

ACCESS TO HEALTHCARE IN 16 EUROPEAN COUNTRIES



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Introduction

When addressing the topic of access to healthcare for people facing multiple vulnerabilities, the first obstacles we meet are difficulties in collecting information and a scarcity of legal provisions, as laws generally tend to provide for the majority and not for the specific situations. Beyond the law is the practice. People who fall through the cracks of universal healthcare may experience severe hurdles in keeping with a decent life, especially when financial resources are missing.

This legal report intends to collect and gather legal and field information about access to healthcare for people facing multiple vulnerabilities. We prefer using the concept of “vulnerabilities” rather than “vulnerable people”, for several reasons. On one hand, people do not necessarily identify with the category of “vulnerable”, and using a broad and vague concept is not relevant. On the other hand, everyone is likely to be vulnerable at a given moment of his/her life, and vulnerability may only be a transitory situation. In other words, the concept of “vulnerabilities” enables us to better understand and pinpoint what the obstacles to access healthcare are.



The European Network to Reduce Vulnerabilities in Health, hosted by Médecins du Monde France, was created in 2015 and is composed of 23 members in 22 European countries. We advocate for better access to healthcare for people facing vulnerabilities through robust data collected among the partners and representation

¹Belgium (BE), France (FR), Germany (DE), Greece (EL), Ireland (IE), Italy (IT), Luxemburg (LU), The Netherlands (NL), Norway (NO), Romania (Ro), Slovenia (SI), Spain (ES), Sweden (SE), Switzerland (CH), Turkey (TR), United kingdom (UK)

towards European institutions and stakeholders.

Working methodology

In the framework of the Network, the legal report aims to describe 16 national healthcare systems¹, using both legal expertise and feedback from the field. The public healthcare system of each country is described as it is foreseen by the national laws, completed by a description of the reality of access to healthcare. Several categories of people are highlighted as specific provisions apply to them, generally restricting their access to the public healthcare system.

The main legal changes for 2017

France

The third-party payment system allowing for access to healthcare, free at the point of use, was intended to be applicable to everyone covered by social health insurance before the end of 2017. However, the new French Minister for Solidarity and Health stated in July 2017 that this provision would not be in vigour by the end of 2017.

The law n°2016-297 of 14 March 2016 relating to child protection forbids any medical examination of the pubertal development for age assessment purposes.² Instead, bone X-rays are to be performed but only as a last resort. This law also states that medical examination alone cannot be a sufficient proof for the denial of protection.

With the law on real equality for overseas France, adopted on February 2017, the CMU-C (Complementary Universal Medical Coverage) should become applicable in Mayotte by 2025.³

²Annual activity report 2016 – unaccompanied minors mission (March 2017) http://www.justice.gouv.fr/art_pix/1_RAA_MMNA_2016.pdf

³Strategic document – Mayotte 2025 an ambition for the French Republic p.16

Germany

A new law on access to social welfare (*GrSiAuslG*), in vigour since the beginning of 2017, has drastically reduced the rights of some EU citizens legally residing in Germany to access social services such as healthcare insurance. It concerns people coming from the new EU member states, unemployed, without sufficient means of existence or acquiring a residence permit through their children, and it applies for the first five years of their stay in Germany.

Ireland

The government dropped the Universal Health Insurance plan, initiated by the reform programme of the health system, for being unaffordable.

Free GP care for children under 12 years old, initially due for October 2016, has been delayed.

Italy

On March 2017, a new law on the protection of unaccompanied minors was adopted. The law provides for a better protection and reception system, which will be standardised at a national level. Among the provisions is a ban on deportation for children; a maximum period of detention into the reception centres of 30 days (instead of 60 days); a strengthening of the children's rights to access healthcare and education.⁴

On May 2017, the government issued a decree making vaccination against measles and nine other diseases compulsory for

<http://www.mayotte.pref.gouv.fr/content/download/5164/43644/file/Mayotte%202025%20Une%20ambition%20pour%20la%20R%C3%A9publique%20-%20document%20strat%C3%A9gique.pdf>

⁴ Italian Committee for UNICEF
<https://www.unicef.it/doc/7324/approvata-la-legge-zampa-per-minori-stranieri-non-accompagnati.htm>

⁵ Article from the newspaper *La Stampa* (6 April 2017)

children under the age of 17. Parents who do not comply with the new decree risk sanctions. This decree became a law after a vote in the Parliament on July 2017. Vaccines included in the compulsory list should be free.

A reform of the co-payment system (*ticket sanitario*) is currently under discussion at government and regional levels.⁵

United Kingdom

In January 2017, a memorandum of understanding came into effect allowing the National Health System (NHS) digital to share non-clinical data with the Home Office of those suspected of committing immigration offences; this includes names and addresses of immigration offenders. The memorandum is intended to “[encourage] voluntary return by denying access to benefits and services to which [those staying in the UK illegally] are not entitled” thus, creating another deterrent for migrants to access healthcare.⁶

Until June 2017, Northern Irish pregnant women could travel to England to terminate their pregnancy, but would not be covered by the NHS and would have to pay full cost. In June 2017, the Parliament passed an amendment allowing Northern Irish women to be covered by the NHS for abortion in England.

A new rule requiring hospitals to check upfront whether their foreign patients are entitled to free NHS treatments should come into force before the end of the year. However, immediately necessary or urgent

<http://www.lastampa.it/2017/04/06/economia/ticket-sanitari-meno-cari-ma-stretta-sulle-esenzioni-attraverso-il-reddito-isee-9YDmllCDUpflEueMJQ9L1M/pagina.html>

⁶ Memorandum of Understanding between Health and Social Care information centre and the Home Office, pp.4-6
www.gov.uk/government/uploads/system/uploads/

treatment should not be withheld pending payment.⁷

Spain

On 12 September 2017, a political agreement was reached between the Spanish civil society (NGOs, healthcare associations and trade unions) and several political parties.⁸ Pursuant to this agreement, the signatory political parties commit themselves to adopt essential legal provisions to ensure a public and universal healthcare system. They should submit a law to the Parliament, before the end of 2017, which will aim at guaranteeing universal access to every person living in Spain, regardless their administrative status.

Sweden

A new temporary law entered into force on 20 July 2016. This law considerably limits asylum seeker's possibilities to obtain a permanent residence permit and to be eligible for family reunification. It will be valid for three years and applies for asylum seekers who arrived after 24 November 2015. Before the temporary law of July 2016, asylum seekers, refugees and people in need of subsidiary protection, who had been granted a residence permit, would receive a permanent residence permit.⁹ Moreover, when someone was granted a permanent residence permit, his/her family could apply for a residence permit, in accordance with the family reunification process. Pursuant to the new temporary law, people considered refugees are granted a three-year residence permit, and people in

need of subsidiary protection are granted a 13-month residence permit.¹⁰

New rules for age assessment have been implemented in March 2017. People can undergo a voluntary medical age assessment (consisting of X-ray and MRI) which estimated outcome will be included in the decision process for the refugee status.¹¹ However, this age assessment methodology is imprecise and can only produce an estimation of the minority of the applicant. The uncertainty of the results has been the subject of much debate in Sweden.

⁷<http://www.independent.co.uk/news/uk/politics/brexit-migrants-nhs-treatment-pay-upfront-fees-hospital-charge-date-when-a7833111.html>

⁸ *Pacto político y social por un sistema nacional de salud público y universal*

⁹ *Swedish migration agency*
<https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/When-you-have-received-a-decision-on-your-asylum-application/If-you-are-allowed-to-stay/Protection-status.html>

¹⁰ *Swedish migration agency*
<https://www.migrationsverket.se/English/About-the-Migration-Agency/Legislative-changes-2016/Limited-possibilities-of-being-granted-a-residence-permit-in-Sweden.html>

¹¹ *Swedish municipality and county council*
<https://skl.se/download/18.413f4ad015c773324e5ef95e/1497526194251/PM%20-%20EDoMH%20-%20%C3%84ndrade%20%C3%A5ldersbed%20%C3%B6mningar%20av%20ensamkommande%20barn.pdf>

Summary and comparative tables on access to healthcare

In order to facilitate the reading of the report, the following four summary tables give a quick overview of access to healthcare for four categories of persons facing vulnerabilities.

Note: these are concise tables and may not accurately represent the complexity of the situation and the law for each country. Moreover, the columns are not to be considered with a value-based judgement; for instance, “access to healthcare on the same basis as authorised residents” may be more or less positive depending on each country’s health policies. Thus, you can refer to the detailed chapters for an in-depth legal analysis.

The first one gives an overview of access to healthcare for asylum seekers in 16 European countries. Four of the selected countries only allow asylum seekers to access limited healthcare. In one of them (Slovenia) asylum seekers are only entitled to emergency healthcare.

| Access to healthcare for asylum seekers | Access to healthcare on the same basis as authorised residents | Access to limited ¹² healthcare | No access to healthcare except for urgent medical assistance |
|---|--|--|--|
| Belgium | | ✓ | |
| France | ✓ | | |
| Germany | | ✓ | |
| Greece | ✓ | | |
| Ireland | ✓ | | |
| Italy | ✓ | | |
| Luxembourg | | ✓ | |
| Netherlands | ✓ | | |
| Norway | ✓ | | |
| Romania | ✓ | | |
| Slovenia | | | ✓ |
| Spain | ✓ | | |
| Sweden | | ✓ | |
| Switzerland | ✓ | | |
| Turkey | ✓ | | |
| United Kingdom | ✓ | | |

The second table provides an overview of access to healthcare for undocumented migrants in 16 European countries. Five of the selected countries grant undocumented migrants access to a specific healthcare scheme under certain conditions (e.g. resources, residence, time, application). In two countries, undocumented migrants can access limited healthcare on the same basis as asylum seekers. In the majority of the European countries mentioned in this report, undocumented migrants only have access to healthcare in case of emergency.

¹² E.g. limited in time, in which kind of health services they can access

| Access to healthcare for undocumented migrants | Access to a specific healthcare scheme with conditions | Access to healthcare on the same basis as asylum seekers | Access to healthcare if they can pay for it | No access to healthcare except for urgent medical assistance |
|---|---|---|--|---|
| Belgium | ✓ | | | |
| France | ✓ | | | |
| Germany | | ✓ | | |
| Greece | | | | ✓ |
| Ireland | | | | ✓ |
| Italy | ✓ | | | |
| Luxembourg | | | | ✓ |
| Netherlands | | | | ✓ |
| Norway | | | | ✓ |
| Romania | | | ✓ | |
| Slovenia | | | | ✓ |
| Spain | ✓ ¹³ | | | ✓ |
| Sweden | | ✓ | | ✓ |
| Switzerland | ✓ | | | |
| Turkey | | | | ✓ |
| United Kingdom | | | ✓ | |

The third table provides an overview of access to healthcare for children of undocumented migrants. In five countries, children of undocumented migrants can access healthcare on the same basis as authorised residents. In ten of them, children of undocumented migrants are entitled to access healthcare on the same basis as undocumented adult migrants. This last point is not necessarily negative, as France and Belgium have implemented a specific healthcare scheme for undocumented migrants.

| Access to healthcare for children of undocumented migrants | Access to healthcare on the same basis as authorised residents | Access to healthcare on the same basis as asylum seekers | Access to healthcare on the same basis as undocumented adult migrants |
|---|---|---|--|
| Belgium | | | ✓ |
| France | | | ✓ |
| Germany | | ✓ | |
| Greece | ✓ | | |
| Ireland | | | ✓ |
| Italy | ✓ | | |
| Luxembourg | | | ✓ |
| Netherlands | | | ✓ |
| Norway | | | ✓ |

¹³ The Royal decree 16/2012 excludes undocumented migrants from the healthcare scheme (except for children under 18 years old, pregnant women and emergency care), but most of the autonomous communities provide access to healthcare for undocumented migrants under certain conditions. Thus, we chose to check both categories. For further information, see the chapter on Spain.

| children of undocumented migrants (2) | on the same basis as authorised residents | on the same basis as asylum seekers | on the same basis as undocumented adult migrants |
|--|---|-------------------------------------|--|
| Romania | ✓ | | |
| Slovenia | ✓ | | ✓ |
| Spain | ✓ | | |
| Sweden | | | ✓ |
| Switzerland | | ✓ | |
| Turkey | | | ✓ |
| United Kingdom | | | ✓ |

The fourth table provides an overview of access to healthcare for unaccompanied minors. In some countries, access to healthcare depends on whether the unaccompanied minors have submitted an application for international protection or asylum.

| Access to healthcare for unaccompanied minors | Access to healthcare on the same basis as authorised residents with conditions | Access to healthcare on the same basis as asylum seekers | Specific measures and facilities for unaccompanied children | Access to healthcare on the same basis as children of undocumented migrants |
|--|--|--|---|---|
| Belgium | ✓ | | ✓ | |
| France | ✓ | | ✓ | |
| Germany | ✓ | | ✓ | |
| Greece | | | ✓ | |
| Ireland | | ✓ | ✓ | |
| Italy | ✓ | | | |
| Luxembourg | | | ✓ | |
| Netherlands | ✓ | | ✓ | |
| Norway | ✓ ¹⁴ | | ✓ | ✓ ¹⁵ |
| Romania | ✓ | | ✓ | |
| Slovenia | ✓ ¹⁶ | | ✓ | ✓ ¹⁷ |
| Spain | ✓ | | | |
| Sweden | | ✓ | ✓ | |
| Switzerland | ✓ | | ✓ | |
| Turkey | | | ✓ | |
| United Kingdom | ✓ | | ✓ | |

¹⁴ If they submit an application for asylum

¹⁵ If they do not submit an application for asylum

¹⁶ If they submit an application for asylum

¹⁷ If they do not submit an application for asylum

Acronyms

| | | | |
|----------|---|---------|--|
| AC | Autonomous Community – ES | | (<i>Caisse Auxiliaire d'Assurance Maladie-Invalidité</i>) – BE |
| ACS | Supplementary Health Insurance Assistance Scheme (<i>Aide Complémentaire Santé</i>) – FR | CCAS | Communal Centre for Social Support (<i>Centre Communal d'Action Sociale</i>) – FR |
| AIDS | Acquired Immunodeficiency Syndrome | CCG | Clinical Commissioning Group – UK |
| ALD | Long-term chronic illnesses (<i>Affection de Longue Durée</i>) – FR | CDAG | Free and anonymous testing centre (<i>Centre de dépistage anonyme et gratuit</i>) – FR |
| AME | Medical Aid (<i>Aide Médicale de l'Etat</i>) – FR | CeGIDD | Information centre for free testing and diagnosis of sexually transmitted infections (<i>Centre gratuits d'information, de dépistage et de diagnostic</i>) – FR |
| AMU | Urgent Medical Aid (<i>Aide Médicale Urgente</i>) – BE | CEPS | Economic Committee for Healthcare products (<i>Comité Economique des produits de Santé</i>) – FR |
| ARS | Regional Health Agencies (<i>Agence Régionale de Santé</i>) – FR | CESEDA | Code on Entry and Residence of Foreign Nationals and Right of Asylum (<i>Code de l'entrée et du séjour des étrangers et du droit d'asile</i>) – FR |
| ASE | Child welfare services (<i>Aide Sociale à l'Enfance</i>) – FR | CH | Switzerland |
| ASEM | Association for Solidarity and Support for Migrants – TR | CHF | Swiss franc |
| ASL | Local Health Authorities (<i>Aziende Sanitarie Locali</i>) – IT | CHIH | County Health Insurance House – RO |
| AsylBLG | Asylum Seekers' Benefits Law – DE | CIDDIST | Information centre for testing and diagnosis of sexually transmitted infections (<i>Centre d'information, de dépistage et de diagnostic des infections sexuellement transmissibles</i>) – FR |
| AufenthG | Residence Act – DE | CIRE | Certificate of Inscription in the Register of Foreign Nationals (<i>Certificat</i> |
| BBi | Blood-Borne Infections | | |
| BE | Belgium | | |
| BIM | Increased refund of the healthcare insurance (<i>Bénéficiaire de l'Intervention Majorée</i>) – BE | | |
| BMA | State Medical Service – NL | | |
| CAAMI | Auxiliary Illness and Disability Insurance Fund | | |

| | | | |
|--------|--|----------------|--|
| | <i>d’Inscription au Registre des Étrangers</i>) – BE | DCO | Designated Country of Origin |
| CLAT | Centre for Fighting Tuberculosis (<i>Centre de Lutte Anti Tuberculeuse</i>) – FR | DE DFI | Germany Federal Department of the Interior (<i>Département Fédéral de l’Interieur</i>) – CH |
| CMU | Universal Medical Coverage (<i>Couverture Maladie Universelle</i>) – FR | DH DMH | Department of Health – UK Urgent Medical Aid (<i>Dringende Medische Hulp</i>) – BE |
| CMU-C | Complementary Universal Medical Coverage (<i>Couverture Maladie complémentaire</i>) – FR | DOM | French overseas departments (<i>Département d’Outre-Mer</i>) – FR |
| CNAMTS | National Health Insurance Fund for Salaried Workers (<i>Caisse Nationale d’Assurance Maladie des Travailleurs Salariés</i>) – FR | ECHR ECtHR | European Convention on Human Rights European Court of Human Rights |
| CNS | National Health Fund (<i>Caisse Nationale de Santé</i>) – LU | EEA EHIC | European Economic Area European Health Insurance Card |
| COA | Central Agency for the Reception of Asylum Seekers (<i>Centraal Orgaan opvang asielzoekers</i>) – NL | EL ENI code | Greece Code for EU citizens on the Italian territory for more than three months and not registered as authorised residents (<i>Europei Non Iscritti</i>) – IT |
| CoE | Council of Europe | | |
| COMEDE | Medical Committee for Exiles (<i>Comité Médical pour les exilés</i>) – FR | EOPYY | National Organisation for Healthcare Provision – EL |
| CPAM | Primary Health Insurance Funds (<i>Caisse Primaire d’Assurance Maladie</i>) – FR | EPIM | European Programme for Integration and Migration |
| CPAS | Public Social Welfare Centre (<i>Centre Public d’Action Sociale</i>) – BE | ES ESY | Spain National Healthcare System (<i>Ethniko Systema Ygeias</i>) – EL |
| CRAM | Regional Health Insurance Funds (<i>Caisses Régionale d’Assurance Maladie</i>) – FR | EU FADSP | European Union Associations Defending Public Health (<i>Federacion de Asociaciones en Defensa de la Sanidad Publica</i>) – ES |
| CRC | Convention on the Rights of the Child | | |

| | | | |
|-----------|--|-------|---|
| FARES | The Respiratory Diseases Fund (<i>Fonds des Affections Respiratoires</i>) – BE | IE | <i>Invalideitsverzekering</i>) – BE |
| FOSI | Federal Office for Social Insurance – CH | IHC | Ireland |
| FR | France | IKA | Individual Healthcare Card – ES |
| FSUV | Fund for Vital and Urgent Care (<i>Fonds pour les soins urgents et vitaux</i>) – FR | INAMI | Private Employees’ Fund – EL |
| GDP | Gross Domestic Product | | National Institute for Health and Disability Insurance (<i>Institut National d’Assurance Maladie-Invalidité</i>) – BE |
| GHIS | General Health Insurance System – TR | | Immigration and Naturalisation Service – NL |
| GKV | Statutory Health Insurance (<i>Gesetzliche Krankenversicherung</i>) – DE | IND | National Institute of Social Security – NL |
| GP | General Practitioner | INSS | Italy |
| GrSiAuslG | <i>Gesetz zur Regelung von Ansprüchen ausländischer Personen in der Grundsicherung für Arbeitsuchende nach dem Zweiten Buch Sozialgesetzbuch und in der Sozialhilfe nach dem Zwölften Buch Sozialgesetzbuch</i> – DE | IT | Federal Law on Compulsory Healthcare – CH |
| | | LAMal | Asylum Law – CH |
| | | LAsi | Essential levels of assistance (<i>livelli essenziali di assistenza</i>) – IT |
| | | LEA | Federal Act on Foreign Nationals – CH |
| | | LETr | Law on Foreigners and International Protection – TR |
| HAS | High Authority for Health (<i>Haute Autorité de Santé</i>) – FR | LFIP | Luxembourg |
| HIV | Human Immunodeficiency Virus | LU | Doctor from the Regional Health Agency (<i>Médecin de l’ARS</i>) – FR |
| HOD | Ministry of Health and Care Services – NO | MARS | Doctors of the World (<i>Médecins du monde</i> – Mdm) |
| HPSC | Health Protection Surveillance Centre – IE | MdM | Ministry of Health – RO |
| HSE | Health Service Executive – IE | MOH | Ministry of Interior |
| HTP | Health Transformation Programme – CH | MOI | Magnetic Resonance Imaging |
| HZIV | Auxiliary Illness and Disability Insurance Fund (<i>Hulpkas voor Ziekte en</i> | MRI | Agricultural scheme (<i>Mutualité Sociale Agricole</i>) –FR |
| | | MSA | |

| | | | |
|-------|--|------------|---|
| NEF | Network of European Foundations | ONSS | National Social Security Office (<i>Office National de Sécurité Sociale</i>) – BE |
| NGO | Non-governmental organisation | OPAD | Public Employees' Fund – EL |
| NHIF | National Health Insurance Fund – RO | PASS | Free Medical Centre (<i>Permanence d'accès aux soins de santé</i>) – FR |
| NHIH | National Health Insurance House – RO | PCT | Primary Care Trust – UK |
| NHS | National Health System – UK – SE | PHC | Primary healthcare – EL |
| NIS | National Insurance Scheme – NO | PICUM | Platform for International Cooperation on Undocumented Migrants |
| NL | Netherlands | PKV | Private Health Insurance (<i>Private Krankenversicherung</i>) – DE |
| NO | Norway | PMI | Mother and child health centre (<i>Protection maternelle et infantile</i>) – FR |
| NOK | Norwegian krone | PPC | Prescription Prepayment Certificate – UK |
| NTPF | National Treatment Purchase Fund – IE | PPS number | Personal Public Service Number – IE |
| OAEF | Self-employed/Entrepreneurs' Fund – EL | PUMA | Universal Medical Protection (Protection Maladie Universelle) – FR |
| OAMal | Health Insurance Ordinance – CH | RHA | Regional Health Authorities – NO |
| OCMW | Public Social Welfare Centre (<i>Openbaar Centrum voor Maatschappelijk Welzijn</i>) – BE | RIZIV | National Institute for Health and Disability Insurance (Rijksinstituut voor ziekte- en invaliditeitsverzekering) – BE |
| ODSE | Observatory for Foreigners' Right to Healthcare (<i>Observatoire du Droit à la Santé des Etrangers</i>) – FR | RO | Romania |
| OFII | French Immigration and Integration Office (<i>Office Français de l'Immigration et de l'Intégration</i>) – FR | RSI | Scheme for the self-employed (<i>Régime Social des Indépendants</i>) – FR |
| OGA | Farmers' Fund – EL | RSZ | National Social Security Office <i>Rijksdienst voor Sociale Zekerheid</i> |
| OLAI | Luxembourg Reception and Integration Agency (<i>Office luxembourgeois de l'accueil et de l'intégration</i>) – LU | SE | Sweden |

| | | | |
|----------|---|------|---|
| SEK | Swedish krona | VRGT | The Respiratory |
| SI | Slovenia | | Healthcare and |
| SMR | Therapeutic benefit evaluation system (<i>Service Médical Rendu</i>) – FR | | Tuberculosis Association (<i>Vereniging voor Respiratoire</i> |
| SSI | Social Security Institution (<i>Sosyal Güvenlik Kurumu</i>) – TR | | <i>Gezondheidszorg en Tuberculosebestrijding</i>) – BE |
| SSN | National Health Service (<i>Servizio Sanitario Nazionale</i>) – IT | WHO | World Health Organisation |
| STD | Sexually Transmitted Diseases | ZZZS | Health Insurance Institute of Slovenia – SL |
| STI | Sexually Transmitted Infections | | |
| STP code | Code for undocumented foreigners temporarily on the Italian territory (<i>Stranieri Temporaneamente Presenti</i>) – IT | | |
| TB | Tuberculosis | | |
| TLV | Dental and Pharmaceutical Benefits Agency – SE | | |
| TPS | Third-party Social Payment (<i>tiers-payant social</i>) – LU | | |
| TR | Turkey | | |
| TRY | Turkish lira | | |
| UK | The United Kingdom | | |
| UKBA | United Kingdom Border Agency – UK | | |
| UN | United Nations | | |
| UNCAM | National Union of Health Insurance Funds (<i>Union Nationale des Caisses d'Assurance Maladie</i>) – FR | | |
| UNHCR | United Nations High Commissioner for Refugees | | |
| UNICEF | United Nations International Children's Emergency Fund | | |

Glossary

Access to healthcare

The WHO gives three dimensions to access to healthcare:

- *Physical accessibility. This is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organisation and delivery that allow people to obtain the services when they need them.*
- *Financial affordability. This is a measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work). Affordability is influenced by the wider health financing system and by household income.*
- *Acceptability. This captures people's willingness to seek services. Acceptability is low when patients perceive services to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services.*¹⁸

Children of asylum seekers, refugees and undocumented migrants

We consider that no minor can be considered as an asylum seeker, refugee or undocumented migrant. In this report, we use the terms “children of asylum seekers”,

“children of refugees” or “children of undocumented migrants”.

EU mobile citizens

We call EU mobile citizens the people who decide to move from the EU country of their nationality to live in another EU country.

Healthcare

Healthcare refers to the services that are provided to “for the purpose of promoting, maintaining, monitoring or restoring health”.¹⁹

Primary care

Primary care is “first-contact, accessible, continued, comprehensive and coordinated care? First-contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person rather than the short duration of the disease”.²⁰

The Bismarck system

Named after the Prussian Chancellor Otto von Bismarck (1815-1898), the Bismarck system is based on work and financed by contributions. In 1883, he established a system where employers pay one third and workers two thirds. By means of this welfare measure, he succeeded to block the workers' demands about the right to vote and divert their support for the Socialist Party.

The Beveridge system

Named after William Beveridge, this system relies on universal access to healthcare and health services financed by the government through taxes. The principle is that no one should live below a minimum standard throughout his/her lifetime, so healthcare must be free for everyone.

¹⁸ David B Evans, Justine Hsu, Ties Boerma Bulletin of the World Health Organization 2013, Volume 91, Number 8, August 2013, 545-620

¹⁹ Centre for Health Development Ageing and Health Technical Report Volume 5, A glossary of terms for

community healthcare and services for older persons, World Health Organization 2004

²⁰ WHO/Europe 2004

Third-country nationals

Third-country nationals are individuals who are citizens of non-EU countries.

Undocumented EU citizens

European Directive 2004/38/CE foresees that EU citizens can lose their authorisation to reside, thereby making them, in a certain way - undocumented in a Member State.

Article 7 of the above-mentioned directive states conditions for EU citizens to obtain the right to reside for more than three months. One of these is to prove that they have sufficient resources for themselves and their family members, so that they will not become a burden on the welfare system of the host Member State during their period of residence, and to have comprehensive health coverage in the host Member State.

Therefore, destitute EU citizens do not have the right to reside after three months in the host Member State, if they do not have sufficient resources or/and health coverage. They can be expelled, in the same way as third-country nationals – although stricter rules need to be respected by the Member States. In this document, we refer to this group as undocumented EU citizens.

Universal health coverage (UHC)

There is Universal Health Coverage when everyone can access *“the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”*.²¹

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WHO
http://www.who.int/health_financing/universal_coverage_definition/en/

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National Health System

Constitutional basis

Article 23 of the Belgian Constitution of 1994 establishes that “*everyone has the right to lead a life in keeping with human dignity [...] To this end, the laws, federate laws and rules referred to in Article 134 guarantee economic, social and cultural rights, taking into account corresponding obligations, and determine the conditions for exercising them. These rights include among others: the right to social security, to healthcare and to social, medical and legal aid*”.²²

Organisation and funding of Belgian healthcare system

Belgium has a complex state structure, which has an impact on the national health system. Indeed, health competences are shared between the federal government (curative care) and federated entities (prevention).

The Belgian health system is a Bismarck-type one, based on the principles of equal access and freedom of choice (regarding health providers, mutual insurance plans). National health insurance is compulsory.²³

The national health system consists of a mix of private and public actors and is funded by employer and employee contributions, and federal government subsidies. Social security contributions are deducted automatically from salaries and are paid to the National Social Security Office.²⁴

The details of what is covered by the mandatory health insurance, organised by the National Institute for Health and Disability Insurance (INAMI (in French) or RIZIV (in Dutch)), is determined by a scale (INAMI nomenclature).

RIZIV-INAMI oversees the general organisation of the compulsory health insurance; however, the task of actually providing insurance falls to the sickness funds. These are non-profit organisations with a public interest mission and receive the majority of their financial resources from RIZIV-INAMI.²⁵

For the general scheme for employed persons, the National Social Security Office (*Office National de Sécurité Sociale – ONSS* (in French) and *Rijksdienst voor Sociale Zekerheid – RSZ* (in Dutch)) collects and administers payroll taxes and employment taxes. Then, the ONSS distributes the contributions between health insurance companies. These are all private health insurance companies, called *mutualités* (mutual insurance plans) or sickness funds except for one public health insurance company called the Auxiliary Illness and Disability Insurance Fund (*Caisse Auxiliaire d'Assurance Maladie-Invalidité – CAAMI* (in French) and *Hulpkas voor Ziekte en Invaliditeitsverzekering – HZIV* (in Dutch)). The auxiliary fund is available for people who do not wish to join one of the other mutual insurance plans.

The mutual insurance plans take care of the reimbursement of medical expenses. In practice, for most medical expenses, patients are only responsible for small co-payments for drugs and transport.²⁶

²² *Constitution of Belgium 1994* (last updated 8 May 2007),

<http://home.scarlet.be/dirkvanheule/compons/ConstitutionBelgium/ConstitutionBelgium.htm>

²³ S. Gerkens and S. Merkur, “Belgium: Health system review”, *Health Systems in Transition*, vol. 12, No. 5, XVI, 2010,

http://www.euro.who.int/data/assets/pdf_file/0014/120425/E94245.PDF

²⁴ <http://belgium.angloinfo.com/money/social-security/>

²⁵ Op. cit. note 23

²⁶ W. Van Biesen, N. Lameire, P. Peeters, R. Vanholder, “Belgium’s mixed private/public health care system and its impact on the cost of end-stage

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Although there are several health insurance companies, the social security system reimburses them equally for medical services. Competition between mutual health insurance funds, therefore, is based on the quality of services provided and on their complementary service offer.

With the law of 26 April 2010²⁷, which came into effect on 1 January 2012, individuals affiliated to one of the mutual insurance plans are obliged to subscribe to supplementary activities and services, such as prevention or welfare services, by paying a contribution if these services are offered by the sickness fund (e.g. orthodontic treatments, homeopathic care, birth grants).

Article 67 of the 2010 Law mentions that no segmentation of contributions is allowed but there can be differentiation based on household composition or social status, in accordance with Article 37 of the Law of 14 July 1994 on Compulsory Medical Care and Sickness Benefit Insurance.²⁸ Moreover, the annual contribution may vary from one mutual insurance plan to another, from €30 to €250.²⁹

An alternative for destitute people (provided they have permission to reside) is to be affiliated to the CAAMI-HZIV, which is free. The CAAMI-HZIV provides access to all services covered by the RIZIV-INAMI nomenclature, but not to any supplementary services.³⁰

Accessing Belgium healthcare system

Nationals and authorised residents in Belgium must register with a health

renal disease”, *the International Journal of Health Care Finance and Economics*, 2007

<https://biblio.ugent.be/publication/519184>

²⁷Law of 26 April 2010,

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2010042607&table_name=loi

²⁸Law of 14 July 1994,

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1994071438&table_name=loi

insurance company of their choice. They pay contributions for their membership as well as a fixed amount established by law for the cost of the services.

Nationals and authorised residents must pay in advance for the medical consultation fees charged by the doctor or hospital. They must submit their receipts for reimbursement and the money is then paid directly into the claimant’s bank account. In general, the cost of a GP consultation is €25.³¹ The health insurance company reimburses €19 leaving €6 paid by the patient.³² It should be noted that some individuals, depending on their means, pay less for most medical services.³³ The local public social welfare centre (*Centre Public d’Action Sociale – CPAS* (in French) and *Openbaar Centrum voor Maatschappelijk Welzijn – OCMW* (in Dutch)) may also decide – in their internal policy – to contribute to the medical costs of authorised residents who are too destitute to pay for important health expenses.

To join a health insurance company, a membership application must be submitted to one of the mutual insurance plans or to the CAAMI-HZIV. Being private organisations, the mutual insurance plans may refuse membership to an applicant. The public fund, however, may not refuse membership to an applicant. This guarantees the availability of health insurance to all Belgians. The individual is bound by his/her choice of mutual insurance plan or the CAAMI-HZIV for a one-year period. One advantage is that if affiliated members become undocumented, they keep

²⁹ L. Baekelandt, « La cotisation de mutuelle est désormais obligatoire », *Plusmagazine.be*, 26 January 2012, <http://plusmagazine.levif.be/fr/011-1548-La-cotisation-de-mutuelle-est-desormaisobligatoire.html>

³⁰<https://www.caami-hziv.fgov.be/fr/devenir-membre>

³¹http://www.riziv.fgov.be/SiteCollectionDocument/s/tarif_medecins_partie01_20170101_corr01.pdf

³² Op. cit. note 30

³³http://www.belgium.be/fr/sante/cout_des_soins/remboursements_specifiques/

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their healthcare coverage for up to a year after their last payment. Dependent children are bound by their parents' choice.

The contents of the mandatory health insurance organised by RIZIV-INAMI is determined by the RIZIV-INAMI nomenclature³⁴, which lists over 8,000 partially or fully reimbursable services. RIZIV-INAMI contributes to the cost of medication to different degrees, according to medical necessity (the degree of seriousness of the pathology in the absence of treatment)³⁵ and has also frozen the prices of essential drugs. Thus, eight categories of drugs have been defined.³⁶

Access to healthcare for migrants

Asylum seekers, refugees and those eligible for subsidiary protection³⁷

The 2007 law on the reception of asylum seekers and other categories of foreign nationals and stateless people³⁸ defines the entitlement of asylum seekers to medical care. According to this law, all asylum seekers are entitled free of charge to health services in order to guarantee them a life in conditions of human dignity. Access to

³⁴http://www.inami.fgov.be/fr/nomenclature/nomenclature/Pages/default.aspx#.VL5oNkeG_94

³⁵ I. Cleemput and al. « Détermination du ticket modérateur en fonction de la valeur sociétale de la prestation ou du produit », Health Services Research (HSR), Bruxelles : Centre Fédéral d'Expertise des Soins de Santé (KCE), KCE Report 186BS, 2012. https://kce.fgov.be/sites/default/files/page_documents/KCE_186B_determination_ticket_moderateur_syntthese_second_print_0.pdf

³⁶ Category A: drugs of vital importance (cancer or diabetes treatment); category B: therapy treatment (antibiotics); category C: drugs with symptoms effects; category Cs: vaccine against flu; category Cx: contraceptives; category Fa: drugs of vital importance for which the reimbursed part is fixed; category Fb: essential drugs for which the reimbursed part is fixed; category D: drugs considered not "essential" and consequently not reimbursable such as vitamins, but also paracetamol. All patients, including those on a low income, must pay the full cost of D medication, whatever aid mechanism they benefit from.

healthcare services is based on the RIZIV-INAMI nomenclature with two exceptions:

- Healthcare services which are listed in the RIZIV-INAMI nomenclature but not applicable to asylum seekers because these services are not considered as necessary in order to lead a life in keeping with human dignity (orthodontics, infertility treatment, etc.)
- Healthcare services, which are not listed in the RIZIV-INAMI nomenclature but are granted to asylum seekers, as they are part of daily life (certain category D drugs, glasses for children, etc.).

Asylum seekers living in a reception centre are also entitled to free medical services not included in the RIZIV-INAMI nomenclature. These services are listed in the royal decree of 9 April 2007³⁹ and include:

- Orthodontics
- Investigation and treatment of infertility
- Dentures, when there is no chewing problem

<http://www.inami.fgov.be/fr/themes/cout-remboursement/par-mutualite/medicament-produits->

[sante/remboursement/specialites/Pages/liste-specialites-pharmaceutiques-remboursables-categories-remboursement.aspx#.WUqEYOGPcs](http://www.inami.fgov.be/fr/themes/cout-remboursement/par-mutualite/medicament-produits-sante/remboursement/specialites/Pages/liste-specialites-pharmaceutiques-remboursables-categories-remboursement.aspx#.WUqEYOGPcs)

³⁷ Anyone who is not entitled, does not respond, according to the Belgian asylum authorities, to asylum in the refugee definition may nevertheless be eligible for subsidiary protection if he/she is actually exposed to serious threats if he/she returned to their country of origin.

³⁸ *Law on the reception of asylum seekers and other categories of foreign nationals and stateless people – 2007*

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2007011252&table_name=loi

³⁹ *Royal decree of 9 April 2007*

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2007040946&table_name=loi

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- Cosmetic procedures, except reconstruction after surgery or trauma
- Dental care under general anaesthesia

It is to be noted that the OCMW-CPAS hosting asylum seekers are only reimbursed for medical care following the nomenclature, thus, medical care not included in it will not be reimbursed to the OCMW-CPAS.⁴⁰

While living in a reception centre, asylum seekers' medical expenses are normally covered by *Fedasil* (*Agence fédérale pour l'accueil des demandeurs d'asile – federaal agentschap voor de opvang van asielzoekers* – the federal agency for reception of asylum seekers) or one of its reception partners. If they do not live in a centre (“no shows”)⁴¹, they must obtain a “payment warranty” (“*réquisitoire*”) before they can receive care and treatment without having to pay. If they do not obtain this payment warranty, the doctor must attach a certificate to their bill, to prove that the treatment was necessary. The administrative procedure is quite complicated and many healthcare providers are unfamiliar with it.

Individuals who go through the asylum procedure and obtain protection in Belgium under the UN Refugee Convention of 1951 are described as “*recognised refugees*”.⁴² They receive a Certificate of Inscription in the Register of Foreign Nationals (*Certificat d’Inscription au Registre des Étrangers CIRE – Bewijs van inschrijving in het vreemdelingenregister BIVR*) which remains valid for one year and is renewable on request.⁴³ The CIRE-BIVR gives them

entitlement to health insurance under the RIZIV-INAMI scheme.⁴⁴

After four months since the beginning of the asylum procedure, asylum seekers have the right to work. If they do, they can join a health insurance.⁴⁵

Pregnant asylum seekers and refugees

Pregnant women seeking asylum or who have obtained refugee status have access to antenatal, delivery and postnatal care as authorised residents. They also have access to free termination of pregnancy within the legal period (up to 12 weeks).

Children of asylum seekers and refugees

Children of asylum seekers and children of refugees have access to the same healthcare as adult asylum seekers, but also to vaccinations as authorised residents under the RIZIV-INAMI scheme.

Undocumented migrants

In Belgium, undocumented migrants have access to healthcare through the Urgent Medical Aid (*Aide Médicale Urgente – AMU in French and Dringende Medische Hulp – DMH in Dutch*) specified in the Royal Decree of 12 December 1996 relating to “*urgent medical assistance granted by the OCMW-CPAS to foreign nationals residing in Belgium illegally*”.⁴⁶ Despite its name, AMU-DMH covers both preventive and curative care, and individuals entitled to this medical coverage must be granted access to health services beyond emergency care.

Obtaining AMU-DMH⁴⁷ is subject to four conditions. The individual must:

- Be an undocumented migrant

⁴⁰<http://www.medimmigrant.be/?idbericht=24&idmenu=2&lang=fr>

⁴¹ Asylum seekers who are not living in a reception structure are called “no shows”.

⁴²<http://www.medimmigrant.be/index.asp?idbericht=193&idmenu=2&lang=fr>

⁴³ Ibid.

⁴⁴ Op. cit. note 38

⁴⁵ Op. cit. note 40

⁴⁶<http://www.medimmigrant.be/uploads/tijdelijk/AR%2012%20DECEMBRE%201996%20modificati ons%20MB%20juillet%202014.docx>

⁴⁷<http://www.medimmigrant.be/?idbericht=50&idmenu=3&lang=fr>

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- Obtain a medical certificate proving health needs signed by a doctor;
- Prove their place of residence in a municipality;
- Prove their lack of financial resources through a mandatory social inquiry from the OCMW-CPAS.

The OCMW-CPAS must check whether the claimant is undocumented, regardless of how s/he entered Belgium. The claimant is asked many questions: on arrival conditions (illegally, visa, etc.) and on administrative formalities in Belgium (request for regularisation, asylum, etc.). Questions may vary considerably from one OCMW-CPAS to another.

The circular of 25 March 2010⁴⁸ on the social investigation required for the reimbursement of medical charges specifies that each OCMW-CPAS must understand how it can establish the destitute situation of the claimant. On this point, the law is not sufficiently specific and leaves room for arbitrary treatment.

In addition, the Law of 30 December 2009⁴⁹, states that in the case of AMU-DMH requests, social investigations must be systematic. These provisions added the following subsection to Article 11 Section 1 of 2 April 1965 on the funding of healthcare provided by the OCMW-CPAS: *“the reimbursement of the charges specified in the aforementioned Article 4 may only be made if a social investigation carried out beforehand certifies the existence and extent of the need for social assistance”*.⁵⁰

During the home visit, the OCMW-CPAS representative requests personal documents, such as the lease, rent receipts, invoices and certificate from cohabitants, etc. The

circular of 25 March 2010 notes that the OCMW-CPAS may conduct its investigation by the means it judges appropriate. An important barrier to accessing healthcare is that the social investigation can take up to a month (as defined by law). Health problems might become more serious after such a long period of time. Another barrier for access to healthcare is the fact that the first doctor’s consultation in order to obtain the medical certificate proving health needs, has to be paid by the undocumented migrant.

Moreover, many undocumented migrants have difficulty proving their *“place of residence”*, particularly if they are temporarily staying with friends, in churches, in shelters or are rough sleeping. Often considerable discretion is exercised at local level to decide what constitutes sufficient evidence of place of residence.⁵¹

In practice, this freedom concerning assessment at the discretion of each OCMW-CPAS seems to be a source of insecurity for applicants, as there is no visibility concerning the criteria used to assess their situation. It also means that these criteria are different depending on where in Belgium undocumented migrants sleep.

This mandatory social investigation is very intrusive in the claimant’s life and in the life of those who host them. It often prevents individuals entitled to the AMU-DMH from submitting a request to benefit from it. Furthermore, an OCMW-CPAS can refuse AMU-DMH due to the applicants’ alleged refusal to collaborate with the social investigation.

If all the conditions are fulfilled, the claimant may benefit from healthcare

⁴⁸Circular of 25 March 2010, <http://www.ejustice.just.fgov.be/cgi/api2.pl?lg=fr&pd=2010-05-06&numac=2010011203>

⁴⁹Law of 30 December 2009 http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2009123001&table_name=loi

⁵⁰ Ibid.

⁵¹ European Union Agency for Fundamental Rights (FRA), *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*, Luxembourg, 2011.

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coverage (AMU-DMH). The parameters of this coverage, such as the period for which AMU-DMH is granted (ranging from one consultation to one year for chronically ill patients), or which (local) healthcare providers can be consulted and how to ask a healthcare provider for care or treatment, are defined by the concerned OCMW-CPAS.⁵²

Overall, once an undocumented migrant is entitled to AMU-DMH, his/her healthcare expenses will be directly reimbursed to health professionals by the OCMW-CPAS or the federal authorities, except for those who do not have a RIZIV-INAMI nomenclature code.

Healthcare providers can refuse to treat an undocumented migrant who has a medical card granted from an OCMW-CPAS in another region, because the OCMW-CPAS might not reimburse the costs of care.⁵³ If a person makes an appointment with a doctor before receiving the certificate from the OCMW-CPAS they must pay for the appointment themselves and the OCMW-CPAS often refuses to reimburse the costs because it did not agree to the appointment and had not yet granted AMU-DMH. Some OCMW-CPAS collaborate with doctors or put in place a system with a first free consultation in order to make the process easier for patients but others do not make such an effort.⁵⁴

Undocumented pregnant women

As mentioned above, the Royal decree refers to “urgent care”, a term that might well be misleading as the AMU-DMH encompasses a broad range of preventive,

primary and secondary health services, including maternal care.

Undocumented pregnant women must have full free access to antenatal and postnatal care as authorised residents if they have obtained AMU-DMH.

Postnatal follow-up care is financed and organised by the federated entities: the Birth and Childhood Offices (the *Office de la Naissance et de l’Enfance* (in French) and the *Kind en Gezin* (in Dutch)). Access to Community-financed postnatal consultations is free of charge for all women, even without AMU-DMH coverage.

However, certain OCMW-CPAS, often due to unwillingness or lack of awareness, impede access to health services for undocumented migrants, including pregnant women, refusing to grant AMU-DMH.

Pregnancy termination is covered by the AMU-DMH. However, pregnant women must respect the legal period of 12 weeks of pregnancy for termination, even though the OCMW-CPAS response to the AMU-DMH application usually comes one month later.⁵⁵ In practice, between the pregnancy being certified and AMU-DMH being granted, those 12 weeks have already passed. However, certain OCMW-CPAS have reached agreements with hospitals in order to speed up the procedure.⁵⁶

Therefore, pregnant women usually prefer to try to find the money for the termination and pay it directly to the practitioner.⁵⁷

⁵²https://kce.fgov.be/sites/default/files/page_documents/KCE_257B_Soins_de_sante_migrants_Synthese.pdf

⁵³ Ibid.

⁵⁴Platform for International Cooperation on Undocumented Migrants (PICUM), *Undocumented Migrants’ Health Needs and Strategies to Access Health Care in 17 EU countries, Country Report Belgium*, June 2010,

<http://files.nowhereland.info/706.pdf>

⁵⁵<http://www.viefeminine.be/spip.php?article2701>

⁵⁶<http://www.medimmigrant.be/?idbericht=273&idmenu=4&lang=fr>

⁵⁷INAMI, Kluwer a Wolters Kluwer Business, Médecins du Monde, *Livre vert sur l’accès aux soins en Belgique*, Waterloo, 2014.

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If they succeed in being covered by AMU-DMH, they pay €1.80 for the preliminary examination and €1.80 for the medical procedure. For pregnant women who do not have health coverage, termination of pregnancy costs €460.

Children of undocumented migrants

Children are entitled to the same healthcare as undocumented adults. They must obtain AMU-DMH in order to gain access to curative healthcare.

Since 2004, children are entitled to receive benefits in kind (accommodation, food, clothes, medical and social assistance).⁵⁸

As regards preventive healthcare, every child under the age of six has free access to vaccinations through the Birth and Childhood Office (*Office de la Naissance et de l'Enfance – Kind en Gezin*). After the age of six, they must obtain AMU-DMH like adults for all curative and preventive care.

EU mobile citizens

France and Belgium are the only member states to include – under strict conditions – destitute EU migrants in their healthcare system for undocumented migrants. Yet for many OCMW-CPAS, this right remains merely theoretical, as EU mobile citizens are faced with several administrative barriers.

The Law of 19 January 2012⁵⁹ confirmed the practices of a majority of OCMW-CPAS: access to healthcare for destitute EU migrants was restricted. This law, modifying legislation relating to the reception of asylum seekers, adds Article 57

⁵⁸http://www.ocmw-info-cpas.be/images/uploads_x/FV_aidemedicaleurgente_Fr.pdf

⁵⁹ *Law of 19 January 2012*
http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2012011913

⁶⁰ *Law of 8 July 1976*,

quinquies to the Organic Law of 8 July 1976⁶⁰ relating to OCMW-CPAS centres, according to which:

“Notwithstanding the provision of this law, the centre is not obliged to provide social assistance to European Union Member State nationals or members of their families during the first three months of their stay or, if applicable, during the longer period provided for in Article 40, Section 4, Subsection 1, of the law of 15 December 1980 on access to the territory, residence, establishment and return of foreign nationals, neither is it obliged, prior to the acquisition of the right of permanent residence, to grant maintenance assistance.” This legal provision came into force in February 2012.

However, on 30 June 2014⁶¹, the Constitutional Court of Belgium ruled that Article 12 of the Law of 19 January 2012 breaches Article 10 and 11 of the Constitution in that it allows OCMW-CPAS to refuse AMU-DMH to EU citizens during the first three months of their stay in Belgium. Indeed, this measure creates a difference of treatment, which is discriminatory to EU citizens and their family members, since they cannot claim for AMU-DMH to OCMW-CPAS, whereas extra-European undocumented migrants in Belgium can benefit from AMU-DMH. This judgment is directly binding and so partially abolished the interpretation of Article 57 quinquies of the Law of 8 July 1976 modified by the Law of 19 January 2012.

Since then, a circular of 5 August 2014⁶² has been adopted in order to warn OCMW-

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1976070801&table_name=loi

⁶¹ Judgement of the Constitutional Court, 30 June 2014,
<http://www.const-court.be/public/f/2014/2014-095f.pdf>

⁶² *Circular of 5 August 2014*,
http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl?s ql=%28text%20contains%20%28%27%27%29%29

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CPAS presidents about the new interpretation of Article 57 quinquies.

The Constitutional Court considers that Article 57 quinquies must be read as follows:

- Persons who fall within the scope of this article are not precluded from the right to AMU-DMH;
- EU mobile citizens residing in Belgium, whether or not they are employed, are not temporarily precluded from the right to social aid.

Therefore, in the light of this judgment, EU migrants in Belgium must have access to AMU-DMH during the first three months of their stay.

Pregnant women and children who are EU mobile citizens should have access to AMU-DMH as other undocumented migrants.

However, access to termination of pregnancy for pregnant EU women is complex due to the legal period of 12 weeks and the length of time necessary for the application to the AMU-DMH to be processed.

Unaccompanied minors

Initially, the law made a distinction between unaccompanied EU minors and unaccompanied minors from non-EU countries. The protection granted to third-country-national unaccompanied minors was much greater than the one for unaccompanied EU minors.

As a result of the Constitutional Court's judgment of 18 July 2013, the law of 12 May 2014⁶³ was adopted and modified the Programme Law of 24 December 2002.⁶⁴

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&rech=1&tri=dd%20AS%20RANK&value=&table_name=loi&F=&cn=2014080501&caller=image_al&fromtab=loi&la=F

⁶³ Law of 12 May 2014,

http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2002122445

This law added a new Article 5/1 without prejudice to Article 5 of the Programme Law providing for the guardianship of third-country unaccompanied minors. Article 5/1 provides that the guardianship referred to in Article 3, §1st, al 1st, shall apply to “nationals of European Economic Area (EEA) countries”.

Thus, whether the unaccompanied minors are EU citizens or not, they have the same protection under Belgian law. Article 10§1 of the Law of 24 December 2014 states that “the guardian ensures that the minor goes to school and receives psychological support and appropriate medical care”.

Therefore, unaccompanied minors have access to healthcare under the RIZIV-INAMI scheme.

However, unlike unaccompanied minors, unaccompanied EU minors are not entitled to accommodation via *Fedasil* because the law of 12 January 2007 on reception has not been modified accordingly.⁶⁵

Moreover, the 25 July 2008 circular determines the conditions for access to health coverage for third-country unaccompanied minors (and, since 2014, for unaccompanied minors from an EEA country):

- Going to school for three consecutive months at an educational establishment recognised by a Belgian authority;
- Being registered at a Birth and Childhood Office or registered at an establishment of preschool education;
- The minor is not required to go to school by the competent regional service.

⁶⁴ Programme Law of 24 December 2002, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2002122445&table_name=loi

⁶⁵ <http://www.dgde.cfwb.be/index.php?id=2803>

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Consequently, unaccompanied minors, especially older ones have to wait three months before accessing healthcare.

Protection of seriously ill foreign nationals

In Belgium, by law, seriously ill foreign nationals benefit from special protection, which prevents the authorities from expelling them to their country of origin or the country where they are resident.

Indeed, according Article 9ter of the Law of 15 December 1980 on access to Belgium, residence, establishment and return of foreign nationals⁶⁶, *“a foreign national residing in Belgium who proves his/her identity in accordance with §2 and who suffers from a disease which causes a real risk to his/her life or physical integrity or a real risk of inhuman or degrading treatment if there is no adequate treatment in his/her country of origin or in the country where s/he stays can request a residence permit for Belgium from the Minister or his/her representative (...) The foreign national delivers with the applications all relevant and recent information regarding his/her illness and the possibility of and access to adequate treatment in his/her country of origin or in the country where s/he stays”*.

This procedure includes two very long phases: the admissibility of the application and the substantive decision.

The admissibility of the application

A representative of the Immigration Office (*Office des étrangers/Vreemdelingenzaken*) examines whether the formal requirements for the submission of the application are met (proof of identity, medical certificate issued less than three months ago clearly indicating the condition, its severity and estimated treatment needed,

etc.). Once the request has been submitted, the medical officer of the Immigration Office is responsible, since the introduction of a medical filter in February 2012, for assessing whether the illness is serious enough. If the condition clearly does not meet the threshold of gravity, that is to say, it does not cause a real risk to life or physical integrity or risk of inhuman or degrading treatment, the application of Article 9ter may be declared inadmissible.

If the application is deemed complete, passes the medical filter and the residential investigation conducted by the municipality is positive (it means that homeless people cannot apply for 9ter) the Immigration Office declares Article 9ter admissible and issues a certificate of registration, known as an “Orange Card” for three months. This certificate can be renewed three times for a further three months and then every month until the Immigration Office takes a substantive decision. This card does not entitle the holder to access a health insurance fund or employment. However, the holder can request AMU-DMH from the OCMW-CPAS of their place of residence.⁶⁷

The substantive decision

The Immigration Office examines whether the necessary treatment for the individual’s condition is available in their country of origin or in the country where they are resident. In theory, this involves a review of the availability but also the accessibility of the treatment. If the administration and the medical officer judge that the treatment is not available or not accessible, a one-year residence permit is granted.

In practice, the Immigration Office bases its decision on the degree of severity of the illness. The foreign national must be extremely ill to be granted a one-year residence permit under Article 9ter. This

⁶⁶ *Law of 15 December 1980*, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1980121530&table_name=loi

⁶⁷ <http://www.medimmigrant.be/index.asp?idbericht=74&idmenu=5&state=72&lang=fr>

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residence permit enables the holder to join a health insurance fund, to access the labour market and to benefit from social assistance from the OCMW-CPAS if they are destitute. Alternatively, the individual will be issued with a reasoned negative decision and an order to leave Belgium. The individual can appeal the decision to the Council for Foreigners Law Litigation (*Conseil du Contentieux des Etrangers*).⁶⁸

In the judgment of the Court of Justice of the European Union (Grand Chamber) of 18 December 2014⁶⁹, the Court rules that Article 9ter of the Law of 15 December 1980 violates Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

Indeed, Article 9ter violates the Directive because it does not grant a suspensive effect to the appeal against a negative decision which orders a seriously ill third-country national to leave the territory of a Member State, when the execution of the decision may expose the third-country national to a substantial risk of serious and irreversible damage to their health; and because the law does not provide, as far as possible, the support of basic needs to the third-country national in order to ensure that emergency medical care and essential treatment of diseases can be effectively provided during the period in which the Member State shall postpone the expulsion of the same third-country national following the appeal of the decision.

Thus, since this judgment, the appeal against a negative decision from the Immigration Office should be suspensive. It means that seriously ill foreign nationals

who appeal the decision must still benefit from AMU-DMH and can stay in Belgium during the appeal. However, the appeal is not automatically suspensive and a request of suspension has to be made to the *Conseil du contentieux des étrangers* (the competent jurisdiction for the appeal).⁷⁰

The European Court of Human Rights and the Paposhvili v. Belgium case

Over the last decades, the European Court of Human Rights (ECtHR) has ruled several times in cases related to the expulsion of seriously ill migrants. Article 3 of the European Convention on Human Rights (ECHR) protects a person from being expelled, when there are substantial grounds for believing there is a real risk of being subjected to an inhuman or degrading treatment. Until December 2016, in cases concerning the removal of a foreigner suffering from serious illness the ECtHR used to rule that only in a very exceptional case a medical condition may raise an issue under Article 3. This "*very exceptional case*" only applied to a person at imminent risk of dying. In a recent decision in the case *Paposhvili v. Belgium* of 13 December 2016 the ECtHR has departed from the excessively restrictive approach.

In the case *Paposhvili v. Belgium* the ECtHR ruled that "*article 3 should be understood to refer to situations involving the removal of a seriously ill person, in which substantial grounds have been shown for believing that s/he, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country, or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his/her state of health resulting in*

⁶⁸<http://www.medimmigrant.be/index.asp?idbericht=74&idmenu=5&state=72&lang=fr>

⁶⁹*Centre public d'action sociale d'Ottignies-Louvain-la-Neuve v Moussa Abdida*, 18 December 2014, Judgement of the Court of Justice of the European Union (Grand Chamber),

<http://curia.europa.eu/juris/celex.jsf?celex=62013CJ0562&lang1=fr&type=TXT&ancre>

⁷⁰<http://www.medimmigrant.be/index.asp?idbericht=74&idmenu=5&state=72&lang=fr>

*intense suffering or to a significant reduction in life expectancy”.*⁷¹ Moreover, “*Where, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the persons concerned – on account of the general situation in the receiving country and/or their individual situation – the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the persons concerned so that they do not find themselves in a situation contrary to Article 3”.*⁷²

The decision shows that the question of availability and accessibility should be part of the assessment whether a seriously ill migrant needs to be granted protection from removal from Belgium.

Prevention and treatment of infectious diseases

The Royal Decree of 1 March 1971⁷³ on the prevention of contagious diseases covers the list of notifiable diseases on Belgian territory.

The Royal Decree of 13 January 2003 modifying the Royal Decree of 12 December 1996 states in its article 1 that “*in case of infectious disease, recognised as such by the competent authorities and subjected to prophylactic measures, the AMU-DMH granted to a patient must ensure the continuity of care if they are essential to the overall public health”.*⁷⁴

The Respiratory Diseases Fund (*Fonds des Affections Respiratoires – FARES*) and the Respiratory Healthcare and Tuberculosis Association (*Vereniging voor Respiratoire*

Gezondheidszorg en Tuberculosebestrijding – VRGT) offer free screening for tuberculosis to all those who request it (without taking into account residence status) and provide free treatment and follow-up in the case of a positive result.

A number of referral centres offer Sexually Transmitted Infections (STI) screening upon request. Although screening is free (and anonymous) for anyone without medical insurance, these centres are obliged to check systematically whether the patient has medical insurance, which is an additional threshold.

Furthermore, most of these referral centres cannot guarantee the provision of treatment if the individual does not have access to healthcare.

Access to organ transplantation for foreign people

Article 13ter of the Law on organ removal and organ transplantation, states that “*to be registered as a recipient candidate in a Belgian transplant centre, an individual must either have the Belgian nationality or to be registered in the population register, or for at least 6 months in the foreigner register, or have the nationality of a state that shares the same organ allocation organisation, or have been domiciled in that state for at least 6 months”.* Thus, undocumented migrants and foreigners who have been residing in Belgium for more than 6 months cannot receive an organ transplant.

⁷¹ Case of *Paposhvili v. Belgium*, 13 December 2016, paragraph 183

⁷² Case of *Paposhvili v. Belgium*, 13 December 2016, paragraph 191

⁷³ Royal decree of 1 march 1971

http://www.gallilex.cfwb.be/document/pdf/24713_000.pdf

⁷⁴ Royal Decree of 13 January 2003 http://www.etaamb.be/fr/arrete-royal-du-13-janvier-2003_n2003022014.html

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National Health System

Constitutional basis

The Preamble to the Constitution of 27 October 1946⁷⁵, the Declaration of the Rights of Man and of the Citizen of 26 August 1789 as well as the Charter for the Environment of 2004⁷⁶ have formed part of the “*constitutional block*”, together with the Constitution of 4 October 1958, since the decision of the Constitutional Council in 1971.

Firstly, the Preamble to the Constitution guarantees in paragraph 11 “*to all, notably to children, mothers and elderly workers, protection of their health, material security, rest and leisure. All people who, by virtue of their age, physical or mental condition, or economic situation, are incapable of working shall have to the right to receive suitable means of existence from society*”.⁷⁷

Moreover, the Charter for the Environment of 2004 declares that “*everyone has the right to live in a balanced environment which shows due respect for health*”.⁷⁸

Organisation and funding of French healthcare system

Healthcare in France is characterised by a social security system based on solidarity, which was created after the Second World War as conceived by the Resistance: all

citizens contribute according to their means and receive healthcare services according to their needs. Article L. 1110-1 of the Public Health Code states that, “*health providers, health facilities [...] contribute to [...] guaranteeing equal access to healthcare for each individual as required by their health condition*”.⁷⁹

Healthcare is managed almost entirely by the state and publicly financed through employee and employer payroll contributions and earmarked income taxes, revenue from taxes levied on tobacco and alcohol and state subsidies and transfers from other branches of social security.⁸⁰

The health insurance system is dominated by the National Health Insurance Fund for Salaried Workers (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés – CNAMTS*).⁸¹ It covers the majority of the population, including beneficiaries of universal medical protection (PUMA).

Other basic funds cover specific occupational groups: for instance, the agricultural scheme (*Mutualité Sociale Agricole – MSA*) or the scheme for the self-employed (*Régime Social des Indépendants – RSI*).⁸²

These three main schemes (CNAMTS, MSA and RSI) were federated into a National Union of Health Insurance Funds (*Union Nationale des Caisses d'Assurance Maladie – UNCAM*) by the 2004 health

⁷⁵Preamble to the Constitution of 1946, http://www.conseil-constitutionnel.fr/conseil-constitutionnel/root/bank_mm/anglais/cst3.pdf

⁷⁶Constitutional Law of 2 March 2005 related to the 2004 Charter for the Environment, <http://www.legifrance.gouv.fr/Droit-francais/Constitution/Charte-de-l-environnement-de-2004>

⁷⁷Preamble to the Constitution of 1946

⁷⁸Op. cit. note 76

⁷⁹Article L. 1110-1 of the Public Health Code, http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=L_EGIARTI000006685741&dateTexte=&categorieLien=cid

⁸⁰The Commonwealth Fund, *INTERNATIONAL PROFILES of Health Care Systems, Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*, New-York, 2013

<http://www.commonwealthfund.org/publications/fund-reports/2013/nov/international-profiles-of-health-care-systems>

⁸¹Civitas, *Health care Systems: France*, updated by Emily Clarke (2012) and Elliot Bidgood (January 2013), Based on the 2001 Civitas Report by David Green and Benedict Irvine, <http://civitas.org.uk/content/files/france.pdf>

⁸²Ibid.

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insurance reform.⁸³ This federation has become the sole representative of the insured people in negotiations with healthcare providers.

The Primary Health Insurance Funds (*Caisses Primaire d'Assurance Maladie – CPAMs*) are responsible for the reimbursement of claims and benefits.⁸⁴ They also manage preventive services and general health and social care in their area.⁸⁵

The former Regional Health Insurance Funds (*Caisses Régionales d'Assurance Maladie – CRAMs*) which now fall under their respective Regional Health Agencies (*Agences Régionales de Santé – ARS*), assume responsibility for the CPAMs in their area.⁸⁶

For the majority of patients, medical goods and services are not free at the point of use.

Accessing France healthcare system

All residents are entitled to receive publicly financed healthcare through statutory health insurance from non-competitive statutory health insurance funds - statutory entities whose membership is based on occupation.⁸⁷ Statutory health insurance fund eligibility is granted either through employment (to salaried or self-employed working people and their children) or as a benefit to those formerly employed who have lost their jobs (and their children), students and retired people.⁸⁸ In addition, universal access is guaranteed for those on low incomes and/or with chronic conditions⁸⁹ who also fulfil the condition of residence.

⁸³ K. Chevreul et al., “France: Health system review”, *Health Systems in Transition*, Vol 12, No 6, 2010, http://www.euro.who.int/data/assets/pdf_file/0008/135809/E94856.pdf

⁸⁴ Ibid.

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Op. cit. note 80

⁸⁸ Op. cit. note 80

⁸⁹ Op. cit. note 80

French citizens residing in France for more than three months⁹⁰ and foreign nationals with permission to reside or who have started a regularisation process, must register with their local CPAM for national health insurance coverage.⁹¹ Having done this, an individual is issued with a medical card, called *carte vitale*, which indicates the individual's national insurance rights in electronic form.⁹² This card is not a means of payment, but this electronic treatment does facilitate a quicker reimbursement and simplifies the procedure for health professionals and patients.

The rate of health insurance system coverage (reimbursement) varies across goods and services but there are several reasons for patients being exempt from co-payment (*ticket modérateur*). This applies especially to those with long-term chronic illnesses (*Affections de Longue Durée – ALD*⁹³), such as diabetes and HIV/AIDS, or those who are entitled to supplementary universal medical coverage (CMU-C) or pregnant women from the first day of the sixth month of their pregnancy.⁹⁴

Statutory health insurance funds cover:

- Hospital care and treatment in public or private rehabilitation or physiotherapy institutions;
- Outpatient care provided by general practitioners (GPs), specialists, dentists and midwives;
- Diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals (nurses, physiotherapists, speech therapists, etc.);

⁹⁰ The article D 160-2 II of the Social Security Code provides 5 exemptions

⁹¹ Op. cit. note 81

⁹² Op. cit. note 81

⁹³ List of long-term chronic illnesses http://www.fondshs.fr/Media/Default/Images/Ressources-Allocations/Liste_des_ALD_30.pdf

⁹⁴ <http://www.ameli.fr/assures/soins-et-remboursements/ce-qui-est-a-votre-charge/le-ticket-moderateur.php>

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- Prescription drugs, medical appliances and prostheses that have been approved for reimbursement; and
- Prescribed healthcare-related transport.⁹⁵

Statutory health insurance also partially covers long-term and mental healthcare and provides minimal coverage of outpatient vision and dental care.⁹⁶

Universal Medical Coverage: PUMA and CMU-C

The French Universal Medical Coverage is divided in two separate schemes, both intended to ensure a health coverage for the entire population, included destitute individuals: the Universal Medical Protection (PUMA), which allows free access to basic health insurance benefits, and the Complementary Universal Medical Coverage (CMU-C), which allows to additionally benefit from a free complementary health insurance.

Since January 1st, 2016, the PUMA (Universal Medical Protection), created by the Social Security Financing Act of 2016⁹⁷ has replaced the basic Universal Medical Coverage (CMU).

The CMU basic universal coverage, created by the CMU Law of 27 July 1999⁹⁸, enabled people who were not covered by the health insurance scheme to have access to healthcare. The PUMA extended the scope of the health coverage system: any person who works or lives legally in France in a stable manner for over three months has the right to obtain a health coverage (including asylum seekers upon the submission of their

request, without waiting for the three months).

This evolution makes it easier to access healthcare and allows its continuity, even during periods of unemployment. The status of *ayant droit*, giving rights to health coverage to partners of individuals who are entitled to it has also been suppressed for adults: it became useless as any individual living legally and in a stable manner in France, even unemployed, has now access to the Universal Medical protection, independently from his/her partner. This reform therefore allowed an individualisation of access to healthcare.

However, this reform also led to an intensification of the control of the beneficiary's residence. Besides, the decrees implementing the PUMA reform make it difficult to holders of residency permits or asylum requests to access the PUMA scheme and may cause delays in obtaining their health insurance coverage. The complexification of the administrative procedures may thus alter the achievements of the former CMU.

The Universal Medical protection does not concern undocumented migrants, who are covered by a specific scheme called AME (see below).

PUMA: Universal Medical Protection

The Universal Medical Protection allows those eligible to be covered by the basic health care scheme. The conditions of eligibility are to work and/or to live in France in a legal and stable manner. To meet the residency condition, an individual must live in France (mainland France⁹⁹ or the French overseas departments

⁹⁵ Op. cit. note 80

⁹⁶ Op. cit. note 80

⁹⁷ <https://www.legifrance.gouv.fr/eli/loi/2015/12/21/FCPX1523191L/jo/texte>

⁹⁸ *Basic Universal Coverage (CMU) Law of 27 July 1999*, <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000198392>

⁹⁹ The country of France comprises metropolitan France, including the islands around its coast and Corsica, and a number of overseas departments and territories outside the continent of Europe. In this report the term "mainland France" is used to describe all of France excluding the overseas departments and territories.

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(*Départements d’Outre-Mer – DOM*), with the exception of Mayotte where the scheme is different (see below)) continuously for more than three months.¹⁰⁰ Foreign nationals must additionally¹⁰¹ prove the legality of their residency. EU citizens have a specific status (see below). This condition of residency is considered satisfied for asylum seekers as soon as they start their claim process, and for holders of a Temporary Residency Permit for Health Care. However, lodging a request for asylum and obtaining the necessary certificates for claiming health coverage can take quite a long time, during which the applicant is not covered.

There is no income-condition to access the PUMA. However, the PUMA is free for individuals on a low income, i.e. below €817.25 per month. Beyond this threshold, it is still possible to benefit from the PUMA, but it becomes chargeable through a contribution based on 8% of the individual’s income.¹⁰²

In practice, the patient pays for health related goods and services (medical consultations, medication, etc.) but a part of the amount will be reimbursed. As an example, for a GP consultation, costing €25 total, the health insurance reimburses the mandatory part, known as the “social security part” (€16.10) and the patient has to pay the supplementary part (€7.50) and the flat-rate contribution (€1).¹⁰³ People can take out a private complementary health insurance (called *mutuelle*) to cover the supplementary part. Children are exempted from the flat-rate contribution.

CMU-C: Complementary Universal Medical Coverage

The law introducing the PUMA had no impact on the Complementary Universal Medical Coverage, the CMU-C.

The CMU-C is a free supplementary health insurance. It enables those eligible to have free access to healthcare at the point of use, including healthcare services in hospital.

To be entitled to CMU-C, an individual must be on a low income: below €727 per month (€8,723 per year) in mainland France or below €809 per month (€9,709 per year) in the overseas departments (except Mayotte).¹⁰⁴ The same conditions of residency must be met as for the PUMA (to live in France in a legal and stable manner for more than three months).

Supplementary health insurance assistance scheme: ACS

The Complementary Health Help, called ACS (*Aide Complémentaire Santé*), was created in 2005. It provides financial assistance to access supplementary health insurance. People who have access to ACS receive financial support for supplementary health insurance of between €100 and €550 per year depending on age.¹⁰⁵

The ACS was created for people who cannot benefit from the CMU-C, but whose incomes are below the poverty threshold. To be entitled to ACS, an individual must have an income, which does not exceed the threshold for access to CMU-C by more than 35%¹⁰⁶: €11,776 per year in mainland France or €13,107 per year in the DOM, except Mayotte. The ACS is valid for one year and its renewal is not automatic.

Since July 2015, users of ACS benefit from the full third-party payment system (*tiers*

¹⁰⁰ The article D 160-2 II of the Social Security Code provides 5 exemptions

¹⁰¹ <http://www.cmu.fr/resider-en-france-stable-regulier.php>

¹⁰² <http://www.jechange.fr/assurance/mutuelle-sante/guides/la-cmu-2571>

¹⁰³ http://www.cmu.fr/les_droits_a_la_couverture_maladie.php

¹⁰⁴ <http://www.cmu.fr/plafonds.php>

¹⁰⁵ http://www.info-acs.fr/acs_qu_est_ce_que_1_acs.php

¹⁰⁶ Ibid.

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payant): they do not need to pay for their medical expenses upfront and are exempted from the €1 flat-rate payment.¹⁰⁷

The free medical centre system (*Permanence d'Accès aux Soins – PASS*)

The law against social exclusion of 29 July 1998¹⁰⁸ created the hospital PASS system on the model of MdM clinics. This system aims to enable anyone to access outpatient hospital care, even without health coverage and even before administrative procedures have been completed. This system dedicates a specific budget line for these consultations, which the hospitals can use as they choose.

Some hospitals offer a multidisciplinary set-up that places social services on the frontline: patients who wish to benefit from the PASS system must first be seen by the dedicated social service, and receive a “PASS token” to cover their consultation; some specialties will be included in the system, others will not. Other hospitals have a “dedicated PASS”: a GP service, which offers general consultations for free to those who cannot afford the consultations because they have no health coverage, have financial difficulties, etc.

Medical consultations are accompanied by a social consultation, in which social workers help gather all the necessary documents and provide information on how to get health coverage. Some PASS only agree to see patients who have a potential right to health coverage, others allow unconditional access to their services and the hospital.

On 18 June 2013, a circular on the organisation and functioning of PASS¹⁰⁹ created a regional coordination structure with a PASS framework, which evaluates every PASS in France. MdM FR participated actively in designing what a PASS should be.

In practice, the application of the PASS system is very heterogeneous and imperfect: as the system is different in every hospital, it is difficult for patients to understand and there is no guarantee that they will find the service they need at the hospital in their area of residence.

It should be noted that this scheme enables people who cannot afford consultations to gain access to outpatient care only. For any access to inpatient services, individuals must be in an emergency situation or must wait until they have health coverage.

Positive reform on eligibility criteria

The financial resources eligibility criteria for CMU-C and supplementary health insurance assistance (ACS) has been widened, to reach €981¹¹⁰ per month in March 2017.

In 2016, 1,363,506 people were using ACS in mainland and overseas France (2% of the population)¹¹¹, compared with 826,257 before the widening of the eligibility criteria.¹¹²

In 2016, 5,383,003 people (8% of the population)¹¹³ had CMU-C compared with 4,649,533 in June 2013, before the widening of the eligibility criteria.

New healthcare bill – January 2016

A new healthcare bill was adopted on 26 January 2016¹¹⁴, bringing several

¹⁰⁷ Op. cit. Note 105

¹⁰⁸ http://reaannecy.free.fr/Documents/congres/Congre_IDE/PASS_texte.pdf

¹⁰⁹ *Circular of 18 June 2013*, http://www.sante.gouv.fr/fichiers/bo/2013/13-07/ste_20130007_0000_0078.pdf

¹¹⁰ <http://www.cmu.fr/acs.php>

¹¹¹ http://www.cmu.fr/effectifs_acs.php

¹¹² http://www.cmu.fr/fichier-utilisateur/fichiers/Annuaire_statistique_12-2013.pdf

¹¹³ http://www.cmu.fr/effectifs_cmuc.php

¹¹⁴ *Law on the modernization of the healthcare system – 2016*

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significant evolutions to the French healthcare system as:

- the creation of safe supervised drug injection centres, which unlocks new opportunities regarding drug users' care and treatment;
- the expansion of the third party payment system (*tiers-payant*), widening the conditions of free access to care at point of use, aiming to reduce the amount of patients giving up seeking care¹¹⁵;
- the acknowledgement of the beneficial character of the presence of interpreters and health mediators in health structures;
- associations can call upon the High Authority for Health (*Haute Autorité de Santé – HAS*);
- the Economic Committee for Healthcare products (*Comité Economique des produits de Santé – CEPS*) can make a framework agreement with registered associations;
- midwives can now perform Voluntary Termination of Pregnancy using drugs, which expands possibilities of safe abortion
- accreditation of more organisations to distribute STD (sexually transmitted diseases) and STI (sexually transmitted infections) testing equipment and support to STI & STD prevention
- Homosexual can now be blood donors (but with restrictions)

https://www.legifrance.gouv.fr/eli/loi/2016/1/26/AF_SX1418355L/jo/texte

¹¹⁵ Only to the social security part, excluding the part reimbursed by the optional insurance. The expansion started January 2016 and shall be full on 30 November 2017

However, this law has several flaws:

- Simplification of access to rights and care should be a priority of this bill. All NGOs are waiting for the integration of the AME into the PUMA. Another expected measure is a multi-year CMU-C instead of a yearly renewal.
- Foreseen negative impact on the access to healthcare for migrants with a short permission to stay: breaches of the continuity of health coverage due to complex administrative rules¹¹⁶.
- No change to reduce refusal of healthcare. The notion of refusal to healthcare should be clearly defined, the burden of proof should be reversed and an independent observatory should examine refusals of healthcare through a situational test.
- New healthcare bill announces actions aiming to improve access to care in the overseas territories but it is still missing the opportunity to match up law in Mayotte with mainland law regarding health coverage.

Access to healthcare for migrants

Asylum seekers and refugees

According to Article R. 380-1 of the Social Security Code, asylum seekers and refugees have the same access to healthcare as authorised residents. In theory, they obtain social security health coverage upon arrival on French territory.

They have access to the PUMA and CMU-C if they fulfil the financial conditions upon

¹¹⁶For more details, see: <http://www.medecinsdumonde.org/actualites/presse/2016/03/17/reforme-de-la-protection-maladie-universelle-puma>

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the submission of their request. If they have no official documentation, they can make a sworn statement regarding their financial resources. They are exempt from the necessity to prove a three-month long residency in France.¹¹⁷

They can also apply for CMU-C, which will be granted depending on their financial resources, as mentioned above. As nationals entitled to CMU-C, all their medical expenses will be supported at the 100% rate of social security.

It should be noted that asylum seekers need to provide an address when they submit their asylum application to the prefecture, which then eventually entitles them to health coverage (PUMA and CMU-C). However, providing an address is often complicated, as asylum seekers' accommodation is usually precarious and so they must use an administrative address to receive their mail. This administrative address may be provided by entitled non-profit organisations, which are overwhelmed with requests, or a CCAS (*Centre Communal d'Action Sociale* – Community Centre for Social Action). For instance, in Paris, it may take around five months to get an address.

Some asylum seekers are excluded from the general legal system by local prefectures:

- Those who are subject to the Dublin III regulation.¹¹⁸ This Regulation establishes the principle that only one Member State is responsible for examining an asylum application and defines criteria to determine which State is responsible. If another state is examining the

¹¹⁷<http://www.cmu.fr/resider-en-france-stable-regulier.php>

¹¹⁸ *Dublin III Regulation - 2013*
<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:180:0031:0059:EN:PDF>

¹¹⁹ https://www.ldh-france.org/wp-content/uploads/2017/10/CP_Prefectures-Hors-la-loi1.pdf

asylum application, it is forbidden for the French authorities to consider it. Asylum seekers subjected to the Dublin III system are not entitled to social security but to the AME, as undocumented migrants, according to the circular n° DSS/2A/2011/351 of 8 September 2011. In October 2017, several French human rights associations have raised concern about local prefectures detaining asylum seekers subject to the Dublin III regulation before expelling them, in violation of the rulings of the Court of Justice of the European Union (of 15 March 2017) and the French Court of Cassation (of 27 September 2017).¹¹⁹

- those from “safe countries”¹²⁰ who are subject to the accelerated procedure, which denies them a temporary residence permit, while granting them the “right to stay in France” until a decision is made by the authorities about their asylum application (officially 15 days for the Office for the Protection of Refugees and Stateless Persons (OFPRA) and four days for people in an administrative detention centre¹²¹).

Thus, they can only access AME under certain conditions (three-month residence, income conditions, proof of address) and access healthcare through PASS while they have no medical coverage.

Pregnant asylum seekers and refugees

In theory, pregnant women have the same access to free of charge antenatal, delivery

¹²⁰List of the “safe countries”, considered as respectful of principles as democracy, rule of law and human rights (art. L741 CESEDA), defined by the OFPRA
http://www.ofpra.gouv.fr/sites/default/files/atoms/files/150909_ldu_liste_pos.pdf

¹²¹<https://www.service-public.fr/particuliers/vosdroits/F15376>

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and postnatal care as nationals and authorised residents.¹²² This includes termination of pregnancy.

Children of asylum seekers and refugees

In theory, children of asylum seekers and refugees have the same access to healthcare as the children of nationals or authorised residents, as children healthcare is always considered as a priority.

- They can access mother and child health centres (*Protection Maternelle et Infantile – PMI*) without any status requirements and for free. The PMI centres offer preventive care, follow-up and vaccination for babies and children up to six years old. In some areas, however, these centres are overcrowded and face difficulties with responding to the needs.
- In theory, even before starting the asylum process, minors should have access to AME health coverage as soon as they arrive in France. In practice, their parents lack information and often don't request AME before they have been in the country for at least three months, and actually obtaining AME takes several months.

Undocumented migrants

Undocumented migrants benefit from specific healthcare mechanism: the State Medical Help - AME (*Aide Médicale d'Etat*). Article L251-1 of the Social Action and Family Code states that an undocumented individual is entitled to AME if he/she has been residing illegally in France for more than three month and if his/her resources are lower than €727 per

month in mainland France and €809 in the DOMs.¹²³

AME gives access to all healthcare providers without paying at the point of service. Costs are fully covered, except for prosthesis (dental, optical, etc.), medically assisted reproduction and medicines with limited therapeutic value, according to the therapeutic benefit evaluation system, *Service Médical Rendu - SMR*¹²⁴, which are reimbursed at 15%. However, AME coverage is regularly revised by law, as the principle of covering the health costs of undocumented migrants is publicly questioned by many political leaders.

The AME is valid for one year. However, the delay in obtaining AME can be several months after the request is submitted. The validity of the AME begins on the day of submission with a possible retroactivity of 30 days.¹²⁵ If the migrant is still undocumented after one year, s/he can request a renewal of AME. In theory, migrants should submit the request for renewal two months before the AME expires. In practice, the renewal takes much more than two months and there is no health coverage during the gap in between.

Circular n°2005-407 §1.4 stipulates that an accelerated procedure for the attribution of the AME is possible when the health condition of the applicant requires a prompt treatment, and a GP certifies the need for it.

As undocumented migrants are not allowed to work, they have to declare their resources (no need of formal proof) and expenses. When an undocumented person has resources above the threshold, s/he is not entitled to any health coverage and must pay the full costs of health services.

¹²² Article L251-2 of the Social Action and Family Code

¹²³ <https://www.service-public.fr/particuliers/vosdroits/F3079>

¹²⁴ The SMR is a criteria used in public health to classify drugs or medical devices according to their therapeutic or diagnostic utility.

¹²⁵ Article 44-1 of the decree of 2 September 1954 <https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000492230#LEGIARTI000006682759>

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Moreover, to benefit from AME, undocumented migrants must be able to prove their identity. Some migrants do not possess an adequate identity document (which can be a student card for example)¹²⁶ and therefore experience difficulty in submitting a request. Furthermore, if a migrant wants to prove his/her identity with a birth certificate, said document may have to be translated by an official translator¹²⁷, which is often expensive and not easily available.

The residence condition, added to the proof of identity, can create a real barrier to access to healthcare for undocumented migrants. Those who are unable to prove that they have been resident in France for more than three months are only entitled to hospital services for care that is deemed urgent (pregnancy, pregnancy termination, etc.). Moreover, the documents that are accepted in fulfilment of the residence condition are not the same for all the social security agencies in France. In each department, the local CPAM has its own way of applying the regulation and can decide whether to accept certain documents. For example, certificates delivered by non-profit organisations like MdM are recognised as proof of residence by some CPAMs and not by others. This creates difficult and unequal access to health coverage.

An address is also necessary in order to apply for AME. However, most undocumented migrants cannot prove their address and must then request either support from a relative by using their address (although the conditions for using a relative's address are not the same in all departments) or an administrative address. This can be provided either by the

Communal Centre for Social Support (*Centre Communal d'Action Sociale – CCAS*) of the city where the individual lives (if they fulfil the conditions of the CCAS, which are often extremely complicated) or by a entitled association. In many areas (especially Paris and its suburbs), organisations face difficulties in responding to the level of need, as the CCASs do not always fulfil their role.

In order to overcome these gaps and under the pressure of the ODSE, the circular DHOS/DSS/DGAS adopted on 16 March 2005¹²⁸ (Article L254-1 of the Social Action and Family Code¹²⁹) created the Fund for Vital and Urgent Care (*Fonds pour les soins urgents et vitaux – FSUV*), valid only in hospitals.

The fund aims to finance the delivery of essential care to individuals who do not benefit from AME, i.e. those who do not fulfil the three months residence condition or cannot prove their identity. Under this urgent care scheme, healthcare is always considered as essential care for pregnant women and children.

The fund covers:

- Care that cannot be postponed without threatening the life or possibly damaging the health of a person
- Treatment of infectious diseases
- Antenatal and postnatal care, delivery
- Pregnancy termination¹³⁰

Undocumented pregnant women

Pregnant women may have access to AME. Under this scheme, they may access antenatal, delivery and postnatal care. In

¹²⁶<http://www.ameli.fr/assures/droits-et-demarches/par-situation-personnelle/vous-avez-des-difficultes/l-8217-aide-medicale-de-l-8217-etat/les-conditions-pour-beneficier-de-l-ame.php>

¹²⁷Ibid.

¹²⁸*Circular of 16 March 2005*
http://circulaires.legifrance.gouv.fr/pdf/2009/04/cir_18852.pdf

¹²⁹ *Social Action and Family Code*, Article 254-1
<http://legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006074069&idArticle=LEGIARTI000006797164&dateTexte=&categorieLien=cid>

¹³⁰ http://www.cmu.fr/soins_urgents.php

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addition, they can access termination of pregnancy. However, because of the above-mentioned administrative barriers, it is very difficult for them to access the AME scheme.

This is why the Vital and urgent care circular¹³¹ ensures that undocumented pregnant women who do not benefit from AME have access to antenatal, delivery and postnatal care and termination of pregnancy, because these health services are always considered to be essential.

Children of undocumented migrants

In French law, only adults are required to have an authorisation to stay on the territory, thus, children are never considered undocumented migrants.

In principle, children of undocumented migrants are entitled to the AME scheme upon arrival in France (without the three-month residence condition), even if their parents are not eligible. The right is granted for one year.¹³²

In practice, several CPAMs wait for the entitlement to AME of their parents (after three months of residence) to affiliate children as assignees, whereas children should be affiliated on their own behalf. They can use the PASS system and invoke the 2005 Vital and urgent care circular¹³³ but access to healthcare differs from one PASS to another.

¹³² Circular of 8 September 2011, http://www.sante.gouv.fr/fichiers/bo/2011/11-10/ste_20110010_0100_0055.pdf

¹³³ Op. cit. note 128

¹³⁴ Op. cit. note 128

¹³⁵ <http://www.ameli.fr/assures/prevention-sante/la-vaccination.php>

¹³⁶ Comité Médical pour les Exilés (COMEDE), *Migrants/étrangers en situation précaire*, 2008, <http://docplayer.fr/5525447-Rapport-2014-du-comede-introduction-2.html>

and <http://www.immigration.interieur.gouv.fr/Asile/L->

Children who do not benefit from AME can go to hospital and have free access to healthcare, because care for children is considered emergency care.¹³⁴

Moreover, children can receive vaccinations against all the principal diseases free of charge.¹³⁵ In accordance with the general health system, all children have access to immunisations at PMI centres.¹³⁶

EU citizens

Pursuant to the Directive 2004/38/EC¹³⁷, destitute EU citizens are considered as undocumented migrants (no health coverage, insufficient financial resources)¹³⁸ and they can access AME under the same conditions as any other undocumented migrant.¹³⁹

They have to prove three months of residence in France. Moreover, CPAMs must find evidence that they have no health coverage in their country of origin. In practice, CPAMs ask EU citizens to prove that they do not have health coverage in their country of origin, which is an important administrative barrier.¹⁴⁰ Some CPAMs also ask EU citizens to request PUMA first before they can apply for AME, even if they will clearly not obtain it, because they do not fulfil the conditions. The process for an EU citizen to obtain AME is in general quite complicated, as the practice of each CPAM varies and makes it

[accueil-des-demandeurs-d-asile/Les-droits-sociaux-des-demandeurs-d-asile](http://www.immigration.interieur.gouv.fr/Asile/L-accueil-des-demandeurs-d-asile/Les-droits-sociaux-des-demandeurs-d-asile)

¹³⁷ Directive 2004/38/EC

<http://eur-lex.europa.eu/legal-content/FR/TXT/?uri=celex%3A32004L0038>

¹³⁸ These are conditions to be authorised to reside in France for inactive individuals.

¹³⁹ Circular of 9 June 2011,

http://circulaire.legifrance.gouv.fr/pdf/2011/07/cir_33406.pdf

¹⁴⁰ Médecins du Monde 2014, *Report on access to healthcare in France*

<http://www.medecinsdumonde.org/actualites/publications/2015/10/17/observatoire-2014-de-lacces-aux-droits-et-aux-soins-en-france>

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difficult for individuals to understand the rules that apply.

However, since the circular DSS/2A/DGAS/DHOS, adopted on 7 January 2008¹⁴¹, modifying the above-mentioned circular of 2005, destitute EU citizens benefit from the FSUV and have access to emergency care. This circular specifies that while EU citizens have the right to move and reside freely within the territory of a member state, they do not have full freedom to settle and reside in France. Therefore, they can be considered as undocumented migrants regarding provisions governing entry and stay on French territory.

In the same way, third country nationals who are authorised residents in one EU country face difficulties in accessing healthcare in another EU country.

Unaccompanied minors

Unaccompanied minors in France should have access to healthcare through the health insurance system in the same way as the children of national or authorised residents do.

The care of unaccompanied minors falls under Child Protection, which is the responsibility of the departmental council through child welfare services (*Aide Sociale à l'Enfance – ASE*). Children taken into care by social services can benefit from accommodation, socio-educational measures, counselling, and access to healthcare and education until they reach their majority. In order to determine their eligibility to such measures, these services must assess the minor's situation through an evaluation. This evaluation aims to determine whether young people seeking

protection are under the age of majority and unaccompanied.

Regrettably, unaccompanied minors are too often faced with distrust and questioning of their claim. Even when they are presented with documentary evidence of their age, the authorities often rely on medical age assessment techniques, such as X-rays of bones and teeth.¹⁴²

MdM strongly criticises these practices, considered as imprecise, unethical and unreliable. MdM advocates a process of age assessment based on a multi-disciplinary approach, which focuses not on chronological age exclusively, but rather on the needs of children and young people.

MdM is also calling, as the National Consultative Commission on Human Rights did in an advice of 26 June 2014, for the prohibition of medical age assessment and for the application of a presumption of minority in the case of those who present themselves as minors.

Protection of seriously ill foreign nationals

In this area, French legislation is rather protective. In accordance with the Code on Entry and Residence of Foreign Nationals and Right of Asylum¹⁴³, an ill foreign national can obtain a residence permit if his/her state of health requires medical assistance, which lack could cause him/her consequences of an exceptional gravity, on the condition that no treatment of this condition is available in his/her country. This additional criterion was introduced, despite strong opposition from organisations and some members of the parliament, by a reform related to immigration, integration and nationality,

¹⁴¹*Circular of 7 January 2008*,
<http://www.sante.gouv.fr/fichiers/bo/2008/08-02/a0020048.htm>

¹⁴²
http://www.justice.gouv.fr/art_pix/1_RAA_MMNA_2016.pdf

¹⁴³https://www.legifrance.gouv.fr/affichCode.do;jsessionid=BBBD8FB9D375F5A55806266730FB10E5.tpdila09v_3?idSectionTA=LEGISCTA000006180199&cidTexte=LEGITEXT000006070158&dateTexte=20160311

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promulgated on 16 June 2011 (*Loi Besson*).¹⁴⁴ It does not apply to Algerians, who have a specific statute and depend from the 1968 Agreement between France and Algeria, however, in practice, the authorities apply to them the same rules as for other foreigners.

Thus, the verification of the existence of appropriate treatment in the country of return would consequently be sufficient to decide that the individual can be sent to his/her home country to be treated. There is nevertheless an exception, in case of exceptional humanitarian circumstances. Furthermore, the ECHR condemns the expulsion of ill foreigners when they are in too serious condition to be transported.

Law on foreigners of 7 March 2016 contains several positive measures, as adding the notion of “effectivity” of the access to treatment in the condition of availability of care in the home country, putting more health-related restrictions on expulsion and allowing both parents of an ill child to obtain a residence permit with the possibility to work.

Seriously ill foreign nationals can apply for a temporary, renewable, one-year residence permit for “private and family life”, if they have been in France for more than one year or a provisional residence permit for care of six months maximum if they have only been in France for a short time.¹⁴⁵ To determine the type of protection to be granted, the prefecture considers administrative criteria as ordinary residence, and evaluates

whether the foreigner could be a possible “threat to public order”.

The final decision belongs to the prefect who has to take into account the medical advice of a doctor from the French Office of Immigration and Integration (OFII – *Office Français de l’Immigration et de l’Intégration*), which depends on the Ministry of Interior, pursuant to article 20 of the Law on foreigners of 7 March 2016.¹⁴⁶

This procedure has numbers of flaws in practice. Many prefectures require more documents from ill foreigners, than the law specifies, and complicate the procedures¹⁴⁷, making access to residency for health reasons long and complicated to obtain. The medical confidentiality is frequently breached and the prefects use this medical information to make their decision.¹⁴⁸

In 2013, around 6,000 new applications were accepted and the total amount of people living with a permit to stay due to medical reasons was around 30,000.¹⁴⁹ According to 1,398 patients followed by some NGOs, the rate of positive decisions was 85%.¹⁵⁰

In order to avoid a restrictive and arbitrary interpretation of this ambiguous concept of “*absence of appropriate treatment*”, the Ministry of Health provided clarification in an instruction of 10 November 2011.¹⁵¹ After reiterating the medical ethical obligations for the application procedure, such as continuity of care and the observance of professional secrecy, the

¹⁴⁴ *Law of 16 June 2011*, <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000024191380&categorieLien=id>

¹⁴⁵ <http://www.immigration.interieur.gouv.fr/Immigration/Les-etrangers-malades-et-leurs-accompagnants2>

¹⁴⁶ http://solidarites-sante.gouv.fr/fichiers/bo/2017/17-01/ste_20170001_0000_0001.pdf

¹⁴⁷ <http://www.comede.org/wp-content/uploads/2017/05/VF2-Brochure-ODSE-mars-2017.pdf>

¹⁴⁸ Op. cit. note 140

¹⁴⁹ « *La régularisation pour soins des étrangers : symptômes d’une pathologisation d’un droit de l’homme* », Nicolas Klausser, 2017 <https://revdh.revues.org/2890#ftn6>

¹⁵⁰ Comité pour la Santé des Exilés (COMEDE), *Rapport COMEDE 2014*, <http://docplayer.fr/5525447-Rapport-2014-du-comede-introduction-2.html>

¹⁵¹ *Instruction of 10 November 2011*, http://www.sante.gouv.fr/fichiers/bo/2011/11-12/ste_20110012_0100_0085.pdf

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instruction specifies the meaning of “*absence of appropriate treatment*”.

“*Treatment*” is defined as all means implemented to treat (drugs, healthcare, follow-up tests, full assessment tests); the absence or presence of “*appropriate treatment*” is assessed according to the individual’s health (stage of the disease, complications) and care services in the country (health infrastructure, medical demography, etc.).¹⁵²

Prevention and treatment of infectious diseases

Sexually Transmitted Infections

Before 2016, there were two types of facilities for the prevention and testing of sexually transmitted infections.

- Free and anonymous testing centres (*Centres de dépistage anonyme et gratuit – CDAG*) for HIV and hepatitis, funded by health insurance;
- Information centres for testing and diagnosis of sexually transmitted infections (*Centres d’information, de dépistage et de diagnostic des infections sexuellement transmissibles – CIDDIST*) where testing was carried out for specific sexually transmitted infections

With the Social Security Financing Act for 2016, these two types of facility were merged into one, called Centres for Free Information, Testing and Diagnosis of HIV, hepatitis virus and sexually transmitted infections (*Centres Gratuits d’Information, de Dépistage et de Diagnostic pour les infections par les Virus de l’Immunodéficience Humaine (VIH) des hépatites virales et des infections sexuellement transmissibles – CeGIDD*). They are funded by the health insurance.

These facilities are open to all individuals, minors and adults. The absence of health coverage or residence permit is not an obstacle.

If a person is diagnosed with an infectious disease, access to treatment depends on the disease and his/her situation relating to health coverage:

- **HIV:** this infection is considered an emergency even if the person has no health coverage. The patient will be treated in hospital and the costs covered by the PASS system or by the FSUV.
- **Hepatitis B and C:** if a person is diagnosed but the disease is not active (hepatitis can remain “silent” for several years before starting to affect the patient’s health), there is usually no access to treatment if there is no health coverage. Access to treatment will then depend on access to AME or CMU, depending on the person’s status. The cost of treatment being very high, if there is a major obstacle to health coverage (no identity papers, no address, no information on rights to health, etc.), there will be no possibility for access to healthcare.

Tuberculosis

Dedicated facilities for the prevention, testing and treatment of tuberculosis (TB) also exist in France: Centres for Fighting Tuberculosis (*Centres de Lutte Anti-Tuberculeuse – CLAT*).

If a person is diagnosed with TB, even without health coverage, his/her treatment will be covered by the PASS or the urgent care scheme and fully covered, including hospitalisation.

¹⁵²AIDES, *Observatoire des étrangers malades - Droit au séjour pour soins*, 2012,

http://www.aides.org/sites/default/files/doc/120418_Rapport_EMA.pdf

The situation in Mayotte

Discrimination by the healthcare scheme

In Mayotte, PUMA, CMU-C and AME do not exist.

Until 2005, the entire population had free access to healthcare in public healthcare facilities (clinics and hospitals). Then, a specific social security system was implemented, which was only open to French citizens and foreign nationals with permission to reside, excluding from health protection about a quarter of the population. This is the case for foreign nationals without permission to reside¹⁵³, but also part of the population of Mayotte (French people born in Mayotte) who are unable to provide proof of their marital status or present other documents illegitimately required (including proof of residence and bank account details).

Children can only be affiliated as dependents of a French citizen residing in Mayotte or of a foreign national with permission to reside in Mayotte. Children of undocumented migrants or unaccompanied minors do not have access to any form of health protection, except for unaccompanied minors supported by the child welfare services since 2013. In 2015, 75% of minors were not affiliated to social security.¹⁵⁴

Regarding access to healthcare, PASS do not provide medical consultations and the circular creating the FSUV is not applicable in Mayotte.

¹⁵³Order of 20 December 1996, <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=LEGITEXT000005622330&dateTexte=20080126>

¹⁵⁴http://www.defenseurdesdroits.fr/sites/default/files/atoms/files/dde_mayotte_2015_definitif.pdf

A special scheme is provided for exemption from payment in case of emergency care, but it does not always work and definition of emergency care is more restrictive than in mainland France. Thus, undocumented migrants, about one third of the population, must pay a fee (€20 for a medical consultation with a GP and up to €658 per day for hospitalisation in gynaecology¹⁵⁵). This is much too expensive in relation to their financial resources (one in five inhabitants earns less than €100 per month).

However, the order adopted on 31 May 2012¹⁵⁶ provides that expenses for minors and unborn babies are fully supported if their parents' resources are less than a certain amount, even where there is no emergency.¹⁵⁷ This change was a major legal advance, which enshrined the principle of free access to healthcare in the public system for minors and pregnant women in precarious situations. The scheme does not include private GPs' consultations, emergency transportation, nursing home care, medical equipment are not free of charge.

It should be noted that this order is not systematically applied in Mayotte.

Compliance to law

Mayotte became the outermost region of the European Union on 1 January 2014 after becoming a French department in 2011. Its legislation must comply with EU and national standards. Thus, the CESEDA (Code on Entry and Residence of Foreign Nationals and Right of Asylum) now applies to Mayotte. However, the transposition of these laws in Mayotte is subject to derogations that continue to

¹⁵⁵Order of 21 July 2014, http://www.gisti.org/IMG/pdf/arrete_ars-mayotte_no182_2014-07-21.pdf

¹⁵⁶<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000025943780&fastPos=2&fastReqId=721478700&categorieLien=cid&oldAction=rechTexte>

¹⁵⁷This amount is not set by any law.

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deprive foreign nationals of the rights they would be entitled to in mainland France.

Pursuant to the programming law no 2017-256 of 28 February 2017 on real equality for overseas communities and other social and economic matters, the CMU-C should become progressively applicable overseas. However, as of July 2017 it is still not applicable in Mayotte.

GERMANY

National Health System

Organisation and funding German healthcare system

German laws regarding access to healthcare are made at the national level. However, as a federal country, responsibilities for the healthcare system in Germany are shared between the Länder (federal states), the federal government and civil society organisations¹⁵⁸ (i.e. important competencies are legally delegated to membership-based, self-regulated organisations of payers and providers)¹⁵⁹, thus combining vertical implementation of policies with strong horizontal decision-making.¹⁶⁰

There are two insurance systems: statutory health insurance (Gesetzliche Krankenversicherung – GKV) and private health insurance (Private Krankenversicherung – PKV). Since 2009, it is compulsory for all German citizens and long-term residents to have health insurance. Employees earning less than €57,600 per year (as of 2017), are mandatorily covered by the statutory health insurance scheme (GKV). Anyone earning more than this opt-out threshold can choose to be covered by private health insurance (PKV) or by statutory health insurance

¹⁵⁸For instance, there are “Kassenärztliche Vereinigung” (represents the interests of approximately 24.000 registered doctors) or “Bundesärztekammer” (umbrella organisation that represents political interests of almost half a million doctors) or “Deutsche Patientenvereinigung” (organisation for patients).

¹⁵⁹ R. Busse and J. Wasem, “The German Health Care System – Organisation, Financing, Reforms, Challenges...” *European Observatory on Health Systems and Policies*, Brussels, 2013. https://www.mig.tuberlin.de/fileadmin/a38331600/2013.lectures/Brussels_2013.02.13.rb_GermanyHealthCareSystem-FINAL.pdf

¹⁶⁰ Civitas, *Health care Systems: Germany*, updated by Emily Clarke (2012) and Elliot Bidgood (January 2013), Based on the 2001 Civitas Report by David

(GKV).¹⁶¹ Approximately 85% of the population belong to the statutory health insurance scheme (GKV), whereas 15% have private health insurance (PKV).¹⁶²

The GKV is based on the principle of solidarity and the principle of benefits in kind, meaning that services do not depend on income or contribution and that the insured receive benefits without up-front payments on their part. Insurance payments are based on a percentage of income and shared between employees and employers.

Since 2009, the government has set a uniform contribution rate to the GKV. As of 2016, employees or pensioners with health coverage contribute 7.3% of their gross incomes, while the employer or pension fund adds another 7.3%.¹⁶³ In addition, supplementary premiums of between 0.3% and 1.9% are collected from the employees’ gross salaries. Since 2011, the employers’ share has been fixed at 7.3%, so that health insurance fund members will have to fund future expenditure increases in the healthcare sector solely via their supplementary premiums of the employees.¹⁶⁴

Within the GKV, this contribution also covers dependents i.e. non-earning spouses and children.¹⁶⁵

There are 113 competing, not-for-profit statutory health insurance funds

Green and Benedict Irvine, <http://www.civitas.org.uk/nhs/download/germany.pdf>

¹⁶¹ Busse R, Blümel M., *Germany: health system review*. Health Systems in Transition, 2014, p. 121 http://www.euro.who.int/_data/assets/pdf_file/0008/255932/HiT-Germany.pdf?ua=1

¹⁶² The Commonwealth Fund, *2015 International Profiles of health Care Systems*, January 2016 http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf

¹⁶³ Op. cit. note 162

¹⁶⁴ Op. cit. note 161, p. 253

¹⁶⁵ Op. cit. note 162, p. 69

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(Krankenkassen). Citizens and long-term residents choose to which sickness fund they want to belong.

In the case of the PKV, contributions depend not on income but on the person's health status, age and gender. Since the 2009 reforms, however, PKV private health insurance companies are required to offer a basic rate that corresponds to the services offered by the GKV statutory health insurance.

Insurance of destitute nationals depends on their individual situations. Those with health coverage must pay the compulsory insurance (*Pflichtversicherung*). This costs a minimum of €135 per month, depending on the individual's income. If they receive welfare benefit, then the social welfare office (*Sozialamt*) normally pays.

However, if the person has had a "gap" in his/her insurance payments and has to repay his/her debts retrospectively, the social welfare office does not cover this. This is why in many cases the debt keeps the person from having full coverage (in such cases the insurance only covers emergency bills).

MdM DE teams treat many German citizens at MdM's programmes. Most of them were privately insured before the reform but cannot afford the monthly fees anymore. Some of them also come because they were not insured prior to when health insurance became mandatory and cannot pay their debts.

Accessing Germany healthcare system

Statutory health insurance (GKV) covers¹⁶⁶:

- Preventive services, inpatient and outpatient hospital care;
- Physician services;
- Mental healthcare;

- Dental care;
- Optometry;
- Physiotherapy;
- Prescription drugs;
- Medical aids;
- Rehabilitation;
- Hospice and palliative care;
- Sick leave compensation.

Members of the GKV do not have to pay for medical consultations, as health providers are directly reimbursed by the health insurance funds. Small out-of-pocket-payments must however be made for other medical services such as physiotherapy or specific dental care.

Some health services, such as medical cosmetic procedures or acupuncture, have been excluded from the statutory insurance coverage scope since the Federal Joint Committee (*Gemeinsamer Bundesausschuss*)¹⁶⁷, as they go beyond what is defined by law as sufficient, appropriate and economic patient care. These "Individual Health Services" (*Individuelle Gesundheitsleistungen* - IGeL) have to be fully paid for and are usually not reimbursed.¹⁶⁸

For medication, patients have to pay 10% of the cost of the medication. This co-payment amounts to at least €5 and at most €10 per prescription.¹⁶⁹

Measures have also been put in place to prevent extreme financial burden. Annual expenditure on co-payments for any German citizen must not exceed 2% of gross annual household income. That limit was established to prevent unreasonable costs for those on low incomes. The 2% calculation is based on the household income, from which an allowance for each household member is subtracted. In addition, people with chronic illnesses or disabilities do not have to pay more than 1%

¹⁶⁶ Ibid.

¹⁶⁷ Guidelines §92 of the Social Code, Book V
https://www.gesetze-im-internet.de/sgb_5/_92.html

¹⁶⁸ <http://www.kbv.de/html/igel.php>

¹⁶⁹ Social Code, Book V, Statutory Health Insurance, Section 61
http://www.gesetze-im-internet.de/sgb_5/

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of gross annual household income. Persons receiving social aid (*Sozialhilfe*) pay a maximum of €49.08 (if chronically ill) or €98.16 (if not) per year. Children under 18 are exempted of any co-payment.¹⁷⁰

Access to healthcare for migrants

Asylum seekers and refugees

The Asylum Seekers Benefits Act¹⁷¹ (*Asylbewerberleistungsgesetz – AsylbLG*) regulates the entitlement to state subsidies for medical care of refugees, asylum seekers, people who hold a certain residence permit for humanitarian reasons, people with a “temporary tolerated stay” (*Duldung*) and for those who are obliged to leave.

Unlike in most European countries, asylum seekers and refugees living in Germany do not have the same access to healthcare as nationals. According to Section 2 of the AsylbLG, during their first 15 months on the German territory, they are only entitled to basic healthcare services determined in Section 4 of the AsylbLG and Section 19 of the Law on Infectious diseases (*Infektionsschutzgesetz*).¹⁷²

The basic services covered are:

- treatment for severe illnesses or acute pain and everything necessary for curing, improving or relieving the illnesses and their consequences, including dental care
- antenatal and postnatal care
- vaccinations
- preventive medical tests and anonymous counselling and screening for infectious and sexually transmitted diseases

¹⁷⁰ Op. cit. note 162

¹⁷¹ *Asylum Seekers benefit Act* – 1993
<http://www.gesetze-im-internet.de/bundesrecht/asylblg/gesamt.pdf>

¹⁷² *Law on Infectious diseases* – 2000
<http://www.gesetze-im-internet.de/bundesrecht/ifsg/gesamt.pdf>

The coverage also depends on each federal state’s policies.¹⁷³

Medically necessary care for chronic diseases is only provided after special approval. This includes psychotherapy for asylum seekers suffering from PTSD (post-traumatic stress disorder) (§6 AsylbLG). Translation is also covered for psychotherapy.

After 15 months of having received benefits under the Asylum Seekers Benefits Act asylum seekers and refugees are entitled to welfare benefits and they may have access to healthcare under the same conditions that apply to German citizens. However, a reduction in benefits may be applied for more than 15 months (i.e. without any time limit) to people who have “*abused the law to affect the duration of their stay*”.¹⁷⁴

In emergency situations, asylum seekers and refugees can go directly to the emergency department for care. For non-emergency situations, asylum seekers in many federal states and municipalities must first request a health voucher (*Krankenschein*) or health insurance certificate from the municipal social services department in order to gain access to healthcare. This document allows them free access to the medical services they are entitled to under the Asylum Seekers Act (AsylbLG)¹⁷⁵; the care provider is then reimbursed directly.

The municipal departments, which do not have medical expertise, are in charge of delivering the health vouchers. This causes a heterogeneous application of the law throughout the country, as municipalities may interpret it in a more or less restrictive

¹⁷³ <http://www.hspm.org/countries/germany28082014/livinghit.aspx?Section=5.14%20Health%20services%20for%20specific%20populations&Type=Section>

¹⁷⁴ <http://www.asylumineurope.org/reports/country/germany/reception-conditions/health-care>

¹⁷⁵ Op. cit. note 171

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way and thus may not issue health vouchers under the same conditions.

In contrast, some federal states (e.g. Bremen, Hamburg, Brandenburg and Berlin) have agreements with statutory health insurance funds and issue health insurance cards to asylum seekers. While the benefits are the same, this saves asylum seekers from having to request a health voucher every time they need access to care. It is also much easier for health providers. Other federal states are discussing the introduction of this model in their own schemes.¹⁷⁶

In most cities in Germany, a health voucher is valid for consultations with primary care physicians for three months. However, if the general practitioner refers an asylum seeker or a refugee to a specialist, another health voucher has to be requested.

If the doctor prescribes medication, the prescription states that the patient is exempt from co-payments. When a chronic illness is diagnosed, in some municipalities a municipal public health department physician must confirm the diagnosis and the need for treatment.

With the new Asylpaket II in vigor since March 2016, Germany has been implementing a stricter asylum system. Asylum seekers who are granted subsidiary protection (and not refugee status) are denied their right to family reunification for two years.

Pregnant asylum seekers and refugees

The Asylum Seekers Benefits Act contains a special provision for pregnant women and for women who have recently given birth in its Section 4. They are entitled to “medical

and nursing help and support”, including midwifery assistance. Furthermore, vaccination and “necessary preventive medical check-ups” must be provided. Therefore, they have the same access to health coverage for antenatal and postnatal care as German citizens covered by statutory health insurance.

Children of asylum seekers and refugees

Children of asylum seekers and refugees are subject to the same system as adults. However, the law stipulates that children can receive other care meeting their specific needs (Section 6 AsylbLG), although this provision does not specify the particular treatments that children may receive. As discussed above, Section 4 AsylbLG stipulates that asylum seekers and refugees who have been in Germany for less than 15 months are entitled to vaccinations from the first day they arrive.¹⁷⁷ However, vaccinations (Section 4.3 AsylbLG) are not compulsory in Germany, but merely recommended¹⁷⁸, with the exception of children at the time they enter childcare institutions, who have to be vaccinated. The vaccines recommended by the WHO are free of charge.

It should be noted that, according to a UNICEF (United Nations International Children's Emergency Fund) report published on 9 September 2014, children of refugees in Germany do not have a standard of living equal to their German peers, due to discrimination in health and education services.¹⁷⁹ The study, “Children first and foremost” states that, despite the daily difficulties they encounter, children of refugees have inadequate governmental support, which goes against the principles

¹⁷⁶ Op. cit. note 174

¹⁷⁷ List of vaccinations

<http://www.bmg.bund.de/themen/praevention/frueh-erkennung-und-vorsorge/impfungen.html>

¹⁷⁸ There are strong reservations against compulsory public health measures in Germany, due to historical reasons

¹⁷⁹ Z. Dogusan, “Refugee children discriminated against in Germany, UNICEF says”, *Daily Sabah*, 10 September 2014

<http://www.dailysabah.com/europe/2014/09/10/refugee-children-discriminated-against-in-germany-unicef-says>

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of the United Nations Convention on the Rights of the Child (CRC).¹⁸⁰

Undocumented migrants

According to the Asylum Seekers Benefits Act of 1 November 1993 (AsylbLG)¹⁸¹, undocumented migrants are afforded by law the same access to health services as asylum seekers who have been in Germany for less than 15 months.¹⁸²

These health services are less comprehensive than those provided by the social security scheme, as they only cover:

- emergency care
- treatment for acute illnesses and severe pain;
- antenatal and postnatal care;
- recommended immunisations;
- preventive medical tests; and
- anonymous counselling and screening for infectious and sexually transmitted diseases
- HIV/AIDS treatment, if the patient cannot afford it

In order to access financial coverage of non-emergency care and treatment, a certificate (Krankenschein) needs to be obtained from the social service department.

According to the Residence Act of 30 July 2004 (*Aufenthaltsgesetz – AufenthG*), Section 87(2) 1 and 2, however, “*Public bodies [with the exception of schools and other educational and care establishments for young people] shall notify the competent foreign nationals’ registration authority forthwith, if, in discharging their duties, they obtain knowledge of*¹⁸³”:

- the whereabouts of a foreign national who does not possess the required

residence permit and whose expulsion has not been suspended;

- a breach of a geographical restriction;
- any other grounds for expulsion

This means that social service departments have an obligation to report any undocumented migrants encountered in the course of their work to the immigration authorities. Thus, undocumented migrants, de facto, do not have access to financial coverage of non-emergency healthcare.

In cases of emergency treatment, the hospital can request reimbursement from the social service department. Hospital administrative and medical staff are bound by medical confidentiality, as are social services departments, if they obtain information on the status of an undocumented migrant from members of the medical personnel.

Nevertheless, in practice, the reimbursement request process is fairly complicated because the social services department has to verify that the person is indeed in need, and to do that, it needs to contact the immigration department.

As a result, undocumented migrants often choose neither to seek treatment nor to bring their children for treatment, even in severe cases, for fear of being reported and expelled from the country.

Undocumented pregnant women

According to the law, undocumented pregnant women have access to healthcare services in the same way as German women covered by statutory health insurance. In practice, however, cost-free healthcare services are provided to pregnant women

¹⁸⁰ Ibid.

¹⁸¹ Op. cit. note 171

¹⁸² §II, art.1 Decision of the Germany’s Federal Constitutional Court 18 July 2012 <https://www.bundesverfassungsgericht.de/SharedD>

[ocs/Entscheidungen/DE/2012/07/ls20120718_1bv1001010.html](https://www.bundesverfassungsgericht.de/SharedD/ocs/Entscheidungen/DE/2012/07/ls20120718_1bv1001010.html)

¹⁸³ Residence Act of 30 July 2004, Section 87

http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.htm#p1120

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only in the case of emergency care (see above).

A “temporary tolerated stay” is granted for pregnant women six weeks before and eight weeks after delivery. Within this time, pregnant women will not be expelled and can thus access non-emergency healthcare without cost.

However, for the first six months of their pregnancy, undocumented women risk expulsion when applying for cost reimbursement so they often do not get appropriate antenatal care (starting at 14th week at the latest).

Children of undocumented migrants

The children of undocumented migrants are concerned by the provisions of the Asylum Seekers Benefit Act¹⁸⁴, so they should have the same access to healthcare as the children of asylum seekers. In theory, immunisations for children of undocumented migrants must be provided free of charge. However, due to the duty to report, undocumented families are hindered from seeking non-emergency healthcare.

In practice, most children of undocumented migrants do not have access to immunisation free of charge. They face paying the full costs of the medical consultation (around €45) and the costs of the vaccine (€70 per vaccine).

Termination of pregnancy

Section 218a of the Criminal Code¹⁸⁵, which resulted from the adoption of the 21 August 1995 law on antenatal assistance and aid to families, indicates the conditions under which termination of pregnancy is not considered illegal.

This section specifies that termination of pregnancy is not punishable if all of the following conditions are met:

- the woman requests the procedure;
- the woman presents a medical certificate proving that she went to an approved consultation centre at least three days earlier;
- the procedure is performed by a doctor; and
- the procedure is performed within 12 weeks of conception

In case of rape, which has to be certified by a medical professional, consultation is not obligatory, termination is possible after the 12th week and the cost of the termination is covered by the health insurance.¹⁸⁶

A termination of pregnancy beyond 12 weeks is also possible if it is medically indicated, that is, if the woman’s physical or mental health renders it necessary and the risk cannot be dealt with by other means. This provision also applies in cases where there is a risk of serious congenital malformation. In medically indicated cases, the cost of the termination is covered by the health insurance.

In case of termination of pregnancy without criminal or medical indication, the cost of termination of pregnancy is borne by the patient and is not reimbursed. A medical abortion costs around €350. The examination before the termination and treatment of complications are however, covered by the health insurer.¹⁸⁷

For women whose income minus rent and children’s allowance is below €1,036 per month pregnancy termination is fully covered. According to the law, female asylum seekers and undocumented women

¹⁸⁴Op. cit. note 171

¹⁸⁵ *Criminal Code (last amended on July 2017)* s218a

http://www.gesetze-im-internet.de/stgb/_218a.html

¹⁸⁶<http://www.familienplanung.de/beratung/schwangerschaftsabbruch/rechtslage-und-indikationen/>

¹⁸⁷ Ibid.

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are also entitled to coverage. However, access remains very difficult for undocumented women, due to the need for a health voucher and the risk of being reported, as discussed above.

Indeed, the experience of MdM DE teams has shown that it is very difficult for female asylum seekers and undocumented women to obtain reimbursement for termination of pregnancy.

EU citizens

Access to health insurance and welfare benefits for EU citizens depends on their working situation and on the reason of their stay in Germany. Job seekers and individuals who are not capable of employment (for health reasons or on the basis of immigration law) are not entitled to welfare benefits, pursuant to Section 23 of the 12th book of the German Social Security Code.¹⁸⁸ They can obtain health coverage through private insurance if they can afford the contributions.

In the case *C-299/14 Vestische Arbeit Jobcenter Kreis Recklinghausen v Jovanna García-Nieto and Others*, the Court of Justice of the European Union confirmed that “a Member State may exclude nationals of other Member States from certain social benefits during their first three months of residence”.¹⁸⁹

Pursuant to the 2004 European Directive 2004/38/EC¹⁹⁰, after three months of residence in Germany, if an EU citizen has insufficient funds and no insurance to cover his/her healthcare, s/he loses his/her right of residence.

In any case, EU citizens are entitled to assistance in case of emergencies,

¹⁸⁸ Social Security Code, Book XII http://www.gesetze-im-internet.de/bundesrecht/sgb_12/gesamt.pdf

¹⁸⁹ *Case C-299/14 Vestische Arbeit Jobcenter Kreis Recklinghausen v Jovanna García-Nieto and Others*, 25 February 2016

according to the 12th book of the German Social Security Code.¹⁹¹ This can mean, depending on the circumstances, that the costs for an urgent operation might be reimbursed by social services.

A new law on access to social welfare (GrSiAuslG), in vigour since the beginning of 2017, has reduced the rights of some EU citizens legally residing in Germany to access social services such as healthcare. It concerns people coming from EU member states who are unemployed, without sufficient means of existence or acquiring residence permit through their children, and it applies for the first five years of their stay in Germany. People affected by this new law may be entitled to limited social benefits and healthcare services for a period of one month, and only once every two years, in order to facilitate their return to their own country.

EU pregnant women

Healthcare related to pregnancy is not seen as emergency care. Therefore, uninsured pregnant EU citizens are advised by the social welfare office to go back to their home country. Sometimes, the Ministry of Labour and Social Affairs covers the costs of the travel.

Unaccompanied minors

Unaccompanied minors' access to healthcare is foreseen, in parallel with their care requirements based on their residence status and their care needs due to the absence of anyone with parental responsibility for them.¹⁹² “If assistance is

<https://curia.europa.eu/jcms/upload/docs/application/pdf/2016-02/cp160018en.pdf>

¹⁹⁰ Directive 2004/38/EC

¹⁹¹ Op. cit. note 188

¹⁹² A. Muller, “Unaccompanied Minors in Germany Focus-Study by the German National Contact Point for the European Migration Network (EMN)”

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granted in accordance with Sections 33 to 35 or Section 35a subsection 2 Nos. 3 or 4 [Social Security Code Book VIII¹⁹³], health benefits must also be granted as specified in Sections 47 to 52 of the 12th book of the German Social Security Code”.¹⁹⁴

The health benefits granted shall meet all of the requirements in each individual case. They have to cover any additional charges and contributions (Section 40 Social Security Code Book VIII¹⁹⁵). This also covers any need for psychological care, including translation fees.¹⁹⁶

Unaccompanied minors recognised as asylum seekers, who have been granted subsidiary protection or refugee status and those for whom a prohibition of expulsion has been established are entitled to health benefits based on the sections of the Social Security Code, commensurate with their situation, even if it has been established that they do not need assistance from the Youth Welfare Office.¹⁹⁷

The situation is different in respect of unaccompanied minors whose expulsion has been suspended or who have been granted permission to stay for the duration of the asylum procedure and who have not been granted any assistance by the Youth Welfare Office. They are merely entitled to medical care under the Asylum Seekers Benefits Act.¹⁹⁸ Therefore, they have access to health packages as quoted above.

Protection of seriously ill foreign nationals

According to Section 60a.2 of the Residence Act (AufenthG)¹⁹⁹, a foreign national may be granted a temporary

tolerated stay (Duldung) if his/her continued presence in Germany is necessary on urgent humanitarian or personal grounds (including medical grounds) or due to substantial public interests. As a result, the expulsion of a foreign national must be suspended for as long as expulsion is impossible in fact or in law. However, no residence permit is granted. Since March 2016 with the Asylpaket II, stricter regulations were passed for proving that a medical condition makes an expulsion impossible (AufenthG §60a Section 2c and 2d), thus making it easier for German authorities to expel seriously ill foreigners.

In the case of chronic diseases, the foreign nationals' registration office (*Ausländerbehörde*) may grant a residence permit according to Section 25.5 AufenthG if a specialist doctor declares in a detailed certificate that a person is unable to travel or cannot stop treatment in Germany. The temporary permit to reside ceases to apply once the patient is fit to travel again.

In addition, if the patient is considered able to travel despite their illness, but the treatment required by their condition is not possible anywhere in their country of origin, a residence permit for humanitarian reasons can be issued, in accordance with Section 25.3 AufenthG and Section 60.7 AufenthG. The Federal Office for Migration and Refugees (*Bundesamt für Migration und Flüchtlinge*) checks this residence permit in the framework of the asylum procedure or readmission procedure of a previous asylum request.

To obtain a residence permit for humanitarian reasons, the applicant must

Federal Office for Migration and Refugees, Nuremberg, 2014,

https://www.bamf.de/SharedDocs/Anlagen/EN/Publikationen/EMN/Studien/wp60-emn-minderjaehrige-in-deutschland.pdf?__blob=publicationFile

¹⁹³ Social Security Code, Book VIII http://www.gesetze-im-internet.de/bundesrecht/sgb_8/gesamt.pdf

¹⁹⁴ Op. cit. Note 188

¹⁹⁵ Op. cit. note 193

¹⁹⁶ Op. cit. note 192

¹⁹⁷ Directive 2004/38/EC

¹⁹⁸ Op. cit. note 192

¹⁹⁹ Op. cit. note 183

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demonstrate to the relevant authorities that there is a serious risk to his/her health in his/her country of origin. Data on the national health system and the person's economic and social situation must be presented.

Finally, certain seriously ill foreigners can obtain a residence permit "on hardship grounds". However, this request concerns extremely specific situations, examined on a case-by-case basis and does not include medical grounds. It applies to people who, in theory, cannot stay in Germany, but who are granted a residence permit for special reasons, in accordance with Section 23 of the Residence Act.²⁰⁰

The evolution of asylum law in 2016²⁰¹, which foresees a faster asylum procedure of about three weeks, makes it extremely difficult for asylum seekers to present this information in time. Several countries have been classified as "safe countries"²⁰², increasing the number of asylum seekers affected by the fast asylum procedure.

Prevention and treatment of infectious diseases

According to the Section 19 of the law on infectious diseases²⁰³, everyone, including undocumented migrants is entitled to counselling and testing for transmissible diseases and to outpatient care (for STIs, TB, hepatitis, etc.). The law also provides for free HIV/AIDS treatment if the patient cannot bear the costs.

However, the duty to report prevents effective access to care and, in practice, only those with temporary residence permits have access.

Yet, in most large German cities, such as Cologne or Munich, the authorities set up

special counselling services for people with STIs (*Beratungsstelle für sexuell übertragbare Krankheiten*), accessible to all, regardless of legal status. These services were launched many years ago, at first for sex workers and drug users. They offer anonymous services, generally testing and counselling and sometimes consultation with a doctor.

Access to HIV and hepatitis treatment, however, is far from being accessible to undocumented migrants in practice, as patients are asked to apply for the voucher.

²⁰⁰ Op. cit. note 183

²⁰¹ http://www.bgbl.de/xaver/bgbl/start.xav?startbk=Bundesanzeiger_BGBl&jumpTo=bgbl116s0390.pdf

²⁰² http://www.fluechtlingsinfo-berlin.de/fr/pdf/1808039_GE_Maghreb_sicher.pdf

²⁰³ *Law on Preventing and Combating infectious diseases in humans of 20 July 2000 (Protection against Infection Act)*, http://www.gesetze-im-internet.de/ifsg/_19.html

GREECE

National Health System

Constitutional basis

Health is enshrined in the Greek Constitution as a social right. Article 21 of the Constitution of Greece of 1975 establishes that, “*the State shall care for the health of citizens and shall adopt special measures for the protection of youth, old age, disability and for the relief of the needy*”.²⁰⁴

Historical background

The founding law of the Greek health system (Law 1397/1983)²⁰⁵ was passed in September 1983 and to date is considered to be the most significant attempt to make a radical change in the health sector, which would gradually lead to a comprehensive public healthcare system.²⁰⁶ This law can be characterised as the foundation of the Greek healthcare system.²⁰⁷

The philosophy of the law that introduced the notion of the National Health System in its Article 1 was based on the principle that health is a social good and it should be provided free of charge at the point of delivery by the state equitably for everyone, regardless of social and economic status.²⁰⁸ According to its provisions, there should be universal coverage, equal access to health services and the State should be fully responsible for the provision of services to the population.

²⁰⁴ *Constitution of Greece of 1975* (last amendment of 2008),

<http://www.hri.org/MFA/syntagma/artcl25.html>

²⁰⁵ <http://www.mednet.gr/eecaa/pdf/law-1397-1983.pdf>

²⁰⁶ C. Economou, “Greece: Health system review”, *Health Systems in Transition*, 2010, vol. 12, No. 7, http://www.euro.who.int/_data/assets/pdf_file/0004/130729/e94660.pdf

²⁰⁷ Ibid.

²⁰⁸ Ibid.

Organisation and funding of Greek healthcare system

The Greek healthcare system (*Ethniko Systima Ygeias – ESY*) comprises elements from both the public and private sectors²⁰⁹. In relation to the public sector, elements of the Bismarck and Beveridge models coexist.²¹⁰

The Greek public healthcare system is financed by a mix of public and private resources. Public statutory funding is based on social insurance. The primary source of revenue for the social insurance funds is constituted by the contributions of employees and employers (including contributions by the State as an employer).²¹¹ The State budget, via direct and indirect tax revenues, has to cover administration expenditures, funding health centres and rural surgeries, providing subsidies to public hospitals and insurance funds, investing in capital stock and funding health education.²¹²

The private sector includes profit-making hospitals, diagnostic centres and independent practices, financed mainly from out-of-pocket payments and, to a lesser extent, by private health insurance.

Recent reforms of the healthcare system

In 2014, the Greek Parliament adopted a primary healthcare law (Law 4238/14²¹³), based on the core values of the Declaration of Alma-Ata, to ensure better health of the Greek people.²¹⁴ With this law, Greece intended to build a comprehensive and

²⁰⁹ Ibid.

²¹⁰ Ibid.

²¹¹ Ibid.

²¹² Ibid.

²¹³ *Law 4238/14 – 2014*

<http://www.moh.gov.gr/articles/newspaper/nomothesia-kanonismoi/3246-nomothesia-hlektronikhs-ygeias?fdl=8084>

²¹⁴ <http://www.euro.who.int/en/countries/greece/news/news/2014/02/greece-launches-new-primary-health-care-law>

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strong nation-wide primary healthcare service.²¹⁵

In a nutshell, the Greek health system is now a mixture of three main components:

- a tax-based National Health System that is responsible for public hospitals and health centres in rural and urban areas;
 - an extensive network of polyclinics (previously belonging to insurance funds but transferred to EOPYY_National Organisation for Healthcare Services Provision_Εθνικός Οργανισμός Παροχής Υπηρεσιών Υγείας), financed by insurance contributions paid by employees and employers. These units are mainly located in urban areas, covering more than 50% of the population. Their control and management were transferred from EOPPY to Health Region Administrations (DYPEs) in 2014;
- a private insurance system (mainly consisting of complementary insurance) and a private delivery system which consist of private hospitals, diagnostic centres and private doctors, most of whom also have contracts with EOPYY.²¹⁶

A major law concerning healthcare was adopted on 20 February 2016: Law 4368/2016²¹⁷, implemented by the joint ministerial decision n° A3(c)/GP/oik.25132/2016 on 4 April 2016²¹⁸, opened access to the public health system to uninsured and vulnerable people and minimised the bureaucratic procedures.

²¹⁵ Ibid.

²¹⁶ N. Polyzos et al., “The introduction of Greek Central Health Fund: Has the reform met its goal in the sector of Primary Health Care or is there a new model needed?”, *BMC Health Services Research*, 2014,

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255662/pdf/12913_2014_Article_583.pdf

²¹⁷ Law 4368/2016 - 2016

Pursuant to Article 33 of the 4368/2016 law, uninsured people and vulnerable social groups now have free access to public health facilities, nursing and medical services.

Section 2 of Article 33 further provides that beneficiaries of the rights stated in Section 1 are:

- Uninsured Greek nationals, authorised residents and their family members (spouse and dependent children)
- Vulnerable groups, regardless of their legal status:
 - children up to 18 years old,
 - pregnant women,
 - chronically ill people,
 - beneficiaries of a form of international protection,
 - holders of a residence permit for humanitarian reasons,
 - asylum seekers and their families,
 - persons accommodated in mental units,
 - victims of certain crimes,
 - people with a disability of 67% or more,
 - seriously ill people,
 - inmates²¹⁹

The 4368/2016 law also simplified the administrative procedure to obtain healthcare for Greek nationals, who now simply have to present their social security number to obtain care; and abolished the committees that used to determine on a case-by-case basis who was entitled to healthcare benefits.

<https://www.minedu.gov.gr/publications/docs2016/%CE%A6%CE%95%CE%9A.pdf>

²¹⁸ Joint ministerial decision implementing law 4368/2016

<http://www.opengov.gr/yyka/wp-content/uploads/downloads/2015/04/sxedio-kya-anasfalistwn.pdf>

²¹⁹ For the detailed list, see article 3 of the Joint Ministerial Decision mentioned above

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In addition of opening rights to free healthcare, the Joint ministerial decision²²⁰ implementing law 4368 also introduced a system combining income, social and clinical criteria to exempt vulnerable social groups from pharmaceutical spending. Thus, vulnerable groups as chronically ill or disabled people, and individuals and families whose income does not exceed €200 monthly for a single person, €300 for couples or a single person with a dependent member, up to €550²²¹ for a couple with five dependents, are exempted from medication costs.²²²

This reform, allowing thousands of people to access free healthcare, follows the Common ministerial decree no. Y4α/ΓΠ/οικ.48985/2014 of 2014, which opened access to healthcare for a part of uninsured Greek citizens and authorised residents.

The new law 4461/2017 voted in Parliament in July 2017 plans for the setting up of a new primary care system (including family doctors and local health units) in its article 107. This law will be implemented during the year 2017 and aims at improving the system through decentralisation.

Functioning of Greek healthcare system

Primary healthcare is a key element of the Greek health system, acting both as a point of first contact and a gatekeeping mechanism.²²³ Primary healthcare in Greece is provided by both National Health System (ESY) and EOPYY units. However,

a large number of self-employed health professionals exist.²²⁴

More specifically, primary healthcare relies on health centres and private or public hospitals and outpatient clinics, assigned to the National Health System; EOPYY's polyclinics and medical centres; and doctors, nurses, pharmacists, physiotherapists and other self-employed health professionals contracted with the EOPYY.²²⁵ The current scheme allows free choice of provider but not of the insurer.²²⁶

Structurally, there is a shortage of general practitioners (GPs) in Greece compared to specialists, there are few nurses per thousand people and urban areas attract most providers and patients.²²⁷

The 2011 reform in the Greek health social insurance market resulted in a unified central fund (EOPYY) which simultaneously assumed the majority of primary health care provision.²²⁸

EOPYY's primary mission is the provision of health services to employed members, pensioners and their family dependants registered with the merged healthcare funds. EOPYY unified the majority of healthcare funds, amongst them the Private Employees' Fund (IKA), the Public Employees' Fund (OPAD), the Farmers' Fund (OGA) and the Self-employed/Entrepreneurs' Fund (OAEE).²²⁹

As a result, EOPYY covers over 98% of people with health coverage.²³⁰

²²⁰ Joint ministerial decision implementing law 4368/2016

²²¹ <http://www.moh.gov.gr/articles/health/anapyksh-monadwn-ygeias/3999-prosbash-twn-anasfalistwn-sto-dhmosio-sythma-ygeias>

²²² Article 6, joint ministerial decision n° A3(c)/GP/oik.25132/2016 Op. cit. note 220

²²³ Ibid.

²²⁴ Op. cit. note 216

²²⁵ Op. cit. note 216

²²⁶ S. Karakolias and N. Polyzos, "The Newly Established Unified Healthcare Fund (EOPYY): Current Situation and Proposed Structural Changes,

towards an Upgraded Model of Primary Health Care, in Greece", *Scientific Research*, 2014, <http://www.scirp.org/journal/PaperDownload.aspx?paperID=44338>

²²⁷ WHO regional Office for Europe, *Profile for health and Well-Being – Greece*, 2016 http://www.euro.who.int/_data/assets/pdf_file/001/0/308836/Profile-Health-Well-being-Greece.pdf?ua=1

²²⁸ Ibid.

²²⁹ Ibid.

²³⁰ Op. cit. note 216

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For primary healthcare, EOPYY also undertakes the operational coordination and cooperation between (public and private) healthcare units and health professionals constituting the primary healthcare network.²³¹

Generally, Greek citizens seem to prefer inpatient/hospital primary healthcare services, as they consider them more effective.²³² In Greece, the system is based on a “free-choice” model, which means each patient can choose freely any healthcare provider of the National Health System or EOPYY.²³³

Accessing Greece healthcare system

All Greek citizens are entitled to access healthcare free at the point of delivery. Authorised residents in Greece are entitled to the same access to healthcare as Greek citizens. Formal access to the free services of the National Health System is dependent on registered employment and regular status, unless one is part of one of the groups defined by the 4368/2016 law of February 2016 (see next section).

Although the EOPYY could theoretically reduce administrative costs and improve access to healthcare, a series of immediate measures transferred a portion of costs to the insured population.²³⁴ For example, EOPYY immediately restricted access to many essential health services, such as medical care, glasses, dental care and physiotherapy services.²³⁵

The new fund has also increased co-payments for private hospital services, starting at 20% and reaching 50% for farmers. These measures increased the

insured population’s out-of-pocket participation at a time when their total income has decreased by about 35%.²³⁶ Patients are also required to pay 25% of the cost of the medicines.²³⁷

The former government started abolishing EOPYY’s existing primary care structures and services, converting it from a medical service supplier with its own doctors and dentists into a medical services purchasing body.²³⁸

EOPYY provides free primary care services to the insured population in urban areas through its salary-based healthcare professionals (some professionals serve on a contractual basis).²³⁹

The new fund is obliged to cover all citizens, even those who are unemployed or bankrupt (i.e. providing free access to doctors and medicines, regardless of insurance status). Those who are without health coverage because of the economic crisis or other reasons could be covered by the public budget or other sources (e.g. European Social Fund) on a pre-determined annual basis.²⁴⁰ However, these budgets targeted only a small part of this population group. Thus, a new law was adopted on 20 February 2016, opening access to healthcare to the uninsured population and vulnerable individuals (see next section).

Termination of pregnancy

Pursuant to the article 304 of the Greek penal code (as amended by the law 1609/1986), abortion is permitted until the 12th week of pregnancy, until the 19th week if the pregnancy results from rape, incest or seduction of a minor²⁴¹, and until the 24th

²³¹ Op. cit. note 216

²³² Op. cit. note 216

²³³ Op. cit. note 216

²³⁴ D. Niakas, “Greek economic crisis and health reforms: correcting the wrong prescription”, *International Journal of Health Services*, Vol 43, No 4, 2013,

<http://www.iatronet.gr/photos/enimerosi/niakas.pdf>

²³⁵ Ibid.

²³⁶ Ibid.

²³⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255662/table/Tab1/>

²³⁸ Op. cit. note 234

²³⁹ Op. cit. note 234

²⁴⁰ Op. cit. note 234

²⁴¹ <http://www.un.org/esa/population/publications/abortion/doc/greece.doc>

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week, if there is evidence of severe abnormality of the foetus. Abortion is also permitted without a time limit, if there is an inherent risk to the pregnant woman's life or the risk of serious and permanent harm to her physical or mental health, ascertained by a corresponding physician.

Access to healthcare for migrants

Asylum seekers and refugees

According to article 33 Section 2 of the 4368/2016²⁴² law, asylum seekers and refugees are considered vulnerable groups and thus have access to the public healthcare system for free, in the same way as destitute Greek nationals.

Before the 2016 law, the Common ministerial decision KYA Y4α/48566/05 provided free healthcare for asylum seekers and refugees.

Moreover, Article 14 of the Presidential Decree 220/2007 on the transposition into the Greek legislation of Council Directive 2003/9/EC from January 27, 2003 laying down minimum standards for the reception of asylum seekers, already stated that *“applicants [for refugee status] shall receive free of charge the necessary health, pharmaceutical and hospital care, on condition that they are uninsured and financially indigent. Such care shall include: a. Clinical and medical examinations in public hospitals, health centres or regional medical centres. b. Medication provided on prescription from a medical doctor serving in one of the above institutions and acknowledged by their director. c. Hospital-based care in public hospitals, class C of hospitalisation. 2. In*

²⁴² Joint ministerial decision implementing law 4368/2016

²⁴³ Presidential Decree of 2007, <http://www.refworld.org/docid/49676abb2.html>

²⁴⁴ Law 4368/2016

²⁴⁵ Law 4368/2016

*all cases, emergency aid shall be provided to applicants free of charge”.*²⁴³

In principle, asylum seekers and refugees have free access to hospitals and medical care. However, Greece is witnessing an unprecedented increase in the inflow of refugees and migrants to its territory and, even though the Greek state and population showed great solidarity with asylum seekers, the ability of the Greek health system to provide adequate healthcare to refugees upon entry is severely stretched. Thus, asylum seekers and refugees still encounter difficulties in gaining access to healthcare.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum and pregnant refugees are entitled to free antenatal and postnatal care, delivery care and abortion.²⁴⁴

Children of asylum seekers and refugees

Children of asylum seekers have the same access to primary and secondary healthcare, including immunisation as nationals and authorised residents.

Undocumented migrants

In Greece, there is a legislation prohibiting care beyond emergency care for adult undocumented migrants. However, the new law 4368/2016 (Article 33, section 2)²⁴⁵ and Article 3 of the joint ministerial decision implementing it²⁴⁶ introduced exceptions to this rule, allowing the most vulnerable categories of people to access healthcare.

The new Migration Code, implemented by Law 4251/2014²⁴⁷ and repealing Law

²⁴⁶ Joint ministerial decision implementing law 4368/2016

²⁴⁷ Law 4251/2014 - 2014

<http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/100567/120684/F-12516934/GRC100567%20Grk.pdf>

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3386/2005, continues to prohibit healthcare for undocumented migrants.²⁴⁸

In particular, Article 26§1 Law 4251/2014 states that “*public services, legal entities of public law, local authorities, public utilities and social security organisations shall not provide their services to third-country nationals who do not have a passport or any other travel document recognised by international conventions, an entry visa or a residence permit and, generally, who cannot prove that they have entered and reside legally in Greece. Third-country nationals who are objectively deprived of their passport shall be given the right to transact with the agencies referred to above, simply by showing their residence permit*”.

In addition, Article 26.2a states that “*the arrangements of the previous paragraph shall not apply to hospitals, treatment centres and clinics in the case of third-country minors and nationals who are urgently admitted for hospitalisation and childbirth, and the social security structures which operate under local authorities*”.

It should be noted that Law 4251/2014 expressly excludes minors of the prohibition to provide healthcare.

Concerning the vulnerable groups and their entitlement to free healthcare, in practice, vulnerable individuals are not always properly identified in the reception centres and thus may not be able to claim their right to free healthcare.

Undocumented pregnant women

Pursuant to the 4368/2016 law²⁴⁹, undocumented pregnant women are entitled to free healthcare. Indeed, they are

²⁴⁸ A. Triandafyllidou, “Migration in Greece Recent Developments in 2014”, *Hellenic Foundation For European and Foreign Policy*, 2014, http://www.eliamep.gr/wp-content/uploads/2014/10/Migration-in-Greece-Recent-Developments-2014_2.pdf

²⁴⁹ Law 4368/2016

considered as one of the vulnerable groups eligible for free healthcare independently of the person’s legal status.

It should be noted that Article 41 of Law 3907/2011²⁵⁰ establishes that undocumented pregnant women may not be removed from the territory during their pregnancy and for six months after delivery, unless they are considered to pose a risk for national security, public order or public health.

Children of undocumented migrants

Children of undocumented migrants are entitled to free healthcare until they are 18 years old, as stated in the 4368/2016 law.²⁵¹ They are indeed considered as a vulnerable group.

EU citizens

In accordance with Directive 2004/38/EC²⁵² of 29 April 2004, after three months of residency in Greece, EU citizens with no resources and/or health coverage are considered to be undocumented migrants. They have the same access to healthcare as undocumented third-country nationals.

Unaccompanied minors

According to Article 19 of Directive 2003/9/EC, which sets out minimum standards for the reception of asylum seekers, unaccompanied minors must be placed in accommodation centres with special provisions for minors, a condition incorporated in Article 11-3 of the Directive 2013/33/EC²⁵³, which provides for a general ban on detaining minors except under “exceptional circumstances”.

²⁵⁰ Law 3907/2011 (last modified by law 4461-2017) <http://www.refworld.org/docid/4da6ee7e2.html>

²⁵¹ Law 4368/2016

²⁵² Directive 2013/33/EC - 2013

²⁵³ Directive 2013/33/EC - 2013

<http://www.refworld.org/docid/51d29db54.html>

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For each unaccompanied child, the Public Prosecutor for Children or the First Instance Prosecutor is informed and acts as the temporary guardian for the child and undertakes the necessary actions for the appointment of a guardian.²⁵⁴ Given the particular characteristics of unaccompanied children, as well as their numbers, the effective exercise of guardianship functions by temporary or permanent guardians becomes particularly difficult, resulting in children not being able to enjoy the protection and rights enshrined in the Convention of the Rights of the Child.²⁵⁵

Besides, when arriving in Greece, unaccompanied children are not accurately or adequately identified, including through proper age assessment procedures.²⁵⁶ Indeed, although the Common Ministerial Decision KYA 1982/2016²⁵⁷ provides that age assessment should first be performed by a paediatrician and then, if doubts remain, by a psychologist and social worker. In most cases, carpal X-ray and dental examination, which should be the last resort, are used to assess the age.

However, age assessment based on physical characteristics is not considered a reliable method, and can only produce an inaccurate estimation of the minority of the applicant. As stated in the Médecins du Monde Greece's submission before the UN Human Rights Committee, "*the measurements do*

not take into account fluctuations due to ethnic and racial background, nutrition and social and economic background, while maturation may also be affected by any diseases the interested party may have".²⁵⁸

Greek law does not prohibit detention of unaccompanied minors who enter Greece without valid papers, although it enjoins authorities to "avoid it" (Article 13(6) (c) PD 114/2010; Article 46 (10)b of law 4375/2016). Unaccompanied children can be detained only until a place in a special facility for minors is found²⁵⁹. What is more, Article 32 of Law No 3907/2011²⁶⁰ (implementing Directive 2008/115/EC) stipulates that minors and families with minor children should only be detained as a measure of last resort, and only if no other adequate but less burdensome measures can be taken, and for the shortest appropriate period of time.

Yet, the authorities detain unaccompanied children, either on arrival or when they are found without valid documents, for periods of ranging from a few hours to several days or months.²⁶¹ The reasons for detaining children for longer or shorter periods appear to be arbitrary.²⁶² The detention of children is also caused by the fact that the large influx of asylum seekers to Greece has overwhelmed existing centres.

²⁵⁴ *Article 19 of Presidential Decree 220/2007* <http://www.refworld.org/docid/49676abb2.html>
²⁵⁵

United Nations High Commissioner for Refugees Greece, *Current Issues of Refugee Protection in Greece*, July 2013, https://www.unhcr.gr/fileadmin/Greece/News/2013/PCjuly/Greece_Positions_July_2013_EN.pdf

²⁵⁶ Ibid.

²⁵⁷ *Ministerial Decision KYA 1982/2016 – 2016* <http://asylo.gov.gr/wp-content/uploads/2016/02/%CE%91%CE%9D%CE%97%CE%9B%CE%99%CE%9A%CE%9F%CE%A4%CE%97%CE%A4%CE%91.pdf>

²⁵⁸

http://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/GRC/INT_CCPR_NGS_GRC_2723_6_E.pdf

²⁵⁹ <http://www.asylumineurope.org/reports/country/greece/detention-asylum-seekers/legal-framework-detention/detention-vulnerable#sthash.iSUsTK8H.dpuf>

²⁶⁰ *Law 3907/2011*

<https://www.e-nomothesia.gr/kat-allodapoi/n-3907-2011.html>

²⁶¹ Platform for International Cooperation on Undocumented Migrants (PICUM), *Recommendations to the European Union to Urgently Address Criminalisation and Violence Against Migrants in Greece*, Brussels, 2014, http://picum.org/picum.org/uploads/publication/Recommendations%20to%20address%20criminalisation%20and%20violence%20against%20migrants%20in%20Greece_Reprint%20May%202014_2.pdf

²⁶² Ibid.

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Reception capacity for children is insufficient: at national level, there are 1,294 places in special centres for unaccompanied minors and 1,013 unaccompanied children on waiting lists for shelter (including 173 in reception and identification centres and 61 in protective custody) as of 15 May 2017.²⁶³

There is no institutionalised procedure for determining the best interests of the child, a guiding principle of the protection of children according to international standards and Greece's obligations as a signatory to the CRC (Convention on the Rights of the Child).²⁶⁴ As a result of existing shortcomings in the Greek child protection system, unaccompanied minors remain in administrative detention, often for a long time, in contravention of applicable national and international law.²⁶⁵

What is more, unaccompanied children are often detained in unsanitary and degrading conditions in overcrowded spaces. Most of the cells, children are detained in, are dirty, bug-infested and do not include proper beds.²⁶⁶

Despite prohibitions in international and Greek law, some of the minors, particularly when there is a doubt concerning their age, share their cell with adults, which puts them in danger of physical and sexual abuse.²⁶⁷

In 2016, the UN Special Rapporteur on the human rights of migrants, after his visit to Greece, regrets "the Greek government's policy of increasing the use of detention of persons irregularly entering the Greek territory, including unaccompanied children

and families" and recommends the Greek government to "urgently consider alternatives to detention for all migrants, and especially unaccompanied minors and families with children [and to] develop a substantial and effective guardianship system".²⁶⁸

Protection of seriously ill foreign nationals

Seriously ill foreign nationals are entitled to free healthcare in public facilities, independently of their legal status pursuant to article 33 of the 4368/2016 law.²⁶⁹ Indeed, they are considered as particularly vulnerable.

Pursuant to Article 19A of Law 4251/2014, persons following an approved legal therapeutic mental dependency program, as demonstrated by a written confirmation from the Director of the programme can obtain a residence permit for one year, renewable up to two years.

Prevention and treatment of infectious diseases

Detention on public health grounds

Article 76 of Law 3386/2005, as amended by Law 4075 of April 2012²⁷⁰ (remaining in force pursuant to article 139 (2) of Law 4251/2014) provides for the detention and expulsion of migrants and asylum seekers on public health grounds. The law permits the detention for up to 18 months of a migrant or asylum seeker who represents a danger to public health.²⁷¹ in order to proceed with the expulsion: if they are

²⁶³ EKKA, National Centre for Social Solidarity, with support from Unicef <http://www.ekka.org.gr/files/aglika15052017.pdf>

²⁶⁴ Op. cit. note 255

²⁶⁵ Op. cit. note 255

²⁶⁶ Human Rights Watch, "Why are you keeping me here" *Unaccompanied Children detained in Greece*, 8 September 2016

²⁶⁷ Ibid.

²⁶⁸

<http://www.ohchr.org/EN/NewsEvents/Pages/Displ>

[ayNews.aspx?NewsID=19972&LangID=E#sthash.UtAn6Vjd.dpuf](http://www.ayNews.aspx?NewsID=19972&LangID=E#sthash.UtAn6Vjd.dpuf)

²⁶⁹ Law 4368/2016

²⁷⁰ Law 3386/2005 (pursuant to article 139(2) of the law 4251/2014, articles 76, 77, 78, 80, 81, 82, 83 and 89 (paragraphs 1-3) of the Law 3386/2005 remain applicable)

<http://www.refworld.org/docid/4c5270962.html>

²⁷¹ <http://www.globaldetentionproject.org/countries/europe/greece>

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suffering from an infectious disease; if they belong to a group vulnerable to infectious diseases (with assessment permissible on the basis of country of origin); if they are intravenous drug users or sex workers; or if they live in conditions that do not meet minimum standards of hygiene.²⁷² MdM EL team reports that in some cases the decision was taken exclusively by Police officers.

HIV testing and treatment

Since the Circular Y4α/οικ 93443/11 of 18 August 2011²⁷³ has been adopted, HIV testing and treatment are free for all people living in Greece, regardless of their legal status and health coverage. Thus, it includes Greek citizens without health coverage and undocumented migrants.

However, HIV treatment is not always effectively available and patients have to endure periods of interruption of this essential treatment. Indeed, because of the economic crisis, hospitals in Greece are in financial difficulty and some of them do not have sufficient budget to buy all necessary medicine, which results in drug shortages.

Repeal of measure 39A of the Health Act

A Ministerial Decision published in the Government Gazette on 17 April 2015²⁷⁴ repealed the restoration of measure 39A of the Health Act. This law was implemented by the Minister of Health Andreas Loverdos and was then repealed in 2013 by the Minister of Health Fotini Skopouli (of Democratic Left) before being reactivated by the Minister of Health Adonis Georgiadis (far right).

Decree 39A has been the cause of hundreds of police operations since 2012, mainly targeting drug users and sex workers. It allowed the authorities to conduct forced

HIV tests on citizens with the help of security forces.

Several women were detained during the election campaign in 2012. They were arrested and then forced to undergo HIV screening and were detained for several months merely because they were HIV positive.

It is thus a positive development that the Greek authorities have decided to repeal this measure, which violated human rights and affected human dignity.

²⁷² Op. cit. note 255

²⁷³ Circular Y4α/οικ 93443/11 – Clarifications on access to the country's medical and nursing system to foreigners and uninsured persons

See Circular Y4α/οικ 45610 of 2012 https://www.synigoros.gr/resources/docs/egkyklios_2.pdf

²⁷⁴ http://omniatv.com/images/easyblog_images/62/fek-katarghsh-39A.pdf

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National Health System

Basis, Organisation and funding of Irish healthcare system

Basis

The Irish Constitution or legislation does not contain any express recognition of health as a human right.

However, some judicial statements suggest that there is an un-enumerated right to health protected by the Constitution. In the case of *Heeney vs Dublin Corporation*²⁷⁵, the Irish Supreme Court recognised that “there is a hierarchy of constitutional rights and at the top of the list is the right to life, followed by the right to health”.²⁷⁶ In another matter RE Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004, it was argued that a constitutional right to healthcare could be derived from the right to life, the right to personal dignity and /or the right to bodily integrity. Yet, in 2005²⁷⁷, the Irish Courts rejected the existence of the right to health where that would create an obligation upon the state to provide free healthcare.²⁷⁸

Organisation

Healthcare in Ireland is a two-tier system: private and public healthcare systems. The public healthcare system is governed by the Health Act 2004²⁷⁹, which established the Health Service Executive (HSE), the body responsible for the budget, the management and the provision of health and personal social services to everyone living in Ireland. The HSE is directly accountable to the Minister for Health.

²⁷⁵ *Heeney v. Dublin Corporation* [1998] IESC 26 (17th August, 1998)

²⁷⁶ Malcolm Longford, *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, Cambridge University Press, 2009

²⁷⁷ Unreported Supreme Court decision of 16th February 2005

The HSE is divided into four administrative regions (HSE Dublin Mid-Leinster, HSE Dublin North-East, HSE South and HSE West) and manages the delivery of the entire health service as a single national entity.²⁸⁰

The HSE organisational structure is divided into three main areas: Health and Personal Social Services, Support Services and Reform and Innovation. Health and Personal Social Services is further divided into three service delivery units:

- National Hospitals Office which manages acute hospital and ambulance services
- Primary, Community and Continuing Care which delivers health and personal social services in the community and other settings
- Population Health, which promotes and protects the health of the entire population²⁸¹.

From primary to acute healthcare

Primary care plays a central role in the provision of healthcare services in Ireland and is delivered by private General Practitioners (GPs), doctors who provide health services to people in their surgery or in the patient’s home. GPs are also gatekeepers for hospital treatment, providing referral letters to acute care for the patients. GPs are located in the community in single or multi person practices. If the patient does not have a Medical Card or a GP Visit Card, the service has to be paid for by the patient. The charges for GP visits vary from €30 to €65 across state. The return visits may be charged at the discounted rate (around €30).

²⁷⁸ Ibid.

²⁷⁹ <http://www.irishstatutebook.ie/eli/2004/act/42/en/acted/en/html>

²⁸⁰ http://www.hse.ie/eng/services/publications/corporate/Towards_Better_Healthcare.pdf

²⁸¹ Ibid.

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Primary, community and continuing care (PCCC) is provided by a range of health professionals such as community-based pharmacists, public health nurses, healthcare assistants, social workers, home help, midwives and the like. There are also public and private facilities that provide non – acute long-term healthcare. Such long stay public units include homes, district and community hospitals, and HSE welfare homes.

Acute healthcare services are delivered in the HSE public, voluntary public and private hospitals. Voluntary hospitals are primarily financed by the State but may be owned and operated by religious orders or lay boards of governors.²⁸²

Private healthcare system is provided mainly by GPs and private hospitals. The private sector also manages the private nursing homes. A substantial amount of private healthcare takes place within the state – funded public hospital infrastructure, which is quite unique in Ireland. The private provision of healthcare services is integrated into the public health system. For example, under the National Health Strategy, public hospitals are mandated to ensure that 20% of hospital beds are reserved for private patients. A similar situation exists in the primary provision of care: GPs have both private and public patients.²⁸³

Funding

In Ireland, the healthcare system is predominantly tax funded with additional contributions from private health insurance and out-of-pocket payments such as household expenditure on GP visits payments, pharmaceuticals and private/public hospital stays. Approximately 70%

of public funding comes from taxation and 30% from private healthcare insurance. Further to this, the Irish government oversees a medical card system for low-income members of the population. Although all Irish individuals are entitled to public healthcare, many choose to take out private health insurance to top up their entitlements to obtain faster and more advanced medical treatments. The downside to this system is the inequitable level of access to treatment and the long waiting lists.²⁸⁴

In June 2017, 2,157 million, or 45.8% of the Irish population, have private health insurance.²⁸⁵ While the level of healthcare coverage depends on the purchased package of health insurance, most private health insurance cover the hospital related costs, not the primary care. The Irish health insurance market is mainly regulated by the Health Insurance Acts 1994²⁸⁶ to 2014²⁸⁷ and Regulations made under those Acts. Health Insurance Authority regulates the private health insurance providers.

Reform of the Health Service

On 1 June 2016, the Dáil (National Assembly of Ireland) agreed to establish a Special Committee -- the Committee on the Future of Healthcare -- to achieve cross-party consensus on a single long-term vision for health care and the direction of health policy in Ireland, and to make recommendations to the Dáil in that regard. The Committee's agreed vision is for a universal single-tier health and social care system where everyone has equitable access to services based on need and not ability to pay. Over time, everyone will have entitlement to a comprehensive range of primary, acute and social care services at no cost or reduced cost. The vast majority of

²⁸² Amnesty International, *Healthcare Guaranteed? The Right to Health in Ireland*, June 2011

²⁸³ http://www.hse.ie/eng/services/publications/corporate/Towards_Better_Healthcare.pdf

²⁸⁴ EMN Report, *Migrant Access to Social Security and Healthcare: Policies and Practice in Ireland*, 2014

<https://www.esri.ie/pubs/BKMNEXT261.pdf>

²⁸⁵ https://www.hia.ie/sites/default/files/Final%20HIA%20Aug%20Newsletter%202017_1.pdf

²⁸⁶ <http://www.irishstatutebook.ie/eli/1994/act/16/enacted/en/html>

²⁸⁷ <http://www.irishstatutebook.ie/eli/2014/act/42/enacted/en/html>

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care will be provided in the primary and community settings.²⁸⁸

Shifting care out of hospitals and into the primary and community setting will in turn help address the challenge of access to the hospital system, but other measures are also needed including waiting time guarantees for hospital care, expanded hospital capacity and the phased elimination of private care in public hospitals.

Accessing Ireland healthcare system

Ordinarily residents

All persons legally residing in Ireland are entitled to receive healthcare through the public healthcare system.

A wide range of public healthcare services are accessible free of charge or subsidised by the Irish government for those who fulfil the ordinary residence condition. It requires that an applicant has been resident or intends to be resident in the State for at least one year.²⁸⁹

The ordinary residence condition was introduced by way of the Health Amendment Act 1991²⁹⁰ as the criterion to determine eligibility for healthcare services in Ireland. As it was not precisely defined, guidelines on the Ordinarily Resident Condition for eligibility for health services were issued by the Department of Health in July 1992 (Circular 13/92) to Health Boards and Voluntary/ Joint Board Hospitals.²⁹¹

HSE is responsible to determine whether a person meets the “ordinary residence” condition. Assessment of “ordinary residence” is made at the point of payment/non-payment for a service. If a person seeking to access the service fails to supply

insurance details or fails to demonstrate that s/he is covered under the EU rules, the hospital accounts department will issue a bill for a full applicable charge. The onus then rests on the individual to show that s/he is not liable for the fee. In order to establish that a person is ordinarily resident, the HSE may require the documentary evidence such as proof of property purchase or rental, evidence of funds, a residence permit or a work permit.

The medical card system

Only medical cardholders have full eligibility to free healthcare in Ireland. The Health Act 1970²⁹² introduced the Medical Card system entitling free access to health services within the public system.

Determination of the eligibility for a Medical Card is the responsibility of the HSE. To determine such eligibility, the three primary means are applied: means test, discretionary assessment and EU entitlements.

Both the means test and the discretionary assessment are based on the concept of avoiding the “undue hardship” to an individual if they had to pay their own medical costs. The primary way to assess the likelihood of the “undue hardship” is through a means test of income. The income guidelines are used to establish eligibility and are intended to ensure that individuals below certain levels of income have access to healthcare without any cost.²⁹³

The criteria to determine whether someone has access are numerous and there is no unique threshold below which a person is automatically declared in “undue hardship”. However, to give an example, the weekly income limit for a single person aged under

²⁸⁸ *Committee on the Future of Healthcare final report* May 2017
<http://beta.oireachtas.ie/en/committees/32/future-of-healthcare/>

²⁸⁹ <http://www.hse.ie/eng/services/publications/corporate/medcardgpvisit.pdf>

²⁹⁰ <http://www.irishstatutebook.ie/eli/1991/act/15/enacted/en/html>

²⁹¹ Op. cit. note 284

²⁹² <http://www.irishstatutebook.ie/eli/1970/act/1/enacted/en/html>

²⁹³ <http://www.hse.ie/eng/services/list/1/schemes/mc/forms/medicalcardguidelines2015.pdf>

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66 and living alone, to obtain the medical card is of €184.²⁹⁴ It is of €500 for people aged over 70.²⁹⁵

Individuals with Medical Cards also have free of cost access to acute healthcare. Non-Medical Cardholders are liable for statutory in-patient charges and outpatient charges for public care in public hospitals.

Medical Cardholders are entitled to the following services free of charge:

- Doctor visits: A range of GP services from a chosen doctor in their local area
- Prescription Medicines: The supply of prescribed approved medicines, aids and appliances such as wheelchairs and crutches
- Certain dental, eye and ear health services
- Hospital Care: All in-patient services in public wards in public hospitals, including public consultant services
- Hospital visits: All outpatient services in public hospitals, including public consultant services
- Maternity Cash Grant on the birth of each child
- Medical & Midwifery Care for Mothers, including healthcare related to pregnancy and the care of the child for six weeks after birth
- Some personal and social care services, for example, public health nursing, social work services and other community care services based on client need

GP Visit Cards entitle the holders to access primary care provided by the GPs free of charge.

²⁹⁴http://www.citizensinformation.ie/en/health/medical_cards_and_gp_visit_cards/medical_card_means_test_under_70s.html

²⁹⁵http://www.citizensinformation.ie/en/health/medical_cards_and_gp_visit_cards/medical_card_means_test_over_70s.html

Anybody in Ireland with a medical emergency is entitled to attend the Emergency Department. A patient visiting the Emergency Department, either will be treated and sent home, or will be admitted to a ward as an in-patient. A fee of €100 applies unless the patient is referred to this service by the GP.²⁹⁶

Drug payment scheme

The Drug Payment Scheme allows individuals and families who do not hold medical cards to limit the amount they have to spend on prescribed drugs. Under the Drug Payment Scheme, the patient will not pay more than €144 in any calendar month for approved prescribed drugs, medicines and appliances. The “ordinarily resident” condition is applicable for the eligibility for this scheme.²⁹⁷

Long-term illness scheme

The Long-Term Illness Scheme allows people with certain long-term conditions to obtain the medicines and medical and surgical appliances they require for the treatment of their condition, free of charge. This scheme is not subjected to a means test or any income requirement and is separate from the Medical Card Scheme and the GP Visit Card Scheme. However, only “ordinarily residents” can qualify for this scheme.²⁹⁸

Waiting times

The structure of the Irish healthcare system, divided in public and private schemes generates sometimes long waiting times for treatments. It is common to have separate waiting lists for public and private patients for most procedures against which it is possible to ensure. This results in disparities in waiting times that depend on means rather than clinical need. It is the most

²⁹⁶<http://www.hse.ie/eng/services/publications/corporate/medcardgpvisit.pdf>

²⁹⁷<http://www.hse.ie/eng/services/list/1/schemes/drugpaymentscheme/>

²⁹⁸<http://www.hse.ie/eng/services/list/1/schemes/lti/>

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visible aspect of inequity in the Irish healthcare system.²⁹⁹

The National Treatment Purchase Fund (NTPF) was created in 2002 to address the waiting time issues. The NTPF is an independent statutory agency with the aim of overseeing the faster access to elective hospital-based treatment; it involves the government paying for patients to be treated for free in private hospitals in Ireland.

Access to healthcare for migrants

In Ireland, the same conditions on access to healthcare generally apply to migrants as to non-migrants. However, the rules, especially residence-related rules, have a different impact on migrants than on non-migrants.

According to the Health (Amendment) Act 1991, entitlement to access the healthcare is based on residency rather than on citizenship or the ability to contribute towards general taxation. Therefore, migrants who meet the requirement of “ordinary residence” condition are entitled to access state-subsidized healthcare services, including the Medical Card System. Both regular and irregular migrants who do not meet this requirement may be asked to pay the full charges for healthcare services.³⁰⁰

In addition, certain categories of non-EEA migrants are required to purchase private healthcare insurance in order to register with the immigration authorities, these include international students and family dependents of work permit holders.

There are some adaptive structures to migrants in healthcare in Ireland. The National Intercultural Health Strategy 2007

²⁹⁹<http://www.ucd.ie/geary/static/publications/workpapers/gearywp200735.pdf>

³⁰⁰ Op. cit. note 282

³⁰¹http://www.hse.ie/eng/services/publications/SocialInclusion/National_Intercultural_Health_Strategy_2007_-_2012.pdf

– 2012³⁰¹ provided a range of initiatives such as translated informational material in different languages on health services. It also provided resources, training and support initiatives for staff in the healthcare system to be able to assist migrants more effectively.

Asylum seekers and refugees

Asylum seekers and refugees have access to healthcare on the same basis than Irish citizens.

Asylum seekers are entitled to the same range of health services as Medical Card Holders. While their application to remain in the state is being processed, they reside in the Direct Provision Centres and do not have to fulfil the “ordinary residence” or means- testing criteria to receive healthcare services. Services available to asylum seekers under the Medical Card Scheme include:

- GP services
- Public Hospital in-patient and outpatient services
- Prescriptions/medicines
- Women’s health services
- Counselling services for people traumatized by torture, rape and other critical life experiences
- Optical tests and glasses
- Hearing tests and aids
- Dental treatment for adults³⁰²

However, if asylum seekers chose to live outside the Direct Provision Centres for a variety of reasons, they will face difficulties in accessing Medical Card System. Indeed, asylum seekers have difficulties in providing sufficient evidence of their means as they are effectively excluded from receiving any social supports from the State

³⁰²http://www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refugees/services_for_a_sylum_seekers_in_ireland/medical_services_and_entitlements_for_asylum_seekers.html

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by virtue of Habitual Residence Condition introduced in Section 17 of the Social Welfare (Miscellaneous Provisions) Act 2004.³⁰³ Such asylum seekers are unable to meet “means test” criteria and this, in turn, results in medical card refusal.³⁰⁴ This means that this vulnerable group of people has no access to free of charge primary care and GP service.

Individuals who obtain the refugee status are regarded as ordinarily residents and fall under the same rules for entitlement for health services as Irish nationals.

It is to be noted that, according to the Dublin III Regulation³⁰⁵, during the three first months of the asylum application, another country can request the responsibility to consider the application. As only one country can examine an asylum application, if this occurs, the asylum seeker will lose his status and the rights attached to it in Ireland, and will be transferred to the country declared competent to examine his application.

Pregnant asylum seekers and refugees

Maternity services are available free of charge for pregnant asylum seekers and refugees under the Maternity and Infant Care Scheme even without a Medical Card or GP visit card. It entitles women to free GP consultations, in-patient, outpatient and accident and emergency services in public hospitals in respect of the pregnancy and the birth, and visits from a public health nurse.³⁰⁶

Children of asylum seekers and refugees

Children in Ireland have the same entitlement to health as their parents. Some services are however provided free of charge for children independently of their

parents, generally as part of maternity and infant care welfare services and school health services. The principal legislation providing for children’s health services is the health Act 1970, but no legislation specifies precisely what services are to be provided. In practice, children have access to immunisation services, developmental paediatric examinations, school health examinations and visits by public health nurses. All Children under six are also entitled to the GP visit card.³⁰⁷

Undocumented migrants

The Irish law excludes undocumented migrants, including children, from the entitlement to access all but urgent medical treatment: the full economic cost can be applied for any services provided. However, the cost of hospital charges can be reduced or even waived if financial hardship is incurred.

Access to healthcare over and above the urgent medical treatment (primary or secondary care) requires undocumented migrants to have financial means to access private healthcare, usually GPs in private practice.

Access to medical services such as hospitals, require a Personal Public Service Number (PPS number). This allows treatments for chronic illnesses. To apply for a PPS number, an individual needs to provide a proof of identity and a home address. The PPS number is also used for employment. As the Social Welfare passes details to the Gardaí National Immigration Bureau, undocumented migrants applying for a PPS number risk deportation.

Undocumented migrants have no access to the Medical Card System as they are unable to meet the lawful residence requirement.

³⁰³<http://www.irishstatutebook.ie/eli/2004/act/9/ enacted/en/html>

³⁰⁴http://www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refugees/services_for_asylum_seekers_in_ireland/direct_provision.html#1f4da

³⁰⁵Op. cit. note 303

³⁰⁶http://www.citizensinformation.ie/en/health/women_s_health/maternity_and_infant_welfare_services.html

³⁰⁷http://www.citizensinformation.ie/en/health/children_s_health/child_health_services.html

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This excludes this vulnerable group of people from accessing free healthcare system in Ireland.³⁰⁸

Undocumented pregnant women

Every woman, irrespective of legal status, who is pregnant and ordinarily resident in Ireland, is entitled to maternity care (antenatal and postnatal) under the Maternity and Infant care Scheme.³⁰⁹ This Scheme provides an agreed program of care to all expectant mothers who are ordinarily resident in Ireland. This service is provided by GPs and a hospital obstetrician. Women are entitled to this service even if they do not hold a medical card. Generally, all GPs have agreements with the Health Service Executive to provide these services; they do not have to be part of the GPs and Medical Cards System. The Scheme also provides for two post-natal visits to the general practitioner.

If the woman has a significant illness, e.g. diabetes or hypertension, she may have up to five additional visits to the GP free of charge. Care for other illnesses which the woman may have at this time, but which are not related to pregnancy, is not covered by the Scheme.

Mothers are entitled to free in-patient and outpatient public hospital services in respect of the pregnancy and the birth and are not liable for any of the standard in-patient hospital charges.

Children of undocumented migrants

All children under 6 years of age who live in Ireland or intend to live in Ireland for at least one year are entitled to GP services free of charge under the GP Visit Card for children under six' scheme.³¹⁰ However, access to a PPS number may be a barrier in

securing a GP card, as applying to a PPS number may expose undocumented migrants to the risk of deportation.

Termination of pregnancy

Ireland has a very restrictive abortion law. Unborn life is constitutionally protected by way of Art. 40.3.3 as amended in 1983, which states that "*The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right*".³¹¹

Information on abortion services outside the state is also constitutionally protected, and is regulated by the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995.³¹² However, the Act also prohibits the promotion or advocacy of abortion while providing information.

In 1992, a landmark Supreme Court case had a profound influence on abortion legislation in Ireland and brought the Irish abortion debate to international attention. In the 1992 "X case"³¹³, a 14-year-old rape victim was prevented by a High Court injunction from travelling to the United Kingdom to obtain an abortion. The girl's family claimed that she was at risk of suicide if she was not allowed to obtain an abortion. This decision was appealed to the Supreme Court, which overturned the High Court order, stating that if there was a real and substantial risk to the life of the mother that could only be averted by termination of the pregnancy, this would be lawful. The Supreme Court thus accepted risk of suicide as a real and substantial risk to life,

³⁰⁸http://www.citizensinformation.ie/en/health/entitlement_to_health_services/health_services_and_visitors_to_ireland.html

³⁰⁹<http://www.hse.ie/eng/services/list/3/maternity/combinedcare.html>

³¹⁰ Op. cit. note 303

³¹¹https://www.constitution.ie/Documents/Bhunreacht_na_hEireann_web.pdf

³¹²<http://www.irishstatutebook.ie/eli/1995/act/5/enacted/en/html>

³¹³[http://www.supremecourt.ie/supremecourt/sclib/ry3.nsf/\(WebFiles\)/B95A1F8B726975F18025765E003C2C6E/\\$FILE/AG%20v%20X_1992.rtf](http://www.supremecourt.ie/supremecourt/sclib/ry3.nsf/(WebFiles)/B95A1F8B726975F18025765E003C2C6E/$FILE/AG%20v%20X_1992.rtf)

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effectively making abortion legal in Ireland under these restricted circumstances.

However, it took two decades for the Irish State to enact the legislation on foot of Supreme Court ruling in the “X case”. After the 2010 condemnation of Ireland by the European Court of Human Rights in the *A, B and C v. Ireland*³¹⁴ case for of its failure to implement the existing constitutional right to a lawful abortion, the protection of Life during Pregnancy Act³¹⁵, which currently regulates abortion, was enacted in 2013.

The Protection of Life During Pregnancy Act 2013 provides for a limited right to the termination of pregnancy if the woman’s life is at risk, including from suicide and where the procedures carried out in the Act are complied with. Yet, this Act limits legal abortion to this unique situation, as abortion remains illegal even in cases of rape, incest, foetal anomaly or risk to a woman’s health.

Furthermore, this restrictive abortion law has a discriminatory impact on women who do not have the financial means to travel to another country to get an abortion, which was criticised among others by the UN Human Rights Committee. Serious breaches of medical confidentiality are also reported as each termination of pregnancy (carried out in Ireland) is notified to the Minister of Health.³¹⁶ In addition, to access safe and legal abortion services, women must travel to another country, which is not possible for undocumented women, as it requires having a legal status and up-to-date valid passport.

Article 22 of the 2013 Act also defines the offence of intentional destruction of

“unborn human life”, with a maximum sentence of 14 years of imprisonment.

EU Mobile citizens

EU citizens ordinarily residing in Ireland have the same access to healthcare as the nationals. None of the provisions in the Health Act 2004³¹⁷ affects the operation of the EC regulations, which govern health service entitlements for EEA nationals.

A range of services are available to EU mobile citizens on a temporary stay in Ireland and holders of the European Health Insurance Card (EHIC) under the EU Regulation 1408/71.³¹⁸ EU residents may qualify for a medical card if they fulfil the “ordinarily resident” condition, get a social security pension from another EU/EEA country or Switzerland, or work and pay social insurance in one of these countries and are not subject to Irish social security legislation.

EU mobile citizens, who are on a temporary stay in Ireland and who are not covered by the EHIC, will not be able to meet “ordinarily resident” condition and will be subjected to full charges for healthcare.³¹⁹

The European Communities (Free Movement of Persons) Regulations 2015 provide that a non-EEA national family member of EU citizen may in general receive the same medical care and services as those to which the nationals or ordinarily residents are entitled to.³²⁰

Pursuant to the 2004 European Directive 2004/38/EC³²¹, after three months of residence in Ireland, if an EU mobile citizen has insufficient funds and no health coverage, s/he will be considered as an

³¹⁴ <http://hudoc.echr.coe.int/eng?i=001-102332>

³¹⁵ *Protection of life during pregnancy Act – 2013* <http://www.irishstatutebook.ie/eli/2013/act/35/enacted/en/html>

³¹⁶ <https://www.ifpa.ie/Hot-Topics/Abortion/Abortion-in-Ireland-Timeline>

³¹⁷ <http://www.irishstatutebook.ie/eli/2004/act/42/enacted/en/html>

³¹⁸ Op. cit. note 304

³¹⁹ http://www.citizensinformation.ie/en/health/entitlement_to_health_services/entitlement_to_public_health_services.html

³²⁰ <http://www.irishstatutebook.ie/eli/2015/si/548/made/en/print>

³²¹ *Directive 2013/33/EC - 2013*

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undocumented migrant and will then be entitled to the same rights as undocumented third country nationals.

Reciprocal health agreement

Ireland has a reciprocal health agreement with Australia, which entitles Australian nationals to receive emergency public hospital treatment subject to the standard charges for non-medical cardholders in Ireland, and to receive assistance towards the cost of prescribed drugs and medicines on the same basis as people normally resident in Ireland.³²²

Unaccompanied minors

The care of the unaccompanied minors falls under Child Protection, which is the responsibility of the HSE. The Child Care Act 1991³²³ is concerned with the welfare of the children who are not receiving adequate care and protection; and contains several provisions relating to the unaccompanied minors. Children taken into the care can access and benefit from accommodation, education, counselling and access to healthcare until they reach the age of majority.

Child and Family Agency was set up under the auspices of the Child and Family Agency Act 2013³²⁴ responsible for providing a wide range of services to improve the wellbeing and outcome for all children, including unaccompanied minors.

All unaccompanied children under 18 are entitled to access medical care and health screening free of charge, the same way as asylum seekers.

Protection of seriously ill foreign nationals

³²²<http://www.irishstatutebook.ie/eli/2013/act/40/en/acted/en/html>

³²³<http://www.irishstatutebook.ie/eli/1991/act/17/en/acted/en/html>

³²⁴ Op. cit. note 322

A non-EEA national can make an application for humanitarian leave to remain under Section 3 of the Immigration Act 1999³²⁵ after s/he has been issued with a Notification of Intention to Deport pursuant to Section 3 of the Immigration Act 1999.

As a legal status, leave to remain is normally granted where asylum seekers do not fit the strict definition of a refugee under the 1951 Convention relating to the Status of Refugees and where subsequent application for subsidiary protection is refused but humanitarian reasons exist for not returning the person to their country of origin. This is provided for under section 17 of the Refugee Act 1996.³²⁶ However, leave to remain can be granted in broader circumstances than this, as it is a discretionary status.

Section 3(6) of the 1999 Act sets out the matters to which the Minister must have regard to when determining to make a deportation order. Under this section, the Minister is required to consider a number of humanitarian grounds when determining the application, including the applicant's connections to the State, his/her family situation, his/her employment prospects and conduct. If the individual or a dependent has fallen seriously ill and there is no alternative treatment in their countries of origin, or if s/he has undergone some other calamity, a number of the section 3(6) headings would apply when the Minister is considering the matter.

Serious health conditions are thus taken into consideration in the decision to grant a permission to stay but there is no guarantee of receiving a positive outcome.

If, having considered these humanitarian factors, the Minister decides not to make a

³²⁵<http://www.irishstatutebook.ie/eli/1999/act/22/en/acted/en/html>

³²⁶<http://www.irishstatutebook.ie/eli/1996/act/17/en/acted/en/html>

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deportation order; it follows that the person will be granted leave to remain in the State.³²⁷ When humanitarian leave to remain is granted, the person has the same access to the healthcare system as ordinarily residents.

Non-EEA nationals are also allowed to apply for a medical treatment visa if the required medical procedure cannot be performed in the country of permanent residence. The appointment with a private hospital in Ireland has to be set up prior to the visa application and the patient has to demonstrate that s/he has sufficient resources to cover the treatment. The visa is issued only for the purpose of a medical treatment and does not provide any entitlement to residency or work rights in Ireland.³²⁸

Prevention and treatment of infectious diseases

The Health Act 1947³²⁹ entitles the Minister for Health to declare by regulations diseases that are infectious, covered by legislation, and that require notification to a Medical Officer of Health. The infectious diseases notifiable in Ireland are regulated in the 1981 Infectious Diseases Regulations as amended most recently by the Infectious Diseases (Amendment) Regulations 2016 (S.I. No.276 of 2016)³³⁰, which identifies a list of notifiable communicable diseases.

The Health Protection Surveillance Centre (HPSC) is the specialist agency mandated for the surveillance of communicable diseases in Ireland.

³²⁷http://www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refugees/refugee_status_and_leave_to_remain/leave_to_remain.html

³²⁸http://www.citizensinformation.ie/en/moving_country/moving_to_ireland/rights_of_residence_in_ireland/residence_rights_of_non_eea_nationals_in_ireland.html

³²⁹<http://www.irishstatutebook.ie/eli/1947/act/28/enacted/en/html>

HPSC Scientific Advisory Committee publishes national guidelines on communicable disease screening in Ireland. The 2015 guidelines³³¹ provide a comprehensive assessment of infectious diseases for migrants offered on a voluntary and confidential basis in any medical setting where migrants present for healthcare. The following infectious disease are included in the recommended assessment programme:

- Chickenpox
- Hepatitis B
- Hepatitis C
- HIV
- Intestinal Parasites
- Malaria
- Measles
- Polio
- Rubella
- Sexually Transmitted Diseases
- Tuberculosis

Asylum seekers, refugees and their families are entitled, free of charge, to medical screening, vaccination and follow-up medical treatment for these diseases, under the medical card scheme.³³²

People receiving treatment for infectious diseases are also exempted of the €100 fee if they use accident and emergency services or receive outpatient care without being referred by a GP, and of the charges for in-patient and day services.³³³

In Ireland, HIV treatment is provided free of charge for everyone, regardless of immigration status.

Hepatitis C treatment is free only for patients considered as seriously ill and

³³⁰<http://www.irishstatutebook.ie/eli/2016/si/276/made/en/print>

³³¹Health Protection Surveillance Centre (July 2015), *Infectious Disease Assessment for Migrants* <https://www.hpsc.ie/A-Z/SpecificPopulations/Migrants/Guidance/File,14742.en.pdf>

³³²Op. cit. note 282

³³³http://www.citizensinformation.ie/en/health/hospital_services/hospital_charges.html

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people who contracted it through the administration of blood within Ireland.³³⁴ Others have to cover its full price, which amounts to around €45,000.

Irish travellers: a national specific situation

Irish Travellers are an ethnic minority group that has been part of Irish society for centuries. They have a value system, language, customs and traditions, which make them an identifiable group both to themselves and to others. Their distinctive lifestyle and culture, based on a nomadic tradition, sets them apart from the general population.

The Traveller community in Ireland suffers from markedly worse health problems related to social exclusion as compared with the general population. Poor living conditions, social exclusion and low levels of education are some of the many factors that contribute to substandard health in the Traveller community. Traveller women live on average 12 years less than women in the general population and traveller men live on average 10 years less than men in the general population.³³⁵

Recent data suggest that Irish Travellers have the same options in availing of healthcare services as the settled population.³³⁶ In addition, the use of GP and emergency services is higher in the Traveller community than in the settled population. Irish Traveller women's health screening rates are higher than the general population. This does not necessarily imply equal access, since Travellers are not denied specific services, but this demonstrates that the challenges facing healthcare workers in providing equal care to Irish Travellers are

more complex than just availability of services.

Primary Health Care for Travellers Projects (PHCTPs) established a model for Traveller participation in the development of health services. Travellers work as Community Health Workers, allowing primary healthcare to be developed based on the Traveller community's own values and perceptions to achieve positive outcomes with long-term effects.³³⁷

The strategic direction of Traveller healthcare is outlined in the National Traveller Health Strategy and the National Intercultural Health Strategy.

³³⁴http://www.citizensinformation.ie/en/health/health_services/blood_and_organ_donation/hepatitis_c_and_health_amendment_act_cards.html

³³⁵<http://www.hse.ie/eng/services/yourhealthservice/SUI/Library/participation/inclusion.pdf>

³³⁶ Royal College of Surgeons in Ireland, Student Medical Journal 2011; 4(1), Cultural Competence:

An Overview of the Health Needs of the Irish Traveller Community.

<http://www.rcsismj.com/wp-content/uploads/RCSismj-Vol4-Srev-Irish-Traveller.pdf>

³³⁷<http://www.hse.ie/eng/services/yourhealthservice/SUI/Library/participation/inclusion.pdf>

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National Health System

Constitutional basis

Article 32 of the Italian Constitution³³⁸ states that “*The Republic protects individual health as a basic right and in the public interest; it provides free medical care to the poor.*”

Pursuant to article 117 of the Italian Constitution, the responsibility for healthcare is “*shared by the national government and the 19 regions and 2 autonomous provinces*”.

Organisation and funding of Italy healthcare system

Organisation

Italy’s healthcare system is a regionally based National Health Service (*Servizio Sanitario Nazionale*, SSN). It offers universal coverage, largely free at the point of use.

The SSN organisation is divided in three levels: national, regional and local.

The national level, embodied by the Ministry of Health and several specialised agencies, is responsible for defining the principles and objectives of the health system, determining the scope of the benefit package of services guaranteed by the SSN and of allocating national funds to the regions.

³³⁸Italian Constitution
<http://www.jus.unitn.it/dsg/pubblicazioni/costituzione/costituzione%20genn2008eng.pdf>

³³⁹Ferré F, de Belvis AG, Valerio L, Longhi S, Lazzari A, Fattore G, Ricciardi W, Maresso A. Italy: Health System Review. Health Systems in Transition, 2014, 16(4):1–168

Regional governments are in charge of ensuring the delivery of public health services.

Finally, local health authorities (*Aziende Sanitarie Locali*, ASL), and public or private accredited hospitals deliver health services.³³⁹

Funding

The public system is financed through a corporate tax, collected nationally and allocated back to regions; through a co-payment for some services and prescriptions; and through a fixed proportion of national value-added tax income, collected by the national government. Then, the collected amount is partially redistributed to the regions that are unable to gather sufficient resources to ensure essential levels of care.³⁴⁰

Regions are authorised to produce their own additional revenue.

Private health insurance has a limited role in the health system. In 2016, it accounted for 25% of the total spending for health.³⁴¹ Private health insurances are of two sorts: corporate and non-corporate.

Accessing the Italian healthcare system

The National Public Health Service (SSN) coverage is automatic and includes Italian citizens and authorised foreign residents. Temporary visitors can access all services upon payment.

Primary and inpatient care covered by the National Health Service are free at the point of use. There are positive and negative lists that define the respective services covered and not covered by the SSN. Some services

³⁴⁰The Commonwealth Fund, *2015 international Profiles of health Care Systems*, January 2016
http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf

³⁴¹<https://www.istat.it/it/archivio/201944>

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can also be covered on a case-by-case basis. These lists are identified using criteria as medical necessity, efficiency, human dignity and effectiveness.

Services and goods covered by the SSN are included in the list of LEA (Essential levels of assistance – *livelli essenziali di assistenza*), which includes:

- Primary care
- inpatient care
- outpatient specialist care
- home care
- preventive medicine
- pharmaceuticals
- dental care (only for specific populations such as children up to 16 years old, vulnerable people (disabled persons, people suffering from rare diseases or HIV), destitute people, and individuals with urgent/emergency needs)

Mental health, preventive, long-term-care and public health services are not specifically listed in the LEA. Instead, national legislation defines an organisational framework to be applied by the regions, which provide for these health services.

The coverage of prescription medicines is dependent on their clinical and cost effectiveness. Medicines are divided into three tiers:

- the first tier is always covered (A class medicines)
- the second tier is covered only in hospitals (H class medicines)
- the third tier is not covered (C class medicines)

Services as cosmetic surgery are not covered.

Services as orthodontics and laser eye surgery are covered on a case-by-case basis.

On January 2017 was published a new list of LEA, adding new vaccines, updating the list of rare or chronic diseases, and including the medically-assisted procreation into the SSN coverage.³⁴²

Regions have the possibility to offer services not included in the essentials levels of care, if they can finance themselves.³⁴³

Cost sharing (*ticket sanitario*)

GP consultations and hospital admission stays are free of charge, but patients have to pay a small part of the specialist visit and ambulatory examination costs. This fee is limited to a ceiling determined by law, which is currently of €36.15 per prescription.³⁴⁴

However, there are exemptions from cost sharing, which apply to:

- low income households
- people under 6 years old and over 65 years old who live in households with a gross income below the nationally defined threshold (€36,151.98 for the year 2017)
- severely disabled people
- unemployed people with an annual income below €8,263.31
- prisoners
- people with chronic or rare diseases
- HIV screening tests
- Pregnant women (the exemption applies only to care related to their pregnancy)
- Tests for early detection of tumours

³⁴² DPCM (*Decreto del Presidente del Consiglio dei Ministri* – Decree of the President of the Ministers Council), 12 January 2017

³⁴³ Op. cit. note 340

³⁴⁴ <http://www.salute.gov.it/portale/esenzioni/dettaglioContenutiEsenzioni.jsp?lingua=italiano&id=4674&area=esenzioni&menu=vuoto>

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A reform of the *ticket sanitario* is currently under discussion.³⁴⁵

Termination of pregnancy

Pursuant to the Law No. 194 of 22 May 1978, abortion is authorised in Italy up to 90 days from the conception. The law provides for a reflection period of 7 days between a medical examination for abortion and the termination of pregnancy. Termination of pregnancy is covered by the SSN.

In case of serious risk for the health, mental health or life of the mother, abortion is possible up to the fourth month of pregnancy. An obstetrician-gynaecologist must certify the existence of the risk.

In March 2017, the United Nations Human Rights Committee raised concern about access to abortion for women in Italy, in regards to the high percentage of gynaecologists who refuse to perform abortion³⁴⁶.

Access to healthcare for migrants³⁴⁷

Asylum seekers, refugees, beneficiaries of subsidiary protection and humanitarian protection

Asylum seekers, refugees, beneficiaries of subsidiary protection and humanitarian protection are entitled to healthcare as Italian citizens. They can register to the SSN.

In the first six months of residence in Italy they cannot work, and as such are exempt from the co-payment (*ticket sanitario*).³⁴⁸

Undocumented migrants

For undocumented migrants, the services provided and co-payment modalities are similar to those in force for Italian citizens.

If an undocumented migrant is poor and signs a “statement of poverty” valid for 6 months³⁴⁹, s/he may ask for the assignation of a STP code (for Extra-EU citizens) or an ENI code (for EU citizens) to obtain healthcare without a co-payment.

Extra-EU migrants shall also be exempt from co-payment for a specific health service in case of proven indigence (if so, an X01 code is assigned).

Undocumented migrants can access urgent and essential care.

Urgent care

“Urgent care” comprises treatments that cannot be postponed without threatening the life or possibly damaging the health of a person.³⁵⁰

These services are co-payment exempt, pursuant to the Legislative Decree no. 286/98, art. 35, paragraph 4³⁵¹ and to the ministerial circular no. 5, of 24 March 2000³⁵², on the same basis as Italian citizens.³⁵³

³⁴⁵<http://www.lastampa.it/2017/04/06/economia/ticket-sanitari-meno-cari-ma-stretta-sulle-esenzioni-attraverso-il-reddito-isee-9YDmllCDUpfleUeMJO9L1M/pagina.html>

³⁴⁶<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21362&LangID=E>

³⁴⁷ The following content is based on the work and observations of NAGA-Milano

³⁴⁸https://www.salute.gov.it/imgs/C_17_opuscoliPoster_118_allegato.pdf

³⁴⁹ See form 1, annexed to the Ministerial Circular no. 5 of 24th March 2000 (Official Gazette no. 126 of 1st June 2000), p. 44 O.G. and the State-Regions

Agreement no. 255/CSR of 20 December 2012 (Official Gazette General Series no. 32 of 7-2-2013, ordinary integration no. 9)

³⁵⁰ Ministerial Circular no. 5 of 24 March 2000 (Official Gazette no. 126 of 1st June 2000, [pages 36-43])

³⁵¹ Legislative Decree no. 286 of 25 July 1998 (ordinary integration no. 139/L to the Official Gazette no. 191 of 18th August 1998);

³⁵² Op. cit. note 350

³⁵³ Pursuant to art. 1, par. 796 item p of the law no. 296/2006

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Essential care

*“Essential care means all health, diagnostic and therapeutic services (even continuous) related to pathologies that are not dangerous, immediately or in the short term, but which might originate a major health damage or endanger the life of the person in the long term (complications, chronicity or worsened conditions)”.*³⁵⁴

These treatments include:

- First-level ambulatory health services (with direct access) and specialised services to be provided at local health facilities or public/private accredited health centres in the form of general ambulatories or hospitals, possibly in connection with specifically experienced volunteering associations³⁵⁵
- Hospitalisations: to be made upon request by the doctor who works in the facilities³⁵⁶

All the services, prescriptions and reporting practices shall be completed using the Temporary Present Foreigner (STP - *Stranieri Temporaneamente Presenti*) code³⁵⁷, for Extra-EU citizens, or the Non Registrable European (ENI - *Europei Non Iscritti*) code for EU citizens.³⁵⁸ The Local Health Units, by Hospitals, University Polyclinics and the Institutes for Treatment and Research, shall issue the STP and ENI codes.

³⁵⁴ Ministerial Circular no. 5 of 24 March 2000

³⁵⁵ Presidential Decree no. 394 of 31 August 1999 (ordinary integration no. 190/L to the Official Gazette no. 258 of 3 November 1999), article 43 par. 8

and Ministerial circular no.5, of 24-3-2000

³⁵⁶ Presidential Decree no. 394 of 31 August 1999, Article 43 par. 8

³⁵⁷ As provided for in the ministerial circular no. 5 of 24-3-2000, page. 42 and in the State-Regions Agreement no. 255 CSR, of 12 December 2012

³⁵⁸ Note by the Ministry of Health DG RUERI/I/II/3152-P/1.3.b/1, 19/2/08

In general, health services for essential care shall be provided on the same basis of co-payment as Italian citizens.³⁵⁹

More specifically, a third-country national may be assigned with a specific X01 code³⁶⁰ (if s/he has submitted a second declaration of indigence) but it is only valid for a single service and not for the purchase of medicines.

In addition, there are some special situations in which migrants who had irregularly entered the territory or who have overstayed their visa are however entitled to register under the SSN, pursuant to the State-Regions Agreement no. 255/CSR:

- Request of international protection/asylum,
- Custody (including minors without parents),
- Awaiting regularisation (temporary registration for foreigners awaiting regularisation or to emerge from irregular work),
- Pregnant women up to six months after the child's birth,
- Prisoners in adult or minor's jails, patients in judicial psychiatric hospitals, under custodial sentence allowing work outside prison or subject to alternative measures,
- Victims of slavery entered into social protection programs (Leg. Decree no. 286, of 25 July 1998, art. 18)

Finally, it is to be noted that undocumented migrants who access a health facility cannot be reported in any way to the authorities, unless it is mandatory for Italian citizens

and State-Regions Agreement no. 255/CSR of 20 December 2012

³⁵⁹ Pursuant to the Leg. Decree no. 286/98, art.35, par. 4 and to the ministerial circular no. 5, of 24-3-2000, p. 42 in the Official Gazette

³⁶⁰Annex to the Decree by the Ministry of Economics and Finance of 17 March 2008. 8.27 Annex 12-National codes for exemptions from co-payment. Official Gazette no. 86 of 11 April 2008. And

State-Regions Agreement no. 255/CSR of 20 December 2012 (Official Gazette General Series no. 32 of 7-2-2013, ordinary integration no. 9

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too, pursuant to the Leg. Decree no. 286 of 25 July 1998, art.35 par. 5.

Undocumented pregnant women

Pregnant women can temporarily register to the SSN and receive free healthcare related to pregnancy and maternity during their pregnancy and up to six months after the child's birth.

The father of the child can also temporarily register to the SSN.

Children of undocumented migrants

All children can apply for a residence permit as minors (as they cannot be expelled). With a residence permit, they can register to the SSN.

Children waiting for residence permit can also register to the SSN.³⁶¹

Health services to children (0 to 18 years of age)³⁶² of undocumented migrants are provided through the registration under the Regional Health Service (*Servizio sanitario regionale*), pursuant to the State-Regions Agreement no. 255/CSR of 20th December 2012.

Children from 0 to 6 years old can register with a paediatrician (in Italy children do not register to general practitioners, but to paediatricians). From 6 to 14 years, they can choose either to register with a paediatrician or a GP. After 14 years old, children must register with a GP.

Foreign minors from age 0 to 6 are exempt from co-payment, on the same basis as Italian citizens³⁶³, as stated in the Leg. Decree no. 286 of 25 July 1998, art 35, par. 3, item b and in the State-Regions Agreement no. 255 CSR, of 12 December 2012, page 20 and page 37.

In many regions, children of undocumented migrants aged from 14 to 18 years encounter great difficulties to register to the SSN and claim their rights to healthcare. For children of undocumented migrants, a privileged health assistance is in place, with the registration under the SSN, compared to that for adults (using the STP or ENI code). However, only three regions (Liguria, Lazio, Campania) currently acknowledge this privilege until 18 years of age.

In the other regions, the age bracket from 14 to 18 is generally excluded.³⁶⁴ The reason for this exclusion could be the difficulty to identify the exact age, in the absence of evidence document. In 2014, the Cross-Regional Migration and Health Services Commission (of the Health Commission Coordination at the Conference of Regions) issued a "Protocol for the identification and holistic multidisciplinary ascertainment of the age of minors without parents". However, the procedure was conceived for minors without parents and it would be generally complex and expensive to extend its implementation to minors in general.

Thus, the age bracket between 14 and 18 is often excluded from the possibility to register to the SSN.

³⁶¹ Decree of the President of the Ministers Council of 21 January 2017, article 63.4 http://www.gazzettaufficiale.it/atto/serie_generale/caricaArticolo?art.progressivo=0&art.idArticolo=63&art.versione=1&art.codiceRedazionale=17A02015&art.dataPubblicazioneGazzetta=2017-03-18&art.idGruppo=6&art.idSottoArticolo1=10&art.idSottoArticolo=1&art.flagTipoArticolo=0#art

³⁶²The Law no. 176 of 27 May 1991: Ratification and execution of the New York Convention on the Rights of Children of 20 November 1989, art. 1 "children as intended as all human beings aged below 18"

³⁶³At national level, the E01 exemption provides for Italian minors not to pay the health service if below the age of 6 and the total family income is lower than €36,151.98 per year (N. L. no. 537, of 24 February 1993 art. 8 par. 16 and the following modifications).

³⁶⁴ The bracket between 14 and 17 is considered as still belonging to the lower age range by the Convention on the Rights of Children, ratified and implemented pursuant to the law no. 176 of 27th May 1991. The Convention and the related ratification law are also referred to in item b of paragraph 3 in the Consolidated Text no. 286/98 art. 35.

Implementation of the national health legislation for undocumented migrants

The national health legislation guarantees access to healthcare for undocumented migrants. Yet, the implementation level of the provided services is not satisfactory.

First, the fragmentation of the national legislation in the different regional legislations tends to reduce its effectiveness. The health legislation in Italy currently falls under the competence of both the State and the Regions.³⁶⁵

Indeed, the Constitutional Law no. 3 of 18 October 2001 “*Changes in title 5 of the second part of the constitution*” states however “*the protection of health is one of the subjects of the concurrent legislation. In the concurrent legislation subjects, the Regions are assigned with the legislative power, with the exception of the definition of the fundamental principles which is reserved to the State*”.

This possible legislative ambiguity fostered some interpretation differences in the national law, founded on arbitrary readings of the essential levels of care, that were translated into partial regional health regulations that are quite different. To remedy this situation and make all the regional legislations uniform, the State and the Regions signed an Agreement (no. 255/CSR) on 20 December 2012. The implementation of this Agreement is however currently incomplete, which causes differences in the implementation.

Second, the access of Romanians and Bulgarians (defined as neo-EU citizens for some time) in the European Union in 2007 created an unbalance as regards the health service provision. Unlike the other EU member states, not all Romanian and Bulgarian citizens can register under the SSN. This involved some difficulties in the application of the mutual health service as

already implemented among the other EU member states. The Italian State progressively codified this service for EU citizens that cannot be served under a mutual scheme, by issuing some national indications, which however suffered late and incomplete conversions at regional level.

These critical points can be attributable mostly to a misunderstood regional autonomy in the implementation of the national principles and to the problems connected with the arrival of a large number of EU citizens to Italy, a part of whom does not meet the requisites to register under the SSN.

However, the difference in the implementation of the law does not concern urgent care. Indeed, all regions provide for urgent care for free to both Extra-EU and EU undocumented migrants, adults and minors, at public or private hospitals under agreement with the SSN. Essential medicine health services to undocumented migrants are also guaranteed in all the Regions, under different modalities, however always in compliance with the principles in paragraph 8 of art. 43 in the Presidential Decree no. 394/99. Molise is the only exception, where it is currently possible to enjoy ambulatory services for essential pathologies only at Emergency Rooms.

The difference between regions applies for essential medicine ambulatory services, as different modalities exist within the public facilities for the provision of these services.

Unaccompanied minors

The DPCM (*decreto del presidente del consiglio dei ministri*), of 10 November 2016 no. 234, establishes mechanisms for the age determination of unaccompanied minors victims of human trafficking, using a multidisciplinary approach. These

³⁶⁵ L. no. 59 of 15 March 1997

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mechanisms are in the process of being extended to all unaccompanied minors.³⁶⁶

On March 2017, a new law was passed that protects unaccompanied minors (refugees and migrants) and allows them to register to the SSN.³⁶⁷ The law provides for a better protection and reception system, which will be standardised at a national level. Among the provisions is a ban on deportation for children; a maximum period of detention into the reception centres of 30 days (instead of 60 days); a strengthening of the children's rights to access healthcare and education.³⁶⁸

EU mobile citizens

The law makes a difference between EU citizens and extra EU citizens.

The X01 exemption code, that cancels co-payment for a specific health service and that applies when the patient cannot pay, is not applicable to EU mobile citizens.

In two regions (Lombardy and Umbria) no ENI code is assigned to EU citizens. For this group of EU adult citizens, this involves the impossibility to enjoy essential medicine ambulatory services, if not at the Emergency Rooms that often – however not always – meet those requirements without being able to guarantee continuous treatment. In Puglia, a recent regional resolution (20 December 2015) abolished the ENI code “*limiting it to urgencies only*”, thus putting this region in a situation which is similar to that of Lombardy and Umbria.

³⁶⁶<http://www.garanteinfanzia.org/news/garante-albano-vigore-il-decreto-determinare-l%E2%80%99et%C3%A0-dei-minori-vittime-di-tratta-passo-avanti>

³⁶⁷ Law no. 47 of April 7, 2017

³⁶⁸ Italian Committee for UNICEF <https://www.unicef.it/doc/7324/approvata-la-legge-zampa-per-minori-stranieri-non-accompagnati.htm>

³⁶⁹Law no. 176 of 27th May 1991, art. 2. “*The States commit to respect the rights stated in this Convention*

Children of EU mobile citizens

The right to register under the SSN for all foreign minors represents an example of inconsistency in the text of the Italian Health legislative framework. This right is stated in a different way for extra-EU and EU citizens.

For extra-EU citizens, the State-Regions Agreement specifically provides for “*the mandatory registration of foreign minors on the territory*”. The possibility to register under the SSN for EU minors (not meeting the requirements) is not specifically stated, however it can be understood from the statement (State-Regions Agreement page 36): “*the protection of the minor’s health is specifically guaranteed as provided for in the Convention on the right of Children (20-11-1989), ratified and made executive pursuant to the law no.176 of 27th May 1991*”.³⁶⁹ The right to register under the SSN for the EU minors (not meeting the requirements) is confirmed in art. 1 par. 2 of the Consolidated Text no.189/02 too.³⁷⁰

Prevention and treatment of infectious diseases

Pursuant to article 35-3 of the Legislative Decree no. 286 of 25 July 1998, undocumented migrants can access prevention, diagnosis and treatment of infectious diseases. Article 35-4 states that these services can be provided without charge to undocumented migrants who lack resources (except for the remaining co-payment, on the same basis as Italian citizens).³⁷¹

and to guarantee them to all the children in their jurisdictions, without any differences”

³⁷⁰Par. 2 in art.1 of the Leg. Decree no.189/02 states “*This single text shall not apply to the EU-member-states’ citizens if not to the extent that they are more favourable regulations”*

³⁷¹ Legislative Decree no. 286 of 25 July 1998 “*Consolidated text of provisions governing immigration and the status of aliens”*

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On the Memorandum DGRUER1/11/3152-P/1.3.b/1 of 19 February 2008, the Department of Prevention and Communication of the Ministry of Health specifies that destitute EU citizens should have access to prevention, diagnosis and treatment of infectious diseases.

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National Health System

Constitutional basis

Article 11 § 5 of the 1868 Constitution provides for the right to healthcare as follows: “*The law regulates [...] social security, the protection of health, the rights of workers, [and] the struggle against poverty and the social integration of citizens affected by disability*”.³⁷²

Organisation and funding of the healthcare system

The financing of Luxembourg’s healthcare system is based on social participation by employees and employers and also on public funds contributed by the State. The contributions from employees and employers amount to approximately half of the budget. The State contribution is funded through general tax income.³⁷³

The necessary financial resources to fund the health system are based on contributions, except for the financing of maternity care, which is paid by the State.³⁷⁴

Contributions are shared equally between employees and employers, who each contribute 2.8% of the employee’s gross income (up to a maximum taxable income of €9,992.93 per month³⁷⁵) on average to the National Health Fund (*Caisse Nationale de Santé – CNS*).³⁷⁶

³⁷² *Constitution of Luxembourg of 1868* http://www.legilux.public.lu/leg/textescoordonnes/r/ecueils/Constitution/constitution_gdl.pdf

³⁷³ http://www.cleiss.fr/docs/regimes/regime_luxembourg-salaries.html#generalites

³⁷⁴ *Ibid.*

³⁷⁵ <http://www.sante.public.lu/fr/politique-sante/systeme/financement/cotisations-sociales/index.html>

³⁷⁶ <http://www.cdm.lu/entreprise/conseils-aux-entreprises/gestion-personnel/charges-sociales>

Long-term care is financed through separate insurance called “*assurance dépendance*” (nursing care insurance). This is funded by contributions from all active workers and retired individuals. They all pay a 1.4% contribution of all their professional and real estate incomes. These contributions are also complemented by State and electricity sector funding.³⁷⁷

Accessing Luxembourg healthcare system

According to Article 1 of the Social Security Code, health insurance is compulsory in Luxembourg.³⁷⁸

Nonetheless, one of the key issues in Luxembourg is that access to healthcare and social protection is directly linked to the patient’s registered address.

State benefits for destitute people are paid for healthcare contributions. The benefit authority pays the contributions in the same way an employer would. The rate amounts to 5.2% divided equally between the benefit authority and the beneficiary.³⁷⁹

All dependent family members are covered by contributing family members, pursuant to Article 7 of the Social Security Code.³⁸⁰ Students and unemployed children are covered up until 27 years of age.³⁸¹

The national healthcare system covers the majority of treatment provided by general practitioners and specialists as well as laboratory tests, pregnancy, childbirth,

³⁷⁷ http://www.mss.public.lu/dependance/ad_finance/ment/index.html

³⁷⁸ *Social Security Code*, http://data.legilux.public.lu/file/eli-etat-leg-code-securite_sociale-20160101-fr-pdf.pdf

³⁷⁹ <http://www.sante.public.lu/fr/politique-sante/systeme/financement/cotisations-sociales/index.html>

³⁸⁰ *Op. cit.* note 378

³⁸¹ <http://www.sante.public.lu/fr/politique-sante/systeme/financement/cotisations-sociales/index.html>

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rehabilitation, prescriptions and hospitalisation.³⁸²

All medical fees in the country are set by the illness insurance fund. Fees are revised on an annual basis. By law, all healthcare providers must observe these fees and there are strict penalties for abuse of the system.³⁸³

The patient must pay all costs and then submit receipts to the National Health Fund for reimbursement. The amount received as a reimbursement varies from 80% to 100%. The first consultation at a GP is reimbursed at 88%³⁸⁴ and further consultations, which occur within 28 days, are reimbursed at 95% up to the cost of €44.90 per consultation. The part of the cost per consultation beyond this threshold is fully reimbursed.³⁸⁵

Usually the reimbursement for prescription medicine is 80%, although there are four categories of reimbursement for prescription medicine and levels range from 0% to 100%.³⁸⁶

Prescription drugs can only be prescribed by doctors and consultants and the costs are reimbursed by the *Caisse Nationale de Santé*. Non-prescription drugs are priced much higher and are generally not reimbursed.

The annual participation of insured individuals to their healthcare costs cannot exceed 2.5% of their contributory income of the preceding year. If this occurs, all cost

above this threshold will be reimbursed by the competent illness insurance fund.³⁸⁷

If a patient has paid healthcare fees in advance and is not willing to wait for a bank transfer to be reimbursed, s/he can also be reimbursed via a bank cheque. There are two conditions for reimbursement by cheque: the payment must have been made less than 15 days beforehand and the amount must be over €100.³⁸⁸

Since 1 January 2013, and in accordance with Article 24.2 of the Social Security Code, if authorised residents in Luxembourg are not able to pay their healthcare costs in advance, they can apply to the relevant Social Welfare Office for Third-party Social Payment (*tiers payant social – TPS*).³⁸⁹

According to the law, TPS can be granted to any resident in Luxembourg. The Social Welfare Office is the only body competent to assess whether or not an individual should benefit from it.³⁹⁰

When a person is granted TPS, s/he is given a certificate and a book of special labels.³⁹¹ From this point on, s/he will not have to pay in advance for any care. When s/he access healthcare s/he is asked to give the practitioner a label and the CNS will pay directly for each episode of care. Indeed, the practitioner after receiving the patient will send the prescription to the CNS together with the label, in order to obtain payment.³⁹²

³⁸²http://www.mss.public.lu/publications/rapport_general/rg2015/rg_2015.pdf

³⁸³<http://www.sante.public.lu/fr/politique-sante/systeme/financement/cotisations-sociales/index.html>

³⁸⁴ <https://www.wort.lu/fr/luxembourg/a-partir-de-janvier-nouveaux-tarifs-pour-les-medecins-et-les-dentistes-5863b96053590682caf16ceb>

³⁸⁵ http://www.mss.public.lu/publications/droit_secure_sociale/droit2002/droit_2002.pdf

³⁸⁶<http://www.cns.public.lu/fr/professionnels-sante/medicaments/liste-positive.html>

³⁸⁷<http://cns.public.lu/en/assure/vie-privee/depenses-sante/avance-frais/paiement-complementaire.html>

³⁸⁸<http://cns.public.lu/en/assure/vie-privee/depenses-sante/avance-frais/remboursement-cheque.html>

³⁸⁹<http://www.cns.public.lu/fr/assure/vie-privee/depenses-sante/tiers-payant-social.html>

³⁹⁰<http://www.cns.public.lu/fr/assure/vie-privee/depenses-sante/tiers-payant-social.html>

³⁹¹<http://www.cns.public.lu/fr/assure/vie-privee/depenses-sante/tiers-payant-social.html>

³⁹²<http://www.cns.public.lu/fr/assure/vie-privee/depenses-sante/tiers-payant-social.html>

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The aim of TPS is to facilitate access to healthcare for people with limited income.³⁹³ It can be granted for three months, and exceptionally for six months.³⁹⁴ At the end of the three months, the beneficiary can ask the Social Welfare Office for an extension.³⁹⁵

As written above, access to healthcare and social protection in Luxembourg are directly linked to the patient's address. In other words, if an individual does not have a proper registered address they will not be able to access social protection. This is why Doctors of the World – Médecins du monde (MdM) Luxembourg currently mostly treats homeless people, EU citizens and third country nationals who are not resident.

People can also take out an additional health insurance coverage, which is mostly used to pay for services classified as non-essential under the compulsory scheme. Private health insurance is provided by non-profit agencies or mutual associations (*mutuelles*), which are also allied to the Ministry of Social Security.

There are no private hospitals in Luxembourg, as all hospitals are state-run by the CNS and patients must have a referral from their doctor for an admission to hospital, unless it is an emergency.³⁹⁶ In practice, people go to hospitals even if they do not have a referral from a doctor.

In theory, all emergency care is provided at hospitals. It is important to stress that, in practice, when patients with no insurance arrive at hospitals in order to get emergency

care they are asked for a financial guarantee before they are treated.

Luxembourg also has specialist hospitals and specialist doctors available for consultation but an appointment is necessary.

Access to healthcare for migrants

Asylum seekers and refugees

The main regulations on International protection in Luxembourg are the Law on International and Temporary Protection³⁹⁷ and the Law on the Reception of Applicants for International Protection and Temporary Protection³⁹⁸, both adopted on 18 December 2015.

Asylum seekers

The law on the Reception of Applicants for International Protection and Temporary Protection of 18 December 2015³⁹⁹ regulates the rights of asylum seekers.

Pursuant to article 8-1 of this law, asylum seekers are entitled to a standard of living that “ensures their subsistence and protects their physical and mental health”. Medical care is provided by the Luxembourg Reception and Integration Agency (OLAI).⁴⁰⁰

However, according to article 8-3, to benefit from the material reception conditions and medical care, the applicant must be without sufficient financial resources and stay at a

³⁹³<http://cns.public.lu/en/assure/vie-privee/depenses-sante/avance-frais/remboursement-cheque.html>

³⁹⁴<http://www.cns.public.lu/en/assure/vie-privee/depenses-sante/tiers-payant-social.html>

³⁹⁵<http://www.cns.public.lu/fr/assure/vie-privee/depenses-sante/tiers-payant-social.html>

³⁹⁶http://www.expatica.com/lu/healthcare/Healthcare-in-Luxembourg_105466.html

³⁹⁷Law on International and Temporary Protection of 18 December 2015

<http://www.legilux.public.lu/leg/a/archives/2015/02/55/a255.pdf#page=2>

³⁹⁸ Law on the Reception of Applicants for International Protection and Temporary Protection – 2015

<http://eli.legilux.public.lu/eli/etat/leg/loi/2015/12/18/n16>

³⁹⁹Op. cit. note 397

⁴⁰⁰ <http://www.olai.public.lu/en/index.html>

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place determined by the competent authority.

Asylum seekers are entitled, to free housing and food distribution, as well as a monthly allocation. If food is provided, the monthly allocation amounts to €26.27 for adults and unaccompanied minors and to €13.13 for minor children, in accordance with article 13-1 of the law on the Reception of Applicants for International Protection and Temporary Protection.⁴⁰¹

In cases where it is not possible to provide access to food, the monthly allocation is €231.27 for adults and for unaccompanied minors, and of €192.5 for minors pursuant to article 13-2 of the same law.⁴⁰²

The monthly allowance is supplemented by benefits in kind or vouchers that cover costs as accommodation and medical costs.⁴⁰³

Asylum seekers who are victims of rape or other serious violence are entitled to adequate medical and psychological care.⁴⁰⁴

The complete removal of material reception conditions of asylum seekers by the authorities is prohibited. Access to basic healthcare and a dignified and adequate standard of living of the applicant, are guaranteed in all circumstances by article 24 of the Law on the Reception of Applicants for International Protection and Temporary Protection.

Refugees

The Law on International and Temporary Protection⁴⁰⁵ repealed the Law on asylum

and other complementary forms of protection of 5 May 2006, which was the former central legislation concerning international protection.

Pursuant to article 62-1 of the Law on International and Temporary Protection, beneficiaries of a form of international protection have the same access to healthcare as Luxembourg nationals.

Article 62-2 of this law further provides that beneficiaries of a form of international protection with special needs are also entitled to free mental healthcare. This category comprises: pregnant women; disabled individuals; victims of torture, of rape or of any severe form of mental violence; minors victim of any form of abuse, negligence, inhumane or degrading treatment; and minors victim of armed conflicts.

Undocumented migrants

Undocumented migrants include visa or permit “overstayers”, rejected asylum seekers and individuals who have entered the country without a permit. In Luxembourg, undocumented migrants have no access to healthcare.⁴⁰⁶

Moreover, children of undocumented migrants have access to inclusive healthcare only if they are unaccompanied, whereas children of undocumented migrants living with their families often face considerable difficulties in accessing basic preventive and follow-up care.⁴⁰⁷

⁴⁰¹<http://www.olai.public.lu/fr/actualites/2017/02/espace-communes/tout-savoir-sur.pdf>

⁴⁰²<http://www.olai.public.lu/fr/actualites/2017/02/espace-communes/tout-savoir-sur.pdf>

⁴⁰³Law on the Reception of Applicants for International Protection and Temporary Protection, Article 13-3

⁴⁰⁴Law on the Reception of Applicants for International Protection and Temporary Protection, Article 17

⁴⁰⁵Op. cit. note 397

⁴⁰⁶Bernd Rechel et al., “Migration and health

in the European Union”, *European Observatory on Health Systems and Policies*, 2011, http://www.euro.who.int/_data/assets/pdf_file/0019/161560/e96458.pdf

⁴⁰⁷Platform for International Cooperation on Undocumented Migrants (PICUM), *Preventing undocumented pregnant Women and Children from Accessing health Care: fostering health inequalities in Europe*, March 2011, <http://picum.org/picum.org/uploads/publication/Publication%20hearing%20on%20access%20to%20health%20care%20for%20undocumented%20pregnant%20w>

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With regard to this issue, the European Committee of Social Rights, (Council of Europe), issued conclusions in 2013 on the conformity of Luxembourg's health system regarding the European Social Charter.⁴⁰⁸ These conclusions are quite revealing concerning undocumented migrants' access to emergency care.

The report concludes that Luxembourg's legislation and practice do not guarantee that all foreign nationals in an irregular situation can benefit from emergency care for as long as they may need to. The Committee notes that there is no specific legislation concerning undocumented migrants' access to health. Moreover, their access to emergency care has been limited to two or three days.⁴⁰⁹

Unaccompanied minors

Pursuant to the Law of 18 December 2015 relating to the reception of applicants for international and temporary protections, unaccompanied minors are entitled to accommodation upon their entry on the territory⁴¹⁰ and to social benefits. They are assigned a guardian to assist them with the legal procedures.⁴¹¹

Termination of pregnancy

The most recent law regulating termination of pregnancy was adopted on 17 December 2014⁴¹², modifying the 1978 law that authorised abortion in Luxembourg.

Termination of pregnancy is legal in Luxembourg up to 12 weeks from the date

[omen%20and%20children%20-%202018%20December%202010_1.pdf](http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/State/LuxembourgXX2_fr.pdf)

⁴⁰⁸European Social Charter, European Committee of social rights, Conclusions, Conclusions XX-2 (2013), (LUXEMBOURG) Articles 3, 11, 12, 13 et 14 of the 1961 Charter, March 2014, http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/State/LuxembourgXX2_fr.pdf

⁴⁰⁹ Ibid.

⁴¹⁰ Article 21 of the *Law of 18 December 2015 relating to the reception of applicants for international and temporary protections*

of conception⁴¹³ for all women⁴¹⁴, provided that:

- The woman has obtained a certificate of pregnancy, information and documentation after consulting a specialist in gynaecology and obstetrics at least three days beforehand
- A licensed specialist in gynaecology and obstetrics carries out the termination of pregnancy and provides information on the available psychosocial support and counselling

The consent of the parents, guardians or a judge is required for minors under 18.

Under exceptional circumstances (life-threatening risk to the mother or the unborn child), a pregnancy termination may take place after 12 weeks. In these cases two physicians must state in writing that there is a serious risk to the woman's health. A doctor has the right to refuse to perform a pregnancy termination.

The cost of a pregnancy termination is reimbursed by the social security service.⁴¹⁵

Protection of seriously ill foreign nationals

In Luxembourg, the Immigration Medical Department makes sure that the organisation of the medical part of the legislation on the free circulation of people and immigration⁴¹⁶ is properly implemented.

⁴¹¹ Ibid. Article 20

⁴¹² *Law on termination of pregnancy – 2014* <http://www.sante.public.lu/fr/legislation/droits/interruption-volontaire-grossesse/interruption-volontaire-grossesse-modification-code-penal-2014-12-17-loi.pdf>

⁴¹³ Law on termination of pregnancy, article 12

⁴¹⁴ <http://www.sante.public.lu/fr/droits/ivg/femme-non-residente/index.html>

⁴¹⁵ Law on termination of pregnancy, Article 14

⁴¹⁶ *Law on free circulation of 2008*, modified by the law of 8 March 2017

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This service has four principal missions: to organise the medical check-ups of third-country nationals, to assess whether or not foreign nationals may have their expulsion from Luxembourg deferred for medical reasons, to assess whether or not foreign nationals may stay in Luxembourg in order to receive medical treatment which is not covered by social security and to give advice on limitations to the right for EU citizens and their family members to circulate and live freely in Luxembourg.⁴¹⁷

According to the Law of 29 August 2008, modified by the law of 8 March 2017⁴¹⁸, the Immigration Medical Department (SMI – *Service Médical de l'Immigration*) of the National Health Directorate (*Direction de la Santé*) must issue medical advice when requested by the Ministry of Immigration in order for the expulsion of an individual from the country to be deferred.⁴¹⁹

A foreign national may benefit from such a deferment if:

- His/her health condition requires treatment which cannot be refused to him/her without serious consequences for his/her health
- And the person concerned is not able to get the treatment in the country s/he is about to be sent back to.⁴²⁰

If all the requirements are met, the individual will obtain a deferment of expulsion for a maximum of six months⁴²¹,

<http://www.gouvernement.lu/5702060/Loi-modifiee-du-29-aout-2008-sur-la-libre-circulation-des-personnes-et-l-immigration---TC-au-11-fevrier-2016.pdf>

⁴¹⁷<http://www.guichet.public.lu/citoyens/fr/organismes/ministere-sante/service-medical-immigration/index.html>

⁴¹⁸ *Law on free circulation of 2008, modified by the law of 8 March 2017*

<http://www.gouvernement.lu/5702060/Loi-modifiee-du-29-aout-2008-sur-la-libre-circulation-des-personnes-et-l-immigration---TC-au-11-fevrier-2016.pdf>

⁴¹⁹<http://www.sante.public.lu/fr/prevention/travail/service-sante-migrant/sursis-eloignement/index.html>

with the possibility of renewal not exceeding two years.⁴²²

If after two years the individual's health state has not improved and still needs the treatment, then s/he can apply for a residency permit for medical reasons.⁴²³

The deferment can be extended to members of the individual's family. People who benefit from such a deferment receive a certificate of deferment which grants them healthcare and access to social aid.⁴²⁴ For a foreign national who wants to have access to a specific medical treatment in Luxembourg, different documents have to be presented to authorities:

- Medical certificates proving the necessity of such a treatment, with specific mention of the type of treatment and its length.⁴²⁵
- A certificate from the medical authorities from his/her country of origin proving that the person cannot receive the treatment in his/her country.⁴²⁶
- An agreement from the health establishment for the admission of the patient on a certain date, signed by the head of the service that will treat the patient.⁴²⁷
- An estimate of the cost of the treatment and proof that the financing of it is guaranteed by the person.⁴²⁸

⁴²⁰<http://www.sante.public.lu/fr/prevention/travail/service-sante-migrant/sursis-eloignement/index.html>

⁴²¹ *Law on free circulation of 2008, modified by the law of 8 March 2017*

⁴²² Ibid.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Ibid.

⁴²⁶ Ibid.

⁴²⁷<http://www.sante.public.lu/fr/prevention/travail/service-sante-migrant/soins-etrangers-luxembourg/index.html>

⁴²⁸<http://www.sante.public.lu/fr/prevention/travail/service-sante-migrant/soins-etrangers-luxembourg/index.html>

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As it is nearly impossible to obtain a certificate proving that a treatment is inaccessible and since the patient has to cover the cost of his/her treatment, this procedure is extremely restrictive.

Prevention and treatment of infectious diseases

In Luxembourg, the Ministry of Health has adopted a national strategy and an action plan to fight against HIV/AIDS (2011-2015).⁴²⁹

In this plan, it is stated that migrants face multiple vulnerabilities such as increased risk to infectious diseases.⁴³⁰ The government has assessed the need to raise awareness regarding these diseases and the necessity for these migrants to access free HIV screening tests.⁴³¹ People asking for international protection can voluntarily undergo HIV screening tests during the process. No specific mention is made for undocumented migrants.

There are national health facilities which provide such services for free and anonymously. There are six of them throughout Luxembourg.⁴³²

The Ministry of Health or the National Health Fund in Luxembourg should cover payment of treatment for people who are not insured or are unable to afford it.⁴³³ Nonetheless, the Ministry of Health has recognised that a number of administrative barriers often impede vulnerable groups in accessing treatment when they need it.⁴³⁴

Moreover, in relation to the treatment of infectious diseases in Luxembourg, on 27 February 2015 the government adopted a regulation creating a special Monitoring

Committee for HIV, hepatitis and other sexually transmissible infections.⁴³⁵ This Committee is mandated to inform the public, targeted groups and professionals about all issues regarding these infections, to collaborate with national and international organisations to develop programmes in order to fight HIV, to provide advice on all questions relating to this issue, and to propose measures to improve the prevention of and fight against infectious diseases.⁴³⁶

⁴²⁹ Ministry of Health of the Grand Duchy of Luxembourg, *National strategy and action plan regarding the fight against HIV/AIDS 2011-2015* <http://www.sante.public.lu/fr/publications/s/strategie-plan-action-vihsida-2011-2015/index.html>

⁴³⁰ Ibid.

⁴³¹ Op. cit. note 429

⁴³² <http://www.dimps.lu/files/mds-sida-annoncea4-hd-pdf>

⁴³³ Op. cit. note 429

⁴³⁴ Op. cit. note 429

⁴³⁵ *Regulation of 27 February 2015*, <http://eli.legilux.public.lu/eli/etat/leg/rgc/2015/02/27/n1>

⁴³⁶ Regulation of 27 February 2015, Art.1

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National Health System

Constitutional basis

According to the Dutch Constitution, the government has a duty to ensure social security for all and to ensure the distribution of wealth (Article 20), as well as public health (Article 22).⁴³⁷ Articles 1 (equal treatment), 10 (the right to respect and protection of personal privacy) and 11 (the right to the inviolability of one's person) are also relevant to the right to health.

It is to be noted that, pursuant to Article 120 of the Dutch Constitution, it is prohibited for the courts to check the constitutionality of the law.

Organisation and funding of Dutch healthcare system

Since 2006, a dual system of public and private insurance for curative care has been replaced by a single compulsory health insurance scheme. Competing insurers negotiate with providers on price and quality, and patients are free to choose the provider they prefer and join the health insurance policy which best fits their situation. According to the European Observatory on Health Systems and Policies, primary care is well developed, with GPs acting as gatekeepers to the system in order to prevent unnecessary use of more expensive secondary care. The government's role is limited to controlling

⁴³⁷http://wetten.overheid.nl/BWBR0001840/geldigheidsdatum_21-05-2015

⁴³⁸ W. Schäfer et al., "Germany: Health system review", *Health Systems in Transition*, vol. 12, No 1, 2010

http://www.euro.who.int/data/assets/pdf_file/0008/85391/E93667.pdf

⁴³⁹ *Health Insurance Act of 16 June 2005*, Art. 2
http://wetten.overheid.nl/BWBR0018450/Hoofdstuk2/Paragraaf21/Artikel2/geldigheidsdatum_06-02-2015

quality, accessibility and affordability of healthcare.⁴³⁸

Accessing the Netherlands healthcare system

Taking out standard (private) health insurance, is obligatory for authorised residents.⁴³⁹ An open enrolment system obliges insurers to accept any application for insurance; they cannot "risk assess" to deny coverage to individuals deemed to be "high-risk" on account of their age, gender or health profile.⁴⁴⁰ All insurance providers offer the same standard package. This package includes GP visits, outpatient treatments in hospital, hospitalisation, emergency treatment, transport to the hospital, antenatal, delivery and postnatal care, and mental healthcare (individual psychological consultations).⁴⁴¹

Contraception is not included in the basic package. Pregnancy termination is not included either, but is fully reimbursed under the Long-Term Care Act.⁴⁴²

To cover costs not included in the standard package, for example physiotherapy or dental care for adults, people older than 18 years old may opt to take out additional insurance. The premium for this extra package is freely established by private insurers.

The monthly premiums for health insurance currently (June 2017) range from €92 to €114.95 per month. Prices vary between providers, but also depending on age, sex, residence and which formula the individual chooses: access to a limited number of

⁴⁴⁰Civitas, *Health care Systems: The Netherlands*, By Claire Daley and James Gubb

updated by Emily Clarke (December 2011) and Elliot Bidgood (January 2013), <http://www.civitas.org.uk/nhs/download/netherlands.pdf>

⁴⁴¹<http://www.rijksoverheid.nl/onderwerpen/zorgverzekering/vraag-en-antwoord/basispakket-zorgverzekering-2015.html>

⁴⁴²<http://www.rijksoverheid.nl/onderwerpen/zorg-in-zorginstelling/wet-langdurige-zorg-wlz>

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contracted care providers (versus a larger or even unlimited choice), opting in or out of (partial) reimbursement of dental care, glasses and the amount of the policy excess (see below). In addition, an income-dependent employer contribution is deducted through the employee's payroll and transferred to a Health Insurance Fund.

Authorised residents on a low income are eligible for healthcare benefits. A single person can receive help up to €1,066, couples up to €2,043 a year.⁴⁴³ Single people with yearly incomes lower than €27,857 have a right to financial help; for couples the income ceiling is €35,116. Only people with limited capital have a right to these benefits.

When accessing healthcare services and treatment, people aged 18 or over first need to pay a “franchise”, a policy excess, which is currently (July 2017) – as defined by law – at least €385 a year⁴⁴⁴, but can go up to €885 depending on their chosen insurance formula (the voluntary excess adding to the compulsory excess).⁴⁴⁵ An increasing number of patients facing poverty have difficulty paying this franchise. In order to pay lower monthly premiums, they often opt for a higher franchise – a tempting offer as long as one does not fall seriously ill. The franchise does not apply to care for minors (nor does it apply to their dental care), GP visits, antenatal care, or for integrated care schemes for chronic diseases (e.g. diabetes).⁴⁴⁶ Vaccinations are freely

accessible for all children through preventive frontline infant consultations (0-4 years) at the Early Childhood clinics, and according to the national immunisation calendar.⁴⁴⁷

Authorised residents who do not take out obligatory insurance are proactively contacted by the National Healthcare Institute (*Zorginstituut Nederland*), asking them to take out insurance within three months. Those who do not take out insurance are fined €382.50 – up to two times – before the institution automatically contracts health insurance for them and deducts the insurance premiums automatically from the income of the newly insured individual.⁴⁴⁸ Those who do not pay their monthly premiums face financial penalties.

Termination of pregnancy

For authorised residents, pregnancy termination is free at the point of delivery under the Act on Long-term Healthcare.⁴⁴⁹ For women who are 12 to 16 days pregnant, there is no waiting period. After 16 days and up to 13 weeks, there is a “cooling off period” of five days between the first consultation and the termination (as determined by the 1981 Termination of Pregnancy Act⁴⁵⁰). The gestational limit stated in the Law is 24 weeks (based on foetal viability).⁴⁵¹

In case a late termination is needed – after 24 weeks – doctors are obliged to report

⁴⁴³http://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/prive/toeslagen/zorgtoeslag/zorgtoeslag_2016/voorwaarden_2016/inkomen/bedragen_per_maand

⁴⁴⁴<https://www.hollandzorg.com/dutch-healthcare-insurance/public-healthcare/excess>

⁴⁴⁵ The amount of the franchise has drastically been raised over the past few years: from €150 in 2008, €220 in 2012, €350 in 2013, €360 in 2014, €375 in 2015 to 385€ in 2016.

<http://www.rijksoverheid.nl/ministeries/vws/documenten-en-publicaties/kamerstukken/2015/02/06/kamerbrief-over-verbeteren-kwaliteit-en-betalbaarheid-zorg.html>

⁴⁴⁶<http://www.independer.nl/zorgverzekering/info/eigen-risico.aspx>

⁴⁴⁷http://www.rivm.nl/Onderwerpen/R/Rijksvaccinatieprogramma/De_inenting/Vaccinatieschema

⁴⁴⁸<http://www.rijksoverheid.nl/onderwerpen/zorgverzekering/vraag-en-antwoord/wat-gebeurt-er-als-ik-niet-verzekerd-ben-voor-de-zorgverzekering.html>

⁴⁴⁹ <http://wetten.overheid.nl/BWBR0035917/2017-07-01>

⁴⁵⁰http://wetten.overheid.nl/BWBR0003396/geldigheidsdatum_22-04-2015

⁴⁵¹ *New regulation on Late-term Abortions and Terminations of Lives of Neonates* - 2011 <http://wetten.overheid.nl/BWBR0003396/2011-10-10>

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these to a central committee.⁴⁵² Under the New Regulation on late-term abortions and Termination of Life in Neonates⁴⁵³, which entered into force on February 2016, late-term termination is authorised when an unborn baby has an untreatable disease expected to lead inevitably to its death during or immediately after birth, or if an unborn baby has a disease that has led to serious and irreparable impairment, where only a small chance of survival exists.

A termination may only be performed by a physician in a licensed hospital or clinic and has to ensure that “*an adequate opportunity is made available for providing the woman with responsible information on methods of preventing unwanted pregnancies*”.⁴⁵⁴

Access to healthcare for migrants

Asylum seekers, refugees and persons eligible for subsidiary protection

As authorised residents, recognised refugees and people who have obtained subsidiary protection have the same duties and rights as Dutch citizens. Asylum seekers access healthcare through a parallel scheme of primary care contracting, organised by *Arts en Zorg* (from January 2018)⁴⁵⁵, a non-profit insurance company commissioned by the Central Agency for the Reception of Asylum Seekers (*Centraal Orgaan opvang asielzoekers* – COA). On the one hand, this means that they can only turn to GPs, physiotherapists, dentists, hospitals and pharmacies that are contracted. On the other hand, no out-of-

pocket payment at all (not even a franchise) is required.⁴⁵⁶

As for Dutch residents, GPs are the gatekeepers of access to other healthcare services. The basket of care is similar to that of the basic package for authorised residents (but, for example, dental care for adults is also accessible in case of pain or chewing problems⁴⁵⁷). Upon entry, asylum seekers undergo compulsory TB screening. Asylum seekers coming from high-risk countries are offered voluntary follow-up screening for a period of two years.⁴⁵⁸

Pregnant asylum seekers and refugees

Pregnant asylum seekers and refugees have access to antenatal, delivery and postnatal healthcare free at the point of delivery. Because of their specific vulnerabilities, those women are entitled to more intensive antenatal care (with more consultations). They are also entitled to access pregnancy termination services free of charge. However, asylum seekers and refugees aged 21 and over have to pay for contraceptives themselves.⁴⁵⁹

Children of asylum seekers

All children can access free vaccination at preventive frontline infant consultations (0-4 years), including children of asylum seekers. For other care (including vaccinations after the age of 4), they can only access care under the same specific scheme for asylum seekers as their parents.

⁴⁵²<http://www.rijksoverheid.nl/onderwerpen/levenseinde-en-euthanasie/late-zwangerschapafbreking-en-levensbeeindiging-bij-pasgeborenen>

⁴⁵³ Op. cit. note 451

⁴⁵⁴ *Termination of Pregnancy Act of 1 May 1981*, Article 5(2a), http://wetten.overheid.nl/BWBR0003396/geldigheidsdatum_21-05-2015

⁴⁵⁵ <http://www.rzasielzoekers.nl/>

⁴⁵⁶ <http://www.rzasielzoekers.nl/home/zorg-voor-asielzoekers.html>

⁴⁵⁷ http://www.rzasielzoekers.nl/dynamic/media/28/documents/rzaenbijlagen/Bijlage_5_noodhulplijst_2015.pdf

⁴⁵⁸ http://www.rzasielzoekers.nl/dynamic/media/28/documents/overige_documenten/2012_factsheet_Menzis_HR.pdf

⁴⁵⁹ S. Goosen, “Induced abortions and teenage births among asylum seekers in the Netherlands: analysis of national surveillance data”, *Journal of Epidemiology and Community Health*, 2009 <http://www.ggdghorkennisnet.nl/?file=1204&m=1310635532&action=file.download>

Undocumented migrants

Undocumented migrants cannot take out health insurance, even with an authorisation for temporary stay. Indeed, the Linkage Act of 1998⁴⁶⁰ linked the right to state medical insurance to authorised residency. They have a right to emergency care, and “medically necessary care” (including all antenatal and delivery care), as well as care needed in “situations that would jeopardise public health”.⁴⁶¹

In 2007, an independent commission of medical (and social and legal) experts, clearly defined “medically necessary care”⁴⁶²: doctors must provide adequate and appropriate care by following the same guidelines, protocols and code of conduct that medical and academic professional organisations adhere to in care for any other patient. Continuity of medical care should not be affected by uncertainty about the duration of the patient’s stay in the Netherlands. Doctors and healthcare institutions should focus primarily on the medical and healthcare-related aspects and not on the financial aspects and funding issues.

According to the Dutch authorities⁴⁶³, undocumented migrants are expected to pay for treatment themselves, unless it is proven that they have difficulty in paying. In that case, GPs can recover 80% of the cost of a consultation for an undocumented patient (the full cost being €27.63 for a short consultation and €54.27 for a consultation that takes longer than 20 minutes) from the healthcare authorities. In the case of secondary care, medical costs are only

reimbursed for the 31 hospitals, which entered into an agreement with the healthcare authorities.

In practice, there are many barriers (e.g. GPs who refuse patients because they refuse to use the reimbursement scheme or because the patient cannot pay the remaining 20% of the consultation fee, lack of knowledge of the reimbursement scheme). In 2014, the authorities drafted a short document to help healthcare professionals determine who is undocumented⁴⁶⁴, although the language used is rather stigmatising.⁴⁶⁵ The National Ombudsman also confirmed the existence of barriers to healthcare for undocumented people in 2013.⁴⁶⁶

Before 2014, contracted pharmacies could recover between 80% and 100% of all the costs for undocumented migrants who were unable to pay. However, since January 2014, a €5 payment for every pharmaceutical prescription has been imposed. Several support organisations paid the €5 for those who needed a lot of medication. As a result of their advocacy work, some municipalities agreed to start an emergency fund, to compensate the support organisations which had covered the costs. For instance, in 2015, Amsterdam signed a covenant with pharmacies and support organisations (including Doctors of the World) to manage this fund for patients who cannot pay. However, various hurdles remain in order for undocumented migrants to benefit from such a fund.

The European Committee of Social Rights ruled in 2014 that the Dutch government

⁴⁶⁰ *The Linkage Act of 26 March 1998*, http://wetten.overheid.nl/BWBR0009511/geldigheidsdatum_02-06-2015

⁴⁶¹ *Foreigners Act – 2000*

<http://www.refworld.org/docid/3b5fd9491.html>

⁴⁶² http://www.pharos.nl/documents/doc/webshop/arts_en_vreemdeling-rapport.pdf

⁴⁶³ <http://www.zorginstituutnederland.nl/verzekering/onverzekerbare+vreemdelingen>

⁴⁶⁴ [\[www/documenten/rubrieken/verzekering/onverzekerbare-vreemdelingen/1307-hoe-stel-ik-vast-dat-iemand-illegaal-in-nederland-verblijft/Hoe+stel+ik+vast+dat+iemand+illegaal+in+Nederland+verblijft.pdf\]\(http://www.documenten/rubrieken/verzekering/onverzekerbare-vreemdelingen/1307-hoe-stel-ik-vast-dat-iemand-illegaal-in-nederland-verblijft/Hoe+stel+ik+vast+dat+iemand+illegaal+in+Nederland+verblijft.pdf\)](http://www.zorginstituutnederland.nl/binaries/content/documents/zinl-</p>
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⁴⁶⁵ http://picum.org/uploads/file_/Leaflet_NL_forPrinting_7Nov.2014.pdf

⁴⁶⁶ [Medische zorg vreemdelingen. Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers](http://www.zorginstituutnederland.nl/binaries/content/documents/zinl-)

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should ensure the provision of the necessary food, water, shelter and clothing to adult migrants in an irregular situation and to asylum seekers whose applications for protection have been rejected.⁴⁶⁷ The Dutch Association of Municipalities (*Vereniging Nederlandse Gemeenten*) has taken the same view concerning rejected asylum seekers.⁴⁶⁸

Undocumented pregnant women

They have access to antenatal, delivery and postnatal care, but this access is not free at the point of use. Undocumented migrants are expected to pay for treatment themselves, unless it is proved that they cannot pay. In the case of pregnancy and delivery, authorities can decide to reimburse contracted hospitals and pharmacies up to 100% of the unpaid bills. However, it sometimes happens that undocumented women are urged to pay straight away in cash, requested to sign up for payment by instalments or receive a bill and reminders at home, and sometimes are followed by debt collectors contracted by healthcare providers.

Pregnant women can obtain a postponement of their departure from the Netherlands under Article 64 of the Foreigners Act⁴⁶⁹ due to being unfit to travel six weeks before and six weeks after giving birth.⁴⁷⁰ During this period, women have access to healthcare under the same scheme as pregnant asylum seekers.

Maternity care, contraception and pregnancy termination have to be fully paid for by undocumented women.

⁴⁶⁷European Committee Of Social Rights, *Conference of European Churches (CEC) v the Netherlands*, 1 July 2014, http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/CC90Merits_en.pdf

⁴⁶⁸<https://www.vng.nl/onderwerpen/index/integratie-en-asiel/vreemdelingenzaken/nieuws/gemeenten-willen-uitgeprocedeerde-asielzoekers-opvang-kunnen-bieden>

Children of undocumented migrants

All children can access free vaccination at preventive frontline infant consultations (0-4 years), including children of undocumented parents. For curative care, and for vaccinations after the age of four, the children of undocumented migrants face the same barriers to care as their parents. If they get Dutch nationality, they will be entitled to free healthcare through the regular insurance scheme.

EU citizens

In accordance with Directive 2004/38/CE, EU citizens are considered as “undocumented” after three months of stay in the Netherlands without health coverage and sufficient resources. If EU citizens in the Netherlands do not have a European Health Insurance Card (EHIC), they only have free access to emergency care.⁴⁷¹ There are no specific legal provisions for children of destitute EU citizens.

Unaccompanied minors

Unaccompanied children seeking asylum have access to healthcare services on the same basis as other children. They receive extra assistance in separate reception facilities.⁴⁷² They are attributed a guardian from the Nidos Foundation, who is responsible for accommodating the children and providing them with a health insurance. If their application is rejected, they keep their right to live in the asylum reception centres, to benefit from healthcare services and their right to education until departure, according to Article 6 of the Measures regarding asylum seekers and other

⁴⁶⁹*Foreigners Act* – 2000 http://wetten.overheid.nl/BWBR0011823/Hoofdstuk6/Afdeling2/Artikel64/geldigheidsdatum_27-04-2015

⁴⁷⁰ Foreigners Circular 2000, A3/7.3.2.6

⁴⁷¹http://www.pharos.nl/documents/doc/pharos_verslag_expertmeeting_gezondheid_en_zorggebruik_midden-en_oost-europese_migranten-8juni2012.pdf

⁴⁷²<http://www.coa.nl/nl/asielzoekers/wonen-op-een-azc/kind-in-de-opvang>

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categories of foreign nationals.⁴⁷³ In order to determine minors' age, medical examination methods as X-rays of the wrist and collarbone are often used. MdM strongly criticises these practices, considered as imprecise, unethical and unreliable.⁴⁷⁴

Protection of seriously ill foreign nationals

Case law of the European Court of Human rights

Over the last decades, the European Court of Human Rights (ECtHR) has ruled several times in cases related to the expulsion of seriously ill migrants. Article 3 of the European Convention on Human Rights (ECHR) protects a person from being expelled, when there are substantial grounds for believing there is a real risk of being subjected to an inhuman or degrading treatment. Until December 2016, in cases concerning the removal of a foreigner suffering from serious illness the ECtHR used to rule that only in a very exceptional case a medical condition may raise an issue under Article 3. This "very exceptional case" only applied to a person at imminent risk of dying.⁴⁷⁵ In a recent decision in the case *Paposhvili v. Belgium* of 13 December 2016⁴⁷⁶ the ECtHR has departed from the excessively restrictive approach.

In the case *Paposhvili v. Belgium* the ECtHR ruled that article 3 should be understood to refer to situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that s/he,

although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his/her state of health resulting in intense suffering or to a significant reduction in life expectancy.⁴⁷⁷ Where, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the persons concerned – on account of the general situation in the receiving country and/or their individual situation – the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the persons concerned so that they do not find themselves in a situation contrary to Article 3.⁴⁷⁸ The decision thus shows that the question of availability and accessibility should be part of the assessment whether a seriously ill migrant needs to be granted protection from removal from The Netherlands.

The Netherlands has integrated the decision of the ECtHR in the Foreigners Act of 2000 through an amendment on the 29 August 2017.⁴⁷⁹

If a seriously ill foreigner can prove that his/her condition requires necessary medical treatment and that there is reason to believe that the necessary medical care is not available in his/her country of origin, s/he can be granted a postponed departure, based on article 64 of the Foreigners Act of

⁴⁷³ Measures regarding asylum seekers and other categories of foreign nationals http://wetten.overheid.nl/BWBR0017959/geldigheidsdatum_22-04-2015#HoofdstukIII_Artikel6

⁴⁷⁴ <http://www.vluchtelingenwerk.nl/feiten-cijfers/alleenstaande-minderjarigen>

⁴⁷⁵ *N. v. The United Kingdom*, <http://hudoc.echr.coe.int/eng?i=001-86490>

⁴⁷⁶ <http://hudoc.echr.coe.int/eng?i=001-169662>

⁴⁷⁷ Par. 183, *Paposhvili v. Belgium*

⁴⁷⁸ Par. 187, *Paposhvili v. Belgium*

⁴⁷⁹ WBV 2017/8

<https://zoek.officielebekendmakingen.nl/stcrt-2017-50078.html>

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2000.⁴⁸⁰ During this postponed departure, the Service of Return and Departure (*Dienst Terugkeer & Vertrek_DT&V*) will examine the availability and accessibility of the treatment.

Unfit to travel and medical emergencies

According to Article 64 of the Foreigners Act of 2000⁴⁸¹, in conjunction with Article 3.4 of the Foreigners Decree 2000⁴⁸², the expulsion of undocumented migrants can be suspended as long as their (or a family member's) state of health would make it "inadvisable" for them to travel. This means that "*termination of medical treatment would lead to death, disability or another form of serious psychological or physical damage within three months*".⁴⁸³ As this suspension of expulsion is only applicable in emergencies, it is usually granted for six months. However, the law states that a postponed departure can be granted for a maximum of one year.

People who have been admitted involuntarily to a psychiatric hospital are automatically granted a postponed departure for the period of the hospitalisation for a maximum of six months. After six months, the situation is reassessed, and if the person is still hospitalised, the postponed departure will be extended for six months.

Residence permit for medical treatment after one year of postponed departure (Article 64)

After one year of postponed departure due to a medical emergency under Article 64, patients can file for a residence permit for

medical treatment. For this procedure, previous authorisation to enter the Netherlands is not required.

Once the application⁴⁸⁴ process is completed with the Immigration and Naturalisation Service (IND), the State Medical Service (BMA) issues an opinion determining whether there is a medical emergency, whether the applicant is unable to travel due to this emergency, and whether the country of origin offers the necessary medical treatment. Previously, no mention was made of verification if there was effective access. Since the decision regarding the case *Paposhvili v. Belgium* an assessment on the individual availability and accessibility has to be made.

Seriously ill undocumented migrants have a legal right to await the decision on their request for a residence permit on medical grounds in a reception facility for asylum seekers⁴⁸⁵, although in practice this does not often happen.

In 2013, the National Ombudsman⁴⁸⁶ condemned the many barriers to accessing the procedure and effective protection: the need for formal proof of identity and medical declarations from *all* the healthcare providers involved, issued within the last six weeks, makes the application process particularly difficult. Furthermore, being allowed to stay in a reception facility while the application is processed is only possible if no appeal with the Council of State has been lodged against a negative decision on a request for asylum.

⁴⁸⁰ Foreigners Act Op. cit. note 448

⁴⁸¹ Foreigners Act Op. cit. note 448

⁴⁸² *Foreigners Decree* – 2000

http://wetten.overheid.nl/BWBR0011825/Hoofdstuk3/Afdeling2/Paragraaf1/Subparagraaf5/Artikel346/geldigheidsdatum_27-04-2015

⁴⁸³ Foreigners Circular 2000, Article B8/9.1.3, http://wetten.overheid.nl/BWBR0012289/B8/9/91/913/Tekst/geldigheidsdatum_27-04-2015

⁴⁸⁴ <https://ind.nl/documents/7050.pdf>

⁴⁸⁵ <https://www.ind.nl/EN/Documents/2009%20EA-UT%20Motie-Spekman.pdf>

⁴⁸⁶ Letter from the National Ombudsman to the Secretary of State for Security and Justice, 4 September 2013,

http://www.inlia.nl/uploads/File/Brief%20aan%20staats%20Teeven%204%20sep%202013%20zorgen%20over%20motie_spekman%20opvang%20voor%20zieke%20asielzoekers.pdf

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In a report from March 2015⁴⁸⁷, the Ombudsman also held a critical view regarding the assessment of the BMA about the accessibility and availability of care in the country of origin: the sources of the information used about the country of origin remain anonymous. This makes it impossible to determine whether the person who collects the information is qualified and uses objectively verifiable information-gathering methodologies and for what level of remuneration, etc. As a result, the Ombudsman raised serious questions about the quality of the data used. The Ombudsman recommended that the BMA should take a more critical attitude towards the quality of the research, and that the IND should be more critical about BMA decisions as well.

Prevention and treatment of infectious diseases

HIV and hepatitis screening and treatments are included in the basic package of the compulsory health insurance.⁴⁸⁸ Therefore, every authorised resident in the Netherlands is entitled to be fully reimbursed by his/her insurance company for costs related to HIV, hepatitis and STI screening, treatment and care (provided that the individual does not have any outstanding “franchise” costs to pay, in which case these costs will be borne by the individual).

Treatment for these diseases is certainly part of the “medically necessary care” to which undocumented third-country nationals are entitled, even if many barriers remain in practice. EU citizens with no

financial resources or health coverage cannot access testing or treatment.

HIV, hepatitis and STI screening can be done at a GP’s office or at the Health Centre for Asylum seekers. Furthermore, a national “complementary sexual healthcare subsidies” system allows municipal health services (*Gemeentelijke Gezondheidsdienst_GGD*) to offer anonymous and free-of-charge STI screening to most at-risk populations in STI polyclinics. The definition for these populations is broad (e.g. it includes undocumented migrants⁴⁸⁹, men having sex with other men, sex workers and their clients, people coming from a region where an STI is endemic, anyone who has had more than three sexual partners in the last six months, anyone whose partner is considered at risk, and anyone under 25 years old⁴⁹⁰). However, in the future, the number of groups who can access these services could be restricted.⁴⁹¹

Migrant suffering from tuberculosis

Migrants (and their family members) suffering from TB will receive treatment until contamination danger has ceased and will automatically be granted a postponement of their departure from the Netherlands under Article 64 of the Foreigners Act during the treatment.⁴⁹² The postponement ends when the migrant withdraws from the treatment or when the contamination danger has ceased.

⁴⁸⁷Care across borders, report following a complaint to the Medical Advice Bureau, National Ombudsman, Marche 2015 <https://www.nationaleombudsman.nl/uploads/rapport/Rapport%202015-053%20BMA%20en%20IND%20webversie.pdf>

⁴⁸⁸<http://www.soaaid.nl/nl/professionals/interventies/structurele-interventies/toegang-soa-en-hiv-zorg>

⁴⁸⁹Inverardi, Gaia, *Assessing HIV prevention, testing, treatment care and support in Europe as a migrant with irregular status in Europe: A*

comparative 10-country legal survey, Aids action Europe, 2016

<http://www.aidsactioneurope.org/en/publication/assessing-hiv-prevention-testing-treatment-care-and-support-europe-migrant-irregular>

⁴⁹⁰<https://www.soaaid.nl/nl/professionals/interventies/structurele-interventies/aanvullende-seksuele-gezondheidszorg>

⁴⁹¹<http://www.ggdghorkennisnet.nl/?file=13972&id=1375704358&action=file.download>

⁴⁹² Foreigners Circular 2000, A3/7.3.2.7

Medical Health Services in detention centres

Undocumented migrants in detention centres

Undocumented migrants who are detained prior to a forced removal from the Netherlands receive basic medical care through the Medical Service of detention center (DJI). In cases of special psychiatric care, a transfer will be made to a Penitentiary Psychiatric Center (*Penitentiair Psychiatrisch Centrum: PPC*)⁴⁹³.

Prior to any form of detention, the principle of proportionality dictates that the measure should achieve the stated aim (which is the forced return of undocumented migrants) and no less severe measure is possible to achieve this aim. In practice, detention of asylum seekers or undocumented migrants at the border is automatic and the test of proportionality is not carried out properly.

Once a detention measure has been applied, there could occur urgent reasons leading to the conclusion that a person is not fit to stay in detention or that special care is needed (*detentieongeschiktheid*). The Medical Service in the detention center carries out a medical examination. A first critical note is that the examination to determine whether one is fit to stay in detention, is carried out once the person is already detained, whereas this examination should be prior to the application of the detention measure. Secondly, in practice it is very difficult to request the medical examination itself.

⁴⁹³ There are Penitentiary Psychiatric Centers in Amsterdam, Den Haag, Vught and Zwolle.

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National Health System

Constitutional basis

The Norwegian Constitution contains only one direct mention of access to healthcare in its Article 104, which affirms the right of children to social and health security.⁴⁹⁴

However, human rights can be invoked as an indirect source of right to healthcare. The Norwegian Constitution promotes human rights in its Article 2 and a series of articles on human rights were enshrined in articles 92 to 113 of the Constitution of 13 May 2014.

Norway is also part of international human rights treaties, which, if in conflict with the national law, will take priority over it, pursuant to Section 2 of the 1999 Norwegian Human Rights Act.⁴⁹⁵ The International Covenant on Economic, Social and Cultural Rights in particular contains provisions regarding to health, as the right of everyone to “the enjoyment of the highest attainable standard of physical and mental health”.⁴⁹⁶

Organisation and funding of Norwegian healthcare system

Organisation

The healthcare system in Norway is a public responsibility. It is organised into three levels: national, regional and local.⁴⁹⁷ While health care policy is controlled centrally,

responsibility for the provision of health care is decentralised.

Regulation of healthcare

At the national level⁴⁹⁸, The Ministry of Health and Care Services (HOD) is responsible for the healthcare policy and is the legislative authority.

The Norwegian Medicines Agency (NoMA), subordinated to the HOD, regulates matters concerning medication and its price.

The Ministry of Labour is indirectly involved in the governance of healthcare, mainly through the Labour and Welfare Administration (NAV).

The Directorate of Health and Care services⁴⁹⁹ and the County Governor are in charge of carrying out of the policies laid down by the Ministry.

The Norwegian Health Economics Administration (HELFO) is a department of The Directorate of Health and Care Services, which manages the National Insurance Scheme.

Finally, the Norwegian Board of Health Supervision⁵⁰⁰, organised under the Ministry of Health and Care Services, supervises the provision of health and social services.

Provision of healthcare

The state is responsible for the specialist health services.⁵⁰¹ Specialist services comprises hospital services, laboratory and radiology services, urgent care and health

⁴⁹⁴ Norwegian Constitution

<https://lovdata.no/dokument/NL/lov/1814-05-17>

⁴⁹⁵<http://app.uio.no/ub/ujur/oversatte-lover/data/lov-19990521-030-eng.pdf>

⁴⁹⁶ICESCR, Article 12

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

⁴⁹⁷*Municipal Health and Care Act* Section 3-4 Chapter 3

<https://lovdata.no/dokument/NL/lov/2011-06-24-30>

and *Specialist Health Care Act* 1999 Section 2-1 e. Chapter 2

⁴⁹⁸<https://lovdata.no/dokument/NL/lov/1999-07-02-61>
<http://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=2.1%20Overview%20of%20the%20health%20system&Type=Section>

⁴⁹⁹<https://helsedirektoratet.no/>

⁵⁰⁰<https://www.helsetilsynet.no/Norwegian-Board-of-Health-Supervision/>

⁵⁰¹ *Specialist Health Care Act* Op. cit. note 497 Section 2-1.

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related transportation like the ambulance system.⁵⁰²

Norway is divided into four regions. Each region has a Regional Health Authority (RHA), which provides the specialist healthcare.⁵⁰³ As every patient has the right to necessary and emergency healthcare from the specialist health care services⁵⁰⁴, if the Regional Health Authority cannot provide it, the patient has the right to necessary healthcare from a private provider.⁵⁰⁵

The 428 municipalities⁵⁰⁶ are in charge of financing, planning, organising and operating the primary health care according to local demand.⁵⁰⁷ The state finances a significant part of the municipalities' healthcare services through direct subsidies from the State Budget.⁵⁰⁸ The municipalities have a great deal of freedom in organising health services.

Counties have a limited role in the provision of healthcare services. They are mainly responsible for the provision of statutory dental care and have some responsibilities related to public health.⁵⁰⁹

Funding

As a public commitment, healthcare in Norway is mostly publicly financed by state, counties and municipalities taxation.⁵¹⁰ The rest of the funding comes from income-related employee and employer contributions and, in a much lesser extent, from out-of-pocket-payments.⁵¹¹

⁵⁰² Specialist Health Care Act Op. cit. Note 497 Section 2-1 a.

⁵⁰³ Ibid.

⁵⁰⁴ Patient's Rights Act, Section 2-1 b
<https://lovdata.no/dokument/NL/lov/1999-07-02-63>

⁵⁰⁵ Ibid.

⁵⁰⁶ <http://kartverket.no/Kunnskap/Fakta-om-Norge/Fylker-og-kommuner/Tabell/>

⁵⁰⁷ <http://www.legemiddelverket.no/english/the-norwegian-health-care-system-and-pharmaceutical-system/sider/default.aspx>

⁵⁰⁸ The Municipal Health and Care Act Op. cit. note 497 Section 11-5.

Accessing Norwegian healthcare system

All citizens and authorised residents in Norway are entitled to public health care, according to the Act of 2 July 1999 n°63 relating to Patients' Rights (Patient's Rights Act).⁵¹²

This entitlement is also included in social insurance legislation (the National Insurance Act of 1997) and in healthcare legislation on care funded by the municipalities (the Municipal Health and Care Act of 2011) and specialist care (the Specialist Health Care Act of 1999). These acts also delineate the scope of coverage by this right.

As stated in the Patient's Rights Act, Section 1-2, the scope of coverage by the Norwegian healthcare system can be extended, as an exception, "for persons who are not Norwegian nationals or who do not reside permanently in the realm."

Every Norwegian resident has the right to a permanent GP and to change doctor twice a year.⁵¹³

It is to be noted that somatic and mental health situations are equalised.⁵¹⁴ This means in principal there is no difference in the right to health care regarding somatic or mental illnesses.

The National Insurance Scheme

Pursuant to Section 2-1 of the National Insurance Act⁵¹⁵, every person residing in the realm is a mandatory member of the National Insurance Scheme (NIS).

⁵⁰⁹ Op. cit. note 497

⁵¹⁰ http://www.euro.who.int/_data/assets/pdf_file/0/018/237204/HiT-Norway.pdf

⁵¹¹ Op. cit. note 497

⁵¹² Patient's rights Act Op. cit. note 504

⁵¹³ Patient's Rights Act op. cit. note 504 Section 2-1c§2

⁵¹⁴ Syse, Aslak, "Pasient- og brukerrettighetsloven med kommentarer." Gyldendal Norsk forlag, Norway, Oslo, Fourth edition. 2015, p. 145

⁵¹⁵ National Insurance Act - 1997

<https://lovdata.no/dokument/NL/lov/1997-02-28-19>

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However, one must have an authorised residency in Norway to be a member of the NIS.

Tourists are not covered by the NIS, however, they may be covered by EEA-regulations or a reciprocal agreement between Norway and their country of origin.⁵¹⁶

The National Insurance Scheme covers the costs related to healthcare service for all citizens who are members of NIS and their surviving spouse and child if they reside in Norway.⁵¹⁷

The scope of NIS coverage is determined by the Parliament, in accordance with the National insurance Act.⁵¹⁸ It includes:

- Examination and treatment by a doctor⁵¹⁹, a psychologist⁵²⁰ and under certain circumstances a chiropractor⁵²¹
- Physiotherapy⁵²²
- Treatment related to language and speech defects⁵²³
- Treatment by an orthopaedist⁵²⁴
- Tests and examinations at private laboratories and Roentgen institutes, including x-rays⁵²⁵
- Dental care but only if related to diseases⁵²⁶

The scope of the NIS coverage is not precisely defined. In practice, it also covers⁵²⁷:

- Hospital and ambulatory care, if it is essential for the patient
- Emergency care
- Rehabilitation
- Drugs included in the “blue list” i.e. approved prescription drugs for chronically sick persons or long-term illness patients (the national insurance scheme covers from 62% to 100% of the price⁵²⁸)
- Dental care for children and vulnerable groups
- Medical eye-care (glasses excluded)
- Home nursing

Cost sharing

GP and outpatient specialist visits require flat fee co-payments (in 2017 it costs respectively NOK152 (€16.3⁵²⁹) and NOK345 (€36) per visit).⁵³⁰

Covered prescription drugs also require a flat fee contribution of 39% of the cost of the prescription, up to NOK520⁵³¹ (€54.3) per prescription, as do radiology and laboratory tests (of NOK245 (€26.3) and NOK54 (€5.6) in 2017, respectively).⁵³²

Certain groups of people are exempted from cost-sharing provisions⁵³³:

⁵¹⁶ Norwegian state party's report 2012-10-29 UN's Committee on Economic, Social and Cultural Rights para 395

⁵¹⁷ *National Insurance Act* Section 5-2

⁵¹⁸ Op. cit. note 515

⁵¹⁹ *National Insurance Act* Section 5-4

⁵²⁰ *National Insurance Act* Section 5-7

⁵²¹ *National Insurance Act* Section 5-9

⁵²² *National Insurance Act* Section 5-8

⁵²³ *National Insurance Act* Section 5-10

⁵²⁴ *National Insurance Act* Section 5-10-a

⁵²⁵ *National Insurance Act* Section 5-5

⁵²⁶ *National Insurance Act* Section 5-6

⁵²⁷ <http://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=3.3%20Overview%20of%20the%20statutory%20financing%20system&Type=Section>

⁵²⁸(p.30)

https://legemiddelverket.no/Documents/English/Price%20and%20reimbursement/PPRI_Pharma_Profile_Norway_20150626_final.pdf

⁵²⁹ Exchange rate for July 2017

⁵³⁰ <https://helsenorge.no/betaling-for-helsetjenester/betaling-hos-lege>

⁵³¹ <https://helsenorge.no/legemidler/blaresept>

⁵³² The Commonwealth Fund, *2015 International Profiles of Health Care Systems*, January 2016, p.134

⁵³³ Ringard Å, Sagan A, Sperre Saunes I, Lindahl AK. Norway: Health system review. *Health Systems in Transition*, 2013, p. 58

http://www.euro.who.int/_data/assets/pdf_file/0018/237204/HiT-Norway.pdf

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- Children under the age of 7 are exempted from cost-sharing for treatment received from a physician or a physiotherapist, essential drugs and travel expenses
- Children under the age of 16 receive free physician treatment and access to drugs from the “blue list”, and are exempted from cost-sharing for travel expenses.⁵³⁴
- Children under the age of 18 are exempted from co-payments for psychotherapy and dental treatment
- Pregnant women receive medical examinations during and after pregnancy for free

Certain services are free of charge and do not require co-payment:

- Consultations for prevention and treatment of transmittable diseases and treatment of sexually transmitted diseases
- Hospital admissions and inpatient treatment
- Child health clinics and school health clinics in which all children can be examined and vaccinated

Services provided by non-contracted private providers and goods and services excluded from the statutory coverage have to be fully paid for.⁵³⁵

Cost shared ceiling

A cost-shared ceiling was introduced in the 1980s to limit individual’s healthcare expenditure. With this free pass system, personal contributions are limited to a certain amount per year for the following goods and services⁵³⁶:

- Services from doctors

- Services from psychologists
- Important medication and medical equipment
- Transport costs
- Radiological examination and treatment
- Laboratorial tests
- Polyclinic healthcare

This amount is decided by the Parliament every year. In 2017, the amount was set at NOK2205⁵³⁷ (€237⁵³⁸).

Once this limit is reached, the national Insurance Scheme issues an exemption card and covers its holder’s health expenses for the rest of the calendar year.⁵³⁹ Cost-sharing for children under the age of 16 is included with one parent’s ceiling: they do not pay the cost-sharing fee for the first ceiling.⁵⁴⁰

A second ceiling is also set every year by the Parliament for costs concerning⁵⁴¹:

- Dental care (only related to health issues for special groups of persons)
- Physiotherapy
- Fees for accommodation in rehabilitation centres
- Treatment abroad

As of 2017, the amount of the second ceiling was set at NOK1990⁵⁴² (€219.3).

These two ceilings are not related to individual income.

The Ministry of Health issues regulations concerning deductible plans⁵⁴³

There is also a safety net: if the treatment is necessary, but not mentioned in the National Insurance Act, the National Insurance Scheme may cover the costs for

⁵³⁴ Patient’s travel regulation – 2015, §24
<https://lovdata.no/dokument/SF/forskrift/2015-06-25-793>

⁵³⁵ Op. cit. note 533, p. 66

⁵³⁶ *The National Insurance Act* Section 5-3§1

⁵³⁷ <https://helsenorge.no/betaling-for-helsehjelp/frikort-for-helsetjenester>

⁵³⁸ Exchange rate of January 2017

⁵³⁹ *National Insurance Act* Section 5-3§3

⁵⁴⁰ Op. cit. note 533, p. 60

⁵⁴¹ *National Insurance Act* Section 5-3§2

⁵⁴² <https://helsenorge.no/betaling-for-helsehjelp/frikort-for-helsetjenester>

⁵⁴³ *National Insurance Act* Section § 3-5 last paragraph

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this treatment as well, under certain conditions set forth by the Ministry of Health.⁵⁴⁴

Healthcare providers have to inform the patients about the duty to pay and to indicate an approximately amount before they provide health services. They cannot claim payment in advance.⁵⁴⁵

Individuals who are not able to pay the patient charge can apply for social support, according to the Social Care Act.⁵⁴⁶ This Act applies to all persons residing in the realm⁵⁴⁷, although exceptions can be made regarding people who do not reside permanently in the realm.

Voluntary health insurance

As, in principle, all Norwegians are covered by the public insurance scheme, voluntary health insurance does not play a significant role in the Norwegian health system.

Most voluntary health insurance schemes offer supplementary cover and shorter waiting times for publicly covered services and specialist consultations in private facilities.⁵⁴⁸

Urgent medical assistance

Everyone, independently of his/her immigration or insurance status, is entitled to emergency healthcare and care that cannot wait.⁵⁴⁹ This applies both to somatic and mental health.

The determination of the urgency of the situation is made by the medical personnel.

Moreover, everyone is entitled to an assessment of his/her health needs.⁵⁵⁰

The Norwegian government has many times stated that “it is not [...] permitted to refuse to give emergency health care to a person on the basis that he or she is unable to pay”.⁵⁵¹

In Circular letter I-2011-5⁵⁵² chapter 3, the Ministry of Health specifies that the healthcare provider cannot claim payment in advance for specialist health care, which cannot be postponed.

Barriers to access to healthcare

Compared to other countries, Norway has long waiting times for hospital treatment, especially for elective surgery.⁵⁵³

Another difficulty in access to healthcare is related to the sometimes long distances between populated areas in Norway and the lack infrastructures connecting some of them. People living in rural and remote parts of Norway may experience difficulties and have to travel longer to access healthcare. GPs are fairly well distributed across the country, but practising specialists are mostly concentrated in big urban areas. GPs in remote areas often have to treat conditions that would be handled by hospitals in other parts of the country.⁵⁵⁴

⁵⁴⁴ *National Insurance Act* Section 5-22

⁵⁴⁵ Søvig, Karl Harald. ”Tilgang til velferdstjenester for irregulære migranter etter det norske regelverket I: Eksepsjonell velferd? Irregulære migranter i det norske velferdssamfunnet. Bendixen, Synnøve K and others (Red). Norway, Oslo. 2015, p. 56

⁵⁴⁶ *Social Care Act* Sections 18 & 19.
<https://lovdata.no/dokument/NL/lov/2009-12-18-131>

⁵⁴⁷ *Ibid.* Section 2.

⁵⁴⁸ *Op. cit.* note 532

⁵⁴⁹ *Circular letter I-2011-5* chap 2.1

<https://www.regjeringen.no/no/dokumenter/i-52011-helsehjelp-til-personer-uten-fas/id662225/>

⁵⁵⁰ *Ibid.*

⁵⁵¹ Norwegian state party’s report 2012-10-29 UN’s Committee on Economic, Social and Cultural Rights para. 395

⁵⁵² *Op. cit.* Note 549

⁵⁵³ <http://www.oecd.org/norway/Health-at-a-Glance-2015-Key-Findings-NORWAY.pdf>

⁵⁵⁴ <http://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=7.3%20User%20experience%20and%20equity%20of%20access%20to%20health%20care&Type=Section>

Access to healthcare for migrants

Asylum seekers and refugees

All Norwegian nationals and authorised residents are entitled to public healthcare.

As authorised residents pursuant to the Immigration Act⁵⁵⁵, asylum seekers and refugees are entitled to the same access to healthcare as Norwegian citizens⁵⁵⁶, though with some exceptions related to the National Insurance Scheme.⁵⁵⁷

During the transit phase before being transferred to a reception centre, immigrants are obliged to undertake a health examination at the transit reception centre. The main purpose of this measure is to detect infectious or severe diseases as tuberculosis.⁵⁵⁸

During the three first month of the asylum application, another country can request the responsibility to consider it. Pursuant to the “Dublin III” European Regulation⁵⁵⁹, only one country can examine an asylum application. Thus, if this occurs, the asylum seeker will lose his/her status of authorised resident in Norway and every right attached to it.

Asylum seekers whose application received a final refusal are considered as undocumented migrants regarding access to healthcare. Yet, the NIS can financially

⁵⁵⁵ *Immigration Act - 2008*

<https://www.regjeringen.no/en/dokumenter/immigration-act/id585772/>

⁵⁵⁶ The Patient’s Rights Act Section 1-2, The Regulation 1255 Section 2, and the Specialist Health Care Act Chapter 5, Circular letter I-2/2008 chapter 2

⁵⁵⁷ The Parliament has delegated regulation competence to the Government according to The Public Insurance Scheme Act Section 2-16, and FOR-2008-05-14-460. Ordinance on Insurance Coverage for Asylum Seekers and their Family Members - 2008

<https://lovdata.no/dokument/SF/forskrift/2008-05-14-460>

cover health care regulated in chapter 5 of the National Insurance Act⁵⁶⁰ if it is acute care.⁵⁶¹ The Directorate of Health and Social Care specified that this regulation applies solely for people who unsuccessfully applied for asylum, not to all undocumented migrants.

Pregnant asylum seekers and refugees

Pregnant woman seeking asylum are entitled to the same access to healthcare than Norwegian women affiliated to the National Insurance Scheme, though with some minimal exceptions.⁵⁶²

They have access to contraceptive counselling and to pregnancy termination free of charge. They have to pay a fee of NOK150-200 (€16-23) for a GP consultation.

Rubella vaccines are offered free of charge to any woman of childbearing age who does not have immunity against rubella.⁵⁶³

Children of asylum seekers and refugees

As authorised residents, children of asylum seekers have the same access to public health care, medical and dental care as children of Norwegian nationals.⁵⁶⁴

Undocumented migrants

Pursuant to the Regulation 1255 on the right to healthcare for people without a permanent residency in Norway of 2011⁵⁶⁵,

⁵⁵⁸ http://www.euro.who.int/_data/assets/pdf_file/0/18/237204/HiT-Norway.pdf, p. 144

⁵⁵⁹ *Dublin III Regulation -2013*

⁵⁶⁰ *The Patient’s Rights Act*

⁵⁶¹ FOR-2008-05 §2

⁵⁶² The Parliament has delegated regulation competence to the Government according to Folketrygdloven § 2-16, and FOR-2008-05-14-460.
⁵⁶³

http://www.euro.who.int/_data/assets/pdf_file/001/8/237204/HiT-Norway.pdf, p.126

⁵⁶⁴ Op. cit. note 542

⁵⁶⁵ *Regulation 1255 on the right to healthcare for people without a permanent residency in Norway of 16th December 2011*, implemented on 1 January 2012

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undocumented migrants are only entitled to emergency healthcare⁵⁶⁶, and to “most necessary healthcare”.⁵⁶⁷

However, no provision prohibits from providing healthcare to undocumented migrants.

The right to emergency healthcare covers both the primary and the specialist healthcare.⁵⁶⁸ It applies to both somatic and mental health. Undocumented migrants have the same right as every other citizen in Norway when it comes to quantity and quality of healthcare. They also have the right to examination and a right to access the documents and information about their condition. If necessary, supplementary information about the patient shall be gathered.⁵⁶⁹

Healthcare is considered “most necessary” when it cannot be postponed without imminent risk of death, permanent severe disability, serious injury or pain.⁵⁷⁰

It is meant as a right to healthcare when the patient is at a stage in which healthcare is necessary, but the state of the patient is not critical at the time of the health evaluation. Hence, if it is necessary to treat the condition during the timeframe of three weeks determined by the Ministry of Health⁵⁷¹, one has the right to health care.⁵⁷² If not, the Ministry of Health considers that this will be enough time for the undocumented migrant to leave the country.

The right to most necessary healthcare can also be interpreted as applying in cases in which imminent risk of death, permanent

severe disability or serious injury or pain could appear within three weeks.

Pursuant to section 5 of the 1255 Regulation⁵⁷³, medical care that cannot wait also includes:

- necessary care for new-borns
- abortion, and
- healthcare related to control of communicable diseases, which includes evaluation, treatment and care.

Furthermore, if an undocumented migrant suffers from a mental illness and is an “evident and serious danger” for himself and others⁵⁷⁴, he will be entitled to, and can be forced to, get mental healthcare regardless of the “most necessary healthcare, which cannot be postponed” threshold.

Payment of health services

Undocumented migrants have to pay for all the healthcare goods and services they receive. However, the healthcare provider cannot claim payment in advance if it is emergency care or most necessary healthcare, which cannot be postponed.⁵⁷⁵ Besides, some exemptions exist for care received by children and pregnant women.

The price is an important barrier to healthcare for undocumented migrants, who rarely can afford healthcare and often forgo medical treatment because of the risk to be billed more than they can afford.

If the undocumented migrant is unable to pay for specialist healthcare, the care provider has to cover the price of the

<https://lovdata.no/dokument/SF/forskrift/2011-12-16-1255>

⁵⁶⁶ Regulation 1255 §3

⁵⁶⁷ Regulation 1255 §4-5

⁵⁶⁸ Regulation 1255 Section 3, The Patient’s Rights Act Section 2-1a §1 and 2-1b §1

⁵⁶⁹ Circular letter I-2011-5

⁵⁷⁰ Regulation 1255 §5 a)

⁵⁷¹ See Circular letter I-2011-5 chap 2.2. §2

⁵⁷² Ibid.

⁵⁷³ Regulation 1255

⁵⁷⁴ Regulation 1255 Section 5. The criterion in Regulation 1255 is very similar to the one in the Mental Health Care Act Section 3-3 nr. 3 litra b, however, it determines a lower threshold and covers a larger group of people.

⁵⁷⁵ Op. cit. note 545

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service, according to the Specialist healthcare Act Section 5-3.⁵⁷⁶

As to primary healthcare, it is not specifically regulated whether a provider has to cover the price of the service if an undocumented migrant patient does not have sufficient means to pay for it.

The regulations are also unclear concerning the coverage of the fees for necessary medicine for migrants without means. The Regional Health Care Authorities are supposed to pay for medicines in emergency cases but the NIS does not cover these expenses for undocumented migrants. The Norwegian Directorate of Health and Social Care acknowledged the need for new guidelines related to this, and passed the question to the Ministry of Health and Social Care.

Undocumented pregnant women

Undocumented women have the right to receive antenatal, delivery and postnatal care, however they have to pay for it.⁵⁷⁷

Indeed, undocumented pregnant women have the same right (but not the same access) to antenatal care as Norwegian women and authorised resident women.⁵⁷⁸ This includes preventive, primary and secondary healthcare. The guidelines set forth by the Directorate of Health and Care Services concerning antenatal care apply for the undocumented pregnant women.⁵⁷⁹

As healthcare regarding giving birth is considered as “emergency help”, undocumented women are entitled to such care.⁵⁸⁰

Furthermore, women have the same rights to termination of pregnancy as Norwegian and authorised resident women.⁵⁸¹

If an undocumented pregnant woman cannot afford to pay for maternity care, she might get it for free if she proves her lack of financial means.

Children of undocumented migrants

Before 2011, it was commonly considered in Norway that children of undocumented migrants had the same rights as every other citizen in Norway.

Since the 2011 Regulation 1255⁵⁸², children of undocumented migrants have, as their parents, only the right to emergency healthcare and to necessary healthcare that cannot be postponed.⁵⁸³

An exception was made in 2011 to the provision of necessary healthcare to children when it is in the interest of the child that the healthcare shall not be provided. This exception regards both primary and specialist healthcare and was made in regard to children who are about to leave the country.

Thus, if the treatment cannot be fulfilled before the child leaves the country and an unfinished treatment will harm the child, the health care personnel who knows about the departure, shall not start the treatment.⁵⁸⁴ As follows, access to necessary healthcare for undocumented children is left to the personal appreciation of the consequences of treatment in regard to a possible departure date made by the healthcare personnel.

The entitlement of undocumented children to GP services is unclear. Although the

⁵⁷⁶ Op. cit. note 497

⁵⁷⁷ Circular letter I-2011-5 pkt. 3

⁵⁷⁸ Circular letter I-2011-5 chap 2.3.

⁵⁷⁹ Circular letter I-2011-5 pkt. 2.3

See the guidelines here:

<https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/404/National-clinical-guideline-for-antenatal-care-short-version%20-IS-1339.pdf>

⁵⁸⁰ Regulation 1255 Section 3

⁵⁸¹ Regulation 1255 Section 5c.

⁵⁸² Op. cit. note 545

⁵⁸³ Regulation 1255, Sections 3 and 4

⁵⁸⁴ Circular letter I-2011-5 p. 6

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Ministry of Health and Care Services issued a decision regarding this, which supposedly excludes them from the right to GP services.⁵⁸⁵ It can be argued that the Government meant to exclude children of undocumented migrants only from the GP-arrangement as it is organised for the nationals, and not from the right to a similar service.⁵⁸⁶

The healthcare provider cannot claim payment in advance, or collect a payment claim after the healthcare is provided.⁵⁸⁷

Termination of pregnancy

Every woman in Norway has the right to pregnancy termination following the Termination of Pregnancy Act⁵⁸⁸, regardless of her immigration status. Abortion is free for Norway nationals and women legally residing in Norway. Others have to pay for it, but the hospital cannot require prepayment.⁵⁸⁹

EU and EEA citizens

Norway is not a member of the European Union (EU), but is a part of the EEA-agreement.

EEA and EU citizens with an authorised residency are entitled to the same healthcare as Norwegian citizens, usually upon presentation of their EHIC.⁵⁹⁰ They have to pay the patient charges as Norwegian

citizens.⁵⁹¹ Some fees may be reimbursed by their country of origin.⁵⁹²

The first three months of residence are authorised without condition for EU and EEA citizens. To stay more than three months, one has to have sufficient economical means. EEA citizens seeking a job can stay for up to six months without registration.⁵⁹³

Unaccompanied minors

When the unaccompanied minor is an asylum seeker, s/he is considered as an authorised resident and is thus entitled to the same rights as a Norwegian citizen in terms of healthcare.

The authorities responsible of unaccompanied minors are the Immigration Directory (UDI)⁵⁹⁴ and the Children welfare authorities⁵⁹⁵, along with the healthcare authorities.

Unaccompanied minor asylum seekers have the right to a provisional guardian who shall assist them in health and legal procedures and communicate with the authorities cited above.⁵⁹⁶

Most of minor asylum seekers obtain an authorised residency: in 2015, 92% of unaccompanied minors obtained it, 89% as refugees and 4% on humanitarian grounds.⁵⁹⁷

⁵⁸⁵Op. cit. note 545, p. 55

⁵⁸⁶Op. cit. note 545, p. 57

⁵⁸⁷ Søvig 2013, Karl Harald I: Undring og erkjennelse: Festskrift til Jan Fridtjof Bernt, 2013, Rasmussen, Ørnulf; Schütz, Sigrid Eskeland; Søvig, Karl Harald (Red.)Fagbokforlaget, Norway, Bergen 2013, p. 707

⁵⁸⁸*Termination of Pregnancy Act - 1975*

<https://lovdata.no/dokument/NL/lov/1975-06-13-50>

⁵⁸⁹<https://helsedirektoratet.no/folkehelse/seksuell-helse/abort>

⁵⁹⁰Circular letter I-3/2017 chap.6-1

<https://www.regjeringen.no/no/dokumenter/dekning-av-utgifter-ved-helsehjelp-i-helseinstitusjoner-under-den-offentlige-spesialisthelsetjenesten-blant-annet-for-personer-som-ikke-er-bosatt-i-norge/id2539897/>

and <https://helsenorge.no/foreigners-in-norway/health-care-benefits-during-a-temporary-stay-in-norway>

⁵⁹¹ Circular letter I-3/2017 Op. cit. note 590 p. 5

⁵⁹² Op. cit. note 590

⁵⁹³ Circular letter RS 2011-037 chap 3

<https://www.udiregelverk.no/no/rettskilder/udirundskriv/rs-2011-037/>

⁵⁹⁴<https://www.udi.no>

⁵⁹⁵https://www.bufdir.no/Statistikk_og_analyse/Opvekst/Barn_pa_flukt/

⁵⁹⁶http://www.noas.no/wp-content/uploads/2013/12/Brosjyre-EMA-Engelsk_web.pdf

⁵⁹⁷ Op. cit. note 595

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If an unaccompanied minor does not seek asylum or did not obtain it, s/he is entitled to the same rights as children of undocumented migrants.

Protection of seriously ill foreign nationals

In Norway, a residence permit can be granted to a foreigner if s/he has strong humanitarian needs or an extraordinary integration, based on an overall assessment of his/her situation.⁵⁹⁸

A seriously ill foreign national can thus obtain a permit to stay for humanitarian reasons if it is absolutely necessary for health reasons for him/her to stay in Norway, for instance if it is impossible for him/her to be treated in his/her country of origin.

Children may be granted residence for health reasons under the same condition as adults, although, as a vulnerable part of the population, it is less difficult for them to prove the necessity to stay in Norway.

In practice, health issues are very rarely the only reason for granting residence permit, but are rather one of the reasons of obtaining it in the overall assessment.

Prevention and treatment of infectious diseases

Everyone, including undocumented migrants, has the right to healthcare related to infectious diseases, as it is considered as most necessary care, according to section 6-1 of the 1995 Law on Control of Communicable Diseases.⁵⁹⁹

This comprises evaluation, diagnoses, treatment, care and other necessary healthcare⁶⁰⁰, which people receive for free.

Access to healthcare related to infectious diseases is supposedly wide, as it is in the interest of public health to treat everyone. In practice, however, access to treatment of infectious diseases is very limited for undocumented migrants, as they are not entitled to GP consultation.

⁵⁹⁸ *Immigration Act* Chapter 5 Section 38

⁵⁹⁹ *Law on Control of Communicable Diseases-1994*
<https://lovdata.no/dokument/NL/lov/1994-08-05-55>

⁶⁰⁰ HOD 2010, The Ministry of Health and Care Services, Hearing of 25.10.2010 regarding changes

in the health care regulations towards people with unauthorized residency in Norway. Preparatory works for the Regulation 1255, p. 15
<http://www.regjeringen.no/contentassets/de615e594e94466085abb7b39e77d303/hoeringsnotat.pdf>

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National Health System

Constitutional basis

The Romanian Constitution of 1991⁶⁰¹ guarantees protection of health as a fundamental right in its Article 34, which bounds the State to take measures to ensure public hygiene and health.

Social protection is acknowledged as a right at work in article 41 of the Constitution and as a part of living standards to preserve in article 47. Article 49 also prohibits the employment of minors in activities that may harm their health, and article 35 recognises the right of every person to a healthy environment.

The exercise of the right to healthcare may be restricted by law. However, pursuant to article 53 of the Constitution, this restriction must be necessary, cannot be based on discrimination and cannot infringe on the existence of this right.

Organisation and funding of Romania healthcare system

Organisation

The main law regulating healthcare in Romania is the 95/2006 Law on healthcare reform⁶⁰² of 14 April 2006. It governs the functioning and the principles of the system, determines the categories of insured population, the benefits they are entitled to and the categories of insured population exempted from the payment of contributions.

The Law on Healthcare Reform also established the National Health Insurance Fund (NHIF) as an autonomous central

body, which administrates the social health insurance system. The NHIF is the third party payer of the system and its main financial source. It manages the funds collected by the National Agency for Fiscal Administration, subordinated to the Ministry of Finance.

The Ministry of Health (MoH) is the central authority responsible for regulation and legislative initiatives, health policy formulation and public health.⁶⁰³

Some of the Ministry of Health's responsibilities have been gradually transferred to the local public authorities through decentralisation, such as the ownership and administration of public hospitals and the responsibility for the delivery of several public healthcare services at the local level, including school medicine, community nurses or Roma health mediators.

In 2015, the National Authority for Management in Health Care was created. In collaboration with the MoH, this body is in charge of establishing quality criteria for health care providers.

Cross-sector approaches in health policy are ensured at the national level through collaboration between the Ministry of Health and the Ministry of Labour, Social Solidarity and Family, the Ministry of Interior, the Ministry of Finance, the Ministry of Social Solidarity and Family and the Ministry of Education.⁶⁰⁴

Romania is administratively divided into 41 counties and the Municipality of Bucharest. In each county and in Bucharest, there is a Ministry of Health's deconcentrated body: a District Public Health Authority (DPHA) responsible for the management of the national preventive health programs at county level; and a National Health

⁶⁰¹<http://www.constitutiaromaniei.ro/>

⁶⁰²*Law on healthcare reform – 2006*
<http://legislatie.just.ro/Public/DetaliiDocument/71139>

⁶⁰³Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health system review.

Health Systems in Transition, 2016
http://www.euro.who.int/_data/assets/pdf_file/0017/317240/Hit-Romania.pdf?ua=1

⁶⁰⁴ Ibid. p. 43

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Insurance House subordinated body: a District Health Insurance House (DHIH), which signs contracts with the county healthcare providers every year.

Funding

Romania health insurance system is funded by a mix of compulsory and voluntary elements. Since 1998, the dominant contribution mechanism is social insurance.⁶⁰⁵

Most of the health funds derive from the population, predominantly through third party payment mechanisms i.e. social health insurance contributions and taxation; and through out-of-pocket payments i.e. co-payments and direct payments.

The contribution for the mandatory health insurance amounts to 5.5% of employee's monthly wage plus 5.2% added by their employers.⁶⁰⁶ It is collected into a national health insurance fund, included in the state budget.

Each year, the Ministry of Health, the National Health Insurance House and the College of Physicians agree on a Governmental Decision (yearly framework contract): it settles which health services shall be contracted and reimbursed within the health insurance system and the level of payment for both public and private healthcare providers.

Healthcare funding is completed by national public health programs financed by the state budget and addressing the entire population, including uninsured people.

Since the fall of the communist regime in 1990, the Romanian government allocates each year an increasing amount of financial resources to the healthcare sector. Still, this sector is severely underfunded, as Romania was allocating only 5.6% of its GDP to

health in 2014, the lowest public budget devoted to health among the EU Member States.⁶⁰⁷

Accessing Romania healthcare system

The Romanian healthcare system is based on a mandatory health insurance scheme, which covers all Romanian citizens and foreigners legally residing in Romania.⁶⁰⁸

The insured population has access to a basic package of health services, pharmaceuticals and medical devices through a system of National Health Insurance Card. Covered medical services include:⁶⁰⁹

- preventive healthcare services
- curative health services
- ambulatory healthcare
- hospital care
- dental services
- laboratory analyses
- medical emergency services
- complementary medical rehabilitation services
- pre-, intra- and post-birth medical assistance
- home care nursing
- prescribed medication
- healthcare materials
- orthopaedic devices and prosthetics
- medical transport

Insured persons are entitled to medical services from the first day of sickness, or the date of an accident, until they fully recover.

The coverage of medicines depends on their classification:

- class A medicines (important and cost-effective) are reimbursed up to 90%
- class B medicines (less essential or less cost-effective compared to class

⁶⁰⁵Op. cit. note 603, p. 61

⁶⁰⁶<http://www.euprimarycare.org/column/primary-care-romania>

⁶⁰⁷ Health at a Glance: Europe 2014, European Commission, 2014

http://ec.europa.eu/health/reports/docs/health_glance_2014_infograph_en.pdf

⁶⁰⁸Op. cit. note 603, pages 47-48

⁶⁰⁹Detailed list available at <http://www.cnas.ro/casmb/page/care-sunt-serviciile-medicale-de-care-beneficiez.html>

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- A medicines) are reimbursed up to 50%
- class C medicines (for severe chronic diseases, requiring special medical prescription, or distributed through hospital pharmacies) are fully covered⁶¹⁰

Pursuant to article 213 of the Law on healthcare reform⁶¹¹, certain categories of insured population are exempted from the payment of the contribution, as:

- children up to 18 years old
- young people up to 26 years old if they are enrolled in education
- pregnant women with no income or on a sub-minimum income
- disabled persons with no income
- People whose infection is covered by National Health Programmes
- war veterans and their widows
- victims of political persecution between 1948 and 1989

Children up to 18 and young people, up to 26 years, enrolled in a form of education, patients with diseases included in national health programs, with no income, persons on a very low income and pregnant women are also exempted from co-payments.⁶¹²

Despite social health insurance being compulsory for every citizen and foreign resident in Romania, in 2014, around 14% of the population was not insured.⁶¹³ The non-insured population has access to a minimum package of services, which includes far less services:

- some preventive services

- medical services for communicable diseases that may represent a public health threat
- pregnancy related care (pre- and postnatal care, delivery)
- life threatening emergencies.

Uninsured people are required to pay for medical ambulatory care they receive, except in cases comprised in the minimum package of services.

Barriers to access healthcare

Access to healthcare in Romania is characterised by strong disparities between the rural and urban regions, notably because most physicians are concentrated in the big cities, leaving the rural areas with insufficient human resources for healthcare.

Another important barrier to access healthcare is the financial one, associated with formal and informal out-of-pocket-payments. In 2011, over 60% of patients made informal payments to their doctors, reflecting a lack of concern for patient's rights in certain medical facilities.⁶¹⁴

Recent reforms

Most recent law reforms in Romania focused on harmonising the national legislation with the EU law, as the Directive 2011/24/EU on patient's rights in cross-border healthcare in 2014, transposed by an ordinance of 29 January 2014.⁶¹⁵

Reforms were recently taken on the improvement of the minimum benefit package for uninsured people, starting January 2015. It includes several additional health services, such as prevention and

⁶¹⁰(p.37)

http://www.euro.who.int/_data/assets/pdf_file/0017/317240/Hit-Romania.pdf?ua=1

⁶¹¹ Op. cit. note 602

⁶¹²Law on healthcare reform Op. cit. note 602 Article 225

⁶¹³

<http://www.hspm.org/countries/romania23092016/linghit.aspx?Section=3.7%20Payment%20mechanisms&Type=Chapter>

⁶¹⁴World Bank. 2011. *Romania - Functional review: health sector*. Washington, DC: World Bank., p. 8

<http://documents.worldbank.org/curated/en/2011/05/17056888/romania-functional-review-health-sector>

⁶¹⁵*OUG 2/29.01.2014*, integrated in the consolidated reform law 95/2006

http://www.anm.ro/anmdm/_LEGIORDONANTE/OUG_2_din_29.01.2014.pdf

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reproductive health/family planning services. Moreover, the reforms also aimed at increasing access to subsidised prescribed drugs, through the introduction of the HTA system (health technology assessment), the introduction of new innovative molecules on the list of subsidised drugs, the implementation of policies for the reduction of medicine prices, regulations in the pharmaceutical sector (related to the claw-back tax), the patient electronic card and the electronic prescription of subsidised drugs.

The ongoing National Health Strategy 2014-2020, adopted through the Governmental Decision 1028/18.11.2014⁶¹⁶ defined specific objectives in the areas of public health, health services and regarding vulnerable categories of people. It is aimed at improving access to healthcare of quality for poor or vulnerable groups, with a focus on rural populations and Roma people.

Access to healthcare for migrants

Asylum seekers, refugees and those eligible for subsidiary protection

Foreigners who received a form of international protection in Romania have access to medical care in the same conditions as Romanian citizens, pursuant to article 7 of the 2004 Government Ordinance no. 44/2004 regarding the social integration of foreigners who were granted a form of protection in Romania.⁶¹⁷

Article 1 of the 44/2004 Ordinance states that its aim is to facilitate the integration of foreigners with a residence through

⁶¹⁶<http://ms.gov.ro/upload/HG%201.0282014%20-%20Strategia%20Nationala%20de%20Sanatate%202014-2020.pdf>

⁶¹⁷Ordinance no. 44/2004

<http://legeaz.net/og-44-2004-integrarea-sociala-a-strainilor/>

⁶¹⁸Law no. 122/2006 regarding asylum in Romania, last amended through Law no. 331/2015 on the approval of the Government Ordinance no. 25/2016

provision of the right to healthcare and social assistance, among others.

The main law regulating the status and rights of refugees and asylum seekers in Romania is the 2006 law no.122/2006 regarding asylum in Romania.⁶¹⁸

As stated in article 17, para.1-M of the 112/2006 law, individuals who seek a form of international protection are entitled, free of charge, to:

- primary medical care
- adequate treatment
- emergency hospitalisation
- healthcare and treatment in cases of acute or chronic diseases which imminently endanger their life.
- be included in national public health programmes aimed at the prevention, surveillance and control of communicable diseases in epidemiological risk situations

Furthermore, the 122/2006 law affirms in its article 17 para 1-N the right of asylum seekers with special needs to receive adequate care.

These healthcare services are provided by the medical services of the accommodation centre or by other health units.

Article 19-H of the 122/2006 law provides that, individuals who seek a form of protection have - among others - the obligation to present themselves to the medical examinations that are established for them.

However, article 8 of the Methodological Norms of Application of Law no. 122/2006⁶¹⁹ specifies that asylum seekers

http://igi.mai.gov.ro/sites/all/themes/multipurpose_zymphonies_theme/images/pdf/LEGEA122ANUL2006.pdf

⁶¹⁹Methodological Norms of Application of Law no. 122/2006

<http://www.mmuncii.ro/pub/imagemanager/images/file/Legislatie/HOTARARI-DE-GUVERN/HG1251-2006.pdf>

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have to be present only for the medical examinations that are established for reasons of public health.

Romania is bound by the Dublin III Regulation⁶²⁰, which determines the responsibility of European states in the consideration of asylum applications. However, Romania is mostly seen as a transit country by migrants who wish to seek asylum in other EU countries.⁶²¹

The International Organisation for Migration (IOM), the UNHCR and the Romanian Government have a tripartite agreement regarding refugees in Romania. The outcome of this agreement is the Centre for emergency transit in Timisoara. This centre is an “evacuation facility”, meant to provide temporary shelter for refugees who need to be immediately evacuated from their first country of refuge and will be relocated to another one.⁶²² It also operates as a non-secure reception centre for asylum seekers being processed under Romanian national law.⁶²³

Refugees in the Emergency Transit Centre can receive a complete medical examination including a laboratory analysis and pulmonary radiography for those older than 15 years of age to establish their health status, and treatment if needed.⁶²⁴

The refugees benefiting from a transit visa can stay no longer than six months on Romanian territory. However, this period can be prolonged should a certain treatment be necessary e.g. for tuberculosis. If a child is diagnosed with tuberculosis, his/her whole family can usually remain with him/her for the prolonged period, pursuant to Article 69² of the Government Ordinance

194/2002 regarding the regime of foreign nationals.⁶²⁵

Before they leave the centre, refugees are requested to undergo a fitness for travel procedure that determines if they may travel by air. It is a medical examination that takes place 24-48 hours before take-off. Pregnant women, of more than 32 weeks, are not allowed to fly.

Pursuant to article 17-H of the Government Ordinance no. 44/2004⁶²⁶, asylum seekers have the right to work and are entitled to assistance in job search. Having the right to work makes asylum seekers eligible for health insurance, if they can afford to pay the contribution.

Pregnant asylum seekers and refugees

Pregnant asylum seekers are entitled to ante- and post-natal care and to family planning services.

Family planning services are included in the basic package of services for insured women and are thus reimbursed by the county Health Insurance House.

Children of asylum seekers and refugees

Children of asylum seekers benefit from the same rights guaranteed to Romanian Children by the law 272/2004 regarding the protection and promotion of children's rights⁶²⁷ as stated in its Article 3.

Pursuant to article 46 of the 272/2004 Law, children of asylum seekers and refugees have the right to benefit from the highest attainable standard of health and to benefit from the medical and recovery services necessary to ensure the realisation of this

⁶²⁰ *Dublin III Regulation* – 2013

⁶²¹ European network for technical cooperation on the application of the Dublin II Regulation, 2012, *National Report Romania, The application of the Dublin II Regulation in Romania*, p. 22

⁶²² <http://www.unhcr-centraleurope.org/en/what-we-do/resettlement/etc-timisoara.html>

⁶²³ <http://www.globaldetentionproject.org/countries/europe/romania>

⁶²⁴ <http://www.unhcr.org/50aa08d39.pdf>

⁶²⁵ *Government Ordinance 194/2002 regarding the regime of foreign nationals* http://www.mae.ro/sites/default/files/file/userfiles/file/pdf/servicii-consulare/2012.07.30_oug_194_2002.pdf

⁶²⁶ Op. cit. note 617

⁶²⁷ *Law no. 272/2004 regarding the protection and promotion of children's rights*, republished in 2014 <http://www.mmuncii.ro/j33/images/Documente/Legislatie/L272-2004-R.pdf>

right.

Moreover, the access of children to medical and recovery services, as well as to the adequate medication pertaining to their state of health is guaranteed by the state and the costs are covered by the National Health Insurance Fund and by the state budget.⁶²⁸

Children of asylum seekers are exempted from paying the contribution to the mandatory health insurance and can benefit from it until they are 18.⁶²⁹

Undocumented migrants

Undocumented migrants are only entitled to free emergency care, in case of epidemic diseases, life-threatening emergency, pregnancy related care and family planning support.

They can access all other health services but only if they can cover the full costs.

Pursuant to Article 102² of the Government Emergency Ordinance 194/2002 regarding the regime of foreign nationals⁶³⁰, if an undocumented migrant is unable to leave the Romanian territory for objective reasons independent of her/his will, s/he can be granted a status of toleration for a renewable period of six months.

Throughout the period of the tolerated stay, foreigners have access to work in the same conditions as Romanian citizens, which opens the possibility to be insured upon payment of the contributions.⁶³¹

Undocumented pregnant women

The Law on Healthcare Reform stipulates universal healthcare services for all

pregnant women, regardless their health insurance statute.⁶³²

In addition, according to Article 46 of the Law no. 272/2004⁶³³ regarding the protection and promotion of children's rights, all necessary measures are to be taken in order to ensure that pregnant women receive medical services in the pre-, intra- and postnatal period, independently of their insurance status.

Family planning services are included in both the basic and the minimum packages of services delivered at the primary healthcare level and are reimbursed by the county health insurance houses.

Children of undocumented migrants

Article 213 of the Law on healthcare reform⁶³⁴ states that all children under 18 years of age and up to 26 years of age if enrolled in any form of education benefit from health insurance, without having to pay the contribution.

In practice, children of undocumented migrants experience difficulties registering on a family physician's list because their parents do not benefit from health insurance.⁶³⁵

Foreigners in accommodation centres

Article 213, par. 2 e) of the Law on Healthcare Reform⁶³⁶ provides that foreigners who stay in accommodation centres in order to be returned or expelled and also those who are victims of human trafficking and are currently undergoing identification procedures benefit from

⁶²⁸ Ibid. Article 46

⁶²⁹ *Law on healthcare reform*, Article 213

⁶³⁰ Government Emergency Ordinance no. 194/2002 regarding the regime of foreign nationals Op. cit. note 618

⁶³¹ Inspectorate-General of Immigration information Website <http://igi.mai.gov.ro/en/content/long-stay-visa-employment-secondment>

⁶³² *Law on healthcare reform* Articles 224 & 225

⁶³³ Op. cit. note 627

⁶³⁴ *Law on healthcare reform*

⁶³⁵ Ovidiu Voicu, Andra Bucur, Victoria Cojocariu, Luciana Lăzărescu, Marana Matei, Daniela Tarnovschi, "The Barometer for the Integration of Immigrants -Final Research Report", *Electronic Edition*, 2015, <http://www.fundatia.ro/sites/default/files/BII%202015%20final%202015.pdf>, p. 78

⁶³⁶ *Law on healthcare reform*

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health insurance without having to pay the contribution.

EU mobile citizens

The European Health Insurance Card, defined in the Law on healthcare reform⁶³⁷, allows EU citizens who hold it to access healthcare in Romania.

In accordance with Directive 2004/38/EC of 29 April 2004⁶³⁸, after three months of residence in Romania, EU citizens who do not have sufficient financial means lose their entitlement to access to the same healthcare services as Romanian nationals. Destitute EU citizens are considered as undocumented migrants and have the same access to healthcare as them.

However, pursuant to Article 213 of the Law on healthcare reform⁶³⁹, children of EU citizens have access to health insurance without having to pay the contribution.

Unaccompanied minors

As minors, unaccompanied children are entitled to free health insurance, pursuant to article 213 of the Law on healthcare reform.⁶⁴⁰

Unaccompanied minors are one of the special cases regulated by the Government Ordinance no. 44/2004 regarding the social integration of foreigners who have received either international protection or a stay permit in Romania or who are EU citizens.⁶⁴¹

If an unaccompanied child has been granted international protection, s/he will be entitled to healthcare in the same conditions as Romanian citizens, as stated in article 7 of the 44/2004 ordinance.

Article 35-2 of the 44/2004 ordinance further provides that unaccompanied minors who have received a form of protection in Romania are included in the children protection system.

When unaccompanied minors are placed in the care of a person, a maternal nurse or a residential service in order to receive care or protection, their treatment is periodically verified, pursuant to articles 3 and 46 of the Law regarding the protection and promotion of children's rights.⁶⁴²

Protection of seriously ill foreign nationals

Medical care is generally conditioned by payment of the contribution to health insurance and the Romanian law does not specifically exempt seriously ill individuals who do not have an income from paying the health insurance contribution. Thus, unless it is an emergency (or a situation as mentioned in a previous chapter), foreign nationals who are not exempted from the mandatory contribution will only access healthcare if they can afford it.

Moreover, after the expiration of the foreigner's permit to stay, it will be possible to extend it only if s/he has a health insurance.⁶⁴³ Thus, destitute ill individuals who are not able to pay a health insurance cannot stay in Romania to access healthcare.⁶⁴⁴

Indeed, as stated in article 69 of the 194/2002 Ordinance.⁶⁴⁵ foreigners who undergo a form of long-term medical treatment can have their permit to stay extended, providing they present a letter of acceptance from a public or private medical facility, which should specify the diagnosis

⁶³⁷ *Law on healthcare reform*, Articles 325-326 and 327-336

⁶³⁸ *Directive 2004/38/EC*

⁶³⁹ *Law on healthcare reform*

⁶⁴⁰ Op. cit. note 617

⁶⁴¹ Op. cit. note 617, Article 33

⁶⁴² Op. cit. note 627

⁶⁴³ The Barometer for the Integration of Immigrants op. cit. note 635, p. 67

⁶⁴⁴ The Barometer for the Integration of Immigrants Op. cit. note 635, p. 77

⁶⁴⁵ European Centre for Disease Prevention and Control. Country mission Romania: HIV, sexually transmitted infections, and hepatitis B and C. Stockholm: ECDC; 2012, p. 1

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and duration of treatment, a proof of social health insurance and a proof of sufficient means of existence. A residence permit may also be issued to an accompanying person if the foreigner is not able to care for him/herself, and if this is expressly mentioned in the letter of acceptance.⁶⁴⁶

The Government Ordinance no. 194/2002 regarding the regime of foreign nationals⁶⁴⁷ provides that foreign nationals benefit from social protection in the same conditions as Romanian citizens. In practice however, the only foreigners with stay permits who have access to the social benefits system are foreigners who come for family reunions and the persons who have obtained a form of protection in Romania, because they usually have sufficient means of existence and a long stay permit.⁶⁴⁸

Furthermore, Article 92 of the 194/2002 Ordinance states that the removal of the foreigner is prohibited if s/he:

- is a minor whose parents have a stay permit in Romania
- is the parent of the minor Romanian citizen and has to take care of the latter or to pay alimony
- is married to a Romanian citizen and the marriage is not for convenience and still effective
- is married to another foreigner who has a stay permit for the long run and the marriage is not for convenience
- is older than 80 years of age

However, even in these cases, it is possible to remove the foreigner from the Romanian territory if s/he constitutes a danger to public order or national security or if s/he suffers from a disease that threatens public health and refuses to submit him/herself to

measures against it as stated in Article 77, para 3-C of the 194/2002 Ordinance.

When the removal has already been decided, it can be suspended if there are justified chances that the foreigner's life would be put in danger or that they will be submitted to torture or inhuman or degrading treatment in the country s/he would have to return to, or if the health condition of the foreigner makes it impossible, pursuant to article 96 para.1 of the 194/2002 Ordinance.

Prevention and treatment of infectious diseases

Article 38 of the Law on healthcare reform⁶⁴⁹ provides that any person on Romanian territory must submit themselves to preventative and combative measures regarding infectious diseases, thoroughly respect hygiene and public health norms, provide any requested information to the authorities, and apply the established measures regarding the conditions for prevention of diseases and for the health promotion of the individual and public health.

The diagnosis of sexually transmitted infections (STI) is provided free of charge for insured and uninsured individuals.⁶⁵⁰

HIV and Tuberculosis are part of the declared public health priorities in Romania. On one hand, ambulatory and inpatient medical services related to these diseases are reimbursed from the health insurance funds, through contracts signed between county Health Insurance House and medical providers. On the other hand, the Ministry of Health pays for the treatment through national health programmes.⁶⁵¹

⁶⁴⁶<http://igi.mai.gov.ro/en/content/other-purposes>

⁶⁴⁷ Op. cit. note 645

⁶⁴⁸The Barometer for the Integration of Immigrants Op. cit. note 635, p. 73

⁶⁴⁹Law on healthcare reform – 2006

⁶⁵⁰European Centre for Disease Prevention and Control. Country mission Romania: HIV, sexually transmitted infections, and hepatitis B and C. Stockholm: ECDC; 2012, p. 1

⁶⁵¹MoH Ordinance no 386/2015 for approval of the implementing norms for the national public health

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Since 2002, the Law no.584/2002⁶⁵² regulates the prevention of HIV/AIDS and the measures to ensure the social protection of people living with HIV or AIDS.

The management and control related to HIV is achieved through a national HIV network, composed by 9 regional centres and around 50 county centres. The prevention services covered by the programme consist in screening tests, prophylactic-post-exposure ARV therapy, information, education, communication activities (IEC) and syringe exchanges. HIV testing services are included in the antenatal health services package at national level.⁶⁵³

Prevention interventions in the national health programmes, accessible to uninsured people, are limited to medical services provided within the healthcare facilities.

Being funded from the state budget, diagnosis and treatment are in theory available free of charge for all citizens, regardless of their insured status.

In practice, uninsured HIV positive patients are asked either to pay the contribution to the health insurance fund or to get a certificate of disability, in order to receive a complete diagnostic, treatment and care. Access to prevention for vulnerable groups, as injection drug users, is very low.

With the highest tuberculosis incidence among the EU Member States, Romania is included in the 18 high-priority countries to fight TB in the WHO European Region.⁶⁵⁴ In February 2015, the Government issued the Government Decision 121/2015⁶⁵⁵, endorsing the National Strategy for TB

Control 2015 -2020, in continuity with the previous national strategy to reduce the mortality and transmission of TB.

The National Institute for Public Health is responsible for the surveillance of STI, hepatitis B and hepatitis C through the National Centre for Communicable Disease Surveillance and Control (*Centrul National de Supravegheresi Control al Bolilor Transmisibile – CNSCBT*).

Romania lacks specific detection, prevention and treatment policies on infectious diseases, mostly because of insufficient budget resources.

The Roma minority

According to official figures, the Roma population represents 3% of the national population.⁶⁵⁶

The health of the Roma population is particularly poor. The life expectancy is on average 6 years lower than the non-Roma population in Romania.⁶⁵⁷

Poor health outcomes are also caused by the ineffective use of available health services by the Roma population. Indeed, even though a number of health services are free, many Romanian Roma do not seek healthcare because of their lack of financial resources and uncertainty about what to pay.⁶⁵⁸

Even though some healthcare services can be accessed, free of charge, Roma individuals often have to forego prescribed treatment because of the price of the medication.

programs in 2015 and 2016
<http://legeaz.net/monitorul-oficial-221-2015/ordinul-ministerului-sanatatii-386-2015>

⁶⁵²Law on measures to prevent the spread of AIDS in Romania and protection of people living with HIV or AIDS – 2002
<http://legislatie.just.ro/Public/DetaliiDocument/39744>

⁶⁵³Op. cit. note 645, p. 2

⁶⁵⁴WHO Review of the national tuberculosis programme in Romania

http://www.euro.who.int/_data/assets/pdf_file/0007/269269/Review-of-the-national-tuberculosis-programme-in-Romania.pdf

⁶⁵⁵Government decision 121/2015

<http://legislatie.just.ro/Public/DetaliiDocument/166577>

⁶⁵⁶from the 2011 census

⁶⁵⁷“Diagnostics and policy advice for supporting Roma inclusion in Romania”, World Bank, 2014, p.152.

<http://www.worldbank.org/en/region/eca/brief/roma>

⁶⁵⁸Ibid. p. 154

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Roma population faces discrimination in access to healthcare due to the lack of identity papers, of health insurance and of registration with a family doctor, even though the Law on Healthcare Reform⁶⁵⁹ foresees non-discriminatory access to healthcare for all citizens, based on their insurance status and that even the uninsured have the right to register with a family doctor and to receive the minimum package of health services.

The health of Roma women and maternal mortality are of particular concern, as is also the prevalence of early marriage and teenage pregnancy. According to the World Bank, the frequency of reproductive health check-ups remains low among Roma women.⁶⁶⁰

Prenatal and postnatal care is also low among Roma women: more than half the adolescent mothers lack counselling during pregnancy and register the highest prevalence of non-users (10%) and under-users (51,4%) of prenatal care services in 2011.⁶⁶¹

The risk of infant mortality among Roma infants is four times greater than among general population in urban areas. Almost half (45.7%) of the Roma children do not receive all the vaccines included into the National Immunisation Program although they are mandatory and free of charge.⁶⁶²

The rate of diagnosis of TB among Roma respondents is more than double that of the general population, while in the 55-to-64-age group, diagnosis is four time higher among Roma respondents, according to the 2013 European Roma Rights Centre survey.⁶⁶³

Roma in Romania face a variety of barriers to healthcare such as discrimination, lack of health education and information on health services, lack of financial means, and difficult geographic access for those living in rural areas.

Since 2002, the Promotion of Mother and Child Health at Community Level programme has introduced health mediators in order to facilitate communication between the medical staff and the Roma people, in order to improve effective access to healthcare for mothers and children. However the number of health mediators available has since steadily decreased.⁶⁶⁴

⁶⁵⁹ *Law on healthcare reform* – 2006, Article 230

⁶⁶⁰ Op. cit. note 657, p. 164

⁶⁶¹ Nanu M and all “Evaluarea intervențiilor în programele naționale privind nutriția copiilor” IOMC, MS, UNICEF, 2011

⁶⁶² UNICEF, *Roma Early Childhood Inclusion Report*, 2012
<http://www.unicef.org/romania/RECI-Overview.pdf>

⁶⁶³ *Hidden Health Crisis - A Report by The European Roma Rights Centre: Health Inequalities and Disaggregated Data*, October 2013, p.6

<http://www.errc.org/cms/upload/file/hidden-health-crisis-31-october-2013.pdf>

⁶⁶⁴ http://www.euro.who.int/_data/assets/pdf_file/0/017/317240/Hit-Romania.pdf?ua=1 (p.123)

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National Health System

Constitutional basis

The Republic of Slovenia Constitution of 28th December 1991⁶⁶⁵ provides for the right to health in its article 51 which states that “everyone has the right to health care under conditions provided by law”, the rights to healthcare from public funds shall be provided by law and no one may be compelled to undergo medical treatment except in cases provided by law”.

Furthermore, Article 13 of the Constitution states that foreigners benefit from all the rights guaranteed by the Slovene Constitution and laws, except for the rights reserved to the citizens of Slovenia.

Organisation and funding of the Slovenian healthcare system

Organisation

The legal basis of the Slovenian health system was formed by the Law on Health Care and Health Insurance (ZZVZZ) of 1992.⁶⁶⁶

The Slovene health system comprises two types of health insurance: compulsory and voluntary or supplementary health insurance.

It is mainly public, with a few private practices incorporated into the public system and some strictly private service providers.⁶⁶⁷

⁶⁶⁵<http://unpan1.un.org/intradoc/groups/public/documents/UNTC/UNPAN014895.pdf>

⁶⁶⁶ *Law on Health Care and Health Insurance – 1992 (Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju)*
<http://www.pisrs.si/Pis.web/pregledPredpisa?sop=1992-01-0459>.

⁶⁶⁷For more information see <http://www.zzs.si/zzs/internet/zzseng.nsf/o/021E>

Several structures are in charge of healthcare in Slovenia. The highest authority is the Ministry of Health, which prepares legislation related to healthcare and health protection, ensures the implementation of national and international law regarding health and prepares strategic plans for public health and health financing matters.

The Health Insurance Institute of Slovenia⁶⁶⁸ (ZZZS), based in Ljubljana, is the public institute in charge for implementation of compulsory health insurance as a public service. The Institute is organised in such a way that the service is available to insured persons the nearest as possible to their home of residence. Institute establishes organisational units for specific sectors and for specific areas (Article 69 of the Law on Health Care and Health Insurance⁶⁶⁹).

The National Institute of Public Health⁶⁷⁰ (NIJZ) is the main national institution whose main purpose is to study, protect and increase the level of health of the population of the Republic of Slovenia through awareness raising and prevention measures. In addition to the central role in public health activities in Slovenia, the NIJZ is actively involved in international projects.

Lastly, four health insurance companies are in charge of providing voluntary health insurance in Slovenia. Their function is determined by the Insurance Act of 22th December 2015.⁶⁷¹ The insurance companies can provide only an additional voluntary insurance to compulsory insured persons or other supplementary insurances,

[89171B7F7B7DC1256E890048B206?open&nas=Accessing%20healthcare%20in%20SLO](http://www.zzs.si/zzs/internet/zzseng.nsf/o/021E89171B7F7B7DC1256E890048B206?open&nas=Accessing%20healthcare%20in%20SLO).

⁶⁶⁸ <http://www.zzs.si/indexeng.html>

⁶⁶⁹ Op. cit. note 666

⁶⁷⁰ <http://www.nijz.si/en>

⁶⁷¹ *Insurance Act* - 2015
<http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO6183> in

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which cannot substitute the compulsory insurance.

In 1999, the Health Insurance Card (Kartica zdravstvenega zavarovanja) was introduced. This card is a public document that the compulsory insured persons have to submit to demonstrate their health insurance rights. It was an important technological step permitting faster treatment and transfer of data between insured persons, insurers and health care providers as well as the centralisation of health providers in one network.

Funding

Slovenia's health system, based on the Bismarckian model, is mainly funded by compulsory health insurance contributions, tied to employment. They amount to 6.36% of employees' gross salaries and 6.56% from their employers.⁶⁷²

The remaining funding comes from voluntary health insurance premiums, household out-of-pocket and state and municipalities tax revenues.

Accessing Slovenia healthcare system

All Slovenes, persons with an authorisation to reside in Slovenia and their close family members are entitled to health insurance and care.⁶⁷³

Access to non-urgent healthcare is possible only through personal physicians. Every person in Slovenia has to designate a general physician of his/her choice as

his/her personal physician and optionally a personal dentist and gynaecologist.⁶⁷⁴

The personal physician is authorised and obliged to, among others, refer his/her patients who need it to a specialist, to a hospital, to a medical committee and to the Disability commission⁶⁷⁵; prescribe medications and medical devices and establish temporary absence from work.⁶⁷⁶

Access to general practitioners is good in Slovenia, even in remote rural areas. However, a limit to the Slovene healthcare system is the existence of long waiting lists to access primary care, especially dental care because of a lack of dentists.⁶⁷⁷

Urgent medical assistance can be accessed without the referral of a physician and without the need to show the Health Insurance Card beforehand.⁶⁷⁸ In practice, the medical staff most often ask to see the Health insurance Card.

The Health Services Act of 13th February 1992⁶⁷⁹, last amended on 30th December 2016 is the main legal instrument determining the operation of healthcare services.

Following its provisions, health care services at the primary level are the responsibility of the municipalities and are performed by public healthcare centres, whereas public health services at the secondary and tertiary level are both provided by the state at a national level.⁶⁸⁰

⁶⁷² Table of contributions for different types of insured persons
<http://www.zzzs.si/zzzs/internet/zzzs.nsf/0dbed6c0a93d31d8c1256a67006844b3/7f079796008ee60ec1256d3a00460146?OpenDocument>.

⁶⁷³ Article 15 of the Law on Health Care and Health Insurance (op. cit. note 666) lists categories of people entitled to health insurance and care

⁶⁷⁴ *Law on Health Care and Health Insurance*: op. cit. note 666, Articles 80 to 85, and *Rules on compulsory health insurance*
<http://www.pisrs.si/Pis.web/pregledPredpisa?sop=1994-01-2855> of 17th November 2014, Articles 161 to 180.

⁶⁷⁵ <http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/711DAD33F7FB1CB8C1257BB000456695>.

⁶⁷⁶ *Law on Health Care and Health Insurance* op. cit. note 666, article 81

⁶⁷⁷ European Observatory on health systems and policies – Health systems and policy monitor
<http://www.hspm.org/countries/slovenia25062012/countrypage.aspx>

⁶⁷⁸ *Rules on compulsory health insurance* op. cit. note 674 - Article 179

⁶⁷⁹ <http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO214>

⁶⁸⁰ Public network of Primary, Secondary and Tertiary healthcare services, Ministry of Health,

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It is to be noted that compliance with the law and general acts of the Health Insurance Institute is necessary to be reimbursed for medical services and other benefits.

Compulsory health insurance

The Slovene social insurance system is based on a single insurer providing the compulsory health insurance. This insurance is universal and based on a clear employment status or on a legally defined dependency status.⁶⁸¹

The institution regulating the compulsory insurance is the Health Insurance Institute of Slovenia, under the Law on Health Care and Health Insurance⁶⁸² and Rules on compulsory health insurance.⁶⁸³ Both of these legal texts define and regulate the nature and extent of the rights of the insured persons, but also which services are covered as a whole or in a certain percentage of the services price.

The compulsory health insurance is mandatory for everyone who can access it.

Compulsory insured persons are entitled to receive basic health services; dental care; services of specialised doctors, hospitals or institutions; prescription medications; medical and technical devices; spa treatments; rehabilitation, ambulance and other vehicles transportation; and, when travelling and living abroad, to receive medical treatment abroad.

The price of the healthcare services and goods at the points of use is regulated by article 23 of the Law on Health Care and Health Insurance, which determines the percentage of the price to be covered depending on the service or good and on the person who receives it.⁶⁸⁴

http://www.mz.gov.si/si/delovna_podrocja_in_prioritete/zdravstveno_varstvo/mreza_na_primarni_sekundarni_in_terciarni_ravni/

⁶⁸¹http://www.euro.who.int/_data/assets/pdf_file/004/96367/E92607.pdf

⁶⁸² Op. cit. note 674

⁶⁸³ Op. cit. note 674

For instance, compulsory health insurance covers in full:⁶⁸⁵

- treatment and rehabilitation of children, pupils and students up to 26 years who are regularly attending school
- medical consultations related to pregnancy
- Health protection of women in relation to the advice of family planning, contraception, pregnancy and childbirth
- Prevention, detection and treatment of HIV and infectious diseases, for which is required by law to implement measures to prevent their spread,
- treatment after injury at work
- treatment and rehabilitation of a number of serious diseases
- emergency medical assistance including emergency rescue services and transportation

As for goods and services covered in part:

- hospital treatment is covered in the amount of at least 90% of the value of the service
- primary care services, treatments of dental and oral diseases, healthcare related to fertility and certain medical devices are covered in the amount of at least 80% of the value of services
- health services in continuation to hospital treatment and certain prescribed medications are covered in the amount of at least 70% of their value

⁶⁸⁴<http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>

⁶⁸⁵ Rules on compulsory Health insurance op. cit. note 674, article 22

and
<http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>

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- Not necessary emergency services and spa treatment are covered up to 60%
- Medical devices for improving vision for adults are covered at up to 50% of the value

To the extent provided by the Law on Health Care and Health Insurance, the compulsory insurance also covers salary compensation during temporary absence from work and reimbursement of travel expenses related to the promotion of health services.

Destitute Slovene nationals are entitled to compulsory health insurance.⁶⁸⁶ If they cannot pay for voluntary insurance they can apply for social assistance and meet the conditions to get it, the state pays for the costs not covered by the compulsory insurance. Municipalities too are obliged to pay contributions for persons listed in Article 15 of the Law on Health Care and Health Insurance, point 21.⁶⁸⁷

The 1992 Law on Health Care and Health Insurance introduced cost-sharing in the form of co-payments: patients in Slovenia are charged a flat rate for most health related services. Vulnerable groups, as children, unemployed individuals, those with a very low income or chronically ill people are exempted from these fees.

Voluntary health insurance

In order to be covered for the full value of healthcare, it is possible to subscribe to a voluntary health insurance in addition to the compulsory one.

Voluntary health insurance is managed by private insurance companies, in accordance

with the Law on Health Care and Health Insurance.⁶⁸⁸

Voluntary health insurance covers the insured costs of healthcare and related services, supply of medicines and medical devices, as well as the payment of the agreed cash benefits in the event of illness, injury or a specific medical condition.

The amount of the value covered generally corresponds to the difference up to the full value of services covered by the compulsory insurance.⁶⁸⁹

Urgent medical assistance

Every person, even uninsured, has the right to urgent medical assistance.

Urgent medical assistance includes medical services necessary to maintain life functions or to prevent serious deterioration of health condition of suddenly sick, injured and chronically ill people. Services are provided until the stabilisation of vital functions or the beginning of treatment in an appropriate place. Urgent transportation services are included in the urgent services.⁶⁹⁰

The urgency of treatment is decided by assessment of the personal physician or competent health committee in accordance with the general acts of the Health Insurance Institute. Consequently, access to healthcare can be denied if the case is considered as non-urgent. Medical assistance may also be billed after it occurred if the case is later considered as non-urgent.

For non-insured women, as abortion is supposed to be considered as an urgency, it is covered by the Ministry of Health. Yet, the practice shows that there is still no common direction on how to proceed in

⁶⁸⁶Article 15 Law on Health Care and Health Insurance op. cit. note 666

⁶⁸⁷Op. cit. note 666

⁶⁸⁸Ibid.

⁶⁸⁹For health services covered by the supplementary insurance, see

<http://www.zzs.si/zzs/internet/zzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C>.

⁶⁹⁰Article 25 of the Law on Health Care and Health Insurance Op. cit. note 666

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those situations and the bill may be issued to the patient as the abortion is sometimes considered as a non-urgent care.

Slovenia provides funds from the state budget to cover urgent care for individuals of unknown residence and foreign nationals from states with whom international agreements have not been concluded.⁶⁹¹

Access to healthcare for migrants

Authorised non-EU residents

Non-EU citizens with permission to reside in Slovenia have mandatory health insurance as employed, self-employed, students or unemployed persons. Their family members are insured if they are registered as permanent residents in Slovenia, unless differently provided by international agreement.⁶⁹²

Non-EU citizens with long-term residence permit and registered permanent residence in Slovenia, receiving financial social assistance or fulfilling conditions to receive it, and their family members⁶⁹³ are entitled to the coverage of the difference between the full cost of the health treatment and the amount covered by the compulsory insurance, unless it is already fully covered. This difference is paid by the state.⁶⁹⁴

Asylum seekers

Asylum seekers are only entitled to urgent medical assistance, which is defined in Article 86 of the International protection Act in force from 24 April 2016.⁶⁹⁵ Besides,

⁶⁹¹ Ibid.

⁶⁹² Article 20 of the Law on Health Care and Health Insurance Op. cit. note 666

⁶⁹³ Law on the exercise of rights from public funds (ZUPJS) in force since 2012 - Article 29 <http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO4780>

⁶⁹⁴ Article 24 of the Law on Health Care and Health Insurance op. cit. note 666

⁶⁹⁵ *International Protection Act (ZMZ-I)* – 2016 <http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO7103>

medical screening may be required at the entrance of the Slovene territory.

Article 86 also determines that vulnerable persons with special needs, and exceptionally other asylum seekers, are entitled to additional health services, including psychotherapeutic assistance approved and established by the Commission designated by the Minister of Health.

In practice, asylum seekers accommodated in Asylum Home have access to regular basic medical examinations by a medical professional who refers the asylum seeker to urgent care or a medical consultation in a Health centre if needed.

Access to healthcare is much more difficult for asylum seekers who are not accommodated in Asylum Home, mostly because asylum seekers do not have a Health Insurance Card. They can go to Health centres but the medical personnel may not be familiar with their situation and their rights.

It should be noted that, since the 2013 Dublin III Regulation⁶⁹⁶, only one country can consider an asylum application. Thus, if another country requests the responsibility for the application within the first three months of the proceedings, the asylum seeker will lose his/her right to reside in Slovenia and any rights attached to it.

Pregnant asylum seekers

Asylum seekers are entitled to free contraceptives, abortion, and healthcare

⁶⁹⁶ The Commonwealth Fund, *INTERNATIONAL PROFILES of Health Care Systems, Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*, New-York, 2013 <http://www.commonwealthfund.org/publications/fund-reports/2013/nov/international-profiles-of-health-care-systems>

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during pregnancy and childbirth, but not to postnatal care.⁶⁹⁷

Children of asylum seekers

Children of asylum seekers are entitled to healthcare under the same conditions as nationals of the Republic of Slovenia. This means that there are entitled to compulsory insurance, which covers all medical services.⁶⁹⁸

Refugees and persons under international protection

Refugees have the same rights as the nationals of the Republic of Slovenia concerning access to healthcare.

Articles 90 and 98 of the International Protection Act⁶⁹⁹ states that persons who are granted international protection in Slovenia have the right to reside and to receive healthcare.

Refugees are also cited in the Article 15 of the Law on Health Care and Health Insurance as one of the vulnerable groups entitled to compulsory health insurance, unless they are insured somewhere else.

Pregnant refugees

Women who obtained the refugee status are entitled to the same care as Slovenia nationals. Pregnant refugee women are thus entitled to pre- and post-natal care and delivery care.

Children of refugees

Children of refugees are entitled to healthcare under the same conditions as nationals of the Republic of Slovenia. This means that there are entitled to compulsory insurance, which covers all medical services.⁷⁰⁰

Undocumented migrants

⁶⁹⁷ Article 86 of the *International Protection Act* Op. cit. note 695

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid.

⁷⁰⁰ Ibid.

Undocumented migrants are not covered by the compulsory health insurance. They are only entitled to free urgent treatment.⁷⁰¹

In some cases, enumerated in article 73 of the Foreigners Act of 23th June 2011⁷⁰², undocumented migrants can get a status of tolerance or a permit to stay on the territory. Article 75 of the same act states that foreigners with tolerated status have the right to urgent medical assistance.

In practice, undocumented migrants and persons with tolerated status turn to health centres for persons without compulsory health insurance, to pro bono clinics or to NGOs.

Undocumented pregnant women

Undocumented pregnant women only have the right to urgent medical assistance.

Women who are not compulsory insured in Slovenia must pay for delivery as it is considered foreseen and thus not an urgent medical procedure. However, the termination of pregnancy should be considered as emergency medical assistance.

Children of undocumented migrants

Children of undocumented migrants are not covered by the compulsory health insurance.

However, Article 9 §25 of the Rules on compulsory health insurance⁷⁰³ states that children up to 18 years attending school and not compulsorily insured, because their parents do not provide care for them or because their parents do not qualify for inclusion in the compulsory insurance can access compulsory insurance if and when the municipality they live in decides it.

⁷⁰¹ Op. cit. note 677

⁷⁰² *The Foreigners Act – 2011 (Zakon o tujcih)*
<http://www.uradni-list.si/1/objava.jsp?sop=2011-01-2360>

⁷⁰³ Op. cit. note 666

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In practice, municipalities grant healthcare insurance under this provision only to children who hold at least a temporary permit of residence in Slovenia.

Termination of pregnancy

The right to abortion in Slovenia is provided in the Article 55 of the Constitution of the Republic of Slovenia and regulated by the Health Measures in Exercising Freedom of Choice in Childbearing Act of 1977 (ZZUUP).⁷⁰⁴

Abortion is carried out at the request of the woman, with a referral from a personal physician until the 10th week of the pregnancy. After this time limit, abortion is possible only if the risk of the procedure to the life and health of the pregnant women and for her future motherhood is lower than the danger threatening the pregnant woman or a child due to the continuation of the pregnancy.

Termination of pregnancy is reimbursed up to 80% of the amount by the compulsory insurance.⁷⁰⁵

Uninsured women have to pay for the termination of their pregnancy. The price for abortion varies greatly depending on the health service providers.

EU mobile citizens

Since the 2004 European Directive 2004/38/EC⁷⁰⁶, after three months of residence in Slovenia, EU citizens with insufficient resources and no health coverage are considered undocumented migrants. They have the same access to healthcare as undocumented third-country

nationals and are thus only entitled to urgent medical assistance.

EU mobile citizens without insurance but with a minimum income can access the compulsory health insurance if they fall into one of the categories listed in article 15 of the Law on Health Care and Health Insurance.⁷⁰⁷

EU mobile citizens insured in their country of origin can access healthcare services in Slovenia with their European Health Insurance Card (EHIC), if they can cover the potential costs.

The EHIC covers its holder for the treatment of medical conditions, emergency care services and maternity care, providing the reason of the visit in Slovenia is not to give birth. It does not cover planned treatment.⁷⁰⁸

Bilateral agreements

Slovenia concluded international agreements with a number of countries. Agreements with countries of the former Yugoslavia in particular contain bilateral measures in the field of health. People insured in their country of origin and their family members have facilitated access to healthcare in Slovenia pursuant to the agreements.⁷⁰⁹

Thanks to the bilateral agreements with Bosnia and Herzegovina and Macedonia, insured persons from one contractor state holding permanent residence in another contractor state are provided access to health treatment in their place of residence.⁷¹⁰

⁷⁰⁴ *Freedom Of Choice In Childbearing Act – 1977*
<http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO408>

⁷⁰⁵ Article 23 of the Law on Health Care and Health Insurance op. cit. note 666

⁷⁰⁶ *Directive 2004/38/EC*

⁷⁰⁷ Op. cit note 666

⁷⁰⁸ <http://www.zzs.si/zzs/internet/zzseng.nsf/o/41A664904BA3992AC1256E890048C1AB>

⁷⁰⁹ https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/european_migration_network/reports/docs/emn-studies/illegally-resident/24.slovenia_national_report_social_security_en_version.pdf

⁷¹⁰ Art. 12/3 in both agreements

Agreement on Social Security between the Republic of Slovenia and Bosnia and Herzegovina (Official Gazette of RS, No. 37/2008 – MP No. 10/2008)

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Agreements with Serbia and Montenegro permit access to medical treatment, in conformity with the legislation of the second state and to the burden of the competent holders from the first state, to certain categories of posted workers regardless of their permanent or temporary residence.⁷¹¹

Unaccompanied minors

Unaccompanied minors asking for asylum are entitled to healthcare under the same conditions as nationals of the Republic of Slovenia.

They are attributed legal representatives who accompany them in the asylum process and make sure they receive the necessary help.

Unaccompanied minors who do not apply for asylum are considered as undocumented migrants and are thus only entitled to urgent medical assistance.

Protection of seriously ill foreign nationals

According to Article 73 of the Foreigners Act⁷¹², a foreigner who was ordered to leave Slovenia can get a permission to stay if a doctor advises against immediate removal from the country because of the foreigner's state of health.

The expulsion of undocumented migrants can be suspended as long as their (or a family member's) state of health would make it "inadvisable" for them to travel.

Potentially ill foreigners can be refused a temporary residence in Slovenia when they come from areas where there are contagious

disease epidemics as listed in the international health rules of the World Health Organization, or from areas where there are contagious diseases that might endanger human health and for which according to the law regulating contagious diseases (Contagious Diseases Act), special measures have to be taken.⁷¹³ This also applies to EU citizens, who can be denied admission in Slovenia.⁷¹⁴

Article 119 §3 of the Foreigners Act⁷¹⁵ states that EU citizens can apply for a residency permit in Slovenia for "family reunification and other reasons". Seriously ill EU citizens can thus apply for residency under this provision, although positive outcomes are unlikely.

Prevention and treatment of infectious diseases

According to the Contagious Diseases Act of 2006, everyone has the right to protection against infectious diseases and nosocomial infections and the duty to protect their health and the health of others against these diseases.⁷¹⁶ Prevention, testing and treatment of infectious diseases are defined in Contagious Diseases Act.

As stated in the article 23 of Law on Health Care and Health Insurance⁷¹⁷ prevention, detection and treatment of HIV infection and contagious diseases for which it is required by the law to implement measures to prevent their spread, are provided and fully covered by the compulsory health insurance.

Agreement on Social Security between the Republic of Slovenia and the Republic of Macedonia (Official Gazette of RS, No. 35/2000 – MP No. 10/2000)

⁷¹¹ Art. 12/3 in both agreements

Agreement on Social Security between the Republic of Slovenia and the Republic of Serbia (Official Gazette of RS, No. 30/2010 – MP No. 5/2010)

<http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/89293/102546/F9055267/MGO-2011-L-89293.pdf>

⁷¹² *The Foreigners Act* - 2011

⁷¹³ *Foreigners Act* – Article 55

⁷¹⁴ *Foreigners Act* – Article 118

⁷¹⁵ *Foreigners Act*

⁷¹⁶ Contagious Diseases Act of 7th March 2006

http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZA_KO4833. – Article 4

⁷¹⁷ *Op. cit.* note 666

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Contagious diseases for which it is required to take measures are determined in Article 8 of the Contagious Diseases Act.⁷¹⁸

Article 22 of the Contagious Diseases Act lists the diseases against which vaccination is compulsory and covered by the compulsory insurance. Thus, vaccination is compulsory for hepatitis B, diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella and other infectious diseases.⁷¹⁹

Uninsured people can get anonymous and free of charge testing and counselling for HIV and Hepatitis C at a Clinic for Infectious Diseases and Febrile Illnesses (*Klinika za infekcijske bolezni in vročinska stanja*), but no treatment is guaranteed.

Health centres for uninsured persons

Health centres for persons without compulsory health insurance exist in Slovenia. These pro-bono clinics, located in Ljubljana, Maribor, Koper and other cities across the country are the result of programmes established by different organisations as Caritas or Slovene Philanthropy.

Health centres provide medical assistance and services carried out by physicians at the primary level and specialists, who are all volunteers in the health centre. Medical services provided include vaccination for children and antenatal and postnatal care for women.

The population seeking healthcare in these centres is composed mostly of homeless people, persons who do not have a residence permit as undocumented migrants and foreign nationals with police tolerance status and persons who are not entitled to compulsory insurance or who just lost their entitlement and who do not have sufficient resources to pay for the healthcare.

The Ljubljana centre also provides healthcare to “erased people”. Erased persons are persons from other republics of the former Yugoslavia who were at the time of declaration of independence living in Slovenia but did not apply for or did not obtain Slovene nationality. Therefore, they were left without legal Slovene documents.

⁷¹⁸ Op. cit. note 716

⁷¹⁹ Op. cit. note 716

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National Health System

Constitutional basis

The Spanish Constitution of 1978 recognises in Article 43 the “*right to health protection*”.⁷²⁰ It also claims that “*it is incumbent upon the public authorities to organise and watch over public health by means of preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all in this respect*”.⁷²¹

Organisation and funding of Spanish healthcare system

The Spanish healthcare system is based on solidarity. It aims to redistribute income amongst Spanish citizens.⁷²² Indeed, all citizens contribute according to their incomes and receive healthcare services according to their health needs.

The National Health System comprises the public healthcare administration of both the Central Government Administration and the autonomous communities (AC), working in coordination to cover all the healthcare duties and benefits for which the public authorities are legally responsible.⁷²³

Accessing Spain healthcare system after 2012 Royal-Decree

General Health Law No. 14/1986 of 25 April 1986⁷²⁴ states that “*every Spanish citizen, as well as foreign nationals who have established their residence in the*

country, are entitled to the protection of their health and to healthcare”.

Access to care within the Spanish National Health System is regulated by Article 3 of Law 16/2003 of 28 May 2003 on the cohesion and quality of the National Health System.⁷²⁵

As part of its austerity measures, the Spanish parliament adopted Royal Decree-Law 16/2012 on 20 April 2012 “*on urgent measures to ensure sustainability of the national health system and to improve the quality and safety of its services*”, which came into force on 1 September 2012.

Article 1 of Royal Decree-Law 16/2012⁷²⁶ modifies Article 3 of Law 16/2003⁷²⁷ and Article 12 of Organic Law 4/2000.⁷²⁸ According to the new provisions, only individuals in the following situations have the right to be covered by the National Health System (Article 3, Section 2 and 4 of Law 16/2003⁷²⁹):

- workers, retired people and beneficiaries of social security services (e.g. unemployment benefits);
- people who have “exhausted” their right to unemployment benefits and do not benefit from any other allowances;
- spouses, dependent ex-spouses, descendants or dependants under 26 years old (or older in the case of people with disabilities categorised as equal to or over 65%) of an insured person.

⁷²⁰Constitution of Spain of 1978, https://www.essex.ac.uk/armedcon/world/europe/western_europe/spain/SpainConstitution.pdf

⁷²¹ Ibid.

⁷²² Health Information Institute, *National Health System of Spain*, Madrid, 2010, <http://www.msssi.gob.es/organizacion/sns/docs/sns2010/Main.pdf>

⁷²³ Ibid.

⁷²⁴Law of 25 April 1986 <http://www.boe.es/buscar/doc.php?id=BOE-A-1986-10499>

⁷²⁵Law of 28 May 2003 http://www.boe.es/diario_boe/txt.php?id=BOE-A-2003-10715

⁷²⁶ Royal Decree-Law of 20 April 2012 http://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

⁷²⁷ Op. cit. note 725

⁷²⁸Organic Law of 11 January 2000, <http://www.boe.es/buscar/act.php?id=BOE-A-2000-544>

⁷²⁹ Op. cit. note 725

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Access to public health services is obtained through the Individual Healthcare Card (IHC) issued by each health service. This is the document which identifies every citizen or resident as a healthcare user throughout the National Health System. This Individual Health Card was (before 2012) obtained under three conditions: the person had to be registered with the local municipality, provide a valid identity document and provide proof of residence in the autonomous community.⁷³⁰

Since the Royal Decree-Law 1192/2012 regulating the insured and beneficiary status for the purpose of medical care in Spain, covered by the public funds through the National Health System, it is necessary to fall in the “insured” or “beneficiary” categories, as defined by the National Institute of Social Security (INSS) to benefit from health coverage. Then, with the required documents issued by the INSS, individuals may apply for the IHC at any health centre.

All IHC holders can benefit from all healthcare levels, primary and specialist care.

Primary healthcare makes basic healthcare services available from any place of residence. The main facilities are the healthcare centres, staffed by multidisciplinary teams comprising general practitioners, paediatricians, nurses and administrative staff and, in some cases, social workers, midwives and physiotherapists. Since primary healthcare services are located within the community,

they also deal with health promotion and disease prevention.

A patient with health coverage does not have to pay doctors’ fees in advance. However, each patient has to pay a part of the costs of medicines⁷³¹ which are included in the catalogue of medicines covered by the social security system⁷³² (others are not covered).⁷³³ In the latter case, the patient must pay for the treatment in its entirety.

Specialist care is provided in specialist care centres and hospitals in the form of outpatient and inpatient care. Patients who receive specialist care and treatment are expected to be referred back to their primary healthcare doctor who, based on the patient’s full medical history, including the medical notes issued by the specialist, assumes responsibility for any necessary follow-up treatment and care.

Reform ending universal access to care

Before April 2012, the Law 16/2003⁷³⁴ considered as holders of “*the right to health protection and healthcare*”:

- all Spanish citizens and foreign nationals who are on Spanish territory within the conditions provided in [old] Article 12 of Organic Law no. 4/2000;
- EU citizens with health coverage and sufficient resources [who have rights derived from European legislation];
- nationals of non-EU countries [who have rights derived from different international treaties].

In this respect, Spain was the only country with real access to care for all people

⁷³⁰ Health For Undocumented Migrants and Asylum seekers (HUMA) Network, *Accès aux soins des personnes sans autorisation de séjour et des demandeurs d’asile dans 10 pays de l’UE – Législation et Pratique*, 2009, http://www.aedh.eu/plugins/fckeditor/userfiles/file/Asile%20et%20immigration/Legislation_et_pratique_rapport_HUMA_FR.pdf

⁷³¹ Op. cit. note 726; [http://www.boe.es/diario_boe/txt.php?id=BOE-A-](http://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403)

<http://www.ocu.org/salud/derechos-paciente/noticias/reforma-sanitaria-copago>

⁷³² There are more than 15 000 medicines covered, <http://www.msssi.gob.es/profesionales/nomenclator.do>

⁷³³ List of medicines which have been excluded in 2012,

<http://www.msssi.gob.es/profesionales/farmacia/pdf/BOEA201210952.pdf>

⁷³⁴ Op. cit. note 725

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residing in the country whatever their financial resources or legal status.

With the Royal-Decree 1192/2012, access to care is considerably reduced. This reform radically changed Spanish health coverage, leaving thousands of undocumented migrants without health insurance, among whom EU nationals staying more than three months without sufficient resources and without health coverage. This measure abandoned large sections of the population unable to afford private health insurance.⁷³⁵

These provisions mean that the IHC can now only be obtained on the grounds of working status (indeed, except for dependants, only ex-workers who have worked long enough can benefit from social security benefits). The “*residence*” criterion is no longer sufficient to be eligible for the National Health System.

However, according to Royal Decree 1192/2012, Spanish citizens, EU-EEA-Swiss citizens and third-country nationals who hold a Spanish residence permit but who do not belong to one of the categories mentioned above can be considered as “*insured*” if their annual income does not exceed €100,000 and if they do not have health coverage.⁷³⁶ In this case, they have to register with their municipality in order to obtain their IHC, under the same conditions as before the reform.

Finally, patients who cannot claim “*insured*” status (as a consequence of Article 3 of Law 16/2003 mentioned above) can only access healthcare services if they pay for it themselves or if they are eligible for a “special provision”. Furthermore, the services included in this special provision

(which, in reality, is the same as private insurance) are limited to the “basic package of services” of the National Health System, meaning that expenses such as non-urgent medical transportation, drugs or external prosthesis (e.g. a wheelchair) are not included in the package. However, emergency transportation is included in the “basic package” (Article 8bis of Law 16/2003).

The change in the law motivated six autonomous communities to appeal to the Constitutional Court, alleging a breach of universality as a principle. The appeals were also submitted on the grounds of procedural issues (e.g. the Government had not justified the “extraordinary and urgent necessity” required to use legal terms of the Royal Decree), as well as on the grounds of a breach of regional competences, since the management of healthcare is an issue of regional domain, whereas this Decree has a national scope. Three of the appeals have already been rejected (those concerning Navarra, Andalusia and Asturias).

The European Committee of Social Rights stated in November 2014 that “*the economic crisis cannot serve as a pretext for a restriction or denial of access to healthcare that affects the very substance of the right of access to healthcare*”, meaning that states have the obligation to provide assistance to people regardless of their residency status.⁷³⁷

Consequences of the 2012 health reform in Spain

Royal Decree 16/2012⁷³⁸, adopted on 20 April 2012, establishes in Spain a health system close to that of insurance and

⁷³⁵ Europe Public Health Alliance (EPHA), *EPHA Press Release: Spain on brink of failing its most vulnerable via new health law - A law bringing to an end decades-long free and universal health care does not benefit anybody*, Brussels, 2012, <http://www.ephah.org/a/5161>

⁷³⁶ Op. cit. note 726

⁷³⁷ European social charter, European Committee of Social Rights Conclusions XX-2 (ESPAGNE)

Articles 3, 11, 12, 13 and 14 of the 1961 Charter, November 2014, http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/State/SpainXX2_en.pdf

⁷³⁸ Royal Decree 16/2012

https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

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therefore far from the idea of a system of universal access to healthcare.⁷³⁹ It constitutes a structural transformation.

The consequences of the reform seriously hinder access to care for people suffering from mental health issues, drug users and other vulnerable groups such as homeless people. It may also have real, dangerous effects on the population's health, "specifically concerning infectious diseases like tuberculosis or HIV-infected patients".⁷⁴⁰

According to data from the Federation of Associations Defending Public Health (*Federacion de Asociaciones en Defensa de la Sanidad Publica – FADSP*), the healthcare co-payment established by the Royal Decree has had a severe impact on individuals with low incomes, such as pensioners: 17% of pensioners have been unable to continue a course of treatment due to high and increasing costs.

In addition, with regard to the Royal Decree-Law, the European Committee of Social Rights has considered repressive the fact that undocumented migrants are excluded from the healthcare system.⁷⁴¹ It also added that times of economic crisis cannot be an excuse to denying or restricting the right to health to this vulnerable group.⁷⁴²

MdM ES reports situations in which people are asked, before they receive any kind of treatment, to sign a commitment to pay by the emergency care services. They receive a bill after being treated and have to apply for it to be annulled.⁷⁴³

⁷³⁹ Doctors of the World – Médecins du Monde ES, *Dos años de reforma sanitaria : más vidas humanas en riesgo*, April 2014, http://www.medicosdelmundo.org/index.php/mod.d omentos/mem.descargar/fichero.documentos_Im pacto-Reforma-Sanitaria-Medicos-del-Mundo_3ec0bdf9%232E%23pdf

⁷⁴⁰ H. Legido-Quigley, "Erosion of universal health coverage in Spain", *The Lancet*, 2013.

In 2015, the Spanish government repeatedly announced a change in the law, allowing all undocumented migrants to access healthcare again, without going completely back to the former health cards system. Yet, this change was never realised.

Access to healthcare for migrants

Asylum seekers and refugees

Access to healthcare services for asylum seekers is regulated at national level by Articles 16, §2 and 18§1 of Law 12/2009⁷⁴⁴ as well as by the fourth additional provision of Royal Decree 1192/2012.⁷⁴⁵ They are entitled to access healthcare on equal grounds to Spanish nationals and authorised residents with regard to coverage and conditions.

Refugees and those benefitting from subsidiary protection have access to health services either as recipients of social security benefits (workers, unemployed people or those dependent on an insured person) or as non-nationals holding a residence permit.⁷⁴⁶ As asylum seekers, they have the same access to healthcare as nationals and authorised residents.

In order to obtain their IHC, they have to register with their municipality under the same conditions as prior to the 2012 reform.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum or with refugee status have the same access to healthcare as nationals and authorised residents. They have access to antenatal,

⁷⁴¹ Op. cit. note 739

⁷⁴² Op. cit. note 739

⁷⁴³ Op. cit. note 739

⁷⁴⁴ Law of 30 October 2009, <http://www.boe.es/buscar/act.php?id=BOE-A-2009-17242>

⁷⁴⁵ Royal Decree of 3 August 2012

⁷⁴⁶ Op. cit. note 744

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delivery and postnatal care and pregnancy termination.

Children of asylum seekers and refugees

Pursuing to Article 1 of Royal Decree-Law 16/2012, children of asylum seekers and refugees have the same access to healthcare as the children of nationals and authorised residents. This includes vaccinations.

Undocumented migrants

Before the adoption of Royal Decree 16/2012⁷⁴⁷, access to the Spanish National Health System was universal and free of charge for everyone, including undocumented migrants, on production of the IHC. This could be obtained by registering with the local municipality and with proof of identity and residence in most regions.

Article 1 of Royal Decree-Law 16/2012⁷⁴⁸ introduced a new Article 3ter to Law 16/2003⁷⁴⁹ which modified the old system.

According to Article 3ter, undocumented migrants are completely excluded from the healthcare scheme except that:

- children under 18 years old and pregnant women have access to primary and secondary care (including antenatal, delivery and postnatal care and vaccination, however they must pay a share of their prescriptions under the same conditions as nationals);
- emergency care should remain freely accessible.

⁷⁴⁷ Op. cit. note 726

⁷⁴⁸ Op. cit. note 726

⁷⁴⁹ Op. cit. note 725

⁷⁵⁰ J. A. Pérez-Molina and F. Pulido, “¿Cómo está afectando la aplicación del nuevo marco legal sanitario a la asistencia de los inmigrantes infectados por el VIH en situación irregular en España?”, *Elsevier*, 2014

http://apps.elsevier.es/watermark/ctl_servlet?_f=10&pident_articulo=0&pident_usuario=0&pcontactid=&pident_revista=28&ty=0&accion=L&origen=zo

Undocumented migrants who are excluded from the healthcare scheme may obtain personal health insurance after at least one year of residence in Spain, if they can afford to pay for it. This health insurance costs €60 per month for those below 65 years of age and €157 per month for those aged 65 and above.

Those who cannot afford to pay for personal health insurance and/or who have been living in Spain for less than one year do not have access to healthcare.

It must be stressed that each autonomous community in Spain can implement specific regulations regarding access to and costs of healthcare for undocumented migrants.⁷⁵⁰ This situation creates administrative confusion and therefore inequality in access to healthcare depending on where someone lives.⁷⁵¹

Undocumented pregnant women

Article 1 of Royal Decree-Law 16/2012 introducing the new Article 3ter states that foreign nationals who are neither registered nor authorised to reside in Spain will be covered for antenatal, delivery and postnatal care.

However, since the 2012 reform, a number of Non-Governmental Organisations and media have reported how pregnant women often struggle to gain access to medical care.⁷⁵² Indeed, women are asked to present their IHC and if they do not have one, they are instructed to go to the emergency department.⁷⁵³

[nadelectura&web=www.elsevier.es&lan=es&fichero=S0213-005X\(14\)00362-0.pdf&eop=1&early=si](http://nadelectura&web=www.elsevier.es&lan=es&fichero=S0213-005X(14)00362-0.pdf&eop=1&early=si)

⁷⁵¹ Ibid.

⁷⁵² Op. cit. note 739

⁷⁵³ Yosi - sanidad universal, *Un año de exclusión sanitaria, un año de desobediencia, Campaña de desobediencia al Real Decreto-Ley 16/2012*, 2013, <http://yosisanidaduniversal.net/media/blogs/materiales/DossierAniversarioRDL.pdf>; I. Benitez, “Health Care for Immigrants Crumbling in Spain”, *Inter Press Service News Agency*, 24 May 2013,

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Furthermore, because of the poor level of information around the reform, health providers and undocumented pregnant women often do not know that the 2012 Royal Decree allows the latter to have access to healthcare during their pregnancy.

The consequences are serious, as many women only seek medical attention when their situation is already concerning and complicated. It has been reported that women who have been through a complicated birth have sometimes had to pay a bill of up to €3,300.⁷⁵⁴

The legal framework implemented by the Royal Decree is theoretically relatively adequate for emergency situations and pregnancies. Nonetheless, in practice, women struggle with the administration to get the necessary IHC and therefore do not have proper access to the medical care they need.

Children of undocumented migrants

Article 1 of Royal Decree-Law 16/2012 modifying Article 3ter of Law 16/2003 provides that “*in any case, foreign nationals who are less than 18 years old receive healthcare under the same conditions as Spanish citizens*”.⁷⁵⁵

This provision states clearly that all minors in Spain, whatever their administrative status, will be granted access to all healthcare services, under the same conditions as Spanish minors i.e. free of charge.

Article 2 of Royal Decree-Law 16/2012 provides for the basic health services package, which includes prevention services.⁷⁵⁶ Indeed, the Spanish National

<http://www.ipsnews.net/2013/05/health-care-for-immigrants-crumbling-in-spain/>

⁷⁵⁴G. Sanchez, “Embarazadas, menores y urgencias : los incumplimientos de una ley sanitaria discriminatoria”, *eldiario.es*, 31 August 2013, http://www.eldiario.es/desalambre/inmigracion-sanidad_sin_papeles-un_ano_sin_sanidad_universal_0_170433089.html

⁷⁵⁵Op. cit. note 726

Health System provides childhood immunisations, regardless of their nationality or status in the country.

To receive healthcare under the same conditions as Spanish citizens, children of undocumented migrants must have an Individual Healthcare Card. The IHC can only be obtained under three conditions: the person has to be registered at the local municipality (*Padron*), provide a valid identity document and provide proof of residence in the autonomous community.

EU citizens

Directive 2004/38 was transposed into the Spanish legal framework by Royal Decree 240/2007 of 16 February, on the entry, free movement and residence in Spain of citizens of the Member States of the European Union and other states parties to the agreement on the European Economic Area.

Royal Decree 240/2007 modified by Royal Decree 16/2012 states that EU citizens have the right to reside only if they have health coverage and have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State. This provision excludes destitute EU citizens.

In addition, in 2013, the European Commission raised concerns about the issue of the EHIC.⁷⁵⁷ European patients who hold an EHIC have been denied access to public healthcare.⁷⁵⁸

Unaccompanied minors

Article 3ter, subparagraph 4 of Law 16/2003⁷⁵⁹ (introduced by Article 1 of

⁷⁵⁶Op. cit. note 726

⁷⁵⁷European Commission, *European Health Insurance Card: Commission expresses concerns about refusals by Spanish public hospitals to recognise EHIC*, Brussels, 30 May 2013, http://europa.eu/rapid/press-release_IP-13-474_en.htm?locale=en

⁷⁵⁸Ibid.

⁷⁵⁹Op. cit. note 725

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Royal Decree-Law 16/2012) provides that “*in any case, foreign nationals who are less than 18 years old receive healthcare under the same conditions as Spanish citizens*”. This provision states clearly that all minors, including unaccompanied minors, have access to healthcare services, under the same conditions as Spanish minors, i.e. free of charge.

Regarding more specifically unaccompanied minors “seeking asylum”, Article 47 of Law 12/2009 points out that minors seeking international protection and who are “*victims of any form of abuse [...] or victims of an armed conflict, receive all healthcare as well as necessary specialized and psychological care*”.

Autonomous communities

Cantabria

Cantabria’s Programme of Social Protection and Public Health⁷⁶⁰ enables access to primary and specialised healthcare, as well as pharmaceutical benefits, for those migrants excluded by the Royal Decree Law, provided they fulfil certain administrative conditions.

We have no information on any other alternatives to access to treatment for those people – as people with infectious diseases – who cannot benefit from the programme.

Navarre

In March 2013, the Regional Parliament passed a law (*Ley Foral 8/2013*⁷⁶¹), granting any resident in Navarre – including undocumented ones – the right to free and public healthcare. This law has been appealed before the Constitutional Court. The court issued a decision on 8 April 2014 and decided to maintain the suspension of the provisions of the 8/2013 Law

⁷⁶⁰<http://www.saludcantabria.es/index.php?page=programa-cantabro-de-proteccion-social-de-la-salud-publica>

⁷⁶¹*Ley Foral 8/2013*

recognising the right to free healthcare for undocumented migrants and to lift the suspension of the other provisions of the law.⁷⁶²

To support this decision, it was argued that, given the vulnerability of the Spanish economy, a region could not decide to fully cover healthcare for undocumented migrants.

Castile and Leon – La Rioja

Concerning Castile and Leon, and La Rioja, no specific regulation was implemented. Nonetheless, it is important to stress that in Castile and Leon, undocumented migrants who were not able to renew their IHC after the 2012 Royal Decree-Law can still access healthcare if they had one before the reform.⁷⁶³ Both regions provide healthcare in cases of risk for national public health.

To access healthcare in La Rioja, undocumented migrants must have resided there for at least three months.

Andalusia – Asturias – Basque Country

These regions have contested the Royal Decree-Law, rejecting its enforcement and developing mechanisms to ensure access to medical assistance for undocumented migrants on the same terms as the rest of the population. The way this is implemented varies from one case to another (e.g. the General Directorate of Health Services in Andalusia provides a temporary health card – *Documento de reconocimiento temporal del derecho a la Asistencia Sanitaria*) and, in the case of, the Basque Country requires a minimum period of registration in the local census.

However, in general terms, they all provide access to both primary and specialised healthcare, as well to pharmaceutical

http://www.navarra.es/home_es/Actualidad/BON/Buletines/2013/43/Anuncio-5/

⁷⁶²<http://hj.tribunalconstitucional.es/en/Resolucion/Show/23930>

⁷⁶³ Op. cit. note 750

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services, thus covering care for people with infectious diseases.

Madrid – Balearic Islands – Catalonia

In Madrid, the Balearic Islands and Catalonia, the medical treatment of infectious diseases such as HIV or tuberculosis is considered as a matter of public health included in the scope of the 2012 Royal Decree.⁷⁶⁴ Nonetheless, in Madrid, this treatment is charged to the patient. In the Balearic Islands, the treatment is free and the same is true for Catalonia.⁷⁶⁵

The Community of Madrid did not issue any law for providing access to healthcare for undocumented migrants but sent an internal statement to Health Centres with the order to provide medical attention to everyone.

Castile-La-Mancha

Since 1st March 2017, undocumented migrants can apply for a medical card that allows them to have free access to public healthcare. It concerns undocumented migrants aged 18 or over, effectively residing in Castile-La-Mancha and who lack sufficient resources.⁷⁶⁶

Valencian Community

In 2015, the Valencian Community enacted a law to allow the same access to healthcare as Spanish citizens for undocumented migrants without private insurance and residing for more than three months in the

Valencian Community.⁷⁶⁷ In the same year, however the Spanish Constitutional Court decided to suspend the law, before lifting the suspension in 2016.⁷⁶⁸

Galicia – Region of Murcia – Aragon

The government of Galicia decided to maintain access to healthcare for undocumented migrants who lack sufficient resources, do not receive benefits and reside in Galicia for more than 6 months.⁷⁶⁹

In the Region of Murcia, undocumented migrants without insurance, who lack sufficient resources and who are effectively residing in Murcia can access healthcare through the Social Protection Program for the prevention and promotion of healthcare.⁷⁷⁰

The same is true for undocumented migrants residing in Aragon, through Aragon's Social protection and public health programme.⁷⁷¹

Extremadura

In 2016, the government of Extremadura enacted a law to fight social exclusion, providing access to healthcare for undocumented migrants residing for more than 6 months in Extremadura.⁷⁷²

Canary Islands

In the Canary Islands, undocumented migrants can access healthcare after three months of residence in the community.⁷⁷³

⁷⁶⁴ Op. cit. note 750

⁷⁶⁵ Op. cit. note 750

⁷⁶⁶ http://docm.castillalamancha.es/portaldocm/descargarArchivo.do?ruta=2016/02/23/pdf/2016_1920.pdf&tipo=rutaDocm

⁷⁶⁷ https://elpais.com/ccaa/2015/07/16/valencia/1437042745_880644.html

⁷⁶⁸ http://www.eldiario.es/cv/Constitucional-levanta-suspension-universal-valenciana_0_491001207.html

⁷⁶⁹

<http://emigracion.xunta.gal/es/actualidad/noticia/sanidade-garantiza-acceso-la-asistencia-las-y-inmigrantes-irregulares-sin>

⁷⁷⁰ Instrucciones 2/2016 y 6/2015, del Director Gerente del Servicio Murciano de Salud <https://www.borm.es/borm/documento?obj=anu&id=738537>

⁷⁷¹ Instrucción of 30 April 2013, government of Aragon http://www.nadiesinfuturo.org/IMG/pdf/Instruccion_de_30_de_abril_2013.pdf

⁷⁷² Decree-law 1/2016, of May 10, on extraordinary measures against social exclusion <https://www.boe.es/buscar/pdf/2016/BOE-A-2016-7692-consolidado.pdf>

⁷⁷³

<https://www.redaccionmedica.com/autonomias/can>

Protection of seriously ill foreign nationals

Article 126 of Royal Decree 557/2011 of 20 April 2011⁷⁷⁴ states that a temporary residence permit on humanitarian grounds can be granted to a foreign national under the following conditions:

- the individual must prove that they are affected by a serious disease which occurred after⁷⁷⁵ their arrival in the country (this condition does not apply to foreign children) and which needs specialist medical care;
- there is no access to the treatment in the country of origin;
- the absence of treatment or its interruption could lead to a serious risk for the patient's health or life.

In order to demonstrate the need, a clinical report must be issued by the competent medical authority. Article 130 of Royal Decree 557/2011 specifies that this residence permit for humanitarian reasons is valid for a one-year period and is renewable as long as the conditions are met.

Treatment of infectious diseases

The entry into force of Royal Decree 16/2012⁷⁷⁶ in Spain in September 2012 led to the exclusion of a large number of undocumented migrants from the National Healthcare System.

Concerning the specific medical attention to be given to undocumented migrants

[arias/asi-es-la-estrategia-de-canarias-para-cobrar-la-sanidad-a-los-sin-papeles--1566](http://www.msssi.gob.es/asi-es-la-estrategia-de-canarias-para-cobrar-la-sanidad-a-los-sin-papeles--1566)

⁷⁷⁴Royal Decree 557/2011

<https://www.boe.es/buscar/act.php?id=BOE-A-2011-7703>

⁷⁷⁵ It is very difficult for doctors to attest if the disease occurred after or before arrival.

⁷⁷⁶ Op. cit. note 726

⁷⁷⁷ Op. cit. note 739

⁷⁷⁸ Op. cit. note 750

(excluding those under 18 years old and pregnant women), some autonomous communities in Spain have developed different laws or regulations in order to allow undocumented migrants access to healthcare⁷⁷⁷ and, in particular, regarding the treatment of infectious diseases.⁷⁷⁸

In February of 2014, the Ministry of Health, Social Services and Equality published a document entitled 'Healthcare interventions in situations of public health risk' (*Intervención Sanitaria en situaciones de riesgo para la Salud Pública*) approved by all the autonomous communities⁷⁷⁹. This document does not specifically refer to undocumented migrants, but broadly to any person who does not benefit from the National Health System.⁷⁸⁰

It establishes the right of everyone to healthcare (including preventive care, follow-up and monitoring) as soon as it is suspected that an individual has an infectious disease subject to epidemiological control and/or elimination at a national or international level and also for people with an infectious disease that requires long-term and chronic medical treatment.⁷⁸¹

Various diseases are included such as HIV, hepatitis B and C, tuberculosis.⁷⁸²

Nevertheless, even though specific regulation may be established in Spain, 37% of doctors who are specialists in infectious diseases said in 2015 that they have real difficulties "always or most of the time" in treating HIV positive patients who are undocumented migrants.⁷⁸³

⁷⁷⁹ Ministerio de Sanidad, servicios sociales e igualdad, *Intervención sanitaria en situaciones de riesgo para la salud pública*, 18 December 2013, <http://www.msssi.gob.es/profesionales/saludPublica/docs/IntervencionSanitariaRiesgoSP.pdf>

⁷⁸⁰ Ibid.

⁷⁸¹ Ibid.

⁷⁸² Ibid.

⁷⁸³ Ibid.

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National Health System

Constitutional basis

The Constitution of the Kingdom of Sweden of 1974, in its Article 2 (Chapter 1), states that “*Public power shall be exercised with respect for the equal worth of all and the liberty and dignity of the private person. The personal, economic and cultural welfare of the private person shall be fundamental aims of public activity. In particular, it shall be incumbent upon the public institutions to secure the right to health, employment, housing and education, and to promote social care and social security [...]*”.⁷⁸⁴

In addition, Article 7 (Chapter 8) establishes that “*with authority in law, the Government may, without hindrance of the provisions of Article 3 or 5, adopt, by means of a statutory instrument, provisions relating to matters other than taxes, provided such provisions relate to any of the following matters: the protection of life, health, or personal safety [...]*”.⁷⁸⁵

Organisation and funding of Swedish healthcare system

The Swedish healthcare system has an explicit public commitment to ensure the health of all citizens. The Health and Medical Services Act 1982⁷⁸⁶ not only incorporated equal access to services based on the needs, but also emphasises a vision of “equal health for all”.⁷⁸⁷

⁷⁸⁴ Constitution of the Kingdom of Sweden of 1974, <http://www.parliament.am/library/sahmanadrutyunnar/Sweden.pdf>

⁷⁸⁵ Ibid.

⁷⁸⁶ The Health and Medical Service Act of 1982, <http://www.ilo.org/dyn/travail/docs/1643/health%20a%20nd%20medical%20insurance%20act.pdf>

⁷⁸⁷ <http://www.euro.who.int/en/countries/sweden>

⁷⁸⁸ Anell A, Glenngård AH, Merkur S. Sweden: Health system review. Health Systems in Transition,

The Swedish healthcare system is organised into three levels: national, regional and local. Predominantly, these three entities handle the funding of the National Health System (NHS). Government funding comes mainly from proportional income taxes levied by county councils/regions and municipalities, and some national and indirect tax revenues.⁷⁸⁸

Only a minor proportion of the population has private health insurance, which is usually paid by their employer. This private insurance is usually purchased to gain a faster access to specialist care.

With primary responsibility for the delivery of quality healthcare at the level of the county councils/regions and municipalities, the Swedish governance model is a mix of a decentralised organisation of healthcare services and centralised setting of standards, supervision and compilation of performance information on county/region-based services.⁷⁸⁹

At the national level, the Ministry of Health and Social Affairs is responsible for overall healthcare policy. It establishes principles and guidelines for care and sets the political agenda for health and medical care.

At the regional and local levels, the Health and Medical Services Act⁷⁹⁰ specifies that the responsibility for ensuring that everyone living in Sweden has access to good healthcare lies with the county councils and municipalities. The Act is designed to give county councils and municipalities considerable freedom with regard to the organisation of their health services.

2012, 14(5):1–159. <http://www.hsppm.org/countries/sweden25022013/li vinghit.aspx?Section=2.1%20Overview%20of%20the%20health%20system&Type=Section>

⁷⁸⁹ OECD (2013), OECD Reviews of Health Care Quality: Sweden 2013: Raising Standards, OECD Publishing

http://www.nsdsm.no/filarkiv/File/Eksterne_rapporter/OECD_rapport_Sverige_1_.pdf

⁷⁹⁰ Op. cit. note 786

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The 21 county councils are responsible for the funding and provision of healthcare services, especially primary care, through a national network of about 1,200 public and private primary health centres covering the country⁷⁹¹, in accordance with Section 3 of the Health and Medical Service act.⁷⁹²

The 290 municipalities are responsible for long-term care for older people living at home, in care homes or nursing homes, and for those with disabilities or long-term mental health problems.

Accessing Sweden healthcare system

The 1982 Health and Medical Services Act⁷⁹³ states in its Article 2 that the health system must cover all nationals and authorised residents.

The publicly financed health system covers:

- public health and preventive services;
- primary care, inpatient and outpatient specialised care;
- emergency care, inpatient and outpatient prescription drugs;
- mental healthcare;
- rehabilitation services;
- disability support services;
- patient transport support services;
- home care and long-term care, including nursing home care;
- dental care for children and young people; and with limited subsidies, adult dental care⁷⁹⁴

The Swedish health system does not provide medicines free of charge to individuals with health coverage. However, according to the 2002 Law on Pharmaceutical Benefits⁷⁹⁵, the State subsidises the cost of certain medicines. For

instance, since 1 January 2016, certain prescribed drugs in the reimbursement system are free for children under 18 years old.⁷⁹⁶

The Dental and Pharmaceutical Benefits Agency (TLV) is a central government agency, which determines whether a pharmaceutical product (or dental care procedure) is to be subsidised by the State.⁷⁹⁷

A high-cost threshold reduces patient costs for prescription medicines. The high-cost applies for a 12-month period, starting after purchases amounting to SEK 1,100 (€ 113⁷⁹⁸) for prescription medicines during a 12-month period.

In practice, the patient pays the full price for their medicines up to around SEK 1,100 (€ 113). Following this, a discount system comes into effect:

- between SEK 1,101 (€113) and SEK 2,100 (€216), the patient pays 50% of the cost of the medicine;
- between SEK 2,101 (€216) and SEK 3,900 (€401), the patient pays 25% of the cost of the medicine;
- between SEK 3,901 (€401) and SEK 5,400 (€555), the patient pays 10% of the cost of the medicine⁷⁹⁹

Patients who bought medicines on prescription for SEK 2,200 (€ 226) within a 12-month period do not pay any more for their medicines during the remaining time in that period.⁸⁰⁰

The medicine fee system is different for asylum seekers and undocumented migrants. According to the Regulation on

⁷⁹¹ The Commonwealth Fund, 2015 *International Profiles of Health Care Systems*, January 2016

⁷⁹² Op. cit. note 786

⁷⁹³ Op. cit. note 786

⁷⁹⁴ Op. cit. note 791

⁷⁹⁵ *Law on Pharmaceutical Benefits of 2002* <http://www.riksdagen.se/sv/Dokument->

[Lagar/Lagar/Svenskforfattningssamling/Lag-2002160-om-lakemedelsfo_sfs-2002-160/](http://www.tlv.se/In-English/in-english/2002160-om-lakemedelsfo_sfs-2002-160/)

⁷⁹⁶ Law on Pharmaceutical benefits, Article 19

⁷⁹⁷ <http://www.tlv.se/In-English/in-english/>

⁷⁹⁸ Exchange rate as of July 2017

⁷⁹⁹ <http://www.tlv.se/In-English/medicines-new/the-swedish-high-cost-threshold/how-it-works/>

⁸⁰⁰ Ibid.

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care fees for foreign nationals staying in Sweden without the necessary permits⁸⁰¹, asylum seekers and undocumented migrants only have to pay a fee of a maximum of SEK 50 (€5.14) per prescribed drug. This applies to medicines subsidised by the State.

The fees for GP consultations are set by each county and vary between SEK 150 and 300 (€15-30) across the country. Annual out-of-pocket payments for healthcare visits are capped nationally at SEK 1,100 (€113) per individual. After reaching this threshold, the patient can obtain a card that gives him/her access to free healthcare until 12 months have passed since the first visit.⁸⁰²

Access to healthcare for migrants

Asylum seekers and refugees

Pursuant to the 2008 Law on Health and Medical Services for Asylum Seekers and Others⁸⁰³, asylum seekers are entitled to subsidised:

- health and dental care that “cannot be postponed”
- contraceptive advice
- pregnancy termination
- maternity care

⁸⁰¹ Regulation on care fees for foreign nationals staying in Sweden without the necessary permits of 2013

http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Forordning-2013412-om-varda_sfs-2013-412/

⁸⁰² Op. cit. note 791

⁸⁰³ Law on Health and Medical Services for Asylum Seekers and Others of 2008, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2008344-om-halso--och-s_sfs-2008-344/

⁸⁰⁴ C. Björngren Cuadra, “Policies on Health Care for Undocumented Migrants in EU27, Country Report, Sweden”, *Healthcare in NOWHERELAND improving services for undocumented migrants in the EU*, 2010,

Asylum seekers aged under 18 are entitled to a broader scope of care (see below).

The Swedish Migration Agency provides asylum seekers with a personal card (LMA card) which is valid for the length of the application process. This card must be produced when seeking care.⁸⁰⁴

Upon their arrival in Sweden, asylum seekers are required to undergo a free health examination.⁸⁰⁵

For any visit to a health centre or hospital, adult asylum seekers pay SEK 50 (€5) for the visit or examination and around SEK 50 (€5) when buying most prescribed medicines from the pharmacy.⁸⁰⁶ For medical transport, they pay a maximum of SEK 40 (€4.11).⁸⁰⁷ According to the Reception of Asylum Seekers Act (LMA)⁸⁰⁸, asylum seekers who are registered are entitled to assistance, including a daily allowance.

If they have paid more than SEK 400 (€41) for doctor’s appointments, medical transport and prescription drugs within six months, asylum seekers can apply for a special allowance. The Swedish Migration Agency can compensate costs over SEK 400 (€41)⁸⁰⁹, paying the county administrative board for medical examinations and care received by asylum seekers.⁸¹⁰ The county administrative board

http://c-hm.com/wp-content/uploads/2015/08/country_report_Sweden.pdf

⁸⁰⁵ Swedish Migration Agency <https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care.html>

⁸⁰⁶ Ibid.

⁸⁰⁷ Ibid.

⁸⁰⁸ Reception of Asylum Seekers Act (1994:137) of 1994,

http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-1994137-om-mottagande-a_sfs-1994-137/

⁸⁰⁹ Op. cit. note 805

⁸¹⁰ G. Abraha, “A Handbook for Asylum

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can also, following an application, receive payment for special costly care.⁸¹¹

Asylum seekers and refugees also have access to emergency care but this is not free of charge. According to the 2013 Regulation on foreign nationals and care fees⁸¹², the caregiver should decide the cost for such care that is not mentioned in the regulation, and emergency care is not mentioned. Therefore, each county decides what the cost for emergency care should be. In Stockholm, and many other counties, the cost is around SEK 300 (€30).

Starting 1 June 2016, amendments made to the Reception of Asylum Seekers' Act (LMA)⁸¹³ entered into effect. Asylum seekers who received a decision of refusal of entry; whose expulsion can no longer be appealed or whose period of voluntary return has ended and who are not living with children under 18 years old will no longer be entitled to stay in Swedish Migration Agency accommodations and will have to return their LMA card opening them access to healthcare.⁸¹⁴ Children will not be affected by this reform, even if their period of voluntary return has expired, until they turn 18 years old.

A new temporary law entered into force on 20 July 2016. This law considerably limits asylum seeker's possibilities to obtain a permanent residence permit and to be eligible for family reunification. It will be valid for three years and applies for asylum seekers who arrived after 24 November 2015.⁸¹⁵ Pursuant to this law, people considered refugees are granted a three-year residence permit, and people in need of

subsidiary protection are granted a 13-month residence permit.

Finally, in accordance with the Dublin III Regulation⁸¹⁶, during the three first months of the asylum application, a country other than Sweden can request the responsibility to consider it. If this occurs, the asylum seeker will lose his/her status and the rights attached to it and will be transferred to the country declared competent to examine his/her application.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum have the right to receive health care under the conditions detailed above.

They are entitled free of charge to contraceptive advice, abortion, preventive maternal care, maternity care and childbirth.⁸¹⁷

Children of asylum seekers and refugees

Children of asylum seekers have the same access to medical and dental care as children of nationals and authorised residents, even after their application for asylum has been rejected.

Their access to healthcare is free of charge.⁸¹⁸ This is regulated by the Law on Health and Medical Services for Asylum Seekers and Others (2008:344).⁸¹⁹

Undocumented migrants

Undocumented migrants have the same access to healthcare as asylum seekers and refugees since the implementation of the Health and Medical Care for Certain

Seekers in Sweden", *Asylum Reception in Focus - A series from NTN-asylum & integration* No. 5, 2007 <http://www.temaasyl.se/Documents/NTG-dokument/A+Handbook+for+Asylum+Seekers+in+Sweden.pdf>

⁸¹¹ Ibid.

⁸¹² Op. cit. note 801

⁸¹³ Op. cit. note 805

⁸¹⁴ <https://www.migrationsverket.se/Privatpersoner/Skydd-och-asyl-i-Sverige/Medan-du-vantar/LMA-kort.html>

⁸¹⁵ <https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/Frequently-asked-questions-.html>

⁸¹⁶ Op. cit. note 791

⁸¹⁷

<https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care.html>

⁸¹⁸ Ibid.

⁸¹⁹ Op. cit. note 803

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Foreigners Residing in Sweden without Proper Documentation Act (2013:407)⁸²⁰ in July 2013.

Prior to the implementation of the 2013:407 Act in 2013, undocumented migrants had to pay full fees for receiving healthcare, even in cases of emergency.

Consequently, undocumented migrants are entitled to:

- medical examination and medicine covered by the Pharmaceutical Benefit⁸²¹
- health care “that cannot be postponed”
- pregnancy termination
- contraceptive counselling
- sexual and reproductive care
- maternity care⁸²²

In addition, the new reform stipulates that county councils should be able to offer undocumented migrants the same level of care that is available to residents.⁸²³ Similarly to asylum seekers, at least in theory, undocumented migrants can also apply for the compensation of costs over €43.

The 2013:407 Act was nonetheless criticised for its imprecision. In February 2014, the National Board of Health and Welfare (*Socialstyrelsen*) came to the conclusion that the terms “that cannot be postponed” are “*not compatible with ethical principles of the medical profession, not medically applicable in health and medical*

care and risk jeopardising patient safety”.⁸²⁴

In its interim report on the implementation of the 2013:407 law released on 15 April 2015, the Swedish Agency for Public management also underlined the difficulty to interpret the formulation “care that cannot be postponed”.⁸²⁵

Undocumented pregnant women

The July 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (2013:407)⁸²⁶ states in its article 7 that undocumented pregnant women are entitled to free maternal healthcare and abortion.

However, in practice, women are often denied maternity care. They are regularly rejected at the stage of signing in for care because they lack an official personal identity number.

Regarding termination of pregnancy, the care related to the procedure is free of charge. However, women have to pay around €5 for the termination itself, which is the same amount as a regular medical consultation.

Children of undocumented migrants

Pursuant to Article 6 of the 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act⁸²⁷, children of undocumented migrants have the same rights to medical and dental care as the children of Swedish nationals.

⁸²⁰ Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (2013:407) <http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2013407-om-halso--och-sjukvard-till-vissa-sfs-2013-407>

⁸²¹ Op. cit. note 795

⁸²² Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (2013:407) Article 7

⁸²³ http://picum.org/picum.org/uploads/publication/CoR%20Report%20Access%20to%20Healthcare%20EN_FR_IT_ES%202013.pdf

⁸²⁴ <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19381/2014-2-28.pdf>

⁸²⁵ Swedish Agency for Public management, *Care for undocumented A follow-up of the Care to people staying in Sweden without permission*, 2015, p. 18 <http://www.statskontoret.se/globalassets/publikationer/2015/201510.pdf>

⁸²⁶ Op. cit. note 822

⁸²⁷ Op. cit. note 822

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Moreover, healthcare in Sweden is free for children under 18 years old.⁸²⁸

All children in Sweden have access to free vaccination, according to a national vaccination programme. The vaccination programme includes ten vaccines: polio, diphtheria, rubella, tetanus, pertussis, hepatitis B, pneumococci, measles, mumps, and HPV (for girls only).⁸²⁹

The vaccination of young children is carried out at the health centre, while children at primary school are vaccinated by the school healthcare facilities. There is no distinction made regarding vaccination between children of undocumented migrants (including children of undocumented EU citizens) and children who are nationals.⁸³⁰

EU mobile citizens

The EU directive 2004/38⁸³¹ transposed into the Foreigners Act (2005:716)⁸³², Chapter 3a, states that, after three months, EU citizens can lose their right to reside in Sweden if they do not have health coverage and sufficient resources. They are then considered as undocumented migrants.

The July 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act is not clear on whether destitute EU citizens who have lost the right to reside are currently able to access healthcare on the same basis as undocumented migrants from a third-country.

⁸²⁸<http://www.1177.se/Other-languages/Engelska/Regler-och-rattigheter/Vard-i-Sverige-om-man-ar-asylsokande-gomd-eller-papperslos/#section-4>

⁸²⁹<http://www.1177.se/Fakta-och-rad/Behandlingar/Vaccinationer-av-barn/>

⁸³⁰<http://www.1177.se/Stockholm/Regler-och-rattigheter/Vard-for-dig-som-befinner-dig-i-Sverige-utan-tillstand/>

⁸³¹ Directive 2004/38/EC

⁸³² Foreigners Act of 2005

The government bill 2012/13:109⁸³³ merely stipulates that this is possible “*only in a few cases*”, without further precision.

However, in December 2014, the National Board of Health and Welfare publicly announced that EU citizens should be considered as undocumented (and have the same access to care as asylum seekers and third-country nationals). It then made a new statement in April 2015 and reiterated the fact that EU citizens who stay longer than three months may, in certain cases, have access to healthcare based on the 2013 law.⁸³⁴

In practice, different county councils provide different solutions for EU mobile citizens without EU Health Insurance Card. Some county councils offer subsidised healthcare, pursuant to the 2013 law, but most of the uninsured EU citizens remain in the former system and have to pay full fees for receiving healthcare in hospitals and health centres.

Unaccompanied minors

Since the 2013:407 law came into force, asylum seekers, refugees and undocumented migrants have the same access to healthcare. Thus, unaccompanied minors, regardless of their status, should have access to healthcare, in particular to vaccination.

The county councils are in charge of providing the same quality of health services, including healthcare, for children under the age of 18 seeking asylum as for other children who are citizens or residents

http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/utlanningslag-2005716_sfs-2005-716

⁸³³ Government Bill on healthcare for people staying in Sweden without permission of 2013, p. 41

http://www.riksdagen.se/sv/Dokument-Lagar/Forslag/Propositioner-och-skrivelser/Halso--och-sjukvard-till-perso_H003109/

⁸³⁴<http://www.socialstyrelsen.se/vardochomsorgfora-sylsokandemedflera/halso-ochsjukvardochtandvard/vilkenvardskaerbjudas>

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in Sweden. This includes child psychiatric and dental care.⁸³⁵

The National Board of Health and Welfare supervises the municipalities' reception of unaccompanied children.

The County administrative boards supervise the chief guardians who appoint guardians for unaccompanied minors seeking asylum.⁸³⁶ Pursuant to Chapter 19 of the 1949 law (1949:381)⁸³⁷, the chief guardian is elected by the city council. They are elected for a four-year period.

New rules for age assessment were implemented in March 2017. Asylum seekers can undergo a voluntary medical age assessment (consisting of X-ray and MRI), which estimated outcome will be included in the decision process for the refugee status⁸³⁸. However, this age assessment methodology is known to be imprecise and can only produce an estimation of the minority of the applicant. The uncertainty of the results has been the subject of much debate in Sweden.

Protection of seriously ill foreign nationals

According to Chapter 5, Section 6 of the Foreigners Act of 29 September 2005⁸³⁹, a residence permit can be granted to a foreign national on grounds of exceptionally distressing circumstances. The evaluation

⁸³⁵ U. Wernesjö, "Conditional Belonging Listening to Unaccompanied Young Refugees' Voices", *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Social Sciences* 93. Uppsala, 2014, <http://www.diva-portal.org/smash/get/diva2:689776/FULLTEXT01.pdf>

⁸³⁶ *Ibid.*

⁸³⁷ *The Children and Parents Code of 1949*, <https://lagen.nu/1949:381>

⁸³⁸

<https://skl.se/download/18.413f4ad015c773324e5ef95e/1497526194251/PM%20-%20EDoMH%20-%20C3%84ndrade%20C3%A5ldersbed%20B6mningar%20av%20ensamkommande%20barn.pdf>

⁸³⁹ *Foreigners Act of 2005*

of eligibility for such a residence permit includes the health state.

However, a new bill entered into force on 20 July 2016 for a period of three years and abolished this category of protection.⁸⁴⁰

This new legislation removes the possibility to obtain a residency permit for seriously ill individuals.

Prevention and treatment of infectious diseases

Infectious diseases are covered by the Diseases Act (*Smittskyddslagen*)⁸⁴¹, which states that certain testing and treatment are free of charge for residents in Sweden and for those who are covered by EU regulation 883/2004 on the coordination of social security systems.⁸⁴²

Since the 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act, undocumented migrants also have access to testing and treatment free of charge.

The law covers diseases such as tuberculosis, HIV and hepatitis.

Pursuant to the Communicable Disease Act of 1998⁸⁴³, physicians are obliged to notify cases of communicable diseases dangerous to society. The identity and immigration

⁸⁴⁰ <https://www.migrationsverket.se/English/About-the-Migration-Agency/Legislative-changes-2016/Limited-possibilities-of-being-granted-a-residence-permit-in-Sweden.html>

⁸⁴¹ *Diseases Act of 2004*, http://www.riksdagen.se/sv/Dokument-Lagar/Ovriga-dokument/Ovrigt-dokument/_sfs-2004-168/

⁸⁴² <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:en:PDF>

⁸⁴³ http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/smittskyddslag-19881472_sfs-1988-1472

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situation of the patients remain covered by oath of confidentiality taken by healthcare professionals.

Destitute EU citizens are not mentioned in the law. According to the Mdm SE team, even if the law does not officially include destitute EU citizens, it is free for them to be tested and to receive treatment.

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National Health System

Constitutional basis

The Federal Constitution of the Swiss Confederation, adopted on 18 April 1999, enshrines the right to health. Article 12 establishes that “*persons in need and unable to provide for themselves have the right to assistance and care, and to the financial means required for a decent standard of living*”.⁸⁴⁴ Article 41(1)a and b states that, “*the Confederation and the Cantons shall, as a complement to personal responsibility and private initiative, endeavour to ensure that: (a) every person has access to social security; (b) every person has access to the healthcare that they require*”.⁸⁴⁵

Moreover, Article 117a1, relating to basic medical care, states that, “*within the limits of their respective powers, the Confederation and the cantons shall ensure that everyone has access to sufficient and high quality basic medical care (...)*”.⁸⁴⁶

In addition, Article 118 enshrines the protection of health, for which “*the Confederation shall, within the limits of its powers, take measures*”.⁸⁴⁷

Organisation and funding of Swiss healthcare system

The Swiss Federal Law on Compulsory Health Care (LAMal) entered into force on 1 January 1996.⁸⁴⁸ This law introduced a managed competition scheme across the country, with “universal” coverage in basic health insurance. Moreover, the LAMal expanded the package of services previously covered by statutory health

insurance and made this “basic package” compulsory across the Swiss confederation.

To facilitate government monitoring of health insurance companies, insurers must register with the Federal Office of Social Insurance (FOSI) in order to offer the basic health insurance package. Moreover, the Swiss system being highly decentralised, the 26 Swiss cantons are largely responsible for the provision of healthcare. Insurance companies (around 90 across the country) operate primarily on a regional basis.

With regard to the funding, there are three components for publicly financed healthcare:

- mandatory health coverage;
- direct financing by government for healthcare providers (tax-financed budgets spent by the Confederation, cantons and municipalities; the largest portion of this spending is given as cantonal subsidies to hospitals providing in-patient acute care);
- social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance and military insurance.⁸⁴⁹

Accessing Switzerland healthcare system

The system is based on the compulsory health insurance for any person residing in Switzerland for more than three months, as foreseen in Article 3 (1) LAMal and in relation to Article 1(1) Health Insurance Ordinance (OAMal) of 27 June 1995 (OAMal/RS 832.102⁸⁵⁰). Article 6 LAMal completes these provisions by explaining that the cantons are in charge of making

⁸⁴⁴ *Federal Constitution of the Swiss Confederation of 1999* (last updated 18 May 2014), <http://www.admin.ch/ch/e/rs/1/101.en.pdf>

⁸⁴⁵ *Ibid.*

⁸⁴⁶ *Ibid.*

⁸⁴⁷ *Ibid.*

⁸⁴⁸ *Law on Compulsory Healthcare (LAMal) - 1994*

<https://www.admin.ch/opc/fr/classified-compilation/19940073/index.html>

⁸⁴⁹ The Commonwealth Fund, *2015 International Profiles of Health Care Systems*, January 2016

⁸⁵⁰ *Health Insurance Ordinance 832.102* <https://www.admin.ch/opc/fr/classified-compilation/19950219/201506010000/832.102.pdf>

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sure that this obligation is respected and that “the authority designated by the canton automatically affiliates any person, who is obliged to take out insurance if that person has not already done so”.

The monthly premiums for health insurance are fixed per family member and independently of income, depending on the region and the chosen insurance model. On average, compulsory health insurance (with accident coverage) for an adult over the age of 26 costs €393 per month, €362 per month for young adults (18-25 years old) and €90 per month for children under the age of 18. Furthermore, the insured person must pay an annual “franchise” which, by law, varies between €275⁸⁵¹ (CHF300) and €2,293 (CHF2500) for adults (the franchise is free for children) and must contribute up to 10% (proportional share) of the cost of the services provided.⁸⁵²

This proportional share is capped at €642 (CHF700) per adult and €321 (CHF350) per child.⁸⁵³ In other words, in addition to the monthly premium, an adult who has opted for a €275 franchise will pay a maximum of €917 (€275 + €642) per year for medical treatment. The higher the annual franchise, the less the monthly premium will be.

The most destitute people therefore often choose this option which creates serious difficulties if they become ill (and can lead to them giving up seeking care), as they cannot cover the resulting costs (they are not refunded until they reach the amount of their franchise).

In the event of non-payment of the monthly compulsory health insurance premiums, the individual receives a summons giving him/her 30 days to pay the premiums due. If the summons remains unanswered, the

insurer will initiate legal proceedings. After the individual receives an order to pay, s/he has 30 days to pay the entire sum claimed, plus the legal expenses.

While the former Article 64a LAMal provided that insurance funds could suspend their services and/or reimbursements if people did not pay, the new Article 64a LAMal (which came into force on 1 January 2012)⁸⁵⁴ modified this provision. Insurance funds no longer have the right to suspend healthcare reimbursements if an individual fails to pay his/her premiums.

In this way, the canton assumes 85% of the debts claimed by the insurance fund. As soon as the individual pays all or part of their debt to the insurance fund, the fund gives 50% of this amount back to the canton. Only if legal proceedings turn out to be impossible or do not result in payment, and after written notification, can the insurer eventually terminate the health insurance (Article 9, OAMal).⁸⁵⁵

A partial reduction or full exemption from monthly premiums is foreseen in Article 65(1) LAMal⁸⁵⁶ for people “on low incomes”. This is the responsibility of the cantons, which is why the granting of premium reductions differs from one canton to another.

Paragraph 1a of this same article also indicates that for low and middle-range incomes, premiums for children and young adults (18-25-year-old students) are reduced by at least 50%.

Article 115 of the Swiss Constitution, completed by the Federal Act of 24 June 1977 on jurisdiction in terms of assistance for persons in need (‘LAS’/RS 851.1⁸⁵⁷)

⁸⁵¹ Exchange rate for June 2017

⁸⁵² <https://www.eda.admin.ch/missions/mission-onu-geneve/en/home/manual-regime-privileges-and-immunities/introduction/manual-insurance/manual-insurance.html>

⁸⁵³ http://www.guidesocial.ch/fr/fiche/55/%23som_134251

⁸⁵⁴ <http://www.admin.ch/opc/fr/classified-compilation/19940073/index.html#a64a>

⁸⁵⁵ Op. cit. note 850

⁸⁵⁶ Op. cit. note 848

⁸⁵⁷ Federal Law on assistance of 1977, <http://www.admin.ch/opc/fr/classified-compilation/19770138/index.html#id-1>

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foresees that “people in need are assisted by the canton of their domicile”. This ‘social assistance’ organised by the cantons is reserved for people who “cannot take care of themselves sufficiently or in time, by their own means” (Article 2 LAS).⁸⁵⁸ Social assistance⁸⁵⁹ is granted if a person in need cannot be looked after by his/her family or cannot claim other legal services to which s/he has a right (principle of subsidiarity).⁸⁶⁰

It includes, notably, prevention measures, personal assistance and material assistance depending on the individual’s needs. Thus, social assistance ensures basic medical care for those concerned, including the coverage of the compulsory basic health insurance.⁸⁶¹

The healthcare services covered by the compulsory (basic) health insurance are indicated in Articles 25 to 31 LAMal and detailed in the Federal Department of the Interior (DFI) order of 29 September 1995 regarding compulsory healthcare services in the event of illness or disease.⁸⁶² The following services are notably included:

- examinations, treatments and care dispensed in the form of outpatient care at the person’s home, in hospitals or in a medical-social centre by doctors, chiropractors and individuals providing services prescribed by a doctor;
- antenatal and postnatal care;
- terminations of pregnancy allowed by Article 119 of the Swiss Criminal Code⁸⁶³ (i.e. within the first three

months or because it is necessary to “reduce or avoid the danger of serious harm to the physical integrity or state of profound distress of the pregnant woman”);

- preventive measures (mammography for some women at risk, gynaecological examinations, examinations of new-born and pre-school children, basic vaccinations for children and elderly people);
- rehabilitation measures carried out or prescribed by a doctor.

Dental care is not included in this catalogue, except if it is caused by a serious and non-avoidable disease of the masticatory system, by another serious disease or its consequences or because it is necessary to treat a serious disease or its consequences (Article 31 LAMal).⁸⁶⁴ Unless they subscribe to additional health insurance cover for dental care, patients with basic health insurance have to pay for the full cost of dental care, which is very expensive in Switzerland.

Access to healthcare for migrants

Asylum seekers and refugees

As Switzerland applies a global health insurance scheme that is obligatory for all people residing in Switzerland for longer than three months, the scheme also includes asylum seekers and refugees.⁸⁶⁵

⁸⁵⁸ Ibid.

⁸⁵⁹ W. Schmid and D. Maravic, “The new CSIAS standards relative to the obligation to provide care under the terms of family rights”, *The fiduciary Expert*, 2009

http://www.trex.ch/custom/trex/pdfarchiv/TREX_2009/Edition_4/Articles_specialises/Walter_Schmid_Danie.pdf

⁸⁶⁰ http://www.fr.ch/sasoc/fr/pub/aide_sociale/buts_aide_sociale.htm

⁸⁶¹ <http://csias.ch/>

⁸⁶² *Healthcare Benefits Ordinance of 1995*, <http://www.admin.ch/opc/fr/classified-compilation/19950275/index.html>

⁸⁶³ *Swiss Criminal Code of 1937*, <http://www.admin.ch/opc/fr/classified-compilation/19370083/index.html#a119>

⁸⁶⁴ Op. cit. note 848

⁸⁶⁵ V. Bilger and C. Hollomey, “Policies on Health Care for Undocumented Migrants in Switzerland, Country Report”, *Healthcare in NOWHERELAND* improving services for undocumented migrants in the EU, 2011,

https://www.unine.ch/files/live/sites/sfm/files/nouvelles%20publications/Booklet-Publikation_FINAL_03082011_A5.pdf

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Thus, asylum seekers and statutory refugees have to take out compulsory health insurance, as they are “*persons domiciled in Switzerland within the meaning of Articles 23-26 of the Swiss Civil Code*”.⁸⁶⁶

They can make a claim for premium reductions if they are on a low income.⁸⁶⁷ They can also benefit from social assistance at the level provided by their canton, as foreseen in Articles 80-81 of the Asylum Act (LAsi).⁸⁶⁸ This social assistance covers basic medical care, including compulsory insurance (especially the amount remaining after premium reductions and franchises).

According to the Asylum Act, asylum seekers who receive a negative asylum decision or a rejection of their application still benefit from ordinary social assistance.

Since 1 February 2014, social assistance is automatically withdrawn from individuals who receive a removal decision with a fixed departure deadline (Article 82(1) LAsi). Those who receive a removal decision may only have access to emergency care on request (Article 82(2) LAsi). This barrier to accessing care goes against the rights of asylum seekers appealing a decision i.e. who are still in the asylum process.

A major modification of the Asylum Act was put to vote and accepted through a referendum on 5 June 2016⁸⁶⁹. As of June 2017, the modification still requires ordinances to be implemented.⁸⁷⁰ This reform may shorten the asylum procedure and the delay for appeal of rejected asylum seekers, which would toughen the current asylum legislation. However, it also includes the obligation for the authorities to provide free legal counselling for all asylum seekers and to take into account the specific

needs of unaccompanied minors, families with children and “particularly vulnerable individuals”. For instance, minor asylum seekers would be entitled to schooling from the beginning of their asylum application until they are 16, which is the age at which schooling is no longer compulsory.

Pregnant asylum seekers and refugees

Under the Swiss health system, pregnant women should have access to antenatal and postnatal care. Cantons are obliged to provide accommodation to asylum seekers and refugees, therefore pregnant women have immediate access to social assistance and premium reductions and thus have access to antenatal and postnatal care. Antenatal and postnatal cares are covered by basic health insurances. Thus, pregnant asylum seekers and refugees who are covered by a health insurance do not have to pay for maternal care; this means they do not pay the franchise nor the 10% proportional share. They also have access to pregnancy termination through social workers who help them with the process.

Children of asylum seekers and refugees

Children of asylum seekers and children of refugees have the same access to healthcare as their parents. They have health coverage, which includes vaccination if their parents are covered.

Undocumented migrants

As already mentioned, any person residing in Switzerland must take out health insurance within three months of residence or birth, including undocumented migrants.

Only authorised residents (including refugees, beneficiaries of subsidiary

⁸⁶⁶ *Swiss Civil Code of 1907*, <http://www.admin.ch/opc/fr/classified-compilation/19070042/index.html>

⁸⁶⁷ <https://www.ch.ch/en/reductions-health-insurance/>

⁸⁶⁸ *Asylum Act (LAsi) - 1998* <https://www.admin.ch/opc/fr/classified-compilation/19995092/index.html>

⁸⁶⁹ <https://www.admin.ch/gov/fr/accueil/documentat/ion/votations/20160605/modification-de-la-loi-sur-asile.html>

⁸⁷⁰ https://www.sem.admin.ch/sem/fr/home/aktuell/gesetzgebung/aend_asylg_neustruktur.html

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protection and asylum seekers) benefit from social assistance. Others can only exercise their right to “*emergency assistance*” under the terms of Article 12 of the Swiss Constitution.⁸⁷¹

Although Article 65(1) LAMal states that destitute undocumented migrants can benefit from the same premium reductions as destitute nationals, this is not possible in all cantons and very difficult to obtain. Indeed, most cantons ask for proof of income tax in order to grant access to premium reductions. Furthermore, in practice, people who ask this provision face serious risk of refusal if they ask for a residence permit.

Thus, because they do not work legally, they do not pay taxes, so they cannot have access to premium reductions. The canton of Neuchâtel asks for proof of domicile, which is in practice very difficult to obtain for someone who is hosted by friends or families and cannot therefore be registered with the residents’ registration office (*le service de contrôle des habitants*). Undocumented migrants are not likely to take the risk of being thrown out of their homes to get this proof. Indeed, according to Article 116 of the law on foreign nationals⁸⁷², individuals who host undocumented migrants can be punished by a fine or imprisonment of up to five years.

Other cantons accept a sworn statement and in this case, undocumented migrants can easily gain access to premium reductions.

Therefore, in practice, undocumented migrants try to obtain health coverage, however the cost is a serious obstacle. They spend most of their wages on private insurance contributions. They opt for the cheapest contributions of around €300. This choice involves having the highest

franchise⁸⁷³, around €2,300 per year. It means that they have to cover the first €2,300 prior to being covered by health insurance. In addition, they must contribute up to 10% (proportional share) of the cost of outpatient services.

Undocumented migrants also have a right to “*emergency assistance*” under the terms of Article 12 of the Swiss Constitution⁸⁷⁴ which foresees that “*Persons in need and unable to provide for themselves have the right to assistance and care, and to the financial means required for a decent standard of living*”. These aid and assistance provisions are free of charge, however the assistance is granted for a short period. In addition, in practice, people requiring the emergency assistance face serious risks of expulsion (unless they are unfit for travel).

The assistance includes, as a minimum, “*accommodation in simple housing (often collective), the supply of food products and hygiene items, emergency medical and dental care, as well as other vital services*”. Significant differences between cantons exist regarding the access procedures and services covered by this emergency assistance system and some cantons are quite restrictive.⁸⁷⁵ In any case, this assistance must be specifically requested by the potential beneficiaries and does not always include affiliation to a health insurance fund.

In practice, undocumented migrants face many difficulties in respecting the obligation to take out health insurance because of lack of financial means, lack of knowledge of the system and fear of being reported. Insurers must maintain confidentiality with regard to third

⁸⁷¹ Op. cit. note 844

⁸⁷² *Federal Act on Foreign Nationals of 2005*, <https://www.admin.ch/opc/fr/classified-compilation/20020232/index.html>

⁸⁷³ The franchise or deductible is the amount, which has to be paid by the patient before the insurance starts paying.

⁸⁷⁴ Op. cit. note 844

⁸⁷⁵ <http://www.guidesocial.ch/fr/fiche/46/>

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parties⁸⁷⁶ but in the event of the non-payment of premiums, the insurer initiates a debt-collecting procedure (Article 64a LAMal, see above), which represents an additional risk of being discovered (see Article 84a(4) LAMal).

Undocumented pregnant women

Every pregnant woman, and undocumented pregnant women who can only afford the cheapest health insurance, is covered for termination of pregnancy, antenatal care, delivery and postnatal care. They do not have to pay for maternal care; this means they do not pay the franchise nor the 10% proportional share.⁸⁷⁷

Regarding pregnant women without health coverage, they have to pay themselves. For instance, antenatal, delivery and postnatal care cost around €5,500 for women without health coverage.

However, mostly, non-governmental organisations work closely with practitioners in public hospitals who provide free healthcare to undocumented pregnant women. In La Chaux-de-Fonds, MdM CH guides them to public hospitals, which agree to provide healthcare free of charge.

In case of emergency, practitioners have to provide healthcare anyway, without asking whether patients have health coverage. MdM CH teams report that many undocumented pregnant women who cannot pay for health services leave the hospital without having paid and without a bill for reimbursement.

Children of undocumented migrants

Children of undocumented migrants have the same access as their parents. In principle, they may have access to premium reductions, which cover the whole

premium. However, in practice, access to premium reductions is very complicated.

Either their parents can afford private health coverage for them (the contributions are cheaper than for adults, around €90 per month), so children have access to vaccinations; or they cannot pay contributions so they have to pay all doctor's fees.

Most undocumented parents succeed in insuring their children. Indeed, children's coverage is compulsory if their parents want to register them for school.

EU citizens

EU citizens, like anyone who resides in Switzerland, are obliged to take out health insurance within three months of their arrival in Switzerland. Destitute EU citizens should have the same access to premium reductions as any resident.

However, since the European crisis, many EU citizens have settled in Switzerland to find a job. Since 2015, those looking for a job or who lost their job after less than a year in Switzerland are not entitled to social benefits. It was reported by the medias that in the Vaud canton, regional social centres, which have responsibility for assistance often reported those who ask for help shortly after their arrival to the Cantonal Office for Population and Migrants.

Pregnant EU citizens

Pregnant EU citizens are required to pay healthcare services related to the pregnancy and delivery, and must ask for a refund in their country of origin. If they do not pay, they face lawsuits, which can be an obstacle to obtaining a work permit in Switzerland.

⁸⁷⁶Federal Law on the general section of social insurance of 2000, Article 33, 84, 92,c <http://www.admin.ch/opc/fr/classified-compilation/20002163/index.html#a33>

⁸⁷⁷http://www.informaternite.ch/en_attendant_bebe/l_assurance_maladie/prestations_de_l_assurance_d_e_base_en_cas_de_grossesse

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Termination of pregnancy

According to Article 119 of the Criminal Code⁸⁷⁸, termination of pregnancy is possible up to 12 weeks following the beginning of a woman's last period. After 12 weeks, termination is only possible if a doctor considers that there is physical danger for the pregnant woman.

Terminations of pregnancy are included in the basic health insurance services and are therefore entirely reimbursed for insured persons (Article 30 LAMal)⁸⁷⁹.

Unaccompanied minors

In certain cantons, unaccompanied minors should be taken into establishments, which assist them and ensure their protection. Those who seek asylum have the same access to healthcare as children of asylum seekers.

According to state regulations, the right to seek asylum is guaranteed for all unaccompanied minors in Switzerland.⁸⁸⁰ This right is strictly personal⁸⁸¹, therefore whether unaccompanied minors reach the age of discernment, they can make an application for asylum personally, or they will have to be represented by a "trustworthy person".⁸⁸² The canton authorities assign these persons.⁸⁸³

It is important to stress that even if an unaccompanied minor reaches the age of discernment and is able to fill out an asylum application on their own, they will have to be assisted by a "trustworthy person" representative during the procedure.⁸⁸⁴

Therefore, the issue of this representative is crucial regarding asylum requests by unaccompanied minors. On 4 February

2015, the United Nations Committee on the Rights of the Child addressed a number of recommendations to Switzerland, one of which relates to the rights of unaccompanied minors.⁸⁸⁵ Indeed, the United Nations experts are concerned that certain cantons may assign representatives who do not have any experience or training and therefore are not able to guarantee the best interests of the minor. Accordingly, the United Nations recommends that representatives be properly trained and that unaccompanied minors be excluded from the accelerated asylum procedure.⁸⁸⁶

In Switzerland, apart from the difference in the cost of compulsory insurance and the obligation to take into account the best interests of the child by the authorities, no specific legal provision exists regarding access to healthcare for unaccompanied minors compared with children who accompany their family.

Protection of seriously ill foreign nationals

People in situations considered of "*serious cases of personal hardship*" can obtain a humanitarian residence permit (B permit). Indeed, people who reside in Switzerland without a residence permit can request the application of Article 30(1)b of the Federal Act on Foreign Nationals (LETr) of 16 December 2005.⁸⁸⁷ The definition of "*serious cases of personal hardship*" depends on the examination of several criteria referred to in Article 31 of the Ordinance of 24 October 2007 related to the

⁸⁷⁸ Op. cit. note 863

⁸⁷⁹ Op. cit. note 848

⁸⁸⁰ <https://www.osar.ch/droit-dasile/procedure-dasile/mineurs.html>

⁸⁸¹ <http://www.sem.admin.ch/dam/data/sem/asyl/verfahren/hb/c/hb-c10-f.pdf>

⁸⁸² Ibid.

⁸⁸³ Ibid.

⁸⁸⁴ <http://www.admin.ch/opc/fr/classified-compilation/19995092/index.html#a82a>

⁸⁸⁵ <http://www.asile.ch/vivre-ensemble/2015/02/07/odae-romand-lonu-sinquiete-des-conditions-daccueil-des-enfants-migrants-en-suisse/>

⁸⁸⁶ Ibid.

⁸⁸⁷ *Federal Act on Foreign Nationals*

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admission, residency and exercise of a lucrative activity.⁸⁸⁸

A serious health condition for which no treatment in the country of origin exists is not sufficient in itself as a criterion, as the Federal Administrative Court systematically examines the person's level of integration into Swiss society, respect for the law, family situation (notably the presence of children), financial situation and duration of stay in Switzerland (preferably more than five years). In practice, obtaining this permit remains exceptional. There is no possibility to appeal the Court's decision.

Provisional admission (F permit) can also be granted to people for whom the execution of an expulsion order is not possible, legal or reasonably enforceable (Article 83 al. 1 LETr). Article 83(4) of the LETr foresees that *"enforcement may be unreasonable for foreign nationals if they are specifically endangered by situations such as war, civil war, general violence and medical emergency in their native country or country of origin"*. The Federal Administrative Court jurisprudence establishes that an expulsion is unenforceable if the person *"can [no longer] receive adequate care guaranteeing the minimum conditions of existence"*.⁸⁸⁹

Treatment of infectious diseases

The basic compulsory health insurance covers the costs linked to HIV screening and HIV treatment.⁸⁹⁰ People need a medical prescription from a doctor.

In term of access to screening and treatment of infectious diseases, there are many differences depending on the canton.

In Neuchâtel, people may have access to anonymous screening. For HIV screening, young people and students have to pay €27 (CHF30) and other people have to pay €55 (CHF60).⁸⁹¹

For undocumented migrants who are not covered by the basic compulsory health insurance, treatments for HIV and hepatitis C are unaffordable. For instance, triple therapy treatment costs around €1,500 per month. This price does not include analysis. Some NGOs decide to pay the monthly contributions to the basic health insurance in a limited way to people with low incomes, especially undocumented migrants, in order for them to get health coverage and thus free treatment for a period of one year. However, this scheme is not enough to cover all undocumented migrants.

⁸⁸⁸ *Ordinance on admission, residence and gainful employment of 2007*, <http://www.admin.ch/opc/fr/classified-compilation/20070993/index.html#a31>

⁸⁸⁹ (art. 6.2) <https://entscheide.weblaw.ch/cache.php?link=23-07-2013-E-2021-2012>

⁸⁹⁰ *Order of the Interior Federal Department (DFI) of 1995*, Article 12d

⁸⁹¹ <http://www.info-sida.ch/> (prices from December 2016)

TURKEY

National Health System

Constitutional basis

Article 56 of the Constitution of Turkey of 1982, amended in 2010, states, “*that it is the duty of the state (...) to ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through the economy and increased productivity, the state shall regulate the central planning and functioning of the health services*”⁸⁹². Article 60 explains that “everyone has the right to social security”.⁸⁹³

Towards universal health coverage

Since 2003, Turkey has been implementing its Health Transformation Programme (HTP) with the goal of realising universal health coverage through the General Health Insurance System (GHIS).⁸⁹⁴

In 2006, the parliament ratified the Law on Social Insurance and Universal Health Insurance (Law No. 5510 – GHI Law).⁸⁹⁵ With this law, the three separate schemes (Bağ-Kur, SSK and GERF⁸⁹⁶) were brought under a single system.

At present, both social security and health insurance (General Security Service) procedures are carried out by the Social

Security Institution (SSI – SGK Sosyal Güvenlik Kurumu).

Organisation and funding of Turkish healthcare system

Health services are financed through the health insurance scheme, the GHIS, which covers the majority of the population, and services are provided by both public and private sector facilities.⁸⁹⁷ The SSI is funded through payments by employers and employees and government contributions in cases of budget deficit.⁸⁹⁸

The Ministry of Health is the main actor in planning and supervising health services.⁸⁹⁹

The private sector has gained power over recent years, particularly after arrangements paved the way for private provision of services to the SSI. Turkey finances healthcare services from multiple sources⁹⁰⁰. Social health insurance contributions take the lead, followed by government sources, out-of-pocket payments and other private sources.⁹⁰¹

The SSI finances the cost of healthcare services, through the premiums collected from universal insurance holders.

The universal health insurance premium is 12.5% of income. Of this premium, 5% is the insurance holder’s share deducted from the gross salary and 7.5% is the employer’s share.⁹⁰²

⁸⁹² *Constitution of the Republic of Turkey of 1982* http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127495.pdf

⁸⁹³ Ibid.

⁸⁹⁴R. Hunter, “TURKEY’S HEALTH CARE REFORM: THE 2023 CHALLENGE”, *TURKISH POLICY Quarterly*, Vol. 12 No. 2, 2013, http://turkishpolicy.com/pdf/vol_12-no_2-hunter.pdf

⁸⁹⁵ *Social Insurance and Universal Health Insurance Law of 2006*,

<http://turkishlaborlaw.com/images/turkish-social-security-law/social-security-law-5510.pdf>

⁸⁹⁶ M. Tatar et al., “Turkey: Health system review”, *Health Systems in Transition*, Vol. 13 No. 6, 2011, http://www.euro.who.int/_data/assets/pdf_file/0006/158883/e96441.pdf

⁸⁹⁷ Ibid.

⁸⁹⁸ Ibid.

⁸⁹⁹ Ibid.

⁹⁰⁰ Ibid.

⁹⁰¹ Ibid.

⁹⁰² <http://www.invest.gov.tr/en-us/investmentguide/investorguide/employeesandocialsecurity/pages/turkishsocialsecuritysystem.aspx>

Accessing Turkey healthcare system

In theory, as introduced by the GHI Law, the GHIS provides individuals residing in the country with comprehensive, fair and equitable access to healthcare services, regardless of their economic situation.

The system is available to foreign residents paying social security contributions. With the Social Insurance and General Health Insurance, everybody residing in the country legally is included in the health system. In addition to this, the new system extended free health coverage for children below 18.⁹⁰³ With the new system, all children get free health services even if their parents have outstanding debts on their insurance payments.

Article 60 of the GHI Law⁹⁰⁴ (as amended by Article 38 of 2008/5754 Law and Article 123 of 2013/6458) states that the following population groups are covered by the GHIS:

- former members of the SSK, Bağ-Kur and GERF, active civil servants and Green Card holders, as well as their dependants;
- specific groups receiving a monthly pension from the government (such as war veterans);
- people recognised as stateless who have applied for or been granted protection;
- people in receipt of unemployment benefit, etc.⁹⁰⁵.

The GHI Law also determined the rules of entitlement. Accordingly, in order to benefit from the GHIS, an individual must have paid a minimum of 30 days of general health insurance contributions in the last year.⁹⁰⁶ Self-employed people (formerly

covered by the Bağ-Kur) and those who were not previously covered by any other scheme must have paid at least 60 days of contributions.⁹⁰⁷

In addition, there has been an extension of the coverage period for former members of the SSK and Bağ-Kur, as well as for active civil servants, when they cancel their membership for any reason.⁹⁰⁸ Previously, they were covered for up to 10 days after cancellation; now both they and their dependants can benefit from the GHIS for 90 days, provided they have paid 90 days of contributions in the last year.⁹⁰⁹

In accordance with Article 60 of the GHI Law⁹¹⁰, refugees do not pay insurance premiums, they are not deemed to be insurance holders, and the same applies to citizens with very low incomes. The latter are defined as citizens whose domestic income per capita is less than one third of the minimum wage, determined using the testing methods and data as stipulated by the SSI, and taking into account their expenses, movable and immovable property and their rights arising from these. The minimum wage is TRY1777.5 (€481.37) as of 1 January 2017⁹¹¹, so destitute citizens have less than approximately €160.46 per month.

Services covered by the SSI:

- protective healthcare services for individuals without considering whether they are sick or not and for preventing abusing substances harmful to human health
- inpatient and ambulatory healthcare services provided in case individuals are sick

⁹⁰³O. Karadeniz, "Extension of Health Services Coverage for Needy in Turkey: From Social Assistance to General Health Insurance", *Journal of Social Security*, 2012, <http://www.acarindex.com/dosyalar/makale/acarindex-1423911988.pdf>

⁹⁰⁴ Op. cit. note 895

⁹⁰⁵ Op. cit. note 896

⁹⁰⁶ Op. cit. note 896

⁹⁰⁷ Op. cit. note 896

⁹⁰⁸ Op. cit. note 896

⁹⁰⁹ Op. cit. note 896

⁹¹⁰ Op. cit. note 895

⁹¹¹ <http://www.fedee.com/pay-job-evaluation/minimum-wage-rates/>

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- inpatient and ambulatory healthcare provided due to work accidents, occupational disease and maternity
- Oral and dental healthcare services and odontotherapy for the individuals under the age of 18
- Assisted reproductive methods⁹¹²

The SSI provides preventive care free of charge for every citizen, even those without health coverage. Regarding medicines, a co-payment of 20% of the total amount of the prescription is required plus an additional TRY3 (€0.81⁹¹³) per prescription up to three medicines, and TRY1 (€0.27) for each extra medicine.⁹¹⁴

There is no co-payment required for medicines at the hospital.⁹¹⁵

Co-payments for outpatient care have been introduced for all those covered by the SSI who present to hospitals without a referral from a primary care physician (GP); patients pay €5 to public hospitals. However, inpatient services are fully covered.⁹¹⁶ Visits to primary care facilities do not require a co-payment.⁹¹⁷

Green Card scheme

In 1992, the government introduced a Green Card scheme for destitute households with incomes below the national minimum and for families on social assistance, financed from general budget revenues.⁹¹⁸ The Green Card scheme provided a special card giving free access to outpatient and inpatient care, covering inpatient medication expenses, but excluding the cost of outpatient drugs. Green Card holders, being poor people, did not directly contribute to the healthcare system, but received benefits free of charge

(with the exception of drug co-payments) when they needed care.

Since 2012, the Green Card system has become part of the GHIS, joining the SSI. Destitute citizens in Turkey can access Turkey's healthcare system, according to the same criteria as under the previous Green Card scheme.

Access to healthcare for migrants

Authorised residents

It is not compulsory for foreign nationals to join the SSI health scheme. Those wishing to join may do so after one year of residence in Turkey with a residence permit. During this year, health services are not free of charge and people have to pay out of pocket for any services.

In practice, in Istanbul, foreign nationals can have access to inpatient services in public hospitals by payment of the fee for people without health insurance ("tourist fee"). A medical consultation with a GP costs around €40.

However, in accordance with Circular No. 2010/16 issued by the Prime Minister, emergency healthcare services for all individuals are supposed to be free without any distinction between private or public healthcare institutions.⁹¹⁹

⁹¹²

http://www.sgk.gov.tr/wps/portal/sgk/en/detail/universal_health_ins

⁹¹³ Exchange rate of January 2017

⁹¹⁴ http://www.asylumineurope.org/sites/default/files/report-download/aida_tr_update.i.pdf

⁹¹⁵

<http://whocc.goeg.at/Literaturliste/Dokumente/CountryInformationPosters/Turkey2015.pdf>

⁹¹⁶ Op. cit. note 896

⁹¹⁷ Op. cit. note 896

⁹¹⁸R. Atun, et al., "Universal health coverage in Turkey: enhancement of equity", *the Lancet*, Vol 382, No 9886, 2013.

⁹¹⁹Adnan Kisa, and Mustafa Z. Younis "Financing Health Care For The Poor In Turkey: Is A Temporary Solution Becoming A Permanent Scheme?" *Public Health Rep.* 2006 Nov-Dec; 121(6): 764–768

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1781919/>

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Asylum seekers and refugees

Turkey was one of the original signatories to the 1951 Refugee Convention.⁹²⁰ However, it adopted the Convention with a “geographical limitation”.⁹²¹

This means that only refugees coming from countries that are members of the Council of Europe are offered the prospect of long-term integration in Turkey. For those coming from outside this zone, Turkey offers limited protection in the form of temporary asylum.⁹²²

The legal framework for asylum in Turkey was shaped by the Law on Foreigners and International Protection (LFIP)⁹²³, which was passed by the Turkish parliament in April 2013 and came into force in April 2014. The LFIP is a milestone in Turkish asylum law, as it overhauled the entire Turkish asylum system and incorporated into Turkish law some procedural safeguards resembling EU migration law.

It is important to bear in mind that in Turkish regulations the term “*refugee*” is defined differently from the established definition based on international law. Indeed, only those people applying for international protection “as a result of events occurring in European countries” can obtain a refugee status in line with the Refugee Convention.⁹²⁴

Individuals coming from a “non-European country of origin” may only apply for a conditional refugee status⁹²⁵ or for

subsidiary protection⁹²⁶, pursuant to the LFIP. Both of these types of international protection are temporary.

Refugees from Syria (i.e. Syrian nationals and stateless Palestinians originating from Syria) benefit from a specific “temporary protection” regime. This separate regime acquired a legal basis in 2014 with the Temporary Protection Regulation (TPR)⁹²⁷, based on Article 91 of the LFIP. The temporary protection status is not specific to any nationality and could be applied to any mass-arrival situation, upon decision of the Turkish Council of Ministers.⁹²⁸

Pursuant to article 89-3a of the Law on Foreigners and International Protection⁹²⁹, “international protection applicants and status holders who do not have any health insurance coverage and do not have the financial means to pay for healthcare services” are to be covered by the General Health Insurance scheme under Turkey’s public social security scheme.

Thus, they can access for free the same healthcare services as Turkish nationals covered by the national insurance scheme.

Applicants and holders of the international protection status are supposed to prove their lack of resources. It is reported that in practice, such means determination is not always carried out and applicants are

⁹²⁰ *Convention relating to the Status of Refugees* - 1951

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx>

⁹²¹ Asylum Information Database, *Country report : Turkey*, December 2015, p. 15

http://www.asylumineurope.org/sites/default/files/report-download/aida_tr_update.i.pdf

⁹²² NOAS, *Seeking asylum in Turkey, a critical review of Turkey’s asylum laws and practices*, 2016 http://www.asylumineurope.org/sites/default/files/resources/noas-rapport-tyrkia-april-2016_0.pdf

⁹²³ *Law 6458 on Foreigners and international Protection (LFIP)* – 2013

<http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=5167fbb20>

⁹²⁴ Law on Foreigners and International Protection, article 61

⁹²⁵ Law on Foreigners and International Protection, article 62

⁹²⁶ Law on Foreigners and International Protection, article 63

⁹²⁷ *Temporary Protection Regulation of 22 October 2013*

<http://www.refworld.org/docid/56572fd74.html>

⁹²⁸ NOAS, *Seeking asylum in Turkey*, 2016, p. 15

⁹²⁹ Op. cit. note 923

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usually extended free healthcare coverage.⁹³⁰

Another prerequisite to obtain this coverage is to have a Foreigners Identification Number, assigned by Provincial DGMM Directorates. Yet, the delays to obtain one are very long, leaving applicants for international protection without health coverage.⁹³¹

Furthermore, applicants processed under the accelerated procedure cannot have access to this benefit since they are not issued the International Protection Applicant Identification Document, thus, they are only entitled to “urgent and basic healthcare services”.⁹³²

These conditions do not apply for “Temporary protection” beneficiaries. Pursuant to article 27 of the Temporary Protection Regulation⁹³³, all registered “temporary protection” beneficiaries, whether residing in the temporary accommodation centres or outside the temporary accommodation centres, are covered under Turkey’s general health insurance scheme. As such, they have the right to access free of charge public healthcare services.

Individuals eligible for “temporary protection” who have not yet completed their registration only have access to emergency medical services and health services pertaining to communicable diseases as delivered by primary health care institutions.

Once they are covered by the general health insurance scheme, international protection applicants and holders, and temporary protection beneficiaries are entitled to spontaneously access initial diagnosis, treatment and rehabilitation services at

primary healthcare institutions. They can also access screening and immunisation for communicable diseases, specialised services for infants, children and teenagers as well as maternal and reproductive health services.⁹³⁴

Generally, they are entitled to access healthcare services only in the province they are registered in.

Victims of psychological, physical or sexual violence are entitled to appropriate care, according to article 67-2 of the LFIP.

As for medication cost, beneficiaries of “international protection” and of “temporary protection” have to contribute 20% of the total amount of the prescribed medication costs.⁹³⁵ In addition, beneficiaries are expected to pay TRY3 (€0.81) per medication item up to three items, and TRY1 (€0.27) for each item if more than three items were prescribed.

In practice, inconsistency in the practices of pharmacies is reported. Some pharmacies, including in Istanbul, are unwilling to provide medication for “temporary protection” beneficiaries because of ongoing delays in reimbursements. In other provinces, pharmacies do not require the 20% co-payment from “temporary protection” beneficiaries.⁹³⁶

The Health Implementation Directive (SUT) sets which health issues entitle beneficiaries of “temporary protection” to access secondary and tertiary healthcare services. For the treatment of health issues which are not included in the SUT or for treatment expenses related to health issues that are covered by the SUT, but exceed the cost ceiling as set by the SUT, beneficiaries of temporary protection may have to provide for additional costs. Free healthcare

⁹³⁰ Asylum Information Database, *Country report : Turkey*, December 2015, p. 87

⁹³¹ Asylum Information Database, *Country report : Turkey*, December 2015, p. 73

⁹³² Ibid.

⁹³³ Op. cit. note 927

⁹³⁴ Asylum Information Database, *Country report : Turkey*, December 2015, p. 88

⁹³⁵ Asylum Information Database, *Country report : Turkey*, December 2015, p. 131

⁹³⁶ Ibid.

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coverage for registered “temporary protection” beneficiaries also extends to mental health services provided by public healthcare institutions.

So far, the transition to the new asylum scheme has been characterised by a lag on implementation of the new legal framework and lack of transparency, which results in inconsistencies affecting access to health care. For instance, although the LFIP required that a separate regulation be issued to determine specific aspects of its implementation, two unpublished (i.e. not publicly available) circulars have instead been shaping the practice until the adoption of the implementing regulation on 17 March 2016⁹³⁷, over a year and a half after the adoption of the LFIP.

Undocumented migrants

Undocumented migrants do not have access to healthcare through the GHIS. Since the circular of 2 November 2011 came into force on 1 January 2012, the government has enforced a “tourist fee” of around €50 for an emergency consultation in public hospitals.⁹³⁸ In practice, these prices are applicable to undocumented migrants who require care.

Moreover, the amount charged for specialised care for a person considered as a tourist is four times that for non-tourists.

In addition, the healthcare system reform in Turkey that has been implemented since 2003 made the primary healthcare centres, accessible only to individuals with health coverage. Therefore, undocumented migrants have to go to expensive private clinics to meet a GP or to vaccinate their children.

Public hospitals are obliged to treat everyone in case of emergency. However,

⁹³⁷ *Regulation on the Implementation of the Law on Foreigners and International Protection* – 2016 <http://www.resmigazete.gov.tr/eskiler/2016/03/20160317-11.htm>

Doctors of the World – Médecins du Monde (MdM)’s partner in Turkey, ASEM has observed in Istanbul that undocumented migrants may often be refused treatment or reported to the police by medical and administrative providers when they present at the emergency departments of public hospitals.⁹³⁹

According to ASEM, in 2014, organisations supporting migrants condemned the arrests by the police of several foreign men who were hospitalised and then taken and interned in the Kumkapi detention centre. This phenomenon has been observed since at least 2010.⁹⁴⁰ In most cases, these arrests break the continuity of care and also demonstrate the cooperation which exists between the police and hospital staff.⁹⁴¹

In contrast, other public hospitals accept undocumented migrants for treatment. For a medical consultation with a GP, they have to pay around €40 (tourist fee), eight times more than individuals with health coverage do. In practice, undocumented migrants have to rely on organisations such as ASEM to act as mediators in their access to public hospitals.

Undocumented pregnant women

In Istanbul, undocumented pregnant women often do not have access to antenatal and postnatal care. ASEM generally sends pregnant women to the Saint-Georges Hospital, with which they have an agreement, so they can have access to antenatal care (this agreement includes four consultations).

Otherwise, pregnant women have to pay out-of-pocket hospital fees. For example, a delivery by caesarean section costs around €3,500 and a vaginal delivery costs around

⁹³⁸ M. Blézat and J. Burtin, « Soigner le mal par le rien », *Plein droit*, juin 2012, No 93.

⁹³⁹ Ibid.

⁹⁴⁰ Ibid.

⁹⁴¹ Ibid.

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TRY1150 (€287).⁹⁴² Sometimes, hospitals are willing to accept payment by instalments and sometimes they call the police who take the woman and her newborn into custody.

Pregnant women in Istanbul do not have access to pregnancy termination. ASEM sends them to a private clinic in Kumkapi which charges between €160 and €180 until four weeks of pregnancy. The price increases the closer the termination is to the end of the legal period of ten weeks.⁹⁴³

Children of undocumented migrants

The minor children of undocumented migrants also have no access to healthcare. They may have access to vaccination at a primary healthcare centre but these centres usually require the child to be registered with the authorities. Each vaccine costs around €18, added to the medical consultation, which costs around €40.

Unaccompanied minors

Thus, there is a difference in treatment between different groups of unaccompanied minors. Those who apply for international protection and who are waiting for the result of their application or who have been accepted as refugees should receive protection from the state and should have access to healthcare. Those who receive a decision and have their application refused may be detained⁹⁴⁴ and are sometimes detained in a manner akin to kidnapping.⁹⁴⁵

⁹⁴² Conversion rate applicable on July 2017

⁹⁴³ Abortion in Turkey is legal until the 10th week after the conception, although that can be extended to the 20th week if the pregnancy threatens the woman's mental and/or physical health, or if the conception occurred through rape.

⁹⁴⁴ "During his visit, the Special Rapporteur on the Human Rights of Migrants expressed concern about the situation of children at both the Kumkapi and Edirne removal centres. Boys over the age of 12 apprehended with their mothers were automatically separated from their mothers and placed in orphanages (SRHRM 2012)" <http://www.globaldetentionproject.org/countries/europe/turkey/introduction.html>

Prior to the Law on Foreigners and International Protection adopted in 2013, there were no specific legal provisions with regard to the detention of minors. The 2006 Ministry of Interior "implementation directive" (Security Circular No.57), defining asylum procedures under Turkey's 1994 Asylum Regulation, stated that temporary asylum applications for unaccompanied minors were to be fast-tracked so that minors could be transferred to shelters of the State Child Protection Agency.⁹⁴⁶

However, the circular recommends the use of medical tests for determining the age of the minors if they do not have documentary proof of their age, or if the police have doubts about the age stated in such documentation.⁹⁴⁷ It specifically allows minors to be held in reception centres. Until the results of these tests are issued they are held with adults and people who may have been accused of and convicted of crimes.⁹⁴⁸

Moreover, there is no margin of error applied to the result of the tests, as recommended by international standards.⁹⁴⁹ Indeed, the 1997 UNHCR "Guidelines on policies and procedures in dealing with unaccompanied children seeking asylum" state that, when scientific procedures are used to determine the age of the child, margins of error should be applied.⁹⁵⁰ In addition, a policy was adopted by the 2005 UNHCR "Procedural standards for refugee status determination under UNHCR's

⁹⁴⁵ <https://www.amnesty.org/en/documents/eur44/3022/2015/en/>

⁹⁴⁶ Global Detention Project, *Immigration Detention in Turkey*, April 2014,

<https://www.globaldetentionproject.org/countries/europe/turkey>

⁹⁴⁷ Refugee Advocacy & Support Program, *Unwelcome Guests: The Detention of Refugees in Turkey's "Foreigners' Guesthouses"*, November 2007,

<https://refuge.journals.yorku.ca/index.php/refuge/article/viewFile/30609/28119>

⁹⁴⁸ Ibid.

⁹⁴⁹ Op. cit. note 947

⁹⁵⁰ Op. cit. note 947

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mandate”, which states that age assessment should be resolved in the favour of the child.⁹⁵¹

The 2013 law provides that the best interest of children shall be respected. However, it also states that families and unaccompanied children can be detained for removal purposes but that they should be given separate accommodation arrangements at removal centres and that children should have access to education (Article 59-1-ç-d).⁹⁵²

The law states that unaccompanied minors who apply for international protection are not to be detained.⁹⁵³ Those aged under 16 will be placed in government-run shelters, while those over 16 can be placed in “*reception and accommodation centres provided that favourable conditions are ensured*” (Article 66).⁹⁵⁴

Protection of seriously ill foreign nationals

Law no. 6458 on Foreigners and International Protection of April 2013⁹⁵⁵ makes provision for a humanitarian residence permit in specific cases.

Article 46 of the law states that, “under the following cases, upon approval of the Ministry, a humanitarian residence permit with a maximum duration of one year at a time may be granted and renewed by the governorates without seeking the conditions for other types of residence permits: a) where the best interest of the child is of concern; b) where, notwithstanding a removal decision or ban on entering Turkey, foreign nationals cannot be removed from Turkey or their departure from Turkey is not reasonable or possible; [...] e) in cases when foreign nationals should be allowed to enter into and stay in Turkey, due to emergency or in view of the protection of the national

interests as well as reasons of public order and security, in the absence of the possibility to obtain one of the other types of residence permits due to their situation that precludes granting a residence permit; f) in extraordinary circumstances”.

In these cases, seriously ill foreign nationals can obtain a humanitarian residence permit and not be expelled to their country of origin or to their country of former usual residence.

Prevention and treatment of infectious diseases

The treatment of infectious diseases is covered by the guarantee package of the GHIS. In medical examinations, STIs such as HIV/AIDS and syphilis, as well as tuberculosis are checked free of charge. Tuberculosis is also checked during employment recruitment processes and for other people who may have contact with infected people (also free of charge).

Turkish citizens, authorised residents, asylum seekers and refugees with health coverage have free access to screening and treatment for hepatitis B and tuberculosis. Local public and family health centres deliver preventive health services for refugees. Immunisation of preschool children is the leading focus among these services.

Turkish citizens without health coverage only have access to free screening and treatment for tuberculosis. Regarding HIV, everyone, even individual with health coverage, has to pay for his/her treatment, which is very expensive.

Undocumented migrants do not have access to treatment.

⁹⁵¹ Op. cit. note 947

⁹⁵² Op. cit. note 946

⁹⁵³ Op. cit. note 946

⁹⁵⁴ Op. cit. note 946

⁹⁵⁵ Op. cit. note 938

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National Health System

Organisation and funding of British healthcare system

In the United Kingdom, the National Health Service Act of 1946 and subsequent legislation, established a comprehensive public health service. The NHS was finally introduced two years later. It was born out of a long-held ideal that quality healthcare should be available to all nationals and residents in the UK and free at the point of use. The NHS is a residence-based system, unlike many other countries, which have insurance-based healthcare systems.

This health system is known as a Beveridgean system, financed by general taxation, which ensures that each person should be protected from cradle to grave. The NHS is managed separately in England, Northern Ireland, Scotland and Wales. Some differences have emerged between these systems in recent years but they remain similar in most respects and continue to be described as a unified system.

Despite numerous political and organisational changes, the NHS remains to date a service available “universally”, that cares for people on the basis of need and not ability to pay, and which is funded by taxes and national insurance contributions. With the exception of charges for some prescriptions and services, the NHS remains free at the point of use. This principle applies throughout the UK but decisions about specific charges may differ in the different countries of the UK.

⁹⁵⁶ *The NHS Constitution for England of 27 July 2015*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

⁹⁵⁷ K. Grosios et al., “Overview of healthcare in the UK”, *EPMA Journal*, 2010,

The Health Act 2009 established the *NHS Constitution*⁹⁵⁶, which formally brings together the purpose and principles of the NHS in England, its values, as they have been developed by patients, public and staff, and the rights, pledges and responsibilities of patients, the public and staff⁹⁵⁷. Scotland, Northern Ireland and Wales have also agreed a high-level statement declaring the principles of the NHS across the UK, even though services may be provided differently in the four countries, reflecting their different health needs and situations.⁹⁵⁸

The NHS is intended to provide universal health coverage to the population in the UK. All “ordinary residents” in the UK are automatically entitled to healthcare that is largely free at the point of use through the NHS⁹⁵⁹, except for certain minor charges.

People from EU countries are also entitled to care, free at the point of delivery, if they have a European Health Insurance Card (EHIC). People who are not ordinarily resident in the UK, such as short-term visitors or undocumented migrants, are only entitled to limited free secondary care in emergency departments and for certain infectious diseases, unless they fit into one of the categories of people who are exempt from treatment charges.

Since April 2013, in England, all GP practices belong to a Clinical Commissioning Group (CCG)⁹⁶⁰ which commissions most health services for the population in its area, including: planned hospital care; rehabilitative care; urgent and emergency care; most community health

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405352/pdf/13167_2010_Article_50.pdf

⁹⁵⁸ Ibid.

⁹⁵⁹ The Commonwealth Fund, *2015 International Profiles of Health Care Systems*, January 2016

⁹⁶⁰ <http://www.patient.co.uk/doctor/clinical-commissioning-groups-ccgs>

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services; maternity services; and mental health and learning disability services.⁹⁶¹

The concept of ordinary residence

The NHS (Amendment) Act 1949 created powers – now contained in Section 175 of the 2006 NHS Act – to charge people in the UK who are not “ordinarily resident” for health services. The powers were first used in 1989⁹⁶² to make Regulations in relation to NHS hospital treatment, now consolidated as the NHS (Charges to Overseas Visitors) Regulations 2015.⁹⁶³

Since 1989, only those “ordinarily resident” in the UK are entitled to free NHS secondary care (i.e. hospital treatment), others will have to pay for them, unless they fall under an exemption category. Nobody is excluded from primary care (i.e. GP treatment). From 23 October 2017, charges will apply to all NHS secondary and tertiary care provided outside hospitals as well, unless an exemption applies.⁹⁶⁴

The concept of ordinary residence appears in many areas of law, but until recently, it had not been defined in legislation. Instead, it took its meaning from case law and meant, broadly, living in the UK on a lawful and properly settled basis for the time being. The leading case in which the term was defined concerned entitlement to grants for

higher education. The House of Lords defined ordinary residence as “*a man’s abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or of long duration*”.⁹⁶⁵

The only caveat in the context of access to NHS secondary care is that the person must be in the UK lawfully, and have the right to be there, but s/he does not need to have the right to reside permanently. “Temporary admission” (a form of entry to the UK granted pending an immigration decision, as an alternative to detention for people liable to detention and removal) does not amount to residence.⁹⁶⁶ Ordinary residence should not be confused with permanent residence, usual residence or other phrases describing residence.⁹⁶⁷

In May 2014, the government published a new Immigration Act 2014⁹⁶⁸, which included provisions regarding entitlement to National Health Service treatment that came into force in April 2015.

According to the Government⁹⁶⁹, the Act was intended to: introduce changes to the removals and appeals system, making it easier and quicker to remove “*illegal immigrants*” from the UK⁹⁷⁰; end the

⁹⁶¹Guide to the Healthcare System in England Including the Statement of NHS Accountability for England, May 2013,

http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF

⁹⁶²NHS (Charges to Overseas Visitors) Regulations 1989/306:

<http://www.legislation.gov.uk/uksi/1989/306/regulation/4/made>

⁹⁶³NHS (Charges to Overseas Visitors) Regulations 2015/238:

<http://www.legislation.gov.uk/uksi/2015/238/contents/made>

⁹⁶⁴ Regulation 2, NHS (Charges to Overseas Visitors) Regulations 2017/756

⁹⁶⁵Shah v Barnet London Borough Council and other appeals [1983] 1 All ER 226

⁹⁶⁶R (YA) v Secretary of State for Health [2010] 1 All E.R. 87,

<http://www.refworld.org/docid/49d1fca62.html>

⁹⁶⁷Department of Health, *Internal review of the overseas visitor charging system - Part 2*

Analysis of the overseas visitor charging system, <http://fullfact.org/sites/fullfact.org/files/782677R%20Chap%202%20of%20Review%20pages%201-52.pdf>

⁹⁶⁸Immigration Act of 2014 - Summary of Provisions, <https://www.jcwi.org.uk/sites/jcwi/files/Immigration%20Act%202014%20Summary%20Provisions.pdf>

⁹⁶⁹Race Equality Foundation, Access to services: the Immigration Act 2014 and key equality impacts, 2014,

<http://www.edf.org.uk/blog/wp-content/uploads/2014/09/Equality-impacts-IA-Sept2014-final.pdf>

⁹⁷⁰Please note that MDM and its partners, especially PICUM, absolutely disagree with the use of “illegal” to describe a person. Only the laws declaring that a

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“abuse” of Article 8 of the European Convention on Human Rights – the right to respect for family and private life; and to prevent “illegal immigrants” accessing and “abusing” public services or the labour market.⁹⁷¹

Section 39 Immigration Act 2014⁹⁷², which came into force on 6 April 2015, introduced an additional element to the definition of “ordinary residence” in the context of eligibility for free NHS treatment, by excluding all those who do not have indefinite leave to remain in the UK.⁹⁷³ This applies to those who need leave to enter or remain but also those currently living and working in the UK with limited leave to remain.⁹⁷⁴ It therefore increased the threshold for “ordinary residence”, as indefinite leave to remain can only be applied for after a minimum of 5 years’ lawful residence in the UK, excluding temporary migrants from free healthcare to which they previously had access.

In addition to the changes in primary and secondary legislation, the Department of Health (DH) has introduced a programme aimed at recovering costs from foreign nationals called the Migrant and Visitor Cost Recovery Programme. The programme is divided into four phases: improving cost recovery from the current charging system, improving identification of those who are eligible for/exempt from charging and implementing the migrant surcharge and extended charges to other services. In 2016, the DH consulted on making changes in primary care, secondary

care, community healthcare and changing current residency requirements for EEA citizens.⁹⁷⁵ Starting 6 April 2016, Australia and New Zealand nationals planning to come to the UK or stay in the UK for more than 6 months will no longer be exempted from the “health surcharge” fee⁹⁷⁶ (see below).

Accessing the NHS

Primary care

As of April 2017, patients in England pay £8.60 (€9.77⁹⁷⁷) per prescription⁹⁷⁸, but some patients who need 14 or more prescriptions per year or four or more prescriptions in three months can buy a Prescription Prepayment Certificate (PPC) in order to freeze prescription related expenses. A 3 month-PPC costs £29.10 (€33.07) and an annual PPC costs £104 (€118.19).⁹⁷⁹ In Wales⁹⁸⁰, Scotland⁹⁸¹ and Northern Ireland⁹⁸², prescription charges have been abolished.

Medicines administered at a hospital, a walk-in centre or a GP practice, prescribed contraceptives, medicines supplied at a hospital or local clinic for the treatment of sexually transmitted infections or tuberculosis are free. Furthermore, all prescriptions are free for patients over 60 years old, under 16 years (under 25 in Wales) and under 18 for full-time students, pregnant women and mothers who have had their child in the last year, chronically ill persons (e.g. cancer and diabetes patients) and disabled patients, as well as for people

person is illegal are illegal. **No one is illegal.**
<http://picum.org/en/our-work/terminology/>

⁹⁷¹ Op. cit. note 969

⁹⁷² <http://www.legislation.gov.uk/ukpga/2014/22/section/39/enacted>

⁹⁷³ Op. cit. note 968

⁹⁷⁴ Op. cit. note 968

⁹⁷⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483870/NHS_charging_acc.pdf

⁹⁷⁶ <https://www.gov.uk/government/news/immigration-health-surcharge-extends-to-australia-and-new-zealand>

⁹⁷⁷ Exchange rate as of July 2017

⁹⁷⁸ <https://www.gov.uk/government/speeches/nhs-charges-from-april-2016>

⁹⁷⁹ <https://www.gov.uk/get-a-ppc>

⁹⁸⁰ <http://www.wales.nhs.uk/nhs-wales/about-us/budget-charges>

⁹⁸¹ <http://www.psd.scot.nhs.uk/prescriptioncharges.html>

⁹⁸² <http://www.nhs.uk/ipgmedia/national/Asthma%20UK/Assets/Prescriptionchargesandasthma.pdf>

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who receive some form of means-tested social security benefit.⁹⁸³

Patients on a low income can claim for help with health costs (by filling out an HC1 form). Help with health costs depends on the patient's financial resources and not on immigration status. The NHS decides whether a patient should receive full help with health costs (an HC2 certificate) or partial help (an HC3 certificate). The certificate is valid from 6 months to 5 years, depending on the circumstances of the applicant, and must be produced each time when collecting a prescription or receiving treatment, e.g. dental care, glasses.⁹⁸⁴

In England, Section 3 NHS Act 2006, as amended by Section 13 Health & Social Care Act 2012⁹⁸⁵ states that Clinical Commissioning Groups (CCGs) “must arrange for the provision of services to patients (...) usually resident in its area”. Usual residence is not formally defined, but Regulation 3 of the National Health Service (CCGs – Disapplication of Responsibility) Regulations 2013⁹⁸⁶ specifies that people are to be treated as “usually resident” at the address given by them (or by someone on their behalf), if they give no address then they are to be treated as usually resident wherever they are present, thereby formally unlinking immigration status from eligibility for primary care.

Regulation 2 of the NHS (General Medical Services Contracts) Regulations 2004⁹⁸⁷

(GMS Regs), which governs the delivery of many NHS primary medical services⁹⁸⁸, defines “*patient*” as including temporary residents. Paragraph 16 of Schedule 6 GMS Regs⁹⁸⁹ goes further in specifying that “*contractors may (...) accept a person as a temporary resident provided it is satisfied that the person is temporarily resident away from his normal place of residence and is not being provided with essential services (or their equivalent) under any other arrangement in the locality where he is temporarily residing; or is moving from place to place and not for the time being resident in any place*”.

In summary, everyone in England is entitled to free primary care regardless of nationality or immigration status. Therefore, asylum seekers, refugees, people on work visas and overseas visitors, whether they have permission to reside in the UK or not, are eligible to register with a GP practice. GPs cannot refuse to register a patient for reasons that are discriminatory (on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition). A GP practice can only refuse to register a patient if: their list is closed to new patients; the patient lives outside the catchment area; or they have other reasonable grounds. Inability to provide proof of address or proof of identity are not reasonable grounds to refuse a registration.⁹⁹⁰

⁹⁸³<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx>

⁹⁸⁴<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/nhs-low-income-scheme.aspx>

⁹⁸⁵*National Health Service Act of 2006,*

<http://www.legislation.gov.uk/ukpga/2006/41/section/3> ; *Health and Social Care Act of 2012,* <http://www.legislation.gov.uk/ukpga/2012/7/section/13>

⁹⁸⁶*The National Health Service (Clinical Commissioning Groups— Disapplication of Responsibility) Regulations of 2013,* <http://www.legislation.gov.uk/uksi/2013/350/regulation/3/made>

⁹⁸⁷*The National Health Service (General Medical Services Contracts) Regulations of 2004,* <http://www.legislation.gov.uk/uksi/2004/291/regulation/2/made>

⁹⁸⁸Many primary medical services are provided under the NHS (Personal Medical Services Agreements) Regulations 2004 (‘the PMS Regs’) instead, but the relevant provisions are identical in both sets of Regulations.

⁹⁸⁹http://www.legislation.gov.uk/uksi/2015/196/pdf/s/uksi_20150196_en.pdf

⁹⁹⁰NHS England, Standard Operating Principles of for Primary Medical Care (General Practice), <https://www.england.nhs.uk/commissioning/wp->

Secondary care

Ordinary residence

All “ordinary residents” of the UK are automatically entitled to secondary healthcare that is largely free at the point of use through the NHS.⁹⁹¹ People who are not ordinary residents, such as visitors or undocumented migrants, are only entitled to limited free secondary care in emergency departments and for certain infectious diseases, unless they come within one of the categories of people who are exempt from charges.

Non EEA nationals

Since 6 April 2015, as provisions of the Immigration Act 2014 came into force, nationals of countries from outside the EEA coming to the UK for longer than six months are required to pay a “health surcharge” when they make their immigration application.⁹⁹² This also concerns third-country nationals already in the UK who apply to extend their stay.

The health surcharge is of £200 (€227.30) per year and £150 (€170.47) per year for students, payable upfront and for the total period of time for which migrants are given permission to stay in the UK. It entitles the payer to NHS funded healthcare on the same basis as ordinary residents. People who live outside the EEA and do not have insurance will be charged at 150% of the NHS national tariff for any secondary care they receive. Certain categories are exempted from charging as UK Crown servants or members of armed forces.⁹⁹³

Reciprocal healthcare agreements

Under Regulation 14 NHS (Charges to Overseas Visitors) Regulations 2015, “no charge may be made or recovered in respect

of any relevant services provided to an overseas visitor where those services are provided in circumstances covered by a reciprocal agreement with a country or territory specified in Schedule 2” of the Regulations.⁹⁹⁴

Exemptions

Some NHS services are free to everyone regardless of the status of the patient:

- Services provided for the treatment of a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence, provided that the overseas visitor has not travelled to the United Kingdom for the purpose of seeking that treatment.⁹⁹⁵ This includes mental health treatment.
- Accident and emergency (A&E) services, whether provided at a hospital accident and emergency department, a minor injuries unit or a walk-in centre or elsewhere.⁹⁹⁶
- Family planning services and treatment of sexually transmitted infections⁹⁹⁷ – although details of the services are not specified in Reg. 9, family planning clinics typically offer advice about sexual and reproductive health, as well as contraception (combined oral contraceptive pills, progestogen-only pills, progestogen injections, emergency contraception and intrauterine devices), limited supplies of free condoms, cervical screening and pregnancy tests⁹⁹⁸, as well as testing for Sexually Transmitted Infections (STIs).
- Diagnosis and treatment for communicable diseases such as

[content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf](https://www.gov.uk/government/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf)

⁹⁹¹Op. cit. note 959

⁹⁹²<https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations/summary-of-changes-made-to-the-way-the-nhs-charges-overseas-visitors-for-nhs-hospital-care>

⁹⁹³ Ibid.

⁹⁹⁴ Op. cit. note 992

⁹⁹⁵<http://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide>

⁹⁹⁶ Ibid.

⁹⁹⁷ Ibid.

⁹⁹⁸<http://www.nhs.uk/Conditions/contraception-guide/Pages/contraception-clinic-services.aspx>

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influenza, measles, mumps, tuberculosis, viral hepatitis and HIV/AIDS.⁹⁹⁹

The following categories of the population are exempt from charges: refugees, asylum seekers, those whose application for asylum was rejected, but who are supported by the Home Office or a local authority, children looked after by a local authority, victims of human trafficking and modern slavery; those receiving compulsory treatment under the Mental Health Act, prisoners and immigration detainees.¹⁰⁰⁰ There may also be exceptional humanitarian reasons where the secretary of state can determine that treatment should be provided, although in practice these will be very rare.¹⁰⁰¹

Any treatment which is considered to be immediately necessary by clinicians (including all maternity care), whilst chargeable, must be provided without waiting for payment or even a deposit. However, the patient may still be billed during or after treatment.¹⁰⁰² Indeed, from 23 October 2017, organisations providing NHS secondary or tertiary care have a legal obligation to secure payment for treatment that clinicians deem to be non-urgent, in advance of providing treatment.¹⁰⁰³

⁹⁹⁹ Schedule 1 of the Regulations specifies those diseases for which no charge is to be made: acute encephalitis, acute poliomyelitis, anthrax, botulism, brucellosis, cholera, diphtheria, enteric fever (typhoid and paratyphoid fever), food poisoning, haemolytic uremic syndrome, infectious bloody diarrhoea, invasive group A streptococcal disease and scarlet fever, invasive meningococcal disease (meningococcal meningitis, meningococcal septicaemia and other forms of invasive disease), legionnaires' disease, leprosy, leptospirosis, malaria, measles, mumps, pandemic influenza or influenza that might become pandemic, plague, rabies, rubella, Severe Acute Respiratory Syndrome (SARS), smallpox, tetanus, tuberculosis, typhus, viral haemorrhagic fever, viral hepatitis, whooping cough, yellow fever and, since the 2012 amendment, also HIV/AIDS.

<http://www.legislation.gov.uk/ukxi/2015/238/schedule/1/made>

¹⁰⁰⁰https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496951/Overseas_visitor_hospital_charging_accs.pdf, p. 11-12

Hospitals are required to inform the Home Office of patients who owe the NHS a debt of more than £500 (€568.25), outstanding for 2 months or more, and such people may be refused visa renewals or regularisation of their immigration status until the debt is paid.¹⁰⁰⁴

Access to healthcare for migrants

Asylum seekers and refugees

Regulation 15 (a) of the NHS (Charges to Overseas Visitors) Regulations 2015 states that anyone who has been granted temporary protection, asylum or humanitarian protection under the immigration rules made under Section 3(2) of the Immigration Act 1971 is exempt from charges. Regulation 15(b) states that anyone who has made a formal application with the Home Office to be granted temporary protection, asylum or humanitarian protection is also fully exempt from charges whilst their application is being processed.¹⁰⁰⁵ This includes applications for leave to remain made on the basis that return to country of origin would breach Article 3 ECHR.¹⁰⁰⁶

¹⁰⁰¹Op. cit. Note 995

¹⁰⁰²Department of Health, *Guidance on implementing the overseas visitor hospital charging regulations 2015*,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418634/Implementing_overseas_charging_regulations_2015.pdf

¹⁰⁰³ Regulation 4 NHS Charges to Overseas Visitors (Amendment) Regulations 2017/756

¹⁰⁰⁴https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507694/Overseas_chargeable_patients_2016.pdf

¹⁰⁰⁵*The National Health Service (Charges to Overseas Visitors) Regulations of 2015*, http://www.legislation.gov.uk/ukxi/2015/238/pdfs/ukxi_20150238_en.pdf

¹⁰⁰⁶ (p.6) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597377/Humanitarian-protection-v5_0.pdf

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This exemption will apply to the immediate family of the asylum seeker if they are living in the UK with that person on a permanent basis.¹⁰⁰⁷ Asylum seekers and rejected asylum seekers who are not entitled to free prescriptions under these categories have to make a Low Income Scheme (LIS) HC1 claim.¹⁰⁰⁸

In 2009, the Court of Appeal in England and Wales, overturning an earlier High Court judgment, ruled that rejected asylum seekers could not be considered ordinary residents in the UK for the purposes of the charging regulations and could not become exempt from charges after living in the UK for 12 months prior to treatment.¹⁰⁰⁹ As health policy is a devolved responsibility, however, different exemptions, policy and guidance exists in each of the four countries and access to free hospital treatment for refused asylum seekers differs from country to country within the UK.¹⁰¹⁰

In Scotland and Wales, asylum seekers and refused asylum seekers are entitled to free secondary healthcare on the same terms as any other ordinary resident.¹⁰¹¹ In England, only refused asylum seekers who receive accommodation and support from the Home Office under section 4(2) Immigration & Asylum Act 1999 or accommodation and support from a local authority under the Care Act 2014 are entitled to free secondary healthcare. However, all refused asylum seekers can continue, free of charge, with any course of treatment already underway before their application was refused.¹⁰¹²

¹⁰⁰⁷ Regulation 25(2) NHS (Charges to Overseas Visitors) Regulations 2015/238
http://www.legislation.gov.uk/ukxi/2015/238/pdfs/ukxi_20150238_en.pdf

¹⁰⁰⁸ <http://www.nhsbsa.nhs.uk/HealthCosts/1136.asp>

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¹⁰⁰⁹ Op. cit. note 966

¹⁰¹⁰ Op. cit. note 1002

¹⁰¹¹ <https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide>

Focus on pregnant women and children

Under this scheme, pregnant asylum seekers and refugees have free access to antenatal, delivery and postnatal care. The children of asylum seekers and refugees, like adults, have free access to the NHS and this includes vaccination.

Undocumented migrants

Undocumented migrants are not excluded from primary care. Indeed, the Secretary of State for Health (health minister) announced that there is no formal requirement to provide documentation when registering with a GP. GPs do not have any financial reason not to register undocumented migrants – their global sum payments in respect of overseas patients do not differ from that of other patients.¹⁰¹³ Finally, there is no minimum period that a person needs to have been in the UK before a GP can register him/her.¹⁰¹⁴

In the same way as UK citizens, undocumented migrants can be exempt from prescription charges, dental care charges, etc. with an HC2 certificate.

Adults over 60 have automatic free prescriptions and eye tests. They can obtain free dental treatment with an HC2 certificate.¹⁰¹⁵ However, obtaining an exemption certificate does not ensure that an undocumented patient can access NHS care – it only helps with the cost of prescriptions. Undocumented migrants do have to pay for NHS hospital and secondary care charges.

Regarding access to secondary care, undocumented migrants are only entitled to

¹⁰¹² Regulation 3(5) NHS (Charges to Overseas Visitors) Regulations 2015/238

¹⁰¹³ <http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121026/text/121026w0001.htm>
¹⁰¹⁴ (p.105)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496951/Overseas_visitor_hospital_charging_accs.pdf

¹⁰¹⁵ <http://patient.info/health/help-with-health-costs>

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limited free secondary care in emergency departments and for certain infectious diseases, unless they come within one of the categories of people who are exempt from charges. Thus, they have to pay to access secondary care, although immediately necessary or urgent treatment should not be withheld pending payment.

A memorandum of understanding between the Home Office and NHS Digital, which came into effect on 1 January 2017 allows NHS Digital to share non-clinical data including name and addresses of immigration offenders for the purpose of “*encouraging voluntary return by denying access to benefits and services to which [those here illegally] are not entitled*”¹⁰¹⁶ thus putting another barrier to access to healthcare.

Moreover, from 21 August 2017, organisations providing NHS services became legally obliged to record patients’ immigration status on their NHS records.¹⁰¹⁷

Undocumented pregnant women

Undocumented pregnant women should receive maternity care but this is chargeable. Indeed, maternity care, including antenatal care, delivery and postnatal care, is not free at the point of use as it is considered as secondary care. Thus, hospitals usually bill for a full course of care throughout the pregnancy, which is around €7,000 if there are no complications.

The Department of Health has stressed repeatedly that providers also have human rights obligations, meaning that treatment considered by clinicians to be immediately necessary (including all maternity treatment) must never be withheld from

chargeable patients, even if they have not paid in advance.

Children of undocumented migrants

Vaccination is available for all children and adults through their GP and baby clinics. All children are exempt from prescription charges, dental care and optometry charges. Charges for secondary care are applied to undocumented children in the same ways as adults.

EU mobile citizens

EU mobile citizens have the same access to primary care as UK nationals and can benefit from the same exemptions from secondary care charging regulations. Entitlement to free NHS treatment will depend on the individual’s circumstances and, in particular, whether s/he is insured in his/her country of origin, which is best demonstrated by having an EHIC. EEA nationals may also be “ordinarily resident” in the UK if they are there lawfully, have been in the UK for more than a short period and intend to remain.

If insured, an EEA or Switzerland national is exempt from charges for “all medically necessary treatment”, i.e. treatment that it is medically necessary to have during his/her temporary stay in the UK, with a view to preventing him/her from being forced to return home for treatment before the end of the planned duration of his/her stay. For instance, regarding England, this means¹⁰¹⁸:

- diagnosis of symptoms or signs occurring for the first time after the visitor’s arrival in the UK;
- any other treatment which, in the opinion of a medical or dental practitioner employed by or under contract with a CCG, is required

¹⁰¹⁶ *Memorandum of Understanding between Health and Social Care information centre and the Home Office*, pp.4-6
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585928/MOU_v3.pdf

¹⁰¹⁷ Regulation 5 NHS Charges to Overseas Visitors (Amendment) Regulations 2017 2017/756
http://www.legislation.gov.uk/uksi/2017/756/pdfs/uksi_20170756_en.pdf

¹⁰¹⁸ Op. cit. note 1002

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promptly for a condition which: arose after the visitor's arrival; or became acutely exacerbated after his/her arrival; or would be likely to become acutely exacerbated without treatment; plus

- the treatment of chronic, or pre-existing, conditions, including routine monitoring and routine maternity care.

If economically active in the UK (i.e. employed, self-employed, involuntarily unemployed for less than six months or temporarily incapacitated), the patient is likely to have a right to reside in the UK under the Immigration (EEA) Regulations 2006 and EU Directive 2004/38. The UK is thus prohibited from treating such patients any differently from UK nationals, so as long as they are not short-term visitors they will have a right to free hospital treatment either by being considered "ordinarily resident" in the UK, or by having an enforceable right to treatment through EU law.¹⁰¹⁹

Termination of pregnancy

Termination of pregnancy is possible during the first 24 weeks of pregnancy (and later in the pregnancy in certain circumstances) and must be carried out in a hospital or a specialist licensed clinic (e.g. in some local family planning clinics or genito-urinary medicine clinics that are also accessible to undocumented women).¹⁰²⁰ However, the Abortion Act of 1967 allowing abortion during the first 24 weeks of pregnancy does not extend to Northern Ireland where women face life sentence for abortion. Until June 2017, women could still travel to England to terminate their pregnancy, but would not be covered by the

NHS and would have to pay the full cost. In June 2017, the Parliament passed an amendment allowing Northern Ireland women to be covered by the NHS for abortion in England.¹⁰²¹

Two doctors must agree that a termination would cause less damage to a woman's physical or mental health than continuing with the pregnancy.¹⁰²² According to the MdM UK team in London, it may be difficult to obtain a termination of pregnancy free of charge without a referral from a GP.

However, as termination of pregnancy is considered secondary care, from 23 October 2017, when the NHS Charges to Overseas Visitors (Amendment) Regulations 2017 come into force, women who are not ordinarily resident in the UK will have to pay for such treatment, failing which, they may not receive it if it is not deemed by a clinician to be "immediately necessary" or "urgent".

Unaccompanied minors

Unaccompanied minors who are "seeking asylum" or have "refugee status" are exempt from charges in the same way as any other asylum seeker or refugee. If there is nobody with parental responsibility who is able to look after them, they can enter local authority care under the Children Act 1989 and become "looked after children", meaning that they are exempt from all charges.¹⁰²³ Unaccompanied minors whose asylum claims are rejected will, once they turn 18 and leave local authority care, no longer be exempt from charging.

¹⁰¹⁹ Op. cit. note 1002

¹⁰²⁰ <http://www.nhs.uk/conditions/Abortion/Pages/Introduction.aspx>

¹⁰²¹ <http://www.bbc.com/news/uk-politics-40438390>

¹⁰²² *Abortion Act of 1967*, this Act covers England, Scotland and Wales

¹⁰²³ J. Simmonds and F. Merredew, "The Health Needs of Unaccompanied Asylum Seeking Children and Young People", *EP23 - LAC 9.4 Unaccompanied asylum seeking children*, <https://www.nice.org.uk/guidance/ph28/evidence/looked-after-children-ep23-unaccompanied-asylum-seeking-children-john-simmonds-and-florence-merredew2>

Protection of seriously ill foreign nationals

Discretionary Leave and Humanitarian Protection were introduced on 1 April 2003 to replace Exceptional Leave to Remain.¹⁰²⁴

Humanitarian Protection is granted when a person is found not to be a refugee under the 1951 Convention relating to the Status of Refugees and the 1967 Protocol (the Refugee Convention) but there is a well-founded fear of the death penalty, torture, inhuman and degrading treatment or a serious threat against his/her life relating to widespread violence resulting from a situation of internal or international armed conflict.

Cases where it is claimed that removal would be a breach of Article 3 of the European Convention on Human Rights on medical grounds will not be considered eligible for Humanitarian Protection, given that “in such cases the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-State bodies, but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country”.¹⁰²⁵ Instead, they should be considered under the Discretionary Leave policy.

This Discretionary Leave can be granted to persons (seeking asylum or not) who require medical, social or another form of assistance which can be provided in the UK. The improvement or stabilisation of an applicant’s medical condition resulting from treatment in the UK and the prospect of serious or fatal relapse on expulsion do

¹⁰²⁴

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460712/Discretionary_Leave_2_v7_0.pdf

¹⁰²⁵ *N. v United Kingdom*, 2008, European Court of Human Rights, <http://www.refworld.org/docid/483d0d542.html>
The European Court of Human Rights reached the same conclusion as the House of Lords.

not in themselves render expulsion inhuman treatment contrary to Article 3 of the European Convention on Human Rights.

The threshold set by Article 3 is therefore a high one as interpreted by the UK and the European Court of Human Rights. It is “*whether the applicant’s illness has reached such a critical stage that it would be inhuman treatment to deprive him/her of the care which s/he is currently receiving and send him/her home to an early death unless there is care available there to enable him/her to meet that fate with dignity*”.¹⁰²⁶

To meet the very high Article 3 threshold, an applicant must show exceptional circumstances that prevent return, namely that there are compelling humanitarian considerations, such as the applicant being in the final stages of a terminal illness without prospect of medical care or family support on return.

The duration of Discretionary Leave granted is determined by a consideration of the individual facts of the case but leave is not normally granted for more than 30 months at a time.¹⁰²⁷ Subsequent periods of leave can be granted providing the applicant continues to meet the relevant criteria. Thus, foreign nationals who apply for Discretionary Leave have to be close to death in order to have a chance to obtain it.

Prevention and treatment of HIV

The question of who should be able to receive free HIV/AIDS screening and treatment in the UK has been a much

¹⁰²⁶ *N. v Secretary of State for the Home Department*, 2005, House of Lords, <http://www.bailii.org/uk/cases/UKHL/2005/31.html>

¹⁰²⁷ Op. cit. note 1024
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460712/Discretionary_Leave_2_v7_0.pdf

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debated public health issue. On 1 October 2012, screening and treatment was made free to anyone in the UK, regardless of their residency status or of how long they have been in the UK.¹⁰²⁸

Treatment is to be provided to undocumented migrants living with HIV and to individuals diagnosed during a stay to the UK. The NHS also provides limited emergency access to treatment to short-term visitors living with HIV who, in the event of unforeseen circumstances, do not have their medication with them, until alternative arrangements are made.

Before 2004, free HIV (and any other chargeable) treatment was available for anyone who had spent the previous twelve months in the UK, whether it was legally or not.

In 2004, the rule was changed, so that the twelve months' residency had to be lawful, so HIV (and any other chargeable) treatment were available only to those legally living in the UK. This meant that short-term overseas visitors and undocumented migrants (such as failed asylum seekers or people who had not applied for legal residence) had to pay to receive antiretroviral HIV treatment through the National Health Service.¹⁰²⁹

However, a High Court case in April 2008 saw a judge declare that refusing free NHS treatment to failed asylum seekers was unlawful and a possible breach of human rights.¹⁰³⁰ In March 2009, this ruling was overturned and the Court of Appeal ruled that failed asylum seekers should not be

classified as ordinarily resident in the UK, meaning they were not entitled to free NHS treatment and care.

The 2012 change in policy was largely made because of the public health benefits of ensuring universal access to HIV treatment. Adherence to HIV treatment (or antiretrovirals) reduces the risk of HIV transmission and therefore prevents new HIV infections. It is hoped that the opportunity to access free HIV screening and treatment will make people more likely to be tested and find out their status.¹⁰³¹

¹⁰²⁸Regarding England: <http://www.aidsmap.com/HIV-treatment-and-care/page/2526102/>
Regarding Scotland: <http://www.legislation.gov.uk/ukxi/1989/364/made>
Regarding Wales: <https://www.welshrefugeecouncil.org/migration-information/legal-briefings/access-to-healthcare-for-migrants-in-wales>

¹⁰²⁹*The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations of 2004*, <http://www.legislation.gov.uk/ukxi/2004/614/contents/made>

¹⁰³⁰S. Boseley, "Asylum seekers have right to full NHS care, high court rules, but government considers appeal"; *The Guardian*, 2008, <http://www.theguardian.com/uk/2008/apr/12/immigration/publicservices>

¹⁰³¹<http://www.avert.org/hiv-treatment-uk.htm>

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NO (Health Centre for Undocumented Migrants - *Helsesenteret for papirløse migranter*) Frode Eick

RO (Carousel)

SE (Médecins du Monde Sweden – *Läkare i Världen*) Niclas Hell

SI (Slovene Philanthropy – *Slovenska Filantropija*) Helena Liberšar

TR (ASEM – *Association de Solidarité et d'entraide aux migrants*) Amadou Diallo; Ayse Lerzan Caner

UK (Doctors of the World) Lucy Jones – Anna Miller – Adam Hundt