



COUNTRY REPORT
GERMANY
MIPEX
HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX *HEALTH STRAND*

Country Report Germany

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IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental body, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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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/2g0GIRd>. 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/29IXgf0), 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.

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) | 80.767.463 | ●●●●● |
| GDP per capita (2014) [EU mean = 100] | 124 | ●●●●○ |
| Accession to the European Union | 1957 | |

Geography: Germany is located in Western and Central Europe, bordering Denmark to the north, Poland and the Czech Republic to the east, Austria to the southeast, Switzerland to the south-southwest, France, Luxembourg, and Belgium to the west, and the Netherlands to the northwest. Germany is also bordered by the North and Baltic Seas, and shares a border with Switzerland and Austria on Lake Constance. The terrain consists of lowlands in the north, forested uplands in the centre, and mountains in the south. The four biggest cities are Berlin, Hamburg, Munich, and Cologne. 75,3% of the population lives in urban settings.

Historical background: After the end of the Nazi regime and the Second World War in 1945, Germany was occupied by the victorious Allied Forces (US, UK, France, and the Soviet Union). Two German states were founded in 1949: the western Federal Republic of Germany (FRG) and the eastern German Democratic Republic (GDR). Under the Marshall plan (1948-1952), the economy of the Federal Republic of Germany quickly grew, unlike that of East Germany. The decline of the USSR and the end of the Cold War lead to German re-unification in 1990. Regional inequalities persist until today.

Government: Germany is a federal republic, composed of 16 states (*Länder*). Germany is a founding member of the EU.

Economy: Germany is Europe's largest economy and the fifth largest economy in the world in terms of purchasing power. In the face of recent crises, the German economy has proved remarkably resilient. Unemployment remained low (5,2% in 2014) even during the 2008-2009 recession. While income inequality is lower than in most OECD economies, the share of low-paying jobs has risen significantly and considerable differences exist between regions and *Länder*. Germany faces significant demographic challenges to sustained long-term growth. Low fertility rates and declining net immigration are putting increasing pressure on the country's social welfare system

2. MIGRATION BACKGROUND

| KEY INDICATORS (2014) | | RANKING |
|--|------|---------|
| Foreign-born population as percentage of total population | 12,2 | ●●●●○ |
| Percentage non-EU/EFTA migrants among foreign-born population | 60 | ●●○○○ |
| Foreigners as percentage of total population | 8,7 | ●●●●○ |
| Non-EU/EFTA citizens as percentage of non-national population | 55 | ●●●○○ |
| Inhabitants per asylum applicant (more = lower ranking) | 398 | ●●●●○ |
| Percentage of positive asylum decisions | 42 | ●●●○○ |
| Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer) | 38 | ●●●○○ |
| MIPEX Score for other strands (MIPEX, 2015) | 63 | ●●●●● |

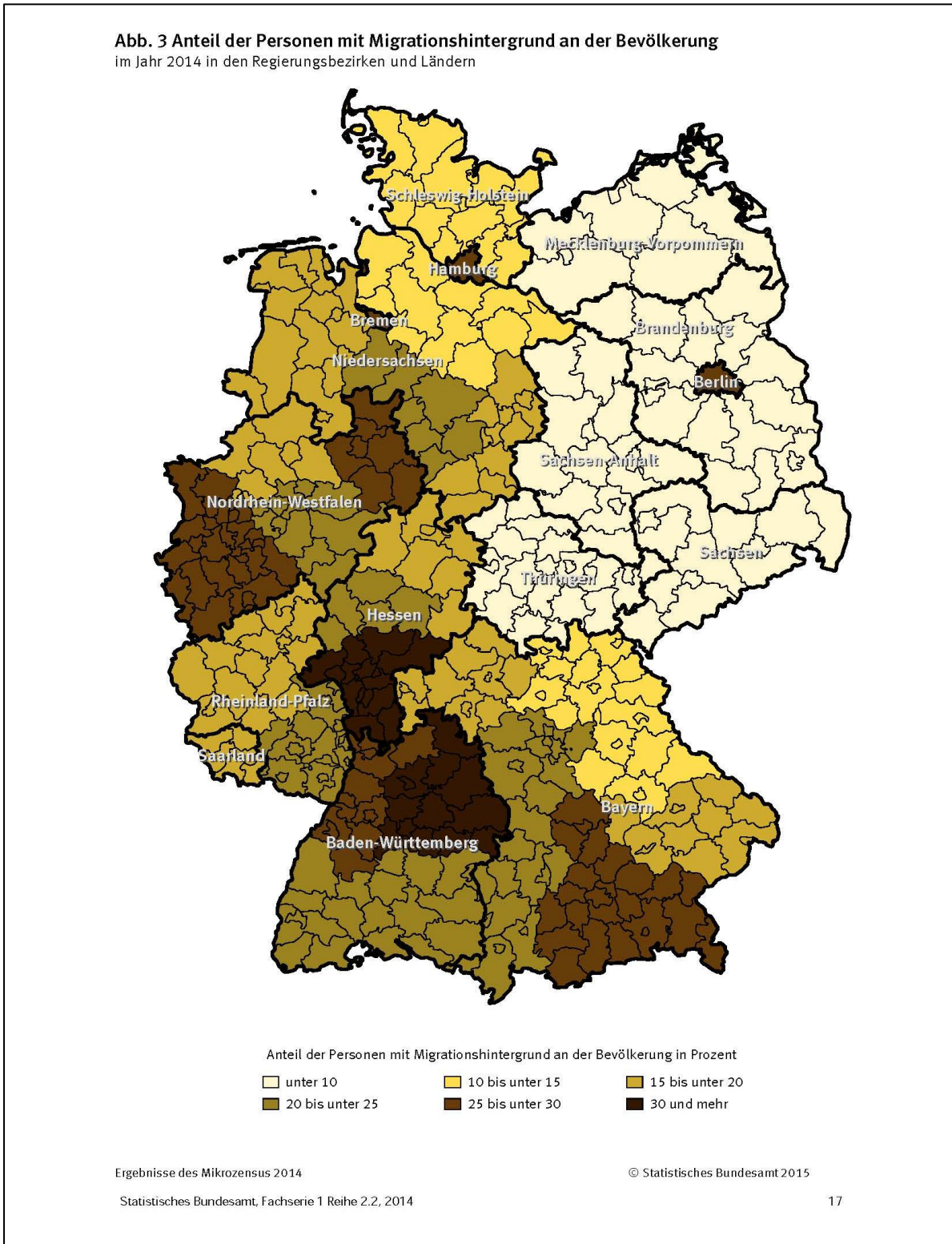
Migration is an essential part of German history. Germany has always been a country of both origin and destination for all different types of migration, according to the changing political, economic, and social conditions. Yet just like migration itself, the ways in which ‘migrants’ are perceived, and the criteria for identifying and distinguishing them have always been – and still are – highly contingent on the particular historical context. This is essential to understanding concepts and policies relating to migrants in Germany.

Statistics, debates, and politics related to migration in Germany today are based on a definition only recently introduced by the Federal Statistical Office of Germany (*Statistisches Bundesamt*), in 2005 (DESTATIS 2006). Prior to that, the distinction between migrants and non-migrants was made only on the basis of nationality. Since 2005, the focus has shifted to the ‘population with migration background’, which includes immigration to the territory comprised of the Federal Republic of Germany since 1950. The large number of immigrants in the immediate aftermath of the Second World War is not considered. The goal of the new definition was to identify the share of population considered to be in need of ‘integration’ (DESTSTIS 2006: 73). The majority of ‘immigrants’ according to this definition are of German nationality, and a considerable number of them were born in Germany (independent of citizenship). Thus, not only migrants (i.e. persons who actually migrated) count as having a ‘migration background’, but also individuals born in Germany with one or more migrant parents; so, in some cases, do persons with an immigrant grandparent.

According to data from DESTATIS for the year 2014 (DESTATIS 2015a), 16,4 million individuals were considered to have a ‘migration background’, representing 20,3% of the resident population. Two-thirds of these individuals actually migrated to Germany since 1950, while the remaining third were born in Germany. In terms of citizenship, foreign nationals comprised 8,7% of the population in 2014, while 12,2% were foreign-born. As Fig. 1 shows, the distribution of ‘persons with a migration background’ within the national territory is uneven, with rather low numbers (<10%) in states on the territory of the

former German Democratic Republic (with the exception of Berlin), and 10% to over 30% on the territory of the former West Germany, with the highest concentrations in Berlin, Hamburg and some regions of southern Hessen and northern Baden-Württemberg.

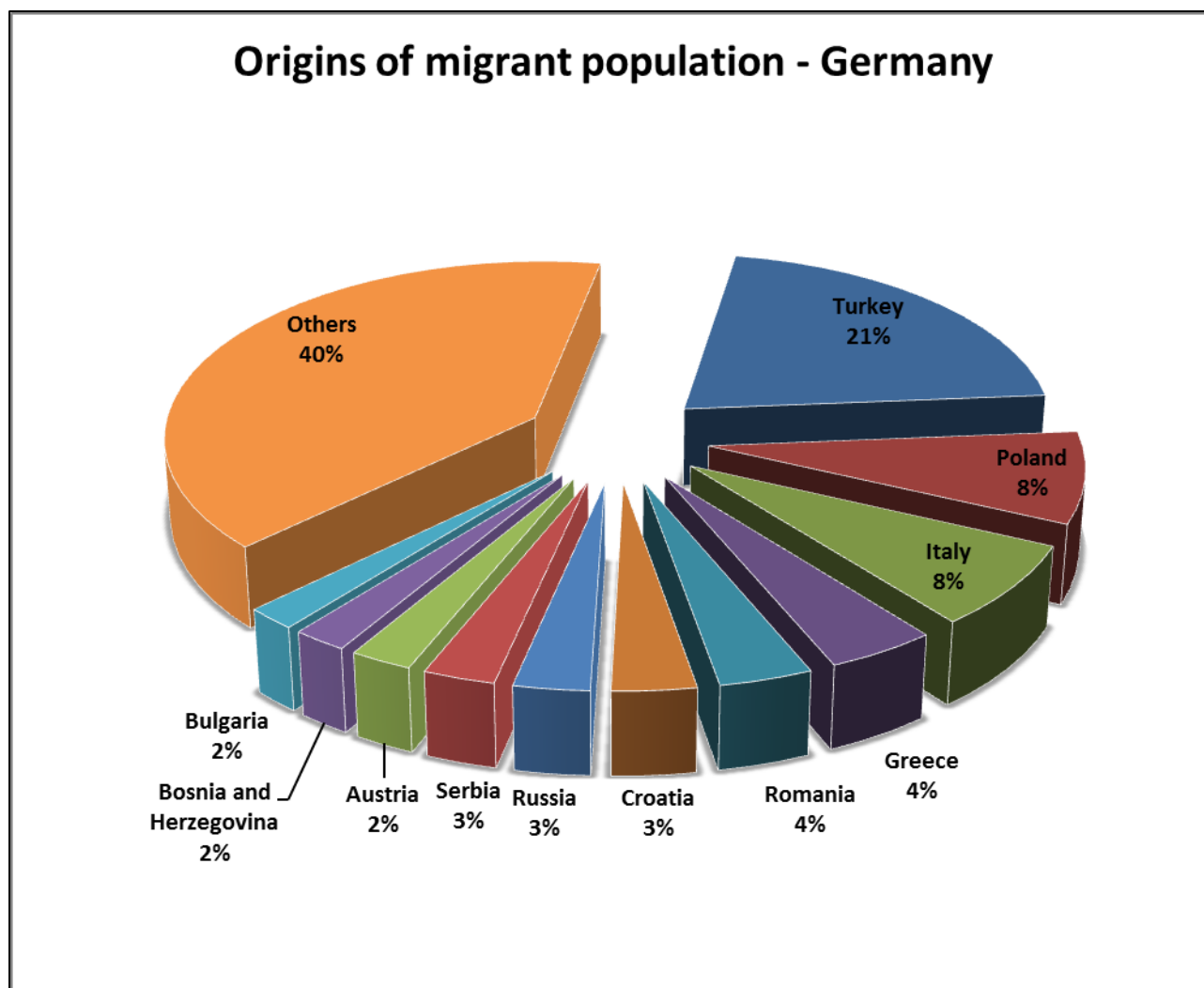
Figure 1 – Percentage of persons with a ‘migration background’ in Germany, 2014



Source: Statistisches Bundesamt (DESTATIS 2015a: 17)

Both in terms of country of birth and nationality, a slight majority of migrants are from outside the EU/EFTA (see Key Indicators). Fig. 2 shows the main nationalities among foreigners living in Germany in 2014. The largest group has Turkish nationality, reflecting the recruitment of Turkish 'guest workers' in 1961-1973 and subsequent immigration. Apart from these figures, 1,4 million immigrants with German nationality are repatriated ethnic Germans from countries of the former Soviet Union (*Aussiedler* and *Spätaussiedler*), who mostly arrived in the 1990s and early 2000s.

Figure 2. Main nationalities among foreigners living in Germany in 2014 (Eurostat)



Regarding refugees and asylum seekers, the numbers of individuals in different stages of the asylum process have to be distinguished: those just entering the country to apply for asylum, those engaged in the application process, and residents after a positive decision has been taken. In 2014, 202.843 people applied for asylum in Germany, compared to 127.023 in 2013, 77.651 in 2012, but only 28.018 in 2008 (BAMF 2015b: 3). As of 31 December 2014, 240.955 individuals held a limited residence permit according to international legal regulations, granted for humanitarian or political reasons in 2014 or before. This group includes most of the refugees who had successfully applied for asylum according to German law or the Geneva Convention. The number of asylum seekers engaged in the corresponding legal proceedings was 177.900 (*Aufenthaltsgestattung*), while 112.767 individuals were rejected asylum seekers with a departure orders, which for humanitarian, political, or other reasons could not be

executed (*Duldung*). The total number of resident foreigners related to asylum proceedings was 531.622 (all numbers: DESTATIS 2015b).

According to DESTATIS, foreigners without regular status (undocumented migrants) numbered 229.611 in 2014. Yet, due to the nature of this category, which comprises people living in clandestine conditions, the real number is most likely higher.

Regarding integration policies, according to the 2015 MIPEX report² Germany has made 'slow but steady' progress in its policies, starting with reform packages in 2005 and 2007 (Leise 2007). A measure of this progress is the fact that in the MIPEX survey for 2004, Germany was below the European average on the strands Labour market inclusion, Long-term residence, Nationality and Anti-discrimination, and only slightly above it on Family reunion. In the 2015 survey, the average of all scores apart from Health put Germany in sixth place among the 31 EU/EFTA countries studied in EQUI-HEALTH: the MIPEX website now concludes that "increasingly, other countries of immigration in Europe and abroad are looking to Germany for inspiration on integration policy". As we shall see, however, the country obtains only average scores on the Health strand.

² <http://www.mipex.eu>

3. HEALTH SYSTEM

| KEY INDICATORS (2013) | | RANKING |
|---|-------|---------|
| Total health expenditure per person (adjusted for purchasing power, in euros) | 3.665 | ●●●●● |
| Health expenditure as percentage of GDP | 11,2 | ●●●●● |
| Percentage of health financing from government National health system (NHS) / social health insurance (SHI) | 8 | SHI |
| Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking) | 13 | ●●●●○ |
| Score on Euro Health Consumer Index (ECHI, 2014) | 812 | ●●●●○ |
| Overall score on MIPEX Health strand (2015) | 43 | ●●●○○ |

The German health care system has its roots in the social legislation introduced by Otto von Bismarck, Chancellor of the German Empire between 1883 and 1889 ('Bismarck System'). It is based on statutory health insurance (*Gesetzliche Krankenversicherung*, or GKV), in which contributions are shared by employers and employees (with dependent family members being covered as well), complemented by private health insurance with individually adjusted fees for higher income groups (*Private Krankenversicherung*, or PKV), and by tax-funded social welfare for low income groups (*Fürsorgeprinzip*).

Around 88% of all citizens are members of the statutory health insurance (GKV). Eligibility and coverage are defined in the 5th Book of the Social Code (*Sozialgesetzbuch V*, or SGB V). Approximately 11,5% are members of the private health insurance system (PKV) (BPB 2015, BMG 2016). Among the remaining 0,5%, 0,3% are covered by social welfare and 0,2% are without coverage (data from 2011). Recipients of unemployment and welfare benefits (*Arbeitslosengeld I* and *II*) are, to a large extent, also covered by GKV (eligibility and possible subsidies are set according to complex legal requirements). Regular GKV contributions are progressive according to income, with an upper monthly income ceiling (currently €4.125). Family members are also covered at no extra charge (children, spouse without income or earning up to €450 per month). With the goal of closing gaps in the complex health insurance system with GKV and PKV, a general duty of health insurance for all residents in Germany was introduced in 2009 (§193, *Versicherungsvertragsgesetz*, or VVG). PKV companies are now required to offer a basic contract to all residents not covered by GKV or other state services.

In addition to statutory health insurance according to SGB V, German residents have access to accident insurance (*Unfallversicherung*) according to SGB VII (statutory accident insurance scheme), social long-term care insurance (*Pflegeversicherung*) according to SGB XI (social long-term care insurance scheme), and statutory pension insurance according to SGB VI (statutory pension insurance scheme). Rehabilitation and services for persons with disability is covered by different entities, according to labour status and other criteria established in the 9th Book of the Social Code – SGB IX (Rehabilitation and participation of persons with disabilities scheme).

Outpatient health care (e.g. physiotherapy, psychotherapy, speech therapy/ speech-language pathology, occupational therapy) is provided by independent physicians and other health professionals, who work in small medical practices or professional groups. Other physicians and health professionals are employed by ambulatory health care centres run by private or public companies. Hospitals are run by public, religious, and private institutions, with an increasing number of them being operated by private companies and for-profit corporations.

Germany's federal structure of government means that health policies are developed on various political levels by different institutions and actors. The state defines health policies on national (*Bundesregierung*), federal (*Landesregierung*), regional (*Landkreis*), and local (*Stadt/Gemeinde*) level, with a high level of federal autonomy and, accordingly, low level of standardization for some health-related issues. While structural decisions regarding issues such as health insurance and financing correspond to national standards, the organisation and surveillance of hospital care, public health, and preventive medicine are the responsibility of the 16 federal states, with regional and community level authorities involved. For example, healthcare services for refugees and asylum seekers are organized by local and regional authorities with federal support and supervision. On the other hand, funding bodies (GKV) and providers (associations of physicians and hospitals, especially the national and the regional Associations of Statutory Health Insurance Physicians, *Kassenärztliche Vereinigungen*) have important competencies for the development and organisation of the German health system. Due to the principle of 'cooperative self-administration' (*gemeinsame Selbstverwaltung*), these non-state actors define standards for services, therapies, and which procedures are to be covered by the statutory health insurance.

4. USE OF DETENTION

Legal grounds for immigration detention are to be found in four fundamental national laws:

- 2008 Act on the Residence, Economic Activity, and Integration of Foreigners in the Federal Territory (Residence Act, in German: *Gesetz über den Aufenthalt, die Erwerbstätigkeit und die Integration von Ausländern im Bundesgebiet; Aufenthaltsgesetz/AufenthG*);
- 2009 General Administrative Regulation to the Residence Act which together provide the grounds for detention, the rules on the length of detention, the basic procedural safeguards and few provisions on the conditions of detention;
- 2008 Asylum Procedure Act which contains the provisions to regulate the detention of asylum seekers (in German: *Asylverfahrensgesetz*, since 2015: *Asylgesetz*);
- 2008 Family Matters and Non-Contentious Matters issued in 2008, which provides the procedural rules governing detention.

This set of laws is to be considered as a general framework within which each *Land* defines its approach to immigration detention. Only three states (Berlin, Brandenburg, and Bremen) have adopted specific laws regulating immigration detention. In the remaining 13 states, where no specific regulations governing detention pending deportation exists, the Prison Act regulates conditions and overall detention regimes. Consequently immigration detainees continue to be subjected to the same rules and restrictions as prisoners.

Types of immigration detention

There are two main types of immigration detention, as a last means for (*Abschiebungshaft*): custody to prepare deportation and custody to secure deportation.

Custody to prepare deportation (*Vorbereitungshaft*)³ can be ordered to secure a person's expulsion and deportation if a deportation order cannot be obtained immediately and when the deportation would be made impossible or hindered if the person was not detained. It is important to underline that custody while awaiting deportation is possible only if a deportation order is legally possible and highly probable, though a judicial decision cannot be rendered straight away.

Preparatory detention may not exceed six weeks, although there are exceptions under which immigration detention can be prolonged, for example when there is a delay in ordering expulsion due to circumstances provoked by the detainee.

Custody to secure deportation (*Sicherungshaft*)⁴ can be ordered if one of the following six justifications for imprisonment exists:

- in case of an enforceable order to leave Germany due to illegal entry;
- in case of an enforceable order due to reason relevant to public security and order, that cannot be executed immediately;

³ Residence Act, Section 62(2).

⁴ Residence Act, Section 62(3).

- when the period allowed for departure has expired and the person changed his or her residency without informing the public authority;
- when the person failed to appear at the appointment fixed for deportation due to reasons, he or she is responsible for;
- if the person evaded deportation by any other way;
- when it is reasonably likely to assume that the person will abscond.

German legislation emphasizes that detention may only last for the shortest period possible. In this case, custody may be ordered for up to six months, but it may be extended to a maximum of 18 months if the detainee hinders his/her deportation process.

Only a judge may sentence a non-citizen to detention, providing valid reasons for detention measures. The district courts - where the non-citizen in question resides or, if he/she does not have a permanent residence, where detention is to take place - are responsible for pre-removal detention (Woods 2014).

Detention of minors and families

According to the German Residence Act, minors and families with minors may be detained pending deportation only in exceptional cases and only for as long as is reasonable.

As a measure to safeguard the well-being of children, the General Administrative Regulation specifies that, in the case of families with underage children, only one parent - generally the father - can be taken into detention pending deportation.⁵

Important provisions, such as those concerning the minimum age of detention, are not defined at national level, with the consequence that certain *Länder* recognize a minimum age of detention at 16 years old – following the provisions of the Convention of the Right of the Child – while in others there are no age restrictions. However, even in the *Länder* where the age-limit is guaranteed, minors can still be detained in special juvenile detention centres.

In the case of **unaccompanied minors**, German law defines detention as a measure of last resort and for the shortest period of time. As a general rule applicable to the entire territory of the federal republic, Youth Welfare Services are obliged to take unaccompanied minors into care (Majcher & Flynn 2014).

Detention of asylum seekers

Asylum seekers can be subject to **detention pending deportation** – which is regulated by the same procedural rules as “custody to secure deportation” – only once the asylum application has been finally rejected as inadmissible or manifestly unfounded.

The sole legal basis to detain a person whose asylum application is still pending concerns asylum seekers who are already detained. Indeed, following the provisions stated by the German Federal High Court in 2014, detention pending deportation ordered on the grounds of illegal border crossing is in itself not a sufficient reason to uphold such detention when an asylum application has been lodged.

⁵ General Administrative Regulations relating to the Residence Act, Section 62(5).

Very often, detained asylum seekers are subject to the EU Dublin regulation whose application has been rejected in the country through which they entered Europe. In accordance with the Dublin regulation II, an asylum seeker whose application is pending in another country may be detained only if there is reason to believe that he or she is trying to abscond in order to avoid deportation (Kalkmann 2015).

Conditions of detention

In the second half of 2012, the NGOs Pro Asyl, Diakonie Hesse and Nassau carried out an extensive study on conditions in facilities of the “detention pending deportation” type (Pelzer & Sextro 2013). This research showed that all the facilities were designed like **prisons**: cells, locked corridors or sections, heavy restriction of movement within the facility, inadequate social support and recreational activities.

Insofar as **health care provisions**, at the time of the study all facilities were able to make sure a doctor was available or accessible if necessary, but in most cases an interpreter was not available during the consultation. More generally, except in emergencies, it was difficult for migrants to receive adequate healthcare. The situation for people with psychological problems or chronic diseases seemed even more complicated.

5. ENTITLEMENT TO HEALTH SERVICES

Score 50 Ranking ●●○○○

A. Legal migrants

Inclusion in health system and services covered

There are no differences in health care coverage between non-migrant nationals and legal migrants, regardless of their nationality. The inclusion in all branches of the German Health Care System depends on the same conditions for both groups.

Special exemptions

None needed.

Barriers to obtaining entitlement

No additional demands for documents exist which may be difficult for migrants to produce; no administrative discretion.

B. Asylum seekers

Inclusion in health system and services covered

The majority of asylum seekers in Germany have only limited entitlement to health care (Razum et al. 2008, Knipper & Bilgin 2009, Lindner 2015, Macherey 2015, Bozorgmehr & Razum 2015). Entitlements are defined by the Asylum Seekers' Benefits Act (AsylbLG), § 4 and § 6, with limited coverage for the first 15 months of stay in Germany. Only after this period of time are asylum seekers entitled to the same social welfare services as regular residents in Germany (independent of nationality) and get access to a GKV statutory health insurance card, according to SGB. The waiting period was reduced from 48 to 15 months in November 2014. For the first 15 months of stay, the Asylum Seekers Benefits Act (AsylbLG, § 4) only grants access to:

- necessary medical and dental treatment (including medication, dressing materials, etc.) in cases of acute pain and illness, (i.e., only emergency treatment);
- maternal care in case of pregnancy and delivery;
- selected vaccinations.

Chronic diseases (e.g. high blood pressure, coronary heart disease, diabetes) and mental health problems are not explicitly covered. In individual cases, when health care beyond the limits of §4 is needed to prevent exacerbation of a medical condition further services can be granted according to AsylbLG, § 6 (1), but on a discretionary basis (Razum & Bozorgmehr 2016). In addition to this, AsylbLG § 6 (2) covers services for individuals with special needs, such as children, victims of torture, and victims of physical, psychological, or sexual violence. However, access is not assured for all individuals because § 6 (2) is bound to § 24.1 of the Residence Law (*Aufenthaltsgesetz*) that limits the applicability of AsylbLG § 6 to foreigners receiving provisional shelter in Germany according to specific decisions of the European Union (EU Directive 2001/55/EG). Thus, it is not applicable to asylum seekers in general.

Unrestricted entitlement to health care during the first 15 months of stay is only possible through employment, but the access of asylum seekers to the labour market is restricted. Despite improvements following the legal reform by the Federal Government in November 2014, asylum seekers have no permission to work during the first three months. In the following months (4–15), the majority of asylum seekers have subordinate access to the labour market, after first having to prove that no nationals, EU-citizens, or regular migrants with the same qualifications are available for the position. Only highly qualified asylum seekers have access to the labour market after three months, under the condition of having (i) a German academic degree or (ii) an academic degree acquired abroad that has been recognized by German authorities, as well as pre-tax income of at least €47.600 a year. Regulations concerning asylum seekers are currently a topic of intense public attention and political debate in Germany.

Special exemptions

Maternal care and selected vaccinations (as mentioned above).

Barriers to obtaining entitlement

In the first weeks and months after arrival, asylum seekers are placed in reception centres with limited access to health care within the facilities (according to §4 AsylbLG). After completing initial administrative procedures (e.g. identification, clearance according to Dublin procedures, application for asylum), asylum seekers are transferred to mid- or long-term residences that are often located in rural areas. According to the procedures established in AsylbLG, in case of health problems asylum seekers have to apply for a health voucher at the corresponding municipal social assistance office (Razum & Bozorgmehr 2016). These institutions are often distant from the residences and have limited opening hours. Access to health care for asylum seekers is thus constrained by distance, travel costs, and complicated administrative procedures. Moreover, the decision whether the voucher is issued or not is taken by administrative staff without medical training. This practice therefore entails a high risk of medically erroneous decisions and discretion. The distinction between ‘acute’ and ‘chronic’ diseases and pain in AsylbLG §4 is, from a medical point of view, unacceptable. In medical terms, the distinction between ‘acute’ and ‘chronic’ conditions is analytical and not categorical. Acute and chronic diseases are not distinct entities, but different manifestations and time-specific expressions of evolving pathologies, providing for specific diagnostic and therapeutic demands that cannot be met in the absence of medical knowledge and adequate facilities.

In sum: limited entitlements for chronic diseases and mental health problems, combined with additional costs (e.g., transport) have a negative effect on access to health care services for asylum seekers. Administrative barriers put a high burden of medical responsibility on untrained administrative staff and are severe obstacles to health care access for asylum seekers. This applies to all asylum seekers in the first 15 months of their stay in Germany. By the end of 2014, only the two small federal states of Bremen and Hamburg had taken measures to significantly improve access and reduce barriers by providing Health Insurance Cards to asylum seekers, in cooperation with a statutory health insurance company in 2005 and 2012, respectively.

C. Undocumented migrants

Inclusion in health system and services covered

In theory, i.e. from a legal perspective, undocumented migrants are subject to the 'Asylum Seekers Benefit Act' (AsylbLG) and thus enjoy access to healthcare as described above. They are entitled to emergency care and maternal care during pregnancy and childbirth, as well as vaccination. In contrast to asylum seekers, however, they do not have the possibility to get full access after 15 months of residency, for two reasons: by definition, the time of residence of undocumented migrants is not documented and thus a change in status cannot be claimed. Moreover, attempting to obtain documentation bears a high risk of detection and detention.

In sum: Undocumented migrants are in fact not included in the health care system, and entitlements beyond emergency care are only theoretical. With the exception of emergency care, services are not covered but have to be paid in full by the user, or by the charity of individuals or humanitarian organizations.

Special exemptions

Maternal care during pregnancy and childbirth; selected vaccinations (cf. above).

Barriers to obtaining entitlement

Undocumented migrants wishing to exercise their entitlement according to AsylbLG § 4 have to access municipal social assistance offices, which means facing the risk of detection and/or detention. According to § 87 Residence Act (*Aufenthaltsgesetz*), employees of public institutions have to report undocumented migrants to immigration authorities. Physicians and assisting staff in public institutions (including administrative employees) are, in theory, exempted from this obligation (§ 88 Residence Act, reform in 2010). For administrative and financial reasons, however, the hospitals have to claim reimbursement of their expenses by providing personal information at the municipal social assistance office, and the exchange of information between municipal social assistance office and immigration authorities is permitted. (except in the case of emergency treatment) (details below: 'obligation to report undocumented migrants'). Another barrier is the administrative discretion inherent in decisions about what constitutes an 'emergency.'

In sum: Administrative barriers and subjection to the individual discretion of health professionals and administrative staff are huge obstacles for undocumented migrants' access to health care in Germany. The legal entitlement according to AsylbLG is rather theoretical, as long as the obligation to report undocumented migrants in § 87 Residence Act is in effect. A positive development is that this obligation was cancelled for the area of education in 2011. The question remains, however, why this exemption has not been extended to the health sector as of yet.

In Germany, health care for undocumented migrants, but also of refugees and asylum seekers, depends largely on individual efforts, humanitarian aid (by institutions like Medinetz, Malteser Migranten Medizin or polyclinics run by advanced medical students who treat patients under the close supervision of experienced physicians, as in Frankfurt/Main). The almost complete *de facto* exclusion of undocumented migrants from health care and the limited access for asylum seekers has been an issue of public debate and advocacy since many years, but the claims of, for example, physicians and civil

society articulated already in 2001 for a political solution of this situation – unacceptable from medical, ethical and human rights perspectives – have not as yet been met (Bühning 2001, Bühning 2004, PICUM 2007, Knipper & Bilgin 2009, PICUM 2014).

6. POLICIES TO FACILITATE ACCESS

Score 30 Ranking ●○○○○○

Information for service providers about migrants' entitlements

Hospitals and other service providers do not receive any systematic and practical information about the entitlements of migrant groups, e.g. according to legal status.

Information for migrants concerning entitlements and use of health services

There is no comprehensive and systematic dissemination of information for migrants on any of the relevant levels. Some initiatives exist, however, such as a growing amount of information on the website of the Federal Office for Migration and Refugees (*Bundesamt für Migration und Flüchtlinge*, or BAMF) with general information on 'health and preventive healthcare' for migrants, however it is available only in English, Russian, and Turkish (BAMF 2015a). An important source of information (via brochures, etc.) is the Federal Centre for Health Education (*Bundeszentrale für Gesundheitliche Aufklärung*, BZgA). On the BZgA website, information materials in several foreign languages are provided on multiple topics - especially from the field of preventive medicine (hygiene, infectious disease, reproductive health, and family planning) (BZgA 2015). An information sheet on HIV transmission and prevention is even offered in 28 languages. Notwithstanding, specific information for migrants concerning entitlements and the use of health services is not provided. Several health insurance companies also provide this kind of information to their insurance holders with a migration background, in keeping with their legal obligation to offer information and advice to their members (SGB I, §13-15).

Other and partially more specific sources of information exist on federal and local level, through websites, brochures, and other means. Some municipalities (e.g. Cologne, Münster, Paderborn, Giessen) offer printed, multilingual 'health guides' (*Gesundheitswegweiser*) for migrants, containing information on local health care providers with particular language skills and other helpful information. However, funding is often granted for only short periods of time, or by external donors, so that often the outdated versions of such 'health guides' cannot be updated or replaced. Cities like Frankfurt, Bremen, and Munich offer comprehensive information and services through specialized offices and programs on health related topics for migrants (including undocumented migrants).

In sum, the situation is largely heterogeneous and fragmented, depending on decisions and commitment on individual and local authority level. Ultimately, vulnerable populations such as undocumented migrants remain largely neglected.

Health education and health promotion for migrants

See previous section.

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

In some places, 'patient navigators' (often migrants themselves) are trained, the most prominent example being the *MiMi* project developed by the NGO *Ethnomedizinisches Zentrum* in Hannover. Another such project is *SprInt*, an initiative for the qualification of linguistic and cultural mediators

(*Sprach- und Integrationsmittler*), who are then trained in health issues, led by Diakonie Wuppertal with financial support of BAMF and European Union. Both projects, however, lack long term funding so that the sustainability of these initiatives is compromised. The provision of ‘cultural mediators’ or ‘patient navigators’ in Germany is thus unreliable and depends on local initiatives with insecure funding.

Is there an obligation to report undocumented migrants?

A major obstacle for access to health care for undocumented migrants is the legal requirement that public institutions have to report to immigration authorities immediately if they get knowledge about the non-regular immigration status of a foreigner (§ 87 Residence Act, *Aufenthaltsgesetz*). This applies to health professionals and administrative staff in health facilities if these are public hospitals or other public institutions (e.g. municipal public health authorities). Physicians are exempted from this duty because of professional discretion. Employees of private or non-state institutions are also exempted, and even in public institutions information about residence status must only be asked for if this is relevant for fulfilling professional duties (e.g., obtaining reimbursement from the social welfare office). Moreover, since 2009, health professionals as well as administrative staff of health providers and public institutions (including social welfare offices) are also exempted from the obligation to report in case of medical emergencies. However, the complicated legal provisions stipulated in §87 Residence Act lead to uncertainty among health professionals and administrative staff regarding the obligation to report, and for even more insecurity, fear, and distrust among undocumented migrants. As already mentioned, this is a major obstacle to undocumented migrants’ healthcare access.

Are there any sanctions against helping undocumented migrants?

This question has been a topic of broad concern among health professionals in Germany until recently, because providing medical aid can and has been legally construed as ‘support’ of undocumented migrants according to § 96 Residence Act, with the threat of legal prosecution or legal consequences. However, in recent years this interpretation of § 96 Residence Act, which originally addressed human trafficking, has not been applied any more against physicians and other health care professionals. Insecurity and fear of prosecution, however, persist.

7. RESPONSIVE HEALTH SERVICES

Score 58 Ranking⁶ ●●●●●

Interpretation services

Qualified interpreters are available at several institutions, especially in regions with high numbers of migrants. However, in many places this option is not available. Availability, quality, and cost coverage, as well as interpreter qualification vary widely with no systematic structure or policy in place. The quality of communication across language barriers is still a matter of chance, with high risk of communication errors and misunderstandings, as well as insecurity about possible financial charges to the patients.

The new federal law on patients' rights avoids a clear statement on the financial responsibility for translator services (amendment of German Civil Code: *Bürgerliches Gesetzbuch*, 20 February 2013). It only states that the care provider has to assure that patients' information is 'comprehensible' (BGB § 630e, 2.1). Current legal debates tend to place the financial burden of interpretation services on patients (Wienke & Sailer 2013). In conclusion, the availability of qualified interpreters in Germany free of charge is still an exception that proves the rule, though progress can be detected due to the individual engagement of people or institutions. Insecurity regarding quality of interpreting competencies and costs remains.

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

Regarding guidelines and standards, the 'National Action Plan for Integration' issued by the German federal government in 2008 does not contain explicit guidelines concerning culturally competent health services (including qualified interpretation services). However, several independent groups and institutions have issued standards and guidelines. There is no coherent policy or systematic assessment of compliance with these standards. Some examples of guidelines are Borde & David (2004), Machleidt et al. (2006), Sievers et al. (2009), Bundesarbeitskreis Migration & Öffentliche Gesundheit (2012), Peters et al. (2014) and Droste et al. (2015).

Training and education of health service staff

Training in 'cultural competence,' or other education programmes for health service staff to increase the preparedness to provide or organize health care in a socially and culturally diverse society, depends strongly on local initiatives. Only in nursing schools is training in 'cultural competence' or 'transcultural nursing' rather well established. In medical schools, by contrast, only a few universities offer such courses for future physicians (e.g., Düsseldorf, Hamburg, Giessen), and even then mainly as electives. However, the recently released German 'Catalogue of Competency Based Learning Objectives for Medical Education' (*Nationaler Kompetenzbasierter Lernzielkatalog Medizin, or NKLm*, 2015) includes a series of learning goals related to cultural competence and cross-cultural communication and interpreting. In-house training is provided by several hospitals, yet depends on the priority given to this

⁶ It should be borne in mind that this ranking is relative to the other European countries in the study, which together have a low average score (eight of them score zero). Germany shares the fourth place with Sweden, Norway and Ireland, behind the UK, Austria and Switzerland. Although it is ranked highly, only slightly more than half of the requirements for a responsive health system (58%) are fulfilled. See the graph on p. 73 of the Summary Report (<http://bit.ly/2g0GIRd>).

topic by individual actors and hospital or institutional management. Even in regions with high numbers of migrants, systematic approaches or training cannot necessarily be found.

Involvement of migrants

Involvement of migrants depends highly on local initiatives and no systematic approach on a national level exists. One important but also limited example is the project 'MiMi' that has already been mentioned above. Other initiatives exist at many other sites, following the engagement of individuals, immigrant groups, federations and other institutions and actors.

Encouraging diversity in the health service workforce

Initiatives to encourage diversity in health care delivery only exist on a local basis, both in hospitals and the offices or polyclinics of statutory health insurance and/or private physicians. However, even the quality of training and support for foreign health professionals who are hired to work in Germany to meet the growing demand for physicians and nurses is an issue of individual engagement by local actors and institutions. It is not embedded in a systematic approach for encouraging diversity in the health services workforce. Moreover, policies do not support the systematic involvement of migrants in information provision, service design, and delivery.

Development of capacity and methods

Adaptation of diagnostic procedures and treatment methods to diverse patient groups is possible, but depends on local actors or specific institutions. In various hospitals (e.g., Giessen University Hospital, Vitos Marburg, and others) mental health services adapted to the needs of migrants and refugees are offered. In 2013 the Federal College of Physicians issued recommendations for treating victims of female genital mutilation (FGM) (BÄK 2013). A number of centres and expert groups dedicated to treatment of traumatized refugees and victims of torture exist throughout the country, e.g., in Berlin, Düsseldorf, Frankfurt, Giessen, Ulm. In this field, too, activities are fragmented. A coherent policy or sustainable political support beyond individual project funding does not exist.

8. MEASURES TO ACHIEVE CHANGE

Score 33 Ranking ●●●○○

As described in relation to the other fields of interest above, Germany has no comprehensive nationwide approach to promoting adequate policies on healthcare for diverse migrant groups.

Data collection

Epidemiological research in this area is methodologically demanding and the use of routing data, which for practical reasons is the most feasible method, has limitations (Schenk & Neuhauser 2005, Zeeb & Razum 2006, Razum et al. 2008). An important attempt to advance epidemiological knowledge and methodologies was the KiGGS (*Kinder- und Jugend-Gesundheitssurvey*), a longitudinal study conducted by the Robert Koch Institute (RKI) on the health of children and adolescents in Germany. It started with a baseline study 2003-2006 that included a systematic and differentiated assessment of 'migration background' (Kamtsiuris et al. 2007, Schenk et al. 2007, KiGGS 2015).

Support for research

Even though funding for migration-related research projects has increased, research and surveillance on migrant health are still not sufficiently developed and established. Migrants are a heterogeneous group with very different legal, social, economic, and cultural conditions among different groups (regular migrants, refugees and asylum seekers, undocumented migrants) and within these groups. Research reflecting the diverse needs and risks of this group would require long-term planning and commitment. Sustainable funding for research and surveillance is needed.

"Health in all policies" approach

A 'health in all policies' approach as defined by WHO (cf. McQueen et al. 2012) - one that systematically addresses migrants' health issues in sectors other than health - hardly exists in Germany. With respect to important fields like immigration and residence laws, health issues are not even considered, as demonstrated by the limits of entitlement to health care defined in §4 and § 6 the Asylum Seekers' Benefits Act (AsylbLG) and the complicated reporting obligations of undocumented migrants in § 87 of Residence Act.

Whole organisation approach

The implementation of 'whole organization approaches' is left to individual initiatives, groups or departments, even in regions with high numbers of migrants.

Leadership by government

At the policy level, there is a serious lack of leadership by the national and federal governments. Health is not a priority in governmental policies on migration. However, the Federal Government Commissioner for Integration, Aydan Özoguz, has declared health the priority of her work at least for the year 2015.

Involvement of stakeholders

There is no systematic involvement of stakeholders in migrant health issues on national, federal, regional, or local level, though exceptions exist at different local sites due to the particular engagement of individuals or institutions. One important institution is a working group of particularly engaged individuals coordinated by the Federal Government Commissioner for Integration (*AK Migration und Öffentliche Gesundheit*).

Migrants' contribution to health policymaking

There is no systematic involvement of migrants or migrants' organizations on migrant health issues on national, federal, or regional/local level, though exceptions exist at different local sites due to the particular engagement of individuals or institutions.

CONCLUSIONS

There is a substantial lack of comprehensive and clear national structures, concepts, frameworks, and policies in health prevention and health care provision for migrant groups in Germany. Health care entitlements differ greatly according to legal status. While legal migrants enjoy entitlements equal to those of nationals, access to health care for asylum seekers and undocumented migrants is deficient. Only two federal states, Hamburg and Bremen, show strong commitment to facilitating equal access for all migrant groups and have demonstrated avenues for substantial improvements throughout Germany.

A great deal of confusion exists among health care providers, administrative staff, and even migrants themselves in terms of entitlements, health care organisation, and the legal obligation to report undocumented migrants. This results in a heightened sense of insecurity and creates substantial barriers to healthcare access.

The provision of information for the different migrant groups (including legal migrants) on organisation, legal aspects, and access to health care is only weakly developed on a national level and depends highly on local initiatives, authorities, and civil society. One useful option for improving the dissemination of information could be to make 'health' and healthcare entitlements an obligatory content in the compulsory 'integration courses' for non-EU migrants, offered by local institutions on behalf of the BAMF. This should also be extended to asylum seekers and undocumented migrants although it would not solve the legal access barriers they face (see below).

The same fragmentation and dependency on individual initiatives and funding applies to interpreter services, cultural mediators, and training in cultural competence of health care staff (with nursing schools being considerably more advanced than medical schools). Nevertheless, efforts are being made by multiple actors (individual and institutional) to improve the responsiveness of the system and to provide patient-oriented services according to the special needs of the diverse group of migrants.

Currently, the lack of political leadership and the complex (and occasionally contradictory) legal regulations pose massive barriers hindering the access of certain migrant groups to appropriate health care. A systematic and comprehensive strategy, based on internationally agreed standards and recommendations, is needed to substantially improve migrants' health in Germany, especially among the most vulnerable groups. The MIPEX Health strand is based on the Council of Europe's *Recommendations on Mobility, migration and access to health care* (2011), which in turn are rooted in human rights law. The fundamental question remains why Germany still refrains from adopting a systematic and coherent rights-based approach to migrants' health in its own country, while strongly promoting human rights based approaches to health as the basis of cooperation with developing countries abroad (BMZ 2009, Silberhorn 2015).

The situation that health promotion, prevention and access to care for migrants in Germany – especially (but not exclusively) for refugees and undocumented migrants – largely depends on individual efforts, humanitarian aid and NGOs like "Medibüros", "Malteser Migranten Medizin" or "Ethnomedizinisches Zentrum Hannover", is - from a medical and human rights perspective - not acceptable. Even economic arguments are not conclusive for defending in particular the restrictions defined by the Asylum Seekers'

Benefits Act (AsylbLG): research has shown that current regulations do not reduce, but actually increase, the costs of care (Bozorgmehr & Razum 2015).

Immediate improvements could be achieved by abolishing the restrictions regarding access to health care in §4 and 6 of the Asylum Seekers' Benefits Act (AsylbLG) and including this part of the resident population in Germany into the coverage of SGB V. Moreover, the reporting obligations concerning undocumented migrants in § 87 and 88 of the Residence Act should be lifted. Based on medical, ethical, human-rights and economic arguments, the amendment of the Asylum Seekers' Benefits Act (*Asylbewerberleistungsgesetz*) and Residency Act (*Aufenthaltsgesetz*) is overdue and strongly recommended.

BIBLIOGRAPHY

- BÄK (2013) *Empfehlungen zum Umgang mit Patientinnen nach weiblicher Genitalverstümmelung* [Female genital mutilation], Bundesärztekammer (BÄK), Stand: 18.01.2013. <http://bit.ly/2m9AYhd>
- BAMF (2015a) *Bundesamt für Migration und Flüchtlinge. Gesundheit und Vorsorge*. Berlin: Bundesamt für Migration und Flüchtlinge. <http://bit.ly/2ocnwy1>
- BAMF (2015b) *Asylgeschäftsstatistik für den Monat Dezember 2014*. Berlin: Bundesamt für Migration und Flüchtlinge. <http://bit.ly/2nPnY4x>
- BMG (2016) *Daten des Gesundheitswesens 2016*. Berlin, Bundesministerium für Gesundheit.
- BMZ (2009) *Gesundheit und Menschenrechte*. BMZ Spezial 1962. Bundesministerium für Wirtschaftliche Zusammenarbeit und Entwicklung (BMZ), Juli 2009.
- Borde T., David M. (2004) Checkliste "Interkulturelle Öffnung von Krankenhäusern und anderen Versorgungseinrichtungen", Berlin 2004. Available through Alice Salomon Hochschule Berlin, University of Applied Sciences. <http://bit.ly/2kAcYHV>
- 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. doi: 10.1371/journal.pone.0131483
- BPB (2015) *Soziale Situation in Deutschland: Krankenversicherungsschutz*. Bonn: Bundeszentrale für Politische Bildung. <http://bit.ly/2luAsh3>
- Bühning, P. (2001) Menschenrechte: "Das Problem wird einfach ausgeblendet". *Deutsches Ärzteblatt* 2001, 98(9): A-508.
- Bühning, P. (2004) Illegale Migranten: Nach Lösungen suchen. Forderungen nach anonymer medizinischer Versorgung und Rechtssicherheit für Ärzte und Krankenhäuser nehmen zu. *Deutsches Ärzteblatt* 101 (34-35): A-2294.
- Bundesarbeitskreis Migration & Öffentliche Gesundheit (2012) *Positionspapier*. Berlin: Bundesarbeitskreis Migration & Öffentliche Gesundheit. <http://bit.ly/2nni8UX>
- BZgA (2015) Bundeszentrale für gesundheitliche Aufklärung [Federal Centre for Health Education], *Gesundheitsförderung für Menschen mit Migrationshintergrund*. <http://bit.ly/2m9uLlq>
- DESTATIS (2006) *Leben in Deutschland - Mikrozensus 2005*. Wiesbaden: Statistisches Bundesamt (DESTATIS). <http://bit.ly/2kKxhgU>

- DESTATIS (2015a) *Bevölkerung und Erwerbstätigkeit. Bevölkerung mit Migrationshintergrund – Ergebnisse des Mikrozensus*. Wiesbaden: Statistisches Bundesamt (DESTATIS).
- DESTATIS (2015b) *Ausländische Bevölkerung*. Wiesbaden: Statistisches Bundesamt (DESTATIS). <http://bit.ly/2luM97b>
- Droste, M., Kemal Gün, A., Kiefer, H., Koch, E., Naimi, I., Heike Reinecke, H., Wächter M, Wesselman, E. (2015). *Das kultursensible Krankenhaus. Ansätze zur interkulturellen Öffnung*. Berlin: Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration. <http://bit.ly/2oeK6q3>
- Kalkmann M. (2015) *Country report: Germany* European Council of Refugees and Exiles (ECRE).
- Knipper M., Bilgin Y. (2009) *Migration und Gesundheit*. St. Augustin/Berlin: Konrad-Adenauer-Stiftung e.V.
- Kiggs (2015) *KiGGS – Studie zur Gesundheit von Kindern und Jugendlichen in Deutschland*. Robert-Koch-Institut, Berlin. <http://www.kiggs-studie.de/english/home.html>
- Leise E. (2007) *Germany Strives to Integrate Immigrants with New Policies*. Washington, DC: Migrant Information Source. <http://bit.ly/2mSDldj>
- Lindner K. (2015) Die gesundheitliche Versorgung von Asylsuchenden in Deutschland. Aktuelle politische Entwicklungen. *Migration und Soziale Arbeit* 1: 81-88.
- Macherey A. M. (2015) *Legal report on access to healthcare in 12 countries*. Brussels: Médecins du monde.
- Machleidt W., Garlipp P., Calliess I. T. (2005) Die 12 Sonnenberger Leitlinien – Handlungsimpulse für die psychiatrisch- psychotherapeutische Versorgung von Migranten. In: Assion, H.-J. (Ed.) *Migration und seelische Gesundheit*. Heidelberg: Springer, S., 215-230.
- Machleidt W., Salman R., Calliess I.T. (Eds.) (2006) *Sonnenberger Leitlinien. Integration von Migranten in Psychiatrie und Psychotherapie. Erfahrungen und Konzepte für Deutschland und Europa*. Berlin: VWB.
- Majcher I. and Flynn M. (2014) *The use of detention and alternatives to detention in Germany*. Study by the German National Contact Point for the European Migration Network (EMN), Federal Office for Migration and Refugees.
- McQueen D.V, Wismar M, Lin V., Jones C.M., Davies M. (Eds.) (2012) *Intersectoral Governance for Health in All Policies. Structures, actions and experiences*. Copenhagen: World Health Organization, European Observatory on Health Systems and Policies.
- Pelzer M. and Sextro U. (2013) *Abschiebungshaft in Deutschland* [Without protection behind bars. Detention pending deportation in Germany], Diakonie in Hessen und Nassau, Pro Asyl, eds. Schutzlos hinter Gittern.

- Peters T., Grützmann T., Bruchhausen W., Coors M., Jacobs F., Kaelin F., Knipper M., Kressing F., Neitzke G. (2014) Grundsätze zum Umgang mit Interkulturalität in Einrichtungen des Gesundheitswesens: Positionspapier der Arbeitsgruppe Interkulturalität in der medizinischen Praxis in der Akademie für Ethik in der Medizin. *Ethik in der Medizin* 26: 65-75.
DOI 10.1007/s00481-013-0289-x
- PICUM (2007) *Report of PICUM International Conference on Access to Health Care for Undocumented Migrants in Europe*. Platform for International Cooperation on Undocumented Migrants (PICUM), Brussels.
- Razum O., Zeeb H., Meesmann U. et al. (2008) *Migration und Gesundheit. Schwerpunktbericht der Gesundheitsberichterstattung des Bundes*. Berlin: Robert Koch-Institut.
- Razum, O., & Bozorgmehr, K. (2016) Restricted entitlements and access to health care for refugees and immigrants: The example of Germany. *Global Social Policy* 16(3), 321-324.
doi:10.1177/1468018116655267
- Schenk L., Neuhauser H. (2005) Methodische Standards für eine migrantensensible Forschung in der Epidemiologie. *Bundesgesundheitsblatt - Gesundheitsforschung – Gesundheitsschutz* 48(3): 279-286.
- Schenk L., Ellert U., Neuhauser H. (2007) Kinder und Jugendliche mit Migrationshintergrund in Deutschland. Methodische Aspekte im Kinder- und Jugendgesundheitsurvey. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* 50 (5/6): 590–599.
- Sievers E., Aksu F., Ipsiroglu O. et al. (2009) *Positionspapier des Fachausschusses Transkulturelle Pädiatrie der Deutschen Gesellschaft für Sozialpädiatrie und Jugendmedizin (DGSPJ): Transkulturelle Pädiatrie – aktuelle Perspektiven und Handlungsoptionen*. Datteln: Deutsche Gesellschaft für Sozialpädiatrie und Jugendmedizin. <http://bit.ly/2njFo5l>
- Silberhorn T. (2015) Germany's Experience in Supporting and Implementing Human Rights-Based Approaches to Health, plus Challenges and Successes in Demonstrating Impact on Health Outcomes. *Health and Human Rights* 17(2):21–29.
- van Ginneken, E. (2015) Health care access for undocumented migrants in Europe leaves much to be desired. *Eurohealth Observer* 20(4), 11-14.
- Wienke A., Sailer R. (2013), Aufklärung und Behandlung trotz Sprachbarriere: Wer trägt die Dolmetscherkosten? *Hessisches Ärzteblatt* 2013, 11: 846-847.
- Woods K. (2014) *Immigration Detention in Germany*. Country Detention Reports, Global Detention Project, Geneva.
- Zeeb, H., & Razum, O. (2006) *Epidemiologische Studien in der Migrationsforschung - ein einleitender Überblick* [Epidemiological research on migrant health in Germany. An overview]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz* 49(9): 845-852.





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