

# PAINFUL EXCLUSION

The costs of denying asylum seekers access  
to healthcare services in Israel, and a proposal for a remedy



PHYSICIANS FOR HUMAN RIGHTS  
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to healthcare services in Israel, and a proposal for a remedy

"...A person who lacks access to  
elementary healthcare is one whose  
human dignity has been violated..."

Former Chief Justice Aharon Barak, 2002

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## Summary

A decade has gone by since the first African asylum seekers arrived in Israel. Still, the Ministry of Health has failed to formulate a comprehensive policy to regulate their access to health services. The following report details the costs of this failure - the health, moral and economic cost of the lack of healthcare policy for asylum seekers. It then offers an alternative: a sustainable solution for that population that includes a state-sponsored insurance arrangement.

Israel is now home to almost 40,000 African asylum seekers, mostly from Eritrea and Sudan. The State of Israel recognizes the mortal danger they face should they return to their countries of origin, and therefore protects them against expulsion. Beyond this protection, however, these people lack any civil status in Israel, and accordingly remain without regular access to health and welfare services, except in emergencies.

Over the past few years, there has been a gradual change in the Ministry of Health's approach, as it has begun offering partial, specific solutions for asylum seekers. As described below, however, these are far from sufficient, leaving many individuals without appropriate healthcare.



Private insurers offer a limited range of services and exclude coverage for "pre-existing conditions". As a result, even those who do have private policies are often not covered. The ministry's Gesher Mental Health Clinic in Jaffa, the only clinic in Israel offering mental health services to asylum seekers, is overloaded and cannot offer mental health treatment to all those in need among this population. Finally, the few services offered by the state at the Terem Clinic for Refugees in downtown Tel Aviv are limited, and do not really meet the needs of chronic patients, patients who need follow-up treatment and rehabilitation, those who require surgery, oncological and other complex treatments. Consequently, asylum seekers have no choice but wait until their health deteriorates and their life is in danger, in which circumstance they would be eligible to emergency hospital care.

**This systematic neglect of the health of asylum seekers takes a heavy toll from their health.** This situation, however, affects not only the asylum seekers themselves, but is also **very costly, ethically and economically, for the entire healthcare system, particularly the hospitals that must bear the burden of emergency care for asylum seekers and cover for the lack of a universal solution for this population.** As suggested by the report, despite some investment by the Ministry of Health in limited solutions, totaling some 40 million NIS in 2016 alone, the hospitals continue to bear the high costs of emergency treatments in the form of bad debts. **The report reveals for the first time that over 2013-2016, these bad debts reached a total of more than 157 million NIS; in 2016 alone, the total was 36 million, with the Tel Aviv Sourasky Medical Center bearing almost 23 million NIS in bad debt.**

The sorry state of human and economic affairs revealed in the following pages suggests the **need to develop a comprehensive healthcare solution for the asylum seekers in Israel.** This solution involves moving from their exclusion towards their inclusion in the public health system; from partial, ad-hoc and specific solutions as a humanitarian response to immediate needs towards a just, equitable and sustainable solution that recognizes their basic right to health and dignity.

This proposed policy change requires activity on several levels. **On the first level,** the proposed change requires abandoning the specific solutions in the form of dedicated clinics and private insurance policies in favor of **a comprehensive and egalitarian state insurance arrangement for asylum seekers.** Studies conducted in other countries indicate that insurance arrangements for documented and undocumented migrants significantly reduce the cost of providing them with health services. The model presented in this report seeks to apply the existing model

for providing health services to minors without civil status (currently provided by the Meuhedet health fund) also to adults, with the required adjustments. Based on this model, most asylum seekers will be required to pay a monthly insurance fee of about 150 NIS, with the Ministry of Health covering the remaining amount. In return, they will enjoy access to the basic service range provided to Israelis through the health funds under the State Health Insurance Law. As shown in the calculation presented below, the investment required by the ministry to ensure the success of this move is **negligible** – some 20 million NIS beyond the present investment in treating uninsured migrants, or **an addition of 0.052% to the annual health budget**. Moreover, it is a wise investment, particularly when we take long-term risks and other considerations into account.

**On the second level**, the proposed change requires preparation by healthcare providers – the medical, paramedical and administrative staff in the health funds and hospitals – to provide healthcare for the population in question, including linguistic and cultural mediation. As described by the report, here, too, a modest and judicious economic investment – using interpreters and cultural mediators rather than expensive equipment or human resources – can reduce the hidden costs for the healthcare system.

**On the third level**, the proposed change also requires working with the asylum seeker community itself, to raise its awareness and familiarity with the Israeli healthcare system. Operating on all three levels thus requires the cooperation of the Ministry of Health, the medical community and healthcare providers, as well as civil society organizations, and particularly those assisting asylum seekers. In many senses, the text below is a call for such cooperation.

The Ministry of Health is already aware of the hopelessly dissatisfactory level of the existing treatment solutions for asylum seekers. Until now, however, it has failed to formulate a real policy to remedy the situation. According to senior ministry officials, their hands are tied, since now more than ever, as the Ministry of the Interior acts to deport asylum seekers and dissuade others from arriving, the Ministry of Health is prevented from improving the living conditions of these inhabitants. But perhaps now is precisely the time for the Ministry of Health to take into due account the broad range of independent considerations directly relevant to its mandate – including medical and ethical considerations related to individual and public health, as well as long-term economic considerations – and formulate a sustainable health policy for the community of asylum seekers living among us. Now is the time for the ministry to make a stand and provide full and equal health services to that community, to alleviate their distress rather than add to their suffering.



## Introduction: Asylum Seekers Live in Israel Without Proper Access to Public Health Services

According to the Ministry of the Interior's Population and Immigration Authority, in April 2017 there were 38,540 African asylum seekers in Israel, over 90% of whom had immigrated from Eritrea or Sudan.<sup>1</sup> Being asylum seekers, and given Israel's acknowledgement of the danger to their lives should they return to their countries of origin, they are protected against expulsion and are not deported. Beyond this protection, they lack civil status and therefore remain without regular access to health services, except in emergencies.<sup>2</sup>

A decade has passed since the first asylum seekers arrived in Israel from Africa, and the Ministry of Health has still not formulated a universal and comprehensive healthcare policy to regulate their access to public health services. In 2014, the State Comptroller published a report criticizing the government's current policy towards asylum seekers.<sup>3</sup>

<sup>1</sup> Population and Immigration Authority - Policy Planning Division, [Data on Aliens in Israel](https://www.gov.il/BlobFolder/generalpage/foreign_workers_stats/he/foreign_workers_stats_q2_2017_1.pdf), Issue no.2/2017, Summary of Q2, 2017: [https://www.gov.il/BlobFolder/generalpage/foreign\\_workers\\_stats/he/foreign\\_workers\\_stats\\_q2\\_2017\\_1.pdf](https://www.gov.il/BlobFolder/generalpage/foreign_workers_stats/he/foreign_workers_stats_q2_2017_1.pdf) [Hebrew]

<sup>2</sup> According to the 1996 Patient's Rights Law, Section C Article 3(b), "In a medical emergency, every person is entitled to urgent medical care without any conditions".

<sup>3</sup> **Non-Deportable Aliens**, Annual Report 2014 (64a), p. 59:

[http://www.mevaker.gov.il/he/Reports/Report\\_248/af07752c-7845-4f1d-ae97-23c45c702624/102-ver-5.pdf](http://www.mevaker.gov.il/he/Reports/Report_248/af07752c-7845-4f1d-ae97-23c45c702624/102-ver-5.pdf) [Hebrew]



Among other things, the report detailed the severe consequences of the failure to provide health and welfare services to the most vulnerable subgroups among the asylum seekers, including people with physical and mental disabilities.

Three years have passed since the report, and the situation it describes has hardly changed. Although the great majority (~80%) of asylum seekers are men in their 20s–40s,<sup>4</sup> and although most of them are healthy,<sup>5</sup> on the long run, the lack of regular access to health services in Israel denies them proper medical treatment and places them at risk. As a result, many asylum seekers seek healthcare only in emergencies or at a stage when their condition becomes complicated or life threatening.

As the Comptroller suggested,

without adequate medical treatment in the community, the healthcare needs of some of the non-deportable aliens are neglected until their condition deteriorates to the point of emergency. [...] There is a real concern that granting [only] limited access to health services to non-deportable aliens suffering from mental illnesses or certain chronic diseases, and sometimes even aliens in need of rehabilitation and nursing, as detailed in the report, is incompatible with the directives of Basic Law: Human Dignity and Liberty, as interpreted in Supreme Court rulings, and with the provisions of the [International] Covenant on [Economic,] Social [and Cultural] Rights. *It is therefore appropriate that steps be taken to make sure that these groups are given the required medical service according to law.* (pp. 63–64, our italics).

Indeed, every month dozens of patients arrive at the Open Clinic of Physicians for Human Rights Israel (PHRI) for questions, continued treatment, follow-up, rehabilitation, and even essential operations, which they are unable to obtain elsewhere due to their inability to pay for them. Often, these patients had received primary emergency care in hospitals, but once they were discharged, they remained with recommendations for further treatment they had no way of following:

Awat,<sup>6</sup> a 25-year-old asylum seeker from Eritrea, suffered intense stomachaches that prevented him from working for several months. When his condition deteriorated, he was rushed to the emergency room. The emergency room staff rushed him to the operating room

<sup>4</sup> See, e.g. report by the Knesset Research and Information Center: Gilad Natan, **Non-Israelis in Israel (Foreigners, Migrant Workers, Refugees, Infiltrators and Asylum Seekers) - 2010–2011 Data**, p. 14 [Hebrew]. According to the report, out of 13,868 asylum seekers who entered Israel by November 2011, 11,567 were men, 1,626 were women and 453 were minors.

<sup>5</sup> On the Healthy Migrant Effect, see Lúdia Farré, **New Evidence on the Healthy Immigrant Effect**, Institute for the Study of Labor, Discussion Paper No. 7840, (2013): <http://ftp.iza.org/dp7840.pdf>; Alexander Domnich, Donatella Panatto, Roberto Gasparini, & Daniela Amicizia, **The “healthy immigrant” Effect: Does It Exist in Europe Today?** Italian Journal of Public Health, Vol. 9 No. 3 (2012): <http://ijphjournal.it/article/view/7532>;

<sup>6</sup> To protect the privacy of our patients, all patients’ names throughout this report are aliases.

due to suspected appendicitis. During the operation, a tumor was found in his belly, and a biopsy was performed. After his discharge, Awat was referred to a day clinic to receive the biopsy results and conduct further tests. When he arrived there, however, he was told that due to his debt for the hospitalization, he was prevented from follow-up treatment, including the further tests and receiving the biopsy results. Only after intervention by physicians from PHRI's Open Clinic were the test results received, and with them the bad news: Awat had been diagnosed with a malignant and particularly aggressive tumor in the large intestine. Now he is facing the additional difficulty of obtaining oncological treatments without health insurance and without being able to afford private care.

★

About five years ago, 40-year-old Daniel began suffering from a vision disorder as a result of a brain tumor, and last year his vision deteriorated drastically. When he was recently examined at the PHRI clinic, the doctor found that he required an urgent MRI scan to assess the condition of the tumor and decide on the type of intervention required to save his eyesight. However, since Daniel is unemployed, he cannot finance the scan, and he is therefore denied the possibility of further treatment.

★

Babikar is a 36-year-old asylum seeker from Sudan who has been suffering chest pains over the last four years. After his pains worsened, he was hospitalized in the Tel Aviv Sourasky Medical Center, where he was diagnosed with a severe rheumatic heart disease for which he urgently requires aortic valve replacement. Since he is unable to work due to his disease, Babikar does not even have migrant worker insurance, and remains untreated. Despite the opinion of specialists who have emphasized the threat to his life, the Ministry of Health declined our request to help fund the operation. The ministry's reply was that once his situation becomes an emergency, he would be able to receive the required care "unconditionally" in the emergency room, based on the Patient's Rights Law. We can only hope this wouldn't be too late.

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While fleeing Eritrea, asylum seeker Mulu was kidnapped and tortured in the Sinai Peninsula. Recently, he began suffering from nightmares and anxieties, making it difficult for him to sleep and function during the day. He arrived at the emergency room with an anxiety attack. There, he was diagnosed as having PTSD and referred to medicinal treatment combined with psychotherapy. However, since Mulu does not have medical insurance, he has no access to such treatment. In fact, as this became obvious already at the emergency

room, the doctors there had no choice but to ask him to return to the emergency room whenever a crisis occurred.

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Zebib, an asylum seeker from Eritrea, was diagnosed with breast cancer. Until recently, she worked and obtained oncological treatments through her private insurance. However, due to her disease, she was forced to stop working, and so her insurance policy was terminated. For long months, Zebib remained without treatment or follow-up, until her condition deteriorated and she was rushed to the emergency room. There, it was found that the metastases had spread throughout her body and she was hospitalized in a severe condition.

Like many other asylum seekers, Awat, Daniel, Babikar, Mulu and Zebib remain without a real solution for their suffering and pain. This situation takes a heavy toll from the health and welfare of the asylum seekers. Their health is neglected and they risk irreversible deterioration that affects their daily functioning and ability to work. This violates the asylum seekers' right to health and dignity.

This situation affects not only the asylum seekers themselves, however, but also exacts a heavy ethical and economic price from the entire health system:

- It places physicians in ethically problematic situations, where they find themselves forced to discharge patients, knowing they will not receive follow-up treatment;<sup>7</sup>
- It already places a heavy financial burden on hospitals, which bear the cost of the expensive and prolonged treatment required following the medical emergencies;
- It has extensive implications for public health;<sup>8</sup>

In the long-term view, the lack of treatment and lack of preventive medicine for a population living in Israel for many years could result in the future in additional economic burdens for the healthcare system and Israeli society in general.

In what follows, we urge to change the current situation and offer a way of doing so. We argue that the relevant considerations of morality and human dignity, of public health, medical ethics, as well as economic considerations – all suggest the need for formulating a comprehensive health policy for regulating medical care of asylum seekers. By demonstrating how limited and partial the few solutions currently

<sup>7</sup>See position paper of PHRI's Ethics Committee:

<http://www.phr.org.il/en/asylum-seekers-without-healthcare-threat-medical-ethics/>.

<sup>8</sup> Fleischman Y, Willen SS, Davidovitch N, Mor Z., **Migration as a social determinant of health for irregular migrants: Israel as case study**, Social, Science & Medicine (December 2015);

Willen SS, Knipper M, Abadía-Barrero CE, Davidovitch N., **Syndemic vulnerability and the right to health**, Lancet (March 2017)

offered to asylum seekers are, we will highlight the urgent need for a systematic, systemic solution in the form of state health insurance.

This comprehensive solution involves moving from excluding the asylum seekers towards their inclusion in the public health system; from partial, ad-hoc and specific solutions as a humanitarian response to immediate needs towards a just, equitable and sustainable solution that recognizes their basic right to health and dignity. This proposed policy change requires activity on several levels. **On the first level**, it requires abandoning the specific solutions in the form of dedicated clinics and private insurance policies in favor of a comprehensive and egalitarian state insurance arrangement for asylum seekers. **On the second level**, the proposed change requires preparation by healthcare providers – the medical, paramedical and administrative staff in health funds and hospitals – to provide healthcare for the population in question, including linguistic and cultural mediation. **On the third level**, it also requires working with the asylum seeker community itself, to raise its awareness and familiarity with the Israeli healthcare system. Operating on all three levels thus requires the cooperation of the Ministry of Health, the medical community and healthcare providers, as well as civil society organizations, and particularly those assisting asylum seekers. In many senses, the text below is a call for such cooperation.

The remainder of this report proceeds as follows. **Section I** presents the normative framework of our discussion and describes Israel's commitment to provide appropriate health services to all those living in its territory, as stipulated in international conventions signed by Israel, as well as its own laws. **Section II** elaborates on the current solutions available to asylum seekers, stressing their limitations and the fact that they still violate their right to health. Consequently, **Section III** proposes the appropriate solution for the challenges posed by the asylum seekers in the form of a comprehensive and egalitarian state insurance arrangement, whose necessity is obvious given the present alternatives. This section also refers to the economic implications of the lack of such a policy, and argues that the solution we propose is not only ethically and medically just, but also economically sound. **Section IV** briefly reviews the ways other developed countries address the healthcare challenges posed by accelerated immigration and refugeehood. Finally, **Section V** emphasizes that a state insurance arrangement can do justice and offer equal access to health only within the framework of an overall attitude change – by those who provide health services and the community that consumes them.



## Section I

### Israel's Duty to Provide Health Services to those Living in its Territory

Being a basic human right, a person's right to health ought not to be affected by her civil status, and it is the duty of the State of Israel to ensure appropriate health services to all persons living under its jurisdiction. This duty, and moreover, the state's duty to protect the right to health of particularly vulnerable populations among those under its control, is grounded in a series of international conventions, as well as in Israeli law.

Thus, according to the Universal Declaration of Human Rights (1948), "Everyone 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..."<sup>9</sup> and this right is even specifically enshrined in the cases of children<sup>10</sup> and women.<sup>11</sup> Subsequently, the 1966 International Covenant on Economic, Social and Cultural Rights,

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<sup>9</sup> Article 25(1)

<sup>10</sup> Article 24 of the Convention on the Rights of the Child (1989)

<sup>11</sup> Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979)



ratified by Israel in 1991, mandates the protection of the right to health and the "creation of conditions which would assure to all medical service and medical attention in the event of sickness" (Article 12(2) (d)). It also prohibits discrimination in access to health services, among other things, on the basis of birth or other status 2(2).<sup>12</sup> The UN expert committee that supervises the implementation of the covenant has further determined that states have a special duty to ensure access to medical services by weak populations, including asylum seekers and undocumented migrants.<sup>13</sup>

In addition, the UN Special Rapporteur states in a report dated April 16, 2010 that "The enjoyment of these rights (health and adequate housing) by all individuals in society regardless of their citizenship, nationality and immigration status is not only an end in itself as a matter of entitlement but also a crucial means to ensure equitable human development and social integration of migrants in host societies."<sup>14</sup>

Moreover, the committee on the Elimination of Racial Discrimination (CERD) referred in 2004 to the need to "Ensure that States parties respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services".<sup>15</sup>

This is doubly true of particularly vulnerable groups within the asylum seeker population, including people with physical and mental disabilities, including due to traumas experienced in their countries of origins or on their way to Israel – particularly torture in the Sinai Peninsula<sup>16</sup>. According to the 2006 Convention on the Rights of Persons with Disabilities, signatory states, including Israel, are obliged to recognize the right of asylum seekers with disability for equality, including in healthcare, training and rehabilitation (Articles 25 & 26), work and employment (27), and adequate standard of living and social protection (28). The 1989 Convention on the Rights of the Child, particularly in Articles 22–24, refers to the protection to which children with physical and mental disabilities are entitled, including

<sup>12</sup> UN Committee on Economic, Social and Cultural Rights, General Comment 14, Article 18 (11.8.2000)

<sup>13</sup> UN Committee on Economic, Social and Cultural Rights, General Comment no. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights, para. 34)

<sup>14</sup> <http://www.refworld.org/docid/4eef18a42.html>

<sup>15</sup> <http://hrlibrary.umn.edu/gencomm/genrec30.html>

<sup>16</sup> Since 2009 Israeli and international human rights organizations have been aware of the phenomenon of torture camps operating in the Sinai Peninsula, where African migrants were being held captive. Survivors' testimonies collected at the PHRI open clinic consistently report being kidnapped and held in captivity for ransom. Torture was inflicted to pressure the families of the individuals to pay the ransom and included shackling in chains for periods of days or months, starvation, whipping, causing burns, rape and sexual assault, and threats of killing and organ harvesting.

<https://www.hrw.org/report/2014/02/11/i-wanted-lie-down-and-die/trafficking-and-torture-eritreans-sudan-and-egypt>

<http://www.hrw.org/sites/default/files/reports/egypt1108webwcover.pdf>

<http://hotline.org.il/wp-content/uploads/202509720-Tortured-in-Sinai-Jailed-in-Israel.pdf>

<http://www.phr.org.il/wp-content/uploads/2016/06/Sinai-Torture-Survivors-speak.pdf>

those considered refugees. Finally, the 1951 Convention Relating to the Status of Refugees discusses ensuring social security for refugees (Article 23), including in cases of disability (24).

The State of Israel also recognized its duty to protect torture survivors, when it ratified the 1984 UN Convention against Torture in 1991.<sup>17</sup> Specifically, it is obliged to comply with Article 14, which explicitly refers to the duties of the signatory states to assist and rehabilitate torture victims in their territory. General Comment 3 on Article 14 details the obligations of states parties towards torture survivors.<sup>18</sup> These include the duty of providing access to rehabilitation programs as soon as possible after an evaluation by a specialist doctor, as well as the duty to adopt a long-term and integrative approach that will ensure prompt, dedicated, adequate and accessible treatments for the victims. Recently, as part of the concluding observations on the fifth periodic report on Israel, the UN Committee Against Torture reiterated that Israel must ensure that all torture survivors subject to its jurisdiction have access to rehabilitation services and holistic care, including medical and psychological assistance.<sup>19</sup>

The right to health and physical integrity is also enshrined in Israeli law as part of the "core of the right for dignified human existence".<sup>20</sup> The duty of ensuring access to medical services for all persons is required by Basic Law: Human Dignity and Liberty, which entitles all persons to protection of their life, body and dignity (Article 4). The courts have interpreted this principle as ensuring basic living conditions for all,<sup>21</sup> and ruled that these are not abstract statements, but an obligation by the state to ensure a "protective net" for the disadvantaged in society, including "medical services which will ensure him access to the facilities of modern medicine".<sup>22</sup>

The basic rights provided for by Basic Law: Human Dignity and Liberty are applicable to all persons in Israel,<sup>23</sup> including those who have entered Israel without permission,<sup>24</sup> and certainly to all those authorized to stay in the country, including asylum seekers defined as "non-deportable

<sup>17</sup> <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>.

<sup>18</sup> [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/C/GC/3](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/C/GC/3)

<sup>19</sup> Committee Against Torture: Concluding Observations on the Fifth Periodic Report on Israel, articles 46-49, pp. 10-11: "[49] The State party should take the measures necessary to ensure that all victims of torture and ill-treatment who are subject to its jurisdiction obtain redress and have an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible, as required by article 14 of the Convention and elaborated in the Committee's general comment No. 3 on the implementation of article 14 by States parties. It should also ensure that specialized, holistic rehabilitation services, including medical and psychological assistance, are available and promptly accessible to all victims of torture and ill-treatment."

<sup>20</sup> High Court of Justice (hereafter, HCJ) 1105/06, *Kav LaOved v. Minister of Welfare* (para. 62)

<sup>21</sup> HCJ 5578/02, *Manor v. Minister of Finance*, (1), 729, 736

<sup>22</sup> HCJ 366/03, *Commitment for Peace and Social Justice v. Minister of Finance*, <http://versa.cardoza.yu.edu/sites/default/files/upload/opinions/Commitment%20to%20Peace%20and%20Social%20Justice%20Society%20v.%20Minister%20of%20Finance.pdf>.

<sup>23</sup> Aharon Barak, *Judicial Interpretation, Vol 3: Constitutional Interpretation* (1994), Tel Aviv: Nevo Publishing, pp. 435-436

<sup>24</sup> HCJ 11437/05, *Kav LaOved v. Minister of the Interior* (April 13, 2011)

aliens". The right to minimal living conditions and to health, as part of human dignity, is also recognized by the Israeli court system as a constitutional human right:

The right of every person... to minimal subsistence is integral to the constitutional protection afforded by Basic Law: Human Dignity and Freedom... A person who does not have access to elementary medical care is a person whose human dignity has been compromised. A person forced to live in humiliating material conditions is a person whose human dignity has been compromised.<sup>25</sup>

Finally, the 1994 National Health Insurance Law states that "The national health insurance provided by this law will be founded on the principles of justice, equality and mutual assistance". Article 56(A)(1) (d) of the law stipulates that the Minister of Health is authorized to lay down special arrangements in registering to health funds and providing health services for people living in Israel who are not insured as provided by that law.

Nevertheless, apart for very few exceptions, the State of Israel has thus far not ensured accessible and comprehensive medical services to meet the healthcare needs of its inhabitants who are not Israeli residents. The next section reviews the main solutions that do exist and highlights their insufficiency.

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<sup>25</sup> Former President of the HCJ, Aharon Barak, in ,paras. 19-20.



## Section II

### The Existing Solutions and their Limitations

A decade passed since the first asylum seekers entered Israel. Still, instead of developing a comprehensive policy, the Ministry of Health chose to gradually offer several dedicated and specific solutions that are either limited or underfunded. We will now review these solutions.

#### 1. Private insurance policies: Dangerous privatization of the asylum seekers health

According to the 1991 Foreign Workers Law and the 2001 Foreign Workers Order, the employer must provide the migrant worker with insurance at his own expense.<sup>26</sup> This insurance is provided by private companies that contract with health funds for service provision. This arrangement applies to the population of migrant workers who have a dedicated work visa (Type B/1) for a limited duration of five years in most cases. Prior to entering Israel, to obtain the work visa, migrant workers are required to present medical documents attesting to their health and fitness to work in Israel.

<sup>26</sup> The employer may deduce up to a third of the cost of the insurance from the employee's monthly salary, and in any case no more than 125 NIS.

Although this arrangement has been designed to regulate the access to health care of migrant workers, upon the entry into Israel of asylum seekers from Eritrea and Sudan, and without a clear and comprehensive policy in place, it was decided that although they were officially not permitted to work, this prohibition would not be enforced against their employers (HCT 10/6312). It was also determined that those among the asylum seekers who would be employed would also be subject to the insurance regulations applicable to migrant workers.<sup>27</sup>

The private "foreign worker" insurance policies are not regulated by the Ministry of Health but rather by the Ministry of Finance's supervisor of Insurance and Capital Markets. The very existence of private health insurance policies thus enabled the Ministry of Health to shirk its responsibility for this population and provided justification for its failure to formulate a comprehensive policy. Accordingly, it is important to elaborate on why the private insurances are an extremely unreliable solution for the asylum seekers and cannot provide the basis for a comprehensive and appropriate arrangement for them.

**First, the very conditioning of access to health service on the ability to work on a regular basis is highly problematic,** particularly as asylum seekers are often people who have run for their lives and been tortured on the way, leaving indelible marks on their body and mind, which often make it difficult for them to function, let alone work. This privatization exposes the asylum seekers to constant violation of their right to health and places real obstacles on their access to public health services.

Second, the private insurance policies offered to the asylum seekers in Israel are inappropriate for their life circumstances, work patterns and health condition. Moreover, the regulations governing these insurances allow the private insurers to deny coverage of essential medical treatments, and even discontinue treatments. The following reviews a few of the unique problems affecting asylum seekers insured by "foreign worker" policies:

#### A. Exclusion of Mental Health Services

"Foreign worker" insurances cover mental health services only in emergencies. This exclusion is odd, to say the least, given the current consensus that there is no health without mental health, and particularly considering findings suggesting that forced migration is a major risk

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<sup>27</sup> These temporary arrangements have created an ongoing reality of ambiguity with regard to the employment of asylum seekers, and consequently their status with reference to the employment laws and the Foreign Workers Law. As a result of this ambiguity, their basic rights as employees are frequently violated. Some of the employers also take advantage of the ambiguity to avoid insuring the asylum seekers they employ, leaving them without regulated access to health services, except in emergencies.



factor for mental disorders. In the case of the asylum seekers in Israel, many have been kidnapped on their way to Israel and held in torture camps in the Sinai desert. An estimated 4,000 survivors of those camps currently live in Israel, without any formal support and rehabilitation services.<sup>28</sup> Even those among them who are employed and therefore insured as "foreign workers" are thus prevented from receiving the mental health services they so sorely need.

Berhana, an asylum seeker from Eritrea who lives and works in Jerusalem, arrived at the Psychiatric Emergency Department of the Hadassah Ein Kerem hospital following deterioration in his mental condition, probably due to the traumas he had experienced in the Sinai desert on his way to Israel. After having been examined there, Berhana was referred to continued treatment and follow-up at his health fund, but when he arrived at his GP who sought to refer him to a psychiatrist, it turned out that his insurance policy did not cover mental health services. Thus, Berhana remained untreated.

## B. Exclusion of Pregnancy Monitoring and Genetic Counselling

Under the terms of the "foreign worker" policy, a female worker is not entitled to pregnancy monitoring services during her first nine months of working in Israel. In practice, this clause is used by the insurance companies to completely deny services to many of the insured, who are required to prove that they have already worked over nine consecutive months in Israel. Moreover, even when asylum seekers are not excluded from pregnancy monitoring, they must pay for genetic counselling out of their own pocket – something many of them cannot afford.

## C. Troubles with Continuity of Coverage

Upon changing employers, whether due to dismissal/resignation or due to an accident that leads to termination, coverage is discontinued and the insured lose their insurance rights. Although the insurance company theoretically allow the insured to continue with the existing policy even during the transition period between employers, in practice many do not benefit from this. First, since the policy terms are often not translated or not translated properly, many workers are not aware of their rights and find it difficult to realize them. Second, since the "foreign worker" policy is issued on behalf of the employer, in many cases of termination the employees have no access to the terms of their own policy; in fact,

<sup>28</sup> A study on the condition of asylum seekers who crossed the Sinai Desert en route to Israel conducted at the University of Haifa in conjunction with PHRI indicates disturbing findings: a particularly high percentage of psychological distress was measured among the study's participants: 42% to 76% of the men, and 35% to 59% of the women suffer PTSD symptoms, including nightmares, intrusive memories, arousal, fear and disassociation; and about 24% of the men and 28% of the women in the study suffer from depression. <http://www.phr.org.il/en/not-passive-victims-report-november-2016/?pr=458>

in most cases, they do not even know the name of their insurance company or agent. This problem is exacerbated by the employment patterns of asylum seekers, who are often forced to change employers and workplaces frequently, up to several times a year. This makes it even more difficult for them to maintain continuity of coverage, and as a result, their illnesses are often untreated.

#### D. Exclusion of Preexisting Condition

In violation of the guidelines in the Foreign Workers Order, insurance policies for "foreign workers" tend to refer to "preexisting condition" as including any medical condition prior to the insured's acquisition of the present policy, and to exclude such preexisting conditions for an unlimited period.<sup>29</sup> *This becomes exceedingly more problematic in the case of asylum seekers who have never planned to enter Israel and have not undergone medical examinations like migrant workers. Many of the asylum seekers do have "preexisting conditions": some have been tortured in Sinai, and given this clause are denied coverage for their physical – and mental – illnesses.*

Adam, an asylum seeker from Sudan, experienced a brain stroke several years ago. Today, he can work and has "foreign worker" insurance, but his policy excludes all the neurosurgical treatments he requires. Therefore, despite being insured, his illness is not monitored or treated.

Moreover, PHRI has recently been contacted by several employees with chronic illnesses, which the insurance companies had refused to insure at all. When employers are unable to arrange for their employees' insurance, they are denied the possibility of being employed under the Foreign Workers Law. Consequently, these people cannot support themselves, while they still live in Israel and must work to ensure a dignified existence.

#### E. Denying Coverage in case of "loss of work capacity"

Article 4(A)(3) of the Foreign Workers Order stipulates that if the employee has fallen ill and been found by an occupational doctor to be unable to perform the work he has been hired to perform for a period of ninety days and more, "the employee would not be entitled to any medical services beyond those he requires to stabilize his medical condition, until such time as he can receive further treatment outside Israel". The rationale of this clause is particularly disturbing, if not Kafkaesque:

<sup>29</sup> The Foreign Workers Order defines "preexisting medical condition" narrowly, to include only medical conditions prior to the insured's acquisition of a first policy in Israel. In addition, the order explicitly limits the exclusion of a preexisting medical condition to a period of three years from the first time an employer has arranged medical insurance for the employee in Israel. As opposed to these explicit directives, the "foreign worker" insurance policy interpret the order freely and broadly.

an employee is entitled to medical treatment only so long as he is healthy and fit to work. Once his work capacity is lost, he is no longer entitled to treatment. When it comes to asylum seekers, this clause has particularly severe implications: since they are non-expellable, once they are considered as having lost their work capacity, the insurance company ceases to cover them and at the same time, there is no option of flying them to continued treatment in their country of origin. These people remain in Israel without receiving the follow-up treatment they so desperately need.

Towelde, a 39-year-old asylum seeker from Eritrea, is married with three children. He used to work as a cleaner and was insured by his employer. After his health deteriorated, he was hospitalized at Wolfson Hospital in Holon, where he was diagnosed with Hepatitis B and cirrhosis. After a prolonged hospitalization, the insurance company referred him to an occupational physician who determined that due to his severe illness he would be work incapacitated for over three months. Accordingly, the insurance company refused to continue covering him, and he remained unable to finance the expensive medicinal treatment he required.

As a result, many asylum seekers – even those insured by their employers – cannot benefit from their coverage at the time they need it most, and continue suffering with no access to appropriate medical treatment. This clearly suggests that relying on private insurers as the solution for the asylum seekers' healthcare needs cannot constitute a comprehensive and adequate solution for their needs.

## **2. The Terem Clinic for Refugees: Inadequate Health Services and Limited Reach**

The main solution currently offered by the Ministry of Health to patients without civil status or insurance is the Terem Clinic for Refugees in downtown Tel Aviv. The ministry allocates an annual budget of about 4.1 million NIS to this clinic, and in 2016, it treated some 36,500 medical cases.<sup>30</sup> Although the very willingness of the ministry to support the clinic is commendable, as it recognizes the state's responsibility for providing medical treatment to the asylum seekers, the services provided by the clinic are highly limited in several respects, leaving many without a real solution for their basic medical needs.

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<sup>30</sup> Email correspondence between PHRI and the Ministry of Health's economist Shir Avramitzky, November 14, 2016; letter from Dr. Vered Ezra, Head of the Ministry of Health's Medical Administration to Knesset Member Karin Elharrar, Chair of the State Control Committee, January 25, 2017. To the best of our understanding, this figure also includes minors whose parents did not insure them through the state-supported Meuhedet agreement for status-less minors.

First, the Terem Clinic provides only emergency services financed by the ministry, and even these are limited. For example, even a procedure such as plaster cast removal is not provided at the clinic and whoever need it must go to a hospital and pay for it out of their own pocket. In addition to the emergency services, the clinic also offers specialist services provided by volunteers. Naturally, these services vary with the availability of those doctors, and are not assured on a continuous and consistent basis.<sup>31</sup> Even when it comes to complex medical treatments, such as oncological monitoring, the ministry chooses to rely on the kindness of volunteers.<sup>32</sup>

Another indication of the Clinic's limited ability is the fact that for a while now, the clinic has been turning to PHRI's Open Clinic – operated by volunteers and funded by donors – for help in a variety of medical examinations and procedures. The very fact that a clinic budgeted by the Ministry of Health turns to an NGO-run clinic for help is indicative of the severity of the situation. It proves that *the services of Terem Clinic cannot be considered a comprehensive, regular and continuous solution* for the population of non-expellable migrants living around it.

Note also that the Terem Clinic offers no hospitalization or rehabilitation services, so that it cannot be a substitute for Israel's public health facilities. In fact, it is no wonder that a single clinic, no matter how resolute its doctors, cannot compensate for the present lack of health services for asylum seekers.

Moreover, even had the clinic expanded its service range, *it is highly problematic to locate the main provider of medical services for this population in downtown of Tel Aviv, and completely ignore all those members of this population living elsewhere in Israel*. Although most asylum seekers still live in the Tel Aviv metropolitan area, where they have most options of making a living and receiving support and assistance, according to recent figures, several thousands of asylum seekers live in southern Israel (mainly in Ashdod, Beersheba and Eilat), and communities of over 1,000 asylum seekers each live also in Petach Tikva, Netanya and Jerusalem.<sup>33</sup> Note also that once the detention term of asylum seekers

<sup>31</sup> For example, on July 20, 2016, we were informed that until further notice, the clinic has no GP, and the patients were subsequently referred to PHRI's Open Clinic.

<sup>32</sup> Moreover, even though the clinic is also supposed to provide pregnancy-monitoring services, it is unable to provide high-risk pregnancy monitoring.

<sup>33</sup> According to recent figures provided by the Population and Immigration Authority and published in *Haaretz* on June 21, 2017, 14,920 asylum seekers live in Tel Aviv – 79% from Eritrea, 15% from Sudan, and 6% from other countries. This figure does not include several thousand children. Comparatively, in response to a query by the Knesset's Information and Research Center, in 2016 the Tel Aviv-Jaffa Municipality estimated the number of asylum seekers in the city at 26,000, whereas the police estimated their number at 30,000.

According to the Population and Immigration Authority, the number of asylum seekers has been continuously decreasing. In late 2014, some 18,300 asylum seekers lived in Tel Aviv. In Eilat, home to some 6,000 asylum seekers some five years ago, only 1,800 live today. After Tel Aviv, the city with the highest number of asylum seekers is Petach Tikva (2,300), followed by

in the Holot facility in the Negev desert was limited to 12 months, it was also ruled that those released from Holot would be prevented from living and/or working in Tel Aviv or Eilat.<sup>34</sup> We may therefore assume that the number of asylum seekers living outside Tel Aviv will grow in the upcoming months, with each group of detainees released from Holot. Restricting their place of residence on the one hand, combined with the lack of accessible medical services on the other, constitutes a violation of these people's right to health and adequate living conditions.

To illustrate the shortage of services countrywide, note that in 2013–16, PHRI's Open Clinic treated 123 patients from southern Israel – 49 from Ashdod, 25 from Ashkelon, and no less than 28 from Eilat, located 350 km away! Note that in most cases, these patients were forced to arrive in our clinic in Jaffa for simple laboratory tests, or for diabetes and hypertension monitoring, optometric and orthopedic examinations, and physiotherapy.

In all those cases and in dozens of others of patients arriving from across the country, they do not require complex services, special infrastructures or unique medical specialties that would justify such a long trip. On the contrary, the basic services for which they need to spend hours travelling by bus are available in the health funds' branches in their towns. Moreover, the complete lack of health services for undocumented migrants is evident not only in remote towns, but also in major cities such as Jerusalem and Haifa, where no services are provided for people without civil status. This requires them to travel to the PHRI or the Terem clinics, or leads to neglect and exacerbation of their condition, to the point of hospitalization.

### **3. The Gesher Mental Health Clinic: Overload and a Precarious Future**

The Gesher Mental Health Clinic was established in February 2014 to serve mental health patients from among the asylum seekers in Israel, including those suffering from posttraumatic disorders due to tortures they had undergone in their country of origin and on their way to Israel. It provides an essential service that has no equivalent in Israel, and the experience accumulated during its ongoing work may position it as a unique therapeutic model, as well as a center of information and training.

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Eilat, Netanya, Ashdod, Bnei Brak and Jerusalem (more than 1,000 each). Note that the Authority has no information as to the whereabouts of some 5,000 of the asylum seekers. <http://www.haaretz.co.il/news/local/premium-1.4192638> [Hebrew]

<sup>34</sup> According to the amended Law on the *Prevention of Infiltration* - 1954 male asylum seekers from Eritrea and Sudan between the ages of 18–60 are summoned to a year-long stay at Holot detention center in the Negev desert. Characterized by the state of Israel as an "open facility", this center still bears much in common with "regular" detention centers. It is run by the Israeli Prison Services, and has the capacity of 3600 detainees at a time. Medical treatment is covered by the MoH.



Over the past three years, however, the meager resources of this clinic have not enabled it to meet the overload and provide the patients knocking on its doors with the assistance they so desperately need. With only one fulltime and one halftime doctor on the payroll and only nine hours of work a week, no wonder that in July 2016, the average waiting time for the Gesher Clinic was ten months, with a waiting list of over 200 patients. At this situation, the dedicated staff suffers from constant exhaustion and frustration, being unable to serve all patients. The burnout and attrition rates are high – by the summer of 2016, seven out of 24 staff members have left the clinic – and given the shortage of resources, the staff is almost unable to reach out to patients who have dropped out of follow-up, and may be in a psychotic state, dangerous to themselves and to their environment. To make matters worse, the clinic has no child psychiatrist, a neglect that is liable to have severe consequences in the future.

Due to this extreme distress, in July 2016 the Gesher Clinic stopped receiving new patients. Over the ten months in which it was active under reduced capacity, more than seventy patients in a severe mental state arrived at the PHRI clinic, seeking assistance for mental health problems, to almost no avail.

Dawit is a 29-year-old asylum seeker from Eritrea who arrived in Israel four years ago. On his way to Israel, he was abducted in the Sinai desert and severely tortured. This experience left its mark on his psyche, and in late November 2016 he was admitted to a psychiatric hospital in central Israel, after his friends had rushed him to an emergency room due to his behavior. In the hospital, he was diagnosed with psychotic and posttraumatic disorder and received medicinal treatment. He was discharged with a recommendation for further monitoring and medicinal treatment, including injections. Dawit arrived at PHRI's Open Clinic and the doctor who examined him diagnosed residual symptoms of the psychotic disorder – he was still hearing voices, and even expressed fear of future self-harm. Moreover, he had PTSD symptoms, including night terrors. However, since the Gesher Clinic could not receive new patients, Dawit could not benefit from regular psychiatric follow-up over the past few months.

Only in June 2017, after a persistent struggle, the annual budget of the Gesher Clinic was increased by 100,000 NIS, and it reopened its gates.<sup>35</sup> However, it is still heavily overloaded, and its continued budgeting and regular operation are in doubt. Note that, the Gesher Clinic is the only place asylum seekers can receive mental health services, however limited.

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<sup>35</sup> This information was provided by the Ministry of Health on July 20, 2017, in response to a Freedom of Information Law request submitted by PHRI.

The need to wait for a diagnostic appointment, for a medical examination or for a therapy session for long months leaves the patients alone in their suffering, exposing them to the danger of further deterioration that may also affects their environment.

Given the limitations of the services reviewed above, the 1996 Patient's Rights Law, and in particular Section C, Article 3(b) - "In a medical emergency, every person is entitled to urgent medical care without any conditions" - became the main avenue through which asylum seekers receive treatment in public health institutions in Israel. However, as described above, this "solution" is extremely unreliable. Next it will become clear that it is also not cost-effective.



### Section III

## The Cost of Exclusion - Towards a Comprehensive Health Policy for Asylum Seekers

We have discussed the duty of the State of Israel to ensure a modicum of dignified existence for its inhabitants without civil status, including ensuring their right to health and making health services accessible to them. We have also described the main services currently available to asylum seekers and emphasized their limitations, resulting in the ongoing violation of their basic right to health and dignity.

It is therefore obvious that to remedy this ongoing injustice and promote the asylum seekers' right to health, Israel must move from specific solutions to a systemic, comprehensive and universal solution that will facilitate equal and just access to the public health services in Israel, and provide for the special needs of asylum seekers and be consistent with the legal – and moral – principles. Such a comprehensive solution requires concerted action on several levels:

1. Formulating a health policy regarding asylum seekers, and particularly formulating a national insurance arrangement for them;

2. Active willingness by healthcare providers – health funds & hospitals, medical and administrative teams – to study the unique problems of the asylum seeker population as well as develop tools for cultural and linguistic access, to ensure adequate care of this community; and
3. Educating & training the asylum seekers on the Israeli health system.

This section discusses the first level of change – a national insurance arrangement for asylum seekers.

## A New Systemic Solution

### A. Applying the National Health Insurance Law to asylum seekers

The most appropriate comprehensive solution for making public health services available to those without civil status is integrating them in the public health system by applying the National Health Insurance Law (NHIL) to those who are non-expellable from Israel.<sup>36</sup> Supported by various international organizations, including the World Health Organization (WHO)<sup>37</sup> and the Israeli Medical Association (IMA),<sup>38</sup> this position relies on a range of considerations not the least of which are fairness, public health and economic efficiency. As for the latter, it is obvious that including a young and mostly healthy population in the insurance system will fill the public coffers and enable the health insurance system to finance the added service consumption of this population without any further investment on its part.

Moreover, this move does not require legislation changes. As suggested above, it may be enabled by applying an existent article in the NHIL, Article 56(A)(1)(d), which stipulates that the Minister of Health is entitled to determine special arrangements regarding the provision of health services to those living in Israel but excluded from the scope of this law.

### B. The Intermediate Model: Administrative Arrangement with Health Funds

An alternative to Solution A would be expanding the current model of insuring minors without civil status that is implemented jointly by the Ministry of Health and the Meuhedet health fund. The current model is funded by insurance payments by the minor's parents matched by the Ministry of Health and is designed to ensure that the service package offered to children without civil status is identical to that of children ensured under NHIL (apart for medical treatments abroad). According to this arrangement, the parents may insure their children at a monthly cost of 120 NIS, with the ministry paying the remaining 160 NIS and providing full subsidization from the third child onwards.

<sup>36</sup> See the ruling by former HCJ President Edna Arbel in HCJ 1105/06: "The healthcare arrangements applied to migrant workers with a strong attachment to Israel should be made similar to those applicable to Israeli inhabitants" (para. 89). Subsequently, Arbel explicitly recommends applying the NHIL to them.

<sup>37</sup> [http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/127526/e94497.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/127526/e94497.pdf)

<sup>38</sup> <http://www.ima.org.il/MainSite/EditClinicalInstruction.aspx?ClinicalInstructionId=86> [Hebrew]

This arrangement attests to the fact that the State of Israel recognizes children's right to health regardless of their origins or civil status. We believe a similar approach should be adopted regarding adult asylum seekers as well, and that a parallel arrangement should be applied to them. Nevertheless, note that the existing model is voluntary, with insurance coverage being dependent on the parent's choice to enroll the child and pay the monthly fees – once the payment stops, the services are denied. We believe this aspect of the arrangement is problematic: leaving the enrollment and the payments to the parent's discretion compromises the children's health as that discretion may be affected by difficult socioeconomic circumstances. Therefore, we believe that should this intermediate model be extended to the entire asylum seeker population, it should become mandatory, like the national health insurance, with adjustments for the unique circumstances and socioeconomic status of the insured, as detailed below.

## **2. The Cost of Exclusion: The Economic Rationale for a Comprehensive Insurance Arrangement for Asylum Seekers**

A comprehensive insurance arrangement that provides access to medical care for asylum seekers within the framework of a formal health insurance plan will contribute not only to greater equality and to the realization of the right for physical and mental health of asylum seekers in Israel, but would also make better economic sense. Given such an insurance, asylum seekers will receive proper care and the hospitals will be relieved of a heavy economic burden – a win-win situation for both asylum seekers and citizens. Below, we present the scope of the hospitals' bad debt and see how including the asylum seekers in an insurance arrangement will reduce them.

### **A. Follow the Money**

Over the years and under the force of circumstances, section c, article 3(b), of the 1996 Patient's Rights Law, which states that in medical emergency, "...every person is entitled to urgent medical care without any conditions" became the main "solution" to many of the health problems of Israel's undocumented migrants. A solution of this kind not only places the patients in danger and reduces their chances of recovery, but is also uneconomic, because it leads to bad debts.

According to a 2013 report by the Knesset's Research Center, the costs of treating asylum seekers and others without civil status who have no insurance are estimated at tens of millions of NIS per year; these costs are borne mostly by the hospitals, due to the lack of a reimbursement mechanism on the part of the Ministry of Health.<sup>39</sup> In previous years, there

<sup>39</sup> Report by the Knesset's Research and Information Center – Neta Moshe, **Health Services for Migrant Workers and People without Civil Status** (2013): <https://knesset.gov.il/mmm/data/pdf/m03198.pdf> [Hebrew]



were disagreements between the Ministries of Finance and Health and the hospitals and health funds with regard to the scope of bad debts. While the ministries estimated the costs of treating refugees borne by the Tel Aviv Sourasky Medical Center at 12.5m NIS annually, the hospital argued that their costs were much higher. Clalit health fund, which operates Yoseftal and Soroka Hospitals in Eilat and Beersheba, respectively, estimated the cost of treating refugees, undocumented migrants and asylum seekers in 2010–12 at 33.7m. According to the estimates of the Barzilai Medical Center in Ashkelon, the total charges of treating patients without civil status in 2011–12 was 1.1m. These charges included only the debts owed by the patients, without attendant treatment costs.<sup>40</sup> No wonder that as early as June 2012, then former Deputy Minister of Health Yaakov Litzman stated that "The health system spends over 50 million NIS annually on financing the healthcare costs of the refugees from Sudan and Eritrea... This is a budgetary burden that leads the hospitals to deficits".<sup>41</sup>

Indeed, as the years went by and the policy or lack thereof remained unchanged, **the situation obviously did not really improve even after the establishment of the Terem Clinic in Tel Aviv.** Information obtained by PHRI from the hospitals indicates that in 2016 alone, the Sourasky Medical Center had to bear the cost of almost 23m NIS for urgent treatments, whereas Wolfson Hospital bore about 2.3. Sheba Hospital in Tel HaShomer estimated these costs at 4.3m, and Soroka at 3m. In fact, in 2015, the bad debts of all hospitals for urgent treatments of patients without civil status totaled some 36 million NIS.<sup>42</sup>

**Table 1: Bad debts incurred in hospitals due to treating asylum seekers<sup>43</sup>**

	Sourasky (Ichilov)	Assaf HaRofe	Beilinson	Barzilai	Wolfson	Yoseftal	Kaplan	Rambam	Sheba	Total
2013	27,234,101	1,330,128	1,014,143	1,350,592	5,506,072	2,909,782	1,060,780	–	4,697,832	45,103,430
2014	26,793,160	1,492,691	1,008,139	1,352,839	4,170,979	781,112	783,688	–	2,981,100	39,363,708
2015	23,917,157	1,017,829	544,287	545,797	5,414,580	1,203,873	913,807	1,685,184	3,327,135	38,569,649
2016	22,859,355	1,138,132	44,520	677,383	2,314,112	1,231,209	779,220	927,038	4,298,769	37,269,738
Total	100,803,773	4,978,780	2,611,089	3,926,611	17,405,743	6,125,976	3,537,495	2,612,222	15,304,836	157,306,525

In addition to the problem of bad debts, this routine of treatment in emergency rooms to the almost complete exclusion of other forms of treatment also imposes hidden costs on the hospitals. Since asylum seekers reaching emergency rooms do not have formal personal documentation that is compatible with medical computer systems, they are inducted each time

<sup>40</sup> The data refer to 2012– <http://www.themarker.com/consumer/health/1.1722804> [Hebrew]

<sup>41</sup> Ibid.

<sup>42</sup> This total is mentioned in a letter by Dr. Vered Ezra, Head of the Medical Administration of the Ministry of Health, to Karin Elharrar, Chair of the Knesset State Control Committee, from January 25, 2017. According to our own estimates, as shown in Table 1, the actual amounts are even higher.

<sup>43</sup> These data have been obtained from the hospitals and the Ministry of Health in response to freedom of information requests. These data are partial since they do not include all hospitals.

under a different name. Consequently, they do not have long-term hospital records and no previous healthcare providers can be contacted to complete these records. As a result, medical teams must often spend a long time reconstructing their medical history and even conduct recurring and unnecessary examinations. All these affect the quality of treatment and add to hospital costs due to inefficient use of scarce resources.

Over the past five years, we have witnessed growing realization by the Ministry of Health of the need to take responsibility for the asylum seekers' health. In practice, however, this responsibility is still met with specific and limited solutions. This involves the allocation of dedicated budgets. For example, the cost of Terem Clinic is about 4.1 million NIS a year, and the cost of the overloaded and understaffed Gesher Mental Health Clinic is 840,000 NIS a year.<sup>44</sup> Additional medical services are also budgeted, such as treatment of tuberculosis and HIV/AIDS patients and the healthcare treatment provided in Holot. These services and a few others cost at least another 40 million NIS annually. Thus, the Ministry of Health already spends an annual total of almost 76 million NIS, albeit in a way that fails to meet the health needs of the target population.<sup>45</sup>

**Table 2: Costs of medical services for foreigners in Israel budgeted by the Ministry of Health**

Service	NIS Cost in 2016
Terem Clinic	4,108,500
Gesher Mental Health Clinic	840,000
Tuberculosis & AIDS	6,500,000
Hospitalization of TB patients	5,500,000
Holot Detention Facility	6,000,000
Soroka Hospital, Beersheba	3,000,000
Meuhedet: insurance for minors	11,450,000
Child & family centers	1,362,000
Shelter for human trafficking victims	473,000
Nursing care	468,000
Total	39,701,500

Taken from *Including the Population of Non-Expellable Foreigners in the Health Basket – Cost Estimate*, Neta Moshe (March 19, 2017)

<sup>44</sup> As mentioned, the ministry has recently reported that this annual spending had been increased by 100,000 NIS.

<sup>45</sup> According to an estimate emailed on November 15, 2016, from Ministry of Health economist Shir Avramitzky. See also **Including the Population of Non-Expellable Foreigners in the Health Basket – Cost Estimate**, Neta Moshe (March 19, 2017), p. 3, <https://www.knesset.gov.il/mmm/data/pdf/m03926.pdf>

Note that these data include the services provided to the entire population of uninsured patients in Israel, not only asylum seekers. These important services – such as treatment of STDs at the Levinsky Clinic in Tel Aviv, the HIV/AIDS Program, diagnosis and treatment of tuberculosis, medical treatment for victims of human trafficking, pregnancy monitoring and infant vaccinations in child and family centers are all budgeted by the Ministry of Health, but are not dedicated to asylum seekers. These solutions are partial in terms of the scope of services provided and fail to resolve the issues detailed in this report. In fact, they only highlight the need to invest resources in a systemic, comprehensive solution, rather than ad-hoc and localized solutions.

We believe the state can spend these public funds more effectively if, *instead of allocating substantial budgets to clinics that can only provide specific and partial services for a small proportion of the population in need, it would establish a comprehensive insurance arrangement, similar to that enjoyed by the Israeli citizen population, that will make many more services available to the entire asylum seeker population.*<sup>46</sup> Such an arrangement would involve insurance payments by the insured together with state funding and regulation, with service provision by the health funds. The following subsection elaborates on the structure of the proposed solution.

### B. The structure of the proposed insurance arrangement

To make matters clear and concrete, we will now try to estimate the financial cost of making public health services available to asylum seekers. To do so, we will examine the option of expanding the Meuhedet health fund model now offered to minors without civil status and apply it to adults as well.

According to the official estimate of the monthly cost of the public health services, the medical insurance cost per capita is 378 NIS a month.<sup>47</sup> This amount is divided so that the premium paid by the asylum seeker to the health fund will be 150 NIS, and the state's share will be 228 NIS per month.<sup>48</sup> Considering that Israel is now home to 38,540 asylum seekers, our calculation will take into account a target audience of 35,000 people:<sup>49</sup>

Annual NIS fee by asylum seekers	$150 \times 12 \text{ months} \times 35,000$	63,000,000
State subsidy	$228 \times 12 \text{ months} \times 35,000$	95,760,000
TOTAL		158,760,000

As you can see, the Ministry of Health's annual investment according to this estimate would be 95,760,000 NIS. As shown above, the cost borne by the ministry as it is, without a comprehensive insurance, is 75,973,000 NIS. We seek to provide asylum seekers with as broad an insurance coverage as possible, like that of Israeli citizens, and at the same time to have them pay for a significant share of their insurance – 40% according to our proposal. This arrangement involves a marginal increase of the health budget – 20 million NIS out of an annual budget of 38 billion NIS, or about 0.052%. Nevertheless, this small investment would enable all asylum seekers

<sup>46</sup> Obviously, some of the dedicated services would still be required after the transition to a comprehensive system. This is particularly true of the mental health services for asylum seekers, where unique training for the staff and linguistic and cultural mediation are extremely important as an integral part of the service.

<sup>47</sup> *Including the Population of Non-Expellable Foreigners in the Health Basket - Cost Estimate*, p. 10

<sup>48</sup> Obviously, a monthly expense of 150 NIS is quite significant, and a system of exemptions and discounts would have to be established for insureds unable to afford it (see subsection C below). Note that already today, an amount of 125 NIS is deducted from the monthly pay of some of the asylum seekers who are employed, to pay for private health insurance, which as we have seen meets only part of their health needs.

<sup>49</sup> This reduced number takes into account the fact that some 3,600 asylum seekers are detained every year in Holot and are not employed, and therefore unable to pay for the medical insurance (the detainees are treated throughout their stay in Holot by the Ministry of Health).

living in Israel to benefit from the full range of health services enjoyed by Israeli citizens. Consequently, more people will have access to optimal and continuous treatment, and at the same time, the scope of hospitals' bad debts would be reduced. Over the long term, this is a sounder investment. Indeed, studies conducted in Europe indicate that providing regular and continuous medical services to undocumented migrants leads to significant savings in the cost of health services for this population.<sup>50</sup> In Germany, for example, the cost of treating 1000 migrants with hypertension who received medical diagnosis, monitoring and treatment over a period of five years, was 2.98 euro, compared with 3.43 for 1000 patients in a similar condition treated only in an emergency. These cost gaps are also documented in Greece and Sweden. Thus, the research literature suggests a direct relationship between providing access to health services and reducing their cost: the longer health services are available and the more people benefit from them, the lower the public expenditure over time.<sup>51</sup>

## C. Response to reservations

### (1) "Not all asylum seekers can afford the monthly insurance fee"

Many asylum seekers are indeed in a difficult economic situation, preventing them from paying even the low fee proposed above. Thus any insurance arrangement for this population ought to include exemption and discount mechanisms for insureds with low income, according to the following criteria:

- Chronically ill persons unable to work
- People with physical or mental disabilities
- People who are work-incapacitated or disabled
- Single parents' households
- Victims of human trafficking
- Victims of torture

Note that today it is those who consume the least amount of health services from among the asylum seekers pay the most – to private insurance companies. Conversely, those who need the most services pay the least

<sup>50</sup> Trummer, U. et al. **Cost savings through timely treatment for irregular migrants and EU citizens without insurance.** Infographic and explanatory note (2016). Available at: <http://equi-health.eea.ion.int/IMAGES/TSSUMMARYPOLICYBRIEF.PDF>; Bozorgmehr, K., and Razum, O. **Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994-2013** (2015): <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0131483>  
Trummer, U., et al. **Migrants and healthcare. Social and economic approaches.** ASEF Public Health Network (2014). Available at: <http://c-hm.com/chm/ueber>

<sup>51</sup> Complex economic models support our argument that regular access to health services makes economic sense. See, e.g., a report by the European Fundamental Rights Agency (FRA): **Cost of exclusion from healthcare: The Case of Migrants in an Irregular Situation.** (September 2015). Available at: <http://fra.europa.eu/en/publication/2015/cost-exclusion-healthcare-case-migrants-irregular-situation>. This report analyzes and compares the costs of offering regular health services compared to the costs of health services provided in emergencies only, without regular access. It demonstrates the difference by analyzing two of the most common health issues in the EU: hypertension and issues related to the lack of pregnancy monitoring. The study examined three countries - Germany, Greece, and Sweden - and proved that in all three, regular services provided to undocumented migrants not only contributed to realizing every person's right to physical and mental health services but also saved costs.

and cost the state the most. An arrangement of the type we propose will enable the state to apply the principle of collective and mutual health insurance, allowing for cross-subsidization of the less healthy by the healthier. Most asylum seekers will pay fees, and the consumption of the needier patients will be partly covered by the fees paid by the healthier population, as practiced in the national model.

**(2) "Israel cannot collect insurance fees from non-residents"**

Given the fact that the state manages to collect income tax and national insurance payments from the employed asylum seekers, and the fact that the state maintains meticulous records of all asylum seekers and regularly renews their visa, we believe there can be several ways of collecting the monthly insurance fees. One possibility is collecting the fees directly in Health funds branches, as in the case of the arrangement for minors. Another is through a monthly health tax deduction from the payroll of employed asylum seekers.

**(3) "Once asylum seekers are insured, many more will arrive in Israel"**

We believe that as a basic human right, the right to health must not be used as a bargaining chip in determining Israel's migration policy. Moreover, in setting its policy, the Ministry of Health must be informed by considerations relevant to its sphere of responsibility, i.e. considerations related to medical ethics and individual and public health, as well as considerations related to the health system's economic health.

In addition, given the fact that since 2013 the fence along the Israeli-Egyptian border physically prevents the entrance of additional asylum seekers, this fear is irrelevant. In 2016, for example, only 18 asylum seekers entered Israel, compared to 17,268 in 2011.<sup>52</sup>

To conclude, by insuring the asylum seekers, the state would insure itself against budgetary potholes and bad debts. This is a sustainable solution that complies with moral and ethical standards, provides for the healthcare needs of people who have been living among us for a decade, and meets the State of Israel's financial needs.

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<sup>52</sup> Population and Immigration Authority - Policy Planning Division, **Data on Foreigners in Israel - Summary of 2016**  
[https://www.gov.il/BlobFolder/generalpage/foreign\\_workers\\_stats/he/foreigners\\_in\\_Israel\\_data\\_2016\\_0.pdf](https://www.gov.il/BlobFolder/generalpage/foreign_workers_stats/he/foreigners_in_Israel_data_2016_0.pdf)



## Section IV

### Global Trends in Providing Health Services to Refugees and Migrants

The entry of asylum seekers into Israel is not a unique event or isolated phenomenon. The scope of migration is increasing at an accelerated rate worldwide, culminating in some 244 million migrants in 2015. Europe particularly is experiencing a so-called "refugee crisis", involving the entry of about two million refugees into the continent over the last three years alone: men, women and children who have fled from countries in the Middle East and Africa, escaping civil wars, terrorism, oppressive regimes, economic hardships and climate changes – hoping for a calmer and safer life.<sup>53</sup>

According to estimates, this trend is expected to increase in the following decades, up to a peak of 400 million migrants in 2050.<sup>54</sup> This accelerated migration requires innovative and adequate solutions to meet a range of challenges, on the international, national and local levels. One of the most critical challenges is facing health systems. Already, even

<sup>53</sup> <http://gmdac.iom.int/global-migration-trends-factsheet>.

<sup>54</sup> <http://www.reuters.com/article/us-migration-idUSTRE6AS00320101129>.

before the developed world has prepared itself for the massive waves of immigration, we can point to certain practices in place in some of the countries that have absorbed most of the refugees in the recent years, and which mark the beginning of a commendable change in health systems' approach to undocumented migrants.<sup>55</sup> The following is a brief review of some leading examples.

*Germany*, which has recently absorbed more than a million migrants,<sup>56</sup> distinguishes between asylum seekers whose asylum requests have been processed for more and less than 15 months. In the latter case, Germany's approach resembles Israel's: providing urgent medical services in emergencies only. After 15 months, however, regardless of their asylum request status, asylum seekers are entitled to full coverage of medical services, like German citizens.<sup>57</sup> Note that most asylum requests are processed during the first 15 months.<sup>58</sup> As mentioned, studies in Germany indicate that this approach reduces the cost of treatment borne by the state.

*France*, where 75,000 asylum requests were submitted in 2015 alone,<sup>59</sup> provides extensive healthcare coverage to foreigners living in its territory, regardless of their civil status. Asylum seekers benefit from unlimited and unconditional access to public health services.<sup>60</sup> Nevertheless, anyone not recognized as an asylum seeker or is undocumented, is required to show an ID and prove a stay of over three months, as well as a certain financial capability, as a condition for receiving health services.

*Italy* also absorbed tens of thousands of asylum seekers, and received 83,000 asylum requests in 2015 alone.<sup>61</sup> Like France, Italy also offers a wide range of medical services to its migrants, including asylum seekers who are entitled to public health services as soon as they are registered as such.<sup>62</sup> Even those whose request has been rejected or whose

<sup>55</sup> In this context, it is important to reiterate the uniqueness of the Israeli case in terms of the state's approach to asylum seekers from Eritrea and Sudan, who are non-expellable, and who are the subject of the present report. On the one hand, Israel allows them to remain in Israel although they are defined as "illegal infiltrators". On the other hand, it denies them the status of refugee or temporary resident that would grant them some basic rights. Thus, in the senses relevant to discussing the right to health, welfare and dignity, the status of asylum seekers living in Israel is more similar to that of undocumented migrants in Europe than to bona fide asylum seekers - since Israel ignores or rejects the large majority of asylum requests.

<sup>56</sup> OECD, *International Migration Outlook 2017*, p. 190 [http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/international-migration-outlook-2017\\_migr\\_outlook-2017-en](http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/international-migration-outlook-2017_migr_outlook-2017-en)

<sup>57</sup> Note, however, that "emergencies" are interpreted more broadly in Germany, often including also chronic illnesses. See report by the International Organization for Migration (IOM): *Summary Report on the MIPEX Health Strand and Country Reports*, No. 52 (2016) [https://publications.iom.int/system/files/mrs\\_52.pdf](https://publications.iom.int/system/files/mrs_52.pdf)

<sup>58</sup> AIDA, Asylum Information Database, Health Care - Germany: [http://www.asylumineurope.org/reports/country/germany/reception-conditions/health-care#footnote1\\_h1zs27m](http://www.asylumineurope.org/reports/country/germany/reception-conditions/health-care#footnote1_h1zs27m)

<sup>59</sup> OECD, *International Migration Outlook 2017*, p. 188. [http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/international-migration-outlook-2017\\_migr\\_outlook-2017-en](http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/international-migration-outlook-2017_migr_outlook-2017-en)

<sup>60</sup> IOM, *Summary Report on the MIPEX Health Strand and Country Reports*, p. 47

<sup>61</sup> Phillip Connor, *Number of Refugees to Europe Surges to Record 1.3 Million in 2015*, Pew Research Center (2 August 2016), <http://www.pewglobal.org/2016/08/02/appendix-a-asylum-applications-1985-through-2015/>.

<sup>62</sup> Healthmanagement.org, *Facts & Figures: The Italian Healthcare System*, vol. 1 issue 1 (Spring 2006), <https://healthmanagement.org/c/it/issuearticle/facts-figures-the-italian-healthcare-system>; IOM, *Summary Report on the MIPEX*



visa has expired and are considered undocumented migrants are offered limited insurance coverage for a predetermined (and extendable) period: they receive an anonymous ID code that enables them to receive treatment without risking detention and deportation.<sup>63</sup>

The millions of Syrian refugees who escaped to *Turkey* in recent years – 900,000 in 2015 alone<sup>64</sup> – are entitled to full medical coverage like Turkish citizens, both in and outside of the refugee camps. Nevertheless, the medical coverage for refugees from other countries living outside the refugee camps is limited.<sup>65</sup>

As a final example, the refugees who are resettled in *Canada* receive public health services according to the specific regulations in their province.<sup>66</sup> Those who are not entitled to coverage subject to those regulations may receive coverage by force of the Interim Federal Health Program (IFHP), which provides temporary and limited coverage until the provincial coverage enters effect.<sup>67</sup>

Despite those commendable national policies, due to the gaps between the formal regulations in each country and the situation on the ground, where thousands of migrants remain without appropriate healthcare, regional and local mechanisms have developed in Europe to ensure that new migrants benefit from health services. For example, the Belgian city of Ghent provides undocumented migrants with access to municipal health services subject to requirements that are more flexible than on the national level, and has established subsidized community mental health services; Helsinki has opened the hospitals and other public health services to all undocumented migrants; and Düsseldorf finances health services for migrants on an anonymous basis to reduce their risk of being deported. Several Dutch cities such as Amsterdam, Utrecht, and Eindhoven finance local organizations that provide medical services to undocumented migrants when these are not covered under national regulations. Finally, Madrid and Barcelona initiated a campaign to raise the awareness of the medical community, as well as the migrants themselves, regarding the latter's entitlement to health services

Health Strand and Country Reports, pp. 35-36

<sup>63</sup> This is called an STP, acronym for "temporarily present foreigners". Corallina Lopez Curzi, *Healthcare for Asylum Seekers in Italy in Theory and in Practice*, legal dialogue (January 2017),

<http://legal-dialogue.org/health-care-asylum-seekers-italy-theory-practice>

<sup>64</sup> OECD, *International Migration Outlook 2017*, p. 238

<sup>65</sup> Kadir Gürsoy, *An Overview of Turkish Healthcare System after Health Transformation Program: Main Successes, Performance Assessment, Further Challenges, and Policy Options*, (March 2015): [https://www.researchgate.net/publication/304241347\\_An\\_Overview\\_of\\_Turkish\\_Healthcare\\_System\\_after\\_Health\\_Transformation\\_Program\\_Main\\_Successes\\_Performance\\_Assessment\\_Further\\_Challenges\\_and\\_Policy\\_Options](https://www.researchgate.net/publication/304241347_An_Overview_of_Turkish_Healthcare_System_after_Health_Transformation_Program_Main_Successes_Performance_Assessment_Further_Challenges_and_Policy_Options)

<sup>66</sup> <http://www.cic.gc.ca/english/resources/publications/tfw-rights.asp>; Denise Balkissoon, *Migrant Farm Workers Deserve Better from Canada*, *The Globe and Mail* (19 September 2016),

<https://www.theglobeandmail.com/opinion/migrant-farm-workers-deserve-better/article31936582/>

<sup>67</sup> Government of Canada, *Interim Federal Health Program: Summary of Coverage*,

<http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp>

regardless of their residency status. In fact, in 2016, Madrid even issued a unique ID card for undocumented migrants, enabling them to access municipal health services without fear.<sup>68</sup>

Even with these impressive local initiatives, Western countries still have a long way to go in improving their migration and absorption policies, particularly in terms of health services. Still, the above review indicates two parallel trends that should be adopted in the Israeli context as well. The first is the availability of well-functioning naturalization and asylum tracks that examine the asylum request submitted to them seriously and within a predetermined timeframe, and provide a civil status and complementary protections to whoever is found eligible to refugee or other status. The second pertains to the insight articulated in recent policies adopted by the countries and cities reviewed above. According to this insight, when it comes to the basic human right to health, medical services should be made completely available, regardless of civil status. Israel will do well to follow both trends.

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<sup>68</sup> [http://picum.org/picum.org/uploads/publication/CityOfRights\\_FINAL\\_WEB\\_EN.pdf](http://picum.org/picum.org/uploads/publication/CityOfRights_FINAL_WEB_EN.pdf)



## Section V

### Health Policy in a Multicultural Era

Equal access to health services is a necessary first step in dealing with the hardships of the asylum seekers in Israel – but it is not sufficient. Together with applying an insurance arrangement for asylum seekers, necessary adjustments must be made among healthcare providers to ensure optimal access. In other words, to further narrow the health gaps between Israeli citizens and residents and the asylum seeker population, recognizing, understanding and attending to the fundamental problems of this population are necessary. This includes emphasis on the individual and collective needs of those marginalized and vulnerable group, particularly when it seeks health services.<sup>69</sup> This further effort is essential to meet the definition of equity in health – a concept broader than the traditional focus on equality in health alone.

This target of health equity will be achieved by operating on two spheres at the same time. First, activity among medical teams and service providers to implement and adjust dedicated tools for treating asylum

<sup>69</sup> Over the past few years, the Ministry of Health has been making growing efforts to reduce inequality in health by identifying the social factors operating outside the health system to produce it and by trying to deal with them in different ways, such as cultural competency. See the ministry training manual *Health Equity in All Policies (HEIAP)* (April 2017), <https://www.health.gov.il/PublicationsFiles/HEIAP.pdf> [Hebrew]

seekers and provide cultural competency training. Second, working with the asylum seeker community to acquaint them with the Israeli health policy and inform them of their rights as patients.

Cultural competency involves the cultural adjustments made by organizations seeking to provide more effective services/treatments to culturally diverse populations. In the healthcare area, this means attending to the patients' culture and sociocultural influences affecting them, and the way awareness of these factors can improve the quality of healthcare provision. Cultural competency encompasses a range of activities to reduce health gaps due to cultural differences between service providers and receivers.

These adjustments require, first and foremost, making health services linguistically accessible. This in turn requires the availability of interpreters in health institutions to ensure optimal mediation between the service provider and receiver, as well as the availability of verbal and written information in the asylum seekers' mother tongue. Beyond the dissemination of translated documents and flyers, call centers must be in place to provide real time answers for patients. The lack of appropriate linguistic mediation is obvious even within the limited and partial services provided to privately insured asylum seekers. For example, many of the insured find it difficult to exercise their rights vis-à-vis the insurance company due to difficulty communicating with its representatives on the phone. The lack of linguistic mediation is also felt in the context of receiving the treatment itself: when the insured are required to schedule an appointment on the phone, they run into a series of obstacles as they find it hard to understand the automatic instructions, and PHRI receives many requests for help in this deceptively straightforward task of scheduling an appointment.

Frewyni, an asylum seeker from Eritrea in her second trimester, arrived at PHRI with screening test results that suggested irregular values and referral to genetic counselling, not covered by her insurance. In the course of attempts to help her schedule an appointment for counseling in a hospital and deal with the Hebrew interactive voice response system, it turned out that she did not even understand the purpose of the counseling required or the importance of further tests – even though her referral form stated: "The patient received an explanation – I made sure she understood".

Note that without linguistic mediation the physician risks communication difficulties that could have real and severe implications for the quality of treatment provided and the health of the patients and their environment:

Tsega, an asylum seeker from Eritrea, arrived at PHRI's Open Clinic with a friend. The friend told us that Tsega had recently had an abortion, and as a result lost her eyesight. She raised the possibility that Tsega became blind as a result of medicines received from questionable practitioners. Prior to being referred to an eye and to a neurological examination, Tsega talked to a volunteer nurse at the clinic, who speaks Tigrinya. Their conversation revealed that Tsega felt terribly guilty for the abortion, and therefore "could no longer look at people in the eye". Consequently, the PHRI's staff realized that Tsega needed mainly psychological support and that her vision was fine.

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Tesfhailem, a 27-year-old asylum seeker from Eritrea, was diagnosed with Hepatitis B. Due to the language difficulties the doctor did a poor job of explaining the nature of the disease and its modes of transmission. When Tesfhailem arrived at PHRI it turned out that he and his partner did not know that she could be infected, and did not take the required precautions.

In addition to linguistic mediation, the medical teams need training on issues related to the living conditions of asylum seekers and the restrictions placed on them in Israel, such as the threat of being detained in Holot, the limited employment options and their socioeconomic status that result in deteriorated living and sanitation conditions. Finally, understanding the cultural background of asylum seekers can help physicians treat them. For example, those with experience in psychiatric treatments for asylum seekers report that their patients often describe their mental disorder using images of a strong burning sensation in their head. In some cases, such descriptions led to their referral to expensive diagnostic tests, as psychiatrists were not familiar enough with their metaphors.

Importantly, investment in linguistic and cultural mediation is also a wise economic investment: no expensive equipment is required, only short trainings and positions for interpreters and cultural mediators. Such investment can contribute significantly to improving the access to and the quality of treatments, as well as to reducing the hidden health costs referred to above that are caused by information and communication gaps.

As mentioned, in addition to adjustments by the service providers, the asylum seekers would also need to adjust. They need to learn about the health system and the way medical insurance works, including knowledge mediation and assistance in dealing with health and insurance bureaucracy. We have gained extensive experience in this work in PHRI,

and once public health services are made available to asylum seekers through an insurance arrangement, we would be able to expand our work with the community to mediate between the asylum seekers and the Israeli health system.

In a recent meeting with women asylum seekers, we explained to them about their right to health, and particularly their right to treatment in an emergency as stipulated in the Patient's Rights Law. One of the participants, a single mother from Eritrea, responded bluntly: "I learned that in Israel there is one law for Israelis and another law for Eritreans". We hope that the policy reform proposed in this document, together with linguistic and cultural adjustments and efforts to inform the community, will make asylum seekers feel different.



## Conclusion

The policy reform proposed in this report requires the Ministry of Health to take responsibility for the population of asylum seekers in Israel. Implementing a policy that ensures health equity requires, in addition to taking responsibility, collaboration between policymakers in the ministry and the civil society organizations that have gained experience in helping the asylum seekers over the past decade. Having gained such experience, and given our familiarity with the community's difficulties as well as the inherent gaps and obstacles characterizing its encounter with the health system, we call for such collaboration both in making decisions and in implementing them.

The Ministry of Health is aware of the hardships of asylum seekers and has recently even admitted to the inadequacy of the solutions currently available to them. From time to time, ministry representatives state that they are considering ways to provide more comprehensive solutions – a claim made repeatedly in formal responses to our pleas. However, the ministry has hitherto failed to formulate any real policy. The solution presented above is being considered, but no real steps have yet been taken to implement it.



According to senior officials in the Ministry of Health their hands are tied, as now more than ever – given the government policy of pressuring the asylum seekers – the ministry is unable to formulate a policy that would truly provide for their health needs. As the Ministry of the Interior acts to deport the asylum seekers and deter others from entering Israel, the Ministry of Health is prevented from improving the living conditions of those who already have.

Precisely given the future health implications of the heavy hand against the asylum seekers, however, it is time to expose and challenge the distorted assumption that guides the ministry's decision makers: the assumption that the health policy towards asylum seekers needs to reflect and even serve the Ministry of the Interior's fight against them. Even if we accept the fact that the State of Israel wishes to prevent additional asylum seekers from entering its territory – a wish that, given current global events, is obviously morally questionable – we cannot accept the fact that it does this by denying basic human rights and neglecting the health of those already living here.

Now is the time for the Ministry of Health to apply the broad range of independent considerations directly relevant to its mandate – including medical and ethical considerations related to individual and public health, as well as long-term economic considerations – and formulate a sustainable health policy for the community of asylum seekers living among us. Now is the time for the ministry to make a stand and meet the challenge posed by the asylum seekers by providing full and equitable health services to that community, to alleviate their distress rather than add to their suffering.