COUNTRY REPORT

CZECH REPUBLIC

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Czech Republic

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	10.512.419	●●●●○
GDP per capita (2014) [EU mean = 100]	84	●●●○○
Accession to the European Union	2004	

Geography: The Czech Republic is a landlocked country located in Central Europe, between Germany, Poland, Slovakia and Austria. The west of the country consists of rolling plains, hills, and plateaus surrounded by low mountains, while the east is very hilly. The largest city is the capital Prague with 1.273.000 inhabitants, while 73% of the population lives in urban settings.

Historical background: After the dissolution of the Austro-Hungarian Empire at the end of World War I, the Czechs became part of Czechoslovakia. On the eve of World War II, Nazi Germany occupied the territory that today comprises the Czech Republic, while Slovakia became independent. After the war, Czechoslovakia was reunited and fell within the Soviet sphere of influence. The Communist Party was swept from power at the end of 1989, and on 1 January 1993, Czechoslovakia split into two countries: the Czech Republic and Slovakia.

Political background: The Czech Republic is a parliamentary democracy divided in 13 regions and a capital city. The country acceded to the EU in 2004.

Economic background: The Czech Republic has the most prosperous economy amongst Central and Eastern European countries. Auto manufacturing is the largest industry and accounts for nearly 24% of total Czech manufacturing. When Western Europe fell into recession in late 2008, demand for Czech goods plunged, leading to double digit drops in industrial production and exports. The economy slowly recovered in the second half of 2009. From the end of 2011 to the spring of 2013, the country underwent its longest-ever recession, due both to a slump in external demand in the EU and to the government's austerity measures; the economy returned to growth in 2014, which currently (2017) averages around 2,5% a year. Unemployment peaked in 2014 at 8,5%, but has since declined steadily to about half that level.[2]

[2] https://ec.europa.eu/info/node/9713

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	3,8	●○○○○
Percentage non-EU/EFTA migrants among foreign-born population	61	●●●○○
Foreigners as percentage of total population	4,1	●●○○○
Non-EU/EFTA citizens as percentage of non-national population	60	●●●●○
Inhabitants per asylum applicant (more = lower ranking)	9.102	●○○○○
Percentage of positive asylum decisions at first instance	37	●●○○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	29	●○○○○
Average MIPEX score for other strands (MIPEX, 2015)	45	●●○○○

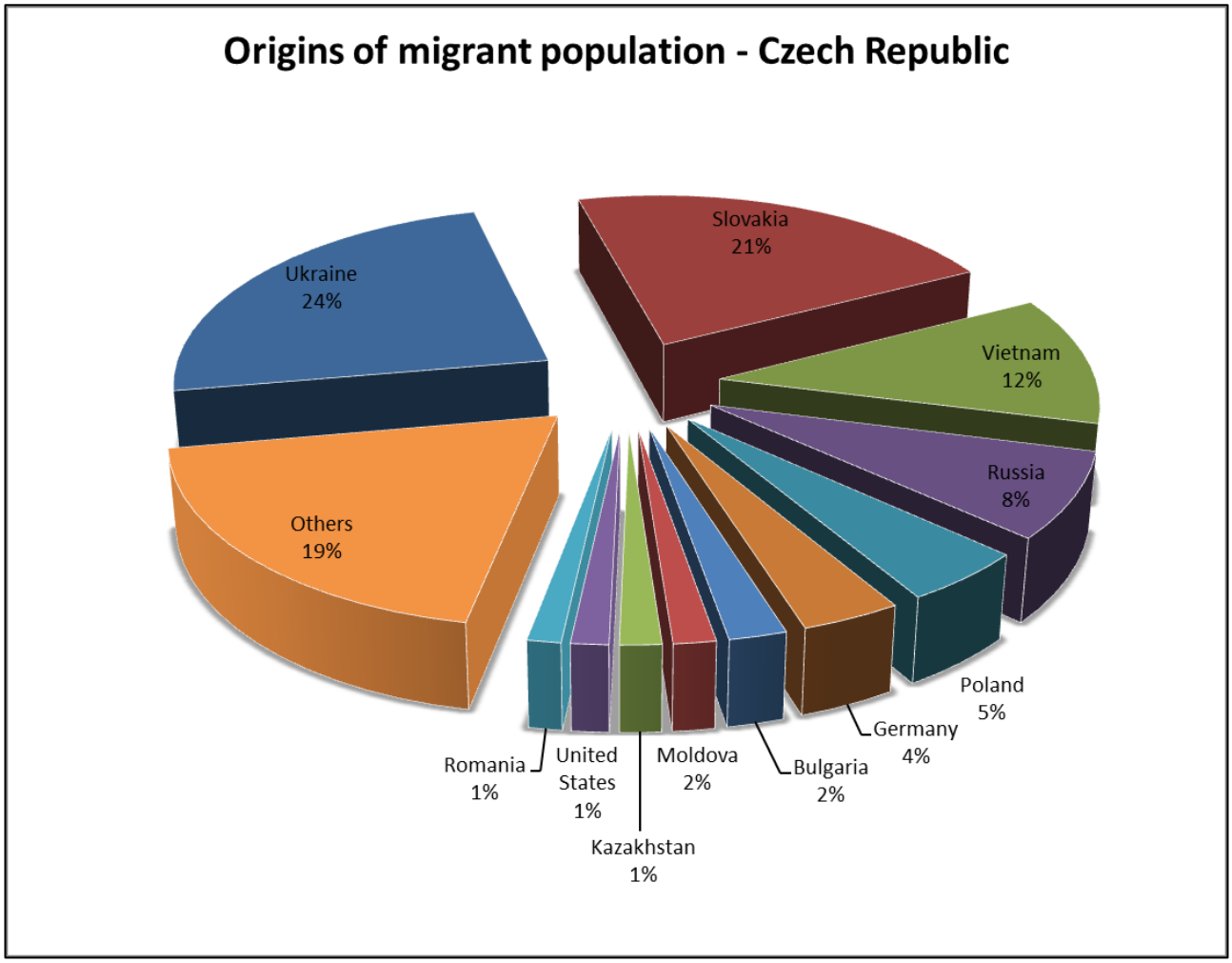
Migration to the Czech Republic

Immigration and related social processes were a relatively new phenomenon in the somewhat homogenous Czech environment after World War II. However, today the Czech Republic has become the country with highest proportion of migrants in the population compared to other countries of Central and Eastern Europe (3,8% in 2014). Since 1990, the Czech Republic has experienced a steady increase in migration, matching its rising GDP. According to the Czech Statistical Office (CSO), in 1990 there were 35.198 legally residing foreigners, whereas in 2014 there were more than 400.000. Two types of residence permits are issued: permanent residence and long-term residence exceeding 90 days. Migrants can become eligible for permanent residence after they have lived in the country continuously for at least five years; this status guarantees to its holders rights and obligations comparable to Czech citizenship.

Most migration to the Czech Republic is for work. Legal employment requires both a residence and an employment permit. The labour character of migration is reflected in the age structure of migrants, most migrants being of an economically productive age. The number of children has been gradually increasing in the context of family reunification since accession to the EU in 2004, and due to the granting of permanent residence to a growing number of long-term migrants (CSO 2017).

As to country of origin, the majority of migrants come from outside the EU - mainly from Ukraine, Vietnam, and Russia (see Fig. 1). The second largest group of migrants are Slovaks: however, this group is hardly distinguished from the majority population and differs very little from it, thanks to the common history, similar language, and ethnic affinity. In everyday life they are not regarded as 'migrants.'

Figure 1. Foreign-born population in 2014 by country of birth (Eurostat)



"Combating illegal migration" is a priority for the Czech government, but official figures regarding irregularity are low. In the last few years, irregular migration is estimated at 3.000 – 4.000 persons per year (CSO 2017). There are two categories of irregular migrants - migrants irregularly crossing the external Schengen border and migrants with irregular stay.[3] The vast majority of the irregular migrants are from the second category, which usually means that migrants who came to Czech territory overstay their initial authorization for different reasons. One common reason is the inability to extend their visas due to job loss. The 2009–2013 economic crisis severely affected the Czech economy, and there were not enough jobs for migrants, leading to a significant stemming of the migrant inflow. Between 2011 and 2016 there was hardly any change in the total number of migrants.

The Czech Republic is not a popular country of destination for asylum seekers: in 2014 the total number of applicants was 1.115. Only 37% of the decisions in first instance made in 2014 were positive.

[3] During the recent 'refugee crisis' the number of unauthorised entrants increased compared to previous years. It is estimated to have roughly doubled (Hospodářské noviny, 2.7. 2015).

Migrant Integration Policy

The Czech government pays more attention to integration policy than most other Central and Eastern European countries. The Ministry of Interior (MoI) has been coordinating the development of a national integration policy, but health aspects are fully within the competence of the Ministry of Health (MoH). Nevertheless, both ministries need to agree on political measures addressing barriers and obstacles in healthcare access for third country nationals (TCNs). The previous strategy for integration policy was expressed in a document entitled *Integration Concept for Foreigners in the Czech Republic – Living Together*, which was issued in 2011. This strategic document provided a long–term framework for migrant integration policy and the objectives to be achieved in all integration areas, including health. The present strategy dates from 2016 and was updated in 2017. It is subtitled *In Mutual Respect.* Integration objectives and timelines are updated every year and progress in implementation is discussed by the government. Individual departments must meet integration objectives in accordance with governmental decrees issued every year. All relevant documents are available on-line (MoI 2017).

The target group addressed in integration policies are TCNs, i.e. mainly Ukrainians, Russians, and Vietnamese. In 2009 regional Migration Integration Centres (MICs) were established in six out of the 14 regions. Creation of the MICs was initiated by the MoI and the intention was to create an adequate infrastructure for the integration of migrants in the regions. MICs have been working as public organizations with the financial support of the European Integration Fund (EIF), and are coordinated by the MoI. In 2015 MICs work in every region and provide - among other things – information and advice on migrants´ healthcare entitlements, as well as information about the Czech healthcare system. Health aspects of the integration policy are focused on TCNs' access to public health insurance. However, this objective has still not been fully achieved, and is thus repeatedly pushed back from year to year. Language barriers are the other topic addressed in the health part of the integration strategy.

Health and health determinants

Routine health statistics as well as public health insurance statistics do not include data on country of origin. However, since 2000 some data on migrant healthcare consumption have been collected, but only for inpatient hospital care, and only for migrants with private health insurance. Migrants' consumption of outpatient care is not monitored at all. Data concerning migrants participating in public health insurance (three-quarters of all migrants) are not processed, analysed, or published. For all migrants, the incidence of TBC, HIV/AIDS and other infectious diseases is monitored regularly. In the framework of mandatory notification of work-related injuries the migration status of an injured person is recorded. However, migrants with permanent residence status are excluded from this monitoring, as they are included in the global statistics of the Czech population regardless of their country of origin.

The results of several research projects carried out in the last decade can be used to supplement data on the health and healthcare demands of migrants. On the basis of available data, it is possible to postulate that migrant status in the Czech Republic is connected to a high work load and disadvantages in the working conditions leading to a higher rate of work injuries, generally lower healthcare consumption, and risky health related behaviour. Notably worse socio-economic living conditions, with a probable negative impact on overall health, were also found (Pikhart et al. 2010, Dobiášová & Hnilicová 2011, Jelínková 2011, Brabcová 2013, Vacková 2012, Vavrečková et al. 2013, Dzúrová et al. 2014).

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.548	●●○○○
Health expenditure as percentage of GDP	7,5	●●○○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	7	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	15	●●●●○
Score on Euro Health Consumer Index (ECHI, 2014)	714	●●●○○
Overall score on MIPEX Health strand (2015)	44	●●●○○

The legal foundation of the Czech healthcare framework is provided by the Constitution, which guarantees health care as a basic human right. (The right to health care was included in the Czechoslovak legal system as long ago as 1966.) Article 31 of the *Charter of Fundamental Rights and Basic Freedoms,* incorporated in the Constitution in 1991, states the right to free provision of health care for all residents. The conditions are set forth in the *Public Health Insurance Act* (No. 48/1997), which defines entitlement to publicly funded health care. In 2001 the Czech Republic also ratified the Council of Europe's *Convention on Human Rights and Biomedicine* (1997), transposing it into Act No. 96/2001.

Public health insurance is based on the solidarity principle and designed as an employment-based health insurance. Participation in the scheme is mandatory for all permanent residents, including TCNs. The premium is a fixed percentage (13,5%) of the employee's gross salary, shared between the employer (9%) and the employee (4,5%). All insured people have the same rights and obligations, while the government pays the insurance premiums of the following groups: children up to 18, students up to 26, pensioners, the unemployed, parents on maternity leave, prisoners, and people living under the poverty line. The *Health Services Law* (No 373/2011) specifies health professionals' obligations and patients' rights which have to be followed when healthcare services are provided, as well as other related rules regulating various aspects of healthcare provision.

Participants in public health insurance may freely choose health providers as well as one of the seven public health insurance companies at which they wishes to be registered. There is no difference between insurers in the scope of care covered within the standard package of services, although public health insurance companies may differ slightly in offering coverage of health services which are not included in public insurance, e.g. flu vaccination, contraceptives, and some others. The *Act on equal treatment and legal protection against discrimination* (No. 198/2009) ('Anti-Discrimination Act', §1) prohibits direct and indirect discrimination in access to health care.

Although health expenditure in the Czech Republic is lower than the EU/EFTA average, the score obtained on the 2014 Euro Health Consumer Index (ECHI)[4] is slightly higher than average, suggesting that the health system provides relatively good value for money. According to the WHO Health system review (Alexa et al. 2015), population health is good compared with other EU13 countries:

> Life expectancy in the Czech Republic at birth is increasing, having reached 75,1 years for men and 81,3 years for women in 2012; these are well above the averages for EU13 Member States of 72,1 years for men and 79,9 years for women, but still below the EU15 averages of 78,8 years for men and 84,1 years for women in 2011. The rate of infant mortality in 2012 was among the lowest in the world: 2,6 deaths per 1000 live births, compared to an EU average of 4 in 2011.

The review concludes that "the Czech population values and is proud of its health system – and rightly so, as several indicators show. However, there is increasing need for financial reform in order to sustain the system." Although the review states that "population coverage is virtually universal", this does not apply to TCNs, as we shall see in Section 5.

[4] http://www.healthpowerhouse.com/files/EHCI_2014/EHCI_2014_report.pdf

4. USE OF DETENTION

There are three migrant detention centres in the Czech Republic, at Bělá-Jezová pod Bezdězem and (since 2015) at Vyšni Lhoty and Drahonice (total capacity 1.030). There are also two centres for asylum seekers, at Zastávka and Prague Ruzyně Airport, which are in fact detention centres because the inmates are not allowed to leave "for the period of time stipulated by law".

Under current Czech legislation, the detention of foreigners and asylum seekers is allowed in two situations:

1) Detention before administrative expulsion or transfer to another country according to international agreements is governed by §124 or §129 of the Act no. 326/1999 Coll., Alien Act. Detention for the purpose of administrative expulsion, i.e. de facto restriction of free movement, often follows the start of administrative deportation proceedings. In principle, such a situation arises if the foreigner did not leave the country upon or before visa expiration. Administrative deportation can be also ordered for a foreigner who is "seriously and repeatedly undermining public order." In practice, this term is often interpreted rather broadly by the Foreign Police in order to justify termination of the residence of foreigners in the Czech Republic.

2) Detention upon entry into the country: The Act on Asylum gives the administrative body the opportunity to limit an applicant's personal liberty immediately upon entering the asylum procedure. In principle, entry into Czech territory is not allowed for foreigners who:

a) are not positively identifiable;
b) have counterfeited or falsified identity documents;
c) may be reasonably considered to constitute danger to national security, public health, or public order.

The MoI is obliged to decide on leave to enter Czech territory within five days after an application for international protection is lodged. The MoI must issue the leave to enter for an alien who has made a statement on international protection in the transit area of an international airport (Schengen border), and transport him/her to a reception centre on Czech territory, provided the person concerned falls within one of the following vulnerable groups: unaccompanied minors, parents or family members with minors or disabled children, disabled persons, pregnant women, victims of torture, victims of rape or other forms of psychological, physical, or sexual violence. Detention of vulnerable persons is not prohibited, although in practice it very rarely used. However, due to the recent 'migration crisis', such situations have occurred much more frequently. Parents with children are detained if they enter Czech territory illegally and their identities have not been sufficiently proven. However, in determining the duration of detention, the police are required to take into account the family situation if and when children are present; and for migrants under 18 and families with minor children, the detention period cannot exceed 90 days.

Many objections have been made to the routine use of detention without genuine consideration of alternatives. The criticism has also addressed the above mentioned-fact that unaccompanied children

and whole families including small children are sometimes detained. A lot of criticism has been aimed at general living conditions in detention centres.[5] According to the Minister of Justice, who visited the detention facility in Bela-Jezová, the overall environment and life conditions of migrants detained in this facility are worse than in a traditional prison.[6] Moreover, in terms of legislation, illegal entry is considered only an administrative offence. Such a situation is hardly acceptable from a human-rights point of view. According to the latest report from the Office of the Ombudsman on the detention facility in Bela-Jezova,[7] detention of children was indeed found to be in violation of Art.3 of the European Charter of Human Rights.

Due to the criticism coming not only from the Ombudsman but also from NGO´s and the Council of the Czech Government for Human Rights, living conditions in detention have been improved. Additionally, due to the European Court of Human Rights decision,[8] detention of families and children has been significantly limited.

[5] See e.g. https://rm.coe.int/1680695680; http://bit.ly/2qB62fi
[6] The Minister expressed this opinion in a Czech TV discussion program in October 4th 2015
[7] https://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/ZARIZENI/Zarizeni_pro_cizince/ZZ-Zarizeni_Bela-Jezova_2014.pdf
[8] http://www.romea.cz/en/news/czech/czech-republic-deporting-afghan-family-whose-case-came-before-the-european-court-of-human-rights

5. ENTITLEMENT TO HEALTH SERVICES

Score 58 **Ranking** ●●●○○

A. Legal migrants

Inclusion in health system and services covered

By law, all foreigners staying in the Czech Republic longer than 90 days are legally obliged to obtain health insurance for the duration of their stay. This requirement applies immediately upon entry, which can be refused if a foreigner is unable to prove that he or she has adequate health insurance. Foreigners can meet this requirement via public health insurance or private (commercial) health insurance.

There are some differences between EU citizens and non-EU citizens in the right to participate in Czech public health insurance. All legal migrants permanently residing in the CR and all migrants from the EU staying on Czech territory more than 90 days (defined as 'long-term stay') have the right to participate; migrants from third countries can also participate as long as they are legally employed in the Czech Republic, i.e. have a job contract and fixed salary. All other TCNs are obliged to purchase private health insurance offered by several commercial insurance bodies. This refers to the following groups: self-employed persons, children, parents and partners of TCNs (if they are not EU nationals or do not have permanent residence status), students who do not study in the framework of international agreements, and some others. The total number of all these migrants is estimated at 80.000, representing about 18% of the overall number of foreigners in the Czech Republic (30% of TCNs).

The adequacy of coverage differs dramatically, depending on whether migrants are included in public health insurance or are relying on commercial health insurance. Before 2014, migrants participating in public health insurance used to struggle to make their co-payments. In the years 2008–2014, this issue was significant for all low income people, including migrants. As most co-payments had been abolished by the beginning of 2015, financial barriers are no longer such an urgent issue. Nevertheless, there are additional charges for medicines, which can be a financial burden for some migrants. While doctors can prescribe drugs without any co-payment, in practice this is not done for many reasons.[9]

Migrants relying on private health insurance are in a significantly worse situation. Private health insurance can be refused on the basis of health risks, age, and gender; therefore there is a possibility that some persons will not be insured at all, namely if they suffer from chronic disease, congenital defect, or any other serious health problem. The scope of the services covered is limited and does not include all types of care (see below). Private insurance works according to market principles, with a minimal level of regulation regarding coverage. By law, private health insurance is required to cover medical expenses amounting to €60.000 at a minimum; up to this amount co-payment is not required for health care covered by the insurance contract (Czech Aliens Act as amended in 2010). However, in practice migrants often have to pay a so-called 'deposit' because health service administrators want a

[9] This issue has long been debated - though not in a connection with migrants - because of the negative impact on poor and chronically ill Czech nationals.

guarantee that all health expenses will be paid.[10] After a doctor´s consultation with the private insurance company on the costs of needed health procedures, this deposit may or may not be given back to the migrant. This means that migrants without sufficient resources could have a problem obtaining medical care, unless the situation requires emergency care.

There is a limit on reimbursements, premiums increase with age, and people over 70 are not usually insurable at a reasonable price. Insurance premiums are paid by lump sum in advance for the whole insured period. Certain insurance companies used to label migrants over 70 and the prematurely born children of migrants 'uninsurable foreigners'. Due to public condemnation this is no longer part of official insurance nomenclature, but in reality it still works this way.

In principle, private health insurance is particularly insufficient in case of any serious illness. Although policies are marketed as 'complex health insurance', there are frequent exclusions and limits of coverage; for example, they do not cover insulin-dependent diabetes, chronic renal insufficiency, haemodialysis, and some other medical conditions. It is paradoxical that some serious diseases, where mandatory treatment is required by the law (Public Health Protection Act), are explicitly excluded from all available kinds of commercial insurance. This concerns illnesses in which the sick patient may be dangerous him/herself or his/her surroundings, and therefore hospitalisation and treatment becomes imperative. These are primarily mental disorders, but also drug addiction and alcohol abuse treatment, sexually transmitted diseases (including HIV/AIDS and some other infectious diseases). Routine dental care is not included in standard insurance policies, but is available through supplementary insurance.

Additionally, insurers may easily terminate the insurance contract (Insurance Act 2009). Generally, the most vulnerable groups are seen as prematurely born children and children born disabled or with congenital defects, since they remain uninsured in a situation of urgent need for intensive neonatal care.[11] Despite this fact, in practice needed care is provided to such children. By law, as well as in accordance with medical ethics, Czech physicians are obliged to provide all care required under the same conditions as for any other children. As a consequence, a certain part of healthcare provided to migrants remains unpaid for. In recent years this has represented about 4-6% of all healthcare costs for foreigners (IHIS 2017).

Debts are usually concentrated in a few large hospitals, typically located in Prague or regional centres. These debts may influence negatively the hospitals' finances, which worsens the position of migrants in need of care there. In addition, the administrative burden of private insurance for medical staff is much higher than that for public insurance, and there is no financial compensation for the extra work.[12] For example, private insurance companies require a physician to consult in advance on the scope of care to be provided. Migrants themselves are also obliged to notify the insurance company of any need for non-urgent care before visiting doctors. In any case, the administrative burden and time necessary to successfully navigate the medical bureaucracy of commercial health insurance create significant barriers for both doctors and migrants. Logically, it might negatively influence communication between migrants and medical staff. In addition, as foreigners are required to pay insurance premiums in advance for the

[10] This is a reaction of health providers to the fact that commercial insurance companies sometimes do not want to pay all costs charged.
[11] In principle, Czech private health insurance for migrants is similar to US health insurance before the Affordable Care Act.
[12] The price of health care paid by private insurance companies is the same as the regulated prices in public health insurance.

entire insurance period (which is usually one year), private insurance creates a great financial burden for low-income migrants, especially for families with children (Dobiášová & Hnilicová 2011; Vavrečková et al. 2013).

Special exemptions

Legal migrants participating in public health insurance do not require special exemptions because the entitlements are uniform and are the same for migrants as for citizens of Czech Republic.

Entitlement to public health insurance for many third-country legal migrants depends on employment status, i.e. to be employed means that employer pays part of the insurance premium. If migrants become unemployed, they also lose their entitlement to public health insurance. In such situations migrants are immediately obliged to purchase commercial health insurance.

For these migrants, prenatal care, childbirth, and postnatal care must by law be included in the mother's standard private health insurance contract (postnatal health care for the new-born child is usually not included). By contrast, the most vulnerable groups such as chronically ill persons, children born with congenital defects, or prematurely born children are explicitly excluded from insurance contracts.

Barriers to obtaining entitlement

As discussed above, migrants forced to depend on private insurance face considerable administrative barriers when trying to buy coverage, and they are subject to a large number of discretionary decisions by the insurance companies.

Limiting access to public health insurance has long been a hotly-debated topic. In 2016, the Ethical Committee of the Ministry of Health recommended including all legal TCMs in public health insurance[13] – a recommendation supported by the Czech Medical Chamber, the Ombudsman, NGOs, and some health providers.[14]

The most important initiative in this respect was the petition of the Municipal Court in Prague and the District Court for Prague 6 for the annulment of Section 2 (1) and Article 3 (1) and (2) B) of Act No. 48/1997 Coll. on Public Health Insurance.[15] During a court hearing of two Ukrainian citizens who had not paid the cost of care provided for delivery and premature birth of a child, the judges found the current public health insurance scheme not in accordance with the Charter of Fundamental Rights and Freedoms and also in contradiction to international conventions binding on the Czech Republic (e.g. UN Convention on Rights of Child, EU Charter of Fundamental Rights) leading to unjustified discrimination against foreigners. For this reason, it was decided to discontinue the proceedings and submit the case for consideration to the Constitutional Court**.**

On May 24th 2017, the Constitutional Court decided by a tight majority of eight to seven that the current legal entitlement to health care for foreign nationals is not contrary to the Constitution of the Czech Republic or other international obligations. Limiting the right of foreigners without permanent

[13] This issue was discussed by the Ethical Commitee in 2015/2016.
[14] http://bit.ly/2sdG0fP
[15] http://bit.ly/2rxgxBB

residence or employment status in the Czech Republic to free health care from the system of public health insurance is not considered a form of discrimination against foreigners. The amendment to public health insurance law was rejected in its entirety.

B. Asylum seekers

Inclusion in health system and services covered

There are no significant problems with asylum seekers' healthcare entitlements, as they are included in public health insurance from the time they initiate the asylum procedure. Nor is there any difference between asylum seekers and Czech nationals in terms of the health services covered.

Asylum seekers residing in asylum facilities are provided with primary healthcare in an on-site General Practitioner´s office (physician and nurse/s), open eight hours per day, Monday to Friday. Medical check-ups at admission and discharge are an obligatory part of the asylum procedure. An ambulance is available for medical emergencies, and migrants themselves can call for emergency care if necessary.

Specialized health services are available within the public health care system outside the asylum centre. Recently, the Ombudsman examined the overall human rights situation of asylum applicants and the compliance with regulations in the process of healthcare services delivery in asylum centres. It was discovered that final medical checks were not carried out in one of the centres, but the situation was rectified after the Ombudsman's intervention (Ombudsman 2015).

By law, *refugees* with asylum status are considered as permanent residents for healthcare purposes. They have the same healthcare rights as Czech nationals. Within eight days of being granted residence in the Czech Republic, they are required to register with a public health insurance company of their choice. They have to register with a general practitioner and, if they have children, register them with a children's general practitioner. Usually, prior to this point, they will have already secured regular employment, so the state covers their health insurance, considering the government actually pays the insurance premiums for some defined groups (see above). Quality and responsiveness of health care, of course, depend on how quickly and how well the refugees are integrated in the Czech Republic and especially to what an extent they are able to navigate the Czech healthcare system. It should be noted that even many Czech citizens have a problem in that respect.

Special exemptions

None required because coverage is complete.

Barriers to obtaining entitlement

Decisions as to whether a situation amounts to a medical emergency, and whether the asylum seeker is able to pay treatment costs, are subject to administrative discretion.

C. Undocumented migrants

Inclusion in health system and services covered

Undocumented migrants are in a completely different position. All of them, including children,[16] are only eligible for emergency care, which in the Czech Republic has to be provided to all persons in case of medical need. The physician in charge is responsible for determining the character and scope of care which has to be provided for an individual migrant in acute need of health care. Emergency health care is not free, however.[17] Undocumented migrants are required to pay for it out of pocket. If they are not able to pay, health care remains unpaid and public hospitals bear the financial burden.

Provision of health care to undocumented migrants in a detention centre, as well as in custody or in prison, is defined by the Aliens Act (§134, §176). In detention, foreigners are provided with emergency health care in situations that are immediately life-threatening, that can cause sudden death, rapid and permanent pathological changes, sudden pain and suffering, or changes in behaviour and actions of the person that endanger the patient or their surroundings; as well as situations relating to pregnancy and childbirth, or mandatory treatment and measures to protect public health. A standard medical examination is part of admission and discharge procedures. Primary health care is provided in a GP´s office located inside prisons, custodial and detention centres. Migrants are informed about the possibility to call personally for emergency care after working hours. If specialized health services are needed, the migrant is be moved to a specialized public health facility outside the centre. In practice, this happens rarely because such health services usually go beyond emergency care; although if necessary, cardiac surgery and other highly specialized health care is given.[18] However, lawyers working for the NGO OPU[19] report relatively frequent complaints about healthcare in detention. Complaints include reluctance to refer migrants to specialized examination in case of sub-acute health problems, poor quality of care for diabetic patients, negative attitudes towards the health needs of migrants, among others. According to OPU staff, the responsible authorities' reaction to the complaints has been rather sluggish and inadequate.[20]

Another issue is the availability of adequate health care for children in detention (see Section 3).[21] GPs for children and youth are not always available in detention centres. This author found that at the beginning of October 2015, a children's GP was on duty once a week in the detention centre[22] to provide needed healthcare for detained children. If there is an urgent need for child healthcare on other days, children are transported to health facilities outside. All children are vaccinated in accordance with the Czech vaccination schedule (hexa vaccine), and also according to the child´s vaccination history and identified medical risks. Parents receive a vaccination certificate.

[16] However, children with the status of undocumented migrants are very rare in the Czech healthcare environment. If they are encountered, because of medical ethics doctors treat them as necessary and usually do not raise financial issues (Dobiášová & Hnilicová 2011).
[17] Prices are the same as within public health insurance.
[18] Information provided by management of health care in detention (personal communication July 2015)
[19] OPU: Organizace na pomoc uprchlíkům / Organization assisting refugees – an NGO specialized in legal aid.
[20] E-mail communication with OPU, 2015.
[21] As to primary health care for children, in the Czech Republic there is a network of GP´s for children and youth up to 18 who are specialized in work for these groups.
[22] This concerns the detention centre in Belá Jezová – the only centre where children are detained.

Special exemptions

Healthcare needed to protect public health and healthcare related to pregnancies are covered.

Barriers to obtaining entitlement

Decisions as to whether a situation constitutes an emergency are subject to administrative discretion.

6. POLICIES TO FACILITATE ACCESS

Score 53 **Ranking** ●●●○○

Information for service providers about migrants' entitlements

Due to the many activities of NGOs,[23] policies on facilitating access to healthcare for migrants have increasingly been discussed in recent years. The focus is on raising the awareness of migrants and health workers about migrants' rights to healthcare. However, research in this area shows that both migrants and health professionals are not adequately informed about migrants´ entitlements to healthcare (Dobiášová & Hnilicová 2011, Vavrečková et al. 2013; Dzúrová et al. 2014).

Service provider organizations can find special information on migrants' entitlements on the websites of the Centre for International Reimbursement, which was established after accession to the EU as a national contact point in providing relevant and updated information. This institution also provides individual advice to health providers and migrants in public health insurance. In 2016 the Centre merged with other institutions and changed its name to the Health Insurance Bureau.[24]

In addition, information about migrants' healthcare entitlements is available on the websites of public as well as private health insurance companies. However, this information is often fragmented and healthcare providers have to make a considerable effort in searching for it. Also, most hospitals have their own information system concerning patients with migrant backgrounds. This applies in particular to information about the rights of individual groups of migrants to healthcare. The situation varies by hospital; some large hospitals issue internal directives relating to information about healthcare provision to migrants without access to public health insurance. Employees are instructed on using internal hospital information channels (mostly intranet systems).

Information for migrants concerning entitlements and use of health services

Brochures, hand-outs, guides, and other publications designed for migrants are available in several languages (English, Ukrainian, Vietnamese, Russian, German, and Mongolian). They are distributed directly in migrant communities, mostly by the NGOs but also by the regional Integration Centres (see below). The websites of MoH and MoI and the websites exclusively dedicated to migration are the most common dissemination method.[25] A weak point is that migrants without access to internet are rather disadvantaged, because printed brochures and booklets are not often available and even when they are, the information is not always up-to-date.

At regional level, information on migrants' healthcare entitlements is available on the websites of the regional authorities. Regional MICs (first established in 2009) contribute significantly to raising TCN's awareness of healthcare related information.

[23] The substantial contribution can be attributed to the well-developed *Campaign for inclusion of TCNs into public health insurance*, see http://nesehnuti.blog.idnes.cz/c/462555/verejne-zdravotni-pojisteni-pro-migranty.html

[24] http://www.kancelarzp.cz/index.php/en

[25] See MIGHEALTHNET (Czech Wiki), list of migration websites: http://mighealth.net/cz/index.php/Webov%C3%A9_str%C3%A1nky_k_migraci

The information is available in Czech and English on the websites of public as well as private health insurance companies. In the case of commercial health insurance companies, the information is also frequently available in Vietnamese and Russian. However, this information is often fragmented and migrants have to make a considerable effort to find it and understand it.

Most hospitals also have their own information distribution channels (see previous item). For asylum seekers residing in the centres, information sheets are available in several languages, and offer details on rights and obligations, including healthcare.

Health education and health promotion for migrants

There are no health education and health promotion programmes specifically for migrants. In this context, only safety and health protection at work is addressed. A specific objective of targeting migrants is included in a national work safety policy (MLSA 2008). Researchers found that about 70% of migrants are regularly trained in work safety rules in a more or less "understandable way." Migrants working for small companies tend more often not to participate in any occupational safety programs (Čermáková et al. 2012).

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

In the Czech Republic, cultural mediators are not available in a systematic way. NGOs provide ad hoc assistance when requested, for but not specifically for healthcare purposes. However, it can be assumed that (at least to a certain extent), interpreters in healthcare also provide some type of mediation, if necessary.

NGOs receive government subsidies for this work on the basis of ad hoc projects, but not systematically.

Is there an obligation to report undocumented migrants?

There is no practice of reporting undocumented migrants to police by healthcare staff because the Czech Medical Chamber Professional Code prohibits this. Moreover, illegal stay in the country is not considered a crime under Czech law. In the past, a few cases have been reported of administrative staff reporting undocumented migrants to the immigration police, when migrants were not be able to pay for provided care (Hnilicová & Dobiášová 2011, Vavrečková et al. 2013). This practice cannot be entirely ruled out at present, but there is no evidence of such cases.

Are there any sanctions against helping undocumented migrants?

There are no legal sanctions or other pressures on professionals to deter them from helping migrants who cannot pay.

7. RESPONSIVE HEALTH SERVICES

Score 29 **Ranking** ●●●○○

Interpretation services

Health providers are obliged to offer interpreting services in order to provide adequate and understandable information, which is necessary for 'informed consent' (Health Services Act 2011). Hospitals with national accreditation have to observe standardised guidelines for interpretation services, which must be available at a professional level. However, accreditation is voluntary and not all hospitals are accredited,[26] though large hospitals where a higher proportion of migrants are treated usually are. A very practical problem is that the law is silent on who is to pay for interpretation. The MoH and the Czech Medical Chamber have agreed that health providers should provide an interpreter and the patient should pay for the service, especially when a professional interpreter is needed. Fortunately, there are a few NGOs specializing in providing free interpretation services, though none are specialized in health care. NGOs receive government subsidies for this type of work on the basis of ad hoc projects supported by EU funds,[27] and so assist health providers on a regular basis.

Nevertheless, in practice, free interpretation is not always available and migrants are often not able to pay, so specific situations require improvisation. Employees with a migrant background are used when practical, as are family members and sometimes even employees from the patient's home country's embassy. Some, but not all, hospitals have developed procedures for managing interpretation services, especially in emergencies. In order to facilitate communication between health professionals and migrants unable to understand Czech when interpreters are not available, MoI supported a project to create multilingual communication cards containing an often-used 'health vocabulary' to facilitate communication.[28] In general, the situation in Czech hospitals is not 'critically bad' in dealing with language barriers, but there is a lot of improvisation. Outside large towns, migrants have practically no opportunity to search for a doctor who is able to communicate in a mutually understandable language.

Requirement for 'culturally competent' or 'diversity-sensitive' services

Although such requirements do not exist, existing standards require that health services take into account the individual characteristics (including ethnicity) of their patients.

Training and education of health service staff

Until now, multicultural education in the Czech Republic was not much developed or incorporated into medical education. However, in the framework of communication skills training, some basic information concerning ethnic and cultural differences is included in health professional training on both graduate and postgraduate levels. Nevertheless, it cannot be considered sufficient. Nursing training addresses this topic in greater depth and detail than medical school curricula. Multicultural nursing is an obligatory

[26] In 2014 about 50% of all hospitals were accredited – see http://www.sakcr.cz/cz-main/akreditovana-zarizeni/rok-2014/
[27] For example MPSV – Intercultural Mediation in the CR: http://portal.mpsv.cz/sz/zahr_zam/projekt_formovani_prof
[28] New communication cards will help foreigners: see http://bit.ly/2qDwX8r

part of curricula in the basic professional education of nurses. It might be due to this fact that multicultural nursing continues to develop beyond the required educational framework.[29]

By contrast, this topic is completely missing in physician training. A few ad hoc training courses which were organized few years ago for a limited number of participants within frame of EIF projects[30] did little to improve the overall state of affairs, although the current situation seems a little better. In the framework of implementation of the 2020 Roma Integration Strategy, topics dealing with specifics of ethnic minorities and migrants are to be systematically included in basic mandatory postgraduate training for all physicians.[31] We will see in the near future how this objective is fulfilled. In summary, health professionals' level of awareness on migrant-sensitive healthcare topics has been improving over the last few years, but a more systematic and coordinated approach is still needed.

Involvement of migrants

Migrants are usually involved in the development of information. In addition, they often participate (ad hoc) in research dealing with migration-related issues. There are also some researchers with a migration background, but this is not a result of any explicit policy measures.

Encouraging diversity in the health service workforce

There is no official policy on encouraging diversity in the health service workforce. However, people with a migrant background do work in healthcare. Russians, Ukrainians, and Vietnamese are employed as physicians, nurses, and auxiliary staff.

Development of capacity and methods

Policies are exclusively focused on standardising diagnostic procedures and treatment methods.

[29] See e.g. online language courses for health workers: http://bit.ly/2qAbgs1
[30] See http://www.ima.cz/research-and-development/grant-projects/czech-projects-completed/eif-2/?lang=en
[31] See http://ec.europa.eu/justice/discrimination/files/roma_czech_republic_strategy2_cs.pdf, p. 67

8. MEASURES TO ACHIEVE CHANGE

Score 33 **Ranking** ●●●○○

Data collection

Concerning collection of information about consumption of healthcare services by migrants, out-patient care is not monitored at all, while hospital care for some migrants is monitored by the following national health registers: National Register of Hospitalized Persons, Registers of TB and other infectious diseases, and National Register of Abortions.

The CSO publishes annually a statistical yearbook entitled *Foreigners in the Czech Republic*; a chapter on 'Health Care for Foreigners' is included. Data collected provides only fragmentary information on migrant healthcare utilization and health status. Routine data collection on health does not include information about migrant status, country of origin, or ethnicity. No health data are collected on migrants insured by public health insurance.

Support for research

Three relevant research projects have been implemented in the five years up to 2015:

- Health and social situation of immigrants and asylum seekers in the Czech Republic (COST project: 2010-11)
- The experience of medical personnel providing health care to migrants (Faculty of Social Sciences, Charles University 2011-12)
- Analysis of legal, institutional, and economic aspects of health care provision to TCMs in the Czech Republic. This study was implemented within a larger research project on quantitative and qualitative integration indicators of third country migrants in light of recent information and knowledge (Research Institute of Labour and Social Affairs 2013).

"Health in all policies" approach

No consideration is given to the impact of policies in non-health sectors on migrant or ethnic minority health. However, there are initiatives on occupational safety for migrants as described in section 6 above.

Whole organisation approach

No systematic attention is paid to migrant or ethnic minority health in any part of the health system. Measures are left to individual initiative.

In some large hospitals (with a higher proportion of migrant patients) special 'Foreigners Departments' have been established. However, this was to facilitate health care provision to those migrants not participating in Czech public health insurance. They are focused on administrative issues, mainly on financial aspects of treatment and not on the special health needs of migrants as such. Staff working in these departments normally speak several languages. They also coordinate treatment procedures in order to ensure medical staff are sufficiently able to communicate with migrants.

Leadership by government

Only ad hoc policies have been introduced on migrant health. However, the Concept of Integration of the Foreigners into the Czech Society, *Living Together*, is an explicit governmental plan for all actions related to migration policy. In this strategic plan, there are overtly stated health/healthcare related objectives to be fulfilled by the Ministry of Health in the near future.

Involvement of stakeholders

a) There is a Committee on the Rights of Foreigners, which is an advisory body of the Czech Government Council for Human Rights. It is a platform for discussion of all legislative initiatives, an opportunity to review and comment on them. The committee consists of members representing state organizations, NGOs, academics, and members of civil society. In the last few years the issue of TCNs' unequal access to public health insurance was often on the committee's agenda.

b) There is also a Consortium of Migrant Assisting Organizations in the Czech Republic, which was established to participate in migration policy development and to coordinate all relevant NGO activities. Although the consortium is not dedicated explicitly to health policy, it is very active in this regard. It is currently managing the campaign for inclusion of third-country migrants into public health insurance.

Migrants' contribution to health policymaking

a) NGO representatives working for and with migrants are full members of the Committee on the Rights of Foreigners, though it is not explicitly laid down that migrants as such should be represented on this committee. This committee discusses all matters relating to migrants; it can initiate changes in the relevant laws and submit comments during legislative sessions.

b) NGOs assisting migrants are considered to represent migrants' interests and act as their defenders. There are some migrants working for these NGOs, but the majority of employees are non-migrant Czechs.

CONCLUSIONS

Although in other respects migrant health policies in the Czech are more advanced than in other Central and Eastern European countries, discrimination against TCNs regarding their legal entitlements to healthcare coverage has long been considered the most significant problem. Before 2004 all migrants, including EU nationals, were insured for health care in private health insurance, but immediately after accession to the EU, eliminating inequalities in access to public health insurance by including all legal migrants became one of the priorities of Czech migration policy. Despite strong support from the *Czech Government Council for Human Rights* and its advisory body *Committee for Foreigners´ Rights*, no significant change in this respect has been achieved so far. Academia, NGOs assisting migrants, the Human Rights Defender and public media (Czech TV and Czech Radio) strongly support change. On other hand, many powerful actors oppose it. The key stakeholder in this respect is the MoH, which systematically rejects the inclusion of TCNs in the public health insurance scheme. The MoH is supported by the Ministry of Finance (MoF), by all commercial insurance bodies, and - rather surprisingly - by the public health insurance companies. All these opponents admit the existence of serious problems to be solved in the current dual system of health insurance for migrants. But all of them definitively prefer some sort of 'reform' of commercial health insurance, which they otherwise wish to maintain.

Over the years the Czech Government has repeatedly responded to strong criticism with only minor modifications to the existing framework in order to correct 'flagrant' problems. For example, the exclusion of injuries associated with alcohol or drug use has been banned (Alien Act as amended in 2010). In 2009, the MoH also introduced regulations on the price of emergency care provided outside public health insurance, to reduce migrants' vulnerability to heavy financial burdens (MoH 2009).

In the ongoing debate on this issue the following arguments are frequently used: the current system is more or less working and commercial health insurance only needs to be modified to make it comparable to public health insurance. Stakeholders who defend the existing system argue that there is a risk of medical tourism and abuse of the Czech health system by migrants. Supporters of change use human rights arguments and emphasize conflicts with international law (*UN Convention on Rights of Child* and other instruments which are binding for the Czech Republic). Additionally, the 'healthy migrant effect' is often used to counter economic objections, since migrant healthcare consumption is proven to be lower than that of the majority population (IHIS 2017, Dobiášová et al. 2004). Last but not least, academics stress the importance of protecting public health (Hnilicová & Dobiášová 2011). A summary of the reasons for inclusion of TCNs into public health was elaborated and used in meetings with politicians and members of Parliament on this issue during the last 5-6 years (Hnilicová 2009 and subsequent years).

It can be concluded that responsible authorities, especially the MoH, have not been active in improving healthcare access for TCNs. In their opinion, the present situation is satisfactory. Nor does the Minister for Human Rights specifically address this issue, even though he deems the current situation unsatisfactory and personally supported NGOs in the campaign for inclusion of TCNs into public health insurance. The task of advocacy for migrants in this respect has been completely taken over by NGOs,

together with some academics. Since 2012, the Consortium of Migrant Assisting NGOs[32] has mounted a vigorous campaign for inclusion of TCNs into public health insurance, involving workshops, meetings with politicians, press conferences, videos, etc. So far, this campaign has been the most visible activity to promote needed changes in Czech health legislation related to migrants. The campaign helped to raise the awareness of the public, health professionals, and the media on the basis of facts rather than myths. No substantial progress has thus far been made, though due to the fact that commercial insurance is "under the microscope," there have been slight improvements in terms of the scope of care covered.[33]

At the time of writing (2015) the MoH together with MoF plan to adopt a completely new law on a commercial health insurance for migrants, in order to eliminate existing problems including 'uninsurable' foreigners. The key problem of this proposed solution is that the price of private health insurance will be not regulated and remains subject to market forces. We may assume that such insurance will remain hardly affordable for vulnerable migrants.

[32] This consortium is an umbrella organization of the NGOs assisting migrants in the Czech Republic (see http://www.konsorcium-nno.cz/en/index.html). Support for its campaign for inclusion of TCNs into public health insurance (http://www.konsorcium-nno.cz/cz/kategorie/2) was expressed by the Czech Ombudsman Anna Šabatová on 22 March 2015 (see http://bit.ly/2ryjmz8). In April 2016 the Consortium published a new information booklet on health insurance for immigrants (see http://bit.ly/2ryAzaW).

[33] For example, the largest commercial health insurance company covers psychiatric care.

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