequate access to healthcare services. There is also a growing concern for the plight of the increasing numbers of unaccompanied children; for the lack of access to national SRH services mainly regarding non-EU/EEA migrant women that suffer from a double marginalisation (“migrants” and “women”); for the chronic patients and the ones facing mental health issues.

The limitations of existing mechanisms to record and monitor access to healthcare services for such groups means that they are not just economically, socially, and politically excluded and disconnected from societal institutions, but also not counted in official data. Thus, they remain invisible in the development of policies and programmes. Capturing them in this report, provides an opportunity for policymakers to address their healthcare needs.

Unrepresentative patient populations or missing data can pose significant obstacles when conducting public health research and there continues to be a need for reported data.⁶¹ Efforts to increase transparency regarding the quality of healthcare are going in parallel with a call for wider accountability in the health sector. Poor data quality, inaccurate data, inconsistencies across data sources, and incomplete (or unavailable) data necessary for operations or decisions adversely influence future operational plans and effective strategies for improvement.⁶² Aside from inadequate reporting, a lack of data standardisation regarding the exchange of surveillance data between health providers and public health authorities and between public health entities and civil society organisations prevents smooth coordination and informed decision making among important health stakeholders.⁶³

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HEALTHCARE NEEDS OF AN EXCLUDED POPULATION

HEALTH STATUS

European health systems, stretched to their limits by the pandemic, are becoming more closed, excluding higher numbers of patients and evidently restricting access to health for all, despite political statements supporting the opposite. A “me first” approach, prevailing during the initial phase of the pandemic in relation to masks’ imports and distribution is sadly repeated during the present phase of vaccines’ roll out, clearly indicating that the collaborative approach required in order to achieve health for all has still a long way to go.

One in four people reported their general health as “very bad” or “bad” (26.7%). As multiple pathologies have been frequently recorded for each individual, for instance, the incidence of comorbidity is high, it becomes evident that the more complex and difficult cases, the ones that require the existence of a more demanding, wider, and multifaceted framework of support to recover, are practically confronted with limited availability of needs-tailored services and are thus eventually excluded from access to health as the national health systems and/or the aid programmes put forward by non-governmental organisations have not been designed to cover such needs.

While caution should be exercised as missing data varied across the three groups (EU/EEA migrants, non-EU/EEA migrants, and nationals), a staggering 91.6% of individuals reported living under the poverty threshold leaving no doubt with regard to the significance of poverty as a social determinant of access to health. At least half of the world’s population lacks access to essential health services; more than 800 million people have to spend at least 10.0% of their household income on health care. Out-of-pocket expenses drive almost 100 million people into poverty each year. If we continue with the same pace, up to one-third of the world’s population will remain underserved by 2030.⁶⁴

The majority of people we saw reported not having healthcare coverage (78.2%). While these figures should be interpreted carefully since missing data varied across the three groups (ie, EU/EEA migrants, non-EU/EEA migrants, and nationals) they nevertheless reveal the fact that access to healthcare equals to acquiring (national) healthcare coverage in European countries. Understandably, nationals have the highest proportion of individuals with full healthcare coverage (17.9%). The issue of national social security number, that is – literally – the ticket for access to state health services has long been debated at EU level under the light of the 2015 migrant reception, when the number of new arrivals of non-EU/EEA migrants to the EU skyrocketed. Sadly, but not unexpectedly, the majority of non-EU/EEA migrants reported not having healthcare coverage (81.1%), followed by 65.1% of EU/EEA migrants. It is also worth noting that a significant 14.0% of EU/EEA migrants did not know if they had healthcare coverage, a fact that highlights the complicity of health systems in place as well as the need for better informing and empowering vulnerable individuals to pursue their health rights. An outstanding 69.0% of people with permission to reside reported not having healthcare coverage, something that exposes the contradictions and flaws of different national legal and administrative processes that have not been harmonised and are thus failing to achieve a smooth reception and an unhampered integration of foreign citizens. Understandably, a higher proportion of EU/EEA migrants without permission to reside had full healthcare coverage (14.4%) compared to non-EU/EEA migrants without permission to reside (4.7%).

SEXUAL AND REPRODUCTIVE HEALTH

Of all women seen in MdM clinics 5.9% were pregnant. When asked if they had access to antenatal care, more than half of women (52.7%) responded that they had not accessed antenatal care prior to visiting an MdM programme. Almost half of women (42.9%) had not accessed antenatal care and were in their second or third trimester of pregnancy. These findings clearly demonstrate that UHC is not achieved, as long as necessary sexual and reproductive services are not unconditionally offered to all women in need without discrimination by national health systems across Europe. SRHR is a core issue in MdM programmes and a vital precondition for gender equality and non-discrimination. SRHR is an integral part of the SDGs and the specific needs of women and girls must therefore be prioritised.

PUBLIC HEALTH

A total of 158 different nationalities were recorded, a clear sign of the multicultural profile of the communities that MdM supports. It is of no surprise that the biggest proportion of patients served by MdM programmes were people without a valid residence permit, in other words, without a defined legal and/or citizenship status that actually “opens the door” to access public healthcare services in Europe. While there is no homogeneity across national health systems, practices encountered across the continent are in general not designed to serve the needs of third country nationals and/or underprivileged and marginalised populations. In some countries, access to national health services is provided only on an emergency basis to people without legal documents. This contradicts the United Nations resolution on UHC that states that UHC does not simply equate to emergency care, but includes “promotive, preventive, curative and rehabilitative basic health services needed and essential, safe, affordable, effective and quality medicines”.

Non-EU/EEA migrants and marginalised populations tend to be excluded from public healthcare services in the pretext of objective barriers, for example, linguistic, as well as subjective barriers, for example, biases and beliefs. The diversity of nationalities encountered in MdM programmes reveals not only the range of the countries of origin, thus the variety of cultures and possible related barriers to access to health but also the variety of routes and different patterns of migration Europe is confronted with today. The most frequently reported nationality was Côte d’Ivoire at 10.9%, followed by Romania at 9.6%, Bulgaria at 6.7%, and Morocco at 6.2%. Overall, most MdM beneficiaries at 51.9% were of African origin; 31.1% were of European origin, 14.5% were of Asian origin, and 2.5% originated from the Americas. Looking deeper, namely, by sub-region, most of MdM patients were from sub-Saharan Africa (35.2%) and Eastern Europe (20.2%), a fact that reaffirms the role of conflicts and poverty as main drivers for migration while also supporting the scope of climate change as a new, additional reason behind people’s mobility.

While extra caution should be exercised with regard to data on children’s vaccination due to a high number of missing and/or non-valid answers, according to the responses received, percentages for routine immunisation range between 42–46%. Though encouraging in terms of access, these percentages highlight additional worries in terms of public health and prevention.

Almost half of individuals, 47.5%, in all MdM programmes lived in insecure housing while one in five (18.9%) were roofless or sleeping rough. Adequate and proper housing is not only an undeniable human right but a precondition for healthcare, regular treatment, and support. Accessing healthcare services is often dependent on housing-related paperwork, such as proof of tenancy or proof of address. A higher proportion of EU/EEA migrants were living in roofless situations: 35.1% compared to 19.5% of non-EU/EEA migrants. The fact however that 58.9% of non-EU/EEA migrants report living in insecure housing is also indicative of an unstable and fragile situation people experience when they depend on state and/or civil society aid. Almost half of nationals were either roofless (19.6%) or experienced houselessness (30.7%),⁶⁵ once more highlighting the results of the widespread poverty that austerity politics and social inequality have underpinned.

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65. These figures should be interpreted carefully since missing data varied across the three groups.

METHODOLOGY AND LIMITATIONS

The purpose of this report is to undertake a common data collection process in order to generate robust data, analysed, and validated by a leading epidemiologist. The data is valuable for policymakers at local, regional, national, and EU levels, enlarging the evidence base on reducing vulnerabilities in health and identifying ways that health systems could become more responsive and adapted. It will also be valuable for academics to review and acquire greater understanding about how vulnerabilities contribute to health inequalities.

The data was collected from January 2019 to December 2020. There were a total of 45,292 consultations (22,334 medical consultations and 22,958 social consultations) recorded in this report.

DATA SOURCE

Data for this report were taken from face-to-face consultations at MdM programmes in seven European countries (Belgium, France, Germany, Greece, Luxembourg, Sweden, and the United Kingdom) by volunteer doctors, nurses, and support workers. Data were collected throughout 2019 and 2020 and consisted of two core parts: i) social consultations; and ii) medical consultations. Social consultations focused on social determinants of health such as housing status, health access, and health coverage. Medical consultations focused on issues such as medical history, current health status, pregnancy, and vaccination status. Within medical consultations, specific diagnoses were recorded using the ICD-10 pathology classification system. In Greece, only qualitative data was collected and is presented as testimonies throughout the report.

In all countries except France and Sweden, all service users surveyed for the observatory social or medical data collection have been included in the report. The data from MdM France excludes individuals who had their first social consultations earlier than 2019, but returned for either a social and/or medical consultation during 2019 or 2020. The data does not include any consultations with specialists. The data from MdM Sweden includes only a proportion of total service users of which about half consent to be part of the data collection.

Individuals may have had multiple face-to-face social or medical consultations. We analysed data using one social consultation record and one medical consultation record per individual. The first consultation record was selected for an individual. If an individual had more than one consultation on the same day or a consultation date was not recorded, the record that contained the most completed data was selected. An algorithm was used to score and identify the records with the most completed demographic data and key points of study. Where a patient had multiple records on the same day and if they had equal levels of completion, one was randomly selected.

There are two exceptions to this rule. First, as the data used in Figure 2 (in section “Who We Saw”) provides an overview of all consultations by country, all data are included and therefore, Figure 2 contains duplicate records for individuals. Second, pathology data consisted of all pathologies recorded for each person from all their medical consultations – there was no exclusion or selection process and as a result, individuals may appear in this dataset more than once, depending on how many pathologies were reported.

STATISTICS

Before analysing the data, all variables were standardised such that the answers to questions were consistent in type across the MdM health centres. For example, immigration status as provided according to each country’s status was equated to a set of statuses as defined by the International Observatory. Country of origin was used to classify individuals into nationals, EU/EEA migrants, and non-EU/EEA migrants. Data are presented throughout the Observatory Report as either simple counts or crude percentages – no weighting of percentages was performed.

LIMITATIONS

The data used in this 2021 Observatory Report were collected as part of the MdM health centre operations and as a result many items presented contained high levels of missing data. This has been reported routinely in the figure notes and highlighted in the report in situations where missing data may be particularly important to consider, as it is likely to bias comparisons between groups. It is also important to note that some data items were not collected by individual countries and so underlying data for each figure is not necessarily representative of all included MdM health centres. The individuals attending consultations at the MdM health centres were not a random sample. The results should be considered to describe the issues of excluded populations seen by MdM, but as representative of excluded populations more generally within each partner country. However, the individuals seen in the MdM health centres include some of the most vulnerable and marginalised within society who are not included in a majority of routine and vital statistics systems. Therefore, this report is an important source of information on some of the most excluded individuals of society. Classification of individuals into nationals, EU/EEA migrants, and non-EU/EEA migrants by country or origin has limitations as country or origin does not necessarily equate to nationality or citizenship. It does not take into consideration the possibility of dual nationality.



MdM Greece: a volunteer doctor performing a medical consultation on a homeless person beside the street, during the COVID-19 pandemic

CONTRIBUTORS AND ABBREVIATIONS

ABBREVIATIONS

CASO	healthcare, advice, and referral centre
COVID-19	coronavirus disease 2019
CSA	Centralförbundet för Social Arbete/National Association of Social Work
EEA	European Economic Area
EPIM	European Programme for Integration and Migration
ESF+	European Social Fund Plus
ETHOS	European Typology of Homelessness and Housing Exclusion
EU	European Union
FEANTSA	European Federation of National Organisations Working with the Homeless
GP	general practitioner
HBV	hepatitis B vaccination
ICD-10	International Statistical Classification of Diseases and Related Health Problems–10th Revision
LMA	Lagen om mottagande av asylsökande
MdM	Médecins du Monde/Doctors of the World
MMR	measles, mumps, and rubella
NEF	Network of European Foundations
PHQ-2	Patient Health Questionnaire-2
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
UCL	University College London
UHC	Universal Healthcare Coverage
WHO	World Health Organization

CONTRIBUTORS

MDM Health Centres

Belgium: Victoria Déom; Emilie Van Limbergen; and MdM Belgium field workers and volunteers.

France: Camille Gutton; Anne Tomasino; and MdM France field workers and volunteers.

Germany: Aélis Malherbe; Christiane Borup; and MdM Germany field workers and volunteers.

Greece: Anastasios Yfantis; Thanos Roussos; and MdM Greece volunteers.

Luxembourg: Paulo Oliveira; Jenny Saloux; Julie Schonne; and MdM Luxembourg volunteers.

Sweden: Elnara Askarova; Karen Lemmens; Celicia Sjöqvist Lyche; Gaffar Allouji; and MdM Sweden volunteers.

United Kingdom: Anna Miller; and MdM United Kingdom volunteers.

ADDITIONAL CONTRIBUTORS

Graphic Designer: Dolling Tahko

Copy Editor: Anastasia Said

AUTHORS

Rachel Burns, Institute of Health Informatics, University College London

Pernilla Graversen, Médecins du Monde Sweden

Elli Xenou, Médecins du Monde Greece

Dr Johanna Offe, Médecins du Monde Germany

Sylvie Martin, Médecins du Monde Luxembourg

Janina Gach, Médecins du Monde Germany

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