

Health Care Policy and Provisions to Illegal Immigrants in Germany
A Comparative Approach
September 2006

Pascal Beckers^a
with contributions by Zina Nimeh and Frieda Vandeninden^b

ABSTRACT

This paper discusses the contradictory setting of health care policy and provisions for illegal immigrants in Germany. It sheds light on the current health care policy for illegal immigrants and explains the resulting outcome of health provisions. Furthermore, it provides a number of normative recommendations based on a European cross-country analysis of best practices.

^a Pascal Beckers, Research Fellow, Graduate School of Governance, Maastricht University, The Netherlands

^b Research Fellows, Graduate School of Governance, Maastricht University, The Netherlands

1) Introduction

As border controls are tightening access to the European Union, this seems to have little impact on inflow of illegal immigrants. It is estimated that every year between 300,000 and 500,000 migrants try to enter the “Fortress of Europe” via the Straits of Gibraltar (Harris, 2001). For those surviving the journeys, the future ahead certainly is not an easy one as human rights are sacrificed in the process of illegal immigration.

Despite growing political concern with illegal immigrants, the policy response in Europe and – as shall be argued – particularly in Germany has been rather limited. Main policy focus has been on improved border controls, and greater fines on employers, carriers, and people trafficking of illegal immigrants. However, policies so far have failed to address the underlying causes of illegal immigration, which are to do with globalization of production processes creating a need for cheap labor in Western countries. As rightly stated by Taran and Geonimi (2003:7), this provides a fertile ground for an illegal immigration market:

‘ ... basic labour economics theory would suggest that placing restrictive barriers between high demand and large supply creates a potentially lucrative market for services of getting the supply to where the demand is.’

Unfortunately, while illegal immigrants enjoy little state protection, they commonly find employment in the so-called ‘three-d’ jobs (i.e. dangerous, dirty and degrading) of the secondary labor market in industries such as construction, agriculture, domestic work, textiles, and hospitality (Taran, 2000). For instance, it is estimated that in 1994 the German construction industry alone employed some 500,000 illegal immigrants, many of which worked for low wages.

Relating to their often critical employment and overall living conditions, illegal immigrants in particular are facing increased health-related risks, which current legislations across EU member countries do not seem to sufficiently

account for as this population group is generally not eligible to social insurance schemes.

This paper outlines the peculiar setting surrounding health care policy and provisions for illegal immigrants in Germany, where the issue has recently attracted considerable political attention. First, some general estimations on illegal immigrants in Germany are provided; second, it is argued why health provisions to this population group are important; third, current health policy and provisions as well as the related outcomes are discussed; finally, a number of policy recommendations are formulated, which are the result of a European cross-country analysis of best practices.

2) Illegal Immigrants in Germany

According to German law (Aufenthaltsgesetz Paragraph 4 Article 1) a foreigner can remain legally in the country by one of the following ways: 1- a short term visa, 2- a permit and 3- a residency permit. When a foreigner does not have one of these permits, his or her status would be considered illegal. German provisions deal with three kinds of illegal immigrants. The first two groups are officially recorded by the government as foreigners who must leave the country, however are still residing in it. The third group, which we are focusing on, is defined as the illegal immigrants who are not recorded in the government register.

The German Federal Bureau for Migration and Refugees classifies four methods of entry which result in an illegal status (*Worbs, 2005*):

- 1- Those who enter the country with a legally acquired visa or without the need for an entry visa and exceed the permitted duration of their legal stay
- 2- Those who enter with falsified documents
- 3- Those who obtain a visa by presenting falsified documents
- 4- Those who manage to enter without any documents or visas

The total population in Germany is 82 million, and despite the fact that illegal immigrants are not accounted for by official sources, various academic estimations propose a number between 100,000 (Lederer, 2004) to more than 1,000,000 illegal immigrants (Cyrus, 2004).

Despite the great spread of these estimates, a number of key factors are thought to influence the origin country-wise decomposition of the illegal immigrant community. First, it is likely that this composition is related to the relative size of legal migrants already residing in Germany. Already in Germany living family members, friends and countrymen can play key roles in the illegal immigration process providing housing and other support. Second, a key factor seems to be the admission and visa regulations to Germany, which differ greatly by origin country. For instance, according to European Law (Paragraph 2 Article 4 FreizügG/EU), from 1 January 2005 on citizens of EU member states can freely reside in Germany without a required permit. Citizens of certain other countries (i.e. Rumania) do not require an entrance visa and are thus encountered in particular frequency as illegal residents during controls.

Based on a consolidation of various criminal statistics, Cyrus (2004) comes up with a number of interesting projections regarding the origin, age, gender, and geographic spread of illegal immigrants in Germany. The largest group of illegal immigrants in Germany originates from the countries of middle and eastern Europe, which commonly migrate back and forth between Germany and their home countries. A great share of the illegals entered Germany without the visa requirement (i.e. citizens of the new EU member states) or with a falsified visa. A second group of illegal immigrants originates from visa required countries that have strong legal immigrant ties with Germany, such as Turkey, the former Jugoslavia, the Russian Federation, Ukraine, and Vietnam. For this group a significant link was found to family members and ethnic communities living in Germany, which aid in the process. A third group of illegal immigrants originates from further away politically and/or economically instable countries. This includes for instance the origin countries

of China, Irak, Afghanistan, India, as well as various countries in the African and Latin American regions. A common practise of entering Germany seems to be assylum seeking that upon rejection is followed by illegal residency. With respect to the age composition, it is estimated that, while people over 40 and children comprise some percentage of the illegal immigrants, according to Cyrus (2004) the majority of illegal immigrants fall within the age range of 20-40. However, it appears that the number of children residing illegally in Germany has increased in the recent past, which is suggested by the increased significance of pregnancies in the work of medical facilities providing care for illegal immigrants. With respect to gender composition, on the overall, the greater share of illegal immigrants seems to be male, while the gender division in specific regions is related to the local job market. For instance, women tend to be commonly employed as private household support and are thus less often detected in the former region of Eastern Germany where service demand is lower. Geographically speaking, illegal immigrants mainly reside in the major German cities such as Berlin, Munich, Hamburg and Cologne and there are some states which are thought to have a larger percentage of illegal immigrants. These include Brandenburg, Sachsen and Mecklenburg-Vorpommern, followed by Hessen, Schleswig-Holstein and Bavaria (Bundeskriminalamt, 2004). This pattern could be attributed to a number of reasons. First, it is clear that since these data are extracted from the criminal statistics, states with external borders tend to have higher numbers of illegal immigrant detentions. Second, illegal immigrants tend to reside in urban rather than rural areas due to the greater availability of work opportunities, housing, and the existence of social networks of ethnic communities. Third, different ethnic groups of illegal immigrants seem to have different geographical centres. Asian illegals tend to be most commonly found in the Rhein-Main region; African illegals are rather found in northern and southern German cities; Latin American illegals tend to be evenly spread across German cities. Furthermore, Polish and Turkish illegal immigrants are overproportionally detected in the states of Berlin and Northrhine-Westfalia, where their largest legal ethnic communities are found, respectively.

3) Provision of Health Care to Illegal Immigrants – Why Should We Care?

Given the steady increase of illegal immigrants in Germany, the issue becomes an ever more important topic of public debate. It seems that especially for the case of the USA, the public burden imposed by illegal immigrants has reached critical dimensions (i.e. Pelner Cosman, 2005; Bastiat, 1995; Federation for American Immigration Reform, 2005). While Cosman argues that intensification of border controls and increased punitive measures will solve the US illegal immigrants problem, we believe that this is not addressing the cause of the problem, namely the unmet demand for low wage workers. Furthermore, while the problem of illegal immigrants is unlikely to be solved in the short term, we must not forget about two important reasons for host countries to provide health care services to illegal immigrants.

a. Health Care - a basic human right?

According to the Universal Declaration of Human Rights, adopted by the United Nations in 1948, “everyone has the right to a standard of living adequate for the health and well-being of oneself and one’s family, including food, clothing, housing, and medical care.” (UDHR Article 25-1) This section states explicitly that everyone in need has a right to health care, but does this apply to those who are illegally residing in a country? Although, the UN Declaration of Human Rights applies to all people including in principle illegal residents, these rights are not legally binding, even though they have significantly affected national policy making. In 1966 these rights were to a large extent made legally binding through their incorporation into the International Covenant on Civil and Political Rights as well as into the Covenant on Economic, Social and Cultural Rights. However, although Germany ratified these International Covenants, the rights constitute state obligations and cannot be enforced by individual legal action. Furthermore, while the basic rights incorporated into German constitution of 1949 (Grundgesetz) are legally enforceable, they do not apply to illegal immigrants (Sinn et al., 2005). This scenario clearly puts illegal immigrants into a critical situation.

b. Health – a public concern?

As has become clear from the US-American experience, health provisions to illegal immigrants ought to be of public interest to host countries. This statement is based on the fact that the health situation of illegal immigrants is not separable from the health situation of the national population. Since interactions between these population groups occur, this implies that the health status of the two groups cannot independently be addressed. This line of reasoning is in line with Rein's poverty as externality approach (1970), which argues for the interdependency of utility functions of the various groups constituting society. Two arguments stress the importance of adequate health care provisions to illegal immigrants. First, Illegal immigrants – since they have not been subjected to any type of medical screening upon entering their host countries – may carry contagious diseases that are present in their countries of origin. US-based studies have for instance pointed to illegal immigrants as the single most prominent cause of the reoccurrence of long-gone diseases such as tuberculosis and leprosy (Walker, 2006; Perner Cosman, 2005). Second, since illegal immigrants in their host countries cannot easily seek medical care, their imported as well as newly acquired illnesses are likely to become more severe over time. Contagious diseases can easily spread through the tightly knit ethnic communities and eventually pose a considerable threat to society. Given this risk, the provision of adequate health care to illegal immigrants ought to be a prime concern of immigration countries such as Germany (Wiedl and Marschalck, 2001; Deutsche Bischofskonferenz, 2001; Münz et al., 2001).

4) German Policy for offering Health Care to Illegal Immigrants

According to the Asylum Seekers Benefits Act (Asylbewerberleistungsgesetz) illegal immigrants, in case of emergency, have the same right to seek medical treatment just like anyone residing legally in Germany (Schönwälder et al., 2004). This act furthermore obligates the social welfare offices to cover the

costs for certain services, which are defined in §§ 3 and 4 AsylbL (Cyrus, 2004).

Despite illegal immigrants' rights to health care, these services are infrequently used. The problem lies in two clauses of the German immigration law which makes it mandatory for public institutions such as hospitals to pass on information about illegal immigrants to social affairs offices and in turn to the Ministry of the Interior (i.e. § 87 AufenthG, chapter 3.2.2; Article 76 of the AuslG). Therefore, doctors who help undocumented people access basic health services may be penalized for not reporting them. Article 76 reads as follows (PICUM, 2002: 44-45):

Transmission to registration office for foreigners:

(2) Public boards must inform the registration office of foreigners if they receive knowledge of:

- a. the stay of a foreigner who does not have any kind of residence permit or Duldung (i.e. temporary suspension of deportation)
- b. the offence against a local restriction or
- c. any other reason for deportation (...)

(5) The Federal Ministry of the Interior lays down (...) that all

- a. registration offices
- b. offices for state affairs
- c. passport offices
- d. social services and youth boards
- e. justice, police and offices for regulation
- f. job centres
- g. revenue and declaration offices
- h. trading offices, must without any request of the registration office for foreigners, inform them of all personal facts of a foreigner.

According to Fudor (2001), the obligation to report illegal immigrants extends only to public authorities but does not apply to general practitioners or public hospitals. However, he points to yet another critical clause in German

immigration policy (i.e. § 96 AufenthG), which puts people at punitive risk while providing humanitarian assistance to illegal immigrants. The clause states more specifically that the assistance of a foreigner in entering the country illegally or the instigation or support of illegal stay are penalised. It is not entirely clear, however, as to whether doctors providing health care to illegal immigrants incur a penalty. This would depend on the impact of the medical treatment on the illegal stay. Thus, if the treatment makes the illegal stay more likely, it is clearly subject to penalty as is the case for repeated support to several illegals. While on the one hand doctors have the professional obligation, conscience, principles of medical ethics and humanity, to help illegal immigrants, on the other hand they face unpaid medical bills and the risk of legal consequences for their profession as a consequence of illegal treatment (Groß, 2005). Since in the German health system, treatment costs are reimbursed by the obligatory patient's insurance provider, uncovered illegal immigrants generally do not have the means to pay for service. Therefore the treatment facility must find other means to cover for the costs, if they choose to treat them.

Under certain circumstances, it is legally permissible for illegal immigrants to make use of health care services. For instance in the case of infectious diseases a relatively new law (Infektionsschutzgesetz) states that severe infections (i.e. tuberculosis) are diagnosed and treated anonymously and free of charge at public health offices. In a similar fashion, sexually transmitted diseases (i.e. syphilis, gonorrhoea, HIV/AIDS) are diagnosed without required proof of lawful residence. The treatment of these diseases, however, is not necessarily paid for unless individuals possess a legal Duldung (i.e. temporary residence permit before deportation). Related to this, pregnant illegal immigrants can apply for Duldung to remain within Germany and receive maternal care from six weeks prior to eight weeks post delivery. Naturally, this 14-week period is likely to be followed by deportation. As a final remark, illegal immigrants are entitled to seek emergency medical care in public hospitals and by general practitioners, which is often referenced by politicians to justify the adequacy of German health provisions to illegal immigrants (Braun and Würflinger, 2001). However, as the following section shall eluminate, the

actual outcome of health care provisions to illegal immigrants greatly diverges from this theoretical scenario.

5) Consequences of Health Care Policy

A number of consequences result from the peculiar legal situation surrounding health care provisions to illegal immigrant in Germany. First, the risky as well as costly provisions of health services to illegal immigrants by general practitioners have led a great number of them to seize treatment of this population group. Second, as a consequence of unmet health needs, a number of charitable organisations have entered the scenes, which do not fear punitive consequences of their operations (Sinn, 2005). These charitable organisations include a number of anti-racists and refugee rights networks, which refer illegals to sympathetic doctors who treat them for free or affordable costs (Kieser et al., 2000). Two successful examples in Berlin have been the Büro für medizinische Flüchtlingshilfe, established in 1996, and the Malteser Migranten Medizin, established in 2001 (Malteser Hilfsdienst, 2005). Both offices have successfully been proving their services to a steadily increasing amount of people. Furthermore, a cooperation of a number of anti-racist, non-governmental organisations currently supports around 10 offices providing health care to illegal immigrants under the campaign 'Kein Mensch ist illegal' (i.e. Nobody is illegal). Interestingly, it seems that these charitable organisations are tolerated by the authorities, possibly because of the concern for people's health, or since they absorb costs that might otherwise be incurred by the state. Third, despite the provisions by charitable organisations, due to fear of being detected or losing their jobs, many illegal immigrants who might need urgent medical care postpone seeking medical treatment or end up not getting it altogether (Hofer, 1993; Anderson, 2003). Considering the particularly harsh living conditions of many illegal immigrants as a result of employment instability, physically demanding and dangerous employment, and the low degree of enforceability of occupational health and safety regulations, this scenario provides considerable reason to be concerned. In fact, as a result of postponing medical treatment or not receiving it, the

medical condition of the illegal immigrants may deteriorate considerably as time passes, this in turn could have an adverse impact both on their community and the society as a whole. This is especially true when we are talking about communicable diseases such as Tuberculosis and AIDS that could have been contained had proper medical treatment taken place at an early stage (Münz et al., 2001).

Scott (2004) presents an interesting overview of the actual health care seeking behaviour of illegal immigrants at various medical providers, which clearly demonstrates the inherent gap between the theoretical scenario of health care provisions to illegal immigrants and the actual policy outcomes. Given the risk of being detected, in the initial stage of illness, illegal immigrants tend to approach members of their own networks seeking adequate health treatment by outside professionals far too late for effective treatment to occur (Braun and Würflinger, 2001). To access medical services, at times the practise of borrowing health insurance cards of friends or family members is used. Despite the legal obligation of hospitals and general practitioners to provide emergency health support to illegal immigrants, in practise this is not necessarily the case. Often medical providers do not willingly commense treatment without prior safeguarding of financial cost recovery. Other common scenarios, as outlined in Scott (2004, 23-24) are the following:

- hospitals retaining personal documents of patients such as passports in an effort to ensure payment
- hospitals calling the police at the point of admission in order to ascertain residence and insurance status before treatment begins. Deportation is, therefore, inevitable, once they have been treated;
- hospitals arranging “deportation” of undocumented patients at their own cost by sending them by ambulance to countries such as Poland or the Ukraine, since transportation is less expensive than hospital treatment in Germany;
- physicians and hospitals have admitted that if insurance and residence status could not be established in advance, then there was a qualitative

- difference in the standard of treatment offered e.g. a fracture would be treated with a plaster dressing instead of being surgically treated;
- undocumented migrants discharging themselves from hospital before treatment has been completed out of a fear of being deported.

As a consequence, often not even severe illnesses of illegal immigrants are attended to, which effectively prohibits this population group from realising their basic human right to adequate health care provisions.

6) Different Country Approaches for providing Health Care to Illegal Immigrants

For the purposes of this paper we looked at the countries of the Netherlands and Italy. Both countries offer unique initiatives with respect to health provisions for illegal immigrants that might be of potential benefit if incorporated into the German system. We shall further explore these measures, namely the provision of anonymous health cards to illegal immigrants in Italy, and the initiation of a health expenditure fund in the Netherlands.

The current Italian immigration policy dates back to the Turco-Napolitano Act of 1998, which subsequently was reformed to its 2002 final state. The Act is based on four pillars, namely 1. prevention and combating of illegal entry; 2. regulation of new flows of foreign workers; 3. promotion of the integration of immigrants holding a valid residence permit; and 4. granting of basic individual right to illegal immigrants (Zincone & Caponio, 2005). It is the fourth pillar that addresses the right to health care for illegal immigrants (DPR no. 394/1999, art. 43). It states that they are entitled to be granted an anonymous health card, which entitles to the access of the following basic health services (Devillanova, 2004): emergency and first aid, and essential treatments (i.e. treatments of potentially worsening pathologies; pre- and post-birth maternal care; geriatrics and pediatrics). Given the public financing of the health care system, regionally coordinated health services are easily be made accessible upon registration with local authorities. However, in the case of illegal

immigrants, the option is given to gain access through registration with the national health bureau, which then provides individuals with a national health card valid in the whole country. Interestingly, their official status is recorded as temporary foreign residents in Italy (Straniero Temporaneamente Presente, STP). It is important to note that according to Italian law, the reporting of illegal immigrants upon card registration is explicitly prohibited (Cyrus, 2004). As a result, the Italian model of health provisions to illegal immigrants seems to work successfully. While service providers are reimbursed for treatment costs and thus do not face financial disincentives for health provisions, at the same time illegal immigrants are less inclined to avoid treatment.

The Netherlands presents a unique option for health care financing of illegal immigrants, which was a response to the in 1998 approved Koppelingswet (i.e. Linkage Law). According to the Koppelingswet, foreigners without legal residence permit were to be excluded from health insurance. This resulted in a challenging situation both for medical providers as for illegal immigrants. On the one hand, medical providers had the continued obligation to provide health support to all human beings in cases of emergency. On the other hand, they no longer were provided with the financial means to cover treatment costs for illegal immigrants. Next to the impact on medical providers, illegal immigrants were effectively deprived of their human rights to health as health-related risk was individualized for this population group (Pluymen & Minderhoud, 2002 – in Cyrus). A precondition to the acceptance of the Koppelingwet in 1998 was that medical care was still available in case of 'urgent need' as well as for the prevention of public health danger (i.e. Article 8b of the Dutch Aliens Act). The following medical conditions are publicly financed (PICUM, 2002):

- In case – or for prevention – of life threatening situations, or in case – or for prevention – of situations of permanent loss of essential functions.
- In case there is a danger for a third party, e.g. certain contagious diseases (in particular TB) and for psychological disturbances and consequent aggressive behaviour.
- Pregnancy care (before and during birth).

- Access for children without a status to preventive Health Care and to a vaccination programme similar to the national vaccination programme.

To ensure that these medical costs were not to be born by the providers, two legal provisions were implemented by the government. First, the Koppelingsfonds (i.e. Linkage Fund), with an initial budget of € 5 million was set up to cover primary medical costs, such as doctors, obstetricians and pharmacies. For the purpose of fund administration a not-for-profit, independent body was created (Stichting Koppeling), which is in charge of negotiating the fund's yearly budget, with doctors' and pharmacies' associations. Medical service providers can then approach their respective association to claim for reimbursement of expenditures at the end of the year. To receive reimbursement, they need to ensure that 1. the medical help was necessary and imposed a substantial financial burden upon the provider ; 2. the patients could not pay for treatment and was not eligible for health insurance. Possibly related to a high degree of bureaucracy surrounding the reimbursement procedure or the low degree of financial burden of treatments on the providers, the fond was actually only partially used in its initial phase. Another reason for this might have been that illegal immigrants did not trust the system as other sections of the Dutch law require doctors to eventually report illegal immigrants after treatment (Worbs, 2005). As a second legal provision, the government enabled hospitals, reha centres and ambulatory health clinics to set up a budget to cover for unpaid bills (i.e. dubieuze debiteuren) from treatment of illegal immigrants. This budget is set up and negotiated on an annual basis between these providers and insurance companies as a means of equal cost spreading for treatment of illegal immigrants (Cyrus, 2004).

7) Conclusion and Recommendation

Health Care should be a right not a privilege as adopted by the Universal Declaration of Human Rights. This should apply to everyone including illegal immigrants. While we acknowledge the problem of illegal immigration, this

problem is not resolved by preventing health care to this group. Furthermore, through the denial of health care to illegal immigrants, an even graver problem arises, namely the potential spread of disease in the immigrant population and eventually the society as whole. This alone should be a sufficient motivation for public health provisions to illegal immigrants.

In addition to the prior motivation, public financing of health care provisions to illegal immigrants is economically justifiable and legally appropriate. It is economically justifiable since, despite of not paying income taxes, illegal immigrants contribute to the economy: 1. directly through their work; and 2. indirectly through consumption tax. At the same time, the German government is legally required by the Asylum Seekers Benefits Act to finance the basic health provisions to this group and should thus assume unconditionally the treatment costs of medical practitioners.

To improve on the current scenario characterised by significant disincentives on part of the health providers as well as for illegal immigrants, we have three policy recommendations. First, we recommend the implementation of a Dutch-style health fund to be financed by the government, which alleviates the financial burden related to health care provisions for illegal immigrants. To limit the potential abuse of the fund and at the same time to ensure necessary medical coverage, the following medical conditions ought to be financed through the fund: 1. Emergency cases; 2. Communicable diseases; 3. Deteriorating medical conditions. Next to assuming financial responsibility, the government needs to provide the legal setting required for the effective functioning of the health provisions system. This translates into the following recommendations. Second, health treatment for illegal immigrants ought to be legalised, and third, health providers are not to report illegal immigrants upon treatment. It is important to realise that for the effective functioning of any health provisions system targeted at this population group, the latter two conditions are paramount. The findings of this study have clearly stressed that the threat of reporting in all sampled countries tended to prevent illegal immigrants from seeking proper medical care. Therefore it is safe to say that by separating the provision of health care from the reporting of illegal

immigrants, patients will be more willing to seek proper medical care. Among the countries we researched, Italy was the only country that does successfully separate provisions from reporting. Needless to mention, this separation would naturally be a requirement to the successful implementation of the Dutch-style health fund.

Finally, despite of the inherent success of the anonymous health cards in Italy, the model is unlikely to be implementable in the German structural setting. Whereas the Italian health care system is publicly financed, the German one is contribution financed. Thus, in the German system health provisions for illegal immigrants are far more likely to trigger public protest as people do not willingly accept the incurred costs to increase their contributions.

List of References

Articles and Reports:

- Aldous, J., *Refugee health in London – Key issues for public health*. The Health of Londoners Project, London, 1999.
- Anderson, P., “*Dass Sie uns nicht vergessen ...*” – *Menschen in der Illegalität in München*, Stelle für interkulturelle Zusammenarbeit, Sozialreferat, Landeshauptstadt München, 2003.
- Bastiat, F., *Selected Essays on Political Economy: What is Seen and What is Unseen*, Irvington-on-Hudson, N.Y., Foundation for Economic Education, 1995.
- Borjas, G., The Economic Benefits from Immigration, *Journal of Economic Perspectives* 1995; 9, 3-22.
- Borjas, G., The Economics of Immigration, *Journal of Economic Literature* 1994; 32, 1667-1717.
- Braun, T., & Würflinger, W., *Access to medical care for undocumented migrants in Germany*, Berlin, 2001.
- Bundeskriminalamt, *Polizeiliche Kriminalstatistik Bundesrepublik Deutschland - Berichtsjahr 2003*, Wiesbaden, 2004.
- Cyrus, N., *Aufenthaltsrechtliche Illegalität in Deutschland – Sozialstrukturbildung – Wechselwirkung – Politische Optionen: Bericht für den Sachverständigenrat für Zuwanderung und Integration*, Oldenburg, 2004.
- Cyrus N., Düvell F. and Vogel D., *Illegale Zuwanderung in Großbritannien und Deutschland: Ein Vergleich*, paper submitted to conference ‘Illegal Migration in Europe’, Evangelische Akademie, 22.11.2002, Berlin (due to be published in ESG).
- Deutsche Bischofskonferenz, *Leben in der Illegalität in Deutschland – eine humanitäre und pastorale Herausforderung*, Die Deutschen Bischöfe – Kommission für Migrationsfragen 25, Sekretariat der Deutschen Bischofskonferenz, Bonn, 2001.
- Devillanova, C., *Undocumented Immigrants’ Social Networks in Milan: An Empirical Assessment*, Milano, 2004.
- Epstein, G.S., & Weiss, A., *A Theory of Immigration Amnesties*, *IZA Discussion Paper No. 302*, 2001.

- Fodor, R., Rechtsgutachten zum Problemkomplex des Aufenthalts von ausländischen Staatsangehörigen ohne Aufenthaltsrecht und ohne Duldung in Deutschland, in: *Alt, J., & Fodor, R., (eds.): Rechtlos? Menschen ohne Papiere: 125-223*, Loeper Literaturverlag, Karlsruhe, 2001.
- Groß, J., *Möglichkeiten und Grenzen der medizinischen Versorgung von Patienten und Patientinnen ohne legalen Aufenthaltsstatus*, Flüchtlingsrat Berlin e.V., 2005.
- Harris, P., A 1000 Mile Trek for Better Life Ends in Death on the Beach, *The Observer, April 15, 2001*. Cited in a written statement submitted by Human Rights Advocates International on Migrant Workers to the Commission on Human Rights, Fifty-eighth session, E/CN.4/2002/NGO/45, January 24th 2002.
- Hofer, K. M., In einer Welt der Illegalität. Unter SchwarzarbeiterInnen aus Polen, in: *Arno Pilgram (ed.): Grenzöffnung, Migration, Kriminalität. Jahrbuch für Rechts- und Kriminalsoziologie*, Nomos, Baden-Baden, 1993.
- Kieser, A. et al., *Country Report: Germany. For the European Project Easy Scapegoats: Sans Papiers in Europe*, Freudenberg Institute, 2000.
- Lederer, H. W., *Indikatoren der Migration – Zur Messung des Umfangs und der Arten der Migration in Deutschland unter besonderer Berücksichtigung des Ehegatten- und Familiennachzugs sowie der illegalen Migration*, European Forum for Migration Studies, Bamberg, 2004.
- Malteser Hilfsdienst e.V., *4 Jahre medizinische Betreuung für Menschen ohne Krankenversicherung*, Malteser Migranten Medizin, Berlin, 2005.
- Münz, R., Alscher, S., Özcan, V., Leben in der Illegalität, in: Klaus J. Bade (ed.): *Integration und Illegalität in Deutschland: 77-90*, IMIS, Osnabrück, 2001.
- Perner Cosman, M., Illegal Aliens and American Medicine, *Journal of American Physicians and Surgeons 2005; 10(1): 6-10*.
- PICUM, *Book of Solidarity Volume 1: Providing Assistance to Undocumented Migrants in Belgium, Germany, The Netherlands and The United Kingdom*, Antwerp, DeWriker, 2002.
- Pluymen, M., Minderhoud, P., Access to public services as an instrument of migration policy in the Netherlands. *Immigration, Asylum and Nationality Law 2002; 16 (4): 208-223*.

- Rao, S., From Privilege to Right: The Debate Over Medical Care for Immigrants, *Journal of American Physicians and Surgeons* 2003; 8(1): 16-17.
- Reijneveld, S., Verheij, R., Van Herten, L., & De Bakker, D., Contacts of general practitioners with illegal immigrants, *Scand J Public Health* 2001; 29: 308-313.
- Rein, M., Problems in the Definition and Measurement of Poverty, in Peter Towson (ed.), *The Concept of Poverty*, Heineman Educational Books, London, 1970.
- Schönwälder, K., Vogel, D., Sciortino, G., *Migration und Illegalität in Deutschland, (AKI-Forschungsbilanz 1)*, WZB, Berlin, 2004.
- Sciortino, G., Palidda, S., Petti, G., Ruspini, P., *Easy Scapegoats: Sans-Papiers Immigrants in Italy*, European Project, 2000.
- Scott, Penelope, Undocumented Migrants in Germany and Britain: The human „rights“ and „Wrongs“ regarding access to health care. *Electronic Journals of Sociology* 2004.
- Sinn, A., Kreienbrink, A., Von Loeffelholz, H.D., *Illegally resident third-country nationals in Germany – Policy approaches, profile and social situation*. Bundesamt für Migration und Flüchtlinge, September 2005.
- Taran, P., & Geonimi, E., *Perspectives on Labour Migration: Globalisation, Labour and Migration – Protection is Paramount*. International Migration Programme, International Labour Organisation, <http://www.sociology.org/content/2004/tier2/www.ilo.org>, 2003.
- Taran, P., *Human Rights of Migrants: Challenges of the New Decade*. IOM/UN International Migration Quarterly Review 38 (6) Special Issue 2, <http://www.sociology.org/content/2004/tier2/www.migrantsrights.org>, 2000.
- Torres A., Health care provision for illegal immigrants: should public health be concerned? *J Epidemiol Community Health* 2000; 54: 478-479.
- Wiedl, K. H., Marschalck, P., Migration, Krankheit und Gesundheit: Probleme der Forschung, Probleme der Versorgung - eine Einführung, in: *dies. (eds.): Migration und Krankheit; IMIS-Schriften 2001; 10: 9-37*, Universitätsverlag Rasch, Osnabrück.
- Worbs S., *Illegalität von Migranten in Deutschland*, Bundesamt für Migration und Flüchtlinge, Nürnberg, Working Paper 2/2005.
- Zincone, G., & Caponio, T., *Immigrant and immigration policy-making: The case of Italy*, IMISCOE Working Paper: Country report.

- Zimmermann, K.F., Tackling the European Migration Problem, *Journal of Economic Perspectives* 1995; 9, 45-62.

Internet sites:

- Federation for American Immigration Reform, Illegal Immigration and Public Health, <http://www.fairus.org>
- http://www.picum.org/BASIC_SOCIAL_RIGHTS/Netherlands.htm
- <http://www.un.org/Overview/rights.html>
- Walker, B., *Public Health Put at Risk*, <http://www.LimitsToGrowth.org>
- Walter, J., *Access to treatment for the undocumented in the Netherlands*, MAHA international working group on immigrants rights and HIV, <http://www.survivreusida.net>, cited June 1998.