THE HEALTH OF MIGRANT PEOPLE

ACCESS TO HEALTHCARE

To address the issue of the health of migrants, refugees and asylum seekers, I would like to draw on my own experience, and above all as a witness.

After more than 35 years in private practice, for two years I worked alternatively with 4 other colleagues, providing Red Cross consultations at the Sangatte detention center. Then, once retired, I continued this type of commitment in Lille with MSL (Médecin Solidarité Lille) for 15 years, and at the same time with Abej-solidarité (Association Baptiste pour l'éducation de la Jeunesse) for eight years.

The Sangatte reception center was opened in 1999 and closed in 2002. The people came from war-torn countries, mainly the former Yugoslavia, Afghanistan and Iran. 65,000 passed through. Most came with the aim of getting to England. At the time, it was much easier to integrate and work there. Their profile was that of young, educated people.

This center had a capacity of over 2,000 people, and we consulted in a porta-cabin accompanied by two nurses. The most common pathologies were trivial infections, and a few digestive or dermatological problems. When there were traumatic lesions, they were caused by injuries from razor blades attached to fences, from falls, or from assaults by police or security guards.

Access to healthcare posed few problems, and if the pathologies were more serious, we had a partnership with the Calais hospital.

The advantage of this reception structure and its organization was its official dimension. Treatment was offered, and in the event of violent behaviour by certain members of the police force, it was possible to lodge a complaint via the Red Cross.

Currently, the information I am gathering on the health situation in these maritime territories is disastrous. Hygiene conditions are not only disregarded, but also blocked by local political authorities.

Marauding and various forms of assistance are provided by a few associations: Utopia, Salam, Secours Catholique, etc. MSF and Médecin du Monde deploy a mobile team of around ten doctors.

Lille is the site of a large number of associations dedicated to welcoming people. The most important of these have joined forces under the acronym RSL: Réseau solidarité Lille.

I know two of them in particular: Médecin Solidarité Lille and Abej, which are by far the most important in terms of access to healthcare.

Migrants are referred to them by the various associations and official structures.

Médecins Solidarité Lille has existed for over 28 years. What makes it special is that it offers people with no right to health care the opportunity to be cared for and welcomed by a team of social workers, nurses, general practitioners, specialists and dentists. Most of the staff are volunteers, and treatment is provided by the center's pharmacy, run by volunteer pharmacists and supplied by PHI...

More than 12,000 people are received each year. Nearly 10,000 consultations, including 9,000 general medical consultations and 280 psychiatric consultations. Over 99 nationalities are represented. 84% of them live in precarious housing or are homeless!

Initially run by a handful of doctors and nurses, the center now employs 51 volunteers and 8 paid staff.

Partnerships have been established with the Lille University Hospital, which is geographically close by, as well as with a private hospital, Saint Vincent, and the Center for Infectious Diseases at the Tourcoing Hospital.

When the migrant has been able to obtain legal access to care through the French state medical aid scheme (Aide Médicale d'Etat - AME) or the PUMA, he or she is referred to our colleagues in town.

In complex situations, such as care after hospitalization, the limited number of health care beds (lits haltes soins santé) offer the possibility of continuing care in a more comfortable and dignified way than staying on the streets.

L'Abej, is another very important structure in the metropolis. It was created over thirty years ago by a few members of the Lille Baptist Church, with a double-decker bus designed to take in and care for homeless people near the Lille train station.

It is now a structure run by over 400 paid staff and 200 volunteers.

It consists of a number of buildings designed to welcome, house and care for both rough sleepers and many migrants. It also takes part in a number of street outreach projects.

One of the particularities of these shelters is that they prefer to employ people of foreign origin, which is a considerable asset in alleviating the difficulties associated with language problems.

More than 3,000 people live on the streets or in squats in metropolitan Lille, many of them women and children.

At MSL, we deal with new arrivals, but at Abej, we also deal with this category, as well as those who have been rejected on administrative grounds, and whose physical and psychological deterioration has only worsened.

Thanks to networks and mutual acquaintance between associations, it is now possible to provide care for migrants. What remains is the permanent difficulty of finding new volunteers to ensure the continuity of these services, and also the money, especially if the AME were to disappear. In any case, there remains the immense difficulty of finding accommodation. Calls to 115 are not only saturated, but housing offers are extremely limited.

Here's a practical guide to accessing care at MSL:

Our social services help identify obstacles to care, so that they can be removed if the law allows. The link with the local CPAM (health insurance fund) is an essential support in monitoring files and keeping abreast of the progress of applications.

For the past 4 years, COALLIA (national operator for the first reception of asylum seekers) has been the platform dedicated to the registration of asylum applications. As a result, PUMA and CSS applications made by MSL have decreased, as COALLIA is in charge of compiling the files.

Each person seeking refuge in France is received by a social worker who registers and organizes the appointment at the prefecture. After three months in France, the person returns to COALLIA to apply for social security cover.

As a result, the basic health coverage of new patients at MSL is: 92% none, 7% PUMA, 1% AME.

A few definitions :

L'AME

Aide Médicale de l'Etat is a scheme enabling illegal immigrants to gain access to healthcare. It is granted on condition of stable residence for at least three months and income. Once granted, the AME is valid for one year. Renewal must be requested each year.

LA PUMA

Replacing the basic CMU, PUMA (Protection Universelle Maladie) came into force on January 1, 2016. It concerns all people (whatever their nationality) who work or reside in France on a stable basis. It guarantees continuous coverage of healthcare costs by the French health insurance system.

There is also a mutual insurance system, with the Assurance Maladie only partially reimbursing healthcare expenses (70%).

But the procedure is more complex, and only 33% of migrants could benefit from it in our statistics.

MSL's social mission, apart from providing health care, is to support people in their application for social security coverage, and then to refer them to general practitioners.

At their first consultation, 33% of people are eligible for PUMA, and 22% for AME.

Barriers to access to healthcare

Lack of information

Language barrier, lack of knowledge of the complex French administrative system, illiteracy.

Access to public services

Dematerialization of procedures, no more walk-in service, paid calls to the CPAM, saturation...

The first application for AME must be physical, CPAM autonomous and requirement different from one department to another, the fear and cost of a trip.

Access to healthcare rights

Complex forms, documents lost by the CPAM, loss of identity documents, more rigid evaluation of documents and longer delays,

very long receipts and residence permits to obtain from the prefecture.

Access to healthcare

In the absence of a permanent address, healthcare is not a priority for patients.

Despite the fact that they have access to their rights, it's difficult for them to get to treatment centers, and with emergency services and general medicine overcrowded, it's hard for them to get out of the systems dedicated to the underprivileged.

Consequences

Difficulty projecting into the future

Loss of self-esteem

Violence against self and others

Mental suffering and social resignation

Aggravation of certain illnesses...

Conclusion

Migrant populations are not vectors for the spread of imported pathologies.

Administrative and financial obstacles to access to care, if the AME is abolished or restricted, can create and induce real pathologies, either psychiatric or infectious, if access to care is hindered.

Overall, this population is young, willing and in good health.

They bring dynamism through their youth, cultural enrichment through their diversity, and material enrichment through their desire to integrate and work.

It should no longer be seen as a problem to be solved or a danger from which society must protect itself.

To stand in its way is to sink into inescapable material and cultural impoverishment.

To welcome it is to enrich ourselves humanly.

Dr. F. MERCKAERT

IN APPENDIX

A quick look at the populations encountered at MSL:

5 tables

These tables are taken from the association's annual report. Here for 2022.

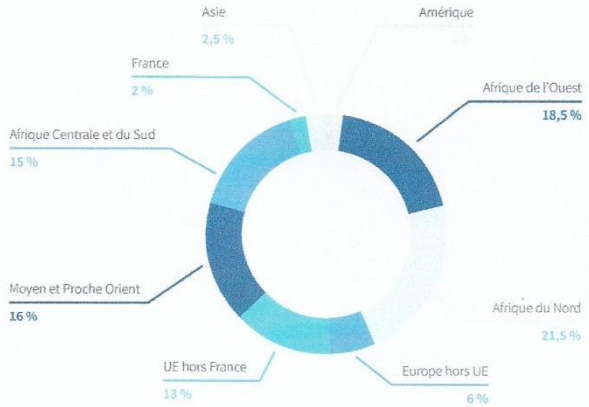
The full report can be found on the official MSL website.

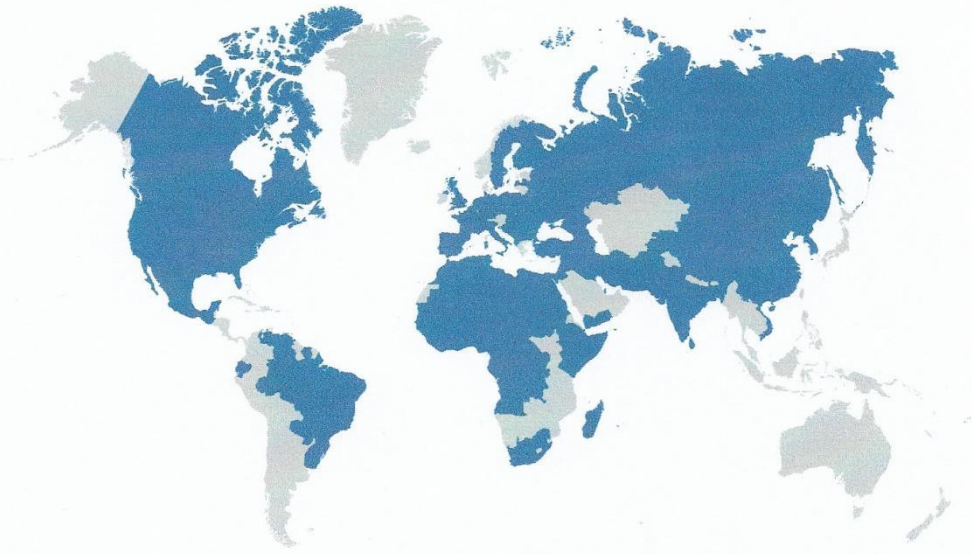
Patient origin (table 1)

BILAN SOCIAL

LA SITUATION DE NOS PATIENTS

ORIGINE DES PATIENTS





Pays d'où viennent les patients en 2022

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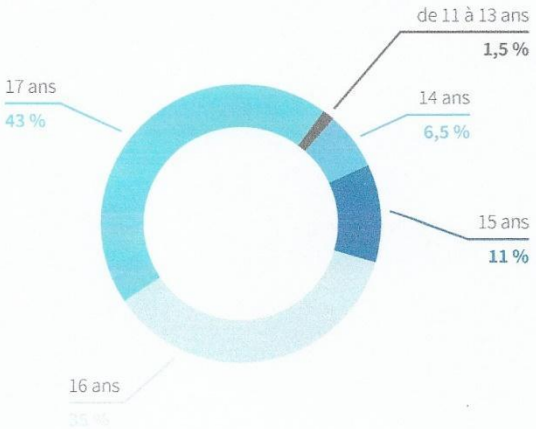
UFMs, Age and geographical origin (table 2)

LES MINEURS NON ACCOMPAGNÉS

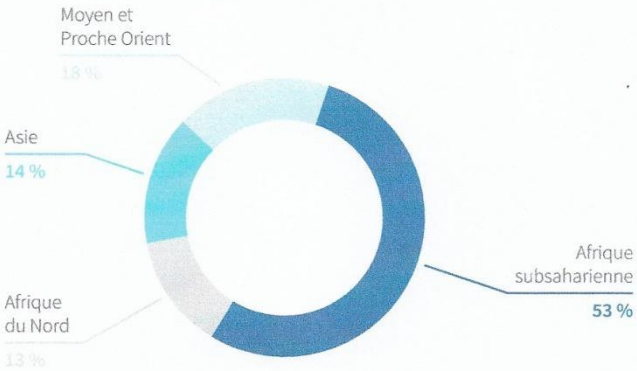
MSL a accueilli 323 nouveaux MNA sur l'année 2022, soit 126 de plus qu'en 2021.

Âge des MNA :



63 % des MNA reçus en 2022 sont des garçons. Sur l'ensemble des MNA, plus de la moitié vient d'Afrique Subsaharienne (160) ; 54 du Proche et Moyen Orient, 44 d'Asie, 40 d'Afrique du Nord.

Origine des MNA :



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Housing (table 3)

BILAN SOCIAL

LA SITUATION DE NOS PATIENTS

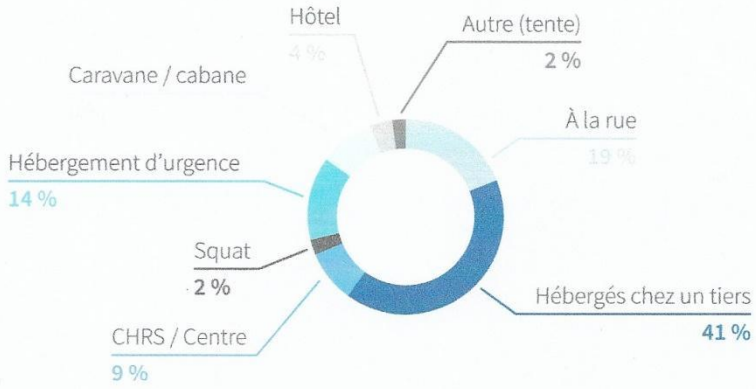
LOGEMENT

16 % de nos patients ont déclaré vivre dans un logement durable (en légère baisse comparé à 2021).
C'est-à-dire de manière indépendante, sur du long terme.

Les conditions de logement de nos patients en 2022 :

84 % des patients vivent dans des conditions précaires.
Parmi ces personnes, celles qui sont à la rue représentent un peu plus de **19 %**.

Focus logement précaire et à la rue :



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Pathologies (table 4)

	2021	2022	% pathologie	Évolution 2021/2022	Commentaires
Psychiatrie	973	859	7%	-12%	117 psychose, 205 anxiété, 156 dépression, 54 addicto
Osteo-articulaire	946	1 156	9%	22%	376 traumato, 779 rhumato
Gynécologie	1 235	1 570	13%	27%	862 grossesses
App respiratoire - ORL	737	954	8%	29%	617 ORL, 335 pneumo
Gastro	790	750	6%	-5%	
Pédiatrie	734	875	7%	19%	240 MG + 455 PDM + 180 bidonville
Cardio	666	817	7%	23%	
Dermatologie	712	857	7%	20%	
Endocrino	561	735	6%	31%	dont 465 diabète
Maladies infectueuses	803	621	5%	-23%	223 covid, 160 depist Hépat B&C, 60 depist VIH, 13 depist IST
Stomato-dentaire	603	637	5%	6%	
Uro-nephro	239	316	3%	32%	
Neuro	246	223	2%	-9%	
Ophtalmo	207	189	2%	-9%	
Hémato	145	165	1%	14%	
Divers	1 018	1 474	12%	45%	dont 917 Bilan&depist, 228 certif, 69 cancer
Total	10 615	12 197		15%	

Les pathologies sont superposables à celles rencontrées
en médecine générale de ville, avec cependant quelques caractéristiques :

- Pathologies prises en charge souvent à un stade plus avancé avec des complications en raison du recours tardif aux soins et aux nombreuses ruptures de suivi. Exemple rupture totale de traitement chez certains diabétiques qui nécessite alors une hospitalisation d'urgence.
- Multiples maux exprimés lors de la visite.
- Consultations plus longues en raison de la barrière de la langue, des multiples pathologies, du temps nécessaire à la prise de connaissance du dossier pour les nouveaux patients, de la délivrance du traitement en fin de consultation et de la nécessité d'une transmission à l'équipe infirmière M.S.L. et aux partenaires concernés par la situation.
- Troubles psychiques très fréquents.
- Les pathologies infectieuses de type VHC, VHB et VIH sont plus fréquentes.

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LES PATHOLOGIES PSYCHIATRIQUES

Elles concernent 7 % des consultations soit 859 consultations.

Une partie des consultations est réalisée par l'équipe de santé mentale : Diogène, constituée d'un psychiatre, d'infirmiers psychiatriques et d'une psychologue. L'équipe consulte 3 à 4 demi-journées par semaine à M.S.L. et permet ainsi une prise en charge médicale des patients en souffrance psychique.

En consultation de médecine générale, la souffrance psychique peut être le motif de la consultation ou peut s'exprimer dans un deuxième temps au cours de celle-ci, ou encore, juste en dernier mot ou à demi-mot à la fin de l'entretien. Elle nécessite de la part du médecin de l'écoute, du temps et de l'empathie pour que le patient puisse exprimer sa souffrance et être orienté au besoin.

La barrière de la langue et de la culture, les urgences de survie, la culpabilité, les craintes, l'impossibilité de « dire » peut empêcher le récit et l'expression de la souffrance. Les chiffres sous-estiment celle-ci.

La fréquence élevée des **troubles anxio-dépressifs** est liée aux événements de vie et à l'histoire des patients, notamment celle des migrants. Ruptures, deuils, violences, séparations, isolement, déracinement, espoir déçu par la non régularisation, le rejet, l'extrême précarité en France...). Les troubles sont quelquefois majeurs et vont jusqu'au désir ou la tentative de suicide.

93 patients souffraient d'un syndrome de stress post traumatique (79 en 2021) après avoir vécu des situations violentes dans le pays d'origine ou au cours de leur parcours migratoire. Deuils dans un contexte violent, viols, tortures, séquestrations, esclavage moderne, noyade d'un proche lors du passage de la mer méditerranée...

La grande majorité arrivaient de pays étrangers en conflit :

- 65 % Afrique subsaharienne dont 22 % de Guinée
- 8 % Afghanistan
- 20 % Algérie
- 4 % Europe de l'Est

- 55 % étaient en demande d'asile dont la moitié dublinés
- 13 % étaient en situation irrégulière (souvent déboutés du droit d'asile)
- 20 % de Mineurs Non Accompagnés
- 33 % sans hébergement et 26 % en hébergement d'urgence.