

Health policies for migrant children in Europe and Australia

More than 300 000 children seeking asylum were registered in the 28 European Union (EU) member states during 2015, including 88 700 unaccompanied minors. These children have considerable health-care needs primarily because of mental health problems, but also as a result of infectious disorders and lack of basic health care (such as immunisations).¹

The rights of these children to health and health care are codified in the UN Convention on the Rights of the Child (UNCRC), a treaty which has been signed by all nations in the world with the exception of the USA. Within the EU-funded project Models of Child Health Appraised (MOCHA), we surveyed the immigrant health-care policies in all EU or European Economic Area (EEA) member states and also Australia. These policies were drawn from official documents, non-government organisation reports and reports by child health professionals in each country.^{2,3} Our analysis of these policies was guided by the UNCRC principle of non-discrimination. Migrant children were categorised as asylum seekers, irregular or undocumented migrants from outside of the EU and irregular migrants within the EU.

Four countries (France, Italy, Portugal, and Spain) explicitly entitle all migrant children, irrespective of legal status, to receive equal care to that of nationals. Additionally, Belgium and Sweden have equal entitlements for non-EU or non-EEA migrant children in transition or in an irregular legal situation. Many other European countries entitle children seeking asylum in that country to equal care. In Australia, entitlement to health care is restricted for children seeking asylum in detention, including those on offshore Pacific islands, and for irregular migrants.

Germany has the highest number of asylum seekers, yet stands out as the country with the most restrictive health-care policy for migrant children. It limits entitlements for all categories of migrant children, except for unaccompanied minors, to emergency care. This unfortunate limitation to necessary or emergency care effectively excludes rights to primary care, which is the most cost-effective way of providing health care for vulnerable children.⁴ Results of our survey also show that irregular and destitute EU migrant children within Europe are rarely entitled to health care other than emergency care.

Thus, most (80%) European countries do not entitle migrant children to the care that has been codified to them in the UNCRC. This fundamental and potentially remediable breach of children's and human rights for already distressed victims of conflict necessitates urgent action.

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25 years after *Intoxicated by My Illness*: challenges for medical humanities

Communicating with patients at the end of life is regarded as a difficult task, and speaking openly about death is often avoided.^{1,2} Around 50% of patients are informed about their diagnosis and prognosis in many European countries. Silence conspiracies are fairly common³—defined as the agreement between health professionals and relatives or carers to hide from the patient information related to their clinical condition.

Studies that investigated the desire for death agree on the importance of communication between health professionals and patients to prevent and address the desire for death. Talking with patients and giving them the opportunity to identify the reason for the desire for death is crucial to formulating an adequate response when dealing with the specific issues that underlie this desire and to relieve suffering.⁴

What is it that prevents an adequate communication in the clinical context? Why avoid talking about death? Is such avoidance because we do not know how to address death anymore? Why is silence the alternative to facing transcendental issues?

The year 2017 marks 25 years since the publication of *Intoxicated by My Illness* by Anatole Broyard.⁵ His words are still an excellent means of presenting the humanities as the source that inspires human experiences. What we are looking for in a doctor is for them to be someone “who is a close reader of illness and a good critic of medicine [...] a doctor who is not only a talented physician, but a bit of a metaphysician, too. Someone who can treat body and soul. There's a physical self who's ill, and there's a metaphysical self who's ill [...] He should be able to imagine the aloneness of the critically ill [...] I want him to be my Virgil, leading



For more on UNCRC see <https://www.unicef.org.uk/what-we-do/un-convention-child-rights/>

For more on MOCHA see <http://www.childhealthservicemodels.eu/>

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