Private Initiatives in the Health Care System for Undocumented Migrants in Rotterdam

Master thesis

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Contents

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Summary

The purpose of this study was to gain more knowledge about private initiatives operating in the field of health care for undocumented migrants (UMs) in the city of Rotterdam. The work of these nonprofit organizations has previously not been a subject of academic research, as research has mainly focused on provision of health care for UMs, their state of health and medical complaints. The aim was to explore the field; which private initiatives are there in Rotterdam that assist UMs somehow related to health care, what their activities are and how is their relationship to each other and the formal health care system. The central question of the thesis is:

Why do private initiatives, which are active locally in the city of Rotterdam, exist in the health care sector for Undocumented migrants (UMs) and what is their relationship to each other and the formal health care system/state agencies?

To answer this question 48 semi-structured interviews with representatives of private initiatives, with people working in the formal health care system and with UMs were performed. In addition (migrant) churches and mosques were contacted about their role in helping UMs with health care. The private initiatives were found by using snowball sampling and a representative from each of the private initiatives was interviewed. Convenience sampling was used to obtain interviews with people from the formal health care system.

Six private initiatives were included in the study. Their activities concerning health care for UMs were mainly practical, including informing UMs about the Dutch health care system and their right to health care, informing 1st line health care providers about Linking Fund and connecting and accompanying UMs to health care services. Some of the private initiatives engaged in lobbying the rights of UMs. Private initiatives were mostly motivated to help UMs because of their Christian belief or medical-humanitarian reasons. Partial support was found for heterogeneity theory and civil society theory in explaining the emergence and existence of ROS and MEDOC project of Doctors of the World. Interdependence theory and social origins theory applied in explaining the emergence and existence of the other private initiatives, except for Mamre project.

In general private initiatives were cooperating with people working in the formal health care system, which gives support to the neo-institutional and interdependence theories. Sometimes the relationship between the actors is tense, because of different interests and values. Most often private initiatives had interaction with the Municipal Health Service of the city (GGD), which organized meetings for organizations working with UMs and gave advice to them. Most private initiatives had also contact with the 1st line health care providers while trying to connect UMs to health care services. The interviewees from the 1st line or 2nd line had hardly ever heard of the private initiatives, due presumably to the fact that they work on a small-scale and their work is 'hidden' as their target group is the illegal immigrants. Locally active private initiatives get together in different meetings and are aware of each others' work for UMs, but still mainly work on their own in their own ways.

GPs, midwives, specialists and UMs were interviewed in order to find out how the provision of health care for UMs is working. As for recommendations for future work of private initiatives, it can be concluded that there is a lack of knowledge among UMs concerning the right to health care, where to receive it, paying for care etc. Therefore private initiatives should focus more to inform UMs about these matters in the future. It is truly a task for the private initiatives, because there does not seem to be will on a political level to perform this task. With cooperation of the private initiatives, churches and mosques more UMs in Rotterdam could be reached and they could receive information and support related to health care.

1 Introduction

1.1 Introduction

Since the early 1990s, the Dutch government has taken various measures to control migration to the Netherlands. Dutch migration policy can be characterised by growing attention to the combat of illegal labour and illegal stay. This "discouragement or exclusion strategy" comprises a wide range of policy measures such as exclusion from public services, intensified inspections by the Aliens Police and e.g. Labour Inspectorate on illegal stay and employment and expulsion. Exclusion is meant to complicate and frustrate illegal immigrants' living and working conditions to such a degree that they will leave the country and try their luck elsewhere. (Broeders & Engbersen 2007, 1593 & Pluymen 2002, 35.) According to an article of Vrij Nederland (Griend, van de 16.2.2008), this exclusion strategy has however had little success. The amount of illegal immigrants has continued to rise: in the beginning of the 1990s it was estimated to be around 50 000, but at the moment the number is three times higher.

In 1998 a law called Benefit Entitlement Act (Koppelingswet) came in force, which can be seen as the centerpiece of migration control in the Netherlands. It linked the legal status of a migrant to benefits of the welfare state. Illegal immigrants were excluded from public services, apart from a few exceptions. One of the exceptions was the right to 'necessary medical care'. Since the Benefit Entitlement Act came into force there have been problems in Undocumented migrants' (UMs) access to health care because of confusion about the definition of necessary medical care and lack of knowledge how the system works among different actors. UMs for example are not necessarily aware of their right to health care or might postpone going to health care services because of fear for being identified, sent to the police and eventually deported. (PICUM 2007, 64). To assist UMs private initiatives have emerged or previously active private initiatives have expanded their operation to new directions, i.e. to connect UMs to health care services.

The bulk of research related to the topic has concentrated in the state of health or medical complaints of UMs (e.g. Verkleij 1999, van Oort & al. 2001), UMs access to health care services and health care provision for UMs (e.g. Burgers & Engbersen 1999, van der Leun 2001, Muijsenbergh 2004). In other words research is focused in one way or another to the formal health care system. Platform for International Cooperation on Undocumented Migrants

(PICUM) has done explorative research on the "informal system"; nonprofit organizations providing humanitarian support to UMs. In its project organizations in several European countries were interviewed that provide assistance to UMs in areas like health care, education, housing and legal advice. Only a few Dutch organizations working in the field of health care were however interviewed. To protect the anonymity of the organizations their activities were usually not specified, but types of assistance are described on a general level. According to PICUM organizations in the Netherlands mainly focus on assisting UMs in accessing the health care, but can also engage in political work or campaigning. An example is given of the work of GIL (Gezondheidszorg Illegalen Leiden). (PICUM 2002.) Besides the work of GIL, PICUM has later highlighted the work of Pharos, Lampion and Doctors of the World (Dokters van de Wereld) (2007, 66-69). More comprehensive academic research on this topic is however lacking. Therefore many questions remain unanswered.

It is intriguing to explore this field because of its exceptional nature. Private initiatives are assisting people who do not have a legal status in the country, but have nevertheless a right to necessary medical care. They are thus operating on the borderline between legality and illegality. Who are these people that assist UMs, in what ways do they do it and why? Do these private initiatives work on their own or cooperate with each other? From a scientific perspective it is interesting to see what kind of roles private initiatives fulfill on this field in society in and how their emergence and existence can be explained.

In addition to exploring the different private initiatives it is also important to find out about their possible relation to professionals in the formal health care system, such as general practitioners and specialists working in hospitals. Are the private initiatives and health care providers in contact with each other and if so, what kind of interaction do they have? These points increase the insight into how the whole system of health care to UMs works. In order to evaluate the necessity private initiatives' activities and give recommendations, it needs to be understood how the formal health care system for UMs functions and what the experiences of UMs are.

The research will be conducted in the city of Rotterdam, which together with Amsterdam is the city where most UMs in the Netherlands reside (Engbersen & al. 2002, 131). This research concentrates on the private initiatives working locally in Rotterdam and excludes the nationally operating organizations. According to an estimation of Rotterdams

Ongedocumenteerden Steunpunt (ROS, 2007) there would have been around 18 000 UMs residing in Rotterdam in July 2007, which means about 3 % of Rotterdam's population would be UMs. This is an estimation of UMs, to whom the generaal pardon regulation does not apply. In generaal pardon UMs can be granted a residence permit, if their first application for asylum was filed before 1 April 2001 and they have since then uninterruptedly lived in the Netherlands (Generaal Pardon). The problem of illegal immigration does not show signs of declining. A report of IND shows that in the first half of 2008 the requests for asylum increased with 43 % compared to last year, while in other European countries the requests declined with 3 %. An explaining factor might be the Dutch generaal pardon regulation. (Koolhoven, 30.8.2008.) It is likely that many of the asylum seekers whose request is declined will become illegal.

1.2 Research questions

The research is explorative in nature as the work and functions of the private initiatives are not well known to the public. The central question of this thesis is:

Why do private initiatives, which are active locally in the city of Rotterdam, exist in the health care system for Undocumented Migrants (UMs) and what is their relationship to each other and the formal health care system/state agencies?

Sub questions derived from this question are:

- *Which private initiatives exist in Rotterdam that deal with health care for UMs?*
- *Why have private initiatives emerged in the health care sector for UMs?*
- *What are the activities of private initiatives concerning health care for UMs and why do the state agencies not perform these activities?*
- *Do the private initiatives cooperate with each other and with the formal health care system, and if so how?*

1.3 Methodology and layout of thesis

This research was conducted by performing both a literature review and an empirical study. A literature review was done to find out the international and national policies concerning health care for UMs. For this several documents of the Dutch government, articles on international humanitarian law and publications of medical professionals were studied. The results, including a definition of a UM and the position of UMs in the health care sector, can be found in chapter 2. To analyze different roles of private initiatives, how they emerge and why they exist, theories of non-profit organizations were used. Chapter 3 gives an overview of these theories.

For the empirical part 48 semi-structured interviews with different people on the field were conducted, including private initiatives, professionals in the formal health care system and UMs. This was done to get an overview of how the system works: what are the activities of private initiatives and the health care professionals and what are the experiences of the people in question: the UMs. In chapter 4 the steps of performing the empirical part of the research are explained. The results of the research are presented in chapter 5. There the empirical findings are related to the theoretical framework. In chapter 6, conclusions are drawn from the research, and the central question of the thesis is answered.

2 Undocumented Migrants and Health Care

2.1 Definition of an Undocumented Migrant[1] (UM)

According to a general definition, everyone who overstays three months in the Netherlands without a valid residence permit is in the country illegally (Van Oort et al. 2001, 7). When referring to undocumented migrants, a difference can be made between three basic types of illegality: (1) entry, (2) residence and (3) employment. The three can coincide, but this is not necessary. For example asylum seekers who stay in the country legally can nonetheless work illegally when they do not have a working permit. (Van der Leun 2001, 10.) Many asylum seekers have crossed Europe's borders clandestinely, and have regularized their status by applying for asylum (PICUM 2002, 10). On the other hand, many undocumented migrants started their journey legally, for example, by travelling on a tourist visa, and became "illegal" when they stayed on after its validity expired (Broeders & Engbersen 2007, 1594). In this thesis the residence criterion is used, thus undocumented migrants (UMs) are people living in the Netherlands without a valid residence permit.

Many different situations can cause a person to become undocumented. UMs may be for example rejected asylum seekers, rejected candidates for family reunification, labor migrants without residence permit or tourists who have overstayed their tourist visa. (PICUM 2002, 10.) The group is very heterogeneous and it consists of people with extended social networks who are relatively integrated in the country as well as of people who live in the margins of the society (Van Oort et al. 2001, 7). A major part of UMs consists of men between 20 and 40 years old (Engbersen et al. 2002, 130). According to van der Leun et al. (1998) biggest groups of UMs come from Turkey, North Africa and Suriname followed by Asia and rest of Africa.

Estimations of the amount of undocumented migrants in the Netherlands vary usually between 75 000 and 225 000. Engbersen et al. (2002) estimated the amount being between 112 000 and 163 000. These numbers are based on the registration of the police and yearly estimations and the authors point out that it is just a rough estimation. According to the most recent estimation, from April 1st 2005 to April 1st 2006, between 74 000 and 184 000 people without a residence permit would have been living in the Netherlands. Probably the amount of Europeans in this group has dropped in the last years, because of the European Union

[1] Terms undocumented migrant (UM) and illegal immigrant are used in the thesis interchangeably, of which the first is a more neutral term and the latter more commonly used.

expansions in 2004 and 2007. (Kromhout et al. 2008, 1.) EU citizens have a right to reside in all EU countries. Based on this recent estimation perhaps around 1 % of the Dutch population consists of UMs.

2.2 UMs' right to health care

2.2.1 International Human Rights Law

In T. H. Marshall's (1950) view civil, political and social rights are universal, but only citizens of the state are entitled to these rights. Since his time the amount of migrants and illegal immigrants has increased rapidly in the world and UMs' rights to social services have been debated. There has been a detachment of the Marshallian idea of rights related to citizenship in favor of entitlements based "on the simple condition of human being" (Kofman 2002).

Health care is regarded nowadays as a fundamental human right. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive clause on the right to health in international human rights law. According to article 12(1), States Parties recognize: "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." In the general comment No. 14 it is further clarified that "States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health care services; abstaining from enforcing discriminatory practices as State policy…".

However, the lack of implementation of these standards together with disinterest in ratifying or acceding to new available instruments symbolizes, in Taran's words (2000, 18), "a broader general resistance to recognition of application of human rights standards to migrants, particularly undocumented migrants". Confirmation to this claim can be found as article 1 of the European Convention on Social and Medical Assistance and article 13 of the European Social Charter explicitly require nationals of a state to be *lawfully* present in the territory of another state to be entitled to medical assistance in equal terms with nationals (Romero-Ortuño 2004, 249). It seems clear that EU member states are not willing to extent full health care coverage to UMs. Official explanations as to why this is the case have not been supplied,

but as Vonk (2001, 317) suggests, it is likely that 'too generous' social rights could act as a 'pull factor' for further illegal immigration. This assumption disregards empirical evidence showing that most UMs do not make a rational choice of their destination country after comparing the benefits of different welfare states (Robinson & Segrott 2002, 50).

2.2.2 National policy of the Netherlands

In July 1998, a new law called Benefit Entitlement Act (Koppelingswet) came into force, which can be seen as the centerpiece of migration control in the Netherlands. (Pluymen 2002, 35.) It refers to a set of 26 amendments in the legislation. According to van der Leun (2001, 120), the Act aimed at preventing the continuation of illegal residence in the country. A major change was that the new law systemically introduced an applicant's valid residence status as a prerequisite for eligibility for public services. Entitlement or access to public services, such as higher education, housing, rent subsidy, health care and all social security benefits, was restricted to the condition of lawful residence. (Pluymen 2002 & van der Leun 2001.)

Prior to the Benefit Entitlement Act, UMs could obtain a health insurance through secret paths, but since the new law this was not possible anymore (van der Leun 2001). The intention of the government was however not to block the access of undocumented migrants to health care since the Act pertained to two exceptions related to health care: "the provision of necessary medical care" and the "prevention of situations that would jeopardize public health" (Benefit Entitlement Act, 1998 art. 1C). Since the Benefit Entitlement Act was passed, there have been several attempts to define the concept 'necessary medical care'. Based on the discussions in the parliament when the Act was accepted, the level of health care for illegal immigrants was extended from acute life-threatening situations to 'necessary medical care'. Medical professionals are obliged on humanitarian and ethical grounds to offer 'necessary medical care' at all times. (Minister of HWS, 1999.) The responsibility to decide what 'necessary medical care' is was explicitly endowed to medical professionals, who should rely on professional standards in order to draw a line unequivocally and equally between necessary care and "not necessary care" (van der Leun 2001, 120).

In 2005, the National Committee on Medical Aspects of Immigration Policy was set up by the Ministry of Justice and the Ministry of Health, Welfare and Sport to investigate the influence of medical aspects upon the influx of foreigners into the Netherlands. The committee found that there is no reason to restrict the concept of necessary medical care for asylum seekers and

illegal immigrants or to deviate from the practice that physicians treat all patients as equals in determining whether care is necessary. The committee concluded that 'necessary medical care' comprises care provided in the basic national health care package. (Smeets et al., 2005.) This basic package in the new health insurance system, which came into force in 2006, covers about the same as the previous system (Just landed). As of 1.1.2008 the basic package includes medical care as provided by GPs, obstetricians, medical specialists and clinical psychologists; admission to and treatment/nursing in hospitals; patient transport; medicines; medical appliances; maternity care; dental care up until the age of 22 years; paramedical care, e.g. physiotherapy. (CVZ, 2008a.) Although dental care for adults is not included in the basic package, UMs can receive dental care, if it is considered 'medically necessary' by the dentist. It is also reimbursed by the Linking Fund.

The hospitals in the region of Rijnmond developed a guideline in the end of 2005 concerning the treatment of uninsured patients. It states: "The minimal duty of hospitals to provide care for all uninsured patients means that there has to be a situation where the provision of medical care cannot be refrained from or be postponed without bringing the life or state of health of the person concerned or the public health in serious danger. This concerns medically necessary care assessed by the medical professional. The term medical necessary care emphasizes that the doctor determines the necessity of care." (SRZ.) According to a newspaper the hospitals were afraid of having more uninsured patients with the new health insurance system and receiving less money from the regional health insurer. The Chairman of the Board of Sint Franciscus Gasthuis (a hospital in Rotterdam), Piet Batenburg commented medical care that cannot be postponed being care that is given in acute life threatening situations, care that prevents invalidity and care for complaints that are infectious (Rosenberg, 14.1.2006).

In practice there was confusion around the concept 'medically necessary care' and in its note of 2006 inspection of health care stated that the concept needs clarification (IGZ, 2006). The Committee Klazinga was initiated by different medical professionals' organizations[2] to create guidelines for treatment of asylum seekers and illegal immigrants. In the report Arts en Vreemdeling (2007) the committee elaborates on the concept of 'necessary medical care' and

[2] The Royal Dutch Medical Association (Koninklijke Nederlandse Maatschappij tot Bevordering der Geneeskunde), the National Association of General Practitioners (Landelijke Huisartsen Vereniging), the Dutch Order of Medical Specialists (Orde van Medisch Specialisten) and the Dutch Society of Psychiatry (Nederlandse Vereniging voor Psychiatrie)

presents practical recommendations. Based on Hippocratic oath, rules of conduct and legislation they conclude that 'necessary medical care' should be 'responsible and appropriate medical care'. Such care is effective and targeted, is given in a patient-oriented manner and is fine-tuned to the patient's actual needs. Doctors apply the same guidelines, protocols, standards and codes of conduct in health care for UMs as they would use in regular health care. If an UM is expected to stay for a short while in the country, doctors can limit the care or provide none at all. However, if the duration of stay in the Netherlands is unclear or long-term, continuity of appropriate medical care is more important and the care given should be the same as the regular basic care given to those carrying health insurance. The Minister of Health, Welfare and Sport has accepted this report as a useful guideline for health care professionals (Minister of HWS, 2007).

As of January 2006, a new insurance system for curative healthcare came into force in the Netherlands. Under the new Health Insurance Act (Zorgverzekeringswet), all regular residents of the Netherlands are obliged to take out a health insurance covering a basic package of essential health care. The system is operated by competing private health insurance companies; the insurers are legally obliged to offer at least a basic package of health care and cannot reject anybody who is applying for it. (Ministry of HWS, 2008.) Insured patients can take out supplementary insurance for care that is not included in the basic package or pay themselves for this care (CVZ, 2008a). The government remains responsible for accessibility, affordability and quality of health care. UMs are however excluded of taking out a health insurance in the Netherlands. All legally registered persons are also automatically insured through the AWBZ, a special scheme for exceptional medical expenses such as long-term care in a nursing home, care for the handicapped or treatment in a psychiatric institution (CVZ, 2008a). The Benefit Entitlement Act excluded UMs from these services.

2.3 The formal health care system

In this thesis, the formal health care system is defined as all actors that provide health care to people residing in the Netherlands. The most important part of the formal health care system consists of 1st line health care, which includes general practitioners (GPs), midwives, dentists, physiotherapists and pharmacists, and the 2nd line health care, that consists of hospitals, rehabilitative centers and ambulance services.

Patients, both legal and illegal, always first have to visit the 1st line of health care. Especially the GPs have a very important role in the health care system. They are gatekeepers, which means without their referral patients do not have access to specialists or hospital care, except in case of emergency. GPs treat common and relatively simple diseases and problems. In around 95 % of cases no additional health care services are needed. If this is the case, the GP refers the patient to a specialist.

2nd line health care is mainly provided by specialists working in hospitals. Hospitals are private non-profit foundations, with the exception of academic hospitals (eight in the Netherlands) that are publicly owned. In general, the specialists are not employed by the hospital, but are self-employed and work on basis of a contract for a hospital.

In addition, the Netherlands has a regional network of municipal health services, which take care of preventive child health screening and examinations, vaccinations, infectious disease control, health protection and health promotion activities. The Municipal Health Service (GGD, Gemeentelijke Gezondheidsdienst), operates next to the 1st line health care. UMs can turn to seek help at GGDs in the following fields (PICUM 2007, 68): infectious diseases, mental health issues (if there is a risk for public order) and health care for children.

Mental care is further provided by the GGZ (de geestelijke gezondheidszorg) or by general psychiatric hospitals (APZs). General hospitals usually also have psychiatric departments, though they tend to be small and only take patients that stay a short period. Also to these institutions patients need to be a referred by a GP, with the exception of crisis situations.

Finally, medicines can be obtained from pharmacies, which are privately owned. Many medicines can only be obtained with a prescription of a GP or specialist. (Exter, Hermans, Dosljak & Busse 2004.)

2.4 Financing of health care for UMs

In principle undocumented migrants who reside in the country unlawfully, should always bear the costs of medical treatment themselves. However, if they cannot pay, medical professionals and health care centers in the 1st line can apply for a reimbursement of expenses from a 'Linking Fund' (Koppelingsfonds) which was established by Ministry Health, Welfare and

Sports in tandem with enactment of the Benefit entitlement Act. (van der Leun 2001, 122.) In 2006, it consisted of 5,5 million euro. It is funded from tax revenue and managed by a public entity. The 'Linking Fund' compensates general practitioners, midwives, pharmacists and dentists. The fund does not pay the bills of patients, but reimburses doctors for their earning losses. (PICUM 2007, 63.) GPs, midwifes, pharmacists and dentists can claim for expenses when (Stichting Koppeling):

- The patient is uninsured as a consequence of the Benefit Entitlement Act
- There is a bill, which the patient cannot pay
- The doctor has provided 'necessary medical care' for the patient

'Linking Fund' cooperates closely with regional platforms. They consist of GGDs and representatives of different medical occupations (the national association of general practitioners, pharmacists, associations of midwifes, circles of dentists and care insurers). The regional platform annually establishes a budget that should cover the costs that care providers within the region are expected to make for treating UMs. On behalf of the regional platform the local GGD is responsible for submitting the subsidy claim, the management of the contribution and for reimbursing the expenses. If the regional subsidy application is approved by the governing board of Linking Fund, the region receives an advance payment of 50% of the promised amount. The rest is paid after account has been given concerning the spending of the contribution.

Just as the health care providers in the 1st line, 2nd line care health care providers try primarily to receive the costs of the care from the uninsured patient. If this is not possible, the 2nd line of health care providers – hospitals and ambulance services – have a budget line within their own budget (0,1% of their total annual budget) arranged with insurance companies called "dubious debtors" (deubieuze debiteuren). Hospitals use this system to cover expenses generated by the provision of services to undocumented migrants. (PICUM 2007, 63-64.) Health insurers compensate for the costs as long as the agreed budget is not exceeded. If this happens, the exceeding part is at the hospitals' own expense. However, "dubious debtors" is not only to cover the expenses of treatment for UMs, but of all uninsured patients. Mental health care and care for drug addicts can in acute cases be covered by "dubious debtors" (Lampion).

On 22nd of April 2008 the parliament agreed with the law proposal arranging the financing of medically necessary care to illegal immigrants. The principle that UMs should bear the costs of medical treatment stays the same. In the new system also hospitals can get reimbursement for their earnings losses. The new regulation makes a difference between care that cannot be planned and care that can be planned. Acute care can be provided by all care institutions, planned care by only contracted institutions. If UMs cannot pay for the health care services, hospitals can declare 80 % for the costs of acute care or care that cannot be planned at CVZ (Health Care Insurance Board). These costs will therefore not be financed anymore form the "dubious debtors" (dubieuze debiteuren). GPs, midwives and dentists will declare their earning losses to regional platforms like they are doing now. GPs will get 80 % of their earning losses compensated and midwives 100 %. Dentists get an 80 % compensation for care given to children and youth until 22 years, who do not have a valid residence permit. The regional platform will no longer declare the costs at Linking Fund, but at Health Care Insurance Board. (CVZ, 2008b.)

For care that can be planned the Health Care Insurance Board will make contracts with a number of specific providers like pharmacists, hospitals and ambulance services. Also the planned AWBZ care, long term care in nursing homes, will be compensated for in contrast to the situation at the moment. These contracted institutions will be 100 % compensated for their earnings losses. This change in the health insurance law is expected to come into force 1.1.2009, under condition that the law proposal in approved by the 1st Chamber. (CVZ, 2008b.)

2.5 Hindrances in health care provision for UMs

In a recent literature study on illegal stay in the Netherlands conducted by the Scientific Research and Documentation Centre of Ministry of Justice the authors have collected hindrances in health care provision for UMs from several studies (Kromhout et al. 2008)
The authors divide these hindrances in two parts.

1) Hindrances of UMs
2) Hindrances of health care providers

Hindrances of UMs

A major barrier in the health care provision for UMs is that many of them do not know that they have a right to necessary medical care, even if they cannot pay for it. Besides UMs are afraid to be discovered and because of that are reluctant towards official institutions. (van den Muijsenbergh, 2004.) UMs have often little knowledge how the Dutch health care system works. Therefore they might look for help at a GPs practice or emergency department to a complaint that should be treated for example by a dentist (van Oort, 2001). Even if UMs receive treatment, there might still be problems in the good continuation of care, for example because they do not have a place to rest or they lack money to buy medicines (van den Muijsenbergh, 2004).

Hindrances of health care providers

The inspection of health care stated in 2005 that health care providers do not always know about UMs' right to health care and the reimbursement possibility from the Linking Fund. Some hospitals refuse UMs and personnel at receptions and emergency departments have little knowledge about treatment duty (zorgplicht) and paying regulations concerning UMs. (IGZ, 2005.) Because it is decided by each individual medical practitioner what 'necessary care' is, in practice differences of interpretation occur, resulting in situations where one UM receives a particular type of treatment, while it is denied to another with the same complaint (PICUM 2007). Costs for exceptional medical expenses (AWBZ), such as stay in a nursing home, cannot be declared and therefore admission is often denied. That is why the admission to hospitals gets also difficult, because hospitals are afraid that UMs need to stay in a there longer than otherwise would be the case (IGZ, 2005).

In addition, UMs are unevenly divided among GPs' practices and hospitals. In the four big cities (Amsterdam, Rotterdam, Utrecht and the Hague) UMs are concentrated to small amount of GPs' practices. One of the causes is that some health care providers are known to be "illegal-friendly" and others often refuse to help them. (Van Oort, 2001.)

When UMs are being treated it is sometimes difficult to take care of monitoring and stable treatment because of the changing and dependent life situations of the patient. Also mental health care providers are hindered because of this. Besides they might have a feeling of not being able to help the patient, because many psychological problems are caused by the illegal status of the client. (van den Muijsenbergh, 2004.)

3 Theoretical Framework

3.1 Definition of a private initiative

In this thesis, the following definition of private initiative is used: *it is a self-governing, non-governmental and non-profit organization, which at least partly relies on volunteer work*.

This definition implies that a private initiative has at least the following characteristics:

- It is an actual registered organization that does not allow distribution of revenues to others (in Dutch law either a "Stichting" or a "Vereniging")
- The organization has a private character (not government owned) and has sufficient control over its own actions (government has no significant influence on behaviour of the organization)
- The organization can have paid staff, but there should at least be some meaningful voluntary participation. In the Dutch health care sector, this last requirement is important because it separates private initiatives from other non-profit organizations in the sector, such as hospitals, which belong to the formal sector.

3.2 Theories on emergence, existence and function of the nonprofit sector

In the following sections I will use the term nonprofit sector, which is widely used in the literature (Salamon 1994; Burger & al. 1997; Burger & Veldheer 2001) to discuss the nonprofit distributing organizations in the area between state agencies and business firms. According to Burger & al. the term private initiative fits most organizations of the nonprofit sector (1997, 1) and therefore it is justified to use nonprofit sector as a general term, which encompasses the private initiatives.

In the latter part of the 20th century, there has been a significant growth in the nonprofit sector around the globe. A huge amount of self-governing nonprofit organizations have emerged, which are not dedicated to distribute profits and are pursuing public purposes outside the formal apparatus of the state (Salamon 1994, 109).

According to Salamon the rise of the nonprofit sector springs from a variety of pressures, from individual citizens, outside institutions and governments. Pressures can come from "below" in the form of spontaneous grass-roots energies, when ordinary people seek to improve their conditions and from the "outside" through the actions of various public and private institutions, e.g. the church. (Salamon 1994, 112−113.) These two types of pressures might be relevant in explaining the emergence of private initiatives in health care for UMs in the Netherlands.

Salamon, Sokolowski and Anheier (2000) elaborate on three theoretical approaches explaining the scale and resurgence of the nonprofit sector. These are *1) heterogeneity theory, 2) interdependence theory and 3) social origins theory.* Other theories covered in this chapter are *neo-institutional theory* and *civil society theory.*

The first two theories are demand and supply perspectives based on welfare economic theories. Unlike economic theories which emphasize efficiency and exchange, in civil society theory distinctive values and social relations of the nonprofit sector are important as well as possible deleterious effects of government to nonprofit organizations. Social origins theory and neo-institutional theory have emerged out of cross-national comparisons of state systems and social policies and from efforts to understand how nonprofit organizations relate to overall societal systems. (Rathgeb Smith & Grønbjerg 2006.)

3.2.1 Heterogeneity Theory

According to *heterogeneity theory or "market failure/government failure"* theory people turn to nonprofit organizations when they cannot receive public goods either from the state or the market. "Government failure" happens most likely where considerable heterogeneity exists in a population and where differences of opinion exist about which public goods to produce. Nonprofit organizations emerge and function to meet the unsatisfied demand for collective goods left behind as a result of failures of both actors. (2000, 7.) Nonprofit organizations are uniquely suited to supply particular types of goods and services and they can meet the unsatisfied demands of people because they have access to special advantages and resources. This may happen if the products cannot be well contracted or suitable for political transactions. Nonprofit organizations are less concerned with the public opinion than the government and are less bureaucratic, which allows them to address the needs of minorities or

the interests of small segments of the general public. They can also take more risks if the small group of decision makers agrees the costs are worth the risk, as they are not beholden to an elected political body or the general public. (Rathgeb Smith & Grønbjerg 2006, 223-224.) In this theory the relationship between the nonprofit sector and the state is competitive and the persistence of a nonprofit sector is at best a byproduct of limitations of the state (Salamon et al. 2000, 12).

3.2.2 Interdependence theory

The *interdependence or transaction theory* does not only focus on the ability of nonprofit organization to compensate for government and market failures, but emphasizes the potential interdependence and opportunities they create for direct exchanges between government and nonprofit sector. Rather than competing with each other as alternative providers of public goods to consumers, government and nonprofit organizations have exchange with each other, including formal contracts that spell out how they will cooperate in making services available. This exchange can happen when for example for ideological reasons resistance against direct state action is strong yet demands arise for protection against social or economical threats. According to Salamon, failures of government and the nonprofit organization, which include insufficiency, amateurism, particularism and paternalism, create the basis for partnerships between government and nonprofit organizations. Contracting and grants are direct forms of government support, but nonprofit organizations have multiple and complex exchange relations with government. Under this theory government is viewed as a potential source of financial as well as political support for the nonprofit sector. (Salamon et al. 2000, Rathgeb Smith & Grønbjerg 2006.)

3.2.3 Social origins theory

Salamon and Anheier's (1998) *social origins theory* builds on Esping-Andersen's welfare regime theory (1990) and B. Moore's (1966) analysis of how three distinct political regimes, democracy, communism and fascism, emerged out of the interaction of the landed elites, rural peasantry, urban middle class, and the state. According to Salamon and Anheier the "social origins" of the national nonprofit sector best explain cross-national differences. The nature of the nonprofit sector must be understood as an integral part of the historical developments by which political institutions are shaped by social class in each country. Political groups are agents of change and once policy decisions have been made, these groups shape the further

evolution of social programs, especially the role the state and its relationship to civil society, including the nonprofit sector. (Rathgeb Smith & Grønbjerg 2006, 234.) The theory identifies four more of less distinct models of nonprofit development, each characterized by a particular state role, position of the nonprofit sector and most importantly by a particular constellation of social forces. (Anheier & Daly 2007, 14.) These models are *liberal model, social democratic model, corporatist model* and a *statist model*.

Anheier and Daly place Netherlands to a civil-society-centered corporatist model together with e.g. Germany and Austria. According to the *corporatist model* state has a strong role and nonprofit organizations are often in some form of subsidiary relation with the state. Nonprofit organizations are part of the social welfare or educational system. After the Second World War, the number nonprofit organizations grew in the Netherlands as part of the development of the welfare state. The state mainly funded social welfare services rather than performed these tasks. (Anheier & Daly 2007, 14−19.)

3.2.4 Neo-institutional theory

Neo-institutional theory offers a more systematic approach to linking nonprofit organizations, the state and societal systems than social origins theory. It focuses on the ways in which the institutional environment shapes the nonprofit sector, where state plays a vital and central role. It suggests that the prevalence and thriving of nonprofit organizations is largely the product of the political, legal and institutional environment. Important variants of this approach focus on the mutual dependence of government and nonprofit organizations. Skopcol (1999) argues that nonprofit organizations thrive in tandem with active government and that government support for voluntary organizations is critical to the growth of the sector. Central to another variant of neo-institutional perspective is the idea of complementarity and embeddedness. Complementarity means that there are mutually supportive relationships between public and private actors, while embeddedness emphasizes the nature and extent of ties between these actors. Effective nonprofit organizations are embedded with a network of social relations that transcend the public, nonprofit and for-profit sectors. The boundaries between the sectors are blurred. (Rathgeb Smith & Grønbjerg 2006, 235−237.)

3.2.5 Civil society theory

In addition to these theoretical approaches, Rathgeb Smith and Grønbjerg (2006) elaborate on *civil society theory*. This perspective pays attention to community organizations and social relations unlike the market related perspectives. Civil society refers to the network of associations, groups and informal activities that exists apart from the state and the market. From this perspective the nonprofit sector is regarded as the embodiment of certain values that are crucial to democracy and good government. Scholars are much less concerned with efficiency and the provision of public goods than they are with other important goals of society such as responsiveness, freedom, cooperation, legitimacy, individual and community responsibility, citizen participation and social capital. This approach dates back to the times of de Tocqueville (early 19th century). He thought nonprofit organizations are for example important means for people to come together and influence government policy. For Berger and Neuhaus (1977) nonprofit organizations are mediating institutions between the individual and government, protecting individual freedom and enhancing community responsibility for social problems. Unlike in other perspectives, the relation to government is not one of exchange or cooperation, but of tension. Government is seen as a coercive force undermining local and community responsibility.

3.3 Why join a private initiative?

According to *micro-structural approach* attaining the explicitly set goal is not the only, or even the most powerful, incentive to become involved in collective action. Other incentives are created by social ties and interaction among individuals. These may include values and expectations what is socially appropriate, opportunities for social bonding or gaining social prestige. (Salamon & Sokolowski 2001, 10.) *Cost-benefit approaches* find that individuals join organizations to attain selective benefits that exceed the costs of membership. Joining an organization is seen as a calculated self-interested decision. Types of incentives include material, solidary and purposive incentives. Material incentives include e.g. free magazines and discounts on products, solidary incentives e.g. making new friends and purposive incentives rewards associated with ideological interests tied to organizational values and goals. According to demographic and social psychological approaches people associate with others who are similar in character. (Tschirhart 2006, 528.)

3.4 Roles of non-profit organizations

From the literature (Salamon, Hems & Chinnock 2000; Anheier & Daly 2007) different roles of non-profit organizations are found, which can be useful in determining what kind of roles the private initiatives in health care for UMs possess. These are:

Higher quality. Because non-profit organizations are not primarily profit-oriented, they can afford to provide higher quality than businesses and wider variety of services than governmental organizations, like community organizing and empowerment.

Complementarity. Non-profit organizations serve otherwise under-supplied groups, when groups have different demands and/or the government cannot afford services for all groups. UMs have different demands relating to health care services than regular insured patients and because government cannot supply services to all groups non-profit organizations assist UMs.

Greater equity. Non-profit organizations are often inclined to serve those in greatest need. UMs can easily be included in this group as they are excluded of almost all public services of the society.

Specialization. Because of their value-based mission and embeddedness in communities of place and need, non-profit organizations can specialize in a problem, a group of people or method of intervention. In this case private initiatives are specialized in UMs and health care, though this might not be their only area of specialization.

The innovation role. Non-profit organizations can be pioneers in particular fields, identifying unaddressed issues, formulating new approaches to problems and serving as a source of innovation in the solution of societal problems. Private initiatives are probably coming up with new solutions in facilitating UMs' access to health care services.

Social and policy change. Besides being innovators, non-profit organizations are also expected to push for changes in government policy or in societal conditions. They seek to promote a more just society, fostering recognition of new needs, and the empowerment of socially excluded. Private initiatives may be pushing for better and exhaustive health care for UMs.

3.5 History of nonprofit sector in the field of health care in the Netherlands

"The Netherlands has a long and rich tradition of private initiatives ranging from medieval guilds and church-related activities to pillarization in the 19th and 20th centuries" (Burger & Veldheer 2001, 221). In the field of health care hospital is one of the oldest services in the nonprofit sector, which dates back to early Christian times. It provided "hospitality" to all who needed it: sick people, strangers, foundlings, orphans and the elderly. Hospitals had strong ties to the church. In the medieval times hospitals were called guesthouses and they were usually located at convents, monasteries or churches. Later differentiation occurred and "god houses", pest houses and madhouses were established. With the rise of urban settlements, a new type of institution, the public infirmary emerged. These institutions were brought under the authority of the city. (Veldheer & Burger 1999, 2; Burger & Veldheer 2001, 229.) In addition to churches, also many wealthy private citizens, individually or collectively, founded guesthouses. Their aim was salvation for themselves and benevolence to others. (Groenveld 1997, 33−37.) Until the late 19th century medical care was expensive and hard to come by, this meant that physicians were basically inaccessible to the poor.

In the second half of the 19th century, hospitals underwent considerable changes because of rapid developments in medical research and natural sciences and ultimately the guesthouses were transformed from care and relief establishments to modern, highly specialized technological medical centers. (Veldheer & Burger 1999, 2.)

Health insurance funds are one of the oldest forms of private initiatives in the field of health care. These initiatives were usually set up by directly interested parties for members of their own group, for example by Catholics to Catholics. At the end of the 19th century medical care was dominated by private initiatives. (Burger & Veldheer 2001, 230.) The state kept its distance and left many matters to private organizations such as the non-denominational white and Green Cross, the Catholic White-Yellow Cross and the Protestant Orange-Green Cross (Pennings 1991, 91-92, cited in Burger and Veldheer 2001, 230). Christian-inspired love of one's neighbor was at the heart of many initiatives of citizens to do well to their fellow citizens (Burger & Veldheer 2001, 240).

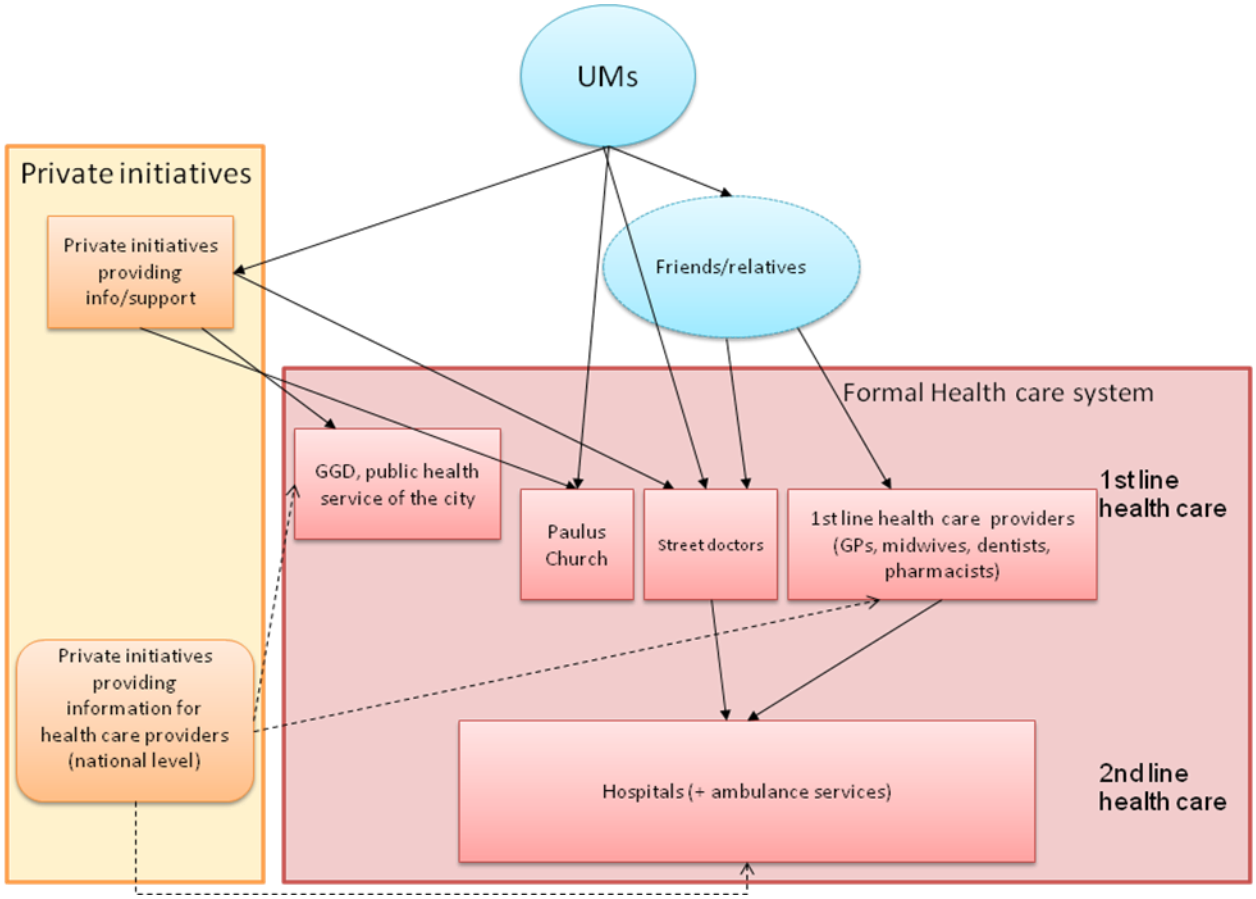
Also private initiatives (such as nursing associations) emerged that were not so much caring for a certain group, but making care accessible to persons of limited means. These modern

associations were founded mostly by people who believed that the care of the poor and sick was deficient, from the point of view either of a well-functioning labor market or of social justice. (Van der Velden 1993, 78, cited in Burger & Veldheer 2001, 230-231.) In the period before 1940, self-employed, well-organized professional medical practitioners and privately run organizations were dominant in the health care sector and national government concentrated on regulating the system by inspections and monitoring health conditions among the population.

After the 2nd World War, a program of legislation was introduced to regulate the organization of health care, transforming the relationship between the state and private initiative. The relationship between these two was structured into consultative bodies. Later on, the state has attempted by means of statutory measures to bring the costs of health care under control by influencing the pricing of services and planning and construction of facilities. Although the state has gained more influence, private health care and its providers still enjoy considerable autonomy. The supply side of Dutch health care services is nowadays privately organized. Where publicly organized services exist, like municipal health services, they are in the hands of local authorities. The funding of the health care system is through the insurance system, not the state. (Veldheer & Burger 1999, 3−4 Burger & Veldheer 2001, 231−232.)

In the last decades as migration has grown substantially, illegal immigration has grown as a by-product. Illegal immigrants can receive health care in the formal health care system like regular insured patients, but in addition other projects and new private initiatives have emerged to help these people. In Rotterdam Paulus Church (Pauluskerk) is most explicitly directed at helping undocumented or illegal patients. The church, which had a reputation of helping underprivileged people, was demolished in 2007, but doctors continued providing health care for uninsured patients under the same name. The Municipal Health Service (GGD) together with a group of GPs initiated some years ago a project called street doctors (straatdokters), which was aimed at providing health care for uninsured Dutch citizens. In practice also UMs receive care at the consultation hours of the GPs. These two projects are a part of the 1st line health care, as the GPs get reimbursed through Linking Fund for their earning losses. Except for these actors there are several small organizations that do not provide health care per se, but assist UMs in different ways to receive health care.

Figure 1. The health care sector for undocumented migrants in the city of Rotterdam



4 Empirical research

In the empirical part of this thesis qualitative research method was used because of the type of research questions. Qualitative research methods are used when the object of the study is some form of social process or meaning which needs to be understood (Mason 1996, 96−97), like in this research. Interviews are good research techniques when the purpose is to know what people think or feel about something (Esterberg 2002, 36). Therefore the research questions could best be answered by individually interviewing representatives from the private initiatives, the formal health care system and UMs. The population of this research are all the private initiatives that help UMs somehow with health care in Rotterdam. Also people in the formal health care system, who have contact with UMs are part of the population and naturally UMs themselves.

To find the private initiatives active in the field snowball sample was used. Because undocumented migrants are a hidden population in the society and there is little information available on private initiatives dealing with health care for UMs, this was the best technique to get in contact with private initiatives. A representative of all private initiatives which were found with snowball sampling in Rotterdam were interviewed provided that they did more for health care of UMs than referring them to a certain health care provider. To find about the role of a particular type of private initiatives, the churches, every 10^{th} church of the church register (kerkenregister) in Rotterdam was selected to get started. These churches were called to ask if: a) UMs sometimes come to their church and ask about health care matters? And b) do the churches help them and if so, how? Churches were contacted because it seemed likely that they provide support for vulnerable people, such as UMs.

Next migrant churches were contacted, because it seemed plausible that UMs would turn to them rather than regular churches for help. Phone numbers were gotten from the site of SKIN (Samen kerk in Nederland) and the representatives were asked the same questions as the representatives of other churches. Every fifth church from the list was selected and contact was sought with them. Two churches were selected because of a hint from an interview with one of the private initiatives. In addition an attempt was made to get in contact with mosques in Rotterdam to find out if and how they help UMs with health care. Not many of the mosques

had phone numbers, so by phone only four mosques were reached. All four claimed never to have seen UMs in their mosque or stated that they cannot do anything for these people.

Of the formal health care system, GPs' practices were contacted in areas of Rotterdam that have a significant migrant population. Practices were called, the purpose of the research explained and asked if there are GPs in the practice that sometimes treat UMs and if it would be possible to have an interview with one of them. In total to 38 practices were contacted, which were mainly situated in South Rotterdam, in areas like Feijenoord, Katendrecht, Afrikaanderbuurt, Hillesluis, Tarwewijk, Charlois, Bloemhof and Zuidwijk, but also practices in the Centre, Oude and Nieuwe Westen, Tussendijken, Spangen, Oude Noorden and Crooswijk. Of these 38 practices 15 were closed because of holidays, which narrowed the possible sample size. Assistants of 12 practices refused the request, 9 of them because GPs do not have time or interest for interviews or that my requested 25 minutes for the interview was too long. In other two cases the response was that no UMs are treated in the practice and one assistant refused the request because the GP does not speak English. In the end six GPs and four assistants from Hillesluis, Tarwewijk, Bloemhof, Charlois, Oude Noorden and Oude Westen were interviewed. In addition a GP from Paulus Church and from Street doctors were interviewed. Paulus Church is a place in Rotterdam which specialised in treating UMs, homeless and drug addicted people. Street doctors (Straatdokters) is a project of seven GPs and GGD, in which the GPs treat mainly homeless people, but also UMs in 10 different locations in the city. The GP who was interviewed spend a few hours of the week treating patients as a Street doctor, otherwise he worked in a regular practice. According to Linking Fund (Stichting Koppeling) 64 GPs in Rotterdam are reimbursed for their earnings losses caused by treating UMs.

There are four general hospitals in Rotterdam, which are Erasmus MC, Ikazia, Medisch Centrum Rijnmond-Zuid (MCRZ) and Sint Franciscus Gasthuis (SFG). In addition there is Havenziekenhuis, which is a subsidiary of Erasmus MC and a specialized hospital for eye illnesses (Oogziekenhuis). Of these hospitals Erasmus MC, Ikazia, MCRZ and SFG were contacted for possible interviews. Like with the GPs a convenience sample had to be used. Specialists who sometimes treated UMs and who I was able to reach were interviewed. From Erasmus MC 13 departments were either called or sent an e-mail to. When calling the departments the usual response was to send this request to the secretary by e-mail. Five departments replied saying they cannot help or they do not have contact or have very little

contact to undocumented patients. From the two departments, cardiology and gynaecology, where the secretary connected me straight to a doctor, appointments with the doctor in question could be made. Interviews with the head of administration of the first aid, the medical coordinator of first aid and a person working at the registration of the outpatient clinics were also done. From Ikazia six departments were called. From four of the departments the response was a denial, because it was holiday time the doctors did not have time. Contacting a different hospital was advised.

MCRZ has two locations, southern (Zuider) and Clara. Contact information of a doctor treating infectious diseases in Clara was received in an interview with a person from a private initiative and therefore this doctor was interviewed. Five departments of Zuider were contacted after receiving the information from Clara that Zuider is more specialized and might be willing to give interviews. Thus interviews with a neurologist at Zuider (sometimes working in emergency dept) and a nurse from neurology department of Clara were done. The nurse arranged an interview with a man working at financial department of location Clara and a person working at a registration of emergency department in Clara. Finally seven departments of SFG were contacted and two responded saying they do not have time or interest for interviews. From a cardiologist an e-mail was received saying that 'illegal immigrants and prisoners form a difficult problem, but we as doctors are expected to help our fellow men and therefore we treat the patients as good as we can and what comes to costs we pretend as we do not know anything about it'. From SFG interviews with a surgeon (sometimes working in emergency dept.), a gynaecologist and an internist working at the emergency department were performed.

Midwives were contacted through an internet site of organisation for midwives, Koninklijke Nederlandse Organisatie van Verloskundigen (KNOV). 12 practices of midwives in Rotterdam were found through the site and five of them were contacted which were situated in areas with a presumable population of UMs. Noticeable is that midwives from all of these five practices agreed for an interview. According to Linking Fund 16 midwives are reimbursed from the fund in Rotterdam.

From GGD an interview with a policy coordinator was performed, who was responsible for submitting the subsidy claims of health care providers in the 1st line to the 'Linking Fund' and reimbursing their expenses and whose task was also to advice the director of GGD about

policies for undocumented migrants/illegal immigrants. Also a few questions were posed to person, who is a coordinator of the Street doctors and a mediator between the hospitals and Street doctors, if there is a difference of interpretation what comes to medically necessary treatment by a specialist in the hospital.

In addition 32 dental practices were called, whose phone numbers were found online. Of these 13 were on holiday at the time of calling in the beginning of August and 9 did not treat illegal patients. Assistants of six practices told me that they have also UMs as patients and one more practice had maybe one UM yearly in the emergency dental care. Only one of these practices was willing to give an interview in August, others said they are too busy, and therefore a decision was made to exclude dental care from the study. Two big institutions of the 2nd line in Rotterdam offering psychiatric care were contacted, Riagg Rijnmond and Bavo Europoort. At Riagg the reply was that their policy is not to give interviews and from Bavo Europoort I contact was made with a consultant of intercultural issues/medical anthropologist, who explained that most of their doctors work only temporary for Bavo Europoort as they are waiting for an opportunity to specialize and also that less than 1 % of the patients in the Bavo Europoort and other mental health institutions belonging to Parnassia Bavo Group are undocumented patients. Because it seemed very difficult in the timeframe of this thesis to get several interviews with mental health care providers working in the 2nd line the decision was made also to exclude mental health services from the thesis.

Finally contact was made with 13 UMs through private initiatives and the GP from Paulus Church. Interviews with UMs concerned their experiences with formal health care system and private initiatives. A convenience sample was used and interviews were performed with UMs who I could find and who were willing to answer questions.

In total 48 interviews were conducted, six with representatives of private initiatives, eight with both GPs and specialists, four with assistants of GPs, five with midwives, 13 with UMs and the rest with a professional at GGD, administrators and a employee of a financial department of a hospital. The sample sizes were considered being large enough to make comparisons, develop explanations and thus answer the research question. As a type of interview semi-structured interviews were used, because they allow a freer exchange between interviewer and interviewee than structured interviews. The questions were open-ended, allowing the interviewees respond in their own words. Interviews were tailored to the

interviewee and his or her responses shaped the order and structure of the interview. Therefore the questions did not necessarily need to be asked in the same order in all the interviews and different words could be used, which would not be possible with structured interviews. Semi structured interviews are useful for exploring a topic in detail and that is why it was a good interview type for this research. (Esterberg 2002, 85−87.) The interviews were recorded on a tape recorder.

5 Results

5.1 How does the health care system for UMs work in Rotterdam?

In order to get an overview of the health care system for UMs works in Rotterdam, health care professionals and UMs were interviewed. The aim was to detect possible problems in health care provision and what could be the role of private initiatives in assisting with these problems.

5.1.1 GPs and assistants

For the thesis eight GPs were interviewed, of whom seven had a private practice and one of them was working one day a week in Paulus Church treating mainly UMs. Four assistants at the practices were also interviewed. How often the GPs treat UMs varied a lot. GP with the least UMs as patients treats them once in two months and the Paulus Church has in total 800−900 UMs yearly as patients. Most of the interviewees told that they treat 1−2 UMs weekly. The definitions of necessary medical care also varied per GP, but the general line of thought was that it should be the same care as given to other insured patients. One GP emphasized that he does not want to categorize patients, as a GP it is your duty to help everyone and if you are going to help, you should do it 100%. Four of the interviewees recognized it as a problem that sometimes UMs postpone going to the practice, and come only when their illness is already severe. The GPs thought the illness could have been treated easier if they would have come earlier to the practice. The assumption of GPs was that this happens because UMs have a lack of knowledge about their right to health care or they are afraid they cannot get treatment if they cannot pay for it.

The GPs did not encounter many problems in their work with UMs, but ensuring treatment for UMs in the 2nd line of health caused more trouble. Most of the interviewees had to spend time in convincing specialists in the hospital about treating these patients. The street doctors and the doctors from Paulus Church are dealing most with this issue as they had the most undocumented patients. Especially in 2006 and before that, there were big problems in getting UMs treated in hospitals. In 2006 street doctors, GGD and the managers of the regions' hospitals agreed that if the specialist agrees with the street doctors (or other GPs) that UMs

need 2nd line health care, an appointment is made. According to the coordinator of street doctors from GGD the system of health care for UMs is working well nowadays, he is only contacted once a month or less by a GP or specialist concerning medical treatment for an UM in a hospital. In the Street doctor's view the new financing regulation including hospitals will further facilitate UMs' access to hospitals.

Table 1. GPs' views of the biggest problems in the health care system for UMs and their suggestions for improvement.

Problem	*Problem description*	*No. of doctors that consider it a problem*	*Suggestions for improvement*
No insurance	UMs cannot get insurance	2	UMs could buy insurance; government could pay for insurance for at least children; Creating a fund that reimburses also hospitals
Lack of knowledge	UMs do not know where to get health care	1	GGD or other org. should inform UMs about right to health care; UMs could call this org. in case of refusal; voluntary treatment by GPs
Specialists do not help UMs	Specialists in hospitals (sometimes) do not treat UMs	2	Fund that reimburses also hospitals
Fear of UMs	UMs think doctors will contact the police and they will be sent way if the go to health care services→ leads to life threatening situations	2	Government should start health care centers for UMs and inform about them openly
UMs not allowed in shelters	UMs cannot sleep in shelters, if they do not have a place to stay, they get ill again, though health care works well	2	Permission for UMs to sleep in shelters
No after care in hospitals	UMs are sent away from hospitals quickly	2	After care should be longer; Fund that reimburses hospitals

5.1.2 Midwives

Five midwives from five different practices of midwives in Rotterdam were interviewed for the thesis. In the practice with most illegal clients 5−10 % of all clients were living illegally in the Netherlands. Two other midwives mentioned about 3 % of their clients being illegal immigrants and two stated the monthly amount of illegal clients, which was 2 to 3.

None of the interviewed midwives questioned UMs right to health care or maternity care and said that everyone has a right to health care whether they are insured or not. Illegal clients were given the same care as for every other client including prenatal care, delivery and postnatal care. All midwives told that when UMs have their first appointment at the practice

paying for the treatment is discussed. The package including all three parts of treatment costs around 800 € and the price is same for all uninsured patients, regardless of how early or late in pregnancy UMs come to the practice. This price is regulated by the government and insurance companies. How many undocumented clients could pay for the care varied between midwives. Usually most (even 80−90 %) UMs would not pay for treatment, some paid a part of the amount. One practice was exceptional as most UMs paid for treatment in parts and at the end the whole amount was paid. Midwives in all of the practices knew about Linking Fund, but one of them had not made use of it yet, as she did not know who the contact person of the fund in GGD is.

The problems midwives had encountered in their work with UMs included:

- Judging whether a person can pay for treatment or not
- UMs' financial difficulties
- UMs postpone coming to practice, assume they can pay less the later they come
- Language problems
- Lack of knowledge about the Dutch health care system
- Treating UMs requires more time and energy than treating regular patients
- UMs often do not have a GP

Midwives considered it sometimes difficult to judge whether an UM can pay for treatment or not and reckoned that with this system there will always be people who do not tell the truth about their financial situation. UMs talk to each other and are aware of existence of Linking Fund, which decreases their willingness to pay. On the other hand midwives were conscious of financial problems of UMs, lack of money causes for example that they cannot purchase anything for themselves or the baby and their apartment might not even have proper circumstances for delivery; in the worst case no electricity or warm water. Midwives have also seen cases in their work when UMs come only very late in the pregnancy to the practice, presumably because they think they later they come the less they can pay for treatment. But if UMs come to the practice for the first time only between 6 and 7 months, the pregnancy is considered uncontrolled and the hospital will take over the responsibility for treatment. This is obviously far more expensive.

Other problems include language problems, UMs lack of knowledge of the health care system in the Netherlands and mothers ignoring advice related to care for the baby. Treating UMs requires sometimes more time and energy from midwives as UMs have more problems than regular patients. They are not entitled to social services and seldom receive mental health

care. Midwives sometimes feel as they should be social workers, psychologists as well as sisters to UMs. They stated that UMs often do not have a GP and then a simple untreated complaint like bladder infection can worsen and at the end the patient needs to go to a hospital for treatment and receives a huge bill.

Midwives considered UMs lack of insurance and inequitable paying policy the biggest problems in the system of health care for UMs. Midwives had considered that UMs should always pay 25 % of care, but decided not to take the policy, because they were afraid that UMs would not come then to practices at all. They thought that UMs should be able to take out insurance or that hospitals should be included in the fund as well. One midwife longed for a clearer policy for all actors involved in health care for UMs and one desired that UMs would be better informed and would come to the practice earlier. But the question is how to inform them, because it is hard to know who they are and where they live.

5.1.3 Specialists and administrators in hospitals

For the thesis eight specialists and a nurse from three different hospitals in Rotterdam were interviewed about their work with UMs. In addition three people working at administration and one from finance department were interviewed to get a clearer idea about admission procedures of UMs to the hospital and billing of medical treatment.

The specialists treated UM much less than GPs, which is quite natural. The amounts varied from two per year to one a week, the doctors at emergency departments treating the most UMs. The views of specialists concerning medically necessary care for UMs differed from each other, most described it as acute care, emergency care, treating life threatening or other serious illnesses or illnesses that can cause a health problem to other people. Often combination of these definitions was used. One specialist who treated UMs coming to the hospital from deportation area elaborated on his view of medically necessary care being acute care. Illness is then in such an acute phase that it needs to be taken care of before UMs can return to where they come from, for example a groin hernia which is a reason for surgery in a few months is not acute and therefore should not be operated.

The specialists who worked in emergency departments met also UMs with less severe illnesses or injuries in their work. This was due to the fact that UMs are often not treated by a

GP and might therefore walk in the emergency department with a complaint that should be treated by a GP. They agreed that doctors might interpret what is care that can be postponed and what not a bit differently. Three of the doctors thought that it is fairly easy to see what urgent or acute care is. Acute cases are taken care of and UMs with for example minor or chronic complaints are advised to see a GP, go to GGD or contact a policlinic for further care. This is the same for insured patients, thus treating insured patients does not differ from treating uninsured patients. One of the doctors found it difficult to judge whether care can be postponed or not and as he did not always know if patients were insured or not he just treated them, even with non-acute problems.

Although specialists agreed that the policy concerning care for uninsured patients had not affected the core of their work with UMs, there were a few implications to their work. One of the doctors at emergency care said he tries to treat UMs more as outpatients than admit them to the clinical wards, because admission is very expensive. This is possible, because UMs are often young patients. Another specialist had been contacted from the financial department to send the undocumented patient pay the bill of treatment and was also advised to send the UMs rather quick away from delivery room to save costs. What became evident in the interviews was the growing emphasis of the financial aspect in treating uninsured patients, which is clear in these examples. Specialists were aware of the high costs of treating UMs, who often do not pay their bills and the dissatisfaction of the boards of hospitals with the situation. One of the specialists mentioned that the "dubious debtors" budget is not covering the losses caused by treating UMs in their hospital. But the specialists also emphasized that as doctors they want to help patients and are not concerned with financial matters.

What appeared in the interviews with administrators and a person working at finances is that the billing procedures for treatment of uninsured patients vary between hospitals and departments. It was becoming however more common to ask for money from UMs before the treatment or try to agree upon a paying plan rather than send bills to them afterwards. In practice UMs cannot often pay for treatment, but all interviewees emphasized that it does not hinder access to treatment. It is always a doctor who decides about treatment, no one else can do that.

Table 2. Problems specialists encounter in their work with UMs

Problem	*Problem description*	*No. of doctors*
Language barrier	Because of language barrier diagnostics is difficult	3
Cultural differences	Not understanding how people of a different culture behave with a certain complaint; UMs "wrong" beliefs concerning diseases	2
Paying for treatment	UMs cannot pay for treatment, causes financial loss for hospital	2
False identity	Creates problems with e.g. blood types	2
Prolonged treatment	How to offer prolonged treatment as UMs seldom come back to emergency department	1
Blaming a doctor unjustified	Family of UMs can blame doctor for not helping the patient because he is illegal, the right reason being that patient's disease was too complicated or advanced	1
Different ideas about medical care	UMs can require diagnostics or medicine the doctor does not find necessary	1
Patients angry because of refusal	UMs might get angry because of refusal though it is for a good reason	1
Nursing homes do not normally accept UMs	UMs cannot get after care in a nursing home→ might need to stay in hospital for weeks; expensive	1

Problems that specialists came across most often were a language barrier, cultural differences, paying for the treatment and false identity. Other problems were mentioned once and can be seen in the table 2. Paying for treatment was considered a problem with UMs as well as using false identity documents and insurance. This can create confusion for example when a person's blood type is different what is stated in the system.

The specialists working in the hospitals agreed that health care for UMs is a political and a financial issue and were cautious of sharing their opinions about how the system works and if and how it should be improved. A few said that it is a question for the government, solutions should not be made on hospital level. Some of the doctors mentioned that they think people who are in the country should get good health care, but also that if UMs are given all care for free, more UMs will come to the country, which is not desirable. One gynecologist thought the system is working well, while the other one said it does not work at all. There are more babies dying during pregnancy than in other big cities in the Netherlands, one of the reasons being that care for illegal immigrants is not good enough.

5.1.4 Undocumented Migrants

For this thesis 11 UMs were interviewed about their experiences on health care services in Rotterdam. In addition one man was interviewed who had received his residence permit in

June 2008, but lived before that several years illegally in the country and one man who had gotten a residence permit based on medical grounds some years ago, but had also lived before that few years illegally in the Netherlands. Of the 11 interviewees 10 were rejected asylum seekers and one had never applied for asylum but lived illegally in the country for eight years. All of the interviewees were men, most between 20 and 40 years old. Two were older than 40 years. The country of origin was not clear in all cases as it was not specifically asked for, but most respondents were from Africa or Asia. Thus the background information of the interviewees matches well to that of a typical illegal immigrant. The interviewees had lived in the Netherlands between 7 and 20 years.

Maybe most striking of these interviews was that five of the UMs did not think they had any right to health care services when they are living illegally in the Netherlands or would not know where to find a GP. These respondents had not received health care services, either because they had not been very ill (and did not seek a doctor) or in one case because he had been refused of care several times. These interviewees had not seen a GP between in three to eight years. This finding confirms the results of previous research, in which UMs lack of knowledge about their right to health care has been found out to be a hindrance in accessing health care (van den Muijsenbergh 2004).

Of the eight interviewees who had been to see a GP while living illegally in the Netherlands, five had been to the Paulus Church, one to Street doctors and two to normal GPs. In addition three of the interviewees had been to see a dentist, two through Paulus Church from where they made appointments to UMs and one found a dentist own his own. The man who had lived 20 years in the Netherlands had not been to see a dentist in the whole time. Six of the interviewees had been to a hospital in Rotterdam. Two of them had hiv or aids, so they had been first to GGD, from where they were referred to get treatment in a hospital. Two said they had visited a hospital one time from a detention centre, where they were held because of residing illegally in the country. One man had a heart condition and he had been to a hospital several times and had two heart operations. In addition one interviewee admitted that he had visited the hospital with insurance of his friend, just as he had visited the GP.
Although eight interviewees had received health care services in the 1st line and six in the 2nd line, they had lack of knowledge about their right to health care or how the Dutch health care system works. Four interviewees who had been to the Paulus Church for health care said either that they do not think they have a right to see other GPs than those at Paulus Church or

that it is the only place they know where to look for help. Also the two men who had been to see a regular GP either with someone else's insurance or with help of a girlfriend said that they think they would not have a right to see a GP without valid papers. The interviewees who had received treatment for hiv or aids in a hospital obviously knew they were entitled to that but for other treatment they turned to either Street doctors or Paulus Church instead of regular GPs. Six of the interviewees had been to a hospital, so they knew they can get treated there, but still there was confusion about what kind of health care they are entitled to in the 1st line health care services and where can they receive this health care.

None of the UMs who were interviewed had paid for the care they had received and at least one had paid for medicine, which was gotten with someone else's insurance. Two of the interviewees had been refused of health care, one man was once refused in a hospital, because he did not have insurance, but this happened in the Hague. The other man claimed to have been refused several times in GP's practices and also at a hospital in Rotterdam because he did not have the adequate documents. All in all the UMs who were interviewed were fairly satisfied with the health care they have received. A general impression was that as many of them thought that they do not have a right to health care or did not know where to look for it, they appreciated the care they did receive. One man commented that "health care at Paulus Church is better than nothing".

Most of the interviewees were rather young and did not need so much health care services excluding the HIV patients. One interviewee was over 50 years old and because of his heart condition needed more care. He was relatively satisfied with the care he had received, but as he did not have a house to live in, his biggest concern was that he does not have a place to rest. He could spend his nights in a shelter, but during the days he was on the street. Many of the interviewed UMs lived at their friends' places, but kept changing the place where they lived, partly because of fear for the police. It seems that UMs can still manage as they are young and do not have serious illnesses, but if they get seriously ill, things get significantly more difficult, especially without round-the-clock accommodation. It is clear that although a doctor would treat the patient as well as he can, but if after that the patient is back to the streets, he will most likely get ill again. Therefore health care for UMs is a considerably wide societal problem, which includes social and economical factors as well as of course political decision making.

Two of the interviewed UMs had been to the information evening and filling in the MEDOC by Doctors of the World, though one of them misunderstood the project as he got a letter home in Dutch, which he does not speak well. He thought he could receive free health care when he had a meeting to fill in the medical project. These two men were however satisfied with the medical document and thought it could be useful for them. One of the interviewees was a client of hiv/aids project of Foundation Mara. He had met the coordinator of hiv/aid project as he was previously treating his girlfriend. He appreciated the conversations with him and even more the housing that he can have through the project. Two interviewees were contacted through a GP of the Paulus Church and the rest through ROS by attending their speaking hours. Almost all UMs who came at the time of the interviews in the beginning of August to ROS had questions related to the generaal pardon procedure. None of the interviewees had been to a private initiative to ask for example about how to find a doctor or help with received bills.

5.2 Private Initiatives in Health Care for Undocumented Migrants and their activities concerning health care for UMs

5.2.1 Churches

Contact was made with representatives of 11 different churches, which included the Reformed (gereformeerde), Evangelist, Dutch Reformed (hervormde), Salvation Army, Pentecostalist (pinkstergemeente) and Roman Catholic churches. From seven of these 11 churches the reply was that UMs do not come to their churches or that no people with health care problems come there. The other churches did not assist UMs themselves, but referred them to Salvation Army, Stichting Ontmoeting or to ROS. An advice was received to contact Oude Westen pastoraat, who have an employee working with UMs. These organizations were then contacted. From Salvation Army's social work the reply was that it is against the policy of Salvation Army to help UMs and therefore they are referred to Sisters of Charity. They offer UMs food and accommodation, but cannot help UMs with health care. UMs with health care problems are referred to Paulus Church. Stichting Ontmoeting, which is an organization helping homeless people, had a nurse until recently who treated also UMs, but now they also refer to UMs to Paulus Church for health care. In addition a street doctor comes once a week to the foundation to treat patients. A person from ROS and Oude Westen pastoraat were later performed.

Next contact was made with different migrant churches, which might attract more UMs than regular churches. Respondents of 11 different migrant churches were talked to, of which some were churches for a specific nationality or a language group. From six of these churches the replies were for example that no illegal immigrants come to the church or that they do not know if people who come are legally or illegally in the country. A few respondents knew UMs and they visited the church, but they had not asked about health care related matters. From two churches UMs were referred to ROS and CVD, which according to one respondent has a list of doctors who help UMs.

In three of the contacted migrant churches UMs with health care issues are referred to a certain doctors who help them. One of these churches had cooperation with a certain GP to whom UMs can go for free health care. In one parish UMs are referred to doctors who the people from the parish know. These are usually members of the parish, who have agreed to help UMs.

As a conclusion it can be said that UMs seem to go to migrant churches more often to ask about health care than to "regular" churches, where mainly people of Dutch origin go to. It is natural that people of certain ethnicity turn to look for help in a church representing that ethnicity. And because migrant churches come across more UMs in need of help than regular churches, at least some of them have arranged ways to help these people. One of the ways is health care provision. A doctor treating UMs is likely to be a member of the church or otherwise known by the parish. As the contacted churches are just a fraction of the (migrant) churches in Rotterdam, this review does not give a complete picture of the role of churches in health care for UMs. It shows however that UMs do sometimes turn to churches to ask for help, also in health care matters. Especially regular churches mainly refer them to another organization they think can help, while migrant churches may refer them straight to a GP they know.

5.2.2 Private initiatives

During the research information about six private initiatives was found, that operate in the field of health care for UMs in Rotterdam. To be included in this category the private initiatives needed to do something more for UMs than just refer them to health care services, like to GGD or the Paulus Church. This means the private initiatives were one way or another

involved in ensuring health care services for UMs. Therefore organizations like CVD, Humanitas or Sisters of Charity were not included. They offer food, shelter and also social support for UMs which form a basis for health and wellbeing. The private initiatives in this research are Doctors of the World (Dokters van de Wereld) House of Hope[3], Mamre project, Mara Foundation (Stichting Mara), Oude Westen pastoraat and ROS (Rotterdams Ongedocumenteerden Steunpunt).

Table 3. Overview private initiatives' activities concerning health care for UMs

Activity	Private initiative
Informing UMs about Dutch health care system and their right to health care	DOTW, ROS, Mamre
Filling in a medical document	DOTW
Testimonies of refused care	DOTW
Lobbying and advocacy work	DOTW, ROS, OWP
Informing nonprofit organizations about work with UMs	ROS
Informing 1st line health care providers about Linking Fund	DOTW, ROS
Accompanying UMs to health care services, arranging appointments	OWP, Mara, Mamre, HH
Contacting health care providers because of billing	ROS, HH
Counseling for UMs	Mara
Buying medicine for UMs	OWP
Gathering funding for health care	OWP
Negotiating about providing health care	ROS, DOTW

DOTW = Doctors of the World, HH = House of Hope, OWP = Oude Westen pastoraat

Doctors of the World is a medical humanitarian organization and a Dutch branch of the international organization Médicines du Monde. It offers medical and psychosocial help to vulnerable groups overall the world. Its other aims are to promote the right to health, to indicate violations of human rights and give information to the public with their experiences as a source. The association of Doctors of the World was set up in 1997 and in 2007 there were 11 paid employees in the head office of Amsterdam as well as several volunteers. MEDOC project for UMs was funded in 2007 by Stichting Loterij Acties, Commissie PIN (Projecten in Nederland), Fonds Nuts Ohra, Cordaid, Stichting Maagdenhuis and SKaN Fonds. (Dokters van de Wereld.)

Doctors of the World differ from the other private initiatives in the sense that they are not working constantly in Rotterdam, but had a MEDOC project aimed at health care for UMs in Rotterdam in the summer of 2008. This project consists of three parts, the MEDOC, testimonies of UMs over refused care or wrong practices and lobbying and advocacy work.

[3] See the part of House of Hope in Appendix 6

The MEDOC part of the project includes an information evening, where UMs are explained how the Dutch health care system works and how they can get access to health care. UMs are given letters to bring to 1st line health care providers explaining what Linking Fund is and how the health care providers can declare their earning losses, if UMs cannot pay for the received care. UMs are also told what the medical document (MEDOC) is; that it is not for example a passport to the hospital, but that in it is written the medical history of the person, how their life circumstances are right now, the family history, allergies and medication. After the information evening there are consulting hours where UMs who want a MEDOC can come and the document is filled in together with a trained volunteer. According to the three volunteers who were present in the interview MEDOC is meant to make the consultation between the GP and UM easier as an UM can just show the document to the GP without an explanation of medical history. This is especially practical if the UM often changes GPs and/or the municipality where she or he lives, as is often the case. MEDOC is also useful if there is a language barrier between the GP and UM.

While filling in the medical document UMs are asked if they have ever been refused of care or have there been problems in receiving care. If there has been such an incident and the UM is willing to tell about it, a time for a testimony can be made. The aim is to map these incidents, where do the problems occur, how often and how could the situation be changed? The third part of the project is lobbying and advocacy work, which is done based on the information received from the testimonies. Doctors of the World try on an individual level to be a mediator between the UM and the health care providers and on a collective level bring the problems to knowledge of the institution in question or the (local) politics. (Dokters van de Wereld, 2008.)

Mamre project is an ecumenical initiative, which is offering hospitality to migrants in the city of Rotterdam. The project got started at a city mission conference in 1996, where many of the churches were faced with the issues of increasing number of migrants, but it was not always possible to offer them hospitality or to help them with their questions. This realization was at the roots of Mamre project. Funding for the project has been sought since 2004 and the project has expanded. Nowadays the project is funded by gifts from companies, individuals and churches. In 2004 a part-time employee started working for the project and besides her there about 10 regular volunteers working for the project. (Mamre project.)

From Mamre project the coordinator of the project was interviewed. She sometimes meets UMs in her work that have a health care problem and do not know where to turn to. In such situations she often refers them to the Paulus Church, but did also arrange few times an appointment with a GP whose number she received from a contact at GGD. She has also been with UMs to see a GP and accompanied them to the outpatient clinics of hospitals to make sure that they will get seen to. Mamre project was also organizing a workshop together with ROS, Paulus Church and SKIN (Samen Kerk in Nederland) some years ago about UMs rights to health care. The coordinator of the project has been asked by ROS if she would be willing to accompany UMs in the future to hospitals if there was any need and she has agreed to do that.

Mara Foundation is a cooperation of three catholic organizations for societal activation work in the province of South Holland. In the beginning of 2006 organizations in the Hague and Rotterdam had a fusion and they continue their work under the name of Mara Foundation. The aim of Mara Foundation is to activate volunteers to help people who have ended up in a disadvantaged or vulnerable position because of developments in the society. Mara Foundation gets funded by the local government, different funds, local churches and big companies. In Mara Foundation there are about 25 paid employees and 100-150 volunteers. (Mara Foundation.)

From Mara Foundation a coordinator of the project for hiv/aids patients was interviewed. The project was started already in the 1990s, but he has worked on the project since he came to work for KZW, the predecessor of Mara Foundation, four years ago. In this project he offers hiv/aids patients counseling and coordinates a meeting place with volunteers. He is also a coordinator of a shelter, which offers accommodation and food for people with crisis situations, who do not have a place to stay. In addition he is involved with a network that organizes activities for people with hiv/aids.

Besides Dutch citizens five UMs with hiv/aids have received counseling in 2008, of which three live in the shelter. The coordinator of the project meets with them regularly, every 3 to 6 weeks. This counseling or mental support is not providing health care in the sense that health care is provided by health care professionals, as the coordinator of the project is not a health care professional, but a theologian. This kind of counseling can be however considered health care according to a broad definition, which includes: the services offering diagnostic,

preventive, therapeutic and rehabilitative interventions, designed to maintain or improve a person's state of health or alleviate a person's suffering. (de Groot 2005.) The interviewee says that he gives people space to talk about their lives, telling their life stories is important and a form of healing. In counseling he talks together with the client for example about the traumatic events in their life, possible torture and the taboo of hiv or aids. Most people have had their disease longer, but according to the interviewee it takes time to talk about the disease. He supports the people in counseling and together with them tries to find sources in their lives. If someone has very severe psychiatric problems that he cannot solve he refers them further to GGZ. In addition if he sees that UMs are in need of physical care, he organizes that they can go to a consultation hour of the Street doctors. He can also send them to social work of hospitals that in turn make an appointment with a doctor. A few times he accompanied UMs to hospital.

Oude Westen pastoraat is one of the 60 projects Of Urban Mission, that in their own way give a place to local residents and people in vulnerable areas of the city (Urban Mission, 2003). According to a fulltime employee who was interviewed Oude Westen pastoraat is a community approach, which is church based, supported by Catholic Reformed and Dutch Reformed Churches. Oude Westen Pastoraat is one of the four locations that belong to the same initiative in Rotterdam. The most important aim of the initiative is to support the people who are "falling through the holes in the welfare network", the weakest people in the society. The pastoraat in Oude Westen was founded in 1982. It has four paid employees, of which two work fulltime. There are also eight regular volunteers, but in the groups there are more volunteers. The employees are paid by churches and for their activities they get funding from the local government and different funds.

In Oude Westen Pastoraat the employee who was interviewed helps UMs maybe two or three times a week with health care issues. Sometimes it is with small things, like getting recipe free medicine from the pharmacy, which he pays from the fund of the pastoraat. He also helps UMs to find a doctor through his contacts. He has an agreement with some GPs, Paulus Church and hospitals that he can call them to make an appointment for an UM. Sometimes he goes together with UMs to GPs practice or hospitals, because they are afraid to be refused of care or are already refused. When they go together, there are no problems. The interviewee believes it is important to have good contacts to doctors in order for UMs to get help. If UMs contact GPs themselves, they can easily be told the GP has enough patients and cannot help.

In addition, the interviewee gathers sometimes funding for dental care of UMs that according to him is not reimbursed through the Linking Fund. This is not true, as according to the policy coordinator at GGD, Linking Fund compensates 15 dentists at the moment in Rotterdam.
Rotterdams Ongedocumenteerden Steunpunt (ROS) is an initiative for refused asylum seekers, migrants without permanent residence permit, volunteers and professionals who work with undocumented people and institutions, self organizations and churches. It offers advice and information during office hours for undocumented migrants about procedures concerning residence permits and is a mediator between undocumented migrants and lawyers, medical care and education. ROS also promotes interests of UMs, does lobbying and protesting. (Stichting KSA.) ROS was founded in 2004 and has two part-time employees and around five volunteers, three of them work for the language school that provides Dutch lessons. ROS gets funded by churches, private donations and funds. This year ROS also receives money from the local government, because they are working on the generaal pardon act for municipality of Rotterdam. This financial support is not structural and next year ROS is dependent on funds and donations from churches.

What comes to health care, ROS advises UMs to contact a health care provider in the neighborhood they live in. To the first appointment with a GP, dentist, midwife or physiotherapist ROS gives a letter to the UM, which explains that the person is uninsured, has no right for income from work and requests the health care provider to provide medically necessary care and declare the costs from Linking Fund by sending the form to GGD. If the health care provider refuses to treat the UM after reading this letter, the employees of ROS will call the health care provider in order to convince him or her to treat the patient. The UM gets another form to be given at the pharmacy if he or she is not able to pay for the medicine. ROS also helps UMs with hospital bills, not by paying them but sending hospitals letters asking them to stop sending bills because UMs cannot pay them. Sometimes it continues and hospitals sent the bills to a debt collector's office (incassobureau), which is forcing people to pay the money. If UMs bring these bills to ROS they will call this office and explain the situation. From the office it is said that they will take contact again to the hospital and after that sending bills normally stops. ROS has organized information evenings for UMs about their right to health care, last together with Doctors of the World. Their plan is to repeat these information evenings every six months if necessary. In spring of 2008 ROS started a meeting for organizations working with UMs, for example churches, to inform people about possibilities for UMs. They also advise these organizations by phone.

These activities of private initiatives can be linked to the different roles of nonprofit organizations. Most clearly the private initiatives in the research have the roles greater equity, specialization and complementarity. Greater equity means that the private initiatives serve those in greatest need. UMs can easily be fitted to this category as they do not have a legal right to be in the country and are entitled to only few services. That is why especially ROS, Doctors of the World, Oude Westen Pastoraat and to some extent Mara Foundation have this role as they are regularly dealing with UMs, who often do not have housing, work, money or knowledge about their rights or obligations in the Netherlands. In case of Mara Foundation they even have a serious illness. ROS is the most specialized of the private initiatives as their target group is UMs. Also the MEDOC project of Doctors of the World is specialized, as it is aimed at UMs' access to health care. With the other private initiatives the specialization gets less, Oude Westen Pastoraat being still for "the weakest people, who fall through the holes of welfare network". UMs can be included in the group, but not exclusively. A central role of the private initiatives is also complementarity. They assist an under-supplied group, UMs, who have different needs related to health care than normal insured patients. UMs need for example information about how the Dutch health care system works and how to access it. (Local) government does not supply these services to UMs. Reasons might be financial constraints or more likely unwillingness to supply services to this group. This role applies to all the private initiatives in the study.

At least ROS and Doctors of the World can be seen possessing the innovation role. Together with Paulus Church and Street doctors they are identifying issues which need attention related to health care of UMs in Rotterdam and also serving innovative solutions to the problems. As an example the MEDOC project can be mentioned. Further ROS and Doctors of the World have also the social and policy change role, as they are pushing for changes in government policy and societal conditions. Also Oude Westen pastoraat is lobbying for the group on a local scale for example in meetings of care network.

5.2.3 Why are the activities of private initiatives not performed by state agencies?

The local government of Rotterdam and the GGD do not perform the activities of private initiatives concerning health care for UMs. It is GGDs responsibility to ensure access to health care. At least information for UMs about the formal health care system in the

Netherlands and their possibility to receive health care could be provided by GGD if its benefits would be looked at from a public health point of view. According to an influential person in the field, the political shift of 2002 explains why services are not provided. In 2002 a new right wing party called Leefbaar Rotterdam formed the government in local elections. Informing UMs about the possibility to health care is not done, because they are not wanted in the city. The local government wants to do the absolutely necessary for them, like offer public health care, but not more.

According to a member of the committee for societal support, public health and participation (De commissie Maatschappelijke ondersteuning, Volksgezondheid en Participatie) in the local government of Rotterdam, the activities of private initiatives concerning health care for UMs cannot be performed by the state agencies because UMs are in the country illegally. There is fear that if the local government openly provides services for UMs, it will stimulate illegal stay and the amount of UMs will increase in the Netherlands.

5.2.4 Why have Private Initiatives emerged in the Health Care Sector for UMs?

Of the private initiatives in the study only ROS was specifically founded to help UMs because the founders of the organization realized that there is nothing arranged in Rotterdam to help also refused asylum seekers and there was need for such organization. Helping UMs with health care is one part of ROS' work, while Doctors of the World exclusively operates in field of health care, UMs being just one of their target groups. The aim of Doctors of the World is to support people all over the world who are vulnerable and need help in accessing health care. For these two organizations helping UMs to receive health care is aim of their work and they also cooperate to achieve this.

The Oude Westen pastoraat was founded to support the weakest people in the society, also UMs. It has not been an explicit aim of the organization to help UMs with health care, but because the interviewee has seen in his work that they need help in health care matters it has become a part of his work. The Mara project for people with hiv/aids was started already in the 1990s when a house was opened which functioned as a safe haven for people with hiv or aids. The project is not especially to help UMs, but the coordinator of the project sees that they need a lot of assistance and he feels it is his duty but also inspiration to help them. House of Hope and Mamre project were founded to help migrants and generally people in need, so

not especially UMs with health care matters. Sometimes people in these organizations however meet UMs, who have a health care issue and they try to help them to the best of their abilities.

Except for ROS and Doctors of the World all the organizations have a religious background and their main motivation to help UMs is their Christian belief. ROS is a humanitarian organization as they want to help people whose human rights are sometimes violated. Doctors of the World want to guarantee sufficient health care for everyone, which is one of the human rights. As a strongest reason why members have joined or founded these organizations are purposive incentives, thus rewards are associated with ideological interests tied to organizational values and goals.

As regards to Salamon's theory about different pressures causing the rise of nonprofit sector, support can be found that of the private initiatives ROS and Doctors of the World have emerged as a result of the pressures from "below" as ordinary people seek to improve the societal conditions. ROS was established by two men wanting to create an organization for UMs and Doctors of the World by doctors wanting to ensure health care for everyone. The rest of the private initiatives have emerged mainly as a result of pressures from "outside" through the actions of churches as in the work of these private initiatives support, funding and also religious views of churches are evident.

Oude Westen Pastoraat and Mara Foundation receive subsidies from the local government and House of Hope from the district of Charlois in Rotterdam which gives support for interdependence theory concerning emergence of private initiatives. Local government and private initiatives are not competing with each other as providers of services but are cooperating. House of Hope and Oude Westen pastoraat are doing community work to improve the lives of people living in underprivileged parts of the city, but do not set UMs as their target group. Thus the aim of their work is politically acceptable and exchange between private initiatives and local government is possible. In the case of Mara Foundation the local government subsidized the opening of a shelter for hiv/aids patients, where also UMs reside. There might be a strong political resistance if the municipality would decide to open such a shelter, but because it is considered a societal problem and even a threat to public health if these people would be wandering in the streets, cooperation between a private initiative and the municipality was agreed upon. Support for social origins theory can also be found.

Subsidizing private initiatives can be a continuation of the 20th century tradition in which the state mainly funded public services rather than performed these tasks.

ROS, Mamre project and MEDOC project of Doctors of the World do not get subsidized by the local government and especially in the case of ROS and MEDOC it seems their emergence is partially supported by the heterogeneity theory. These organizations have emerged because neither state nor the market is offering the services for UMs that they do. This is however not because the state is unable to provide services to UMs because of financial constraints. It is more plausible that there is no political will to provide these services to UMs. For the market UMs are not probable consumers because of their poor financial situation. Especially the work of ROS in different walks of life is not very suitable for political transactions because although UMs can receive necessary medical care in the Netherlands, the policies are aimed at excluding UMs from services and make them return to their country of origin. Therefore cooperation between local government and a private initiative assisting UMs is not very likely, excluding the generaal pardon project to which ROS receives subsidies from the local government.

5.2.5 The interaction among private initiatives and between private initiatives and the formal health care system/state agencies

The volunteers of Doctors of the World do not interact with the formal health care system, but concentrate on the work with UMs. People who are in charge of the project do the lobbying and advocacy work from Amsterdam. GPs and managers of hospitals are for example confronted and appealed for better treatment of UMs based on the information received from testimonies. Doctors of the World was one of the organizations that signed a lobby letter criticizing the new financing system of health care for UMs (Dokters van de Wereld 2008, 7). Civil society theory applies to this kind of interaction with the formal health care system and the government, because there is possible tension between the actors. They might not share the same values, as Doctors of the World emphasizes everyone's right to high quality health care, but the government for example is concerned about the effect of UM's exhaustive health care to (illegal) immigration. Doctors of the World do not cooperate with other private initiatives or nonprofit organizations in Rotterdam except for ROS, whose premises they could use during their work in the city. They were also dependent on the contacts of ROS to UMs, as ROS provided the addresses of UMs that they could be invited to the information evening.

The interviewee from Mara Foundation works regularly together with people from the formal health care system. He gets in contact with his clients through two hospitals he cooperates with. Consultants or nurses from hospitals contact him when it has appeared in an intake discussion with a patient that the (s)he has concerns with mental health care. He will then make an appointment with this patient. Sometimes he is also contacted from social work or the city. With GGD he works together around activities, not example on the topic of hiv/aids prevention. He has attended meetings organized by GGD for people working with UMs, although not lately. Such interaction applies to interdependence theory and neo-institutional model. Mara Foundation and two hospitals have exchange and mutual support. Hospitals mediate the private initiative patients, for whom the private initiative provides counseling. Of nonprofit organizations he works together with different migrants churches.

The cooperation of the interviewee from Oude Westen Pastoraat with other actors in the field is based on the contacts he has made during his long carrier with Paulus Church, some GPs, dentists and specialists in hospitals. When UMs come to him asking help with health care related matters he relies on this network in trying to get help for the UMs. He has an agreement with Paulus Church to send patients there. If UMs have a recipe from a GP or a specialist but they do not have money to pay for the medicine, they can receive a stamp on the recipe from Paulus Church and get the medicine for free from a certain pharmacy. From GGD he has contact with people who are coordinating the local care network (zorgnetwerk), which at least officially cannot do anything for illegal immigrants. In addition to these official actors, the interviewee knows churches and other nonprofit organizations active in helping UMs and has contact with ROS, CVD and other churches. They also see each other in gatherings around this problem.

The coordinator of Mamre project has worked together with ROS, Paulus Church and SKIN to organize a work shop for UMs about health care. From the formal health care system she has had contact with GPs, when she has made appointments for UMs and with hospitals when she has accompanied UMs to hospitals to make sure they receive health care. From GGD she sometimes contacts a policy coordinator for advice, asking what the possibilities are in a certain situation.

Finally ROS has according to one of the founders' words a dual relation to the formal health care system as they are both forcing the actors in formal health care system and cooperating with them. This means that they contact GPs and hospitals if they have refused care for UMs and try to negotiate about helping UMs. They also contact hospitals because of bills they send to UMs, who often cannot pay them. To the local and national government ROS has contact when they try to lobby for better health care for UMs, for example the possibility for ill UMs to receive a pass to homeless people's shelters. Just as with activities of Doctors of the World, there is support for civil society theory, because of possible tension between actors due to different interests and values. ROS is invited to the meetings organized by GGD, where they try to bring out the human rights perspective in work with UMs. In these meetings new developments, problems and solutions in the field are discussed. There is both exchange and mutual support between GGD and organizations working with UMs. The policy coordinator of GGD hears in these meetings what is going on in the field and gives knowledge to organizations about new policies etc. ROS has contact and cooperation with several churches and both local and also national organizations, such as Doctors of the World, Johannes Wier Stichting and Pharos.

Most interviewed GPs, midwives, specialists and administrators did not know any private initiatives or said they knew only Paulus Church, which they considered being a private initiative. In addition few of the interviewees knew Street doctors. There were only few isolated cases who knew one of the private initiatives in this study. A GP cooperated with the Oude Westen Pastoraat as they are neighbors and one specialist had cooperation with Mara Foundation as the coordinator of the project for hiv/aids patients helped his patients. The doctor from Paulus Church was well aware of the private initiatives in the field and had contact with them for example in the meetings arranged by GGD. When GPs were explained about what kind of activities private initiatives have concerning health care for UMs they found the work of private initiatives mostly useful and some suggested that they should make themselves better known, become more active and also cooperate with GPs.

The private initiatives had the strongest connection of the actors in formal health care system to GGD, all of them had been in one way or another in contact with GGD, except the volunteers of MEDOC project. At least ROS and Mara Foundation had taken part in meetings for organizations working with UMs organized by the GGD and Oude Westen pastoraat to meetings of care network coordinated by the GGD, where it tries to lobby for UMs. A policy

coordinator of GGD was contacted by many of the private initiatives for advice. Interaction between private initiatives and GGD can be described as being cooperative. GGD gives advice to private initiatives and keeps them up to date what comes to policy changes. Private initiatives on the other hand let the policy coordinator of GGD know what is going on in the field, what problems they face etc. Mara Foundation and ROS had contacts to hospitals, Mara Foudation because of its cooperation with consultants and nurses in hospitals, who operated as a mediator between him and his clients. ROS sent hospitals letters about UMs' incapability of paying for their treatment. ROS, Oude Westen pastoraat, House of Hope and Mamre project contacted 1st or 2nd line health care providers, when they tried to connect UMs to health care services. Of the private initiatives Doctors of the World and ROS had most cooperation with each other, last with MEDOC project. All the other private initiatives were aware of the work of ROS and ROS, Mara Foundation and Oude Westen pastoraat had met in different gatherings related to UMs. They had also contacts to the churches helping UMs, ROS was providing churches information about possibilities to assist UMs. Except for the policy coordinator of GGD, the interviewees from the formal health care system could not usually name any of the private initiatives and had not been in contact with them at their work, excluding few exceptions.

6 Conclusions and discussion

In this section the sub questions of the thesis are first answered followed by the answer to the central question of the thesis. In addition suggestions to improve the work of private initiatives are provided as well as a reflection of the research.

6.1 Answers to the research questions

Which private initiatives exist in Rotterdam that deal with health care for UMs?

Six private initiatives were found during this study, which operate locally in Rotterdam in the field of health care for UMs. These private initiatives are Doctors of the World (MEDOC), Foundation Mara (hiv/aids project), House of Hope, Mamre project, Oude Westen pastoraat and ROS. Of these Doctors of the World is a national organization, but it was included in the study because of the project in Rotterdam. The private initiatives are in general small in size; the amount of their paid staff varies from one part-time employee to four employees, of which two work fulltime. Besides paid staff, private initiatives have 5 to 10 volunteers working for them.

Why have private initiatives emerged in the health care sector for UMs?

Of the private initiatives in the study only ROS and MEDOC project of Doctors of the World were founded exclusively to assist UMs. ROS emerged because according to the founders there was no organization in Rotterdam to assist UMs, but there was need for one. ROS assists UMs on different fields, health care being one of them. The aim of Doctors of the World is to help vulnerable groups worldwide in accessing health care services. In the Netherlands MEDOC project was started to facilitate UMs' access to health care and to record incidents of refused care or problems in accessing health care services. These two organizations have humanitarian motivations to assist UMs in accessing health care, as they consider the right to health care being an international human right, to which everyone is entitled to. ROS and MEDOC project have emerged as a result of pressures from "below" as ordinary people have sought to improve societal conditions.

The aim of the other private initiatives has not been to assist UMs in accessing health care, but because representatives of the organizations come across these people in their work and realize that they need help, they have created different ways in assisting UMs to receive health care services. These organizations have a religious background, thus their motivation to help UMs stems from their Christian belief. These private initiatives have emerged as a result of pressures from "outside", through the actions of churches.

Oude Westen, Mara Foundation and House of Hope receive money from the local government, which gives support for the interdependence and social origins theory in explaining the emergence of private initiatives. The work of these private initiatives is politically acceptable, because they do not set UMs as their target group. Therefore cooperation between private initiatives and the local government is possible. Heterogeneity theory applies partly in explaining the emergence of ROS and MEDOC project of Doctors of the World. These organizations have emerged to meet the unsatisfied needs of UMs concerning access to health care services left behind the failures of both the state and the market. Unlike the theory suggests the state does not want to provide these services to UMs (or subsidize private initiatives for offering these services), because policies of the government are aimed at excluding UMs from the services in the Netherlands. In addition, neo-institutional theory applies to the existence of all the organizations, because the institutional environment in the Netherlands is favorable to non-profit organizations and half of the private initiatives also receive financial support from state agencies.

What are the activities of private initiatives concerning health care for UMs and why do the state agencies not perform these activities?

The main function of private initiatives, which are active locally in Rotterdam, is to offer practical support to UMs in gaining access to the formal health care system. The most important part of this support consists of informing UMs about the Dutch health care system and their right to receive 'necessary medical care' and on the other hand of trying to ensure that health care providers perform their duty and provide this care to UMs. Private initiatives have different ways to reach the latter goal; they inform health care providers about how to get their money reimbursed from the Linking Fund, contact health care providers if they have refused care, arrange appointments for UMs and accompany them to GPs or hospitals. In addition, there are ways of assistance adopted by only one of the private initiatives, such as

filling in a medical document, buying UMs medicine and funding health care for UMs. Foundation Mara is different from the other private initiatives as it is offering counseling for UMs with hiv/aids. This reflects UMs' difficult situation as recipients of mental health services. Usually, they cannot get mental health services except in acute cases and when there is a danger to society (PICUM 2007, 62) and therefore solutions outside the formal health care system are created. More structural approach to assist UMs is to do advocacy and lobbying for the group. This is done by three of the private initiatives on local or national level.

The local government and the GGD do not perform the activities of private initiatives or subsidize them, because the national policy is to exclude illegal immigrants from public services. As one of the exceptions, UMs have a right to 'necessary medical care', but there is no interest on the political level to invest money on additional services aimed at UMs, such as informing them about this right. Politicians are afraid that offering services to UMs would increase the amount of UMs in the country.

Do the private initiatives cooperate with each other and with the formal health care system/state agencies, and if so how?

ROS has close cooperation with Doctors of the World, and they have also worked together with Mamre project. Mara Foundation, ROS and Oude Westen pastoraat have contact to each other in meetings for organizations working with UMs and especially ROS interacts with churches. Besides that, ROS cooperates with organizations working nationally. All in all, private initiatives are aware of each other's work with UMs, but work pretty much on their own in their own way. Relationship to the formal health care system is mostly cooperative and the actors support each other's work, as the interdependence and neo-institutional theories suggest. This is true especially with GGD, which is the institution private initiatives have most contact with. Sometimes private initiatives need to negotiate with health care providers and persuade them to treat UMs. In such cases as well as with contacts to the (local) government, there is possible tension between the actors due to different values and interests as the civil society theory suggests. Although most health care providers are not aware of the existence of private initiatives, private initiatives' work complements the work done in the formal health care system. The goal of private initiatives is to ensure health care services to

UMs and though it might differ per doctor, mostly their goal is to treat UMs just like insured patients. Thus the actors work in different ways to achieve the same goal.

Why do private initiatives, which are active locally in the city of Rotterdam, exist in the health care system for Undocumented Migrants (UMs) and what is their relationship to each other and the formal health care system/state agencies?

The main function of locally active private initiatives in Rotterdam is to offer practical support to UMs in gaining access to the formal health care system. This is done by informing UMs about the Dutch health care system and their right to receive 'necessary medical care' and on the other hand by trying to ensure that health care providers perform their duty and provide this care to UMs. All the private initiatives in the research are engaged in such activities. Another way to operate is to lobby for the group on national or local level; this is done by three of the private initiatives. These organizations' driving force to assist UMs is either their Christian belief or humanitarian reasons, as they believe that everyone should have a right to health care services. None of the private initiatives work only in the field of health care for UMs, but because they come across hindrances in the health care provision for UMs in their work, they keep on striving to ensure UMs' access to health care services.

Receiving subsidies from the local government supports the existence of Oude Westen Pastoraat, Mara Foundation and House of Hope. Their aims are suitable for political transactions, even in the case of hiv/aids project of Mara Foundation. The state could probably not perform its activities because of political resistance, but there are however demands to deal with the societal problem in question, accommodation and counseling for hiv/aids patients, and that is why transaction between the parties exists. Interdependence theory and social origins theory are in accordance with the existence of these private initiatives. ROS and MEDOC project exist, because neither state nor the market is providing UMs the services they find important and want to provide to UMs. The state is however not competing with the private initiatives over assistance to UMs as the heterogeneity theory suggests, but is unwilling to provide these services to UMs. There may be tensions between the local and the national government and private initiatives, because they disagree about assistance given to UMs. This applies to the civil society theory.

The private initiatives cooperate with each other, recently for example ROS and Doctors of the World cooperated during the MEDOC project. Private initiatives also meet each other in meetings for organizations working with UMs and are aware of each other's work, but still mainly work on their own in their own way. The relationship to the formal health care system is mainly cooperative and there is mutual support between the actors as the interdependence and neo-institutional theories suggest. This is especially true in the relationship between GGD and the private initiatives. GGD gives advice and information about new policies to private initiatives, and private initiatives on the other hand keep the GGD up to date about current happenings, problems etc. on the field. Once in a while the interests of private initiatives and the formal health care system or state agencies clash, when for example a hospital wants compensation for the provided care, but private initiatives claim the UM cannot pay for the care. In such cases the relationship is not one of cooperation, but of tension, which supports the civil society theory.

6.2 Suggestions for improving the work of private initiatives

From the interviews with health care providers it appeared that the formal system of health care is working relatively well for UMs in Rotterdam. Financing the 2nd line health care causes perhaps most complications. In the 1st line 64 GPs, 15 midwives and 15 dentists make use of the Linking Fund and in addition some health care providers treat UMs, but do not make use of the fund. Nothing can be said about mental health care and dental care services, which were excluded from the research. It is likely that UMs' access to 2nd line health care becomes easier and after care will improve when the new financing system compensating also hospitals and rehabilitative centers comes in force in the beginning of 2009. Problems are likely to appear elsewhere, for example dental care will not be compensated for adults anymore.

Health care providers in the 1st and 2nd line do however encounter problems in their work with UMs or recognize problems in the health care provision for UMs. In removing especially hindrances of UMs in health care provision, the contribution of private initiatives is vital. In at least the following problems, encountered by the health care professionals, providing sufficient information to UMs could facilitate their access to health care services:

- UMs postpone going to health care services, because they do not know about their right the health care, even without paying

- UMs do not know where to receive health care services, they are afraid of getting caught by the police
- UMs assume they can pay less to midwives the later they come to the practice
- UMs do not know how the health care system works
- UMs use false identity documents in hospitals

ROS, Doctors of the World and Mamre project have organized information evenings for UMs about their right to health care. But as became evident from the interviews of UMs, there is still a lot of uncertainty among them what comes to health care services. GGD focuses on informing health care providers, for example about the new financing system of care for UMs, but informing UMs seems truly a task for private initiatives as it is not interesting for either the market or the state. Private initiatives have also means to do it, as they are able to reach at least a part of the population of UMs. In order to offer knowledge and support to as many of the UMs as possible, private initiatives should cooperate more with each other as well as with churches and mosques. This is especially important because of the small size and limited resources of the local private initiatives. Projects with nationally operating organizations can be useful as in the cooperation of ROS and Doctors of the World. Communication is important, so that all actors are well informed about current policies etc. In that way, for example funding for care, which can be reimbursed by a health care provider from a special fund, would not be sought as has been the case. A possibility would be to start a same type of internet site as the national Lampion for local organizations working in the field. On the site organizations could keep each other posted of current happenings on the field. Also questions could be asked, to which others could respond to. Although UMs might have limited access to internet, it could be another medium to provide information to them. Besides, as one of the GPs suggested, private initiatives could make their work more known especially to the health care providers on the 1st line. In that way health care professionals could refer UMs to private initiatives. From the private initiatives they could receive assistance which cannot be provided in the formal health care system.

6.3 Reflection of the research

The aim of this explorative research was to gain knowledge about private initiatives in the field of health care for undocumented migrants in Rotterdam. The activities and existence of private initiatives and relationships between private initiatives, the formal health care system and state agencies were researched. The empirical part of the research was conducted by

performing semi-structured interviews with the representatives of all the found private initiatives (6), with health care professionals and other people working in the formal health care system (29) and the UMs (13). In addition literature review on the relevant theories concerning nonprofit organizations and on UM's right to health care was done.

Actors in the field were willing to provide me with enough information. Therefore I managed to get a good view on the system of health care for UMs. Only the activities of mosques remain unknown. The mosques that were contacted either did not cooperate or claimed not to receive UMs. Since churches are an important source of help to UMs, it is likely that also mosques have a role in helping UMs. Further research could be directed at the role of mosques. In addition, the nationally operating private initiatives would be an interesting study object, because their activities might be more versatile than those of local private initiatives. Researchers should keep in mind that politicians are often reluctant to discuss matters concerning UMs and UMs on the other hand might be scared to talk to researchers. This research provides a practical example of how the private initiatives function on a specific field and gives empirical support on theories about nonprofit organizations. The research is especially relevant for the private initiatives in the field, because they can find out about each other's services and receive suggestions to improve their work. Also people working in the formal health care system can benefit of this study by gaining knowledge about activities of private initiatives. Thus when they meet UMs with social or other problems in their work, they could advice UMs about organizations providing assistance to UMs.

Sources

Anheier K. & Daly S. (2007): *The Politics of Foundations*. A comparative analysis. Routledge, London and New York.

Benefit Entitlement Act [Koppelingswet] (1998): art. 1C

Broeders D. & Engbersen G. (2007): The Fight against Illegal Migration: identification Policies and Immigrants' Counterstrategies. In *American Behavioral Scientist* 50, 1592−1609.

Burger A., Dekker P., Ploeg, van der T. & Veen, van W (1997): Defining the Nonprofit Sector: the Netherlands. *Working papers of the Johns Hopkins Comparative Nonprofit Sector Project*, no. 23. Baltimore, U.S.A.

Burger A. & Veldheer V. (2001): The Growth of the Nonprofit Sector in the Netherlands. In *Nonprofit and Voluntary Quarterly* 30; 221.

Burgers J. & Engbersen G. (1999): *De ongekende stad 1. Illegale vreemdelingen in Rotterdam*. Boom, Amsterdam.

Committee Klazinga (2007): *Arts en vreemdeling*. Rapport van de Commissie Medische zorg voor (dreigend) uitgeprocedeerde asielzoekers en illegale vreemdelingen. Pharos, Utrecht.

CVZ (2008a): Taking care of health care. Information on the College voor zorgverzekeringen (Health Care Insurance Board. [Internet, accessed on 10-09-2008] At
http://www.cvz.nl/resources/corporate2008-eng-sep08_tcm28-23203.pdf

CVZ (2008b): Regeling illegalen. Financiering medisch noodzakelijke hulp. [Internet, accessed on 10-09-2008] At
http://www.cvz.nl/

Dokters van de Wereld: [Internet, accessed on 22-08-08] At
www.**dokters**vande**wereld**.org/

Dokters van de Wereld (2008): *De stilte doorbreken. Over toegang tot zorg voor ongedocumenteerden in Nederland*. Resultaten MEDOC project, januari 2007− juli 2008. [Internet, accessed on 30-09-2008] At
http://www.doktersvandewereld.org/cms/publish/content/downloaddocument.asp?document_id=31

Engebersen G., Staring R., Leun, van der J., Boom, de J., Heijden, van der P. & Cruijff M. (2002): *Illegale Vreemdelingen in Nederland. Omfang, overkomst, verblijf en uitzetting*. Risbo, Erasmus Universiteit.

Esterberg K. (2002): *Qualitative Methods in Social Research*. McGraw-Hill Higher Education.

Exter A., Hermans H., Dosljak M & Busse R (2004): *Health Care Systems in Transition – Netherlands*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Generaal Pardon: Onafhankelijke informatie over de Pardonregeling. [Internet, accessed on 20-08-2008]. At
http://www.generaalpardonnu.nl/

Griend, van de R. (16.2.2008): Twintig jaar illegalenbeleid. Veel angst, weinig effect. In *Vrij Nederland* 69 (7), 32−42.

Groenveld S., Dekker J.J.H., Willemse T.R.M & Dane J. Eds. (1997): *Wezen en boefjes: zes eeuwen zorg in wees- en kinderhuizen*. Hilversum, the Netherlands: Verloren.

Groot, de R. (2005): Right to health care and scarcity of resources. In *Health Law, Human Rights and the Biomedicine Convention*, 49−59.

House of Hope: [Internet, accessed on 20-07-2008] At
http://www.houseofhope.nl/

International Covenant on Economic, Social and Cultural Rights (ICESCR): [Internet, accessed on 15-08-2008] At
www.unhchr.ch/html/menu3/b/a_cescr.htm

Inspectie voor de Gezondheidszorg (IGZ, 2005): *Staat van de gezondheidszorg 2005. Openbare gezondheidszorg: hoe houden we het volk gezond?* The Hague.

IGZ (2006): Interne nota van de Inspectie voor de Gezondheidszorg, aan de minister van VWS, 27 juni 2006. [Internet accessed on 14-09-2008] At
http://www.igz.nl/274616/nota_igz_zorg_voor_onverzek1.pdf

Just landed: Health care. The medical system [Internet, accessed on 10-08-2008] At
http://www.justlanded.com/english/Netherlands/Tools/Just-Landed-Guide/Health/Healthcare

Kofman E. (2002): Contemporary European migrations, civic stratification and citizenship. In *Political Geography* 21 (8), 1035−1054.

Koolhoven M. (30.8.2008): Asielexplosie na pardon. In *de Telegraaf* [Internet, accessed on 9.9.2008] At
http://www.telegraaf.nl/binnenland/1806595/__Asielexplosie_na_pardon__.html?cid=rssww
w.telegraaf.nl/binnenland/1809281/__Automatisch_asiel_wordt_doorgelicht__.html?cid=rss

Kromhout M.H.C., Wubs H. & Beenakkers E.M.Th. (2008): *Illegaal verblijf in Nederland*. Een literatuuronderzoek. WODC, den Haag.

Lampion: Financiering [Internet, accessed on 23-09-08]. At
http://www.lampion.info/L1.html#AA2

Leun, van der J., Engbersen G. & Heijden, van der P. (1998): *Illegaliteit en criminaliteit: schattingen, aanhoudingen en uitzettingen*. Faculteit der sociale Wetenschappen/Sociologie, Erasmus Universiteit, Rotterdam.

Leun, van der J. (2001): *Looking for loopholes: processes of incorporation of illegal immigrants in the Netherlands*. Erasmus Universiteit, Rotterdam.

Mamre project: [Internet, accessed on 10-07-2008]. At
http://www.mamre.nl

Mara Foundation: Visie en beleid van stichting Mara 2005-2007. [Internet, accessed on 08-07-2008] At
http://www.maraprojecten.nl/mara/beleid.html

Marshall T. H. (1950): *Citizenship and social class and other essays*. Cambridge: University Press.

Mason J. (1996): *Qualitative Researching*. Sage Publications, London, Thousand Oaks, New Delhi.

Minister of Health, Welfare and Sport (HWS), 2.7.1999: 19637 Vluchtelingenbeleid. 452 Brief van de Minister van Volksgezondheid, Welzijn en Sport.

Minister of HWS (2007): *31 249 Nota naar aanleiding van het verslag*. [Internet, accessed on 02-10-2008] At
http://www.minvws.nl/notas/z/2008/31-249-nota-naar-aanleiding-van-het-verslag.asp

Ministry of HWS (2008): Health insurance system. Last modified July 7th 2008. [Internet, accessed 13-07-2008] At
www.minvws.nl/en/themes/health-insurance-system/default.asp

Muijsenbergh, van den M. (2004): *Ziek en geen papieren – gezondheidszorg voor mensen zonder geldige verblijfspapieren*. Pharos, Utrecht.

Oort, van M., Kulu Glasgow I., Weide M. and Bakker, de D. (2001): *Gezondheidsklachten van illegalen: Een landelijk onderzoek onder huisartsen en Spoedeisende Hulpafdelingen*. Utrecht: Nivel.

Platform for International Cooperation on Undocumented Migrants (PICUM), 2002: *Book of Solidarity*, Volume 1. Brussels, Belgium. [Internet, accessed on 15-11-2007] At
http://www.picum.org/

PICUM (2007): *Access to Health Care for Undocumented Migrants in Europe*. Brussels, Belgium. [Internet, accessed on 09-12-2007] At
http://www.picum.org/

Pluymen M. (2002): Undocumented migrants in the Netherlands. In *Book of Solidarity*, vol. 1, PICUM. Brussels, Belgium. [Internet, accessed on 22-07-2008] At
http://www.picum.org/

Rathgeb Smith S. & Grønbjerg K.A. (2006): Scope and Theory of Government-Nonprofit Relations. In *The Nonprofit sector. A research handbook.* Yale University Press, New Haven and London.

Robinson V. & Segrott J. (2002): *Understanding the decision-making of asylum seekers* (Home Office Research Study 243). Home Office Research, Development and Statistics Directorate, London.

Romero-Ortuño R. (2004): Access to health care for illegal immigrants in the EU: should we be concerned? In *European Journal of Health Law* 11: 245–272.

ROS (2007): Na generaal pardon nog steeds 18.000 illegalen in Rotterdam. [Internet, accessed on 12-04-2008] At http://tweedekamer.blog.nl/binnenlandse_zaken_en_het_koninkrijk/2007/07/02/na-generaal-pardon-nog-steeds-18.000-illegalen-in-rotterdam

Rosenberg E. (14.1.2006): 'Ziekenhuizen moeten hard zijn'. In *NRC Handelsblad.* [Internet, accessed on 28-08-2008] At *http://www.nrc.nl/binnenland/article128686.ece*

Salamon L. M. (1994): The Rise of the Nonprofit Sector. In *Foreign Affairs*, vol. 73, no. 4.

Salamon L.M., Sokolowski, S.W. & Anheier H.K. (2000): Social Origins of Civil Society: An Overview. *Working Papers of the Johns Hopkins Comparative Nonprofit Sector Project, no. 38*. Baltimore, U.S.A.

Salamon L.M., Hems, L.C. & Chinnock K. (2000): The Nonprofit Sector: For What and for Whom? *Working Papers of the Johns Hopkins Comparative Nonprofit Sector Project*, no. 37. Baltimore, U.S.A.

Salamon L. M. & Sokolowski W. (2001): Volunteering in Cross-National perspective: Evidence from 24 countries. *Working papers of the Johns Hopkins Comparative Nonprofit Sector Project*, no. 40. Baltimore, U.S.A.

Smeets R.M.W. et al. (2005): Report National Committee on Medical Aspects of Immigration Policy.

Stichting voor Kerkelijk Sociale Arbeid (KSA): [Internet, accessed on 14-08-2008] At http://www.stichtingksa.nl/vluchtelingen/ros

Stichting Koppeling: [Internet, accessed on 15-07-2008] At http://www.stichtingkoppeling.nl/

Stichting Samenwerkende Rijnmond Ziekenhuizen (SRZ): Onverzekerde patiënten. [Internet, accessed on 02-09-2008]. At http://www.stichting-srz.nl/nl/Actueel/Onverzekerde+pati%EBnten/

Taran P. A. (2000): Human Rights of migrants: challenges of the new decade. In *International Migration* 38 (6): 7–51.

Tschirhart M. (2006): Nonprofit membership Associations. In *The Nonprofit sector. A research handbook.* Yale University Press, New Haven and London.

Urban Mission (2003): *Urban mission brochure 7/11. 24.11.2003*. Samenwerken met mensen die niet gezien of gehoord worden. [Internet, accessed on 21-07-2008] At http://www.netwerkurbanmission.nl/plein_num/pdfbestanden/_URBAN_MISSION_BROCHURE_7=1.pdf

Veldheer V. & Burger A. (1999): History of the nonprofit sector in the Netherlands. *Working papers of the Johns Hopkins Comparative Nonprofit Sector Project*, no. 35. Baltimore, U.S.A.

Verkleij H. (1999): *Monitoring van de gezondheidstoestand van illegalen*. De Dienst Informatie en Analyse (DIA), Ministry of HWS, the Hague.

Vonk G. (2001): Migration, Social Security and the Law: some European dilemmas. In *European Journal of Social Security* 3 (4), 315−332.

Appendix 1: Questions to Private initiatives

Example Oude Westen pastoraat

About Oude Westenpastoraat

- Can you tell me a bit what Oude Westenpastoraat is?
- When was it founded? And why?
- How do you get funded?
- About employees, how many volunteers, paid staff?
- What is your occupation, how long have you worked for Oude Westenpastoraat? Is it your only job?
- What is the goal of your work with UMs?
- Why do you want to help UMs (in general and concerning health care)?
- Where have you received information of UMs rights to health care?
- What are your activities concerning health care for UMs, so how do you help them?

Relation to formal health care system

- Why do you think these activities are not performed by the formal health care system or local government?
- What is your relation to formal health care system, do you cooperate somehow with e.g. doctors in the 1st line or 2nd line health care, GGD? Can you give names of people
- Are there problems in the cooperation?
- Do you think the health care system for UMs works well? Do they get the care they need? If there are problems, where do they occur?
- How could the system be improved?
- Do you think your goals and the goals of people working in the formal health care system clash concerning health care for UMs or are they similar?

UMs

- How often do you help UMs with health care matters?
- Is the number growing?
- What do you think are the different routes through which UMs end up in the formal health system to receive help, where do they turn to for help first?
- Imagine I am an UM with a broken arm/depression, where can I turn to look for help?

Other organizations

- Which other nonprofit organizations do you know that help UMs receive health care in Rotterdam? Contact info
- Do you cooperate with these organizations?

Appendix 2: Questions to UMs

Introduction

- How long have you lived in the Netherlands?
- Do you have a residence permit? If you do, how long have you had it?
- When did you apply for the asylum and got rejected?
- How often have you visited a doctor in the Netherlands without insurance? And a hospital?
- How did you find a doctor the first time? And afterwards?
- If you didn't go to a doctor directly, why not? Where did you go and why?
- Have you received dental care in NL without insurance?

Private initiatives

- How did you get in contact with this organization?
- How did you think they could help you?
- Has the organization been of help to you? If so, in what way?

Formal health care system

- How are your experiences with GPs, doctors at hospitals, administrators? Have you ever had problems with them?
- Have you always received the care you think you needed or has it sometimes been denied? If so what was the reason?
- Have you paid for the health care or medicine you have received?

Appendix 3: Questions to Doctors

Introduction

- How often do you treat UMs?
- With what kind of illnesses do you help them?
- Do you know how UMs come to your practice? Just of their own initiative or maybe through a voluntary org? (for 2nd line: do you know if UMs come to the hospital with help of a voluntary org?)
- Do you know of or have you ever had contact with a nonprofit or voluntary organization that helps UMs with health care? Why?
- How do you see the role of these organizations? Is it useful what they do? (e.g. informing GPs about Koppelingsfonds, informing UMs about their right to health care, taking UMs to hospitals/GPs, documenting incidents where UMs have been refused care, creating a medical document for UMs, contacting hospitals if they send bills to UMs who cannot pay them)
- Why do you think the local government does not perform these activities of P I's?
- Do you think the (local) government should do the work of the P I's or financially support them?

Financing

- If UMs can't pay, do you always get your money reimbursed from the Koppelingsfonds (Linking Fund)? (only for 1st line)
- How long does it take to receive the reimbursement? (only for 1st line) ask assistants

Treating UMs

- What do you think is necessary care that illegal immigrants are entitled to? What does it include?
- 2nd line= I heard the hospitals in Rotterdam have a policy since the end of 2005 that they only offer health care for uninsured patients if it acute and cannot be postponed. Is this true? Did the hospital give instructions how to determine what is care that cannot be postponed? Has it affected your work?
- Do you think that UMs postpone going to GPs and sometimes their illness gets so severe that they need to be treated in a hospital, though they could have been treated by a GP if they would have sought for help earlier?
- What is the goal of your work with UMs?
- Have you ever sent a UM away without helping him? If so, why and for what care did he come to you?
- Do you encounter problems in your work with UMs and if so, what kind of problems?
- Do you feel you are in a different role as a doctor while treating UMs than treating regular insured patients?
- Do you think the current system of health care for UMs is working well? If there are problems, where do they occur?
- What could be improved?

Appendix 4: Questions to people working at administration of hospitals/practices of GPs

Introduction

- How often do you meet UMs at your work? How many come weekly to the hospital/practice?
- What is the procedure with UMs? Which documents do you ask of them when they register to the hospital?
- What if they don't have these documents? Under what circumstances can they still see a doctor? Do you have a standard policy to deal with people that don't have the required papers?
- Does it happen that a UM that does have a reference from a GP is not allowed see a doctor? What is the reason? (2nd line)

Financing

- Do you ask UMs money for their treatment? And does it happen that UMs pay?
- 2nd line=Do you ask sometimes money for patients who cannot identify themselves or don't have insurance before treatment? What happens if they cannot pay?
- If UMs can't pay, do you always get your money reimbursed from the Koppelingsfonds (Linking Fund)? (only for 1st line)
- How long does it take to receive the reimbursement? (only for 1st line) ask assistants

- Have you ever had contact with someone from a voluntary organization, who has helped UMs?
- How do you see the role of these organizations? Is it useful what they do? (e.g. get financing for treatment that is not reimbursed by Koppelingfonds, taking UMs to hospitals/GPs, documenting incidents where doctors have refused care, contacting hospitals if they send bills to UMs who cannot pay them)
- What problems do you encounter in your work with UMs?

Appendix 5: Questions to Midwives

Introduction

- How often do you have UMs/illegal immigrants as clients?
- Do you know how UMs come to your practice? Just of their own initiative or maybe through a voluntary org?
- Do you know of or have you ever had contact with a P I or voluntary organization that helps UMs with health care? Why?
- How do you see the role of PIs? Is it useful what they do? (e.g. get financing for treatment that is not reimbursed by Koppelingfonds, taking UMs to hospitals/GPs, documenting incidents where doctors have refused care, contacting hospitals if they send bills to UMs who cannot pay them)

Financing

- Do you ask UMs money for the care you give them? And does it happen that UMs pay?
- If UMs can't pay, do you always get your money reimbursed from the Koppelingsfonds (Linking Fund)?
- How long does it take to receive the reimbursement?

Providing care for UMs

- Do UMs normally contact you already in the beginning of pregnancy or only when it is almost time to deliver the baby or they have some complications?
- Is the health situation of UMs worse than of insured patients or is there no difference?
- Have you ever sent a UM away without helping her?
- What is the goal of your work with UMs?
- Do you encounter problems in your work with UMs, if so, what kind of problems?
- Do you feel you are in a different role as a midwife when you have UMs as clients than regular insured clients?
- Do you think the current system of health care for UMs is working well? If not, where do you think the problems occur?
- What could be improved?

Appendix 6: House of Hope

Activities

House of Hope is a social project in the area of Tarwewijk in Rotterdam, a place where people from different cultures and of different ages can meet. The project was started to bring people more in contact with each other and strengthen the feeling of solidarity and self-confidence among people. It started out of a church called the International Christian fellowship, but became independent in 2006. House of Hope gets subsidized yearly by the district of Charlois in Rotterdam, different funds, churches and individuals. It has about 80 volunteers four part-time employees. (House of Hope).

A manager of House of Hope was interviewed, who said that sometimes UMs come to them who are in need of medical help, but she did not know how big the amount is, for example how many yearly. In most of the cases they refer these people to Paulus Church or GGD. A few times they did more than that, for example brought a man who was psychotic to Riagg as he was not able to go there himself. Also the crisis service of GGZ was sometimes contacted because of a suicidal person. House of Hope has also been in contact with GGD, acute crisis service of GGZ or the hospitals on behalf of the UMs because they have received bills they cannot pay and people at House of Hope have tried to explain what the situation is and why they cannot pay. In addition it came out in one interview with a midwife that House of Hope also provides information of midwives as sometimes UMs contact their practice after receiving contact information from House of Hope. All in all however, besides referring UMs to health care institutions, House of Hope has very little to do with health care for UMs, but help UMs in other ways, with for example contacting institutions like IND or COA and with filling in the application for generaal pardon.

Co-operation

House of Hope does not have structural cooperation with the formal health care system, but has been sometimes in contact with the acute crisis service of GGZ, with hospitals and GGD to negotiate about a situation of an UM, for example because of bills that hospitals sent and UMs cannot pay. Of other nonprofit organization House of Hope has been in contact with at least Salvation Army and Foundation ArosA relating to matters of UMs. To ROS, GGD or Paulus Church they refer people with health care matters.