

Health care for undocumented migrants in Geneva: safety is the key for success

Yves Jackson, MD, MPH, PhD

Geneva University Hospitals

Global Health Institute, University of Geneva

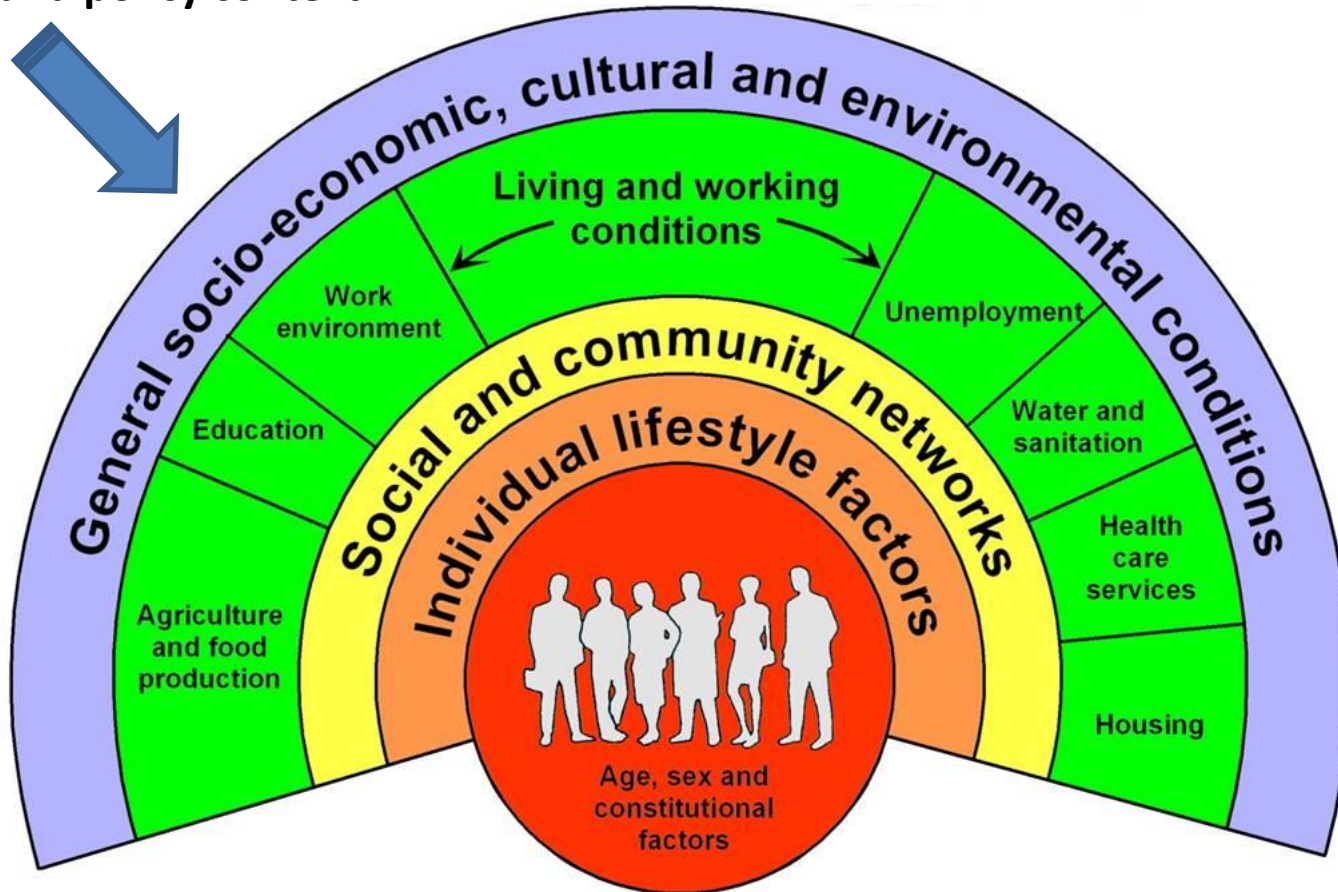
Yves.jackson@hcuge.ch



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Foreword

Legal and policy context



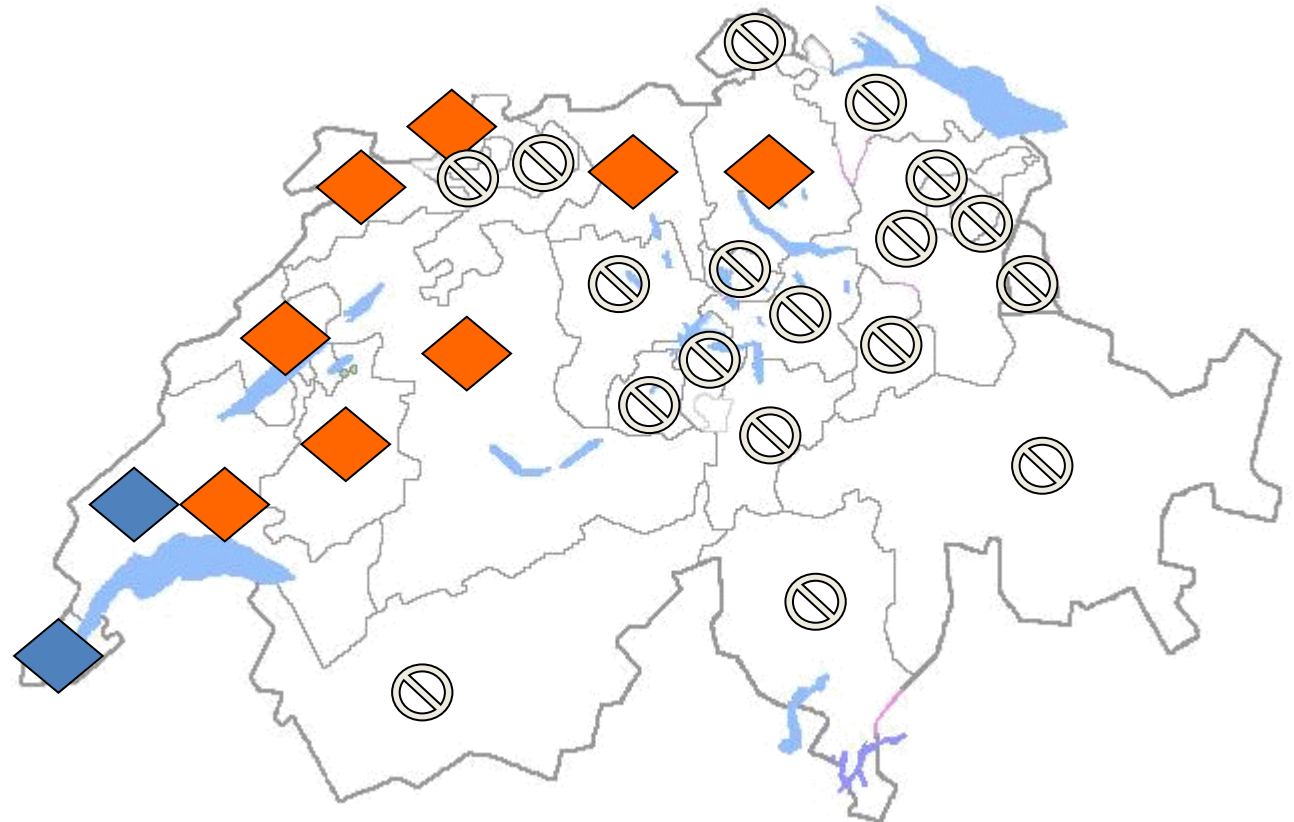
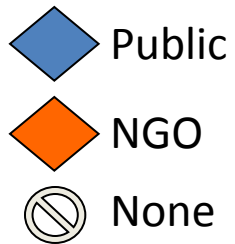
Source: Dahlgren and Whitehead, 1991

Rights to health(care) in CH

- Federal Constitution
 - **art. 12 Right to dignity and protection (aide urgente)**
 - art. 41 Right to receive healthcare...for all residents (art. 23-6 Civil code)
- Health Insurance Law
 - art. 3 Obligation of insurance after 3 months of residency
 - **art. 7 Obligation for insurers to accept all applicants (OAMal),**
 - art. 6 Obligation for Cantons to control mandatory access
 - **art. 65 Right for economically deprived residents to receive subsidies**
- Challenges in accessing to health services for most vulnerable groups
 - Risks/fear of denunciation
 - Administrative barriers towards insurance contracts, subsidies
 - Rights implementation gap

Access to care - CH

- Type of healthcare services for irregular immigrants



Geneva

- 10-15'000 undocumented immigrants, 90% without health insurance
- 1997 Mobile outpatient clinics of community care (CAMSCO) – GVA University Hospitals
 - Bridging the health and access gap
 - Public health scope, clinical services, research and education
 - Integrative and multidimensional, preventive and curative care
 - Health equity
 - Within a network of institutions addressing other social determinants of health
 - Accessibility, affordability, acceptability
 - **Safety (processes, care) → quality:** ↑ trust: early contact, follow-up, adherence
- 4500 patients and 16'000 consultations per year
 - Gatekeeping towards specialized care
 - Community orientated/outreach activities



Data safety

- Outside main Hospital buildings = accessibility and confidentiality
 - Agreement with police for absence of control but possibility to intervene
- Personnal data : **all patients under the same roof in HUG**
 - No difference in data collection and safety procedures: **no mention of legal status**
 - No difference in right to confidentiality
 - No obligation to provide personnal data
 - Medical file strictly confidential even in special situation (prison, children)
 - **No sharing with other administrations**
- Electronic medical and administrative records
 - Federal medical profession Law , art. 40 let. f and Geneva Health Law, art. 87: Health professionals secrecy
 - Geneva Institutions Code: Civil servants secrecy
 - Penal Code, art. 321: revealing privileged information is punishable
 - LAMal, art. 46, 56, 92 and Fed. Law on Accident Insurance, art. 53, 55 : only medical data to be transmitted to insurance and insurance obligation towards data protection and confidentiality
 - Bill of patients rights (HUG)

Data transmission

- Only after formal agreement from patient or representent
- EMR: firewalls within HUG, not accessible for non authorized profesional
- Absence of decisional capacity and request for data sharing: Commission of Professionnal Secrecy to assess interests
- Geneva Health policy: no medical data transmission to other Departments (immigration, security, etc.)

Field experience

- Clear-cut, patient-centered protective legal framework
- Enhance patients engagement in care and clarifies healthcare workers roles (cf Germany, Italy)
- Fits well into existing bioethical principles of clinical practice (autonomy, do no harm,...) and within social determinants of health framework
- Explicit rights: patients empowerment and clinical benefits

Conclusions

- Rights-based initiative within local legal framework and code of best practices
- Overarching political support – public engagement
- Public health interest overlaps with individuals rights
- Tight data protection - firewall
- Safety as a mean to ensure quality of care
- Ingredients for ongoing success