Social security and international migrants: global examples and lessons for Russia

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Executive Summary

As global migration has risen, states have developed different mechanisms for providing social security protection for migrants workers and their families. Almost a century ago, states began to form bilateral and multilateral agreeements, and sign international covenants, protecting the rights of migrants and providing structures of cooperation to ensure that social security is accessible and transferrable across borders. These agreements, which are far from universal, represent the best practice in addressing the problems for migrants associated with the traditional 'principle of territoriality' – that is, entitlement to social security based on residence within a territory. However, they must be complimented by effective information campaigns and efforts to improve awareness of rights and access to entitlements among migrants.

Regarding undocumented migrants, social security protection is often absent, or at best, arbitrary and unpredictable. While in many countries, undocumented migrants have a right to free emergency health care, it can be argued that this is the least efficient approach when taking into account cost and risk to public health. The best practices are evident in states which broaden rights to primary and secondary health care to reduce the high-cost, high-risk development of serious medical conditions, especially since undocumented migrants are at a higher risk of health problems, including communicable diseases such as HIV/AIDS and tuberculosis. Also crucial are targeted interventions among key groups at risk of communicable diseases. In other branches of social security, undocumented migrants should be free to access any benefits to which they have made contributions through employment; if national legislation does not allow this, a reimbursement of contributions should be considered.

In Russia, although a number of bilateral and multilateral agreements on migration exist, only those migrants with permanent residency permits have rights to social security. Russia, Kazakhstan and Belarus have concluded the most extensive agreement to date, the Agreement on the Legal Status of Migrant Workers and Members of their Families; though this to some extent improves access for nationals of these states to social security, and particularly education, even here, access to social security is dependent on provisions within national law. Moreover, though emergency health care is available to all migrants, funding is insufficient; even nationals find it difficult to access the free health care to which they are entitled.

Taking into account best practices globally and the particular situation in Russia, this paper makes a number of recommendations, as follows:

1. Labour migrants in Russia should be granted equal access to social security entitlements and associated obligations as Russian citizens.
2. As part of this, the government should extend its agreement with Belarus and Kazakhstan to address each of the main issues associated with the principle of territoriality; it should increase the branches of social security covered and allow for portability of benefits both in the totalisation of periods of employment and the exportability of acquired benefits. Similar agreements should be reached with other key sending states.
3. As regards undocumented migrants, sufficient funding should be provided to cover the existing emergency health care for migrants, and serious examination should be given in budgetary discussions to the provision of health care beyond emergency assistance for the benefit of individuals and the community at large. NGOs can work to increase understanding among undocumented migrants of their human rights and their specific entitlements.
4. Undocumented migrants should be entitled to any social services to which they or their employer have made contributions. If not, they should be reimbursed for these contributions. The government and other organisations should work to improve information about and access to alternative services, including voluntary health insurance.
5. Information about rights and entitlements should be improved, as well as specifically targeted health information campaigns; governments and other organisations working with migrants should increase their cooperation in the dissemination of information and education. This information should be targeted at key points in the migration cycle: before departure, at transit 'hot spots', at the destination and on the return to a migrant's home country, and should in particular focus on key communicable diseases which affect migrants in Russia, improving the availability of information, treatment and support services. These campaigns can also make use of community links within the migrant national communities in Russia. They should operate at a cross-border level; coordination between organisations and governments in sending and receiving countries can improve support for individuals, preparedness of the host country and ability of the home country to provide services and medical assessments for returning migrants and their families.
6. Information and awareness campaigns should also target the general public in Russia, with the aim to reduce xenophobia and discrimination, which are key contributors to the poor living, working and health conditions of migrants in Russia.
7. The government should strive to increase access to health care to which migrants are already entitled, by ensuring that health institutions are sufficiently funded, that health care professionals are educated in the entitlements of migrants and by cracking down on corruption.

Introduction

The last century has seen an unprecedented increase in migration, both formal and undocumented. According to the UN, the number of international migrants reached 214 million in 2010[1], compared to 150 million in 2000[2] and 75 million in 1965.[3] Projections for 2050 reach as high as 415 million.[4] Of the main destination countries for migrants, the Russian Federation is second only to the United States, with more than 12 million registered immigrants.[5]

States have formulated wide-ranging responses to this growing trend, and in particular, to the question of the rights of migrants outside their home country. The issue of social security mechanisms for migrants has been central, but in each case has depended on a mixture of national legislation, international conventions and bilateral or multinational agreements. While some countries have together developed highly advanced systems of social security provision and portability of benefits, others maintain very limited systems of entitlement.

This paper will analyse some of the systems of social security provision around the world. It will begin with an assessment of mechanisms in place for regular migrants, with and without bilateral and multilateral agreements between sending and receiving countries. It will then turn to provisions for undocumented migrants, both by states and non-governmental organisations. Finally, it will move to the particular situation and needs of the Russian Federation, drawing on examples from elsewhere to provide recommendations for the development of social security mechanisms for migrants in Russia.

Part 1: Legal migrants

National social security mechanisms traditionally work on a principle of territoriality, that is, either employment or residence within a state's territory. International migrant workers are thus vulnerable to gaps or clashes between national systems. They may be entitled neither to provisions in the country where they work (but do not reside) or to those in the country where they reside (but do not work). Alternatively they may be obliged to pay taxes in both countries despite receiving

1 UN DESA, 2011
2 IOM, 2010
3 Holzmann, 2005: 1
4 Sabates-Wheeler, 2010: 116
5 IOM, 2009

services in only one. Or they may split their working life between several countries, and fail to reach the minimum employment period necessary to be eligible for a pension in any of those countries. These gaps and clashes, especially an inability to aggregate employment periods or export earned benefits, may in fact act as a disincentive to participate in the formal economy, if doing so requires contributions which do not later translate into benefits.[6]

Through bilateral and multilateral agreements, and international conventions, states have been attempting to overcome these problems for almost a century. As early as 1919, France and Italy signed a bilateral social security agreement focusing on migrant workers. The International Labour Organization (ILO) followed suit on the issue of pension rights in 1935, adopting Convention 48 concerning the Establishment of an International Scheme for the Maintenance of Rights under Invalidity, Old-Age and Widows' and Orphans' Insurance (1935), and later, Conventions 118 concerning Equality of Treatment of Nationals and Non-Nationals in Social Security (1962) and 157 concerning the Establishment of an International System for the Maintenance of Rights in Social Security (1982). The European Economic Community (EEC), and later European Union (EU), began to formulate a series of regulations addressing these issues from 1948 onwards. In general, such agreements work on a principle of coordinating national legislation, rather than harmonising such legislation in line with a transnational standard.[7]

These various agreements can be assessed in terms of the extent to which they address the issues associated with the territoriality principle. Such issues can be grouped into two main categories. The first is *coverage*, including: who is covered; by what branches of social security they are covered; what country is responsible for their coverage; and whether such coverage can apply simultaneously in more than one country. The second is *portability*, including: the ability to 'import' into a country former periods of employment for the purpose of calculating eligibility for benefits, and therefore to 'totalise' eligibility requirements accumulated in different countries; and the ability to 'export' benefits, either as direct payments or as in kind services such as medical care.

1.1. EEC/EU

The coordination scheme of the EU is the most developed in the world – both a cause and result of the fact that the EU holds the highest proportion of migrants (more than 33% of all global

6 Holzmann et al, 2005: 2
7 Fick and Flechas, 2007: 51

migrants).[8] The original EEC treaty contains several articles guaranteeing freedom of movement for workers and ensuring equal treatment as regards access to employment, working conditions, and "measures in the field of social security as are necessary to provide freedom of movement for workers" (Article 41). The latter refers explicitly to totalisation of periods of employment in various member countries for the purpose of calculating benefit entitlements, as well as payment of benefits to migrants residing in member states other than those in which they earned those benefits. This was followed by EEC Regulation 1408/71 in 1971 on the application of social security schemes to employed persons and to members of their families moving within the Community, and Regulation 574/72 which set out the procedures for its implementation. These were amended many times during the following decades as the EEC, then EU, grew and developed, until the more simplified Regulation 883/2004 on the coordination of social security systems came into force in May 2010, replacing Regulation 1408/71.

Regulation 1408/71 originally applied to employed persons who are nationals of an EEC Member State; to their family members and survivors, regardless of their nationality; and to EEC Member State nationals who are survivors of an employed person of any nationality, who is covered under the social security legislation of an EEC Member State. A person is considered employed if they are insured under any social security scheme for employed persons, even if they would not be considered employed under domestic labour legislation. For example, a person bringing up a child under the age of three in Germany is covered by a form of compulsory 'employees' insurance under the Old Age and Invalidity Act, and thus is considered employed by the Regulation.[9] EEC Regulation 1390/81 (in 1981) extended the applicability of Regulation 1408/71 to self-employed persons, their family and survivors; and EC Regulation 307/1999 (the EEC was formally renamed the European Community (EC) after it was subsumed under the newly created EU in 1993) further extended it to students, and their family and survivors.

Even before this, in EC Regulation 3095/1995, coverage had been extended to any EU nationals covered under the insurance of an EU member who were abroad in another member state temporarily, whether employed or not; and Regulation 883/2004, which replaced 1408/71 when it came into force in 2010, is intended to simplify the rules by removing reference to employed, self-employed and students and simply applying to all EU nationals insured under a member state's social security system, and their families and survivors. Moreover, as early as the 1980s, the

8 Holzmann et al, 2005: 7
9 Fick and Flechas, 2007: 54

question of the rights of third-country nationals (i.e. nationals of countries other than the EEC member states) was becoming a pressing political issue;[10] two decades later, EC Regulation 859/2003 extended applicability of Regulation 1408/71 to third-country nations and their families legally resident in an EU state and moving to another member state, once they have lived in an EU member state for more than five years.

Despite Regulation 1408/71 now having been repealed, for the purposes of this discussion this paper will focus on the provisions in this Regulation as opposed to Regulation 883/2004, since it represents the beginnings and development of social security cooperation in Europe, and the foundations of the simplified Regulation 883/2004.[11]

1.1.1. Regulation 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community

1.1.1.a. Coverage

Regulation 1408/71 was already ahead of other agreements of its time in applicability and scope. It applies to benefits related to: sickness and maternity; invalidity (including those for the maintenance or improvement of earning capacity); old-age; survivors; occupational diseases or accidents; death; unemployment; and family. It excludes social and medical assistance; in the years following the Regulation's introduction, the European Court of Justice has sought to clarify the definition of 'social and medical assistance' as opposed to social security benefits, and has determined that it refers to discretionary payments where an individual does not have an enforceable right to the service, or payments related to any purpose other than those listed above.[12]

With a few exceptions (including seafarers, civil servants and posted workers),[13] a migrant worker always comes under the social security legislation only of the country in which he/she works, not where he/she resides. Discrimination on the basis of nationality is prohibited, both direct – such as having different eligibility requirements for nationals and non-nationals – and indirect – such as

10 Niessen, 1992: 5

11 For further discussion of the new Regulation, see Cremers, 2010

12 ECJ, Case 1/72, Frilli v Belgian State, 1972 ECR 457 ; Case 249/83, Hoeckx v Openbaar Centrum voor Maatschappelihjk Welzijn, 1985 ECR 973, cited in Fick & Flechas, 2007: 55-6

13 Seafarers are subject to the legislation of the state under whose flag the ship sails; civil servants, to the legislation of the employing state; posted workers, abroad for up to 12 months, to that of the country of employment prior to posting; those who regularly work in more than one state, to the legislation of the state of residence if that state is one of the ones in which they work, and if it is not, to that of the state where their employer is registered; those who regularly work in more than one state and for more than one employer with registered offices in different states, to the legislation of the state of residence. If legislation of a state ceases to apply without legislation of another state becoming applicable, the legislation of the state of residence applies; this can be relevant to those who retire or, in some cases, temporarily cease employment.

having a minimum residency period which will disadvantage non-nationals. (Most residency requirements in national social security laws were invalidated as a result of the EEC Regulation.) However, some indirect discrimination may be permitted in cases of "necessity and proportionality" related to public policy, public security or public health.[14]

Short-term benefits cannot be claimed in more than one state simultaneously, even if such benefits relate to different things. For example, as long as the domestic legislation of one of the relevant countries prevents the overlap in its own system of both unemployment and sickness benefits, an individual cannot claim these separately in two different states. However, he/she can overlap long-term benefits (invalidity, old age, death grants or occupational accidents/diseases), under conditions governing the proportion payable by each state (Article 12).[15]

1.1.1.b. Portability

The portability of benefits refers primarily to the ability to 'totalise' periods of employment in different countries for the purpose of calculating entitlements, and to the ability to export benefits to another country, whether monetary or 'in kind' benefits such as medical services.[16] Regarding all but benefits for occupational accidents/diseases, employment history in another EC/EU country must be taken into account for the calculation of benefits, as if those periods of employment were completed in the current state of employment. As for compensation for occupational accidents/diseases, there is not a specific provision for totalisation, but employment in another state must still be taken into account, for example if the calculation of benefits depends on the length of time spent in an activity that is likely to cause the disease. If it depends on average earnings, the current state need only consider earnings in the state of employment at the time of the injury.

Benefits for invalidity, old-age, survivors, occupational accidents/diseases, and death, are fully exportable within member states and cannot be reduced or modified if a recipient lives in or moves to another member state. Family benefits must also be paid as though the family lived with the worker in the insuring state. Since some benefits are 'in kind' in the case of sickness, maternity and accident/disease (that is, in the form of medical care), the country of residence must provide these

14 Fick and Flechas, 2007: 59

15 If the entitlement is based on duration of work, the state where it was acquired pays even if the claimant lives somewhere else later. If it is based on materialisation of a risk, only the state in which the claimant lives when the risk materialises, pays. If the claimant works in two states that use different schemes (duration or risk), he/she will receive a payment from the durational scheme proportional to the duration of his work there, and a full payment from the risk scheme. However, Article 46a allows the state with a risk scheme to deduct what the state with the duration scheme already paid from its own payment. See Fick and Flechas, 2007: 68

16 Holzmann et al, 2005: 2

benefits regardless of eligibility in that country, and the insuring state must reimburse the resident state for these services. Only employment benefits have limited exportability, so as to allow the insuring state to supervise a recipient in looking for work: a recipient must remain in the insuring state and register with its employment service for four weeks, after which he can leave for a maximum of three months, provided that he registers with the employment service in the destination state. If he returns within three months the benefits continue; if not, he loses the right to those benefits.

If nationals of member states move outside of the EU, pensions can be paid to almost any country in the world. However, this may entail reductions. The coverage of health care costs outside the EU is much less developed.[17]

1.1.2. Education

Regulation 1408/71 does not include provisions on education, which should nonetheless also be mentioned. In July 1977, Council Directive 77/486/EEC on the Education of the Children of Migrant Workers required that member states take measures to ensure that free tuition is offered to children of workers from member states "to facilitate initial reception", in particular, through tuition in the official language of the host state. Teaching of the mother tongue and culture of their country of origin was also to be promoted, in cooperation with the state of origin. While no further concrete directive has been issued to extend these provisions to non-European Economic Area (EEA) nationals, policy initiatives on non-discrimination and the integration of third-country nationals have had this effect.[18] However, while these regulations exist in principle, there are problems of implementation for both EEA and third-country nationals, especially in ensuring equality in the quality of education and the educational achievement of children of migrant workers. Awareness of such problems is evident in more recent EU efforts to improve educational standards for migrant children, such as the 2008 Green Paper, 'Migration and Mobility: Challenges and Opportunities for EU Education Systems'.

1.2. International Labour Organization

Three ILO Conventions are relevant to the discussion of social security for migrants in member countries. These are: Convention No. 48 concerning the Establishment of an International Scheme

17 Holzmann et al, 2005: 8
18 For more details, see Atger, 2009

for the Maintenance of Rights under Invalidity, Old-Age and Widows' and Orphans' Insurance (1935); Convention No. 118 concerning Equality of Treatment of Nationals and Non-Nationals in Social Security (1962), which constituted a revision and thus a replacement of Convention No. 48; and Convention No. 157 concerning the Establishment of an International System for the Maintenance of Rights in Social Security (1982).

Convention 118 focused on the issue of equal treatment for migrants, and exportability of benefits earned in one country when moving to another. Convention 157 went further, addressing issues of conflict of laws, aggregation and overlapping benefits. However, while the former was ratified by 38 countries (although the Netherlands denounced it in 2004), only Spain, Sweden, the Philippines and Kyrgyzstan have ratified Convention 157.

1.2.1. Convention 118 Concerning Equality of Treatment of Nationals and Non-Nationals in Social Security

1.2.1.a. Coverage

Convention 118 applies to nationals of ratifying states while they are in the territory of another ratifying state. Survivors' coverage applies to survivors to any such national, regardless of the survivor's own nationality. Family benefits apply only to children of such nationals if they are residing in a ratifying state. Stateless persons and refugees are covered, but civil servants and diplomatic personnel are not.

The branches of social security covered by the Convention include: medical and sickness; maternity; old age; injury at work; unemployment; and family benefits. 'Public assistance', like in the EU case, is not included. However, unlike in the EU case, ratifying states can choose which of these branches of coverage to apply, and which to exclude. The branches it includes must be applied to migrants from ratifying states regardless of the branches their state of origin has included; thus, if a migrant's state of residence has ratified only sickness and maternity benefits, but his/her state of employment has ratified sickness, maternity and family benefits, he/she is entitled to family benefits in the state of employment on the same conditions as nationals. This “asymmetrical reciprocity” is intended to ensure that an individual is not disadvantaged in his/her country of employment on account of the fact that his/her country of residence has less well-developed social security legislation - since, if a certain branch of coverage is not already included in domestic legislation, it cannot be applied when ratifying the Convention.[19] By contrast, if the migrant's

19 ILO, 1997: 20

country of residence does in fact have domestic legislation on a branch of coverage - for example, unemployment - but chooses not to apply it within the Convention (and thus not to grant equality of treatment in the area of unemployment to migrant workers within its own borders), the country of employment is not obliged to show equality of treatment to migrants from that country of residence.

Equal treatment in coverage and benefits between nationals and non-nationals is enshrined in the Convention, and direct discrimination clearly prohibited. However, unlike in the EU, where indirect discrimination is also forbidden (for example through minimum residency periods or other conditions which advantage nationals), there is no explicit prohibition of this in the ILO Convention. The ILO committee of Experts, later interpreting the Convention with regard to conditions of residence in New Zealand, concluded that such conditions "do not appear to constitute an obstacle to ratification in so far as those conditions are identical for nationals and non-nationals."[20]

These residency requirements must be the same for nationals and non-nationals, except in two cases: firstly, where the social security scheme is non-contributory; and secondly, where the scheme does not depend on a minimum period of employment or occupational activity. In either of these situations, benefits can be subject to residency requirements in the following branches: maternity and unemployment (requirement cannot exceed six months); invalidity and survivors' (requirement cannot exceed five years); and old-age benefits (requirement cannot exceed 10 years).

1.2.1.b. Portability

The Convention allows for the exportability of benefits to nationals of ratifying states, whether or not they live in a ratifying state, in the areas of invalidity, old age, survivors, death grants and injuries at work. However, it stipulates that if a ratifying state allows its own nationals to export benefits in additional branches, it must allow non-nationals to do the same. On the question of exportability, asymmetrical reciprocity is not expected though; if state X does not apply the C Convention to coverage regarding injuries at work, state Y does not have to allow for the exportability of injury benefits to nationals of state X.

While the above benefits can be exported to nationals of ratifying states regardless of their state of residence, family benefits have more limited exportability; children must live in a ratifying country in order to receive family benefits earned by their parents in another ratifying country. Moreover,

20 ILO, 1997: 42

payment of these benefits is not directly required by the Convention; the conditions of their payment is instead governed by bilateral agreements between the states concerned.

On the issue of totalisation of eligibility requirements, the Convention stops short of any concrete obligations for ratifying states. Instead, these countries must "endeavour to participate in schemes for the maintenance of the acquired rights and rights in course of acquisition" (Article 7).

1.2.2. Convention 157 concerning the Establishment of an International System for the Maintenance of Rights in Social Security

1.2.2.a. Coverage

Convention 157 sets out guidelines for the formation of bilateral and multilateral agreements aimed at establishing coordination schemes on social security. Though the obligation to establish coordination is thus indirect, the Convention requires that agreements be reached with other ratifying states and that the resulting coordination schemes address certain key issues (while allowing for flexibility in the details of how those issues are addressed). The schemes must also include a number of minimum areas of coverage, including invalidity; old-age; survivors; death grants; injury pensions; unemployment; and family benefits. There are also obligatory categories of beneficiaries: employees who are nationals of ratifying states; their family and survivors; and refugees and stateless persons.

As for which country's social security law applies to a migrant, the Convention proposes that the employing state's law should apply, but it leaves room for states entering bilateral agreements to decide exceptions. Exceptions are already mentioned in the Convention for seafarers (who come under the law of the state whose flag the ship flies) and economically inactive people (who come under the law in the country of residence.)

1.2.2.b. Portability

Coordination schemes established as a result of the Convention must guarantee exportability of benefits related to invalidity, old age, survivors, injury and death grants to nationals of ratifying countries. This applies regardless of their place of residence. As for overlapping benefits, the cost of invalidity, old age, survivors' and occupational disease benefits should be shared among two or more members. In all other branches, the Convention does not uphold a right to receipt of the same type of benefits from several sources "based on the same period of compulsory insurance, employment, occupational activity or residence" (Article 15). If benefits which are not of the same

nature overlap, payments can still be adjusted on the basis of domestic legislation.

The International Labour Conference adopted Recommendation 167 concerning the Maintenance of Social Security Rights in 1983, suggestion model language for bilateral and multilateral social security agreements. However, such Recommendations are purely advisory in nature.

1.2.3. Education

While the ILO as an institution strongly promotes the rights of migrant workers' children to education in a host state,[21] neither of these conventions contains provisions for this. The relevant ILO conventions are No. 138 concerning Minimum Age for Admission to Employment, 1973, and No. 182 concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour, 1999; however, the former is focused on minimum working age rather than education specifically, and the latter contains specific regulations for free education only for children who have been removed from 'the worst forms of child labour'. As for wider applicability, it encourages ratifying states to cooperate and assist one another in support of 'social and economic development, poverty eradication and universal education' (Article 8), but does not include specific requirements. However, every member of the United Nations, except for the United States, Somalia and the new South Sudan, has ratified, accepted or acceded to the UN Convention on the Rights of the Child - albeit with stated reservations or intepretations in some cases. (The United States has signed but not ratified the Convention, due to domestic opposition regarding sovereignty over educational policy and possible threats to homeschooling.) This Convention clearly recognise the right of all children to education, and requires states party to the Convention to make primary education compulsory and free, and secondary education available and accessible, to all children (Article 28).

1.3. Other bilateral or multilateral agreements

Bilateral and multilateral agreements which exist outside, or on the edge, of these frameworks of international conventions vary considerably. The extent to which they attempt to address the complex issues associated with traditional principles of territoriality is particular to each agreement.

For example, the EU founded the Euro-Mediterranean Partnership (EMP) in 1995, bringing ten Mediterranean countries into official partnership with the EU. From this has stemmed multilateral

21 For example, see ILO, 2000: 17

Association Agreements with all EMP members (except Syria), and each of these agreements deals with the question of social protection for migrant workers from these countries. However, the agreements vary, including as to whether they set out binding rules related to social security provisions.[22]

In addition to these Association Agreements, many of Europe's neighbours have concluded bilateral agreements with individual EU states. The differences in provisions between those who have such agreements and those that have not are clear. For example, Germany has a bilateral agreement with Morocco, covering pensions, unemployment and health care, but does not have one with Algeria. A Moroccan can receive a Germany pension after returning to Morocco or moving to any other country, while an Algerian takes a 30% reduction in his German pension if he returns to Algeria. However, if an Algerian lives in Morocco, he can receive his full German pension.

The details of such an agreement are, of course, crucial. The Moroccan receives these benefits because Morocco's agreement with Germany requires that Moroccans must be treated the same as Germans; thus if a German can receive a full German pension in any country in the world, so can a Moroccan. By contrast, Turkey and Tunisia's agreements with Germany do not include this principle of non-discrimination. Thus a Turk must live in the EU, Turkey or another country with which Germany has a bilateral agreement, in order to receive a full German pension; otherwise, he takes a 30% reduction.

However, the German-Turkish agreement is notable in that it includes a key alternative to exportable pensions. A Turk who has paid contributions to the German social security system can apply for a lump-sum reimbursement of contributions upon leaving, rather than taking a German pension. The option has not proved popular since it applies only to the employee's contributions, not those of the employer, so a significant amount of contributions would be lost; moreover, the German government has offered an additional subsidy since 1984 to returning Turks who opted out the German pension system, making the payment of these lump sums even less common. The lump-sum option does not appear in many bilateral agreements but can be noted as a potentially attractive option in some cases. Agreements between the United States and some Western European countries include these provisions, for example where a US citizen has worked in the relevant country for a period of only a few years.[23]

22 Holzmann et al, 2005: 10

23 Holzmann et al, 2005: 15-16

Outside of the EU, a relatively extensive example of a multilateral treaty is the 2003 Andean Social Security Instrument, signed by Bolivia, Columbia, Ecuador, Peru and Venezuela. It addresses all the major issues associated with traditional principles of territoriality in social security coverage, and was followed by a Regulation giving further guidance for implementation. Like in the EU, the goal is the coordination of domestic legislation rather than its replacement. All migrant workers and their dependants are covered; the agreement applies to all social security legislation referring to health benefits (related to common or occupational illness, childbirth and accidents) and economic benefits (including payments for maternity, temporary disability, retirement, employment injuries and diseases, invalidity or death). The treaty does not give the right to overlapping benefits of the same kind at any one time, and the law of the employing country always applies, except in the usual cases of seafarers, air carrier personnel, diplomats and civil servants. The agreement prohibits unequal treatment of nationals and migrants from ratifying states, and periods of insurance in any member country are considered in assessing eligibility for benefits. Benefits must be exportable without reduction of amounts, and in kind benefits, as in the EU case, are provided by the country of residence with reimbursement from the insuring country.

Some agreements are much more limited. The 1968 US-Mexico Social Security Agreement, and the 1972 US-Argentina Social Security Agreement, exist only to ensure exportability of payments, without addressing aggregation, overlap, conflicts of national law, equal treatment and so on. A further agreement between the United States and Mexico on totalisation of periods of employment for the purpose of assessing eligibility for old age, disability and survivors' benefits was signed in 2004, but has been the subject of staunch US political debate and has not yet been ratified. Without this agreement, if a migrant works for less than 40 quarters in the United States and 500 weeks in Mexico, he is eligible for neither country's pension; with the agreement, these would be combined.

Where bilateral agreements cover health care, it is usually the case that the employing country is always responsible for health coverage; thus a returning migrant who enters employment is his/her home country is immediately covered by that country's system, while if he/she is retired but is entitled to at least part of his/her pension from that country, the same is true. If the returning migrant's entire pension comes from the former employing country, he/she continues to be covered by that country's social security system as regards health care. Usually this involves transfers of payments between the employing and home country for medical costs incurred at home. However, it does not always apply: in the agreement between Austria and Turkey, such transfer for 'in kind'

benefits is only possible where the pensioner needs treatment too urgently to be able to travel to Austria for the treatment there. This urgency does not have to be life-threatening: for example, while an individual would have to travel to Austria for an optometrist's appointment for new glasses, pain-relieving dental treatment could be obtained at home.[24]

1.4. In the absence of agreements

In general, where agreements exist, provisions are in place to address at least some of the key issues associated with the traditional principle of territoriality. However, only 20% of global migrants are in fact covered by such bilateral or multilateral agreements.[25] Moreover, these agreements are more common between industrialised countries than between the major migrant-sending (usually developing) countries and the major migrant-receiving countries;[26] research shows that it is predominantly migrants moving between developed countries (about 23% of all migrants) who enjoy access to and portability of social security mechanisms. In fact, 98% of migrants moving among OECD countries are covered by bilateral agreements.[27] The most disadvantaged migrants are those moving between low-income countries.

Where such agreements do not exist, migrants tend to fall into one of three categories, at least as regards portability of benefits. Roughly 55% have access to benefits earned abroad after returning to their home country, on the basis of national legislation either in the country of former employment or the country of residence; although the uncoordinated nature of this access usually entails a reduction of benefits (as in the German-Algerian case). About 5% do not have access to portable benefits from the country of employment, despite working there legally (but this often implies that they do not pay contributions either, and it does not necessarily exclude them from voluntary contributions to long-term benefits in their country of origin). A further 20% of migrants, both legal and undocumented, are estimated to work in the informal sector, thus giving them limited access to benefits either in the country of employment or the country of origin.[28]

In the case of the 55% who need to rely purely on domestic legislation, provisions vary significantly. For example, Canada includes immigrants as residents, thus giving them basic

24 Holzmann et al, 2005: 19-20
25 Holzmann et al, 2005: 8
26 Kulke, 2006: 9
27 Avato et al, 2010: 459
28 Holzmann et al, 2005: 8-9

protection in health care and pensions conditioned on relatively mild requirements, and additionally allowing them to participate in an income-related system. Pensions, but not health care, are in principle exportable. The same is true regarding the exportability of pensions from the United States, however in the US case, there is a minimum requirement of 40 quarters of coverage before this applies. Australia's national pension system is payable abroad, and eligibility requires 10 years of continuous residence; its occupational pension is paid as a lump sum once an employee reaches 55, thus making it fully exportable.

In Asia, portability is mixed but generally limited. Korea, for example, will pay pensions abroad, while Malaysia will pay them as a lump sum when a migrant leaves the country. In many Gulf countries, foreign workers are excluded completely from the social security system; yet the benefit is they do not have to pay contributions, do not face portability issues, and can instead opt for private schemes or continue to pay contributions in their home country.[29] For the latter to be possible, their home country must have provisions for overseas workers – as in the Philippines or Jordan.

As for health care under national legislation only, returning migrants can usually access their home country's services as soon as they are employed there, without a minimum period of insurance. However, retired persons may only be covered (beyond emergency assistance) if they are also eligible for a pension in that country, and without an agreement ensuring totalisation, this may not be the case. In some cases, former employing countries will pay for a portion of medical expenses after a migrant returns home (even in the absence of a bilateral agreement) but this is usually based on the cost of equivalent treatment in the employing country; in light of state subsidies in many first-world countries, and the resulting lower charge to health insurance providers, there can be huge differences in cost, thus leaving a considerable amount for the individual to pay. Other employing countries refuse these payments altogether: the US, for example, will not reimburse medical costs abroad on the basis that it cannot verify the necessity, quality or even existence of the treatment.[30] However, those eligible for a pension in a former employing country can usually travel back to that country and be covered by health insurance there. It is worth noting though that qualification for health insurance can be strict: the US Medicare system requires 40 quarters of contribution, and will not be subject to the totalisation agreement with Mexico. Recognising this and the above-mentioned issues, the Mexican Social Security Authorities recently started offering health insurance

29 Holzmann et al, 2005: 8-9
30 Holzmann et al, 2005: 18

policies for Mexicans working abroad, to cover them while staying in Mexico.

1.5. Best practices

Taking the above examples into account, it is clear that the best approach to ensuring social security protection for migrants is the formation of bilateral and multilateral agreements. These must address the issues of who is covered and whose law applies, especially where there are conflicts of law; and the issue of portability, that is, the exportability of payments and the totalisation of qualifying criteria.

Where bilateral agreements do not exist, countries should strive to address these issues in their national legislation. If exportability of benefits acquired is beyond the bureaucratic capacities of a country, as may be the case in some developing countries where social security apparatus are less well developed overall, the option of reimbursing contributions as a lump sum can be explored. In cases where migrants are not covered by the social security system at all, they should be exempt from making contributions and therefore free to find alternative insurance policies, whether in the employing country or in their country of origin, and sending countries can look to the example of the Philippines or Mexico for special welfare programmes for nationals overseas.

However, making migrants exempt from contributions has its own disadvantages for the employing country, since it could affect the employment rate of nationals. If employers do not have to make social security contributions for migrant workers, they will become cheaper to hire and therefore more attractive than local workers. Bearing this in mind, as well as the drawbacks for migrant workers of seeking private insurance (notably, higher costs and difficulty finding insurance that covers existing medical conditions), bringing migrants fully into the social security system of the employing country seems the best option. Common arguments that doing so would create a significant financial burden for the employing state are in fact misplaced: most scientific studies on this topic have shown that migrants are net contributors to social protection and tax systems.[31] Even ensuring portability of benefits need not cost much for the employing state: the United States Social Security Administration concluded that the as yet unratified totalisation agreement with Mexico would have a negligible impact on the US pension system.[32]

31 Sabates-Wheeler, 2010: 134-5
32 Sabates-Wheeler, 2010: 135

However, even when migrants have full equality with nationals in accessing and exporting social security services, a clear barrier to their use is a lack of awareness of their entitlements. Governments must strive to make known to immigrants their rights and entitlements, and simplify bureaucratic procedures in registering for social security services while in the employing country and once they have moved elsewhere. NGOs can also be effective partners in communicating these entitlements and in assisting migrants in accessing available state services.

Part 2: Undocumented migrants

Access to social services is clearly more arbitrary and complicated for undocumented migrants, who constitute an estimated 10-15% of all global migrants.[33] In most branches of social security, there are very few, or no, provisions for undocumented migrants. This is not because of a general consensus that undocumented migrants have no objective rights to social security provisions: by contrast, international human rights law which specifies the basic rights of all people to life, medical care, adequate housing, freedom from slavery and so on, makes no distinction between nationals and migrants, documented and undocumented.[34] The Universal Declaration on Human Rights of 1948 is now considered to be part of customary international law, and therefore "an obligation for the members of the international community".[35] It states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Article 25). Other international covenants and conventions become binding when states choose to become a party to them. The International Convention on the Elimination of All Forms of Racial Discrimination of 1965 is just one example of a treaty touching on these rights; it has 175 parties and an additional 86 signatories (those who have agreed to the treaty but for whom it has not yet entered into force). Article 5 of the Convention requires that parties "undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: ...(e; iii-v) the right to housing; the right to public health, medical care, social security and social services; the right to education and training."

33 IOM, 2010: 120
34 PICUM, *Undocumented Migrants have Rights*, 2007
35 OHCHR,1996: 4

The International Convention on the Protection of all Migrant Workers and Members of their Families goes the furthest in defining the rights of migrants, giving a relatively broad set of rights to all migrants regardless of their legal or undocumented status, and granting additional rights to those in a regular situation. However, states have been reluctant to sign the Convention: it was adopted in 1990 but only came into force in 2003, when the number of ratifying states had reached the necessary threshold of 20. As of August 2011, 45 states had ratified the Convention and 14 signed it. Notably, this does not include any European Union States, nor any of the top 20 migrant-receiving countries, but it includes seven of the top 20 migrant-sending countries.[36]

In fact, there have been other attempts by migrant-receiving countries to make a distinction between the rights of documented and undocumented migrants: the (revised) European Social Charter, as regards equality of treatment in social security provision between nationals and non-nationals (who are nationals of another contracting state), applies only to non-nationals who are lawfully resident and in regular employment; and the European Convention on the Legal Status of Migrant Workers outlines social protection provisions for migrants but its scope does not extend to undocumented migrants. Moreover, the UN Declaration on the Human Rights of Individuals who are not Nationals of the Country in which they Live limits social protection to those lawfully resident in a country. However, this is a 'soft-law' instrument that cannot supersede the legally binding treaties mentioned above.[37] Furthermore, the European Committee of Social Rights stated in a later case that the Charter must be interpreted with its primary goal as a human rights instrument in mind, and that "legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter."[38]

Yet within the EU, where estimates of the proportion of the migrant population which is undocumented range from 7-15%,[39] social protection for undocumented migrants depends on a variety of factors in each member state. These include the form of the national welfare state, and how migration is dealt with in general. Access to health care, for example, is a universal principle in the EU, enshrined in the constitutions of several member states and founding documents of some

36 The top 20 migrant-receiving countries are the United States, the Russian Federation, Germany, Ukraine, France, India, Canada, Saudi Arabia, Australia, Pakistan, the United Kingdom, the People's Republic of China, Kazakhstan, Cote d'Ivoire, Iran, Israel, Poland, Jordan, the United Arab Emirates and Switzerland. The top 20 migrant-sending countries are the Russian Federation, Mexico, India, Ukraine, the Philippines, Pakistan, the United Kingdom, Bangladesh, Italy, Turkey, the People's Republic of China, Indonesia, Nigeria, Portugal, Thailand, Germany, Vietnam, the Republic of Korea, the United States and Egypt. For more details, see Kulke, 2006, Annex 1 and 2.

37 Cholewinski, 2005: 40

38 Council of Europe, 2005: Article 32

39 Health Care in NowHereLand, *Two Landscapes*, 2010; GCIM, 2005

health care systems. It is included in the EU Charter of Fundamental Rights. Article 35 states that "[e]veryone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices". In Switzerland, too, a global and compulsory health insurance scheme exists for anyone who has lived in the country for more than three months. The right to health care also explicitly applies to undocumented migrants. Yet there is a discrepancy between theoretical rights on the one hand, and on the other, practices or the entitlement status of certain groups: undocumented migrants or failed asylum seekers may find coverage of health care to be almost non-existent, and legal residents may also face barriers as a result of the way that coverage is organised.[40]

2.1. Health care

Access to health care is one of the most pressing of social security branches in the protection of rights for undocumented migrants, since undocumented migrants are often at higher risk of health problems than regular migrants and nationals, whether due to the conditions in their home country which caused them to move, the nature of their migration, including smuggling and trafficking, or the unregulated working environments in which they usually end up employed.[41] However, in most countries which provide any health care at all to undocumented migrants, this care is limited to emergency services, thus leaving any developing health issues unattended until they are at a life-threatening level. Moreover, it can also be argued that the policy of providing only emergency care is the least effective from the perspective of public health: it has high costs, poor outcomes, and increased public health risks due to uncontrolled infectious diseases.[42]

Health Care in NowHereLand, a project by the Centre for Health and Migration at the Danube University Krems, categorises the European countries by their health care policies towards undocumented migrants.[43] The typology is based on the Council of Europe Resolution 1509 (2006) on Human Rights of Irregular Migrants, Article 13.1, which says that emergency care is a minimum right and should be available, and that states should try to provide more holistic care, particularly taking into account needs of vulnerable groups such as children, the elderly, pregnant women and disabled people. The project's assessment focuses on the legal system, rather than practical barriers that might obstruct implementation (though these are explored in more detail in country reports), or

40 Health Care in NowHereLand, 2011: 6
41 Gushulak and MacPherson, 2000
42 Health Care in NowHereLand, *Two Landscapes*, 2010
43 Healthcare in NowHereLand, 2011

the openings that might create loopholes in the rules (for example, an individual provider's discretion or civil society involvement). If an undocumented migrant is expected to contribute financially in line with the general legal standard, that is regarded as access, but if he is expected to pay the full cost, it is not. The typology is based on rights related to adults.

The project groups countries into three categories. Countries with 'no rights' are those where emergency care is inaccessible. This includes places where access is arbitrary or unpredictable, or where full payment is required in advance, or sufficient payment as to have considerable debt implications. Countries with 'minimum rights' are those where emergency care is provided without discrimination. This may involve moderate cost but is predictable without requiring the individual discretion of a health care provider. This includes states where more extensive care may be provided with full cost or unpredictably. Finally, countries with 'rights' are those where more than only emergency care is accessible, such as primary and secondary care. This may include moderate, but predictable, costs. The category includes states where practical barriers may in reality prevent full implementation of legal rights, but the laws exist nonetheless. The project concludes that the EU countries plus Switzerland can be grouped as follows:

	No rights	**Minimum rights**	**Rights**
Countries with tax-based health care schemes	Finland, Ireland, Malta, Sweden	Cyprus, Denmark, UK	Italy, Spain, Portugal
Countries with insurance-based health care schemes	Bulgaria, Czech, Latvia, Luxembourg, Romania	Austria, Belgium, Estonia, Germany, Greece, Hungary, Lithuania, Poland, Slovak Republic, Slovenia	Belgium, Netherlands, Switzerland

As the table demonstrates, very few countries provide more than emergency care, and a significant number do not even provide that. Moreover, as mentioned, the focus on human rights and the right to emergency care can be contrasted with a public health approach which looks at the wider societal benefits of providing more holistic care. The project therefore provides a different categorisation of European countries based on their questions of access rather than rights. Countries granting only emergency care fall into the category of 'no access'. 'Partial access' goes to those with explicit entitlements to specific services (such as primary or maternal services) or specific groups (children and pregnant women, for example). Countries with 'full access' are those countries where

undocumented migrants are entitled to access same range services as nationals providing they can meet certain pre-conditions, such as proof of identity and/or residence. According to this categorisation, the EU countries plus Switzerland, can be grouped as follows:

Full Access	**Partial Access**	**No Access**
Spain, France, Netherlands, Portugal, Switzerland	Belgium, Italy, UK	Austria, Bulgaria, Cyprus, Czech, Germany, Denmark, Estonia, Greece, Finland, Hungary, Ireland, Lithuania, Luxembourg, Latvia, Malta, Poland, Romania, Sweden, Slovakia, Slovenia

Given these findings, it is clear that much of the responsibility for providing health care to undocumented migrants falls to non-governmental organisations (NGOs), and health care workers who provide care through such NGOs on a voluntary basis. This is compounded by the practical barriers that often prevent undocumented migrants from accessing state services, including lack of information about health care entitlements, fees, and fear of being reported to the police and perhaps deported. Another key role of NGOs, therefore, is providing information about rights and entitlements, and assistance in covering fees; although this can put enormous pressure on NGOs with limited resources, especially in countries where legislation is restrictive.[44] It is arguable that NGO services should only ever be a supplement to state services, rather than a replacement, but where legislation is restrictive, this can be difficult, especially when providing such assistance is legally ambiguous in itself. Sometimes such NGOs find that their work is both praised and criminalised. This adds to the practical barriers in accessing health care. Such barriers are prevalent not only in Europe, where social security mechanisms for migrants are the most developed, but even more so in other parts of the world.

The situation is made worse by significant discrimination and xenophobia, which affects all migrants, but undocumented migrants in particular, who are often characterised as criminals due to their undocumented status. This was reflected particularly strongly in California in 1994 by Proposition 187, an initiative which aimed to deny undocumented migrants access to social services, health care and public education. Chairperson of the California Commission for Immigration Reform Barbara Coe, who co-drafted the Proposition, wrote in an op-ed piece that "[i]llegal-alien gangs roam our streets, dealing drugs and searching for innocent victims to rob,

44 PICUM, Access to Healthcare, 2007: 10

rape, and, in many cases, murder those who dare violate their 'turf'".[45] The Proposition was passed by referendum but later ruled unconditional by a federal court. In the United States, "immigration law and criminal law have…become conflated."[46] This is despite the fact that research by the US Department of Justice has shown an underrepresentation of immigrants in US criminal statistics.[47]

2.2. Health problems among undocumented migrants

As mentioned, undocumented migrants can be at a higher risk of health problems. Pre-existing poor health conditions may be a key factor in them choosing irregular forms of migration, if they were unable to meet the conditions for legal migration. Health conditions (pre-existing or not) can be made worse by the nature of irregular migration, which includes smuggling and trafficking; if individuals travel concealed in cargo, they may be injured or become ill as a result of falls, exposure to cargo (including drugs and contraband goods), lack of air and water, and malnutrition. Smuggling often involves overcrowding in unsanitary conditions, and individuals may be subject to violence and abuse by smugglers and traffickers. On arrival, undocumented migrants, as with all migrants, are often exposed to new illnesses, dietary changes and stress, and there is a tendency for higher-risk behaviour once they arrive in the destination country – including employment in unregulated environments, sex work or use of commercial sex workers, tobacco use and violent behaviour.[48]

These conditions and behaviours can put migrants, and especially irregular migrants, at a higher risk of communicable diseases such as HIV/AIDS and tuberculosis (TB). Of the total known new cases of TB in the UK in 2003, 64% were among the foreign-born population. In Norway, the figure was 76%; in Australia, 80%; and in Israel, 85%.[49] Many of these cases are a result of the reactivation of a latent infection acquired before arrival, but person-to-person infection also occurs and is most common among high-risk social groupings including homeless people, chronic alcoholics and within the migrant community.[50] Factors often associated with migration (particularly irregular migration) – and indeed, poverty more broadly - are also those associated with TB vulnerability: "overcrowding, poorly ventilated housing, malnutrition, smoking, stress, social deprivation and

45 Coe, B., *Keep Illegals Out of State,* USA TODAY, Oct. 12, 1994, at 12A., cited in Nanda, 2010-11: 360
46 Nanda, 2010-11: 360
47 Martinez, Jr., R. & Lee, M. T., *On Immigration and Crime, in* THE NATURE OF CRIME: CONTINUITY AND CHANGE 485, 515 (U.S. Dept. of Justice, National Institute of Justice 2000), cited in Nando 2010-11: 360
48 Gushulak and MacPherson, 2000; and Amirkhanian, Y. A. et al, 2011
49 World Health Organisation, *Global Tuberculosis Control: surveillance, planning and financing,* WHO Report 2005, cited in MacPherson and Gushulak, 2006: 715
50 MacPherson and Gushulak, 2006: 716

poor social capital."[51] As Figueroa-Munoz and Ramon-Pardo explain in the Bulletin of the World Health Organisation, isolated communities within wealthier environments, such as cities, can pose a particular challenge in TB prevention. Such communities are common among irregular migrants.

Moreover, as the UN Task Force on Mobility and HIV Vulnerability Reduction put it, "[w]hile mobility is not a definitive risk factor for HIV/AIDS, some mobile people are especially vulnerable to the disease. Factors such as loneliness, separation from regular partners, higher income, peer pressure, and freedom from the control of families and social norms encourage mobile people to take risks - like engaging in unsafe sex or illicit drug use - that leave them vulnerable to HIV."[52] Sexual health education and health services more generally may be inaccessible to these migrants due to cultural and language barriers, undocumented status, or even non-existence of such services in their area. Other issues such as psychological distress, fear of social stigma, poor cultural awareness and disruption of family and social networks can exacerbate this.

Intergovernmental and non-governmental organisations, sometimes in conjunction with national authorities, have developed some model programmes for interventions specifically focused on these risks. The UN Task Force on Mobility and HIV Vulnerability Reduction identifies several key needs when designing a programme for intervention of this type, based on its experience in Asia.[53] Such a programme, it argues, should be holistic in addressing the problem at source, transit and destination sites, but in practice will need to identify 'hot spots' for the targeting of their activities: these should be places with a high density of mobile people (such as urban centres, border towns or large work sites) and high HIV transmission rates, but should also take into account the level of support among local stakeholders, the prospects for sustainability of the work and conditions favourable to a change in the environment through policy and advocacy work. Moreover, pre-departure training is crucial in key origin countries, to encourage safe transit routes, healthy behaviours and raise awareness of risks and services en route and in the destination country. Multi-stakeholder partnerships are vital to successful interventions, and efforts must be made to work with national and international HIV/AIDS programmes in the countries of origin and destination, since migration is a cross-border phenomenon. The programme should be gender-sensitive, taking into account the different and sometimes higher risks of female migrants who may be victims of trafficking and abuse and/or engaged in sex work; or who may themselves stay in their home

51 Figueroa-Munoz, Ramon-Pardo, 2008
52 Lowe and Francis, 2006
53 Lowe and Francis, 2006

country but be vulnerable to HIV/AIDS transmission from their mobile partner. It should focus on key groups including sex workers, injecting drug users and undocumented workers.

A key strategy of migrant-receiving countries in addressing the risk of TB among incoming migrants is pre-entry screening. Those that operate screening in the country of origin before the prospective migrant has left may refuse entry to persons with active cases of TB, while those with screening upon arrival generally refer such cases to local governments for follow up and management.[54] Should a person be infected after arrival, or should a latent infection reactivate, identification in many countries (almost all in Europe) is passive, relying on the diagnosis of health practitioners whom patients seek out.[55] Undocumented migrants, both due to the nature of their arrival and the barriers to accessing health care, are generally excluded from both of these processes. Identifying and treating TB among undocumented migrants thus requires a more proactive approach, and in particular, targeted health education and services among this community. As Figueroa-Munoz and Ramon-Pardo argue, more effective monitoring of TB among this community is needed to help to inform targeted prevention and control activities. Vulnerable groups within wealthy cities should be identified so that services can be tailored to their particular needs and experiences. Involving community organisations, health practitioners, social services and teachers in this can help to enhance awareness of TB and overcome some of the barriers, including distrust and fear, to accessing assistance. Moreover, leaflets and educational materials can be distributed through these various actors in different languages. These partnerships are crucial to effective education, diagnosis and follow-up, as well as evaluation of activities and the exchange of best practice.[56]

2.3. Other branches

Aside from health care, other key rights show a similar pattern of arbitrary and often limited enforcement. As regards the right to housing, the Platform from International Cooperation on Undocumented Migrants (PICUM) has found that in six European countries, undocumented migrants are usually housed in one of five accommodation situations: by homeless organisations; in private accommodation (although landlords often request proof of legal status); in emergency shelters (although these often only provide accommodation for one night and are sometimes closed to undocumented migrants); by NGOs; or, most commonly, by family members and community

54 MacPherson and Gushulak, 2006: 715
55 Rieder et al, 1994: 1547
56 Figueroa-Munoz, Ramon-Pardo, 2008

networks.[57] An EU Council Framework Decision in 2002 made it illegal to assist in the housing of undocumented migrants (where intentional and for 'financial gain'), further exacerbating the housing situation for undocumented migrants.[58]

Article 13 of the International Covenant on Economic, Social and Cultural Rights states that 'everyone' has a right to education. In its General Comment No. 13 on the right to education, the UN Committee on Economic, Social and Cultural Rights clarifies that "the principle of non-discrimination extends to all persons of school age residing in a territory of a State party, including non-nationals, and irrespective of legal status."[59] However, undocumented migrants still often face practical, administrative and legal barriers to accessing education. In Greece in 2003, it was revealed that the Interior Ministry had advised the Ministry of Education not to allow the enrolment of children of irregular migrants into schools, despite the fact that national immigration law does not include this restriction.[60] In Germany, official institutions are obliged to denounce undocumented migrants, although since education comes under regional authority, it us up to regional governments to decide whether this obligation applies in schools, and in fact there have been no known denunciations to date. In Spain, though all children can attend schools until 18, children of undocumented migrants are not given a certificate to show that they have completed their education; nor are they given a certificate in Denmark or Sweden, where there are no formal rights to education for children of undocumented migrants but where may be accepted on a case-by-case basis. Practical obstacles such as moving between schools, higher level of overall vulnerability and poorer quality living conditions add to this, as well as the lack of intercultural education despite regulations stipulating that this should be available in many countries.

In other areas of social security, such as family benefits, accident compensation, pensions and so on, provisions vary. While some conventions such as the (revised) European Social Charter and the European Convention on the Legal Status of Migrant Workers do not extend their scope to undocumented migrants, others make no such distinction. The 1925 ILO Convention 19 concerning Equality of Treatment for Nationals and Foreign Workers as regards Workmen's Compensation for Accidents specifies equal treatment in respect of this compensation, irrespective of residence status

57 PICUM, *Book of Solidarity,* Vol. 1, p. 55, cited in Cholewinski, 2005: 33

58 See Council Framework Decision 2002/946/JHA of 28 November 2002 on the strengthening of the penal framework to prevent the facilitation of unauthorised entry, transit and residence (*OJ* 2002 L 328/1) and Council Directive 2002/90/EC of 28 November 2002 defining the facilitation of unauthorised entry, transit and residence (*OJ* 2002 L 328/17).

59 UN CESCR, 1999

60 Cholewinski, 2005: 36

(Articles 1 and 2). It was ratified by 121 countries. The 1964 ILO Convention 121 concerning Benefits in the Case of Employment Injury also stipulates equality of treatment between nationals and non-nationals, making no reference to residence; although among nationals it allows for some exceptions to the universal entitlement to injury benefits, such as in the case of casual labour (Articles 4 and 27). Undocumented migrants may therefore find themselves excluded on this basis. The 1975 ILO Convention 143 concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers says that irregular migrants are equally entitled to "rights arising from previous employment as regards renumeration, social security and other benefits" (article 9). The UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families affords equal rights with nationals to all migrant workers (without reference to status), within the limits of domestic law and bilateral or multilateral agreements, and suggests that should these laws or agreements exclude a migrant from receiving benefits, states must consider reimbursement of any contributions that migrant has made into the social security system (Article 27). The reference to domestic law and bilateral or multilateral agreements does make the provision rather weak. Nonetheless, as regards national law, many countries do not take into account residency status in rights to contribution-based benefits, since employers often have to make contributions for employees regardless of their status. In some countries, this equality extends to all but unemployment benefits, whereas in others is is limited to accident compensation and occupational diseases. However, the power of undocumented migrants to enforce their rights is often limited, and if they are also engaged in irregular employment they may not be registered as employed and neither they nor their employer will make contributions. Significant discrepancy can exist between actual entitlements and reality of access, both where there are few formal provisions but help is provided at the discretion of local authorities or practitioners, or where there are legal rights but many barriers to access. Both variants are unhelpful; as the Council of Europe's Committee of Experts on Standard-Setting Instruments in the Field of Social Security concluded, the former risks heightening xenophobia and relying too heavily on discretion of particular actors; while the latter weakens the rule of law and increases the frustrations of all migrants (whether legal or undocumented).[61]

2.4. Best practices

Clearly the most concrete step states can take in protecting the rights of undocumented migrants is to sign the International Convention on the Protection of all Migrant Workers and Members of their

61 Council of Europe, 2004

Families and enforce its provisions. With or without this, states should have a clear and predictable framework of entitlements for undocumented migrants: this should include, at minimum, access to emergency health care, but should also extend to primary and secondary care for the sake of both the individuals concerned and public health in general. These entitlements, and any related fees, should be clearly communicated. Education should be available and accessible to all in line with almost universally ratified international conventions, and wider social security provisions and benefits should be clearly defined and enforced, ensuring that undocumented migrants are entitled to benefits arising from any contributions they or their employers have made, or at least to a reimbursement of such contributions.

Collaboration between governments and NGOs can be an important means of communicating these entitlements, as well as promoting healthy living and providing education on the migration process, social services, and health. Often this cooperation happens at a local level to facilate ease of access to services, but co-working between national programmes is also vital, especially as relates to communicable diseases. Moreover, effective pre-departure training, and improving and publicising legal work schemes can make regular migration more appealing. If bilateral agreements are in place between states, and clear social security mechanisms enforced, this will also contribute to the attractiveness of regular migration and regular employment.

Part 3: Russian Federation

Russia hosts more than 12 million registered immigrants,[62] as well as an estimated 5 million undocumented migrants.[63] Three-quarters of these are from the states of the former Soviet Union, with which Russia has a visa-free entry system. Given that migrants can arrive easily through this system and be ready to work immediately, the complicated bureaucratic procedure for registering to work legally leads many migrants and employers to opt for informal employment. The actual number of CIS migrants employed in Russia is probably 5-10 times higher than the official figure.[64]

With the exception of legal migrants from Belarus and Kazakhstan with whom Russia has a Customs Union, only those with permanent residence permits have access to social security; and in 2006, up to 90% of migrant workers in Russia had no residence or work permits.[65] In 2010, Russia

62 IOM, 2009
63 IOM, 2011
64 Ivakhnyuk, 2011
65 Cerami, 2010

ceased the obligation for employers to pay contributions for migrant employees into the national Medical Insurance Fund, thus taking away the entitlement of these migrant workers to anything more the free emergency care.

3.1. Conventions and agreements

Russia is a signatory to the Universal Declaration on Human Rights. It has ratified the UN Convention on the Rights of the Child as well as the International Covenant on Economic, Social and Cultural Rights. These latter conventions are relevant in this discussion as relates to education of children of migrant workers. However, aside from the ILO Minimum Age Convention, 1973 (No. 138) and the Worst Forms of Child Labour Convention, 1999 (No. 182), Russia has not ratified any of the abovementioned ILO conventions regarding the rights of migrants and cooperation in the field of social security protection for migrants. Nor has it ratified the International Convention on the Protection of all Migrant Workers and Members of their Families.

Nonetheless, the members of the Commonwealth of Independent States (CIS) have engaged in a significant amount of cooperation on migration since the fall of the Soviet Union, with early agreements including the Agreement on Visa-Free Movement of Citizens of CIS Countries on the Territory of its Participants (1992), the Agreement on Guarantees of the Rights of Citizens of Member States of the CIS in the Field of Pensions (1992), the Agreement of CIS Member States on Assistance to Refugees and IDPs (1993), the CIS Agreement on Cooperation in Labour Migration and Social Protection of Migrant Workers (1994) and the Convention of the CIS on the Rights of Persons Belonging to National Minorities (1994). Numerous bilateral agreements were also signed. However, several of the newly-independent former Soviet republics feared renewed Russian dominance and did not ratify the treaties. Moreover, in practice, the individual states were in the process of creating their own national regulations on migration, and the failure of ratifying parties to adapt national law in accordance with the agreements meant that social security cooperation for migrant workers remained minimal.

The agreements that were reached, as well as later agreements on cooperation in combating illegal migration, were largely reactive, and there was little clear legal regulation regarding the rights of migrant workers in other CIS states. However, in the 2000s, the CIS states began to take a more proactive approach to addressing migration and necessary cooperation.[66] A new phase in

66 Ivakhnyuk, 2011

collaboration was marked by the creation of a convention in 2008 on the legal rights of migrants and their families, which was signed by all CIS states but has not yet come into force. It is intended to overcome existing discrepancies and act as a single source regulating the situation of migrant workers on the territories of contracting parties.

The most extensive agreement already ratified is the Agreement on the Legal Status of Migrant Workers and Members of their Families between Russia, Kazakhstan and Belarus, signed within the context of their trilateral Customs Union. It defines social security as "compulsory social insurance in case of temporary disability and maternity, compulsory social insurance against industrial accidents and occupational diseases and compulsory health insurance." However, there are no additional provisions or means of cooperation for portability beyond that provided by in domestic law. Social security (excluding pensions) is granted to nationals of member states in accordance with the laws of the state of employment. Children of migrant workers living with their parents in the employing state can attend local schools in accordance with national law in that state, and migrant workers and members of their families can receive free emergency medical care, and other health care, in accordance with national law and international treaties to which the employing state is a party. The Eurasian Development Bank, in analysing the effectiveness of the agreement, recommended that member states' law should be adapted for the provisions of the agreement to have optimal effect. It noted that Belurussian domestic law grants the most rights to migrant workers; Russian law only accords equivalent entitlements to specific categories of migrants such as highly skilled professionals.[67] As regards Russian legislation, the Bank recommends that the state: systematise legislative provisions regarding the legal status of foreign citizens and the rules regarding use and employment of foreign labour; elimate "vague and ambiguous" provisions contained in Federal law on delimitation of the legal status, rights and obligations of foreign citizens and stateless persons; and more strictly enforce (with necessary penalties) federal law relevant to labour migration, including the Federal Law on the Legal Status of Foreign Citizens in the Russian Federation.[68]

3.2. Existing barriers to health care

Even with such agreements, accessing social services and health care, like in the rest of the world, is complicated by other barriers. In Russia, such barriers also exist for the national population. An

67 Eurasian Development Bank, 2012
68 Eurasian Development Bank, 2012

obligatory national Medical Insurance Fund exists, into which employers must pay contributions for their employees, while the government pays contributions for the unemployed, pensioners and students. However, not all parties fulfil their commitments to the fund (this has included the government, although it has made efforts to make up the gap in recent years), and the total sum of contributions does not cover the actual costs of national public health care. Likewise, all migrants are entitled to emergency medical care, but there is no specific budgetary allocation for these medical costs.[69]

This underfunding means that health care providers often seek additional payments from patients. This is made worse by a complicated system which provides some services for free while others require payment (and which allows a formal, paid, queue-jumping service), and results in very low awareness among patients about which services they are entitled to without paying. In fact, this lack of awareness not only affects patients; health care providers are often also ignorant about the entitlements of patients.[70] In addition to this, corruption and bribe-seeking can make the costs of health care even higher for patients. The problems of underfunding, poor awareness of entitlements and corruption affect all nationals, and increase even further the barriers faced by migrants in accessing health care.

3.3. Particular problems faced by migrants in Russia

Taking Tajik migrant workers in Russia as an example, only one-third of these workers have legal employment status, and over 65% of their employment agreements are believed to be without a written contract.[71] A working day for Central Asian migrants in Russia is likely to be at least 9 hours, while more than 10% work over 12 hours. Often, employers fail to pay the full wage; in Yekaterinburg, 80% of migrant workers report being underpaid at least once. Moreover, at least 80% of migrant workers lack access to health care. Between 400-1000 migrants die each year in Russia and Kazakhstan due to poor working conditions, violence, and a lack of access to health care.[72]

The Bishkek office of the International Organization for Migration (IOM) reports that half of all migrants return from Russia to Kyrgyzstan in a worse state of health to when they left.[73] It

69 Eurasian Development Bank, 2012: 46
70 Borovkova, 2012
71 Marat 2009: 30
72 Marat, 2009: 31
73 IOM, *Трудовая миграция из Киргызстана*, 2008: 460, cited in Marat, 2009,:32

attributes this to a number of main causes, including living conditions, barriers to health care, heavy lifting and freezing temperatures. Those who have worked in Siberia usually meet the government criteria to be considered handicapped.[74]

Communicable diseases including HIV/AIDS and sexually transmitted infections, as well as tuberculosis, are also common. Studies have shown that many male migrants have unprotected sex with commercial sex workers and have limited knowledge of HIV/AIDS;[75] many are married and their wives also become infected when they return home. Moreover, female migrants from neighbouring countries often enter sex work in Russia and are even more at risk; the rate of HIV infections among sex workers in Moscow is 30-100 times higher than the general population.[76] A lack of access to health care means that most do not get tested; those that know they are at risk of infection even fear getting tested due to the shame of testing positive and feeling that they could never return home if they did.[77]

3.4. Current projects

A number of projects are already underway to assist migrants in these situations. IOM and other organisations are engaged in interventions among migrants to raise awareness of the risks of communicable diseases, and to provide treatment and counselling services to victims. IOM has also done research into the popularity of voluntary health insurance among among migrant workers; while they are legally required to have health insurance to enter the country, such documents are only checked if the migrant must also enter on a visa. A survey among 419 migrants in 22 regions of Russia showed that 67% would be interested in purchasing such insurance.[78] However, half of the respondents would only be willing to pay 1500 roubles each year for an insurance policy. This limit is based both on low incomes, and on their expenditure to date on health care (most had spent less than 4000 roubles in the past year). Almost 40% of those who were not interested in purchasing a policy based this decision on their current good health (although it is notable that a majority of the respondents were under 35). However, 27% were doubtful that having a policy would actually result in access to health care. These findings show the need to improve awareness both of health risks and of entitlements, and to improve mechanisms to enforce the rights of those wishing to access the services they are entitled to. They also reveal that voluntary insurance

74 Marat, 2009: 32
75 Weine et al, 2008; and Amirkhanian et al, 2011
76 Weine et al, 2008: 462
77 Weine et al, 2008: 462
78 IOM, 2011

policies must be specially tailored to the needs of migrants and their particular health risks, to avoid both unnecessary risk and unnecessary cost; referral links should be further developed between organisations working with migrants and key insurance providers.

It is important that assistance and information is provided at all stages of migration: before departure, in transit, in the destination country and upon returning to the home country. Health assessments on return could also be a positive step towards reducing the vulnerability of the home population to diseases acquired abroad. Furthermore, treatment, counselling and education (as well as efforts to overcome misunderstanding and social stigma) should be extended to home communities.

There is potential to make more use of informal national networks and diaspora communities in supporting migrant workers in Russia; often migrants of the same nationality develop close links and dependencies when they are in Russia. This is even more the case since many arrange their migration through village connections, and village leaders are often registered with diaspora organisations. An example is the Tajik Diaspora Organisation, which provides a key support network for Tajik migrant workers in Russia; its leaders, as well as Imams and leading individuals in workplaces with a high concentration of Tajik workers, are influential and help to maintain unity.[79] Organisations running awareness campaigns could seek to involve these individuals in order to better disseminate information among migrants and do so with the authority that comes from these community leaders. This approach is supported by broader research (not specifically focused on migrants) by Armirkhanian, Kelly and MacAuliffe in St. Petersburg; they argue that a 'social network' based approach is effective in identifying groups at high-risk of HIV/AIDS and thus being able to target interventions effectively. This method can direct resources to the most crucial segmants of the population, who may remain 'hidden' and unreached by traditional outreach programmes. Utilising community leaders and friendship connections in the dissemination of educational material and information about support services can ensure both that it reaches those most at risk and that it can be tailored to their specific needs.[80]

Conclusion and Recommendations

As the second largest migrant-receiving country in the world, Russia should take lessons from other

79 Weine et al, 2008
80 Armirkhanian et al, 2005

states which have, independently and in cooperation with other states, sought to protect the rights of migrants and improve their access to social security. Russia should sign the relevant international conventions on migrant rights and enforce their provisions; as the largest migrant-sending country in the world, the protection mechanisms are as relevant for its own citizens abroad as for non-nationals working within Russia. Based on the best practices identified in other countries and the particular situation in Russia, a number of key steps can be proposed for the improvement of social security protection for migrants within Russian territory:

1. Labour migrants in Russia should be granted equal access to social security entitlements and associated obligations as Russian citizens.

2. As part of this, the government should extend its agreement with Belarus and Kazakhstan to address each of the main issues associated with the principle of territoriality; it should increase the branches of social security covered and allow for portability of benefits both in the totalisation of periods of employment and the exportability of acquired benefits. Similar agreements should be reached with other key sending states.

3. As regards undocumented migrants, sufficient funding should be provided to cover the existing emergency health care for migrants, and serious examination should be given in budgetary discussions to the provision of health care beyond emergency assistance for the benefit of individuals and the community at large. NGOs can work to increase understanding among undocumented migrants of their human rights and their specific entitlements.

4. Undocumented migrants should be entitled to any social services to which they or their employer have made contributions. If not, they should be reimbursed for these contributions. The government and other organisations should work to improve information about and access to alternative services, including voluntary health insurance.

5. Information about rights and entitlements should be improved, as well as specifically targeted health information campaigns; governments and other organisations working with migrants should increase their cooperation in the dissemination of information and education. This information should be targeted at key points in the migration cycle: before departure, at transit 'hot spots', at the destination and on the return to a migrant's home

country, and should in particular focus on key communicable diseases which affect migrants in Russia, improving the availability of information, treatment and support services. These campaigns can also make use of community links within the migrant national communities in Russia. They should operate at a cross-border level; coordination between organisations and governments in sending and receiving countries can improve support for individuals, preparedness of the host country and ability of the home country to provide services and medical assessments for returning migrants and their families.

6. Information and awareness campaigns should also target the general public in Russia, with the aim to reduce xenophobia and discrimination, which are key contributors to the poor living, working and health conditions of migrants in Russia.

7. The government should strive to increase access to health care to which migrants are already entitled, by ensuring that health institutions are sufficiently funded, that health care professionals are educated in the entitlements of migrants and by cracking down on corruption.

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