

# HEALTH INEQUALITIES AND FEMALE MIGRANT DOMESTIC WORKERS: ACCESSING HEALTHCARE AS A HUMAN RIGHT AND BARRIERS DUE TO PRECARIOUS EMPLOYMENT IN GREECE

DESIGUALDADES DE SALUD Y TRABAJADORES DOMÉSTICOS MIGRANTES  
FEMENINOS: ACCESO A LA SALUD COMO DERECHO HUMANO  
Y BARRERAS DEBIDO AL EMPLEO PRECARIO EN GRECIA

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## RESUMEN

Las desigualdades en el acceso a los servicios de salud comprenden un problema complejo que enfrentan principalmente los nacionales de terceros países (NTC) en todos los países de la Unión Europea. Uno de los principales indicadores para examinar el grado de integración de las NTC en la sociedad griega es su acceso a los servicios de salud, tanto a nivel del marco institucional como en los problemas que enfrentan durante la demanda y la utilización de los servicios de salud. En Grecia, las trabajadoras migrantes provienen no solo de los países de los Balcanes, sino también de los países asiáticos y africanos, con un perfil epidemiológico completamente diferente al de los griegos y otros europeos. Uno de los mayores desafíos que Grecia enfrenta actualmente es la existencia de disparidades significativas en la cobertura de la población para los servicios de salud. En

el marco de los Derechos Humanos, este artículo revisa el contexto legal y examina las respuestas de política con referencia a la salud, para revelar las debilidades del contexto institucional griego, y presentar datos sobre el acceso de las trabajadoras migrantes a los servicios de salud. La experiencia de investigación en Grecia enfatiza que los servicios que están abiertos a los terceros países, que incluye un sistema elíptico de política social y de salud que no aborda los reclamos y aspectos importantes de la protección social. La naturaleza incompleta del sistema restringe la capacidad de responder eficazmente a las necesidades específicas que resultan de la presencia de terceros países.

**PALABRAS CLAVE:** cuidado de la salud; desigualdades de la mujer; migración; derechos humanos; Grecia.

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## ABSTRACT

Inequalities in access to health services comprise a complex problem faced predominantly by third-country nationals (TCNs) in all European Union countries. One of the main indicators for examining the degree of integration of TCNs in Greek society is their access to healthcare services, both at the level of institutional framework and in the problems they face during demand and utilization of health services. In Greece, female migrant workers come not only from the Balkan countries but also from Asian and African countries, with a completely different epidemiological profile than that of Greeks and other Europeans. One of the greatest challenges Greece is currently facing is the existence of significant disparities in coverage of the population for health services. In

the framework of human rights, this article revisits the legal context and examines the policy responses with reference to health, in order to reveal the weaknesses of the Greek institutional context, and present data concerning female migrant workers' access to healthcare services. The research experience in Greece emphasizes that services which are open to third-country nationals are included in an elliptical system of health and social policy which fails to address significant claims and aspects of social protection. The sketchy nature of the system restricts the ability to respond effectively to the specific needs that result from the presence of third-country nationals.

**KEYWORDS:** healthcare; inequalities; women; migration; human rights; Greece

## 1. INTRODUCTION

One of the main indicators for examining the degree of integration of third-country nationals (TCNs) in Greek society is their access to healthcare services, both at the level of institutional framework and in the problems they face during demand and utilization of health services. According to the World Health Organization (2018a, p.3) migrants are entitled to the same universal human rights and fundamental freedoms as all people, which must always be respected, defended and safeguarded. The Constitution of the World Health Organization of 1948, stated that “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social con-

dition”. The International Covenant on Economic, Social and Cultural Rights of 1966, declared the right to “enjoyment of the highest attainable standard of physical and mental health” (World Health Organization, 2018a, p.6). This article departs from the legal canon that sets the basis for the realisation of basic human rights, in order to reveal the extent to which the healthcare rights of female migrants in concert with their working rights are actualised or negated in Greece.

The right to health is a basic human right (World Health Organization, 2018a, p.11). The right to access preventive, curative and palliative healthcare, but also the right to the underlying social preconditions for health, is a basic human right under the 1966 International Covenant on Economic, Social and Cultur-

al Rights (World Health Organization, 2018a, p.11). In 2009, the Committee on Economic, Social and Cultural Rights in General Comment 20.30 stated, “Covenant rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation” (World Health Organization, 2018a, p.11). According to the World Health Organization report (2018b, p.9) access to services varies considerably between the Member States of the European Region WHO, although the right to health and, consequently, the right to health services should be universal (World Health Organization, 2018b, p.9). Therefore, it is difficult to generalize the findings on the right to access relevant services, as well as recognizing and assessing the health needs of the refugee and migrant population which are not covered (ibid).

Addressing inequalities in accessing healthcare services by female migrant workers must become a priority in the social policy agenda of Greece. EU countries differ widely in asylum policies, residence, citizenship and integration patterns of migrants. Countries with more restrictive policies not only make life harder for migrants, asylum seekers and refugees, but they are also more likely to limit their access to healthcare. Although there are multiple barriers with reference to the

health of migrants, asylum seekers and refugees in Europe today, additional obstacles are placed by the politically charged nature of migration (i.e. anti-immigrant parties, xenophobia, limitations in collecting data with regards to migrants’ needs). At the same time, there are areas where progress is being made, making health services more accessible and responsive to immigrants while some European countries have chosen to provide universal access to healthcare, including undocumented migrants. Despite the fact that the Charter of Fundamental Rights of the European Union stipulates the right of everyone to have access to preventive healthcare and to benefit from healthcare, immigrants and vulnerable groups including asylum seekers and irregular immigrants in most European Union countries still face legal obstacles in access to healthcare. International and European institutions such as the International Covenant on Economic, Social and Cultural Rights, and the Charter of the World Health Organization (WHO, 1946) established the right of immigrants, to the highest attainable standards of physical and mental health. Although these rights are established in signed international conventions, no European Union Member State has yet acceded to the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families of the United Nations (UN, 1990). There is, therefore, a clear need

to strengthen the national and European legislation for the protection of migrant workers' rights and to ensure their implementation.

In the WHO European Region preventive health care consists of health promotion strategies and diagnostic tests, but also social support programs, education, training of health professionals and awareness-raising initiatives aimed at minority groups (World Health Organization, 2018b, p.9). Health promotion and education are particularly important for refugees and migrants, because they are not always familiar with the health systems of the destination country, and therefore unaware of the support they can receive, and how to access their rights (*ibid*). Furthermore, systematic immunization is recommended for newly arrived refugees and migrants under the national immunization program of each host country due to the level of risk of illnesses refugees and migrants may face (*ibid*).

Female migrants (see Table 1 and Figure 1) are a social group with special health needs, given their generally poor living conditions (both in sending and receiving countries), but also due to additional problems caused by the difficulties to adapt to a new social and cultural environment. Thus, the relationship between social exclusion and the health status of female migrants works in a bidirectional manner. On the one hand, poor living

conditions, low income, difficulties in communication, exclusion from health and other services, racism and xenophobia, has detrimental effects on the health of migrants, on the other hand, poor health status leads to social exclusion due to the difficulty in finding formal employment. For female migrants are mostly employed in precarious, low-status/low-wage jobs and particularly in domestic work (see Table 2), experiencing real income fall. Indeed, international literature (Fouskas, Gikopoulou, Ioannidi and Koulierakis, 2019; Fouskas, Sidirooulos and Vozikis, 2019; Souliotis, et al, 2019) reveals that immigrant workers lack adequate access to healthcare and health insurance and self-evaluate their health status as very low. When the Greek National Health System (NHS) was founded in 1983, it was designed to provide a free, and just health insurance for the entire Greek population, but the needs of newcomers exposed the NHS to a plethora of new challenges.

Concerning documented TCNs in Greece (as of April 2019) (Table 1) regarding the reasons for issuing a residence permit (2013-2018) (see Table 7) one can see that for female migrants the three primary reasons were "Family reunification" (127,381), "Other" (112,821) and "Employment" (20,999).

**Table 1. Documented Third-Country Nationals**

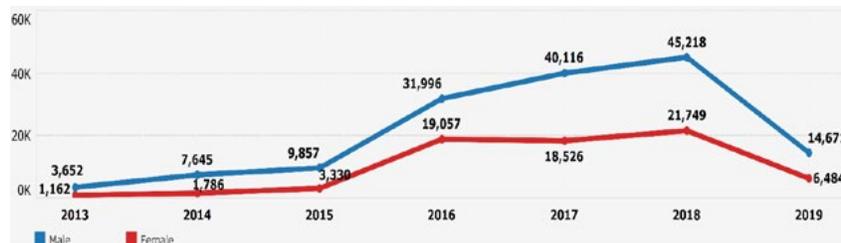
Category	Males	Females	Total
Employment	46,952	20,999	67,951
Family reunification	75,651	127,381	203,032
Studies	889	812	1,701
Other	168,764	112,821	281,585
Total	292,256	262,013	554,269

Source: Hellenic Ministry for Migration Policy.

Regarding asylum application per gender (Figure 1), in 2013, 4,814 applications were recorded with a monthly average of 688 applications. The percentage difference between 2013-2014 increased at 14.3 %. In 2014 respectively, 9,431 applications with a monthly average of 786 applications, with a percentage difference between 2014-2015 increased at 39.8 %. In 2015, 13,187 applications with a monthly average of 1,099 applications, with a percentage difference between 2015-2016 increased at 287,1 %. In 2016,

51,053 applications with a monthly average of 4,254 applications, with a percentage difference between 2016-2017 increased at 14.9 %. In 2017, 58,642 applications with a monthly average of 4,887 applications, with a percentage difference between 2017-2018 increased at 14.2 %. In 2018, 66,966 applications with a monthly average of 5,581 applications. In 2019, 21,155 (April 30, 2019) applications with a monthly average of 5,289 applications, with a percentage difference between 2018-2019 at 5.2%.

**Figure 1. Asylum applications per gender by year from 07/06/2013 to 30/04/2019**



Source: Asylum Service/Hellenic Ministry for Migration Policy, 2019

Furthermore, and until April 2019 applications rose to 30.5 % for women (with 1,427 applications) and 3,249 applications for men (that accords to 69.5 %). Concerning female migrants' participation in the main sectors of economic activity (Table 2), 59.4 %, of female

migrants can be found in the household sector followed by accommodation and food service activities at 17.2 %, manufacturing at 7.2 %, agriculture, forestry and fishing at 3.5 %, and wholesale and retail trade at 2.7 %.

**Table 2. Female migrants' participation in the main sectors of economic activity, 2017**

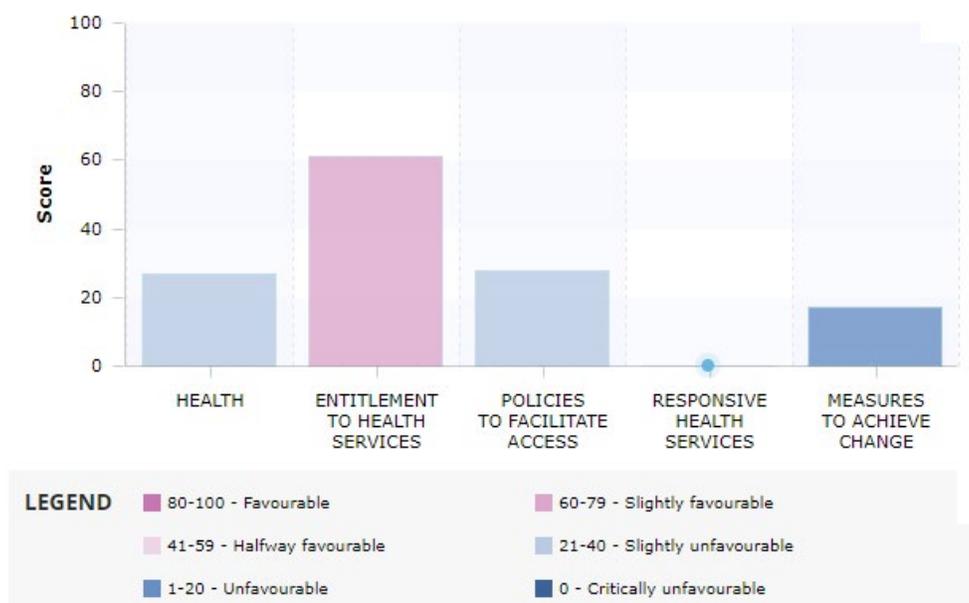
Agriculture, forestry and fishing	3.5%
Manufacturing	7.2%
Wholesale and retail trade	2.7%
Accommodation and food service activities	17.2%
Activities of households as employer	59.4%
Total of migrant women employed	5.8%

Source: Kapsalis, 2018

Following findings of MIPEX (Huddleston et al., 2015) (Figure 3), according to the EWSI 2018 report (Mikaba, 2018) (see Table 4), in half of the Member States (Bulgaria, Croatia, Cyprus, Estonia, Greece, Hungary, Ireland, Latvia, Portugal, Poland, Romania, Slovenia, Spain

and the UK), there is no legislation or policy regarding cultural or health mediators for migrants nor patient navigators, impeding many migrants of fully exercising their rights. Cut-backs regarding interpreters are also observed in Ireland, Estonia and Greece.

**Figure 2. Greece - Strand and four dimensions on health**



Source: Huddleston et al.

In addition, and according to the EWSI report (2018), Greece lacks a national health strategy that targets migrants or an integration policy targeting health-care. At the same time, the country has

not adopted standards on cultural mediators, and on free interpreters and has not designed health indicators for migrants (see also IOM, 2016).

Table 3. Indicator-based health systems?

	Health strategy targeting migrants	Integration strategy targeting health	Standards on cultural mediators	Free interpreters	Health indicators for migrants
Greece	N/A	N/A	N/A	N/A	N/A

Source: EWSI Editorial Team.

According to the World Health Organization (WHO), the concept of equity in health implies that everyone should have equal opportunity to exercise their health rights to the maximum extent, and realistically, to be able to avoid one's state of weakness in order to achieve the above objective (WHO/ECHP, 1999:9). According to Whitehead, equity in health-care is defined as, (i) equal access to available care for equal need, (ii) equal utilization for equal need, and (iii) equal quality of care for all (Whitehead, 1985, 1991, 2006, 2007). Adopting this definition, Townsend et al. (1992) argue that access to health services is divided into three types: economic, geographic and cultural. In particular, *economic access* is associated with the equal provision of goods regardless of the economic capacity of the individual and by offering social goods based on needs and not on the cost of the institution and economic return/contribution of the individual (Townsend et al. 1992:358). Based on this logic, issues of unequal service provision emerge in the health sector, when healthcare services offered to patients from disadvantaged groups cost more than average as they tend to suffer from chronic illnesses (ibid). Moreover, a lon-

ger period of recovery is required due to poor nutrition, bad living conditions and lack of social/welfare support (ibid). Also, financially disadvantaged regions tend to have higher rates of diseases in relation to the more prosperous (ibid). Therefore, a contract calculated at average costs of a particular treatment or average per capita cost, may fail to cover the real costs of these patients' treatment (ibid). On the other hand, geographic access is usually associated with the equitable distribution of services in different areas (e.g., of a country), and particularly with the possibility of movement of the patient (e.g., local difficulties with transport) through the recourse of appropriate services (ibid). Finally, cultural access is associated with the relationship between patients and health professionals or employees of agencies and the extent to which differences in education, gender, culture, religion or nationality create barriers to communication and effective use of social/welfare services (ibid).<sup>1</sup>

<sup>1</sup> Townsend et al. (1992) emphasize that these three types regarding access and quality must be analyzed with focus on: (i) monitoring the effect of funding arrangements, changes in policy, and rationing processes on provision of services for different sections of the population (ii) monitoring uptake rates and patterns of service use and acceptability (iii) monitoring quality of premises, staff numbers and their training, and the distribution of services

## **2. THE RIGHT OF FEMALE MIGRANTS' ACCESS TO HEALTHCARE: INSTITUTIONAL AND POLICY RESPONSES**

Greece in the past, due to the fact that third-country nationals were mostly undocumented and therefore uninsured, they were excluded from healthcare services while the cost of their healthcare was higher than that of insured individuals, making migrants less able to afford the cost of care needed. Undocumented migrant residents lacked national health insurance and social security rights and did not have free access to health services other than in emergencies (Fouskas, 2017). Hospitalization of undocumented third country nationals was feasible only for emergencies and their health was stabilised (Article 84, paragraph 1, Law 3386/2005) (Government Gazette, 2005). This distinction between emergency and non-emergency incidents was greatly criticized since a non-emergency case could develop into a life threatening one if not properly and timely addressed (UNHCR, 2007). The stabilization rather than the full recovery of patient's health comprised a typical wording of the law thus further limiting the extent of the care provided (Fouskas, 2017). The only case where the distinction between

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in different localities, (iv) including equity considerations in the setting and monitoring arrangements for contracts and (v) auditing referral and treatment patterns by social group (Townsend et al. 1992, pp. 358-359).

emergency and non-emergency did not apply was when it came to minors (ibid).

Moreover, exemption from health services in undocumented residents did not apply when the patient, regardless of nationality and residence status, was HIV positive or suffered from other infectious diseases. In those cases, free hospitalisation and medical care was provided, if the individual was in need of treatment which could not be effectively provided in the country of origin (Fouskas, 2017). For the period that the effective treatment took place, third country nationals were entitled to temporary residence and work permits (ibid). In addition, free medical care and hospitalisation was provided to victims of trafficking, since they were excluded from national health insurance and were financially deprived, for as long as protection and assistance measures lasted, provided they held a certificate which had been issued by the Police Directorate in charge of their case (ibid).

As highlighted in the programme "Local Alliance for Integration"<sup>2</sup>, according to the Greek State with Article 33 "Health cov-

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<sup>2</sup> National School of Public Health (NSPH/ESDY), University of Gent, PRAKSIS, European Public Law Organization (EPLO), CMT PROOPTIKI and Syn-Eirmos, "Local Alliance for Integration (776213/LION) (AMIF-2016-AG-INTE) (December 2017- November 2019)", Asylum, Migration and Integration Fund/European Union/National School of Public Health (NSPH/ESDY), University of Gent, PRAKSIS, European Public Law Organization (EPLO), CMT PROOPTIKI and Syn-Eirmos, 2019 <http://allianceforintegration.eu/>

erage of uninsured and vulnerable social groups” (Table 6) of Law 4368/2016<sup>3</sup>, the Joint Ministerial Decision (JMD) A3(c)GP.ec.25132/4-4-2016 “Provisions to ensure access for uninsured persons to the Public Health System”<sup>4</sup> and the Circular A3c/GP.ec.39364/31.05.2016 “Clarifications on ensuring access for the uninsured and socially vulnerable groups to the public health system”<sup>5</sup> provide all refugees and migrants with the right to free access to all public health institutions for the provision of nursing and health care (Ministry of Health, 2019) (Table 9). The Hellenic Government’s interventions were from the outset in support of treating refugee populations like all citizens, without any discrimination, as the only way to protect public health. Law 4368/2016 refers to the most vulnerable groups of migrants and refugees living in Greece with direct access to the National Health System, irrespective of their legal status (Ministry of Digital Policy, Telecommunications and Media/Secretariat for Crisis Man-

agement Communication, 2018). Those who are uninsured (including pregnant women, minors, patients with chronic illnesses, etc.) and do not have a National Insurance Number<sup>6</sup> or cannot acquire one, must necessarily hold a Foreigner’s Health Care Card<sup>7</sup> (NSPH, University of Gent, PRAKSIS, EPLO, CMT PROOPTIKI and Syn-Eirmos, 2019). Third-country nationals can apply for a National Insurance Number and Number of Health Care of Foreigner<sup>8</sup> at any Citizens’ Service Centre<sup>9</sup> while they can acquire a Foreigner’s Health Care Card from Health Protection Offices of Rights of Health Care Receivers or from the Social Services of their local hospital (NSPH, University of Gent, PRAKSIS, EPLO, CMT PROOPTIKI and Syn-Eirmos, 2019).

In Article 33 of Law 4368/2016 a new provision was established regarding the right to access the Greek NHS by all people on the move (regardless of status), as well as those residing in Greece on humanitarian grounds or for exceptional health reasons. The law of 2016 also guaranteed free access to health services to vulnerable groups, such as minors, pregnant women and people with disabilities. The table below provides an overview of access rights depending on legal status of migrants.

3 Government Gazette (2016a). Law 4368: Measures to speed up government work and other provisions. Athens: National Printing House, (in Greek) <https://www.synigoros.gr/resources/docs/160817-n4368.pdf>

4 Government Gazette, (2016b). Joint Ministerial Decision (JMD) No. A3(c)/GP.ec.25132 - Arrangements to ensure access for uninsured persons to the Public Health System. Athens: National Printing House. (in Greek) <https://www.synigoros.gr/resources/160817-ky.pdf>

5 Ministry of Health (2016). Circular No. A3c/GP.ec.39364 Clarifications on ensuring access for the uninsured and socially vulnerable groups to the public health system. Athens: Ministry of Health, (in Greek) <https://www.synigoros.gr/resources/160817-egkiklios.pdf>

6 Greek acronym AMKA.

7 Greek acronym KYPA.

8 Greek acronym AIPA.

9 Greek acronym KEP.

**Table 4. Legal Status and type of access**

Legal Status	Type of Access
Nationals	Access all public structures using AMKA number
Non-national residents	Access all public structures using AMKA number
Undocumented residents belonging to vulnerable groups that need immediate health care (pregnant women, chronically ill, people with mental disorders, etc.)	Entitled to Foreigners' Health Care Card (KYPA) in order to access Public Health Structures. Once KYPA is issued, he/she is entitled to access all hospitals and diagnostic departments of public hospitals.
All people, irrespective of their legal status	Entitled to access the Emergency Departments

Source: Ministry of Health, 2019.

**Table 5. Article 33 "Health coverage of uninsured and vulnerable social groups" of Law 4368/2016**

Paragraph	Sub-section
1. Uninsured and vulnerable social groups as defined in paragraph 2 hereof have the right to free access to Public Health Structures and are entitled to nursing and health care. Nursing care is provided through the Hospitals of the Legislative Decree 2592/1953 (A' 254), of supervised and subsidized by the Ministry of Health nursing institutions, of those supervised and subsidized by the Ministry of Health Legal Entities of Private Law <sup>10</sup> of the Mental Health Units Law 2716/1999 (A' 96), of Primary Health Care Units of the National Health System, those supervised and subsidized by the Ministry of Education, Research and Religious Affairs Hospitals, Municipal Hospitals, as well as supervised by the Ministry of Labour, Social Security and Social Solidarity rehabilitation and other social care institutions. Pharmaceutical care is provided by private pharmacies affiliated with the National Organization for Health Care Provision <sup>11</sup> .	High cost medicines, which fall within the scope of paragraph 2 of Article 12 of the Law 38 <sup>16</sup> /2010 (A' 6), are provided exclusively by Hospital pharmacies and the National Organization for Health Care Provision <sup>12</sup> .
2. Beneficiaries of the rights referred to in paragraph 1 hereof are the following: (a) non-directly or indirectly insured Greek citizens or Greeks of Greek origin, citizens of EU Member States and other third countries who have legalization documents in Greece, and family members (spouse and minor or protected children) of all the aforementioned, (b) (the spouse and minor or protected children) who have lost their insurance cover due to debts and are not entitled to health benefits; (c) the persons of the following categories, irrespective of their legal status and the possession of legitimate residence documents in the country:	i) minors under 18 years of age,
	ii) women in pregnancy,
	ix) beneficiaries of international protection (recognized refugees and beneficiaries of subsidiary protection) and stateless persons and members of their families (spouse and minor or protected children) are either holders of a valid residence permit or a decision is pending on an application for the renewal of the regime for international protection appeal or appeal against a decision rejecting a request for renewal or at the time when there is a right of appeal or appeal,
	x) those residing in Greece with a residence permit for humanitarian or exceptional reasons and their family members (spouse and minor or protected children), in accordance with Article 28 of the Presidential Decree 114/2010 (A' 195) or the Law 3386/2005 (A' 212) or the Law 4251/2014 (A' 80) whether they are in possession of a valid residence permit or a decision is pending on an application for the renewal of an international protection regime or on a civil action or an appeal against a decision rejecting a request for renewal or at the time when there is a right of redress or appeal,
	xi) applicants for international protection and their family members (spouse and minor or protected children) from the date of the declaration of intent to lodge an application for international protection (initial or subsequent) and until the decision on their application for international protection becomes final by decision of the relevant authority requesting the annulment of a decision of a Board of Appeal or if the time limit for filing an appeal has expired,
	xii) victims of crimes of Articles 323, 323A, 349, 351 and 351A of the Criminal Code (in accordance with Presidential Decree 233/2003 (A' 233), who are uninsured and for as long as the protection and assistance measures are in force and aliens that fall under the provisions of Law 3875/2010 (A' 158) "Ratification and implementation of the United Nations Convention against Transnational Organized Crime" and for as long as protection and assistance measures are in place. Citizens of third countries with a written certificate of postponement of expulsion pursuant to the provisions of paragraph 4, article 24 of Law 3907/2011 (A' 7) [17].

Source: Government Gazette, 2016.

<sup>10</sup> Greek acronym NPID.

<sup>11</sup> Greek acronym EOPYY.

<sup>12</sup> Greek acronym EOPYY.

Regardless of the previous law of 2016, recent developments froze all previous efforts to secure social security number to third country nationals. In July 2019 in particular, the new cabinet of Greece suspended the right to issue social security number for TCNs without however releasing further guidelines. In other words, the authorities that were otherwise responsible for issuing AMKA, halted all legal procedures. As of September 2019, neither the relevant institutions nor TCNs are informed with regards to their health insurance (Suspension of Circular no. 80320/28107/1857/20-6-2019) (Hellenic Ministry of Labour, Social Security and Social Solidarity, 2019).

### **3. REPERCUSSIONS OF PRECARIOUS EMPLOYMENT AND DOMESTIC WORK IN FEMALE MIGRANTS' ACCESS TO HEALTHCARE SERVICES IN GREECE**

Precarious work is employment that lacks all the standard forms of labour security. It typically takes the form of wage work, and is characterized by exceptionally limited social benefits and legal rights, job insecurity, low wages and high risk of ill health (Vosko, 2006, pp.3-4). Precarious work creates enormous and complex barriers to labour organization strategies due to the isolated, atomized and non-unionized nature of immigrant employment (Choudry and Thomas, 2012, pp.180-181). With regards to labour rights, migrants experience intense

instability not only in the workplace but also in their relationships with fellow migrant workers. This workforce is distinguished by its lack of work rights and trade union representation. Sassen (1998, pp.153-154) mentions that “the growth of an informal economy in highly developed countries has been explained as the result of immigration from the Third World and the replication here of survival strategies typical of the home countries of migrant workers”. More and more immigrants, regardless of their country of origin, are becoming a part of a workforce reserve that is continually renewed and is divided into sectors according to type of employment. In Greece, Italy, Spain, and Portugal, the underground economy constitutes a structural element. Greece comes first among the 21 OECD country-members where 24% of Greek GDP is formed by the underground/shadow economy (Williams and Schneider, 2013, pp.52-57).

Moreover, the percentage of uninsured workers is among the world's highest (37.3 %) and so is the percentage of undocumented migrants working (4.4 %) (Williams and Schneider, 2013, pp.90-96; Williams, Demetriades and Patra, 2016). According to data from the Hellenic Ministry of Labour, Social Security and Social Solidarity/Unified Social Security Fund (2017)<sup>13</sup> (December 2017, 14/06/2018)<sup>14</sup>, out of the total number of

<sup>13</sup> Greek acronym EFKA.

<sup>14</sup> [http://www.efka.gov.gr/\\_stats/files/apasxolisi\\_12\\_2017.zip](http://www.efka.gov.gr/_stats/files/apasxolisi_12_2017.zip)

insured individuals, 90.32% have Greek nationality, 1.58% other EU nationality, and 8.10% non-EU nationality<sup>15</sup>. Out of the total number of individuals insured in joint businesses, 90.98% have Greek citizenship, 1.57% other EU citizenship and 7.45% non-EU citizenship, while the corresponding percentages in the domain of construction works are 54.44%, 2.38% and 43.17% respectively. Out of the total number of insured foreigners, 52.65% are of Albanian citizenship. With regards to TCN men, 54.25% are of Albanian citizenship, followed by 10.08% of Pakistani origin and 4.87% of Bangladeshi nationality. With regards to TCN women, 49.68% are of Albanian nationality, followed by 8.17% of insured Bulgarian nationals and 7.48% of Romanians.

Regarding domestic work, it is argued that more than 67.1 million (International Labour Organization, 2016) women and men of different age, class and nationality are pushed nowadays to work in businesses, households and for individual employers undertaking various tasks such as cleaning, and providing care, companionship and supervision (Psim-

menos, 2013, pp.15-17). Following the previous argument, one could also add all types of helpers for the care and safety of persons and properties, beauty care, entertainment, agricultural work, manual labour, constructions, crafts, food services, entertainment industry, itinerant trade and the street economy occupations, all of which are characterized by similar types of inequality, the erosion and deregulation of labour gains, collectivities and capabilities of tackling labour market exploitability (Psimmenos, 2013, pp.15-17). According to international research, female migrant domestic workers are depicted as being cut off from family and community ties, shattered networks of solidarity and disassociation from collectivities and claims as they are entrapped in exploitative servitude, servile and precarious, low-status/low wage labour. The impact on health and therefore an important occupational safety and health hazard in the sector (including food and water, body pain and injuries, dermatological issues, allergic reactions, abuses, including verbal, physical, sexual abuse), is well-documented (Fouskas, 2016; Svensson, 2018).

Under precarious, low-status/low wage jobs immigrants are exposed to an unsafe working environment, facing stigma and exposed to physical and moral exploitation. Immigrant workers acquire special relations with official forms of social protection (Psimmenos, 2011, pp.228-230).

<sup>15</sup> Third-country: A country that is not a member of the European Union as well as a country or territory whose citizens do not enjoy the European Union right to free movement, as defined in Art. 2(5) of the Regulation (EU) 2016/399 (Schengen Borders Code). Source: European Migration Network (EMN). (2018). Asylum and Migration Glossary 6.0: A tool for better comparability. Brussels: European Migration Network (EMN)/European Commission, (p. 378) [http://emn.ie/files/p\\_20180521043751interactive\\_glossary\\_6.0\\_final\\_version.pdf](http://emn.ie/files/p_20180521043751interactive_glossary_6.0_final_version.pdf)

In the Greek labour market female migrant workers are mainly found in precarious, low-status/low wage occupations, in undeclared work and underground economy/informal sectors of the economy which demands for its constant reproduction a cheaper, uninsured, mobile, temporary and flexible workforce (Psimmenos, 2011, pp.228-230). Precarious, low-status/low wage employment entraps female migrant workers while integrating them in a context outside labour inspections, labour law and taxation, without social insurance contributions and defiance, and without regulations concerning labour rights. These jobs are usually concealed from the state so that the employer pays less or no tax at all, no social security contributions and avoids adhering to worker rights regulations. Social and financial restructuring, along with government policies have led to the development of financial activity which drives this mobile workforce out of the formal labour market and places female migrants in precarious employment. One problem here is that the workforce is distinguished by the absence of rights and union representation. More and more female migrants are becoming part of a workforce reserve that is continually renewed and is divided into sectors according to types of employment. These female migrants facilitate adjustable production, low technical and technological intervention as well as personal and sentimental contribution to the work ef-

fort. The jobs in which female migrants are employed are defined as non-attractive as they offer no social prestige, are marginal and secondary; they are paid or not paid occupations outside the margins of formal employment and since they are not registered they are considered inferior by society. There are various jobs in every society which have a clear and often necessary function within the overall division of labour but which are seen by the public as 'dirty' – in a metaphorical or literal way- and somehow regarded as morally dubious by the public (Hughes 1958 in Watson, 2008, p.189).

Female migrant domestic workers are pushed to meet their healthcare and social care needs in informal or private practices, which go beyond the safety of the employee, forming a grid of solidarity and stability in this particular labour market (Psimmenos, 2009, pp.145-146). According to Psimmenos (ibid) mostly concerning their health: (i) Regarding medical care clientele relationships with nursing personnel are developed while they may also turn to charity foundations and non-governmental organizations, (ii) for pharmaceutical coverage they turn to the private market, (iii) for hospitalization and emergency cases they turn to employers, relatives or informal networks, (iv) for medical examinations and visits they turn to private doctors and also visit the country of origin, (v) immigrants do not conduct any preventive

monitoring, (vi) for deliveries or abortions they turn to private health facilities or charity foundations, (vii) for psychological needs they adapt themselves to the current requirements, they try to predict the situations and to develop skills. Two main obstacles distance immigrants from health services. *Objective parameters: First*, the lack of legal documents of residence and work leads them to informal and uninsured work (Psimmenos, 2010, pp.99-102). In turn, informal and uninsured work hinders the acquisition, or renewal and maintenance of legal documents (ibid). *Second*, in order to ensure the well-being of the labourer in precarious, low-status/low wage work, there are conditions, rules and practices to be followed, such as multi-share employment or sub-contracting that hinder formal social protection (ibid). And *third*, failure to develop collective bonds distances them from solidarity networks and further hampers access of male and female immigrant workers to formal social protection (ibid). *Subjective parameters:* Difficulties of access are solidified and are not only explained through the legal status and income or the function of the worker in his occupation (ibid). During work employees acquire or develop habits, values and practices that strengthen the informal part of social protection (ibid). One example is the development of work orientations that boost informal protection. Plans of immigrants for instant profits and speedy return to the

country of origin are left behind and work acquires, among others, a sense of skills of development of personal and social relations (ibid).

Moreover, female migrants are employed as contracted live-in domestic workers (cleaning-care giving) with direct-hire in households of Greek employers so as to support themselves and their families back in their homeland. There is still demand in parts of the Greek society for domestic servants, and in particular Filipina female overseas contract workers, due to deficiencies observed in the Greek welfare system, not only from the upper class but from the middle class as well, both for household's social reproduction and also social status attainment. Female migrant domestic workers have multiple duties (maids, maidservants, babysitters, housekeepers, carers and nurses) depending on employer's demands: household cleaning and chores (such as laundry/cooking meals), and/or caring/nursing of the elderly, and child-care. They reside in employers' residences six days a week. They rent and share flats with other live-in domestic workers and go there at weekends; the only time they are allowed to leave the employer's residence. Multiple cases of verbal and physical abuse were reported, including shouts and gesticulation.

Furthermore, they are hired with false labour contracts that often the worker has never read, thus being vulnerable and sus-

ceptible to various forms of exploitation (Fouskas, 2016, 2018). The situation seems further burdened by the control that employers exercise over the domestic worker which results in prolonged stay in domestic work, as they are unable to seek other occupations (ibid). In many cases, employers confiscated their documents, constantly survey them and threaten to denounce them to the authorities resulting in further exploitation by their employers who demand discipline, consent and subordination, obedience and dependency of the domestic worker and thus emerge pseudo-family relationships and pseudo-mothering feelings and roles (ibid).

Female migrant live-in domestic workers rarely claim work rights as they are in an isolated work space. They often leave their employer without having received full pay and blame themselves for not looking into the details of their employment conditions beforehand (Fouskas, 2016, 2018). Through this attitude, they try to maintain low-profile as hard labourers in order to gain the employer's trust and improve the reception society's perception about them, or even to achieve higher wages (ibid). The recession seems to have created greater insecurity and increased dependency upon their employers out of their need to achieve some level of social protection (ibid). This dependency further isolates female migrants, undermining family

relationships in the country of origin, and interaction with their compatriots, colleagues and community associations (ibid).

#### **4. CONCLUSION**

In this article we have argued that possible health problems may limit the ability of migrants to maintain a job, since the majority is drawn to precarious low-status and low wage occupations (Pajnik and Campani, 2011; Fouskas 2013, 2014), or to ones where there is a high incidence of work accidents and occupational health issues. Furthermore, we have included the international legal context regarding rights into the Greek narrative in order to reflect upon the ways in which healthcare rights alongside exploitative working conditions of female migrants coexist in the country. Social policy challenges are insurmountable as general measures may lead to unemployment and/or an increase of informality. Instead, further training and direction of this workforce to employment in other jobs is needed. Due to the situation many immigrants lack the protection of national health insurance, and may be unable to meet the cost of even a simple hospitalization. Female migrant workers are often based on an inhomogeneous provisional or temporary healthcare system where the role of non-governmental organizations or charitable initiatives is significant, stressing the importance of safeguarding healthcare rights at an institutional level. They are thus forced to turn to this

system as they have no other option, a fact that illustrates the repercussions of discriminatory access, as well as the informal, private and individualistic practices that immigrants are pushed to and ultimately choose. Female migrants are often uninsured and excluded from healthcare, while their cost care is higher than the insured, making immigrants less able to pay the care needed. Difficulties such as informal and discriminatory policies of health professionals and perceptions developed by immigrants on welfare, hinder and prevent the use of services by the latter. The end result is that immigrants are much less likely to use preventive health services, hospital services, emergency medical services and dental care than native citizens. The main barriers for immigrant workers and ethnic minorities in accessing healthcare and social care services are summarized in the following points: (a) cost of care, (b) lack of information on access to services such as health, social insurance and the welfare system (e.g., vaccinations and the places of available services), (c) language difficulties in communicating with health professionals and workers in social work/care, (d) prejudices and stereotypes of health professionals towards these groups, (e) fear of these groups towards the operation of public services.

Furthermore, we have also argued that migrants, asylum seekers and refugees have specific vulnerabilities regarding communicable diseases as they come from countries where diseases are prevalent, health systems are weak, and rates of

communicable diseases such as tuberculosis, hepatitis and HIV are generally high. Especially for migrant workers employed in precarious, low-status/low wage employment, there is a higher risk of accidents and they are more likely to be absent from work due to illness or injury while they work without national health insurance and protection gear. Moreover, Greece does not collect systematic data on the health of migrants. The data available often refer only to the health status and do not cover wider determinants on health. There is a clear need for a consistent approach towards improving the monitoring system of migrants' health in Greece and other European Union countries. It is important to collect data beyond disease-based health monitoring, focusing for example on age, gender, social determinants of health, behaviours of migrants when seeking health services, rights, behaviours of healthcare workers/providers/professionals and on how the health system of Greece functions in relation to services provided to migrants.

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