LEGAL REPORT ON ACCESS TO HEALTHCARE IN 17 COUNTRIES


15 NOVEMBER 2016
# TABLE OF CONTENTS

**EXECUTIVE SUMMARY** ........................................................................................................... 6  
**ACRONYMS** ................................................................................................................................. 8  
**GLOSSARY** ................................................................................................................................... 12  
**BELGIUM** ..................................................................................................................................... 13  
  NATIONAL HEALTH SYSTEM ............................................................................................................. 13  
  CONSTITUTIONAL BASIS ................................................................................................................... 13  
  ORGANISATION AND FUNDING OF BELGIAN HEALTHCARE SYSTEM ........................................... 13  
  ACCESSING BELGIUM HEALTHCARE SYSTEM ................................................................................ 14  
  ACCESS TO HEALTHCARE FOR MIGRANTS ..................................................................................... 15  
  ASYLUM SEEKERS, REFUGEES AND THOSE ELIGIBLE FOR SUBSIDIARY PROTECTION ............... 15  
  UNDOCUMENTED MIGRANTS ............................................................................................................ 16  
  EU CITIZENS ..................................................................................................................................... 19  
  UNACCOMPANIED MINORS ............................................................................................................. 20  
  PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS .................................................................. 20  
  THE ADMISSIBILITY OF THE APPLICATION .................................................................................... 21  
  THE SUBSTANTIVE DECISION .......................................................................................................... 21  
  PREVENTION AND TREATMENT OF INFECTIOUS DISEASES .......................................................... 22  
**CANADA (QUEBEC)** ..................................................................................................................... 23  
  NATIONAL HEALTH SYSTEM ............................................................................................................. 23  
  ORGANISATION AND FUNDING OF CANADIAN HEALTHCARE SYSTEM ........................................ 23  
  ACCESSING CANADA HEALTHCARE SYSTEM .................................................................................. 23  
  ACCESSING QUEBEC HEALTHCARE SYSTEM .................................................................................. 24  
  ACCESS TO HEALTHCARE FOR MIGRANTS ..................................................................................... 25  
  ASYLUM SEEKERS AND REFUGEES ................................................................................................ 25  
  UNDOCUMENTED MIGRANTS ............................................................................................................. 29  
  UNACCOMPANIED MINORS ............................................................................................................. 32  
  ABORIGINALS IN QUEBEC ................................................................................................................ 32  
  PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS .................................................................. 33  
  TREATMENT OF INFECTIOUS DISEASES ......................................................................................... 34  
**FRANCE** ....................................................................................................................................... 35  
  NATIONAL HEALTH SYSTEM ............................................................................................................. 35  
  CONSTITUTIONAL BASIS .................................................................................................................. 35  
  ORGANISATION AND FUNDING OF FRENCH HEALTHCARE SYSTEM ........................................... 35  
  ACCESSING FRANCE HEALTHCARE SYSTEM .................................................................................. 36  
  UNIVERSAL MEDICAL COVERAGE: PUMA AND CMU-C ............................................................... 37  
  SUPPLEMENTARY HEALTH INSURANCE ASSISTANCE SCHEME: ACS ....................................... 38  
  THE FREE MEDICAL CENTRE SYSTEM (*PERMANENCE D’ACCES AUX SOINS – PASS*) .............. 39  
  POSITIVE REFORM ON ELIGIBILITY CRITERIA ............................................................................. 39  
  NEW HEALTHCARE BILL – JANUARY 2016 ...................................................................................... 40  
  ACCESS TO HEALTHCARE FOR MIGRANTS ..................................................................................... 40  
  ASYLUM SEEKERS AND REFUGEES ................................................................................................ 40  
  UNDOCUMENTED MIGRANTS ............................................................................................................. 42  
  EU CITIZENS ..................................................................................................................................... 44  
  UNACCOMPANIED MINORS ............................................................................................................. 45  
  PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS .................................................................. 45  
  PREVENTION AND TREATMENT OF INFECTIOUS DISEASES .......................................................... 47
<table>
<thead>
<tr>
<th>Country</th>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>GERMANY</td>
<td>National health system</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Organisation and funding German healthcare system</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Accessing Germany healthcare system</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Recent reforms</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Access to healthcare for migrants</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Asylum seekers and refugees</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Undocumented migrants</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Termination of pregnancy</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>EU citizens</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Unaccompanied minors</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Protection of seriously ill foreign nationals</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Prevention and treatment of infectious diseases</td>
<td>59</td>
</tr>
<tr>
<td>GREECE</td>
<td>National health system</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Constitutional basis</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Historical background</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Organisation and funding of Greek healthcare system</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Recent structural reforms of the healthcare system</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Functioning of Greek healthcare system</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Accessing Greece healthcare system</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Positive reform</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Access to healthcare for migrants</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Asylum seekers and refugees</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Undocumented migrants</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>EU citizens</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Unaccompanied minors</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Protection of seriously ill foreign nationals</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Prevention and treatment of infectious diseases</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Detention on public health grounds</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>HIV testing and treatment</td>
<td>68</td>
</tr>
<tr>
<td>IRELAND</td>
<td>National health system</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Accessing organisation and funding of Irish healthcare system</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Access to healthcare for migrants</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Asylum seekers and refugees</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Undocumented migrants</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>EU citizens</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Reciprocal health agreement</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Unaccompanied minors</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Protection of seriously ill foreign nationals</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Prevention and treatment of infectious diseases</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>Irish travellers: a national specific situation</td>
<td>80</td>
</tr>
<tr>
<td>EU CITIZENS</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>UNACCOMPANIED MINORS</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>PREVENTION AND TREATMENT OF INFECTIOUS DISEASES</td>
<td>114</td>
<td></td>
</tr>
</tbody>
</table>

**SLOVENIA** | 117 |
| NATIONAL HEALTH SYSTEM | 117 |
| CONSTITUTIONAL BASIS | 117 |
| ORGANISATION AND FUNDING OF THE SLOVENIAN HEALTHCARE SYSTEM | 117 |
| ACCESSING SLOVENIA HEALTHCARE SYSTEM | 118 |
| ACCESS TO HEALTHCARE FOR MIGRANTS | 121 |
| AUTHORIZED NON-EU RESIDENTS | 121 |
| ASYLUM SEEKERS | 121 |
| REFUGEES AND PERSONS UNDER INTERNATIONAL PROTECTION | 121 |
| UNDOCUMENTED MIGRANTS | 122 |
| TERMINATION OF PREGNANCY | 122 |
| EU CITIZENS | 123 |
| BILATERAL AGREEMENTS | 123 |
| UNACCOMPANIED MINORS | 123 |
| PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS | 124 |
| PREVENTION AND TREATMENT OF INFECTIOUS DISEASES | 124 |
| HEALTH CENTRES FOR UNINSURED PERSONS | 124 |

**SPAIN** | 126 |
| NATIONAL HEALTH SYSTEM | 126 |
| CONSTITUTIONAL BASIS | 126 |
| ORGANISATION AND FUNDING OF SPANISH HEALTHCARE SYSTEM | 126 |
| ACCESSING SPAIN HEALTHCARE SYSTEM AFTER 2012 ROYAL-DECREED | 126 |
| REFORM ENDING UNIVERSAL ACCESS TO CARE | 127 |
| CONSEQUENCES OF THE 2012 HEALTH REFORM IN SPAIN | 129 |
| ACCESS TO HEALTHCARE FOR MIGRANTS | 129 |
| ASYLUM SEEKERS AND REFUGEES | 129 |
| UNDOCUMENTED MIGRANTS | 130 |
| EU CITIZENS | 131 |
| UNACCOMPANIED MINORS | 132 |
| PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS | 132 |
| TREATMENT OF INFECTIOUS DISEASES | 132 |

**SWEDEN** | 135 |
| NATIONAL HEALTH SYSTEM | 135 |
| CONSTITUTIONAL BASIS | 135 |
| ORGANISATION AND FUNDING OF SWEDISH HEALTHCARE SYSTEM | 135 |
| ACCESSING SWEDEN HEALTHCARE SYSTEM | 136 |
| ACCESS TO HEALTHCARE FOR MIGRANTS | 137 |
| ASYLUM SEEKERS AND REFUGEES | 137 |
| UNDOCUMENTED MIGRANTS | 138 |
| EU CITIZENS | 140 |
| UNACCOMPANIED MINORS | 141 |
| PROTECTION OF SERIOUSLY ILL FOREIGN NATIONALS | 141 |
| PREVENTION AND TREATMENT OF INFECTIOUS DISEASES | 141 |

**SWITZERLAND** | 143 |
<p>| NATIONAL HEALTH SYSTEM | 143 |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>176</td>
</tr>
<tr>
<td>Access to Healthcare for Migrants</td>
<td>146</td>
</tr>
<tr>
<td>Asylum Seekers and Refugees</td>
<td>146</td>
</tr>
<tr>
<td>Documentation Migrants</td>
<td>147</td>
</tr>
<tr>
<td>EU citizens</td>
<td>148</td>
</tr>
<tr>
<td>Protection of Seriously Ill Foreign Nationals</td>
<td>149</td>
</tr>
<tr>
<td>Treatment of Infectious Diseases</td>
<td>150</td>
</tr>
<tr>
<td>Turkey</td>
<td>151</td>
</tr>
<tr>
<td>National Health System</td>
<td>151</td>
</tr>
<tr>
<td>Constitutional Basis</td>
<td>151</td>
</tr>
<tr>
<td>Towards Universal Health Coverage</td>
<td>151</td>
</tr>
<tr>
<td>Organisation and Funding of Turkish Healthcare System</td>
<td>151</td>
</tr>
<tr>
<td>Accessing Turkey Healthcare System</td>
<td>151</td>
</tr>
<tr>
<td>Access to Healthcare for Migrants</td>
<td>153</td>
</tr>
<tr>
<td>Authorised Residents</td>
<td>153</td>
</tr>
<tr>
<td>Asylum Seekers and Refugees</td>
<td>153</td>
</tr>
<tr>
<td>Documentation Migrants</td>
<td>155</td>
</tr>
<tr>
<td>Unaccompanied Minors</td>
<td>157</td>
</tr>
<tr>
<td>Protection of Seriously Ill Foreign Nationals</td>
<td>158</td>
</tr>
<tr>
<td>Prevention and Treatment of Infectious Diseases</td>
<td>158</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>159</td>
</tr>
<tr>
<td>National Health System</td>
<td>159</td>
</tr>
<tr>
<td>Organisation and Funding of British Healthcare System</td>
<td>159</td>
</tr>
<tr>
<td>The Concept of Ordinary Residence</td>
<td>160</td>
</tr>
<tr>
<td>Accessing the NHS</td>
<td>161</td>
</tr>
<tr>
<td>Access to Healthcare for Migrants</td>
<td>164</td>
</tr>
<tr>
<td>Asylum Seekers and Refugees</td>
<td>164</td>
</tr>
<tr>
<td>Documentation Migrants</td>
<td>165</td>
</tr>
<tr>
<td>EU citizens</td>
<td>166</td>
</tr>
<tr>
<td>Protection of Seriously Ill Foreign Nationals</td>
<td>167</td>
</tr>
<tr>
<td>Prevention and Treatment of HIV</td>
<td>168</td>
</tr>
<tr>
<td>Italy</td>
<td>169</td>
</tr>
<tr>
<td>Note Specific to this Section</td>
<td>169</td>
</tr>
<tr>
<td>National Health System</td>
<td>169</td>
</tr>
<tr>
<td>Constitutional Basis</td>
<td>169</td>
</tr>
<tr>
<td>Organisation and Funding of Italian Healthcare System</td>
<td>169</td>
</tr>
<tr>
<td>Accessing Italian Healthcare System</td>
<td>170</td>
</tr>
<tr>
<td>Access to Healthcare for Migrants</td>
<td>170</td>
</tr>
<tr>
<td>Documentation Migrants</td>
<td>170</td>
</tr>
<tr>
<td>EU citizens</td>
<td>173</td>
</tr>
<tr>
<td>Implementation of the National Health Legislation for Undocumented Migrants</td>
<td>174</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Working method
This legal report aiming to describe 17 national healthcare systems was written 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.

Asylum seekers and refugees
The last couple of years were characterized by a great arrival of migrants seeking asylum in Europe. Most of the destination countries provide at least basic healthcare to asylum seekers and refugees for free. In 8 states studied in the report, asylum seekers and refugees have the same access to healthcare as nationals of the country they reside in. In 7 countries, they have a less inclusive but extensive access to free healthcare.

Since 2015, 5 states adopted major laws affecting access to healthcare of asylum seekers and refugees.

EU citizens
In accordance with Directive 2004/38/CE, EU citizens are considered as “undocumented” after three months of stay in an EU country without health coverage and sufficient resources.

The care scheme for undocumented third-country nationals is not applicable to EU citizens without authorisation to reside in most of the EU countries, so they face even more barriers to access healthcare, except in Belgium and France.

Undocumented migrants
Undocumented migrants are the most excluded from access to healthcare. In the majority of countries, they can only access healthcare if they can cover its full price, except for emergency care which is free of charge.

As many as 4 of the studied states explicitly exclude undocumented migrants from their public healthcare systems in non-urgent cases. Only 3 states provide for some limited access to free healthcare beyond emergencies for undocumented migrants. Belgium and France are the only states with a specific health scheme for all undocumented migrants, even though they still remain separated from the mainstream national health scheme.

In 2015-2016, 5 countries adopted important legislations reforming their national health systems and/or immigration laws impacting undocumented migrants’ access to healthcare.

Yet, most of the laws restricting access to care for undocumented migrants stayed in place, as for instance the German law compelling civil servants to report undocumented migrants to the immigration authorities.

Pregnant women
Special provisions are made regarding pregnant women, who are in most states entitled to receive maternity care,

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1 Belgium (BE), Canada (CA), 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)
2 CH, ES, EL, FR, IE, NE, NO, TR
3 BE, CA, CH, DE, LU, SE, UK
4 CA, DE, LU, SE, TR
5 CH, IE, LU, SE, TR, UK
6 Canada and Romania do charge for emergency care
7 CA, EL (with exceptions since 2016), ES, LU
8 DE (access undermined by immigration laws), IT, SE
9 EL, FR
10 CH, TR, UK
independently of their administrative status. Indeed, they are considered a vulnerable group.

Pregnant asylum seekers and refugees are entitled to free prenatal and postnatal care and delivery in 13 of the 16 studied states. In the other studied countries, 3 offer some necessary maternity related care but not at all stages of the pregnancy.

Undocumented pregnant women can access maternity related care for free only in 8 countries.

As little as 3 countries provide termination of pregnancy for all women for free.

**Migrant children**

Children of undocumented parents benefit from a specific status giving them the same access as nationals of the country they reside in or at least an extensive access to healthcare in 9 of the studied states and 11 if they are unaccompanied. In the remaining, they are treated like undocumented adults and face great difficulties to access healthcare.

6 of the countries distinguish unaccompanied minors who seek asylum from those who do not, granting them a more extensive access to healthcare.

Isolated children in every country face distrust from the authorities, who question their minority. In cases of doubt, the migrant’s age is often determined through unreliable methods.

**Seriously ill foreigners**

In cases when treatment is unavailable in their country of origin, seriously ill foreigners may benefit from a temporary protection from expulsion or have the possibility to apply for a temporary residence permit. Yet, this is a possibility merely in half of the reviewed states. Only Canada opens the prospect for a permanent residence permit, though numerous conditions have to be fulfilled to obtain it.

**Prevention and treatment of infectious diseases**

The availability and gratuity of screening and treatment for HIV, Hepatitis, Tuberculosis, STIs and blood-borne infections varies greatly depending on the country.

Undocumented migrants can access screening of some or all infectious diseases in 6 countries only. Treatment is open and free to them in 6 countries as well.

**Conclusion**

Thus, despite some efforts made by the states, migrant’s access to healthcare remains widely insufficient. Even in countries opening their healthcare system to all residents, migrants, especially undocumented, face numerous obstacles undermining their access to care.

MdM calls on States to offer universal public health systems built on solidarity, equality and equity, open to everyone living on their territory.

We hope that this report will be a useful tool to all those working to improve access to healthcare for those facing multiple vulnerabilities.

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11 BE, CA, DE, EL, ES, FR, IE, NL, NO, SE, SI (only refugees), TR, UK
12 SI (asylum seekers), RO
13 BE, DE, ES, EL, FR, IT, RO, SE
14 BE, FR, SE
15 BE, DE, EL, ES, FR, IE (until 6 years old.), IT (until 14 years old), RO, SE
16 BE, CA, FR, EL, ES, IE, IT, LU, SE, RO, UK
17 CA, CH, LU, NL, NO, SI, TR, UK
18 CH, NL, NO, SI, UK
19 in BE, CH, DE, LU, NL, SI
20 in DE, ES, FR, IR, LU, NL, NO, SI, TR, UK + RO (extension of an existing permit only)
21 BE, CA, DE, EL, FR, IE
22 BE, DE, EL, FR, IE, NL
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC</td>
<td>Autonomous Community ES</td>
</tr>
<tr>
<td>ACS</td>
<td>Supplementary Health Insurance Assistance Scheme (Aide Complémentaire Santé)</td>
</tr>
<tr>
<td>ALD</td>
<td>Long-term chronic illnesses (Affection de Longue Durée)</td>
</tr>
<tr>
<td>AME</td>
<td>Medical Aid (Aide Médicale de l’Etat)</td>
</tr>
<tr>
<td>AMU</td>
<td>Urgent Medical Aid (Aide Médicale Urgente)</td>
</tr>
<tr>
<td>ARS</td>
<td>Regional Health Agencies (Agence Régionale de Santé)</td>
</tr>
<tr>
<td>ASE</td>
<td>Child welfare services (Aide Sociale à l’Enfance)</td>
</tr>
<tr>
<td>ASEM</td>
<td>Association for Solidarity and Support for Migrants</td>
</tr>
<tr>
<td>AufenthG</td>
<td>Residence Act DE</td>
</tr>
<tr>
<td>AsylbLG</td>
<td>Asylum Seekers’ Benefits Law DE</td>
</tr>
<tr>
<td>BBI</td>
<td>Blood-Borne Infections</td>
</tr>
<tr>
<td>BE</td>
<td>Belgium</td>
</tr>
<tr>
<td>BIM</td>
<td>Increased refund of the healthcare insurance (Bénéficiaire de l’Intervention Majorée)</td>
</tr>
<tr>
<td>BMA</td>
<td>State Medical Service NL</td>
</tr>
<tr>
<td>CA</td>
<td>Canada</td>
</tr>
<tr>
<td>CAAMI</td>
<td>Auxiliary Illness and Disability Insurance Fund (Caisse Auxiliaire d’Assurance Maladie-Invalidité)</td>
</tr>
<tr>
<td>CCAS</td>
<td>Communal Centre for Social Support (Centre d’Action Sociale)</td>
</tr>
<tr>
<td>CDAG</td>
<td>Free and anonymous testing centre (Centre de dépistage anonyme et gratuit)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group UK</td>
</tr>
<tr>
<td>CEPS</td>
<td>Economic Committee for Healthcare products (Comité Economique des produits de Santé)</td>
</tr>
<tr>
<td>CH</td>
<td>Switzerland</td>
</tr>
<tr>
<td>CHIH</td>
<td>County Health Insurance House</td>
</tr>
<tr>
<td>CHST</td>
<td>Canadian Health and Social Transfer CA</td>
</tr>
<tr>
<td>CESEDA</td>
<td>Code on Entry and Residence of Foreign Nationals and Right of Asylum (Code de l’entrée et du séjour des étrangers et du droit d’asile)</td>
</tr>
<tr>
<td>CIRE</td>
<td>Certificate of Incription in the Register of Foreign Nationals (Certificat d’Inscription au Registre des Étrangers)</td>
</tr>
<tr>
<td>CGIDD</td>
<td>Information centre for free testing and diagnosis of sexually transmitted infections (Centre gratuits d’information, de dépistage et de diagnostic)</td>
</tr>
<tr>
<td>CIDDIST</td>
<td>Information centre for testing and diagnosis of sexually transmitted infections (Centre d’information, de dépistage et de diagnostic des infections sexuellement transmissibles)</td>
</tr>
<tr>
<td>CLAT</td>
<td>Centre for Fighting Tuberculosis (Centre de...</td>
</tr>
<tr>
<td>Term</td>
<td>Acronym</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Lutte Anti Tuberculose</td>
<td>FR</td>
</tr>
<tr>
<td>CLSC</td>
<td>DH</td>
</tr>
<tr>
<td>Universal Medical Coverage</td>
<td>EEA</td>
</tr>
<tr>
<td>CMU</td>
<td>EL</td>
</tr>
<tr>
<td>Complementary Universal</td>
<td>EOPYY</td>
</tr>
<tr>
<td>Medical Coverage</td>
<td>EPIM</td>
</tr>
<tr>
<td>CMUc</td>
<td>ES</td>
</tr>
<tr>
<td>Central Agency for the</td>
<td>ESY</td>
</tr>
<tr>
<td>Reception of Asylum Seekers</td>
<td>NL</td>
</tr>
<tr>
<td>COA</td>
<td>EU</td>
</tr>
<tr>
<td>Medical Committee for Exiles</td>
<td>FADSP</td>
</tr>
<tr>
<td>COMEDE</td>
<td>FR</td>
</tr>
<tr>
<td>National Health Insurance</td>
<td>FARES</td>
</tr>
<tr>
<td>Fund for Salaried Workers</td>
<td>FOSS</td>
</tr>
<tr>
<td>(Caisse Nationale d’Assurance Maladie des Travailleurs Salarisés)</td>
<td>EU</td>
</tr>
<tr>
<td>CNS</td>
<td>FR</td>
</tr>
<tr>
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<td>LU</td>
<td>TR</td>
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<td>CPAM</td>
<td>BE</td>
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<tr>
<td>Primary Health Insurance</td>
<td>GP</td>
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<tr>
<td>Funds (Caisse Primaire</td>
<td>GKV</td>
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<tr>
<td>d’Assurance Maladie) FR</td>
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<td>CPAS</td>
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<td>the Child</td>
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<td>Germany</td>
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<td>Full Name</td>
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<tr>
<td>HAS</td>
<td>High Authority for Health (Haute Autorité de Santé) FR</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HTP</td>
<td>Health Transformation Programme CH</td>
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<td>IE</td>
<td>Ireland</td>
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<td>IFHP</td>
<td>Interim Federal Health Program CA</td>
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<td>IHC</td>
<td>Individual Healthcare Card ES</td>
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<td>IKA</td>
<td>Private Employees’ Fund NL</td>
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<td>INAMI</td>
<td>National Institute for Health and Disability Insurance (Institut National d’Assurance Maladie-Invalidité) BE</td>
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<td>Immigration and Naturalisation Service NL</td>
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<td>INSS</td>
<td>National Institute of Social Security NL</td>
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<td>IRB</td>
<td>Immigration and Refugee Board CA</td>
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<td>IT</td>
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<td>LAMal</td>
<td>Federal Law on Compulsory Healthcare CH</td>
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<td>LAsi</td>
<td>Asylum Law CH</td>
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<td>LETr</td>
<td>Federal Act on Foreign Nationals CH</td>
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<td>LFIP</td>
<td>Law on Foreigners and International Protection TR</td>
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<td>LU</td>
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<td>MARS</td>
<td>Doctor from the Regional Health Agency (Médecin de l’ARS) FR</td>
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<td>MdM</td>
<td>Doctors of the World (Médecins du monde – MdM)</td>
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<td>MSA</td>
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<td>MOI</td>
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<td>National Health Insurance Fund RO</td>
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<td>National Health Insurance House RO</td>
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<td>National Health System UK – SE</td>
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<td>NEF</td>
<td>Network of European Foundations</td>
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<td>NIS</td>
<td>National Insurance Scheme NO</td>
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<td>NL</td>
<td>Netherlands</td>
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<td>NO</td>
<td>Norway</td>
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<td>OAMal</td>
<td>Health Insurance Ordinance CH</td>
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<td>ODSE</td>
<td>Observatoire du Droit à la Santé des Étrangers FR</td>
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<td>OGA</td>
<td>Farmers’ Fund FR</td>
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<td>OLAI</td>
<td>Luxembourg Reception and Integration Agency (Office luxembourgeois de l’accueil et de l’intégration) LU</td>
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<td>ONSS</td>
<td>National Social Security Office (Office National de Sécurité Sociale) BE</td>
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<td>OPAD</td>
<td>Public Employees’ Fund EL</td>
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<td>PASS</td>
<td>Free Medical Centre (Permanence d’accès aux soins de santé) FR</td>
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<td>PCT</td>
<td>Primary Care Trust UK</td>
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<td>PHC</td>
<td>Primary healthcare EL</td>
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<td>PICUM</td>
<td>Platform for International Cooperation on Undocumented Migrants</td>
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<td>PKV</td>
<td>Private Health Insurance (Private Krankenversicherung) DE</td>
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<tr>
<td>PMI</td>
<td>Mother and child health centre (Protection maternelle et infantile) FR</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>PRAIDA</td>
<td>Regional Programme for the Settlement and Integration of Asylum Seekers (Programme Régional d’Accueil et d’Intégration des Demandeurs d’Asile) CA</td>
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<td>PUMA</td>
<td>Universal Medical Protection (Protection Maladie Universelle) FR</td>
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<td>RAMQ</td>
<td>Quebec’s health insurance board (Régime de l’Assurance Maladie du Québec) CA</td>
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<td>RHA</td>
<td>Regional Health Authorities NO</td>
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<td>RIZIV</td>
<td>National Institute for Health and Disability Insurance (Rijksinstituut voor ziekte- en invaliditeitsverzekering) BE</td>
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<td>RO</td>
<td>Romania</td>
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<td>RSI</td>
<td>Scheme for the self-employed (Régime Social des Indépendants) FR</td>
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<td>Slovenia</td>
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<td>SIDEP</td>
<td>Integrated services for screening and prevention CA</td>
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<tr>
<td>SMR</td>
<td>Therapeutic benefit evaluation system (Service Médical Rendu) FR</td>
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<td>SSI</td>
<td>Social Security Institution (Sosyal Güvenlik Kurumu) TR</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TLV</td>
<td>Dental and Pharmaceutical Benefits Agency SE</td>
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<td>TPS</td>
<td>Third-party Social Payment (tiers-payant social) LU</td>
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<td>Turkey</td>
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<td>UK</td>
<td>The United Kingdom</td>
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<td>UKBA</td>
<td>United Kingdom Border Agency UK</td>
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<td>UNCAM</td>
<td>National Union of Health Insurance Funds (Union Nationale des Caisses d’Assurance Maladie) FR</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children's Emergency Fund</td>
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<tr>
<td>VRGT</td>
<td>The Respiratory Healthcare and Tuberculosis Association (Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding) BE</td>
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<tr>
<td>ZZZS</td>
<td>Health Insurance Institute of Slovenia SL</td>
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Glossary

**EU migrants**

We call EU citizens who decide to move for any reasons to move from their EU country to live in another EU country: migrants.

**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”.

**Privately-sponsored refugees**

Canadian citizens and permanent residents can decide to provide additional opportunities for refugees living abroad to find protection and build a new life in Canada through the Private Sponsorship of Refugees (PSR) program. For further information, please see the guide about the PSR program here [http://www.cic.gc.ca/english/pdf/pub/ref-sponsor.pdf](http://www.cic.gc.ca/english/pdf/pub/ref-sponsor.pdf)

**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.

This system exists in BE – DE – ES (since 2012) – FR (except for CMU).

**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 their lifetime, so healthcare must be free for everyone.

This systems exists in UK – SE – NL – FR (CMU).

**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 applies to third-country nationals - although stricter rules need to be respected by the Member State – just as third-country nationals. In this document, we refer to this group as undocumented EU citizens.
BELGIUM

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 health care and to social, medical and legal aid”23.

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 based on the principles of equal access and freedom of choice (health providers, mutuals) for individuals with health coverage, with a Bismarckian type of compulsory national health insurance, which covers the whole population and has a very broad benefits package24.

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 Office25.

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-INAMI26.

For the general scheme for employed persons, the National Social Security Office (Office National de Sécurité Sociale – ONSS) 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” (mutuals) 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). The auxiliary fund is available for people who don’t wish to join one of the other mutuals.

The mutuals 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 transport27.

26 Op. cit. note 24
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 2010, which came into effect on 1 January 2012, individuals affiliated to one of the mutuals 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 (orthodontic treatments, homeopathic care, birth grants, etc.).

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. Moreover, the annual contribution may vary from one mutual health coverage fund to another, from €30 to €250.

An alternative for destitute people (provided they have permission to reside) is to be affiliated to the CAAMI, which costs €2.25 per year for the head of the family (dependent family members pay nothing). The CAAMI provides access to all services covered by the RIZIV-INAMI nomenclature, but not to any supplementary services.

31http://www.caami-riziv.fgov.be/tarieven-artsen-F.htm
33 Op. cit. note 31
34http://www.belgium.be/fr/sante/cout_des_soins/remboursements_specifiques/
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 nomenclature\(^35\), which lists over 8,000 partially or totally 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)\(^36\) and has also frozen the prices of essential drugs. Thus, six categories of drugs have been defined\(^37\).

### Access to healthcare for migrants

**Asylum seekers, refugees and those eligible for subsidiary protection**\(^38\)

The 2007 law on the reception of asylum seekers and other categories of foreign nationals and stateless people\(^39\) 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 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 conditions of 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 INAMI nomenclature but which are needed in everyday life. These services are listed in the royal decree of 9 April 2007\(^40\) and include:

- Orthodontics
- Investigation and treatment of infertility
- Dentures, when there is no chewing problem
- Cosmetic procedures, except reconstruction after surgery or trauma
- Dental care under general anaesthesia

It is to be noted that the CPAS hosting asylum seekers are only reimbursed for medical care following the nomenclature, cost of D medication, whatever aid mechanism they benefit from.

\(^35\) [http://www.inami.fgov.be/fr/nomenclature/nomenclature/Pages/default.aspx#.VL5oNkeG_94](http://www.inami.fgov.be/fr/nomenclature/nomenclature/Pages/default.aspx#.VL5oNkeG_94)

\(^36\) 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_docs/KCE_186B_determination_ticket_moderateur_synthese_second_print_0.pdf](https://kce.fgov.be/sites/default/files/page_docs/KCE_186B_determination_ticket_moderateur_synthese_second_print_0.pdf)

\(^37\) 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 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

\(^38\) 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.

\(^39\) [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)

\(^40\) [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)
thus, medical care not included in it will not be reimbursed to the CPAS.\(^{41}\)

While living in a reception centre, asylum seekers’ medical expenses are normally covered by Fedasil or one of its reception partners. If they don’t live in a centre (“no shows”)\(^{42}\), 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”\(^{43}\). They receive a Certificate of Registration in the Register of Foreign Nationals (Certificat d’Inscription au Registre des Étrangers – CIRE) which remains valid for one year and is renewable on request\(^{44}\). The CIRE gives them entitlement to health insurance under the RIZIV-INAMI scheme\(^{45}\).

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\(^{46}\).

### 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) specified in the Royal Decree of 12 December 1996 relating to “urgent medical assistance granted by the CPAS to foreign nationals residing in Belgium illegally”\(^{47}\). Despite its name, AMU 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\(^{48}\) is subject to four conditions. The individual must:

- Be an undocumented migrant
- 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 CPAS.

The CPAS must check whether the claimant is undocumented, regardless of how they 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 CPAS to another.

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\(^{41}\) [www.medimmigrant.be/?idbericht=24&idmenu=2&lang=fr]

\(^{42}\) Asylum seekers who are not living in a reception structure are called “no shows”.


\(^{44}\) Ibid.

\(^{45}\) Op. cit. note 39

\(^{46}\) Op. cit. note 41


\(^{48}\) [www.medimmigrant.be/?idbericht=50&idmenu=3&lang=fr]
The circular of 25 March 2010 on the social investigation required for the reimbursement of medical charges specifies that each CPAS must understand how it can establish the destitute situation of the claimant. On this point, the law is not sufficiently precise and leaves room for arbitrary treatment.

In addition, the Law of 30 December 2009, states that in the case of AMU 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 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”.

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

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

In practice, this freedom concerning assessment at the discretion of each 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 live.

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 from submitting a request to benefit from it. Furthermore, for example, a CPAS, such as the one in Antwerp, can often refuse AMU due to applicants’ alleged refusal to collaborate with the social investigation.

If all these conditions are fulfilled, the claimant may benefit from healthcare coverage (AMU). The parameters of this coverage, such as the period for which AMU is granted (ranging from one consultation to one year for chronically ill patients), which (local) healthcare providers can be consulted and how to ask a healthcare provider for care or treatment are defined by the specific CPAS concerned.

Overall, once an undocumented migrant is entitled to AMU, their healthcare expenses will be directly reimbursed to healthcare providers by the CPAS or the federal authorities, except for those which do not have a RIZIV-INAMI nomenclature code.

Healthcare providers can refuse to treat an undocumented migrant who has a medical card granted from a CPAS in another

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51 Ibid.
52 European Union Agency for Fundamental Rights (FRA), Migrants in an irregular situation: access to healthcare in 10 European Union Member States, Luxembourg, 2011.
region, because the CPAS might not reimburse the costs of care. If a person makes an appointment with a doctor before receiving the certificate from the CPAS, they must pay for the appointment themselves and the CPAS often refuses to reimburse the costs because it did not agree to the appointment and had not yet granted AMU. Some 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.

Undocumented pregnant women

As mentioned above, the Royal decree refers to “urgent care”, a term that might well be misleading as the AMU 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. However, the same barriers apply for pregnant women and children as for other AMU claimants.

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 and the Kind en Gezin). Access to Community-financed postnatal consultations is free of charge for all women, even without AMU coverage.

Certain CPAS, often due to unwillingness or lack of awareness, impede access to health services for undocumented migrants, including pregnant women, refusing to grant AMU. For instance, the social welfare centre of Antwerp, the country’s second biggest city, has for many years been extremely restrictive in its interpretation of national law.

However, since May 2012, a platform of local healthcare workers and organisations, migrant and medical NGOs as Doctors of the World – Médecins du Monde (MdM), as well as academics, has negotiated a partnership with this local welfare centre, in order to ensure that all pregnant women get early access to antenatal care. As a result, the welfare centre has designated two contact persons who should be able to provide antenatal and postnatal welfare follow-up for undocumented women.

With regard to pregnancy termination, this is a service covered by AMU. However, pregnant women must respect the legal period of 12 weeks of pregnancy for termination, even though the CPAS response to the AMU application usually comes one month later. In practice, between the pregnancy being certified and AMU being granted, those 12 weeks have already passed.

Therefore, pregnant women usually prefer to try and find the money for the termination and pay it directly to the practitioner, whereas they should be covered by the AMU scheme.

If they succeed in being covered by AMU, they pay €1.72 for the preliminary examination and €1.72 for the medical procedure. For pregnant women who do not have health coverage, termination of pregnancy costs €460.

Children of undocumented migrants

The Royal Decree of 12 December 1996 includes children in AMU. They are entitled to the same healthcare as undocumented migrants.

http://files.nowhereland.info/706.pdf
adults. They must obtain AMU in order to gain access to curative healthcare.

As regards preventive healthcare, everyone has free access to vaccinations through the Birth and Childhood Office (the Office de la Naissance et de l’Enfance and the Kind en Gezin) but only until the age of six. After the age of six, they must obtain AMU like adults for all curative and preventive care.

**EU 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 CPAS, this right remains merely theoretical, as EU citizens are faced with several administrative barriers.

The Law of 19 January 2012\(^58\) confirmed the practices of a majority of CPAS: access to healthcare for destitute EU migrants was restricted. This law, modifying legislation relating to the reception of asylum seekers, adds Article 57quinquies to the Organic Law of 8 July 1976\(^59\) relating to 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 2014\(^60\), 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 CPAS to refuse AMU 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 to CPAS, whereas extra-European undocumented migrants in Belgium can benefit from AMU. This judgment is directly binding and so partially abolished the interpretation of Article 57quinquies of the Law of 8 July 1976 modified by the Law of 19 January 2012.

Since then, a circular of 5 August 2014\(^61\) has been adopted in order to warn CPAS presidents about the new interpretation of Article 57quinquies.

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

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

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\(^61\) Circular of 5 August 2014, [http://www.eujustice.just.fgov.be/cgi_loi/loi_a1.pl?sql=%28text%20contains%20%27%27%27%27%29%29%20&language=fr&rech=1&tri=dd%20AS%20RANK&value=&table_name=loi&F=&cn=2014080501&caller=image_a1&fromtab=loi&la=F](http://www.eujustice.just.fgov.be/cgi_loi/loi_a1.pl?sql=%28text%20contains%20%27%27%27%27%29%29%20&language=fr&rech=1&tri=dd%20AS%20RANK&value=&table_name=loi&F=&cn=2014080501&caller=image_a1&fromtab=loi&la=F)
Therefore, in the light of this judgment, EU migrants in Belgium must have access to AMU during the first three months of their stay.

So, pregnant women and children who are EU citizens should have access to AMU as other undocumented migrants. As discussed above, undocumented migrants are already facing issues in accessing AMU. Thus, it seems to be very complicated for pregnant women to gain access to antenatal and postnatal care and for children to gain access to vaccination after the age of six.

Access to termination of pregnancy for pregnant EU women seems nearly impossible. For the first three months of their stay they are considered as tourists: they exceed the legal period of 12 weeks and then do not have access to termination. Their only option is to travel to the Netherlands, where the legal period for pregnancy termination is set at 24 weeks, if the woman is in distress, and pays for a termination out of her pocket.

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 that for unaccompanied EU minors.

As a result of the Constitutional Court’s judgment of 18 July 2013, the law of 12 May 2014 was adopted and modified the Programme Law of 24 December 2002. 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.

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.

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.

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Indeed, according Article 9ter of the Law of 15 December 1980 on access to Belgium, residence, establishment and return of foreign nationals, “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 a substantive decision is taken by the Immigration Office. This card does not entitle the holder to access a health insurance fund or employment. However, the holder can request AMU from the CPAS of their place of residence.

### 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 residence permit enables the holder to join a health insurance fund, to access the labour market and to benefit from social assistance from the 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 Étrangers).

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66 Op. cit. note 65

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 is suspensive. It means that seriously ill foreign nationals who appeal the decision must still benefit from AMU and can stay in Belgium during the appeal.

\textbf{Prevention and treatment of infectious diseases}

The Royal Decree of 1 March 1971\textsuperscript{68} on the prevention of contagious diseases covers the list of notifiable diseases on Belgian territory.

The Respiratory Diseases Fund (\textit{Fonds des Affections Respiratoires} – \textit{FARES}) and the Respiratory Healthcare and Tuberculosis Association (\textit{Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding} – \textit{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. Concerning AMU, the regular barriers apply: being able to provide a residential address and all the possible documents a CPAS might demand during its social investigation, etc.

In recent years, the MdM Antwerp team and their partners have observed undocumented pregnant women who have failed to overcome these hurdles, despite having a chronic illness.

\textsuperscript{67}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).

\textsuperscript{68}Royal decree of 1 march 1971


National Health System

Healthcare in Canada is a publicly funded system, unofficially called “Medicare”. It is guided by the Canada Health Act of 1984, but largely determined by the Constitution of Canada in which roles and responsibilities are divided between the federal, provincial and territorial governments.

This is a mixed public-private system that provides health coverage to all Canadian citizens and permanent residents (some provinces such as Quebec enforce a waiting time of three months for newly arrived permanent residents). Indeed, almost all healthcare services are delivered by the private sector and the public sector is responsible for financing those services.

Publicly funded healthcare is financed with general revenue raised at federal, provincial and territorial levels. The federal government provides funding to provinces and territories for healthcare services through fiscal transfers via the Canadian Health and Social Transfer (CHST). Transfer payments are made as a combination of tax transfers and cash contributions from the government.

The federal government’s role in healthcare is to establish and implement national principles for the system under the Canada Health Act to provide financial support to provinces and territories and fulfil several other functions, including financing and providing primary and supplementary services to certain groups of people. These groups include First Nations people living on reserves, Inuit, Canadian Armed Forces, eligible veterans, inmates in federal penitentiaries and some refugee groups of applicants.

Instead of having a single national plan, Canada’s healthcare programme is made up of provincial and territorial health insurance plans, all of which share certain common features and standards such as “their universality and their accessibility”.

Accessing Canada healthcare system

To be covered by Canada’s healthcare system involves first applying for a provincial health insurance card. The Canada Health Act requires all residents of a province or territory to be accepted for health coverage, excluding prison inmates, the Canadian Armed Forces and certain members of the Royal Canadian Mounted Police.

Thus, new residents in a particular province must apply for health coverage. Upon being granted it, a health card is issued which provides health coverage in that particular province or territory.

However, the main constraint for new residents is the waiting period that generally takes three months before health coverage will be granted. Thus, during this waiting period, new residents have to pay out of pocket to have access to healthcare, even for emergency care (some exceptions apply; there are exceptions to the application of this waiting period for services related to pregnancy, delivery, termination of pregnancy; necessary services to victims of domestic or family violence, or sexual assault; services needed by individuals with infectious diseases that affect public health.)

69 Health Act – 1984
70 http://www.hc-sc.gc.ca/index-eng.php
73 http://www.canadian-healthcare.org/
74 Ibid.
75 This period varies according to the beneficiary. There are exceptions to the application of this waiting period for services related to pregnancy, delivery, termination of pregnancy; necessary services to victims of domestic or family violence, or sexual assault; services needed by individuals with infectious diseases that affect public health.
Under the healthcare system, citizens and permanent residents are provided with preventive care and medical treatments from primary care physicians, as well as with access to hospitals and additional medical services. In addition to standard health coverage as described in the Canada Health Act, provinces may provide additional services which can include physiotherapy care, dental care and some medicines. The province of Quebec does not provide dental care nor vision care except to certain groups of the population, mainly beneficiaries of last resort social assistance schemes.

Most provincial and territorial governments offer and fund supplementary benefits for certain groups, especially low-income residents, such as drugs prescribed outside hospitals, ambulance costs, and hearing, vision and dental care that are not covered under the Canada Health Act.

The public health insurance plan aims to deliver free medical services in public hospitals and local community service centres to RAMQ’s beneficiaries. Individuals covered by public health insurance have to present their health insurance card to benefit from free coverage. If a person with health coverage does not present their health insurance card or if the card has expired, they must pay for the healthcare services they receive and then apply to Quebec’s health insurance board for a reimbursement.

People arriving from another province to take up residence in Quebec become eligible for the Quebec Health Insurance Plan when they cease to be covered by the plan of their province of origin. As authorised residents settling in Quebec, nationals have to wait three months during which they can benefit freely from some services.

For as long as they remain covered by the health insurance plan of their former province, they must present their health insurance card from that province when receiving healthcare from a doctor in Quebec. The health insurance plan of their former province will cover the costs. However, if the Quebec doctor does not accept that card, they will have to pay the doctor’s fees and then apply for a refund with the organisation administering the health insurance plan of their province of origin. In Quebec, a general practitioner’s consultation fees vary from €50 to €400. Indeed, GPs have the discretion to charge any amount for their services. Often, the fee is a lot higher for people not covered by the RAMQ.

If an individual is covered by public or private health insurance, they do not pay

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76 Op. Cit. note 73  
77 Op. Cit. note 73  
78 Op. cit. note 71  
79 Op. cit. note 71  
81 Ibid.  
82 Op. cit. note 80  
83 Op. cit. note 80
doctor’s fees in advance. Instead, the doctor charges Quebec’s health insurance board directly. However, if an individual has no health coverage, s/he has to pay doctor’s fees.

The prescription drug insurance plan has been compulsory for everyone in Quebec since 1997. Indeed, they must be covered by prescription drug insurance, either through the public plan or by private plans. The private plans are usually available in the form of group insurance or employee benefit plans. Individuals may be eligible for a private plan through employment, membership of a professional order or association, their spouse or parents. Individuals admissible to a private plan have to join a private insurance. Anyone who is not eligible for private plans has to join the public plan administered by Quebec’s health insurance board.

People insured with a private plan must pay a premium, whether or not they purchase prescription drugs. In most cases, they pay the premium in the form of regular payroll deductions throughout the year.

Generally speaking, people covered by the public plan must pay a premium (between €0 and €660 from 1 July 2016 to 30 June 2017), whether or not they purchase prescription drugs.

Certain people covered by the public health coverage plan do not pay a premium. These include:

- individuals aged 65 or over receiving 94% to 100% Guaranteed Income Supplement (GIS);
- holders of a claim slip and their children under the age of 18;
- new-born children whose parents are covered by the public plan.

**Access to healthcare for migrants**

**Asylum seekers and refugees**

Individuals who are Quebec residents and who have been granted refugee status are qualified for RAMQ and thus have the same access to healthcare as nationals and authorised residents.

On the national level, refugees and asylum seekers are covered by the Interim Federal Health Program.

**Interim Federal Health Program (IFHP)**

The primary purpose of this programme is to provide limited, temporary coverage of health-care costs for specific groups of people, such as protected persons,

covered by the claim slip, which includes drugs, optometric services, dental services and acrylic dentures, are not accessible to asylum seekers because they have no access to the RAMQ services. A claim slip may also be issued to people whose income exceeds the amount of recognized needs, but is insufficient to cover the drugs they need.
asylum seekers, rejected refugee claimants before their expulsion date\(^{92}\), etc.

For the following groups of beneficiaries, the IFHP also covers the cost of one Immigration Medical Exam (IME): asylum seekers, ineligible refugee claimants, victims of human trafficking, and detainees.

The Minister of Immigration, Refugees and Citizenship has discretion to provide full or partial coverage of health-care costs to individuals not eligible for IFHP coverage who face exceptional circumstances\(^{93}\).

On 1 April 2016, the IFHP was restored to pre-2012 levels of coverage for all beneficiaries, which are similar to health-care coverage provided by health insurance plans in Quebec\(^{94}\).

Basic coverage includes:

- in-patient and out-patient hospital services
- services provided by medical doctors, registered nurses and other health-care professionals licensed in Canada, including pre- and post-natal care
- laboratory, diagnostic and ambulance services

Supplemental coverage includes:

- limited dental and vision care
- home care and long-term care
- services provided by allied health-care practitioners including clinical psychologists, occupational therapists, speech language therapists, physiotherapists
- assistive devices, medical supplies and equipment

IFHP also covers most prescription medications and other products listed on provincial/territorial public drug plan formularies and, for most categories of beneficiaries, the cost of one Immigration Medical Exam and IME-related diagnostic tests required under the Immigration Refugee Protection Act.

The benefits covered by the IFHP are limited to maximum amounts per service\(^{95}\).

As for the duration of the coverage, for asylum seekers, basic, supplemental and prescription drug coverage continues until the beneficiary withdraws his asylum claim or becomes eligible for provincial or territorial health insurance or, if the application for asylum is refused, until the applicant’s deportation date. For refugees, basic, supplemental and prescription drug coverage is provided for 90 days from the date the asylum claim or PRRA is accepted, or until they become eligible for provincial or territorial health insurance\(^{96}\).

Since 10 April 2016, the former twelve month expiry date on coverage for refugee claimants has been eliminated. Consequently, individuals eligible to be referred to the Immigration and Refugee Board (IRB) as a refugee claimant or whose claim has been found ineligible to be referred to the IRB but who are eligible to apply for a pre-removal risk assessment,
will no longer need to apply to extend their coverage every 12 months\textsuperscript{97}. 

The 2016 IFHP policy which started its implementation on 1 April 2016 also provides that, starting no later than 1 April 2017 refugees destined to Canada for resettlement will also be eligible, prior to arrival, for coverage of pre-departure medical services, including immigration medical examinations and follow-up treatment of health conditions that would make an individual inadmissible to Canada under paragraph 38(1)(a) of the Immigration and Refugee Protection Act\textsuperscript{98}, communicable disease prevention and control (vaccinations), outbreak management and control, and medical support required during transit for safe travel\textsuperscript{99}.

It should be noted that, in theory, the IFHP beneficiaries do not have to pay for medical consultations in advance. In practice, medical doctors usually make them pay because the reimbursement process is particularly complex or because they are not aware of the recent reform.

IFHP beneficiaries who pay doctor’s fees in advance, contrary to RAMQ beneficiaries who can be reimbursed by the government if they forget their health card, cannot be reimbursed if they forgot their IFHP document or if it has expired.

In general, asylum seekers have to deal with many issues regarding access to healthcare even if they are eligible for the IFHP. Indeed, it often happens that doctors and hospitals refuse to treat individuals with a valid IFHP or require payment in advance.

### Pregnant asylum seekers

Pregnant women seeking asylum are entitled to the IFHP which covers prenatal care, the delivery of the child and postnatal care.

### Children of asylum seekers

Children eligible for the IFHP who are less than 19 years old or older and unable to be financially self-sufficient due to a physical or mental condition, are entitled to the same health coverage as adult asylum seekers. This coverage includes vaccination.

In Quebec, children under 10 whose parents are resettled refugees are entitled to the same dental services as Quebec children, through RAMQ\textsuperscript{100}.

### Previous reforms

#### IFHP reforms background

On 30 June 2012, changes were applied to the IFHP by the federal government, which considerably limited access to healthcare for groups concerned by the IFHP\textsuperscript{101}.

This reform impacted in particular rejected refugee claimants and refugee claimants from designated “safe” countries of origin (DCO)\textsuperscript{102}, including those whose initial claims have been rejected and still had appeal options. They were not eligible to basic healthcare, including emergency care\textsuperscript{103}. They only had access to healthcare or medications if these were required to

\textsuperscript{97}http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/treatment.asp
\textsuperscript{98} Op. cit. note 91
\textsuperscript{99} Op. cit. note 92
\textsuperscript{100}http://refugeehealth.ca/sites/default/files/IFHP.pdf
\textsuperscript{102}List of countries http://www.cic.gc.ca/english/refugees/reform-safe.asp
prevent or treat a disease posing a risk to public health.\(^{104}\)

However, some people could be granted special dispensation for health services at the discretion of the Immigration Minister,\(^{105}\) in very rare and exceptional circumstances.

However, after the cuts in 2012, Quebec decided to cover free of charge all health services which were no longer covered by the federal government. Thus, in Quebec, refugee claimants, privately-sponsored refugees or rejected claimants until the date of expulsion had access to the same healthcare as before the 2012 reform.

In July 2014, a legal challenge launched on the basis of a violation of the Charter of Rights and Freedoms was successful. The Federal Court ruled that “the changes to the IFHP constitute cruel and unusual treatment of a poor, vulnerable and disadvantaged group by the executive branch of the Canadian government [...] This is particularly, but not exclusively so as it affects children who have been brought to this country by their parents.”\(^{106}\)

The federal government was enjoined to reinstate the original programme.\(^{107}\) The new government, elected in 2015 did re-establish access to healthcare and medications through IFHP for children, pregnant women and asylum seekers from designated countries of origin, before completely going back to the former system in 2016.

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\(^{104}\) Ibid.

\(^{105}\) Op. cit. note 89

\(^{106}\) Canadian Doctors for Refugee Care, the Canadian Association of Refugee Lawyers, Daniel Garcia Rodrigues, Hanif Ayubi and Justice for Children and Youth v Attorney General of Canada and Minister of Citizenship and Immigration, 2014, Federal Court

\(^{107}\) Op. cit. note 86

\(^{108}\) Bill C-31

Bill C-31 is an Act to amend the Protecting Canada’s Immigration System Act that was introduced in the House of Commons on 16 February 2012. Asylum seekers whose claims for protection are deemed eligible have to be heard by the Immigration and Refugee Board of Canada, a quasi-judicial federal body. It often takes up to six weeks. Following this initial interview with an immigration officer, claimants for refugee protection have to proceed to a hearing before a panel of the Immigration and Refugee Board’s Refugee Protection Division. If the initial claim is refused, the refugee claimant can appeal the decision at the Refugee Appeal Division and for judicial review of the Federal Court of Canada. Unsuccessful claimants are sometimes detained before being removed from Canada.

While some of the IFHP cuts have been reversed, Bill C-31 implies that individuals making inland claims are not considered to have an active refugee claim until their interview, leaving them without access to health insurance or services such as social assistance for at least six weeks.

Under the pretext of efficiency and fairness, the bill allows for differentiation between groups of refugee claimants who are then subject to different treatment.\(^{109}\) Therefore, access to healthcare depends on the processing of the application for each group. This bill had a particularly negative impact while the government cut off access to healthcare through the IFHP. It alarmed and confused refugee claimants regarding their access to healthcare.

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\(^{109}\) Statutes of Canada 2012, Chapter 17 2012,
http://www.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_lsz.asp?ls=c31&Parl=41&Ses=1
In Quebec, undocumented migrants have no access to public healthcare. Any emergency care they may receive is at their own expense.

Moreover, families with some members who do not have legal status (e.g., Canadian children whose parents lack legal status) may also renounce to seek care for administrative reasons; for fear that the parents’ immigration status could be exposed or for fear of being reported, detained and threatened with expulsion from Canada.

In addition, the Federal Court of Appeal’s 2011 decision in Nell Toussaint v Attorney General of Canada and the Canadian Civil Liberties Association determined that an undocumented immigrant was properly excluded from a federal health insurance programme and held that benefits under that program were only available to a narrow class of residents and a limited number of undocumented migrants within the control and jurisdiction of the Canadian immigration authorities.

In practice, there is no overarching legal duty in Canada for doctors in clinics or hospitals to treat patients, under some circumstances, namely emergency care.

Several legislative provisions in Quebec indicate a doctor’s duty to treat a patient, particularly where the person is in life-threatening circumstances. In the Quebec Charter of Human Rights and Freedoms, there is a civil duty “to rescue.” According to an Act Respecting Health Services and Social Services, a person entering a healthcare facility “whose life or bodily integrity is endangered is entitled to receive the care required by his condition.” Quebec’s Code of Ethics for doctors also obliges them to “come to the assistance of a patient and provide the best possible care when [they have] reason to believe that the patient has a condition that could entail serious consequences if immediate medical attention is not given.”

Moreover, the act on health services and social services adopted in 1991 states in Article 7 that “every person whose life or bodily integrity is endangered is entitled to receive the care required by his/her condition. Every institution shall, where requested, ensure that such care is provided.”

113 Ibid.
114 Charter of Human Rights and Freedoms, RSQ c C-12, s 2, provides that “[e]very person must come to the aid of anyone whose life is in peril, either personally or calling for aid, by giving him the necessary and immediate physical assistance, unless it involves danger to himself or a third person, or he has another valid reason.”
117 Op. cit. note 115
Articles 513 and 515 of the same act deal with users’ contributions. Article 513 establishes that, “The amount of the contribution may vary according to the circumstances or needs identified by regulation. The contribution shall be required by an institution or by the Minister. The users themselves are bound to pay it [...]”. Article 515 mentions that “the government may prescribe a financial contribution which varies according to whether the user or person of whom payment of the financial contribution may be required is or is not resident in Quebec, and define, for that purpose, the expression ‘resident in Quebec’.”

In addition, there are internal regulations in healthcare facilities and other guidelines pertaining to billing in public hospitals which impede undocumented migrants from having access to healthcare.

Finally, a large number of complaints have been lodged regarding the billing of individuals without health coverage. The college of general practitioners and the college of specialist physicians encourage their members to charge up to three times the usual price\(^{118}\).

Thus, even though there is a generally accepted understanding that doctors in Quebec are under a legal obligation to treat patients in case of emergency, they do not hesitate in practice to charge high fees to undocumented migrants. Since the law does not specify the amount of health costs, healthcare facilities and practitioners may arbitrarily determine them.

**Undocumented pregnant women**

In Quebec, the cost of healthcare is very high for anyone without a valid health insurance card. A gynaecological consultation can cost as much as €350; on top of that is added the cost of blood tests, ultrasounds and any other tests required to ensure the health of the mother and child\(^{119}\).

The average bill for delivery services ranges from €2,800 to €12,000 per consultation, depending on the institution, but fees are often higher if there are complications and if more complex medical attention is needed\(^{120}\).

This amount includes hospital fees for the mother (between €1,700 and €5,800 per day, depending on the hospital) and the baby (between €280 and €830 per day), as well as the doctor’s fees (amount freely determined by the doctor, usually between €1,000 and €2,000). For women who need it, an epidural adds between €140 and €1,000 to the bill, the price being determined by the doctor\(^{121}\). These costs are a direct obstacle to healthcare services that are essential to maternal health.

Furthermore, some hospitals require pregnant women to pay all or part of these amounts before delivery\(^{122}\). This leads women to seriously consider home delivery, to renounce antenatal care and to seek care in the hospital at the last moment and deliver as emergency care.

The constant fear of being reported to the immigration authorities and expelled is

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\(^{118}\) Our teams are working on it and are collecting official documents about this controversy.


\(^{120}\) Ibid.

\(^{121}\) Op. cit. note 99

another significant barrier in accessing healthcare\textsuperscript{123}.

For women who can afford medical fees, they most often have to leave the hospital within an hour or a few hours after giving birth because they do not have the means to pay for an extra night or day\textsuperscript{124}. In some cases, this leads to medical complications that could have been avoided\textsuperscript{125}.

As for pregnancy termination\textsuperscript{126}, undocumented women have to pay 100\% of the services. The price varies according to the stage of pregnancy. By way of indication, women without health coverage, including undocumented women, have to pay:

\begin{itemize}
  \item between €277 and €485 until the 13\textsuperscript{th} week of pregnancy
  \item between €485 and €555 until the 16\textsuperscript{th} week of pregnancy
  \item between €485 and €692 until the 20\textsuperscript{th} week of pregnancy
  \item €1,177 until the 23\textsuperscript{th} week of pregnancy
\end{itemize}

\textbf{Children of undocumented migrants}

The children of undocumented migrants, even when born in Canada (thus immediately obtaining Canadian citizenship) face many issues regarding access to healthcare. Thus, although Canadian-born children should have the right to access the same healthcare services as any other Canadian citizen, they often experience challenges in getting coverage due to their parents’ status.

If one of the parents has RAMQ, the child has the right to a RAMQ card from birth.

If one of the parents is in a status regularisation process (e.g. application for permanent residency), the child also has the right to a RAMQ card from birth.

In these cases, even if children are born in Canada and qualify for provincial coverage, parents often find it difficult to obtain documentation or fear the consequences that seeking healthcare might have on their immigration status.

Finally, if both parents do not have access to RAMQ and are not waiting for the decision to a permanent residency application at the federal level, the child does not have the right to be covered by the RAMQ.

Even though the Canadian courts have consistently recognised that most provisions of the Canadian Charter of Rights and Freedoms\textsuperscript{127}, including the equality rights guaranteed by Section 15, apply to non-citizens present on Canadian territory, there is no law giving free access to vaccination if children are not eligible for the RAMQ. Moreover, in practice, policies and government procedures restrict access to healthcare for many children.

Indeed, there are important barriers regarding the access to free vaccination for children without health coverage, who include undocumented migrants, but also children born to parents with visitor or student visas. Children are denied access to free vaccination in the local community service centres in their neighbourhood (\textit{Centre Local de Services Communautaires – CLSC}). These centres are in charge of giving free vaccines to children after birth. According to the Doctors of the World – Médecins du Monde Canada (MdM CA) team, there is no consistency in the gratuity of the vaccines: some CLSC offer the

\textsuperscript{123} Ibid.
\textsuperscript{124} Op. cit. note 122
\textsuperscript{125} Op. cit. note 122
\textsuperscript{126}http://www.educaloi.qc.ca/en/capsules-abortion-no-legal-time-limits
vaccines for free, some charge a small fee, some ask for a fee up to €100.

For parents who don’t have access to RAMQ, the only way to access free healthcare for their Canadian-born children is through a permanent residency application at the federal level. While the application is still being processed, their children will be eligible for the RAMQ. If the application is refused, the children will be able to keep their coverage until it’s expiration. If the parents are still not admissible for RAMQ and are not waiting for permanent residency at the federal level when the card expires, then the parents won’t be able to renew their child’s RAMQ card. It should be noted that many parents are afraid to take their children to apply for the RAMQ or to be vaccinated in a CLSC.

Unaccompanied minors

Generally speaking, unaccompanied minors are regarded as “people to protect”, making them eligible for the IFHP. Thus, they have the same access to healthcare as asylum seekers and refugees, which includes access to free vaccination.

PRAIDA is a specialist centre that supplies healthcare, medical services and assistance to unaccompanied minors. Indeed, this regional programme is responsible for them from their arrival until they become permanent residents.

Unaccompanied minors seeking asylum in Canada have, in general, a lower rate of success in their asylum claims than accompanied children or adults. However, they also have a lower expulsion rate.

Aboriginals in Quebec

The term “Aboriginal” refers to the first peoples of North America and their descendants. The Canadian Constitution recognises three groups of Aboriginal peoples in Canada: First Nations, Métis and Inuit. These three groups have their own history and their own languages, cultural practices and beliefs.

In Quebec, Aboriginal people represent about 1% of the population. In 2011, the Aboriginal population had 141,915 individuals in the province. They mainly live in 14 Inuit villages and 41 First Nations communities who are united into 10 nations: Abenaki, Algonquin, Atikamekw, Cree, Huron-Wendat, Innu, Maliseet, Mi’gmaq, Mohawk and Naskapi. The Métis status is not recognised in Quebec.

In Quebec, there are three groups of Aboriginal peoples: Cree, Inuit and First Nations. The healthcare structure differs from one community to another, depending on the status of each community.

Communities bound by an agreement

The Quebec government finances health and social services in communities bound by an agreement, i.e. the Cree, Inuit and Naskapi. The territories of the Inuit nation and those of the Cree Nation are two different health regions in Quebec, health regions 17 and 18. Each Inuit village, Cree or Naskapi community has a CLSC. The Cree and Inuit Nations also have hospitals in their territory.

Finally, the Cree and Naskapi Nations, as well as Inuit, continue to benefit from certain health programmes funded by the federal government, including those for home care. They also have access to most community health programmes funded by Health Canada (Federal Ministry of Health).

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128 [https://www.csssdelamontagne.qc.ca/soins-et-services/demandeurs-d-asile-praida/](https://www.csssdelamontagne.qc.ca/soins-et-services/demandeurs-d-asile-praida/)

Communities not bound by an agreement

In Aboriginal communities not bound by an agreement, social and health services are mainly funded by the federal government (Health Canada and the Department of Aboriginal Affairs and Northern Canada Development) and generally under the responsibility of band councils or tribal councils. They ensure the delivery of primary healthcare and social services, especially community health programmes focusing on health promotion and disease prevention. These services are offered by a health centre or a nursing station in the community.

Health Canada also funds the Non-Insured Health Benefits Program that pays the cost of prescription drugs, eye care, dental care, certain medical equipment and supplies and medical transport. Finally, individuals who need secondary or tertiary care in a Quebec facility are covered by the RAMQ.

People living outside the communities

First Nations and Inuit living outside Aboriginal communities receive the same health and social services in Quebec as Quebecers. They also benefit from the Non-Insured Health Benefits Program of Health Canada.

Protection of seriously ill foreign nationals

The Immigration and Refugee Protection Regulations of 2001\textsuperscript{130}, last amended on 11 March 2016, foresees in Division 5 the application for permanent residence within Canada on humanitarian and compassionate grounds if the applicant:

- is a foreign national currently living in Canada; and
- needs an exemption from one or more requirements of the Immigration and Refugee Protection Act or Regulations in order to apply for permanent residence within Canada; and
- believes they would experience unusual and undeserved or disproportionate hardship if they are not granted the exemption they need; and
- is not eligible to apply for permanent residence from within Canada in any of these classes:
  - spouse or common-law partner,
  - live-in caregiver,
  - protected person and Convention refugees,
  - temporary resident permit holder.

In addition, an application for humanitarian and compassionate grounds cannot be introduced if in the last 12 months\textsuperscript{131}:

- a refugee claim was rejected (including claims that were abandoned) by either the Refugee Protection Division or the Refugee Appeal Division of the Immigration Refugee Board;
- a refugee claim has been withdrawn unless the claim was withdrawn before the hearing at the Immigration Refugee Board.

However, there are exceptions to this “12-month ban”. An applicant can apply if:

- they provide sufficient credible and objective evidence that there are children under 18 years of age who would be directly and adversely affected if they are removed from Canada; or
- they provide sufficient credible and objective evidence that they (or a rejected asylum seeker included in

\textsuperscript{130} \textit{Immigration and Refugee protection Regulations} - 2002

\textsuperscript{131}http://www.cic.gc.ca/english/refugees/inside/prra.asp
their application) would be subject to a risk to life if returned to their home country. This risk would be caused by the inability of their country of nationality to provide adequate health or medical care.

- They are from a country to which an exception applies

Individuals facing removal from Canada are eligible for a pre-removal risk assessment (PRRA) in order to suspend or repeal the removal. This procedure was created to avoid people being sent to a country where they would be at risk. Most persons whose PRRA applications are accepted become ‘protected persons’ who may apply to become a permanent resident.

### Treatment of infectious diseases

Integrated services for screening and prevention (SIDEP) of STIs and blood-borne infections (BBIs) are a set of services offered by the CLSC health providers (nurses). These services are anonymous and free. They are meant for people who face multiple vulnerabilities, such as homeless people, sex workers, First Nation people, etc. In particular, they provide immunisation against hepatitis A and B, as well as screening for hepatitis B and HIV.

Everyone has access to these services, even those without health coverage, regardless of their legal status. Thus, undocumented migrants may have access to free and anonymous screening. However, in practice, some receptionists ask for the health insurance card because they do not know the rights of patients.

Treatment for sexually transmitted diseases and blood-borne infections is not accessible without a health insurance card.

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132 List of the countries exempted from the 12 month ban


133 Op. cit. note 135
National Health System

Constitutional basis

The Preamble to the Constitution of 27 October 1946\(^\text{134}\)\(^\text{134}\), the Declaration of the Rights of Man and of the Citizen of 26 August 1789 as well as the Charter for the Environment of 2004\(^\text{135}\)\(^\text{135}\) 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”\(^\text{136}\).

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”\(^\text{137}\).

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”\(^\text{138}\).

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\(^\text{139}\).

The health insurance system is dominated by the National Health Insurance Fund for Salaried Workers (Caisse Nationale d’Assurance Maladie des Travaillleurs Salarisés – CNAMTS)\(^\text{140}\). 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)\(^\text{141}\).

These three main schemes (CNAMTS, MSA and RSI) were federated into a


\(^{136}\)Op. cit. note 134

\(^{137}\)Op. cit. note 135


\(^{141}\)Ibid.
National Union of Health Insurance Funds (Union Nationale des Caisses d’Assurance Maladie – UNCAM) by the 2004 health insurance reform\textsuperscript{142}. This new federation has become the sole representative of the insured in negotiations with healthcare providers.

The Primary Health Insurance Funds (Caisses Primaires d’Assurance Maladie – CPAMs) are responsible for the reimbursement of claims and benefits\textsuperscript{143}. They also manage preventive services and general health and social care in their area\textsuperscript{144}.

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\textsuperscript{145}.

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\textsuperscript{146}. Statutory health insurance fund eligibility is granted either through employment (to salaried or self-employed working people and their families) or as a benefit to those formerly employed who have lost their jobs (and their families), students and retired people\textsuperscript{147}. In addition, universal access is guaranteed for those on low incomes and/or with chronic conditions\textsuperscript{148} who also fulfil the condition of residence.

French citizens residing in France for more than three months 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\textsuperscript{149}. Having done this, an individual is issued with a “carte vitale” with a photo, similar to a credit card, which indicates the individual’s national insurance rights in electronic form\textsuperscript{150}. 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\textsuperscript{151}), 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\textsuperscript{152}.

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;

\textsuperscript{143}Ibid.
\textsuperscript{144}Op. cit. note 142
\textsuperscript{145}Op. cit. note 142
\textsuperscript{146}Op. cit. note 139
\textsuperscript{147}Op. cit. note 139
\textsuperscript{148}Op. cit. note 139
\textsuperscript{149}Op. cit. note 140
\textsuperscript{150}Op. cit. note 140
\textsuperscript{152}http://www.ameli.fr/assures/soins-et-remboursements/ce-qui-est-a-votre-charge/le-ticket-moderateur.php
Diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals (nurses, physiotherapists, speech therapists, etc.);
- Prescription drugs, medical appliances and prostheses that have been approved for reimbursement; and
- Prescribed healthcare-related transport\(^{153}\).

Statutory health insurance also partially covers long-term and mental healthcare and provides minimal coverage of outpatient vision and dental care\(^{154}\).

**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, notably for 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 of a free complementary health insurance.

Since January 1\(^{st}\), 2016, the PUMA (Universal Medical Protection), created by the Social Security Financing Act of 2016\(^{155}\), replaced the basic Universal Medical Coverage (CMU).

The CMU basic universal coverage, created by the CMU Law of 27 July 1999\(^{156}\), enabled people who are 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.

This evolution makes it easier to access health care 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 may make it difficult to holders of residency permits to access the PUMA scheme and may cause interruptions in their health insurance coverage. The expected 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 France\(^{157}\) or

\(^{153}\) Op. cit. note 139  
\(^{154}\) Op. cit. note 139  
\(^{155}\) https://www.legifrance.gouv.fr/eli/loi/2015/12/21/FCPX1523191I/jo/texte  
\(^{156}\) Basic Universal Coverage (CMU) Law of 27 July 1999,  
\(^{157}\) 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...
the French overseas departments (Départements d’Outre-Mer – DOM), with the exception of Mayotte where the scheme is different (see below) continuously for more than three months. Foreign nationals must additionally 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 started their claim process and for holders of a Temporary Residency Permit for Health Care. However, lodging a request for asylum can take quite a long time, during which it is impossible to claim health coverage.

There is no income-condition to access the PUMA. However, the PUMA is free for individuals on a low income i.e. below around €800 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.

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 €23 total, the health insurance reimburses the mandatory part, known as the “social security part” (€15.10) and the patient has to pay the supplementary part (€6.90) and the flat-rate contribution (€1). 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 €720.42 per month (€8,645 per year) in mainland France or below €801.75 per month (€9,621 per year) in the overseas departments (except Mayotte). The same conditions of residency must be met as for CMU.

**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.

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 a access to CMU-C by more than 35%: €11,670 per year in mainland France or €12,989 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 payer”: they do not need to pay for their medical expenses upfront and are exempted from the €1 flat-rate payment.

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160 [http://www.cmu.fr/les_droits_a_la_couverture_maladie.php](http://www.cmu.fr/les_droits_a_la_couverture_maladie.php)
162 [http://www.info-acs.fr/acs_qu_est_ce_que_1_acs.php](http://www.info-acs.fr/acs_qu_est_ce_que_1_acs.php)
163 Ibid.
The free medical centre system
(Permanence d’Accès aux Soins – PASS)

The law against social exclusion of 29 July 1998\textsuperscript{165} 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 won’t. Other hospitals have a “dedicated PASS”: basically, 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, where 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 PASS\textsuperscript{166} created a regional coordination structure with a PASS framework which evaluates every PASS in France. MdM FR participated very 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

Following the President’s policy commitments, from 1 July 2013, the financial resources eligibility criteria for CMU-C and supplementary health insurance assistance (ACS) were widened by 8.3\% (€972.5\textsuperscript{167} per month in March 2016). This revaluation led to a growth of 7.5\% of the amount of CMU-C beneficiaries and of 15.1\% of ACS beneficiaries in one year\textsuperscript{168}.

In May 2014 (figures last updated on 09/03/2016), 920,000 people were using ACS, compared with 826,257 before the widening of the eligibility criteria (an additional 93,743 people)\textsuperscript{169}.

In June 2014, 5,095,097 people had CMU-C compared with 4,649,533 in June 2013, before the widening of the eligibility criteria (an additional 445,564 people).

\textsuperscript{165}http://reaannecy.free.fr/Documents/congres/Congre_IDE/PASS_texte.pdf
\textsuperscript{167}http://www.cmu.fr/acs.php
\textsuperscript{168}http://www.cmu.fr/fichier-utilisateur/fichiers/Annuaire_statistique_12-2013.pdf
\textsuperscript{169}Ibid.
A new healthcare Bill was adopted on 26 January 2016\textsuperscript{170}, bringing several 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, widening the conditions of free access to care at point of use, aiming to reduce the amount of patients giving up seeking care\textsuperscript{171};
- 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 (\textit{Haute Autorité de Santé} – HAS);
- the Economic Committee for Healthcare products (\textit{Comité Économique 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 and STI testing equipment and support to STI & STD prevention
- Homosexual can now be blood donors (but with restrictions)

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 CMU. 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 rules\textsuperscript{172}.
- No change to reduce refusal of healthcare: still monitored by the French Medical Board which is both judge and party. The notion of refusal to healthcare should be clearly defined, the burden of proof should be reversed and an independent observatory should examine refuse 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. If they have no official documentation, they started January 2016 and shall be full on 30 November 2017

\textsuperscript{170} \textit{Law on the modernization of the healthcare system} – 2016 https://www.legifrance.gouv.fr/eli/loi/2016/1/26/AFSX1418355LI/texte

\textsuperscript{171} Only to the social security part, excluding the part reimbursed by the optional insurance. The expansion

\textsuperscript{172} For more details, see : http://www.medecinsdumonde.org/actualites/presse/2016/03/17/reforme-de-la-protection-maladie-universelle-puma
can make a sworn statement regarding their financial resources. They are exempt from the necessity to prove a three month long residency in France\textsuperscript{173}.

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 an address is always needed for administrative procedures. Asylum seekers and refugees therefore need to provide one to the prefecture when they submit their asylum application to the prefecture; this procedure then eventually entitles them to health coverage (PUMA and CMU-C). 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 is provided by entitled non-profit organisations, which are overwhelmed with requests. For instance, in Paris, it takes around five months to get an address. Thus, during this period, they are considered as undocumented migrants. They may only access AME under certain conditions and must access healthcare through PASS while they have no medical coverage.

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

\begin{itemize}
\item those who are subject to the Dublin III regulation\textsuperscript{174}. 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 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
\item those from “safe countries”\textsuperscript{175} who are subject to the “priority” 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 centre\textsuperscript{176}).
\end{itemize}

Thus, they can only access AME under certain conditions (three months’ 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 antenatal, delivery and postnatal care as nationals and authorised residents. This includes termination of pregnancy. In practice, they may face the same barriers as those described above.

**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

\begin{itemize}
\item List of the “safe countries”, considered as respectful of principles as democracy, rule of law
\item and human rights (art. L741 CESEDA), defined by the OFPRA
\item http://www.ofpra.gouv.fr/sites/default/files/atoms/files/150909_ldu_liste_pos.pdf
\item https://www.service-public.fr/particuliers/vosdroits/F15376
\end{itemize}
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.

- Even before starting the asylum process, minors should in theory 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 €720 per month in mainland France and €802 in the DOMs.

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, 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. But the delay in obtaining AME can be several months after the request is submitted, reducing de facto the duration of AME validity, which begins on the day of submission. If the migrant is still undocumented after one year, he/she 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.

The €30 AME admission fee for undocumented migrants, introduced by the previous French government, was repealed by the new socialist one in 2012 as one of its first measures.

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, they are not entitled to any health coverage and must pay the full costs for themselves and their family, which is obviously impossible for most of them.

Another condition undocumented migrants must fulfil to benefit from AME is to prove their identity. Some migrants do not possess an identity document and can therefore not submit a request. Furthermore, if a migrant wants to prove his/her identity with a birth certificate, said document will have to be translated by an official translator, as per the French law.

177 https://www.service-public.fr/particuliers/vosdroits/F3079
178 The SMR is a criteria used in public health to classify drugs or medical devices according to their therapeutic or diagnostic utility.
180 Ibid.
which often costs a lot of money and is 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 which 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 or not 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 don’t 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 2005\(^\text{181}\) (Article L254-1 of the Social Action and Family Code\(^\text{182}\)) 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.

**Undocumented pregnant women**

Pregnant women may have access to AME. Under this scheme, they may access antenatal, delivery and postnatal care. In 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 circular\(^\text{183}\) 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 authorization to stay on the territory, thus, children are never considered as undocumented migrants.

In principle, children of undocumented migrants are entitled to the AME scheme upon arrival in France (without the three-

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\(^{182}\)Social Action and Family Code, Article 254-1

http://legifrance.gouv.fr/affichCodeArticle.do?idCidTexte=LEGITEXT000006074069&idArticle=LEGIRIGHT000006797164&dateTexte=&categorieLien=cid
month residence condition), even if their parents are not eligible. The right is granted for one year.\textsuperscript{184}

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 circular\textsuperscript{185} but access to healthcare differs from one PASS to another.

Children who do not benefit from AME can go to hospital and have free access to healthcare, because care for children is considered as emergency care\textsuperscript{186}.

Moreover, children can receive vaccinations against all the principal diseases free of charge\textsuperscript{187}. In accordance with the general health system, all children have access to immunisations at PMI centres\textsuperscript{188}.

\begin{center}
\textbf{EU citizens}
\end{center}

Pursuant to the Directive 2004/38/EC\textsuperscript{189}, destitute EU citizens are considered as undocumented migrants (no health coverage, insufficient financial resources)\textsuperscript{190} and they can access AME under the same conditions as any other undocumented migrant\textsuperscript{191}.

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\textsuperscript{192}. 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 don’t 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 difficult for individuals to understand the rules that apply.

However, since the circular DSS/2A/DGAS/DHOS, adopted on 7 January 2008\textsuperscript{193}, 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.

\begin{itemize}
\item \textsuperscript{184}Circular of 8 September 2011, \url{http://www.sante.gouv.fr/fichiers/bo/2011/11-10/ste_20110010_0100_0055.pdf}
\item \textsuperscript{185}Op. cit. note 181
\item \textsuperscript{186}Op. cit. note 181
\item \textsuperscript{187}http://www.ameli.fr/assures/prevention-sante/la-vaccination.php
\item \textsuperscript{188}Comité Médical pour les Exilés (COMEDÉ), \textit{Migrants/étrangers en situation précaire}, 2008, \url{http://docplayer.fr/5525447-Rapport-2014-du-come-de-introduction-2.html}
\item \textsuperscript{189}Directive 2004/38/EC
\item \textsuperscript{190}These are conditions to be authorized to reside in France for inactive individuals.
\item \textsuperscript{191}Circular of 9 June 2011, \url{http://circulaire.legifrance.gouv.fr/pdf/2011/07/cir_33406.pdf}
\item \textsuperscript{192}Médecins du Monde 2014, \textit{Report on access to healthcare in France}
\item \textsuperscript{193}Circular of 7 January 2008, \url{http://www.sante.gouv.fr/fichiers/bo/2008/08-02/a0020048.htm}
\end{itemize}
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, 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 or not 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 and pubertal development examinations.

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 Asylum\(^{194}\), an ill foreign national can obtain a residence permit if their state of health requires medical assistance which lack could cause him consequences of an exceptional gravity, on the condition that no treatment of this condition is available in his 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, promulgated on 16 June 2011 (“Loi Besson”)\(^{195}\). 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 their 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.

A new bill on immigration law is currently under discussion\(^{196}\), it contains several positive measures, as adding the notion of

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196[http://www2.assemblee-nationale.fr/documents/notice/14/ta/ta0683/%28index%29/ta](http://www2.assemblee-nationale.fr/documents/notice/14/ta/ta0683/%28index%29/ta)
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. 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 Regional Health Agency (Médecin de l’ARS – MARS). However, the Ministry of the Interior often becomes involved in the medical advice scheme, despite the fact that the competence in this area belongs exclusively to the Ministry of Health. Thus, management of migration interferes with health policies. What is more, pursuing to Article 20 of the Law on foreigners of 7 March 2016, starting January 2017, the competence for medical advice in this procedure will be transferred from the MARS to doctors from the French Office of Immigration and Integration (OFII – Office Français de l’Immigration et de l’Intégration), which depends of the Ministry of Interior.

This procedure has numbers of flaws in practice. Many prefectures require more documents than the law from ill foreigners and complicate the procedures, 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.

Until 2012, medical advice was respected and followed by the prefect. Since 2012, prefects have been increasingly rejecting applications, despite favourable medical advice from the MARS. Some prefects consider that they are not bound by the MARS’ opinion and undertake a new investigation, based on inadequate medical evidence given by physicians who are not listed in the regulation to assess access to healthcare in countries of origin. Thus, in 2014, 6,912 new applications were accepted and the total amount of people living with a permit to stay due to medical reasons is around 30,000, showing a great stability since 1998. According to 1,398 patients followed by some NGOs, the rate of positive decisions was 85%.

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.

After reiterating the medical ethical...
obligations for the application procedure, such as continuity of care and the observance of professional secrecy, the 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.)

However, according to the Medical Committee for Exiles (Comité Médical pour les exilés – COMEDE), in addition to applications begin rejected by the prefect, in spite of favourable medical advice from ARS doctors, applications are also still rejected because some MARS do not respect the instruction of 10 November 2011.

It should also be noted that MdM FR strongly criticised the “Country fact files” for 30 countries produced by the Interministerial Committee for the Management of Immigration in 2007. Furthermore, MdM produces counter expertise proving that there was no effective access to care in most of these countries.

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

Article 47 of the Social Security Financing Act for 2015 aims to merge these two types of facility into one, called information centres for free testing and diagnosis of sexually transmitted infections (Centres gratuits d’information, de dépistage et de diagnostic – CGIDD), with a single legal status and funded by health insurance.

If a person is diagnosed with an infectious disease, access to treatment depends on the disease and their 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

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206 Op. cit. note 183

(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, their treatment will be covered by the PASS or the urgent care scheme and fully covered, including hospitalisation.

**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 with permission to reside, 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.

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

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 gynaecology). 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 2012 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

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211 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000025943780&fastPos=2&fastReqId=721478700&categorieLien=cid&oldAction=rechTexte
emergency\textsuperscript{212}. 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.

\textbf{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 now applies to Mayotte. However, the transposition of these laws in Mayotte is subject to derogations that continue to deprive foreign nationals of the rights they would be entitled to in mainland France.

\textsuperscript{212} This amount is not set by any law.
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 organisations (i.e. important competencies are legally delegated to membership-based, self-regulated organisations of payers and providers), thus combining vertical implementation of policies with strong horizontal decision-making.

There are two insurance systems: statutory health insurance (Gezetzliche Krankenversicherung – GKV) and private health insurance (Private Krankenversicherung – PKV).

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.

For statutory insurance, insurance payments are based on a percentage of income and shared between employees and employers. Approximately 85% of the population belong to the public statutory health insurance scheme, whereas only 15% have private health insurance.

Since 2009, it is compulsory for all German citizens and long-term residents to have health insurance. Employees earning less than €56,250 per year (as of May 2016), are mandatorily covered by the public statutory health insurance scheme (GKV). Anyone earning more than this opt-out threshold can choose to be covered by a private health insurance plan, or by both public and private plans.

Since 2009, a uniform contribution rate to the GKV has been set by the government. 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%. 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.

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213 For instance, there are “Kassenärztliche Vereinigung” (represents the interests of approximately 24,000 registered doctors) or “Bundesärztekammer” (umbrella organisation which represents political interests of almost half a million doctors) or “Deutsche Patientenvereinigung” (organisation for patients).


218 Op. cit. note 216

Within the GKV, this contribution also covers employed citizens’ dependents i.e. non-earning spouses and children.\(^{220}\)

In the case of PKVs, 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 (\textit{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 (\textit{Sozialamt}) normally pays. However, if the person has had a “gap” in their insurance payments and has to repay their 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).

A flaw of this system is its complexity, making it difficult to fill all the right forms and to comply with all rules of the welfare benefits system.

\textbf{Accessing Germany healthcare system}

Health insurance is provided by 118\(^{221}\) competing, not-for-profit, non-governmental health insurance funds called “sickness funds” (\textit{Krankenkassen}), through the statutory health insurance scheme or by voluntary substitutive private health insurance (PKV).\(^{222}\) Citizens and long-term residents choose to which sickness fund they want to belong.

Regarding payments for healthcare (individual co-payments), until the end of 2012 patients had to pay €10 per quarter if they went to the doctor. Since 1 January 2013, this provision no longer applies, as it was eliminated by Section 1 G. v. 20.12.2012 BGBl. I S. 2789\(^{223}\). Patients no longer have to pay anything for medical consultations, for which health providers are reimbursed directly by the health insurance funds. Small out-of-pocket-payments must however be made for other medical services as physiotherapy or specific dental care.

Some health services, as medical cosmetic procedures or acupuncture, were excluded from the statutory insurance coverage scope by the Federal Joint Committee (\textit{Gemeinsamer Bundesausschuss})\(^{224}\), as they go beyond what is defined by law as sufficient, appropriate and economic patient care. These “Individual health services” (\textit{Individuelle Gesundheitsleistungen - IGel}) have to be fully paid for and are usually not reimbursed\(^{225}\).

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.\(^{226}\)

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

\(^{220}\) Op. cit. note 216, p. 69
\(^{221}\) As of May 2016
\(^{222}\) Op. cit. note 139
\(^{223}\) \url{http://www.buzer.de/s1.htm?g=SGB%2BV%2B31.12.2012&a=28}
\(^{224}\) Guidelines §92 of the Social Code, Book V
\(^{225}\) \url{http://www.kbv.de/html/igel.php}
\(^{226}\) Social Code, Book V, Statutory Health Insurance, Section 61
\url{http://www.gesetze-im-internet.de/sgb_5/}
addition, people with chronic illnesses or disabilities do not have to pay more than 1% of gross annual household income. Persons receiving social aid (Sozialhilfe) pay a maximum of €45.84 (if chronically ill) or €91.68 (if not) per year. Children under 18 are exempted of any co-payment.

Statutory health insurance (GKV) covers:

- 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.

Recent reforms

On 25 October 2006, the German government presented a comprehensive healthcare reform bill, entitled the Statutory Health Insurance Competition Strengthening Act, adopted on 30 March 2007. The law aimed to promote competition in health insurance and healthcare delivery, to increase efficiency and to improve quality through more incentives for better coordination of care. The law stipulates that any permanent resident or citizen must be covered by the statutory health insurance if employed and under a certain income ceiling. Some measures of the 2007 law were postponed to 2009. The 2009 law stipulates that any permanent resident/citizen must be covered by private health insurance if they do not want to become affiliated to the statutory health insurance and if they are on a high income.

Since these reforms, individuals who were previously excluded from the statutory health insurance system because they did not pay their contributions have had to be reintegrated.

However, and this is the negative point of these reforms, individuals have to settle their debts with the insurer and retroactively pay contributions since 2007 or whenever they became obliged to be insured. Until they do so, their insurance only covers emergency care. For example, a permanent resident who became affiliated to the statutory health insurer in 2010 has had to repay their debt (absence of monthly contributions) from 2007 to 2010.

This law created a significant dysfunction because many individuals could not repay their debt. Then, a new law came into effect on 11 August 2013, which was adopted to reduce this debt.

Regarding the public insurer, there are two cases:

- If an individual subscribed from April 2007 to 31 December 2013 and did not pay their contributions during this period, but started paying from 1 January 2014, the incurred debt is cancelled.

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227 Op. cit. note 216
228 Ibid.
229 Statutory Health Insurance Competition Strengthening Act – 2007
http://www.bgbl.de/xaver/bgbl/start.xav?startbk=B undesanzeiger_BGBI&start=//%255B%27bgbl107s0378.pdf%27%2527&__bgbl__%27bgbl107s0378.pdf%27%255D__1464082392301
If an individual subscribed from April 2007 to 1 January 2014, but still did not pay their contributions from 31 December 2013, they must pay their debt since this date, plus a 1% rate of interest.

A 2013 guideline of the National Association of Statutory Health Insurances, however, foresees a considerable reduction of the debt. Family members without income continue to receive the full package of health services, even if the debt is not yet fully paid.

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.

Access to healthcare for migrants

Asylum seekers and refugees

The Asylum Seekers Benefits Act regulates the entitlement to state subsidies for medical care of refugees, asylum seekers, some people who hold a residence permit for humanitarian reasons and people with a “temporary tolerated stay” (Duldung).

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 4 of the AsylbLG and Section 19 of the Law on Infectious diseases (Infektionsschutzgesetz), 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).

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

The medically necessary care for chronic diseases has to be provided. This includes psychotherapy for asylum seekers suffering from PTSD (post-traumatic stress disorder) (§6 AsylbLG). Translation is also covered for psychotherapy.

On 18 July 2012, Germany’s Federal Constitutional Court (BVerfG) declared that the Asylum Seekers Benefits Act of 1993 contravenes the Constitution. The court said that the allowance for asylum seekers, which is 40% lower than that for recipients of the very low Hartz IV welfare benefits, the supposed subsistence level in Germany, was “evidently insufficient”. The first chamber of the BVG ordered an immediate increase in the benefits. With immediate effect, an unmarried adult asylum seeker was to receive an allowance

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https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/DE/2012/07/ls20120718_1bvl001010.html
of €359 instead of €224 per month, until the German Parliament enacted a new law.

Since 1 March 2015, after 15 months of having received benefits under the Asylum Seekers Benefits Act, instead of the previous 48 months, as regulated in the 12th Book of the Social Security Code (Sozialgesetzbuch)\textsuperscript{236}, 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 48 months (i.e. without any time-limit) to people who have “abused the law to affect the duration of their stay”\textsuperscript{237}.

In emergency situations, asylum seekers and refugees can go directly to the emergency department for care. For non-emergency situations, asylum seekers in many 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)\textsuperscript{238}; the care provider is then reimbursed directly.

The municipal departments, which do not have medical expertise, are in charge of delivering authorizations for reimbursement of care. This causes a heterogeneous application of the law throughout the country, as municipalities may interpret it in a more or less restrictive way and thus may not issue health vouchers under the same conditions.

In contrast, some municipalities (Bremen, Hamburg, Bavaria and Berlin in particular) 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\textsuperscript{239}.

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, a municipal public health department physician must confirm the diagnosis and the need for treatment.

**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


\textsuperscript{237}http://www.asylumineurope.org/reports/country/germany/reception-conditions/health-care

\textsuperscript{238}Op. cit. note 233

\textsuperscript{239}Op. cit. note 237
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. However, vaccinations (Section 4.3 AsylbLG) are not compulsory in Germany, but merely recommended, with the exception of children at the time they enter child care 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. 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 of the United Nations Convention on the Rights of the Child (CRC).

According to the Asylum Seekers Benefits Act of 1 November 1993 (AsylbLG), 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.

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

According to the Residence Act of 30 July 2004 (Aufenthaltsgesetz – AufenthG), Section 87(2), “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:

- 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 public bodies, with the exceptions mentioned above, have an obligation to report any undocumented migrants encountered in the course of their work to the immigration authorities, which goes completely against medical providers and social services ethics.

In September 2009, thanks to intensive civil society advocacy, the Bundesrat issued an instruction on the application of the duty to report. Hospital administrative and

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240 List of vaccinations
http://www.bmg.bund.de/themen/praevention/frueherkennung-und-vorsorge/impfungen.html

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

242 Z. Dogusan, “Refugee children discriminated against in Germany, UNICEF says”, Daily Sabah, 10 September 2014
http://www.dailysabah.com/europe/2014/09/10/refu

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

244 Op. cit. note 233

245 Op. cit. note 52

246 Residence Act of 30 July 2004, Section 87
http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html#p1120

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.

Even though, in principle, health coverage for undocumented migrants extends beyond emergency services, in practice, coverage is limited to emergency services because the procedure for reimbursing undocumented migrants for the costs of emergency care is confidential, while the one used for non-emergency care is not.

Indeed, for emergency care reimbursements, healthcare providers request reimbursement from social services after the provision of care, a process that extends the medical confidentiality requirement to the social services department (as mentioned above). Nevertheless, the MdM Germany team has observed that, 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.

For non-emergencies, undocumented migrants seeking reimbursement must approach the social welfare office, whose staff has a duty to report them to the administrative authorities and/or the police. This risk renders access to non-emergency healthcare meaningless. 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.

In order to obtain cost-free medication, the same process applies. The undocumented migrants must obtain a health voucher from the social welfare office. Office staff is required to report the status of undocumented migrants to the foreign nationals’ registration authority, hindering in practice their access to cost-free medication. Hence, only those with a “temporary tolerated stay” are likely to be able to access medicines free of charge.

In practice, undocumented migrants do not have real access to healthcare. They can only have access to outpatient services from health providers who would waive their fees.

Undocumented pregnant women

In principle, undocumented pregnant women have access to healthcare services in the same way as German women covered by statutory health insurance. In practice, cost-free healthcare services are provided to pregnant women only in the case of emergency care.

Indeed, because of police reporting requirements linked to non-emergency healthcare, undocumented pregnant women are afraid to go to hospitals, meaning that only undocumented pregnant women with a temporary tolerated stay can access antenatal and postnatal care. The temporary tolerated stay is only granted for a limited time period, when the woman is considered “unfit to travel” (reiseunfähig - generally, according to maternity leave law, six weeks before and 12 weeks after delivery). With this document, they do not have to pay the costs of antenatal and postnatal care.

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248 Op. cit. note 52
249 Op. cit. note 52
250 Op. cit. note 52
251 Op. cit. note 226 - Section 60 a (2) 3rd sentence (pregnancy is considered – with discretion – as urgent personal grounds).
252 Op. cit. note 52
However, for the first six months of their pregnancy, undocumented women risk expulsion when applying for cost reimbursement so they do often not get appropriate antenatal care (starting at 14th week at the latest).

It should also be noted that if pregnant women do not obtain a temporary tolerated stay, they have to pay all costs.

**Children of undocumented migrants**

The children of undocumented migrants are concerned by the provisions of the Asylum Seekers Benefit Act, 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 out primary and secondary healthcare.

In practice, most children of undocumented migrants do not have access to immunisation. 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 Code, 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.

A termination of pregnancy beyond 12 weeks is possible, however, 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 entirely 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.

Women whose income minus rent and children’s allowance is below €1,036 per month can be reimbursed by social security. Theoretically, female asylum seekers and undocumented women are also entitled to reimbursement through a special exceptional remittance from the GKV. 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.

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254 Op. cit. note 233
255 [Criminal Code §218a](http://www.gesetze-im-internet.de/stgb/__218a.html)
257 Ibid.
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. They can obtain health coverage through private insurance if they can afford the contributions.

Pursuant to the 2004 European Directive 2004/38/EC, after three month of residence in Germany, if an EU citizen has insufficient funds and no insurance to cover his healthcare, he/she will be considered as an undocumented migrant and will then be entitled to the same rights as undocumented third country nationals.

In any case, EU citizens are entitled to assistance in case of emergencies, according to the 12th book of the German Social Security Code. This can mean, depending on the circumstances, that the costs for an urgent operation might be reimbursed by social services.

Healthcare related to pregnancy is not seen as emergency care. Therefore, usually, pregnant EU citizens who have lost the right to reside are forced or 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, by and large, 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. “If assistance is granted in accordance with Sections 33 to 35 or Section 35a subsection 2 Nos. 3 or 4 [Social Security Code Book VIII], health benefits must also be granted as specified in Sections 47 to 52 of the 12th book of the German Social Security Code.”

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 VIII). This also covers any need for psychological care, including translation fees.

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.

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. 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), 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, stricter regulations were passed for proving that a medical condition makes an expulsion impossible (AufenthG §60a Section 2c and 2d).

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 doctor declares 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. This residence permit is checked by the Federal Office for Migration and Refugees (Bundesamt für Migration und Flüchtlinge) 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 demonstrate to the relevant authorities that there is a serious risk to his/her health in their 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.

The evolution of asylum law in 2016, 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”, 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 diseases, everyone, including undocumented migrants is entitled to counselling and testing for transmissible infectious diseases in humans of 20 July 2000 (Protection against Infection Act).
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.
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”\(^{(273)}\).

Historical background

The founding law of the Greek health system (Law 1397/1983)\(^{(274)}\) 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\(^{(275)}\). This law can be characterized as the foundation of the Greek healthcare system\(^{(276)}\).

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\(^{(277)}\). 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.

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\(^{(275)}\) C. Economou,”Greece: Health system review”, *Health Systems in Transition*, 2010, vol. 12, No. 7,
almost everything except cosmetic surgery. In addition, most of the funds provided income allowances for lost income due to illness, maternity benefits and others.\(^\text{282}\)

The establishment of the National Organisation for Healthcare Provision (EOPYY) by Law 3918/11\(^\text{283}\) was published on 2 March 2011 and it started operating on 1 January 2012. This health insurance reform unified all social and health insurance funds into a central health fund, EOPYY, which is supervised by the Ministry of Health.

In 2014, the Greek Parliament adopted a primary healthcare law (Law 4238/14\(^\text{284}\)), based on the core values of the Declaration of Alma-Ata, to ensure better health of the Greek people.\(^\text{285}\) With this law, Greece intended to build a comprehensive and strong nation-wide primary healthcare service.\(^\text{286}\)

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), 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 Regional Health Authorities 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.\(^\text{287}\)

### 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.\(^\text{288}\) Primary healthcare in Greece is provided by both National Health System and EOPYY units. However, a large number of self-employed health professionals exist.\(^\text{289}\)

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.\(^\text{290}\) The current scheme allows free choice of provider but not of the insurer.\(^\text{291}\)

Structurally, there is a shortage of general practitioners (GPs) in Greece compared to specialists, there are few nurses per

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\(^\text{282}\) Op. cit. note 255
\(^\text{283}\) Law 3918/11 – 2011
\(^\text{284}\) Law 4238/14 – 2014
\(^\text{285}\) Ibid.
\(^\text{286}\) Ibid.
\(^\text{288}\) Ibid.
\(^\text{289}\) Op. cit. note 287
\(^\text{290}\) Op. cit. note 287
thousand people and urban areas attract most providers and patients.

The 2011 reform in the Greek health social insurance market resulted in a unified central fund (National Organisation for Healthcare Provision—EOPYY) which simultaneously assumed the majority of primary health care provision.

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).

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

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.

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

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. For example, EOPYY immediately restricted access to many essential health services, such as medical care, glasses, dental care and physiotherapy services.

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%.

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.

EOPYY provides free primary care services to the insured population in urban areas through its salary-based healthcare

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292 WHO regional Office for Europe, Profile for health and Well-Being – Greece, 2016 http://www.euro.who.int/__data/assets/pdf_file/0010/308836/Profile-Health-Well-being-Greece.pdf?ua=1
293 Ibid.
294 Op. cit. note 292
295 Op. cit. note 287
296 Op. cit. note 287
297 Op. cit. note 287
298 Op. cit. note 287
300 Ibid.
301 Op. cit. note 299
302 Op. cit. note 299
professionals (some professionals serve on a contractual basis). 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. 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).

Positive reform

Law 4368/2016 of 20 February 2016

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

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, authorized residents and their family members (spouse and dependent children)
- Vulnerable groups, regardless of their legal status i.e. 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, persons with heavy disabilities, seriously ill people, inmates…

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.

As to foreigners entitled to free healthcare under Section 2 of Article 33 of Law 4368/2016, who do not have an SSN, they are granted a special Foreigner Healthcare card (K.Y.P.A.) which they have to display to obtain healthcare. Pursuant to Article 3 of the joint ministerial decision implementing Law 4368/2016, the K.Y.P.A. is valid for six month from the date of issue, and one year if its holder is a pregnant woman.

In addition of opening rights to free healthcare, the joint ministerial decision 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


For the detailed list, see article 3 of the Joint ministerial decision op. cit. note 306
families whose income does not exceed €200 monthly for a single person, €300 for couples or persons with a dependent member plus €600 for each further dependents are exempted from medication costs\textsuperscript{309}.

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 authorized residents.

### Access to healthcare for migrants

#### Asylum seekers and refugees

According to article 33 Section 2 of the 4368/2016\textsuperscript{310} law, asylum seekers and refugees are considered as vulnerable groups and thus have access to the public healthcare system for free, same as destitute Greek nationals.

To access free healthcare, asylum seekers must hold and display a special Foreigner Healthcare Card (K.Y.P.A.).

Before the 2016 law, the Common ministerial decision KYA Y4α/48566/05 provided for 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. 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 all cases, emergency aid shall be provided to applicants free of charge (…)”\textsuperscript{311}.

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 health care 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\textsuperscript{312}.

**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 introduced exceptions to this rule, allowing the most vulnerable categories of people to access healthcare.

\textsuperscript{309} Article 6, joint ministerial decision n° A3(c)/GP/oik.25132/2016 Op. cit. note 306

\textsuperscript{310} Op. cit. note 306

\textsuperscript{311} Presidential Decree of 2007, http://www.refworld.org/docid/49676abb2.html

\textsuperscript{312} Law 4368/2016, op. cit. note 305

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 2910/2001 expressly excludes minors of the prohibition to provide healthcare.

Since April 2016, undocumented migrants can be entitled to free healthcare if they belong to one of the vulnerable groups defined by Article 33, section 2 of the 4368/2016 law and Article 3 of the joint ministerial decision implementing it.

For instance, are entitled to free healthcare, undocumented:

- Pregnant women
- Children
- Chronically ill individuals
- Seriously ill individuals
- Victims of severe crimes
- Disabled individuals...

Undocumented pregnant women

Pursuant to the 4368/2016 law, undocumented pregnant women are entitled to free healthcare. Indeed, they are 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 3907/2011 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. They are indeed considered as a vulnerable group.

EU citizens

In accordance with Directive 2004/38/EC 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.

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313 Law 4251/2014 - 2014

314 A. Triandafyllidou, “Migration in Greece Recent Developments in 2014”, Hellenic Foundation For European and Foreign Policy, 2014,


315 Op. cit. note 305
316 Op. cit. note 306
317 Op. cit. note 305
318 Op. cite. note 305
319 Op. Cit. note 189
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/EC\(^\text{320}\) which provides for a general ban on detaining minors except under “exceptional circumstances”.

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\(^\text{321}\). 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\(^\text{322}\).

Besides, when arriving in Greece, unaccompanied children are not accurately or adequately identified, including through proper age assessment procedures\(^\text{323}\). Indeed, although the Common Ministerial Decision KYA 1982/2016\(^\text{324}\) provides that age assessment should first be performed by a paediatrician then 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.

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 found\(^\text{325}\). What is more, Article 32 of Law No 3907/2011\(^\text{326}\) (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\(^\text{327}\). The reasons for detaining children for longer or shorter periods appear to be arbitrary\(^\text{328}\). The detention of children is also caused by the fact that the large influx of asylum seekers to Greece has overwhelmed existing centres.
Reception capacity for children is insufficient: at national level, there are 432 places in special centres for unaccompanied minors and 240 unaccompanied children are detained in closed premises and police stations due to lack of accommodation facilities (as of 30 March 2016)329.

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 CRC330. As a result of existing shortcomings in Greece’s child protection system, unaccompanied minors remain in administrative detention, often for a long time, in contravention of applicable national and international law331.

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 beds332.

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 abuse333.

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 law334.

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 program 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 2012335 (remaining in force pursuant to article 139 (2) of Law 4251/2014) provides for the detention 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 health336; if they are 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 an intravenous drug user or a sex worker; or if they live in conditions that do not meet minimum standards of hygiene337. 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 2011338 was adopted, HIV testing and treatment are free for all people living in Greece, regardless of their legal status.

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331 Op. cit. note 321
332 Human Rights Watch, “Why are you keeping me here” Unaccompanied Children detained in Greece, 8 September 2016
333 Ibid.
334 Op. cit. note 305
336 http://www.globaldetentionproject.org/countries/europe/greece
337 Op. cit. note 321
GREECE

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 2015 339 repealed the restoration of measure 39A of the Health Act. This law was implemented by 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 current Greek authorities have decided to repeal this measure which violated human rights and affected human dignity.

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[340], the Irish Supreme Court recognized 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”[341]. 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 2005[342], the Irish Courts rejected the existence of the right to health where that would create an obligation upon the state to provide free healthcare.[343]

Organisation

Healthcare in Ireland is a two-tier system: private and public healthcare systems. The public healthcare system is governed by the Health Act 2004[344]. This Act established Health Service Executive (HSE), the body with the responsibility for both the budget and the management and provision of health and personal social services to everyone living in Ireland. The HSE is directly accountable to the Minister for Health.

Health Service Executive 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[345].

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 population[346]

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

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[342] Unreported Supreme Court decision of 16th February 2005
[343] Ibid.
[346] Ibid.
across state. The return visits may be charged at the discounted rate (around €30).

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.

Private health 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.

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 is made up 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.

In June 2015, 2.118 million, or 46% of the Irish population, have private health insurance. 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 1994 to 2014 and Regulations made under those Acts. Health Insurance Authority regulates the private health insurance providers.

Reform of the Health Service

The Irish government initiated a major reform programme of the health system. The goal is to introduce a single-tier health

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service, supported by Universal Health Insurance (UHI) to achieve equal access to healthcare based on medical needs and not on income. This health system will be based on a multi-payer insurer model with competing insurers.

Department of Health publication Future Health- A Strategic Framework for Reform of the Health Service 2012-2015 details the actions to be taken to deliver the reform as the suppression of the distinction between “public” and “private” patients, universal GP care, insurance for a standard package of curative health services for everyone and an Activity Based Funding (ABF) of hospitals rather than a block grant allocation.

The government aims to the realization of this reform by 2019. For now, a Child Family Agency has been established, Activity Based Funding implementation commenced in 2014, a healthcare Pricing Office (HPO) was established and numerous administrative boards have been appointed, but the UHI is not yet in place.

Free GP care for children under 12 years old is set to start in October 2016.

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 subsidized by the Irish government for those who fulfill the “ordinarily resident” condition. It requires that an applicant has been resident or intends to be resident in the State for at least one year.

The “ordinarily resident” condition was introduced by way of the Health Amendment Act 1991 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.

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 he or she 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 he or she 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 card holders have full eligibility to free healthcare in Ireland. The Health Act 1970 introduced the Medical Card system entitling free access to health services within the public system.

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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.

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”. But to give an example, the monthly income limit for a single person living alone to obtain the medical card is of €736.

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

Medical Card holders are entitled to the following services free of charge:

- Doctor visits: A range of GP services from a chosen doctor in your 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 out-patient 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.

Anybody in Ireland with a medical emergency is entitled to attend the Emergency Department. A patient visiting the Emergency Department will either 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.

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.

361 http://www.hse.ie/eng/services/list/1/schemes/mc/forms/medicalcardguidelines2015.pdf
362 http://www.citizensinformation.ie/en/health/medical_cards_and_gp_visit_cards/medical_card_means_test_under_70s.html
364 http://www.hse.ie/eng/services/list/1/schemes/drugpaymentscheme/
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.365

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 visible aspect of inequity in the Irish healthcare system.366 The new healthcare bill aims to correct this inequality.

The reduction of government spending on healthcare since the onset of the financial crisis increased waiting times for treatments. However, according to the 2015 OECD (organisation for Economic Cooperation and Development) report, since the last five years, health expenditures increased in Ireland, which should improve the healthcare system.367

The National Treatment Purchase Fund (NTPF) was set up in 2002 for those waiting for more than 3 months for an operation or procedure. 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 public patients to be treated for free in private hospitals in Ireland. As a result of this fund, over 135,000 patients on the waiting lists have been treated so far. The NTPF has reduced the waiting times for procedures to an average of between two and five months.368

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.369

What is more, 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 – 2012370 provided a range of initiatives such as translated informational material in different languages on health services. It also provided resources, training and

365 http://www.hse.ie/eng/services/list/1/schemes/lti/
368 Op. cit. note 347
369 Op. cit. note 347
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 out-patient 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 adults

However, if the asylum seekers chose to live outside the Direct Provision Centres for a variety of reasons, they will face difficulties in accessing Medical Card System. Such asylum seekers have difficulties in providing sufficient evidence of their means as they are effectively excluded from receiving any social supports from the State by virtue of Habitual Residence Condition introduced in Section 17 of the Social Welfare (Miscellaneous Provisions) Act 2004. Such asylum seekers are unable to meet “means test” criteria and this, in turn, results in medical card refusal. 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 Regulation, during the 3 first month 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. It entitles women to free GP consultations, in-patient, out-patient and accident and emergency services in public hospitals in respect of the pregnancy and the birth, and visits from a public health nurse.

**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

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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.

Undocumented migrants

The Irish law excludes undocumented migrants, including children, from the entitlement to access all but urgent free 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.

Undocumented migrants have no access to Medical Card System as they are unable to meet the lawful residence requirement. This excludes this vulnerable group of people from accessing free healthcare system in Ireland.

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. 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 5 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 out-patient 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 6s scheme. There are current plans to extend this scheme for all children under 12 years of age under the Budget 2016, currently under negotiation with the Irish Medical Organisation.

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”\(^{381}\).

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\(^{382}\). 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”\(^{383}\), a 14-year-old rape victim was prevented by a High Court injunction from travelling to the UK 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, effectively making abortion legal in Ireland under these restricted circumstances.

However, it took two decades for the Irish State to enact 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\(^{384}\) case for of its failure to implement the existing constitutional right to a lawful abortion, the protection of Life during Pregnancy Act\(^{385}\), 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 criticized among others by the UN Human Rights Committee. Serious breaches of medical confidentiality are also reported as each termination of pregnancy is notified to the Minister of health\(^{386}\).

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 citizens**

EU citizens ordinarily residing in Ireland have the same access to healthcare as the nationals. None of the provisions in the Health Act 2004\(^{387}\) affect the operation of the EC regulations, which govern health service entitlements for EEA nationals.

A range of services are available to EU citizens on a temporary stay in Ireland and holders of the European Health Insurance Card (EHIC) under the EU Regulation 1408/71\(^{388}\). EU residents may qualify for a

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\(^{381}\)https://www.constitution.ie/Documents/Bhunreacht_na_hEireann_web.pdf


\(^{384}\)http://hudoc.echr.coe.int/eng/?i=001-102332

\(^{385}\)Protection of life during pregnancy Act – 2013

\(^{386}\)https://www.ifpa.ie/Hot-Topics/Abortion/Abortion-in-Ireland-Timeline


\(^{388}\)Op. cit. note 373
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 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.

Regulation 10 of the Statutory Instrument No 656 of 2006 European Communities (Free Movement of Persons) (No 2) Regulations 2006 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.

Pursuant to the 2004 European Directive 2004/38/EC, after three month of residence in Ireland, if an EU citizen has insufficient funds and no health coverage, he/she will be considered as an undocumented migrant and will then be entitled to the same rights as undocumented third country nationals.

**Unaccompanied minors**

The care of the unaccompanied minors falls under Child Protection which is the responsibility of the HSE. The Child Care Act 1991 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 Act 2013 responsible for providing a wide range of services to improve the wellbeing and outcomes 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**

A non-EEA national can make an application for humanitarian leave to remain under Section 3 of the Immigration Act 1999 after they have 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

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391 Op. cit. note 189
394 Op. cit. note 392
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^{396}. 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 family situation, his 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 he/she 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 deportation order, it follows that the person will be granted leave to remain in the State^{397}. When humanitarian leave to remain is granted, the person has the same access to 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 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^{398}.

### Prevention and treatment of infectious diseases

The Health Act 1947^{399} 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 2011 (S.I. No. 452 of 2011)\(^{400}\), which identifies a list of notifiable communicable diseases, including HIV since 2011.

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

HPSC Scientific Advisory Committee publishes national guidelines on communicable disease screening in Ireland. The 2015 guidelines^{401} 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

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^{397}http://www.citizensinformation.ie/en/moving_country/asylum_seekers_and_refuges/refugee_status_and_leave_to_remain/leave_to_remain.html
^{401}Health Protection Surveillance Centre (July 2015), Infectious Disease Assessment for Migrants https://www.hpsc.ie/A-Z/SpecificPopulations/Migrants/Guidance/File,14742,en.pdf
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.\(^{402}\)

People receiving treatment for infectious diseases are also exempted of the €100 fee if they use accident and emergency services or receive out-patient care without being referred by a GP and of the charges for inpatient and day services.\(^{403}\)

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 people who contracted it through the administration of blood within Ireland.\(^{404}\) Others have to cover its full price, which amounts to around €45,000.

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\(^{402}\) Op. cit. note 347
\(^{403}\) http://www.citizensinformation.ie/en/health/hospital_services/hospital_charges.html
\(^{404}\) http://www.hse.ie/eng/services/list/1/schemes/hepc/
\(^{405}\) http://www.hse.ie/eng/services/yourhealthservice/SUI/Library/participation/inclusion.pdf

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**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.\(^{405}\)

Recent data suggest that Irish Travellers have the same options in availing of healthcare services as the settled population.\(^{406}\) 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 effects⁴⁰⁷.

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

⁴⁰⁷http://www.hse.ie/eng/services/yourhealthservice/SUI/Library/participation/inclusion.pdf
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.”

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.

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.

Contributions are shared equally between employees and employers, who each contribute 2.8% of the employee’s gross income (with a maximum contribution of €9,614.82 per month) on average to the National Health Fund (Caisse Nationale de Santé – CNS).

Long-term care is financed through separate insurance called “assurance dépendance”. This is funded through 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.

Accessing Luxembourg healthcare system

According to Article 1 of the Social Security Code, health insurance is compulsory in Luxembourg.

The system allows access for basic healthcare free at the point of entry to all citizens. 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, as though the benefit authority were paying the contributions in the way an employer would. The rate amounts to 5.2% divided equally between the benefit authority and the beneficiary.

All dependent family members are covered by contributing family members, pursuant to Article 7 of the Social Security Code. Students and unemployed children are covered up until 27 years of age.

The national healthcare system covers the majority of treatment provided by general practitioners and specialists as well as laboratory tests, pregnancy, childbirth,
rehabilitation, prescriptions and hospitalisation\textsuperscript{418}.

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\textsuperscript{419}.

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\%. Thus, the first consultation is reimbursed at 80\% and further consultations which occur within 28 days are reimbursed at 95\%\textsuperscript{420}.

Usually the reimbursement for prescription medicine is 78\%, although there are four categories of reimbursement for prescription medicine and levels range from 0\% to 100\%\textsuperscript{421}.

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\textsuperscript{422}.

If a patient has paid healthcare fees in advance and is not willing to wait for a bank transfer to be reimbursed, they 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 less than €100\textsuperscript{423}.

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)\textsuperscript{424}.

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\textsuperscript{425}.

When a person is granted TPS, s/he is given a certificate and a book of special labels\textsuperscript{426}. From this point on, they will not have to pay in advance for any care. When they access healthcare they are 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\textsuperscript{427}.

The aim of TPS is to facilitate access to healthcare for people with limited income\textsuperscript{428}. It can be granted for three months, six months and, exceptionally, one year. At the end of the three months, the beneficiary can ask the Social Welfare Office for an extension\textsuperscript{429}.

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.

Although 99% of the population is covered by the state healthcare system, private healthcare is also accessible. About 75% of the population purchases 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. 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 and is free at the point of use. 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 Protection and the Law on the Reception of Applicants for International Protection and Temporary Protection, both adopted on 18 December 2015.

**Asylum seekers**

The law on the Reception of Applicants for International Protection and Temporary Protection of 18 December 2015 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).

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 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 €25.63 for adults and unaccompanied minors and of €12.81 for minor children, in accordance with article 13-1 of the law on the Reception of Applicants for International Protection and Temporary Protection.

In cases where it is not possible to provide access to food, the monthly allocation is €225.63 for adults and for unaccompanied minors, and of €187.81 for minors pursuant to article 13-2 of the same law.

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431 Ibid.
432 Op. cit. note 426
433 [Law on International and Temporary Protection of 18 December 2015](http://www.legilux.public.lu/eli/etat/leg/loi/2015/12/18/n16)
434 [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)
435 Op. cit. note 433
The monthly allowance is supplemented by benefits in kind or vouchers that cover costs as accommodation and medical costs\(^437\).

Asylum seekers who are victims of rape or other serious violence are entitled to adequate medical and psychological care\(^438\).

The complete removal of material reception conditions of asylum seekers by the authorities is prohibited. Access to basic health care 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 Protection\(^439\) 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.

<table>
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<tr>
<th>Undocumented migrants</th>
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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\(^440\).

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\(^441\).

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\(^442\). 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

\(^{437}\) Law on the Reception of Applicants for International Protection and Temporary Protection, op. cit. note 433 Article 13-3

\(^{438}\) Law on the Reception of Applicants for International Protection and Temporary Protection, op. cit. note 433 Article 17


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.\textsuperscript{443}

**Termination of pregnancy**

The most recent law regulating termination of pregnancy was adopted on 17 December 2014,\textsuperscript{444} modifying the 1978 law which authorized abortion in Luxembourg.

Termination of pregnancy is legal in Luxembourg up to 12 weeks from the date of conception,\textsuperscript{445} 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.\textsuperscript{446}

**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 immigration\textsuperscript{447} is properly implemented.

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.\textsuperscript{448}

According to the Law of 26 June 2014, modified by the law of 18 December 2015,\textsuperscript{449} the Immigration Medical Department 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.\textsuperscript{450}

\textsuperscript{443}Ibid.

\textsuperscript{444}Law on termination of pregnancy – 2014  

\textsuperscript{445}Law on termination of pregnancy, article 12

\textsuperscript{446}Law on termination of pregnancy, Article 14

\textsuperscript{447}Law on free circulation of 2008, modified by the Law on international protection of 18 December 2015  


\textsuperscript{449}Law of 26 June 2014,  

A foreign national may benefit from such a deferment if:

- their health conditions require treatment which cannot be refused to them without serious consequences for their health
- And the person concerned is not able to get the treatment in the country they are about to be sent back to.

If all the requirements are met, the individual will obtain a deferment of expulsion for a maximum of six months, with the possibility of renewal not exceeding two years.

If after two years the individual’s health state has not improved and still needs the treatment, then they can apply for a residency permit for medical reasons.

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.

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.
- A certificate from the medical authorities from their country of origin proving that the person cannot receive the treatment in their country.

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 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).

In this plan, it is stated that migrants face multiple vulnerabilities such as increased risk to infectious diseases. The government has assessed the need to raise awareness regarding these diseases and the necessity for these migrants to access free HIV screening tests. 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.

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.

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451 Ibid.
459 Ibid.
461 Ibid.
462 Op. cit. note 460
464 Op. cit. note 460
Nonetheless, the Ministry of Health has recognised that a number of administrative barriers often impede vulnerable groups in accessing treatment when they need it\textsuperscript{465}.

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\textsuperscript{466}. 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 against 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\textsuperscript{467}.

\begin{flushleft}
\textsuperscript{465} Op. cit. note 460
\textsuperscript{466} Regulation of 27 February 2015, http://eli.legilux.public.lu/eli/etat/leg/rge/2015/02/27/n1
\textsuperscript{467} Regulation of 27 February 2015, Art.1
\end{flushleft}
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)\textsuperscript{468}. 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.

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 (allowed to make a profit) 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 quality, accessibility and affordability of healthcare\textsuperscript{469}.

Taking out standard (private) health insurance is obligatory for authorised residents\textsuperscript{470}. 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\textsuperscript{471}. 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)\textsuperscript{472}.

Contraception is not included in the basic package. Pregnancy termination is not included either, but is fully reimbursed under the Law on Long-term Healthcare\textsuperscript{473}. To cover costs not included in the standard package, for example physiotherapy or dental care, people may opt to take out additional insurance. The premium for this extra package is freely established by private insurers.

Once they have paid the franchise (see below), insurance holders do not have to pay any costs for services included in the standard package – there is no out-of-pocket expenditure. The monthly premiums for health insurance currently (June 2016)

\begin{itemize}
\item \textsuperscript{468}http://wetten.overheid.nl/BWBR0001840/geldigheidsdatum_21-05-2015
\item \textsuperscript{469} W. Schäfer et al., “Germany: Health system review”, Health Systems in Transition, vol. 12, No 1, 2010
\item \textsuperscript{470} Health Insurance Act of 16 June 2005, Art. 2 http://wetten.overheid.nl/BWBR0018450/Hoofdstuk2/Paragraaf21/Artikel2/geldigheidsdatum_06-02-2015
\item \textsuperscript{471} Civitas, 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
\item \textsuperscript{472} http://www.rijksoverheid.nl/onderwerpen/zorgverzekering/vraag-en-antwoord/basispakket-zorgverzekering-2015.html
\item \textsuperscript{473} http://www.rijksoverheid.nl/onderwerpen/zorg-in-zorginstelling/wet-langdurige-zorg-wlz
\end{itemize}
range from €82 to €112 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 contracted care providers (versus a larger or even unlimited choice), opting in or out of (partial) reimbursement of dental care, glasses and the degree of “own risk” (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 monthly help up to €83, couples up to €158 a month\(^474\). Single people with yearly incomes lower than €27,012 have a right to financial help; for couples the income ceiling is €33,764. Only people with limited capital have a right to these benefits\(^475\). In 2015, benefits have been raised for the lowest incomes, although the average Dutch citizen will have to pay for a larger part of their insurance themselves\(^476\). In July 2014, the Ministry of Health denied the trend of increased giving up seeking healthcare\(^477\) denounced by the national GP association\(^478\).

When accessing healthcare services and treatment, people first need to pay a franchise (their “own risk”), which is currently (July 2016) – as defined by law – at least €385 a year\(^479\), but can go up to €875 depending on their chosen insurance formula\(^480\). 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 doesn’t 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)\(^481\). Vaccinations are freely accessible for all children through preventive frontline infant consultations (0-4 years), and according to the national immunisation calendar\(^482\).

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 €332.25 – 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\(^483\). Those who do not pay


\(^{475}\)The ceiling has been systematically lowered, thereby limiting the number of people with a right to benefits. E.g. for a single person, the income ceiling was €35.059 in 2012 and €30.939 in 2013, until 2016, when it was raised http://www.rijksoverheid.nl/onderwerpen/zorgtoeslag/vraag-en-antwoord/wanneer-heb-ik-recht-op-zorgtoeslag.html

\(^{476}\)http://www.zorgkeus.nl/zorgverzekering/zorgtoeslag-10-euro-omhoog-voor-laagste-inkomens


\(^{478}\)https://www.lhv.nl/actueel/nieuws/zorgmijden-neemt-stoegwikkender-vormen-aan

\(^{479}\)http://www.hspm.org/countries/netherlands25062012/countrypage.aspx

\(^{480}\)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, to €375 in 2015.


\(^{482}\)http://www.independer.nl/zorgverzekering/info/eigen-gebeurtenissen-as-ik-niet-verzekerd-ben-voor-de-zorgverzekering.html

\(^{483}\)http://www.rivm.nl/Onderwerpen/R/RIJKsvaccinatieprogramma/De_inenting/Vaccinatieschema

\(^{484}\)http://www.rivm.nl/Onderwerpen/R/RIJKsvaccinatieprogramma/De_inenting/Vaccinatieschema
their monthly premiums face financial penalties.

### Termination of pregnancy

For residents authorised to reside, pregnancy termination is free at the point of delivery under the Act on Long-term Healthcare. 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 Act). The gestational limit stated in the Law is 24 weeks (based on foetal viability).

In case a late termination is needed – after 24 weeks – doctors are obliged to report these to a central committee. Under the New Regulation on late-term abortions and Termination of Life in Neonates, 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".

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488 Op. cit. note 486
490 http://www.rzasielzoekers.nl/home/zorg-voor-asielzoekers.html
those women are entitled to more intensive antenatal care (with more consultations). They are also entitled to access to pregnancy termination services free of charge. However, asylum seekers and refugees aged 21 and over have to pay for contraceptives themselves.\(^{493}\)

**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.

**Undocumented migrants**

Undocumented migrants cannot take out health insurance. Indeed, the Linkage Act of 1998\(^{494}\) linked the right to state medical insurance to authorized 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”\(^{495}\).

In 2007, an independent commission of medical (and social and legal) experts, clearly defined “medically necessary care”\(^{496}\): 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 authorities\(^{497}\), 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 €27.19 for a short consultation and €54.38 for a consultation that takes longer than 10 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 etc.). In 2014, the authorities drafted a short document to help healthcare professionals determine who is undocumented\(^{498}\), although the language used is rather stigmatising\(^ {499}\). The barriers to healthcare for undocumented people were also confirmed by the National Ombudsman in 2013\(^{500}\).

\(^{493}\) 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
\(^{495}\) *Foreigners Act – 2000*
http://www.refworld.org/docid/3b5fd94991.html
\(^{497}\) http://www.zorginstituutnederland.nl/verzekering/onverzekerbarevreemdelingen
\(^{500}\) Medische zorg vreemdelingen. Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeproceende asielzoekers
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. Consequently, MdM is confronted with many patients for whom even €5 is too much.

The European Committee of Social Rights ruled in 2014 that the Dutch government 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. The Dutch Association of Municipalities (Vereniging Nederlandse Gemeenten) has taken the same view concerning rejected asylum seekers.

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 Act (see below) due to being unfit to travel six weeks before and six weeks after giving birth. During this period, women have access to healthcare under the same scheme as pregnant asylum seekers.

Unlike maternity care, contraception and pregnancy termination have to be fully paid for by undocumented women.

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 4, 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. The care scheme for undocumented third-country nationals is not applicable to EU citizens without authorisation to reside. If the latter do not

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have a European Health Insurance Card (EHIC), they only have free access to emergency care. 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 adult asylum seekers. They receive extra assistance in separate reception facilities. 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 categories of foreign nationals. 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.

Protection of seriously ill foreign nationals

Postponed departure from the Netherlands due to medical emergencies

According to Article 64 of the Foreigners Act 2000, in conjunction with Article 3.4 of the Foreigners Decree 2000, 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” (Article B8/9.1.3 of the Foreigners Circular 2000). 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.

As explained above, pregnant women can be granted a postponed departure due to being unfit to travel six weeks before and six weeks after giving birth. In case of pregnancy, the leave to remain is automatically granted. No proof of identity is needed to start the procedure: a declaration by a gynaecologist or obstetrician and a filled out request form are sufficient. During this period, women have access to healthcare under the same scheme as pregnant asylum seekers.

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

According to Article 14 of the Foreigners Act 2000 in conjunction with Article 3.5 of the Foreigners Decree, a temporary residence permit may be granted if medical treatment is needed in the Netherlands as

505 http://www.coa.nl/nl/asielzoekers/wonen-op-een-aze/kind-in-de-opvang
507 http://www.vluchtingenwerk.nl/feiten-cijfers/alleenstaande-minderjarigen
508 Foreigners Act Op. cit. note 483
the only country in which the special treatment can take place\textsuperscript{513}. This permit is granted for a maximum period of one year, and in exceptional cases for five years. Migrants with this residence permit are not allowed to work. Patients must prove that they can cover their living and treatment costs (e.g. via their own insurance) during their residence. Furthermore, a precondition to obtaining this temporary residence permit is to have obtained advance authorisation to enter the Netherlands\textsuperscript{514}.

**Residence permit for medical treatment after one year of 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 application\textsuperscript{515} 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 (no mention is made of verification that there is effective access). When MdM has medical teams in the concerned countries, they can often provide evidence about non access to care, given to the lawyers to help the seriously ill migrant.

Although, in theory, 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 seekers\textsuperscript{516}, this is often not the case.

In 2013, the National Ombudsman\textsuperscript{517} condemned the many barriers to accessing the procedure and effective protection: the need for formal proof of identity and medical declarations from all 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.

In a report from March 2015\textsuperscript{518}, the Ombudsman also holds 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 raises 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


\textsuperscript{514} http://www.stichtinglos.nl/content/verblijfsvergunning-medische-behandeling

\textsuperscript{515} https://ind.nl/documents/7050.pdf


\textsuperscript{517} Care 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%20webversion.pdf
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. Therefore, every authorised resident in the Netherlands is entitled to be fully reimbursed by their insurance company for costs related to HIV, hepatitis and STI screening, treatment and care (provided that the individual does not have any outstanding “own risk” 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 (see above). 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. Furthermore, a national “complementary sexual healthcare subsidies” system allows municipal health services to offer anonymous and free-of-charge STI screening to most at-risk populations in STI polyclinics. These populations are broadly defined and can include migrants with irregular status, besides men having sex with other men, sex workers and their clients, and people from a region where an STI is endemic; it also includes anyone who has had more than three sexual partners in the last six months, anyone whose partner is considered at risk, patients who show STI symptoms and anyone under 25. However, in the future, the number of groups who can access these services could be restricted.

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520 Inverardi, Gaia, Accessing 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
522 https://www.soaaids.nl/nl/professionals/interventies/structurele-interventies/aanvullende-seksuele-gezondheidszorg
523 http://www.ggdghorkennisnet.nl/?file=13972&m=1375704358&action=file.download
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.

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. 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”.

The health care system in Norway is a public responsibility. It is organized into three levels; the national, regional and local. While health care policy is controlled centrally, responsibility for the provision of health care is decentralised.

At the national level, 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 services and the County Governor are in charge of carrying out 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 Supervision, organized under the Ministry of Health and Care Services, supervises the provision of health and social services.

The state is responsible for the specialist health services. Specialist services comprises hospital services, laboratory and radiology services urgent care and health and Specialist Health Care Act 1999 Section 2-1 e. Chapter 2

http://lovdata.no/dokument/NL/lov/1814-05-17
http://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
http://www.helsedirektoratet.no/
http://www.helsetilsynet.no/Norwegian-Board-of-Health-Supervision/

http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
Municipal Health and Care Act Section 3-4 Chapter 3

ICESCR, Article 12
http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
http://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=2.1%20Overview%20of%20the%20Health%20System&Type=Section
http://www.helsedirektoratet.no/
http://www.helsetilsynet.no/Norwegian-Board-of-Health-Supervision/
related transportation like the ambulance system.\textsuperscript{531}

Norway is divided into four regions. Each region has a Regional Health Authority (RHA), which provides the specialist health care.\textsuperscript{532} As every patient has the right to necessary and emergency healthcare from the specialist health care services, if the Regional Health Authority cannot provide it, the patient has the right to necessary healthcare from a private provider.\textsuperscript{534}

The 428 municipalities\textsuperscript{535} are in charge of financing, planning, organizing and operating the primary health care according to local demand.\textsuperscript{536} The state finances a significant part of the municipalities’ healthcare services through direct subsidies from the State Budget.\textsuperscript{537} The municipalities have a great deal of freedom in organizing 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.\textsuperscript{538}

**Funding**

As a public commitment, healthcare in Norway is mostly publicly financed by state, counties and municipalities taxation.\textsuperscript{539} The rest of the funding comes from income-related employee and employer contributions and, in a much lesser extent, from out-of-pocket-payments.\textsuperscript{540}

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\textsuperscript{531} Specialist Health Care Act Op. cit. Note 506 Section 2-1 a.
\textsuperscript{532} Ibid.
\textsuperscript{533} Patient’s Rights Act, Section 2-1 b
\textsuperscript{534} Ibid.
\textsuperscript{535} http://kartverket.no/Kunnskap/Fakta-om-Norge/Fylker-og-kommuner/Tabell/
\textsuperscript{536} http://www.legemiddelverket.no/english/the-norwegian-health-care-system-and-pharmaceutical-system/sider/default.aspx
\textsuperscript{537} The Municipal Health and Care Act Op. cit. note 526 Section 11-5.

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## Accessing Norwegian healthcare system

All citizens and authorized 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).\textsuperscript{541}

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.”

Everyone has the right to a permanent GP and to change this doctor twice a year.\textsuperscript{542}

It is to be noted that somatic and mental health situations are equalized.\textsuperscript{543} 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 Act\textsuperscript{544}, every person residing in the realm is a mandatory member of the National Insurance Scheme (NIS).
However, one must have an authorized 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\textsuperscript{545}.

The national Insurance Scheme covers the costs related to health care service for all citizens who are members of NIS\textsuperscript{546}.

The scope of NIS coverage is determined by the Parliament, in accordance with the National insurance Act\textsuperscript{547}.

\begin{itemize}
\item Examination and treatment by a doctor\textsuperscript{548}, a psychiatrist\textsuperscript{549} and under certain circumstances a chiropractor\textsuperscript{550}.
\item Physiotherapy\textsuperscript{551}.
\item Treatment related to language and speech defects\textsuperscript{552}.
\item Treatment by an orthopaedist\textsuperscript{553}.
\item Tests and examinations at private laboratories and Roentgen institutes, including x-rays\textsuperscript{554}.
\item Dental care but only if related to diseases\textsuperscript{555}.
\end{itemize}

The scope of the NIS coverage is not precisely defined. In practice, it also covers\textsuperscript{556}:

\begin{itemize}
\item Hospital and ambulatory care, if it is essential for the patient.
\item Emergency care.
\item Rehabilitation.
\item Drugs included on the «blue list» i.e. approved prescription drugs.
\item Dental care for children and vulnerable groups.
\item Medical eye-care (glasses excluded).
\item Home nursing.
\end{itemize}

\textbf{Cost sharing}

GP and outpatient specialist visits require flat fee co-payments (in 2015, NOK 141 (€15.8) and NOK 320 (€35.9) per visit, respectively).\textsuperscript{557}

Covered prescription drugs also require a flat fee contribution of NOK520 (€58.4) per prescription, as do radiology and laboratory tests (of NOK227 (€25.5) and NOK50 (€5.6) in 2015, respectively).\textsuperscript{558}

Certain groups of people are exempted from cost-sharing provisions\textsuperscript{559}:

\begin{itemize}
\item Children under the age of 7 are exempt from cost-sharing for treatment received from a physician or a physiotherapist, essential drugs and travel expenses.
\end{itemize}

\begin{footnotes}
\textsuperscript{545} Norwegian state party’s report 2012-10-29 UN’s Committee on Economic, Social and Cultural Rights para 395.
\textsuperscript{547} Op. cit. note 544.
\textsuperscript{548} National Insurance Act Section 5-4.
\textsuperscript{549} National Insurance Act Section 5-7.
\textsuperscript{550} National Insurance Act Section 5-9.
\textsuperscript{551} National Insurance Act Section 5-8.
\textsuperscript{552} National Insurance Act Section 5-10.
\textsuperscript{553} National Insurance Act Section 5-10-a.
\textsuperscript{554} National Insurance Act Section 5-5.
\textsuperscript{555} National Insurance Act Section 5-6.
\textsuperscript{556} http://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=3.3%20Overview%20of%2
\textsuperscript{558} Ibid.
\end{footnotes}
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\(^{560}\).

Children under the age of 18 are exempt from co-payments for psychotherapy and dental treatment.

Pregnant women receive medical examinations during and after pregnancy for free.

Consultations for prevention and treatment of transmittable diseases and treatment of sexually transmitted diseases are free.

Hospital admissions and inpatient treatment are free.

Cost shared ceiling

A cost shared ceiling was introduced in the 1980’s 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 services\(^{562}\):

- 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 2016 the amount was set at NOK2185\(^{563}\) (€245).

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\(^{564}\). 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\(^{565}\).

A second ceiling is also set every year by the Parliament for costs in regard to\(^{566}\):

- Dental care (only related to health issues for special groups of persons)
- Physiotherapy
- Fees for accommodation in rehabilitation centres
- Treatment abroad

As of 2016, the amount of the second ceiling was set at NOK2670\(^{567}\) (€300).

These two ceilings are not related to individual income.

The Ministry of Health issues regulations concerning deductible plans\(^{568}\).

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 this treatment as well, under certain conditions set forth by the Ministry of Health\(^{569}\).

Healthcare providers have to inform the patients about the duty to pay and to indicate an approximately amount before

\(^{560}\) Patient’s travel regulation – 2015, §24
https://lovdata.no/dokument/SF/forskrift/2015-06-25-793

\(^{561}\) Op. cit. note 559, p. 66

\(^{562}\) The National Insurance Act Op. cit. note 544 Section 5-3§1
https://helsenorge.no/betaling-for-helselhjelp/frikort-for-helsetjenester

\(^{563}\) National Insurance Act Op. cit. note 544 Section 5-3§3

\(^{564}\) Op. cit. note 559, p. 60

\(^{565}\) National Insurance Act Op. cit. note 544 Section 5-3§2

\(^{566}\) https://helsenorge.no/betaling-for-helselhjelp/frikort-for-helsetjenester

\(^{567}\) National Insurance Act Op. cit. note 544 Section § 3-5 last paragraph

\(^{568}\) National Insurance Act Op. cit. note 544 Section 5-22
they provide health services. They cannot claim payment in advance.\textsuperscript{570}

Individuals who are not able to pay the patient charge can apply for social support, according to the Social Care Act.\textsuperscript{571} This Act applies to all persons residing in the realm,\textsuperscript{572} 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.\textsuperscript{573}

Urgent medical assistance

Everyone, independently of their immigration or insurance status, is entitled to emergency healthcare and care that cannot wait.\textsuperscript{574} 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 their health needs.\textsuperscript{575}

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.”\textsuperscript{576}

In Circular letter I-2011-5\textsuperscript{577} 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.\textsuperscript{578}

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.\textsuperscript{579}

Access to healthcare for migrants

Asylum seekers and refugees

All Norwegian nationals and authorized residents are entitled to public healthcare.

As authorized residents pursuant to the Immigration Act\textsuperscript{580} asylum seekers and

\textsuperscript{570} 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


\textsuperscript{572} Social Care Act Op. cit. note 571 Section 2.

\textsuperscript{573} Op. cit. note 557

\textsuperscript{574} Circular letter I-2011-5 chap 2.1 https://www.regjeringen.no/no/dokumenter/i-52011-helsehjelp-til-personer-uten-fas/id662225/

\textsuperscript{575} Ibid.

\textsuperscript{576} Norwegian state party’s report 2012-10-29 UN’s Committee on Economic, Social and Cultural Rights para. 395

\textsuperscript{577} Op. cit. Note 574

\textsuperscript{578} http://www.oecd.org/norway/Health-at-a-Glance-2015-Key-Findings-NORWAY.pdf

\textsuperscript{579} http://www.hspm.org/countries/norway08012014/livinghit.aspx?Section=7.3%20User%20experience%20and%20equity%20of%20access%20to%20healthcare%20care&Type=Section

\textsuperscript{580} Immigration Act - 2008 https://www.regjeringen.no/en/dokumenter/immigration-act/id585772/
refugees are entitled to the same access to healthcare as Norwegian citizens\textsuperscript{581}, though with some exceptions related to the National Insurance Scheme\textsuperscript{582}.

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\textsuperscript{583}.

During the three first month of the asylum application, another country can request the responsibility to consider it. Pursuant to the “Dublin III” European Regulation\textsuperscript{584}, only one country can examine an asylum application. Thus, if this occurs, the asylum seeker will lose his 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 cover health care regulated in chapter 5 of the National Insurance Act\textsuperscript{585} if it is acute care\textsuperscript{586}. 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\textsuperscript{587}.

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\textsuperscript{588}.

Children of asylum seekers and refugees

As authorized residents, children of asylum seekers have the same access to public health care, medical and dental care as children of Norwegian nationals\textsuperscript{589}.

Undocumented migrants

Pursuant to the Regulation 1255 on the right to healthcare for people without a permanent residency in Norway of 2011\textsuperscript{590}, undocumented migrants are only entitled to emergency healthcare\textsuperscript{591}, and to “most necessary healthcare”\textsuperscript{592}.

However, no provision prohibits to provide healthcare to undocumented migrants.

The right to emergency healthcare covers both the primary and the specialist

\textsuperscript{581} 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
\textsuperscript{582} 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
\textsuperscript{583} http://www.euro.who.int/__data/assets/pdf_file/0018/237204/HiT-Norway.pdf, p. 144
\textsuperscript{584} Op. cit. note 174
\textsuperscript{585} Op. cit. note 541
\textsuperscript{586} FOR-2008-05 §2
\textsuperscript{588} Cf. note 567
\textsuperscript{590} Regulation 1255 on the right to healthcare for people without a permanent residency in Norway of 16th December 2011, implemented on 1 January 2012 https://lovdata.no/dokument/SF/forskrift/2011-12-16-1255
\textsuperscript{591} Regulation 1255 §3
\textsuperscript{592} Regulation 1255 §4-5
healthcare. 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 to the documents and information about their condition. If necessary, supplementary information about the patient shall be gathered.

Health care is considered “most necessary” when it cannot be postponed without imminent risk of death, permanent severe disability, serious injury or pain.

It is meant as a right to healthcare when the patient is at a stage where 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 Health, one has the right to health care. 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 where imminent risk of death, permanent severe disability or serious injury or pain could appear within three weeks.

Pursuant to section 5 of the 1255 Regulation, medical care that cannot wait 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 others, 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. 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 service, according to the Specialist healthcare Act Section 5-3.

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

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593 Regulation 1255 Section 3, The Patient’s Rights Act Op. cit. note 513 Section 2-1a §1 and 2-1b §1
595 Regulation 1255 §5 a)
597 Ibid.
598 Op. cit. note 590
599 Regulation 1255 Op. cit. note 590 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.
600 Op. cit. note 570
601 Op. cit. note 526
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, but they have to pay for it. Indeed, undocumented pregnant women have the same right to antenatal care as Norwegian women. 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.

As health care regarding giving birth is considered as “emergency help”, undocumented women are entitled to such care.

Furthermore, women have the same rights to termination of pregnancy as Norwegian women.

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 1255, children of undocumented migrants have, as their parents, the right to emergency healthcare and to necessary healthcare that cannot be postponed.

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. 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 Ministry of health and Care Services issued a decision regarding this which supposedly excludes them from the right to GP services, it can be argued that the Government meant to exclude children of undocumented migrants only from the GP-arrangement as it is organized for the nationals, and not the right to a similar service of payment claims do not apply for children of undocumented migrants.

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605 Regulation 1255 Op. cit. note 590 Section 3
606 Regulation 1255 Op. cit. note 590, Section 5c.
607 Op. cit. note 570
608 Regulation 1255 Op. cit. note 590, Sections 3 and 4
611 Op. cit. note 570, p. 57
The health care provider cannot claim payment in advance, or collect a payment claim after the health care is provided.

**Termination of pregnancy**

Every woman in Norway has the right to pregnancy termination following the Termination of Pregnancy Act, 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.

**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 authorized residency are entitled to the same healthcare as Norwegian citizens, usually upon presentation of their EHIC. They have to pay the patient charges as Norwegian citizens. Some fees may be reimbursed by their country of origin.

The first three months of residence are authorized 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.

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612 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
613 Termination of Pregnancy Act - 1975 
614 https://helsedirektoratet.no/folkehelse/seksuell-helse/abort
615 Circular letter I-2/2008 
https://www.regjeringen.no/no/dokumenter/rundskriv-i-22008/d500745/ and 
617 Op. cit. note 615
618 Circular letter RS 2011-037 chap 3 
https://www.udiregelverk.no/no/rettskilder/udi-rundskriv/rs-2011-037/
619 https://www.udi.no
620 https://www.udi.no/Statistikk_og_analyse/Oppvekst/Barn_som_soker_asyl/Enslige_mindrearige_asylsoker_EMA/
622 Op. cit. note 620
integration, based on an overall assessment of his situation. 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 to stay in Norway, for instance if it is impossible for him to be treated in his 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. This comprises evaluation, diagnoses, treatment, care and other necessary healthcare, 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 consultations.

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623 Immigration Act Op. cit. note 580 Chapter 5 Section 38
The Romanian Constitution of 1991 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.

Health is also 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.

The exercise of the right to healthcare may be restricted by law, but, pursuant to article 53 of the Constitution, only without discrimination and without infringing on the existence of this right.

The main law regulating healthcare in Romania is the 95/2006 Law on healthcare reform 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 central authority is the Ministry of Health (MoH), responsible for regulation and legislative initiatives, health policy formulation and public health. Pursuant to the Law on Healthcare Reform, the MoH is also responsible for establishing quality criteria for provided health care, along with the National Health Insurance House (NHIH).

Some of the Ministry of Health’s responsibilities have been gradually transferred to the local public authorities through decentralization, 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.

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.

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 Public health Directorate (PHD) responsible for the management of the national preventive health programs at county level; and a National Health Insurance House subordinated body: a

626 http://www.constitutiaromaniei.ro/
629 http://www.cnas.ro/
630 Op. cit. note 628, p. 43
County Health Insurance House (CHIH), which sign 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\(^\text{631}\).

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\(^\text{632}\). It is collected into a national health insurance fund, included in the state budget.

Each year, a Governmental Decision (yearly framework Contract) is agreed between the Ministry of Health, the National Health Insurance House and the College of Physicians; 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 health care sector. Still, this sector is severely underfunded, as Romania is allocating only 5.6% of its GDP to health, the lowest public budget devoted to health among the EU Member States\(^\text{633}\).

### 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\(^\text{634}\).

The insured population has access to a basic package of health services, pharmaceuticals and medical devices. Covered medical services include\(^\text{635}\):

- 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
- health care 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 are fully recovered.

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

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\(^{631}\) Op. cit. note 628 p. 61

\(^{632}\) [http://www.euprimarycare.org/column/primary-care-romania](http://www.euprimarycare.org/column/primary-care-romania)

\(^{633}\) Health at a Glance: Europe 2014, European Commission, 2014

\(^{634}\) Op. cit. note 628, pages 47-48

pregnancy related care (pre- and postnatal care, delivery)
- emergency medical services.

Uninsured people are required to pay for medical ambulatory care they receive, except in cases comprised in the minimum package of services.

Pursuant to article 224 of the Law on healthcare reform, 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
- inmates
- war veterans

Children up to 18 and young people 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.

Barriers to access to healthcare

Access to healthcare in Romania is characterized 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 to 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.

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.

Reforms were taken recently regarding the improvement of the minimum benefit package for the uninsured, starting January 2015, with several additional health services, including prevention and reproductive health/family planning services; and regarding the increase of accessibility to subsidized prescribed drugs, through the introduction of HTA (health technology assessment), introduction of new innovative molecules on the list of subsidized drugs, implementation of policies for the reduction of the price of medicines, improved regulations in the pharmaceutical sector, related to the claw-back tax, the patient electronic card and electronic prescription of subsidized drugs.

The ongoing National Health Strategy 2014-2020, adopted through the Governmental Decision 1028/18.11.2014 defined specific objectives in the areas of public health, health services and regarding vulnerable categories of 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

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636 Op. cit. note 627
637 Law on healthcare reform Op. cit. note 627 Article 225
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\(^{641}\).

Article 1 of the 44/2004 Ordinance states that its aim is to facilitate the integration of foreigners with a residence through 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\(^{642}\).

As stated in article 17, para.1 pt. 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 hospitalization
- healthcare and treatment in cases of acute of chronic diseases which imminently endanger their life.

Furthermore, the 122/2006 law affirms in its article 17 para 1 pt. 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 pt. h of the 122/2006 law provides that, individuals who seeks 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. 122/2006\(^{643}\) specifies that asylum seekers have to be present only for the medical examinations which are established for reasons of public health.

Romania is bound by the Dublin III Regulation\(^{644}\), 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\(^{645}\).

The International Organization 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\(^{646}\). It also operates as a non-secure reception centre for asylum seekers being processed under Romanian national law\(^{647}\).

Refugees in the Emergency Transit Centre can receive a complete medical examination including a laboratory analysis and pulmonary radiography for those older

\(^{641}\)Ordinance no. 44/2004  

\(^{642}\)Law no. 122/2006 regarding asylum in Romania, last amended through Law no. 137/2014 on the approval of the Government Ordinance no. 1/2014  

\(^{643}\)Methodological Norms of Application of Law no. 122/2006  

\(^{644}\)Op. cit. note 174  

\(^{645}\)European network for technical cooperation on the application of the Dublin II Régulation,2012, National Report Romania, The application of the Dublin II Regulation in Romania, p. 22  


\(^{647}\)http://www.globaldetentionproject.org/countries/europe/romania
than 15 years of age to establish their health status, and treatment if needed.\textsuperscript{648}

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 or her whole family can usually remain with them for the prolonged period, pursuant to Article 69\textsuperscript{2} of the Government Ordinance 194/2002 regarding the regime of foreign nationals \textsuperscript{649}.

Before they leave the centre, refugees are submitted to 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. 44/2004\textsuperscript{650}, 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 minimum package of services for uninsured women and thus reimbursed by the county HIH.

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\textsuperscript{648} http://www.unhcr.org/50aa08d39.pdf


\textsuperscript{650} Op. cit. note 641


\textsuperscript{652} Ibid. Article 46

\textsuperscript{653} Law on healthcare reform op. cit. note 627 article 213

\textsuperscript{654} Government Emergency Ordinance no. 194/2002 regarding the regime of foreign nationals Op. cit. note 642
status of toleration for a renewable period of six month.

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.655

Undocumented pregnant women

The Law on Healthcare Reform stipulates universal healthcare services for all pregnant women, regardless their health insurance statute.656

In addition, According to Article 46 of the Law no. 272/2004 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 reimbursed by the county health insurance houses.

Children of undocumented migrants

Article 224 of the Law on healthcare reform658 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 insurance659.

Foreigners in accommodation centres

Article 224, para. 2, pt. e of the Law on Healthcare Reform660 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 health insurance without having to pay the contribution.

EU citizens

The European health Insurance Card, defined in the Law on healthcare reform661, allows EU citizens who hold it to access healthcare in Romania.

In accordance with Directive 2004/38/EC of 29 April 2004662, 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 224 of the Law on healthcare reform663, 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 224 of the Law on healthcare reform664.

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655 Inspectorate-General of Immigration information Website http://igi.mai.gov.ro/detalii/pagina/ro/Munca/73
656 Law on healthcare reform Op. cit. note 627 Articles 224 & 225
657 Op. cit. note 651
658 Op. cit. note 627
660 Op. cit. note 627
661 Op. cit. note 627, Articles 325-326 and 327-336
662 Op. cit. note 18
663 Op. cit. note 627
664 Op. cit. note 641
Unaccompanied minors are one of the special cases regulated by the Government Ordinance no. 44/2004 regarding the social integration of foreigners who either have received international protection or a stay permit in Romania or who are EU citizens\(^{665}\).

If an unaccompanied child has been granted international protection, he/she 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.

If 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 will be periodically verified, pursuant to articles 3 and 46 of the Law regarding the protection and promotion of children’s rights\(^{666}\).

### 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, 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 he/she has a health insurance\(^{667}\). Thus, destitute ill individuals who are not able to pay a health insurance cannot stay in Romania to access healthcare\(^{668}\).

Indeed, as stated in article 69 of the 194/2002 Ordinance\(^{669}\), 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 diagnose and duration of treatment. A residence permit may also be issued to a possible accompanying person if the foreigner is not able to care for himself, if this is expressly mentioned in the letter of acceptance.

The Government Ordinance no. 194/2002 regarding the regime of foreign nationals\(^{670}\) 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\(^{671}\).

According to Article 77, para. 3, pt. c of the 194/2002 Ordinance\(^{672}\), the Romanian Office for Immigration can revoke a stay permit if its holder suffers from a disease that puts national health at risk and refuses to submit to the medical treatment measures established by the authorities.

Furthermore, Article 92 of the 194/2002 Ordinance states that the removal of the foreigner is prohibited if he/she:

- is a minor whose parents have a stay permit in Romania

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\(^{665}\) Op. cit. note 641, Article 33  
\(^{666}\) Op. cit. note 651  
\(^{667}\) The Barometer for the Integration of Immigrants op. cit. note 679, p. 67  
\(^{668}\) The Barometer for the Integration of Immigrants Op. cit. note 679, p. 77  
\(^{669}\) Op. cit. Note 674  
\(^{670}\) Ibid.  
\(^{671}\) The Barometer for the Integration of Immigrants Op. cit. note 679, p. 73  
\(^{672}\) Op. cit. note 674
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

The same article provides that, even in these cases, it will be possible to remove the foreigner from the Romanian territory if he/she constitutes a danger to public order or national security or if he/she suffers from a disease that threatens public health and refuses to submit him/herself to measures against it.

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 he/she 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 39 of the Law on healthcare reform provides that any person on Romanian territory must submit themselves to preventative and combative measures regarding infectious diseases, to thoroughly respect hygiene and public health norms, to provide any requested information to the authorities, and to apply the established measures regarding the conditions for prevention of diseases and for the health promotion of the individual and public health.

The diagnosis and of STIs are provided free of charge for insured and uninsured individuals.

HIV and Tuberculosis are part of the declared public health priorities in Romania and ambulatory and inpatient medical services related to these diseases are reimbursed from the health insurance funds, through contracts signed between county HIH and medical providers, while treatment is paid by the Ministry of Health though national health programmes.

Since 2002, a special law, Law no.584/2002, 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 program 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.

Prevention interventions in the national health programmes, accessible to uninsured people, are limited to medical services provided within the health care facilities.

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673 Op. cit. note 627
675 MoH Ordinance no 386/2015 for approval of the implementing norms for the national public health programs in 2015 and 2016
677 Law on measures to prevent the spread of AIDS in Romania and protection of people living with HIV or AIDS – 2002
678 http://legislatie.just.ro/Public/DetaliiDocument/39744
679 Op. cit. note 674, p. 2
Being funded from the state budget, diagnostic and treatment is thus in theory available free of charge for all citizens, regardless of their insured statute.

In practice, uninsured HIV positive patients are asked to either 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 of vulnerable groups as injection drug users is very low.

With the highest tuberculosis incidence among the EU Member States, Romania is also counted among the 18 high-priority countries to fight TB in the WHO European Region. In February 2015, the Government issued the Government Decision 121/2015, 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 STIs, hepatitis B and hepatitis C through the National Centre for Communicable Disease Surveillance and Control (NCCDSC).

Romania lacks specific detection, prevention and treatment policies on infectious diseases, mostly because of insufficient budget resources.

The Roma minority

The Roma population is particularly present in Romania, as it represents 8.6% of the national population.

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.

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, a lot of Romanian Roma do not seek healthcare because of their lack of financial resources and uncertainty about what to pay.

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.

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 Reform 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.

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-

678 WHO Review of the national tuberculosis programme in Romania
679 Government decision 121/2015
http://legislatie.just.ro/Public/DetaliiDocument/166577
681 http://www.touteleurope.eu/actualite/les-roms-en-europe.html
683 Op. cit. note 627, Article 230
users (51.4%) of prenatal care services in 2011.

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 Immunization Program although they are mandatory and free of charge.

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.

Roma in Romania face multiple barriers in access to healthcare, as lack of financial means, lack of health education, lack of information on health services and difficulties in the access to health services related to their place of residence if it is in a rural area and discrimination against them.

\[^{685}^\] Nanu M and all “Evaluarea intervențiilor din programele naționale privind nutriția copiilor” IOMC, MS, UNICEF, 2011

\[^{686}^\] UNICEF, Roma Early Childhood Inclusion Report, 2012

\[^{687}^\] Hidden Health Crisis - A Report by The European Roma Rights Centre: Health Inequalities and Disaggregated Data, October 2013, p.6

Constitutional basis

The Republic of Slovenia Constitution of 28th December 1991 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.

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.

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 Slovenia (ZZZS), based in Ljubljana, is the public institute in charge for implementation of compulsory health insurance as a public service. The Institute is organized in such a way that the service is available to insured persons the nearest as possible to their home of residence. Institute establishes organizational units for specific sectors and for specific areas (Article 69 of the Law on Health Care and Health Insurance).

The National Institute of Public Health (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 17th January 2000. The insurance companies can provide only an additional voluntary insurance to compulsory insured persons or other supplementary insurances which cannot substitute the compulsory insurance.

In 1999, the Health Insurance Card (Kartica zdravstvenega zavarovanja) was introduced. This card is a public document

References:

689 Law on Health Care and Health Insurance – 1992 http://www.pisrs.si/Pis.web/pregledPredpisa?op=1 992-01-0459
690 For more information see http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/021E
691 Op. Cit. Note 689
692 http://www.zzzs.si/indexeng.html
693 http://www.nijz.si/sl
694 http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO1636
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 centralization of health providers in one network.

**Funding**

Slovenia’s health system, based on the Bismarckian model, is mainly founded by compulsory health insurance contributions, tied to employment. They amount to 6.36% of employees’ gross salaries and 6.56% from their employers. 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 authorization to reside in Slovenia and their close family members are entitled to health insurance and care.

Access to non-urgent healthcare is possible only through personal physicians. Every person in Slovenia has to designate a general physician of his choice as his/hers personal physician and optionally a personal dentist and gynaecologist.

The personal physician is authorized and obliged to, among others, refer his patients who need it to a specialist, to a hospital, to a medical committee and to the Disability commission; prescribe medications and medical devices and establish temporary absence from work.

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.

Urgent medical assistance can be accessed without the referral of a physician and without the need to show the Health Insurance Card beforehand. In practice, the medical staff most often ask to see the Health insurance Card.

The Health Services Act of 13th February 1992, last amended on 15th February 2013 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.

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.

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695 Table of contributions for different types of insured persons http://www.zzzs.si/zzzs/internet/zzzs.nsf/0dbed6c0a93d31d8c1256a67006844b3/7f079796008ee60ec1256da00460146?OpenDocument.

696 Article 15 of the Law on Health Care and Health Insurance (op. cit. note 689) lists categories of people entitled to health insurance and care.


699 Law on Health Care and Health Insurance op. cit. note 689, article 81.


701 Rules on compulsory health insurance op. cit. note 697 - Article 179.

702 Public network of Primary healthcare services of September 2013, Ministry of Health, p. 8.
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. The institution regulating the compulsory insurance is the Health Insurance Institute of Slovenia, under the Law on Health Care and Health Insurance and Rules on compulsory health insurance. Both of these legal texts define and regulate the nature and extend of the rights of 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 specialized 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 that receives it.

For instance, compulsory health insurance covers in full:

- 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
- 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

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704 https://www.euro.who.int/__data/assets/pdf_file/0004/96367/E92607.pdf
705 Op. cit. note 697
706 Op. cit. note 697
707 http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C
708 Rules on compulsory Health insurance op. cit. note 697, article 22
And http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C
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 relating to the promotion of health services.

Destitute Slovene nationals are entitled to compulsory health insurance. If they cannot pay for voluntary insurance they 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§1.

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 health care, 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.

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.

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 stabilization of vital functions or the beginning of treatment in an appropriate place. Urgent transportation services are included in the urgent services.

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.

Abortion is supposed to be comprised in the urgency situations and free for everyone. Yet, it is sometimes considered as non-urgent care and thus billed.

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.

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709 Article 15 Law on Health Care and Health Insurance op. cit. note 689
710 Op. cit. note 697
711 Ibid.
712 For health services covered by the supplementary insurance, see http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/87C028D74130DE0AC1256E89004A4C0C.
713 Article 25 of the Law on Health Care and Health Insurance Op. cit. note 689
714 Ibid.
Access to healthcare for migrants

Authorized 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.\textsuperscript{715}

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 members\textsuperscript{716} are entitled to the coverage of the difference to full value of health treatment in addition to the part covered by the compulsory insurance, unless it is already fully covered. This difference is paid by the state.\textsuperscript{717}

Asylum seekers

Asylum seekers are only entitled to urgent medical assistance, which is defined in Article 84 of the International protection Act in force from 4th January 2008.\textsuperscript{718} Besides, medical screening may be required at the entrance of the Slovene territory.

However, the same article 84 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 basic medical examinations by a daily present nurse who decides if the asylum seeker needs urgent care or a medical consultation in a Health centre.

Access to healthcare is much more difficult for asylum seekers who are not accommodated in asylum home, mostly because they do not have a Health insurance Card. They can go to Health centres but the medical personnel is not familiar with their situation and their rights.

It should be noted that, since the 2013 “Dublin III” Regulation\textsuperscript{719}, only one country can consider an asylum application. Thus, if another country requests the responsibility for the application within the first three month of the proceedings, the asylum seeker will lose his right to reside in Slovenia and any rights attached to it.

Refugees and persons under international protection

Refugees have the same rights as the nationals of the Republic of Slovenia concerning access to healthcare.

Article 89 of International Protection Act\textsuperscript{720} 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 asylum seekers and refugees

Asylum seekers are entitled to free contraceptives, abortion, healthcare during pregnancy and childbirth, but not to

\textsuperscript{715}Article 20 of the Law on Health Care and Health Insurance Op. cit. note 689
\textsuperscript{716}Law on the exercise of rights from public funds (ZUPJS) in force since 2012 - Article 29 http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZA KO4780
\textsuperscript{717}Article 24 of the Law on Health Care and Health Insurance op. cit. note 689
\textsuperscript{718}International Protection Act (ZMZ) – 2007 http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZA KO4911
\textsuperscript{719}Op. cit. note 154
\textsuperscript{720}Ibid.
postnatal care. 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 asylum seekers and refugees**

Children of Asylum seekers, of Refugees and applicants who are unaccompanied minors 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.

- **Undocumented migrants**

Undocumented migrants are not covered by compulsory health insurance. They are only entitled to free urgent treatment.

In some cases, enumerated in article 73 of the Foreigners Act of 23th June 2011, 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 compulsorily insured in Slovenia must pay for delivery from their own funds as the delivery is considered foreseen and thus not as 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 insurance states that children up to 18 years attending school and not compulsorily insured, because their parents do not 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.

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).

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, it 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 a pregnant woman or a child due to the continuation of the pregnancy.

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721 Article 84 of the International Protection Act Op. cit. note 718
722 Ibid.
723 Op. cit. note 700
724 *The Foreigners Act – 2011*
725 Op. cit. note 697
726 Freedom Of Choice In Childbearing Act – 1977
http://www.uradni-list.si/1/objava.jsp? sop=2011-01-2360
727 Op. cit. note 697
728 Freedom Of Choice In Childbearing Act – 1977
http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZA KO408
Termination of pregnancy is reimbursed up to 80% of the amount by the compulsory insurance \(^{727}\).

Uninsured women have to pay for the termination of their pregnancy. The price for abortion varies greatly depending on the health service providers.

### EU citizens

Since the 2004 European Directive 2004/38/EC\(^{728}\), after three months of residence in Slovenia, EU citizens with insufficient resources and no health coverage are considered as undocumented migrants. They have the same access to healthcare as undocumented third-country nationals and are thus only entitled to urgent medical assistance.

EU 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\(^{729}\).

EU 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 \(^{730}\).

### 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. These agreements facilitate access to health for insured persons issued from countries Slovenia has an agreement with, and their family members\(^{731}\).

Thanks to the bilateral agreements with Bosnia and Herzegovina and Macedonia, insured persons from one contractor state with permanent residence in another contractor state are provided access to health treatment of the holder in place of residence by legislation, valid for this holder and to the burden of competent holder from the first state\(^{732}\).

Agreements with Serbia and Montenegro permit access to medical treatment in conformity with legislation of the second state and to the burden of competent holders from the first contractor state to certain categories of posted workers regardless of their permanent or temporary residence\(^{733}\).

### Unaccompanied minors

Unaccompanied minors asking for asylum are entitled to healthcare under the same conditions as nationals of the Republic of Slovenia.

Unaccompanied minors who do not apply for asylum are considered as undocumented migrants and are thus only entitled to urgent medical assistance.

\(^{727}\) Article 23 of the Law on Health Care and Health Insurance op. cit. note 689

\(^{728}\) Op. cit. note 189

\(^{729}\) Op. cit note 689

\(^{730}\)http://www.zzzs.si/zzzs/internet/zzzseng.nsf/o/41A664904BA3992AC1256E890048C1AB


\(^{732}\) Art. 12/3 in both agreements

\(^{733}\) Art. 12/3 in both agreements
Protection of seriously ill foreign nationals

According to Article 73 of the Foreigners Act\textsuperscript{734}, 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 temporary residence in Slovenia when they come from areas where contagious diseases epidemics as listed in the international health rules of the World Health Organization, or from areas where contagious diseases are present that might endanger human health and for which according to the law regulating contagious diseases (Contagious Diseases Act\textsuperscript{735}), special measures have to be taken\textsuperscript{735}. This also applies to EU citizens, who can also be denied admission in Slovenia\textsuperscript{736}.

Article 199 §3 of the Foreigners Act\textsuperscript{737} 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\textsuperscript{738}. 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 Insurance\textsuperscript{739} 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 compulsory health insurance.

Contagious diseases for which it is required to take measures are determined in Article 8 of the Contagious Diseases Act\textsuperscript{740}.

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\textsuperscript{741}.

Uninsured people can get anonymous and free of charge testing and counselling for VIH and Hepatitis C at an Infectious Diseases and Febrile Conditions Clinic, but no treatment is guaranteed.

Health centres for uninsured persons

Three Health centres for persons without compulsory health insurance exist in Slovenia.

These pro-bono clinics, located in Ljubljana, Maribor and Koper are the result of programs established by different organizations as Caritas or Slovene Philanthropy starting 2002.

Health centres provide medical assistance and services by physicians at the primary

\textsuperscript{734} Foreigners Act Op. cit. note 724
\textsuperscript{735} Foreigners Act Op. cit. note 724 – Article 55
\textsuperscript{736} Foreigners Act Op. cit. note 724 – Article 118
\textsuperscript{737} Foreigners Act Op. cit. note 724
\textsuperscript{738} Contagious Diseases Act of 7th March 2006
\textsuperscript{739} Op. cit. note 689
\textsuperscript{740} Op. cit. note 738
\textsuperscript{741} Op. cit. note 738
SLOVENIA

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 former 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. They were therefore left without legal Slovene documents.
National Health System

Constitutional basis

The Spanish Constitution of 1978 recognises in Article 43 the "right to health protection". 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”.

Organisation and funding of Spanish healthcare system

The Spanish healthcare system is based on solidarity. It aims to redistribute income amongst Spanish citizens. 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.

Accessing Spain healthcare system after 2012 Royal-Decree

General Health Law No. 14/1986 of 25 April 1986 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.

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.


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 16/2003):

- 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

743 Ibid.
745 Ibid.
749 Op. cit. note 747
751 Op. cit. note 747
equal to or over 65%) of an insured person.

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. Since the Royal Decree-Law 1192/2012 regulating insured and beneficiary status for the purposes of healthcare in Spain charged to public funds through the National Health System, the requirements must be met which are imposed by law to be “insured” or a “beneficiary” – a condition that must be officially recognised by the National Institute of Social Security (INSS). 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 medicines which are included in the catalogue of medicines covered by the social security system (others are not covered). 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 16/2003 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];


753 Royal Decree of 3 August 2012 http://www.seg-social.es/Internet_1/Normativa/169476


755 There are more than 15 000 medicines covered, http://www.msssi.gob.es/profesionales/nomenclador.do

756 List of medicines which have been excluded in 2012, http://www.msssi.gob.es/profesionales/farmacia/pdf/BOEA201210952.pdf

757 Op. cit. note 747
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 residing in the country whatever their financial resources or legal status.

With this Royal-Decree, access to care is considerably reduced. This reform radically changed Spanish health coverage, leaving millions 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.

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. 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

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758 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.epha.org/a/5161

759 Op. cit. note 748

Consequences of the 2012 health reform in Spain

Royal Decree 16/2012, adopted on 20 April 2012, establishes in Spain a health system close to that of insurance and therefore far from the idea of a system of universal access to healthcare. It constitutes a structural transformation.

The consequences of the reform may have real, dangerous effects on the population's health, “specifically concerning infectious diseases like tuberculosis or HIV-infected patients, in addition to endangering access to care for those mentally ill, addicted to drugs or vulnerable groups like homeless individuals.”

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. It also added that times of economic crisis cannot be an excuse to deny or restricting the right to health to this vulnerable group.

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.

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 realized.

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 12/2009 as well as by the fourth additional provision of Royal Decree 1192/2012. 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. 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.

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761 Royal Decree 16/2012


764 Op. cit. note 762

765 Op. cit. note 762

766 Op. cit. note 762

767 Law of 30 October 2009,

768 Op. cit. note 763

769 Op. cit. note 767
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, 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 16/2012, 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 16/2012 introduced a new Article 3ter to Law 16/2003 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);
- emergency care should remain freely accessible.

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. This situation creates administrative confusion and therefore inequality in access to healthcare depending on where someone lives.

Indeed, several Spanish communities restored healthcare coverage for undocumented migrants, with different conditions to obtain it, as Castilla-La Mancha, Andalusia Valencia, Navarra, Aragon Balearic Islands, Cantabria, Valencia, Catalonia, the Canary Islands, Murcia and the Basque Country. The Community of Madrid did not issue any law but sent an internal statement to Health Centers with the order to provide medical attention to everyone.

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

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770 Op. cit. note 748
771 Op. cit. note 748
772 Op. cit. note 747
773 J. A. Pérez-Molina and F. Pulidob, “¿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
774 Ibid.
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. Indeed, women are asked to present their IHC and if they do not have one, they are instructed to go to the emergency department.

Furthermore, because of the poor level of information around the reform, neither health providers nor undocumented pregnant women know that the 2012 Royal Decree allows them 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.

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.”

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. Indeed, the Spanish National 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.

In practice, children in need of healthcare go to health providers and are asked for their IHC. If they do not have one because of administrative barriers and misinformation, they can be denied care and sent to the emergency department in the meantime.

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

775 Op. cit. note 762
778 Op. cit. note 748
779 Op. cit. note 748
780 Op. cit. note 32
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 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.

Thus, EU nationals who have lost their authorisation to reside in Spain must apply for a “special provision”, under the same conditions as undocumented migrants, to be readmitted into the Spanish National Health System.

In addition, in 2013, the European Commission raised concerns about the issue of the EHIC European patients who hold an EHIC have been denied access to public healthcare.

Unaccompanied minors

Article 3ter, subparagraph 4 of Law 16/2003 (introduced by Article 1 of 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”.

Protection of seriously ill foreign nationals

Article 126 of Royal Decree 557/2011 of 20 April 2011 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 after 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 16/2012 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

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782 Ibid.
783 Op. cit. note 747
784 Royal Decree 557/2011
785 It is very difficult for doctors to attest if the disease occurred after or before arrival.
786 Op. cit. note 748
(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 healthcare\textsuperscript{787} and, in particular, regarding the treatment of infectious diseases\textsuperscript{788}.

In six autonomous communities (Aragon, Canary Islands, Catalonia, Extremadura, Galicia and Valencia) there are health programmes with specific rules for each them that enable access to primary and specialised healthcare for undocumented migrants with no resources (therefore it provides healthcare to those people with infectious diseases who have no IHC and no resources); but this does not guarantee free access to medicines.\textsuperscript{789} The undocumented migrants must be registered in the locality and be able to prove their lack of resources\textsuperscript{790} and satisfy other administrative requirements.

There is a very small percentage of undocumented migrants who can access these programmes. For those people with a disease which is considered to be a risk to public health but who do not have an IHC and cannot access this programme, the only alternative is to access healthcare but to be invoiced afterwards for the service (unless they have previously subscribed to a special agreement\textsuperscript{791}).

There is no information on specific provisions to guarantee access to treatment for those with infectious diseases.

**Cantabria**

Cantabria’s Programme of Social Protection and Public Health\textsuperscript{792} 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\textsuperscript{793}), granting any resident in Navarra – 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 recognizing the right to free healthcare for undocumented migrants and to lift the suspension of the other provisions of the law\textsuperscript{794}.

To support this decision, it was argued that, given the vulnerability of the Spanish economy, a region cannot decide to fully cover healthcare for undocumented migrants.

**Castile and Leon – La Rioja**

With regards to 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\textsuperscript{795}. Both

\textsuperscript{787} Op. cit. note 762  
\textsuperscript{788} Op. cit. note 773  
\textsuperscript{789} Op. cit. note 762  
\textsuperscript{790} Op. cit. note 773  
\textsuperscript{791} Op. cit. note 762  
\textsuperscript{792} Op. cit. note 762  
\textsuperscript{793} Ley Foral 8/2013  
\textsuperscript{794} http://hj.tribunalconstitucional.es/en/Resolucion/Show/23930  
\textsuperscript{795} Op. cit. note 773
regions provide healthcare in cases of risk for national public health.

**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 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 Decree796. Nonetheless, in Madrid, this treatment is charged to the patient. In the Balearic Islands, the treatment is free and the same is true for Catalonia797.

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 communities798. This document does not specifically refer to undocumented migrants, but broadly to any person who does not benefit from the National Health System799.

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 treatment800.

Various diseases are included such as HIV, hepatitis B and C, tuberculosis801.

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 migrants802.

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796 Op. cit. note 773  
797 Op. cit. note 773  
799 Ibid.  
800 Op. cit. note 798  
801 Op. cit. note 798  
802 http://www.chueca.com/articulo/la-exclusion-de-migrantes-de-la-sanidad-impide-el-control-de-las-enfermedades-infecciosas
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 [...].”

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 [...].”

The Swedish healthcare system has an explicit public commitment to ensure the health of all citizens. The Health and Medical Services Act 1982 not only incorporated equal access to services on the basis of need, but also emphasises a vision of “equal health for all.”

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.

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.

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 Act 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

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804 Ibid.
806 http://www.euro.who.int/en/countries/sweden
809 Op. cit. note 805
considerable freedom with regard to the organisation of their health services.

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 country, in accordance with Section 3 of the Health and Medical Service act.

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 Act 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 care.

The Swedish health system does not provide medicines free of charge to individuals with health coverage. However, according to the 2002 Law on Pharmaceutical Benefits, 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.

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.

There is a high-cost threshold that reduces patient costs for prescription medicines. The high-cost applies for a 12 month period, starting after purchases amounting to €118 (SEK 1,100) for prescription medicines during a 12-month period.

In practice, the patient pays the full price for their medicines up to around €118 (SEK1,100). Following this, a discount system comes into effect:

- between €118 (SEK 1,101) and €225 (SEK 2,100), the patient pays 50% of the cost of the medicine;
- between €225 (SEK 2,101) and €418 (SEK 3,900), the patient pays 25% of the cost of the medicine;
- between €418 (SEK 3,901) and €580 (SEK 5,400), the patient pays 10% of the cost of the medicine.

Patients who bought medicines on prescription for €236 (SEK 2,200) within a 12-month period do not pay any more for their medicines during the remaining time in that period.

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810 Op. cit. note 216
811 Op. cit. note 805
812 Op. cit. note 805
813 Op. cit. note 216
814 Law on Pharmaceutical Benefits of 2002
815 http://www.tlv.se/In-English/in-english/
816 http://www.tlv.se/In-English/medicines-new/the-swedish-high-cost-threshold/how-it-works/
817 Ibid.
818 Ibid.
The medicine fee system is different for asylum seekers and undocumented migrants. According to Regulation on care fees for foreign nationals staying in Sweden without the necessary permits, asylum seekers and undocumented migrants only have to pay a fee of a maximum of €5.20 (50 SEK) per prescribed drug. This applies to medicines subsidised by the State.

The fees for GP consultations are set by each county and vary between 100 and 300 SEK (€10-32) across the country. Annual out-of-pocket payments for healthcare visits are capped nationally at 1,100 SEK (€118) 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.

Access to healthcare for migrants

Asylum seekers and refugees

Pursuant to the 2008 Law on Health and Medical Services for Asylum Seekers and Others, asylum seekers are entitled to subsidised:

- health and dental care that “cannot be postponed”
- contraceptive advice
- pregnancy termination
- maternity care

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 a determined period (three, four or six months). This card must be presented when seeking care.

Upon their arrival in Sweden, asylum seekers are required to undergo a free health examination.

For any visit to a health centre or hospital, adult asylum seekers pay around €5 (SEK 50) for the visit or examination and around €5 (SEK 50) when buying most prescribed medicines from the pharmacy. For medical transport they pay a maximum of €4.30. According to the Reception of Asylum Seekers Act (LMA), asylum seekers who are registered are entitled to assistance, including a daily allowance.

If they have paid more than €43 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 €43, paying the county administrative board for medical examinations and care received by asylum seekers. The county administrative board

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820 Op. cit. note 216
823 Swedish Migration Agency, http://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care.html
824 Ibid.
825 Ibid.
827 Op. cit. note 823
can also, following an application, receive payment for special costly care.\textsuperscript{829}

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 fees\textsuperscript{830}, 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 €43.

Starting 1 June 2016, amendments made to the Reception of Asylum Seekers’ Act (LMA)\textsuperscript{831} 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.\textsuperscript{832} 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 is expected to enter into force on 20 July 2016. This law will considerably limit 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 will apply for asylum seekers who arrived after 24 November 2015.\textsuperscript{833}

Finally, in accordance with the Dublin III Regulation\textsuperscript{834}, during the 3 first month 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 status and the rights attached to it and will be transferred to the country declared competent to examine his 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.\textsuperscript{835}

**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.\textsuperscript{836}

This is regulated by the Law on Health and Medical Services for Asylum Seekers and Others (2008:344).\textsuperscript{837}

**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 Foreigners Residing in Sweden without

\textsuperscript{829}Ibid.
\textsuperscript{830}Op. cit. note 819
\textsuperscript{831}Op. cit. note 826
\textsuperscript{832}http://www.migrationsverket.se/Om-Migrationsverket/Nya-lagar-2016/Vanliga-fragor-och-svar.html
\textsuperscript{833}http://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/Frequently-asked-questions-.html
\textsuperscript{834}Op. cit. note 154
\textsuperscript{835}http://www.1177.se/Other-languages/Engelska/Regler-och-rattigheter/Vard-i-Sverige-om-man-ar-asyllskande-gomd-eller-papperslos/#section-4
\textsuperscript{836}Ibid.
\textsuperscript{837}Op. cit. note 821

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 Benefit
- health care “that cannot be deferred
- pregnancy termination
- contraceptive counselling
- sexual and reproductive care
- maternity care.

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. 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 criticized 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 jeopardizing patient safety.”

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.”

Since the Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act came into force on July 2013, MdM SE team has observed difficult implementation. Medical staff lack information and understanding about the new law and often apply the former system. Indeed, some public hospitals claim payment for health costs. For instance, GP consultations are sometimes billed €45, whereas they should cost around €5.

What is more, it is extremely easy for the billing departments to know the legal status of a patient, based on their personal identity number. Undocumented migrants do not have any number or have a temporary one assigned by health clinics which does not match the official pattern.

As a result, many undocumented migrants are still denied access to healthcare they are entitled to.

Undocumented pregnant women

The July 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (2013:407) states in its article 7 that undocumented pregnant women are entitled to free maternal healthcare, abortion and contraception.

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839 Op. cit. note 814
840 Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (2013:407) Article 7
844 Op. cit. note 840
However, in practice, women often get 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 Act, children of undocumented migrants have the same rights to medical and dental care as the children of Swedish nationals.

Moreover, healthcare in Sweden is free for children under 18 years old.

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 (girls only).

The vaccination of young children is performed 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.

**EU citizens**

The EU directive 2004/38 transposed into the Foreigners Act (2005:716), 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.

The government bill 2012/13:109 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 on the basis of the 2013 law.

In practice, they remain in the former system and have to pay full fees for...

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845 Op. cit. note 840
847 http://www.1177.se/Fakta-och-rad/Behandlingar/Vaccinationer-av-barn/
849 Op. cit. note 189
850 Foreigners Act of 2005
http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-
receiving healthcare in most 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 service, including healthcare, for children under the age of 18 seeking asylum as for other children who are citizens or residents in Sweden. This includes child psychiatric and dental care.

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. Pursuant to Chapter 19 of the 1949 law (1949:381), the chief guardian is elected by the city council. They are elected for a four-year period.

Protection of seriously ill foreign nationals

According to Chapter 5, Section 6 of the Foreigners Act of 29 September 2005, a residence permit can be granted to a foreign national on grounds of exceptionally distressing circumstances. The evaluation 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.

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) 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.

Since the 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act which grants the same access to healthcare for undocumented migrants as asylum seekers and refugees, undocumented migrants also have access to testing and treatment free of charge.

Diseases such as tuberculosis, HIV and hepatitis are covered by the law.

Pursuant to the Communicable Disease Act of 1998, physicians are obliged to notify...
cases of communicable diseases dangerous to society. The identity and immigration 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 get tested and to receive treatment.
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”\textsuperscript{861}. 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”\textsuperscript{862}.

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 (…)”\textsuperscript{863}.

In addition, Article 118 enshrines the protection of health, for which “the Confederation shall, within the limits of its powers, take measures”\textsuperscript{864}.

Organisation and funding of Swiss healthcare system

The Swiss Federal Law on Compulsory Health Care (LAMal) entered into force on 1 January 1996\textsuperscript{865}. 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\textsuperscript{866}.

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\textsuperscript{867}. Moreover, the Swiss system being highly decentralised, the 26 Swiss cantons are largely responsible for the provision of healthcare and insurance companies (around 90 across the country) operate primarily on a regional basis\textsuperscript{868}.

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 inpatient acute care);
- social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance and military insurance\textsuperscript{869}.

\textsuperscript{861} Federal Constitution of the Swiss Confederation of 1999 (last updated 18 May 2014), http://www.admin.ch/ch/e/rs/1/101.en.pdf

\textsuperscript{862} Ibid.

\textsuperscript{863} Op. cit. note 861

\textsuperscript{864} Ibid.


\textsuperscript{866} Civitas, Health care Systems: Switzerland, by Claire Daley and James Gubb, updated by Emily Clarke (December 2011) and Elliot Bidgood (January 2013), http://www.civitas.org.uk/nhs/download/switzerland.pdf

\textsuperscript{867} Ibid.

\textsuperscript{868} Op. cit. note 866

\textsuperscript{869} Op. cit. note 216
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 832.102). Article 6 LAMal completes these provisions by explaining that the cantons are in charge of making 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 CHF300 (€277) and CHF2500 (€2,310) for adults (CHF0 to CHF600 (€554)) for children and must also contribute up to 10% (proportional share) of the cost of the services provided.

This proportional share is capped at CHF700 (€647) per adult and CHF350 (€323) per child. In other words, in addition to the monthly premium, an adult who has opted for a €277 franchise will pay a maximum of €924 (€277 + €647) 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 them 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, they have 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) modified this provision. Insurance funds no longer have the right to suspend healthcare reimbursements if an individual fails to pay their 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).

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870 Health Insurance Ordinance 832.102 https://www.admin.ch/opc/fr/classified-compilation/19950219/201506010000/832.102.pdf
872 http://www.guidesocial.ch/fr/fiche/55/%23som_134251
873 http://www.admin.ch/opc/fr/classified-compilation/19940073/index.html#a64a
874 Op. cit. note 870
A partial reduction or full exemption from monthly premiums is foreseen in Article 65(1) LAMal\(^875\) 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 851.1\(^876\)) 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)\(^877\). Social assistance\(^878\) is granted if a person in need cannot be looked after by their family or cannot claim other legal services to which they have a right (principle of subsidiarity)\(^879\).

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\(^880\).

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\(^881\). 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 Code\(^882\) (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)\(^883\). 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.

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”.

They can make a claim for premium reductions if they are “on a low income”. 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). 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 through a referendum on 5 June 2016. The results of the vote are provisory as of July 2016, but the law is expected to be adopted with a large majority. 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 they have access to antenatal and postnatal care. 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.

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888 https://www.admin.ch/gov/fr/accueil/documentation/votations/20160605/modification-de-la-loi-sur-lasile.html
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 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.

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.

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 nationals, individuals who host undocumented migrants can be punished by a fine or imprisonment of up to one year.

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, even if it is expensive. 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 franchise, 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 Constitution which foresees that “anyone in distress who cannot take care of himself has the right to aid and assistance and to an existence compliant with human dignity”. These aid and assistance provisions are free of charge.

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. 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

889 Op. cit. note 861
891 The franchise or deductible is the amount which has to be paid by the patient before the insurance starts paying.
892 Op. cit. note 861
893 http://www.guidesocial.ch/fr/fiche/46/
reported. Insurers must maintain confidentiality with regard to third parties 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.

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.

Mostly 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, a lot of 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.

Termination of pregnancy

According to Article 119 of the Criminal Code, termination of pregnancy is possible up to 12 weeks following the beginning of a women’s last period. After 12 weeks, termination is only possible if a

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894 Federal Law on the general section of social insurance of 2000, Article 33, 84, 92, c
895 http://www.bag.admin.ch/themen/krankenversich
erung/04114/04285/index.html?lang=fr
896 Op. cit. note 882
A serious health condition for which no treatment in the country of origin exists is not sufficient in itself as a criterion, as 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.

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 “an extreme seriousness” or 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. The definition of “extreme seriousness” depends on the examination of several criteria referred to in Article 31 of the Ordinance of 24 October 2007 related to the admission, residency and exercise of a lucrative activity.

A serious health condition for which no treatment in the country of origin exists is not sufficient in itself as a criterion, as the

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897 Op. cit. note 865
898 https://www.osar.ch/droit-dasile/procedure-dasile/mineurs.html
900 Ibid.
901 Op. cit. note 899
902 http://www.admin.ch/opc/fr/classified-compilation/19995092/index.html#a82a
904 Ibid.
905 Op. cit. note 890
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) are systematically examined by the Federal Administrative Court. 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 “the execution of the decision cannot be reasonably requested if the deportation or expulsion of the foreign national to his or her country of origin or provenance concretely puts that person in danger, for example in the event of war, civil war, generalised violence or medical necessity”. 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”.

Treatment of infectious diseases

Costs linked to HIV screening and HIV treatment are covered by the basic compulsory health insurance. 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 but they have to pay between €27 (CHF30) and €55 (CHF60) for HIV screening (€27 (CHF30) for those under 20 years old) and between €27 (CHF 30) and €37 (CHF40) for hepatitis C screening.

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 that they can get health coverage and thus free treatment for a period of one year. However, this scheme is not enough to cover all undocumented migrants.

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907 Order of the Interior Federal Department (DFI) of 1995, Article 12d
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”909. Article 60 explains that “everyone has the right to social security”910.

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)911.

In 2006, the parliament ratified the Law on Social Insurance and Universal Health Insurance (Law No. 5510 – GHI Law)912. With this law, the three separate schemes (Bağ-Kur, SSK and GERF913) 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).

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 facilities914. The SSI is funded through payments by employers and employees and government contributions in cases of budget deficit915.

The Ministry of Health is the main actor in planning and supervising health services916.

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 sources917. Social health insurance contributions take the lead, followed by government sources, out-of-pocket payments and other private sources918.

The SSI finances the cost of healthcare services provided by health service providers 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 share919.

Accessing Turkey healthcare system

In theory, as introduced by the GHI Law, the GHIS provides individuals residing in

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910 Ibid.
914 Ibid.
915 Op. cit. note 913
916 Op. cit. note 913
917 Op. cit. note 913
918 Op. cit. note 913
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. 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 Law (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.

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. 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. 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.

In accordance with Article 60 of the GHI Law, 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 around €400 as of 1 January 2016, so destitute citizens have less than approximately €133 per month.

The SSI provides preventive care free of charge for every citizen, even those without health coverage. Regarding medicines, a co-payment of €1 is required for prescriptions. If more than three medicines are included in the prescription, this co-payment increases by €0.30 for each medicine.

Co-payments for outpatient care have been introduced for all those covered by the SSI who present at hospitals without a referral.

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921 Op. cit. note 912
922 Op. cit. note 913
923 Op. cit. note 913
924 Op. cit. note 913
925 Op. cit. note 913
926 Op. cit. note 913
927 Op. cit. note 912
928 http://www.fedee.com/pay-job-evaluation/minimum-wage-rates/
929 http://www.asylumineurope.org/sites/default/files/report-download/aida_tr_update.i.pdf
from a primary care physician (GP); patients pay €5 to public hospitals. However, inpatient services are fully covered\(^9\). Visits to primary care facilities do not require a co-payment\(^9\).

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\(^9\). 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\(^9\).

Asylum seekers and refugees

Turkey was one of the original signatories to the 1951 Refugee Convention\(^9\). However, it adopted the Convention with a “geographical limitation”\(^9\).

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\(^9\).

The legal framework for asylum in Turkey was shaped by the Law on Foreigners and International Protection (LFIP)\(^9\), which was passed by the Turkish parliament in April 2013 and came into force since April 2014. The LFIP is a milestone in Turkish asylum law, as it overhauled the entire Turkish asylum system and incorporated

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\(^9\) Op. cit. note 913
\(^9\) Op. cit. note 913
\(^9\) http://www.admdlaw.com/health-care-services-for-foreigners-in-turkey/#VOCdrku6w7s
\(^9\) Convention relating to the Status of Refugees - 1951
http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx

\(^9\) Asylum Information Database, Country report: Turkey, December 2015, p. 15
http://www.asylumineurope.org/sites/default/files/report-download/aida_tr_update.i.pdf

\(^9\) 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

\(^9\) Law 6458 on Foreigners and International Protection (LFIP) – 2013
http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=5167fbb20
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. Individuals coming from a “non-European country of origin” may only apply for a conditional refugee status or for subsidiary protection, 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), 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.

Pursuant to article 89-3a of the Law on Foreigners and International Protection, “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 usually extended free healthcare coverage.

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.

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”.

These conditions do not apply for “Temporary protection” beneficiaries. Pursuant to article 27 of the Temporary Protection Regulation, all registered “temporary protection” beneficiaries, whether residing in the camps or outside the camps, are covered under Turkey’s general health insurance scheme. As such, they have the right to access free of charge health care services provided by public health care service providers.

Individuals eligible for “temporary protection” who have not yet completed their registration only have access to

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938 Law on Foreigners and International Protection, op. cit. note 937, article 61
939 Law on Foreigners and International Protection, op. cit. note 937, article 62
940 Law on Foreigners and International Protection, op. cit. note 937, article 63
941 Temporary Protection Regulation of 22 October 2013 http://www.refworld.org/docid/56572fd74.html
942 NOAS, Seeking asylum in Turkey, 2016, op. cit. note 936, p. 15
943 Op. cit. note 937
944 Asylum Information Database, Country report: Turkey, December 2015, op. cit. note 935, p. 87
945 Asylum Information Database, Country report: Turkey, December 2015, op. cit. note 935, p. 73
946 Ibid.
947 Op. cit. note 941
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 immunization for communicable diseases, specialized services for infants, children and teenagers as well as maternal and reproductive health services\textsuperscript{948}.

As a general rule, 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\textsuperscript{949}. In addition, beneficiaries are expected to pay TL3 (€0.89) per medication item up to three items, and TL1 (€0.29) for each item in 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\textsuperscript{950}.

“Temporary protection” beneficiaries’ access to secondary and tertiary health care services is conditional upon whether the health issue in question falls within the scope of the Ministry of Health’s Health Implementation Directive (SUT). For treatment of health issues which do not fall within the scope of the SUT or for treatment expenses related to health issues covered by the SUT, which however exceed the maximum financial compensation amounts allowed by the SUT, beneficiaries may be required to make an additional payment. Free health care coverage for registered “temporary protection” beneficiaries also extends to mental health services provided by public health care institutions.

So far, the transition to the new asylum scheme has been characterized 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 (ie, not publicly available) circulars have instead been shaping the practice until the adoption of the implementing regulation on 17 March 2016\textsuperscript{951}, 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\textsuperscript{952}. Moreover, the amount charged

\begin{flushright}
\textsuperscript{948} Asylum Information Database, \textit{Country report : Turkey}, December 2015, op. cit. note 935, p. 88  \\
\textsuperscript{949} Asylum Information Database, \textit{Country report : Turkey}, December 2015, op. cit. note 935, p. 131  \\
\textsuperscript{950} Ibid.  \\
\textsuperscript{951} Regulation on the Implementation of the Law on Foreigners and International Protection – 2016  \\
http://www.resmigazete.gov.tr/eskiler/2016/03/20160317-11.htm  \\
\textsuperscript{952} M. Blézat and J. Burtin, « Soigner le mal par le rien », \textit{Plein droit}, juin 2012, No 93.
\end{flushright}
for specialised care for a person considered to be a tourist is four times that for non-tourists. In practice, these prices are applicable to undocumented migrants who require care.

In addition, the healthcare system reform in Turkey which has been implemented since 2003 made the primary healthcare centre, where undocumented migrants could access healthcare with a GP, accessible only to individuals with health coverage. Undocumented migrants have to go to expensive private clinics to vaccinate their children.

Public hospitals are obliged to treat everyone in case of emergency. However, the team in Istanbul has observed 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.953

According to the Doctors of the World – Médecins de Monde (MdM) partner in Turkey, 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 Kumkapi detention centre. This phenomenon has been observed since at least 2010.954 In most cases, these arrests break the continuity of care and they also demonstrate the cooperation which exists between the police and hospital staff.955

According to the law contradicted by the 2011 circular, everyone should have free access to emergency services regardless of their legal status. However, the law does not define the term “emergency care”, so the interpretation of the law is left to hospital staff. Thus, public hospitals often ask migrants to pay their medical bill for the emergency care they receive.

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. In practice, undocumented migrants have to rely on organisations such as ASEM to act as mediators in their access to public hospitals.

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 comprises two consultations: one at around three months and one at eight months).

Otherwise, pregnant women have to pay out-of-pocket hospital fees. For example, a delivery by caesarean section is around €3,500 and a vaginal delivery is around €1,000. Sometimes, hospitals are willing to accept payment by instalments or sometimes they call the police who take the woman and her new-born 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.956

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 to the 20th week if the pregnancy threatens the woman’s mental and/or physical health, or if the conception occurred through rape.

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953 Op. cit. note 952
954 Op. cit. note 952
955 Op. cit. note 952
956 Abortion in Turkey is legal until the 10th week after the conception, although that can be extended
around €18, added to the medical consultation which costs around €40.

**Unaccompanied minors**

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.

However, the circular recommends the use of medical tests for determining the age of minors if they do not have documentary proof of their age, or if the police have doubts about the age stated in such documentation. It specifically allows minors to be held in reception centres and 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.

Moreover, there is no margin of error applied to the result of the tests, as recommended by international standards. 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.

In addition, a policy was adopted by the 2005 UNHCR ‘Procedural standards for refugee status determination under UNHCR’s mandate’, which states that age assessment should be resolved in the favour of the child.

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)).

The law states that unaccompanied minors who apply for international protection are not to be detained. 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).

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 a refugee should receive protection from the state and should have access to healthcare. Those who receive a decision and have their application refused

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960 Op. cit. note 958
961 Op. cit. note 958
962 Op. cit. note 958
963 Op. cit. note 957
964 Op. cit. note 957
965 Op. cit. note 957
966 Op. cit. note 958
967 Op. cit. note 958
968 Op. cit. note 958
969 Ibid.
may be detained\textsuperscript{966} and are sometimes detained in a manner akin to kidnapping\textsuperscript{967}.

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<th>Protection of seriously ill foreign nationals</th>
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Law no. 6458 on Foreigners and International Protection of April 2013\textsuperscript{968} 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.

\textsuperscript{966} “During his visit, the Special Rapporteur on the Human Rights of Migrants expressed concern about the situation of children at both the Kumkapı 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)”

\textsuperscript{967} http://www.globaldetentionproject.org/countries/europe/turkey/introduction.html

\textsuperscript{968} Op. cit. note 952

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<th>Prevention and treatment of infectious diseases</th>
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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).

Turkish citizens, authorised residents, asylum seekers and refugees with health coverage have free access to screening and treatment for hepatitis B and tuberculosis.

Preventive health services for refugees are delivered by local public and family health centres. 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 individuals with health coverage, has to pay for their treatment which is very expensive.

Finally, undocumented migrants do not have access to treatment. According to the team in Istanbul, most of them would have better access to these treatments in their country of origin through non-governmental organisations working in these areas. Thus, the small minority of undocumented migrants that find out that they are HIV positive often decide to return to their country of origin to be treated.
In the United Kingdom, a comprehensive public health service was established by the National Health Service Act of 1946 and subsequent legislation. 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. That principle remains at its core. 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.

The Health Act 2009 established the NHS Constitution\textsuperscript{969} 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 staff\textsuperscript{970}. 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\textsuperscript{971}.

The NHS is intended to provide universal health coverage to the population in the UK. All “ordinarily resident” in the UK are automatically entitled to healthcare that is largely free at the point of use through the NHS\textsuperscript{972}, except for certain minor charges.

People from EU countries are also entitled to care free at the point of delivery if they have an 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)\textsuperscript{973} which commissions most health services for the population in its area, including: planned hospital care; rehabilitative care; urgent and emergency care; most community health

\textsuperscript{971} Ibid.
\textsuperscript{972} Op. cit. note 139
\textsuperscript{973} http://www.patient.co.uk/doctor/clinical-commissioning-groups-ccgs

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405352/pdf/13167_2010_Article_50.pdf
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 1989975 to make Regulations in relation to NHS hospital treatment, now consolidated as the NHS (Charges to Overseas Visitors) Regulations 2015976.

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 the exemption category. Nobody is excluded from primary care (i.e. GP treatment).

The concept of ordinary residence appears in many areas of law, but until recently it hadn’t 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”977.

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 here, but they do 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 residence978. Ordinary residence should not be confused with permanent residence, usual residence or other phrases describing residence979.

In May 2014, the government published a new Immigration Act 2014980 which included provisions regarding entitlement to National Health Service treatment that came into force in April 2015.

According to the Government981, the Act is intended to: introduce changes to the removals and appeals system, making it easier and quicker to remove “illegal immigrants” from the UK982; end the “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

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975 Shah v Barnet London Borough Council and other appeals [1983] 1 All ER 226
977 Shah v Barnet London Borough Council and other appeals [1983] 1 All ER 226
979 Department of Health, Internal review of the overseas visitor charging system - Part 2
982 Please note that MdM and its partners, especially PICUM, absolutely disagree with the use of « illegal » designing a person. Only the laws declaring that a person is illegal are illegal. No one is illegal. http://picum.org/en/our-work/terminology/
“abusing” public services or the labour market.\(^\text{983}\)

Section 39 Immigration Act 2014\(^\text{984}\), 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\(^\text{985}\). 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\(^\text{986}\). It therefore increased the threshold for “ordinary residence”, as indefinite leave to remain can only be applied for after a minimum of 5 years 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 DH consulted on making changes in primary care, secondary care, community healthcare and changing current residency requirements for EEA citizens\(^\text{987}\). Starting 6 April 2016, Australia and New Zealand nationals planning to come to the UK or stay in the UK for more than 6 month will no longer be exempted from the “health surcharge” fee\(^\text{988}\) (see below).

### Accessing the NHS

#### Primary care

As of March 2015, patients in England pay £8.2 per prescription\(^\text{989}\), but some patients who need more than 13 prescriptions per year or four prescriptions in three months can obtain reductions through a prescription prepayment system\(^\text{990}\). In Wales\(^\text{991}\), Scotland\(^\text{992}\) and Northern Ireland\(^\text{993}\), 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; the chronically ill (e.g. cancer and diabetes patients) and disabled patients; as well as for people who receive some form of means-tested social security benefit\(^\text{994}\).

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 usually valid for one year from

983 Op. cit. note 981
985 Op. cit. note 980
986 Op. cit. note 980
990 Ibid.
993 [http://www.nhs.uk/ipgmedia/national/Asthma%20UK/Assets/Prescriptionchargesandasthma.pdf](http://www.nhs.uk/ipgmedia/national/Asthma%20UK/Assets/Prescriptionchargesandasthma.pdf)
994 [http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx](http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx)
the date of issue and must be produced each time when collecting a prescription or receiving treatment, e.g. dental care, glasses, etc.995.

In England, Section 3 NHS Act 2006, as amended by Section 13 Health & Social Care Act 2012996 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 2013997 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 un linking immigration status from eligibility for primary care.

Regulation 2 of the NHS (General Medical Services Contracts) Regulations 2004998 (GMS Regs), which governs the delivery of many NHS primary medical services999, defines “patient” as including temporary residents. Paragraph 16 of Schedule 6 GMS Regs1000 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 if identity are not reasonable groups to refuse a registration1001.

Secondary care

Ordinarily resident

All “ordinarily residents” of the UK are automatically entitled to secondary healthcare that is largely free at the point of use through the NHS1002. People who are not ordinarily resident, 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

999Many 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.
1002Op. cit. note 139
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. This also concerns third-country nationals already in the UK who apply to extend their stay.

The health surcharge is of £200 per year and £150 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 ordinarily resident. 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.

**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. 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.
- Family planning services and treatment of sexually transmitted infections, 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 tests, as well as testing for STIs.
- Diagnosis and treatment for communicable diseases such as influenza, measles, mumps, tuberculosis, viral hepatitis and HIV/AIDS.

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1004 Ibid.


1006 Op. cit. note 1003

1007 Ibid.

1008 Op. cit. note 1007

1009 http://www.nhs.uk/Conditions/contraception-guide/Pages/contraception-clinic-services.aspx

1010 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 uraemic syndrome, infectious bloody diarrhoea, invasive group A streptococcal disease.
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 a compulsory treatment under the mental health Act, prisoners and immigration detainees. 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.

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. Hospitals are required to inform the Home Office of patients who owe the NHS more than €585 and such people may be refused visa renewals or regularisation of their immigration status until the debt is paid.

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. This includes applications for leave to remain made on the basis that return to country of origin would breach Article 3 ECHR.

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. 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.

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 ordinarily resident 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.
for 12 months prior to treatment\textsuperscript{1019}. 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\textsuperscript{1020}.

In Scotland and Wales, asylum seekers and refused asylum seekers are entitled to free secondary health care on the same terms as any other ordinary resident. 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 health care. However, all refused asylum seekers can continue, free of charge, with any course of treatment already underway before their application was refused\textsuperscript{1021}.

**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\textsuperscript{1022}. Finally, there is no minimum period that a person needs to have been in the UK before a GP can register them\textsuperscript{1023}.

The NHS allows people from abroad – if they are accepted for NHS treatment – to claim help with health costs in the same way as other patients. 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\textsuperscript{1024}. 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 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.

**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.

\textsuperscript{1019}Op. cit. note 978  
\textsuperscript{1020}Op. cit. note 1014  
\textsuperscript{1021}Regulation 3(5) NHS (Charges to Overseas Visitors) Regulations 2015/238  
\textsuperscript{1022}http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121026/text/121026w0001.htm  
\textsuperscript{1023}Op. cit. note 982  
\textsuperscript{1024}http://patient.info/health/help-with-health-costs
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. Children also have free access to dental care. Charges for secondary care are applied to undocumented children in the same ways as adults.

**EU citizens**

EU 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 they are insured in their country of origin, which is best demonstrated by having an EHIC. EEA nationals may also, of course, be “ordinarily resident” in the UK if they are here 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 their temporary stay in the UK, with a view to preventing them from being forced to return home for treatment before the end of the planned duration of their stay. For instance, regarding England, this means 1025:

- 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 promptly for a condition which: arose after the visitor’s arrival; or became acutely exacerbated after their 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 1026.

**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) 1027.

Two doctors must agree that a termination would cause less damage to a woman’s physical or mental health than continuing with the pregnancy 1028. According to the MdM UK team in London, it may be difficult to obtain a termination of

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1025 Op. cit. note 1014
1026 Op. cit. note 1014
1027 http://www.nhs.uk/conditions/Abortion/Pages/Introduction.aspx
1028 Abortion Act of 1967, this Act 1967 covers England, Scotland and Wales but not Northern Ireland
pregnancy free of charge without a referral from a GP. In addition, in some areas, termination of pregnancy is seen as an elective procedure which can then be charged for like maternity care.

### 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 enter local authority care under the Children Act 1989 and become “looked after children”, meaning that they are exempt from all charges1029. Unaccompanied minors whose asylum claims are rejected will, once they turn 18 and leave local authority care, no longer be exempt from charging.

### Protection of seriously ill foreign nationals

Discretionary Leave and Humanitarian Protection were introduced on 1 April 2003 to replace Exceptional Leave to Remain1030.

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”1031. 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 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”1032.


The European Court of Human Rights reached the same conclusion as the House of Lords.

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. 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 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.

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 for short-terms visitors living with HIV who, in the event of unforeseen circumstances, do not have their medication with them, until alternative arrangements are made. Indeed, HIV treatment is always considered as “immediately necessary”.

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 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.

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. 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 get tested and find out their status.

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1033 Op. cit. note 998


1037 [http://www.avert.org/hiv-treatment-uk.htm](http://www.avert.org/hiv-treatment-uk.htm)
Note specific to this section

As the collection of data for this report started in 2015 as for Italy, information is still being gathered for this country.

Thus, this section will specifically deal with the situation of undocumented migrants in Italy. We thank our partner NAGA Milano for the information provided.

National Health System

Constitutional basis

Article 32 of the Italian Constitution\textsuperscript{1038} states that “The Republic protects individual health as a basic right and in the public interest; it provides free medical care to the poor.”

What is more, the responsibility for health care is determined by article 117 of the Italian Constitution: «responsibility for health care is shared by the national government and the 19 regions and 2 autonomous provinces».

Organisation and funding of Italy healthcare system

Organisation

Italy’s health care 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 organization is divided in three levels: national, regional and local.

The national level, embodied by the Ministry of health and several specialized 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.

Regional government are in charge of ensuring the delivery of public health services.

Finally, local health authorities’ (Aziende Sanitarie Locali, ASLs), and public or private accredited hospitals deliver health services\textsuperscript{1039}.

Funding

The public system is financed through a corporate tax, collected nationally and allocated back to regions, and through a fixed proportion of national value-added tax income perceived by the national government and redistributed to regions unable to gather sufficient resources to ensure essential levels of care\textsuperscript{1040}.

Regions are authorized to produce their own additional revenue.

Private health insurance has a very limited role in the health system. In 2009, it accounted for 1% of total spending\textsuperscript{1041}.

Private health insurances are of two sorts: corporate and non-corporate.

\begin{thebibliography}{99}
\bibitem{italian_constitution} Italian Constitution
\end{thebibliography}

\textsuperscript{1038}The Commonwealth Fund, 2015 \textit{international Profiles of health Care Systems}, January 2016
\textsuperscript{1040}Ibid.\textsuperscript{\textsuperscript{1041}}
Accessing Italian healthcare system

The public National Health Service (NHS) coverage is automatic and includes Italian citizens and legal 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 list that define respectively services covered and services not covered by the NHS. Or covered on a case-by-case basis. These lists are determined using criteria as medical necessity, efficiency, human dignity and effectiveness.

Services and goods covered by the NHS include:

- 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 (the disabled, people suffering of rare diseases or HIV), destitute people, and individuals with urgent/emergency need)

For mental health, preventive, long-term-care and public health services are not specifically listed in the essential care list. 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 of their clinical and cost effectiveness. Medicines are divided into three tiers:

- the first tier is always covered
- the second tier is covered only in hospitals
- the third tier is not covered

Services as cosmetic surgery are not covered.

Services as orthodontics and laser eye surgery are covered on a case-by-case basis.

Regions have the possibility to offer services not included in the essentials levels of care, if they can finance hem themselves\textsuperscript{1042}.

Cost-sharing

GP consultations and hospital admission stays are free of charge, but patients have to pay a co-payment for specialist visits. This fee is limited up to a ceiling determined by law, currently €36.15 per prescription\textsuperscript{1043}.

However, there are exemptions from cost-sharing, which apply to:

- people over 65 years and under 6 years old who live in households with a gross income below the nationally defined threshold
- severely disabled people
- prisoners
- people with chronic or rare diseases
- HIV positive people
- Pregnant women (the exemption applies only to care related to their pregnancy)

Access to healthcare for migrants\textsuperscript{1044}

Undocumented migrants

For irregular migrants, the services provided and co-payment modalities are

\textsuperscript{1042} Op. cit. note 1040
\textsuperscript{1043} Op. cit. note 1040
\textsuperscript{1044} The following content is based on the work and observations of NAGA-Milano
similar to those in force for the Italian citizens, with the exception of Extra-EU migrants who shall be exempt from co-payment in case of proven indigence (if so, an X01 code is assigned). The exemption is not provided to EU citizens.

If an irregular migrant is poor and signs a “statement of poverty” valid for 6 months, the same may ask for the assignation of a STP code (for Extra-EU citizens) or an ENI code (for EU citizens) to obtain health care without a co-payment.

Urgent care

“Urgent care” comprises treatments that cannot be postponed without threatening the life or possibly damaging the health of a person.

These services are co-payment exempt, pursuant to the Legislative Decree no. 286/98, art.35, paragraph 4 and to the ministerial circular no. 5, of 24 March 2000, as for the Italian citizens.

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, however they might originate a major health damage or life risk in time { complications, chronicity or worsened conditions}’]

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 associations.

- Hospitalizations: to be made upon request by the doctor who works in the facilities.

All the services, prescriptions and reporting practices shall be completed using the STP (=TPF: Temporary Present Foreigner) code, for Extra-EU citizens, or the ENI (= NRE Non Registrable European) code for EU citizens. The Local Health Units, by Hospitals, University Polyclinics and the Institutes for Treatment and Research, shall issue the STP and ENI codes.

In general, health services for essential care shall be provided:

- With co-payment (to undocumented foreigners), if Italian citizens pay it.

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1045 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 20th December 2012 (Official Gazette General Series no. 32 of 7-2-2013, ordinary integration no. 9).

1046 Ministerial Circular no. 5 of 24th March 2000 (Official Gazette no. 126 of 1st June 2000, [pages 36-43]).

1047 Legislative Decree no. 286 of 25th July 1998 (ordinary integration no. 139/L to the Official Gazette no. 191 of 18th August 1998);


1049 Pursuant to art. 1, par. 796 item p of the law no. 296/2006.

1050 Ministerial Circular no. 5 of 24th March 2000.

1051 Presidential Decree no. 394 of 31st August 1999 (ordinary integration no. 190/L to the Official Gazette no. 258 of 3rd November 1999), article 43 par. 8 and Ministerial circular no.5, of 24-3-2000.

1052 Presidential Decree no. 394 of 31st August 1999, Article 43 par. 8.

1053 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 12th December 2012.

1054 Note by the Ministry of Health DG RUERI/I/II/3152-P/1.3.b/1, 19/2/08 and State-Regions Agreement no. 255/CSR of 20th December 2012.

1055 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.
ITALY

- Otherwise: for free (contrary to what happens for Italian citizens) in case of proven poverty.

The foreigner shall be then assigned with a specific X01 code valid only for a single service and with a second declaration of indigence. The code X01 is in force only for the Extra-EU citizens and not for EU citizens. Therefore, as regards fully free health services, different rights apply to Extra-EU and EU citizens to the benefit of the former.

Exemptions of co-payment applying for undocumented migrants:

- Elderlies (over 65). (If the elderly is in Italy for family reunification and his/her arrival was before 5th November 2008): no co-payment obligation as for Italian citizens
- Women entitled to services aimed at protecting pregnancy and maternity (until 6 months after the child’s birth): no co-payment obligation as for Italian citizens
- People entitled to first-level health services with direct access, without reservation and prescription (for instance: general medicine, Drug Addiction Service (SERT), DSM, Family Services): no co-payment obligation as for Italian citizens.
- People entitled to free services, pursuant to the criteria and the limitations provided for by the regulations in force for Italian citizens, in the presence of chronic diseases, rare pathologies and disabling conditions (with the following issue of the exemption certificate): no co-payment obligation as for Italian citizens.

People entitled to prevention services, to be provided at the local units of the Prevention Department: (national and regional vaccine plan, screening, HIV prevention): no co-payment obligation as for Italian citizens.

In addition, there are some special situations where the foreigner who had irregularly entered the territory or who has become irregular is however entitled to register under the RHS, pursuant to the State-Regions Agreement no. 255/CSR:

- Request of international protection/asylum,
- Custody (including minors without parents),
- Awaiting regularization (temporary registration for foreigners awaiting regularization 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 25th July 1998, art. 18)

Finally, is to be noted that irregular foreigners who access a health facility cannot be reported in any way to the authorities, unless the case when this is

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1056 Annex to the Decree by the Ministry of Economics and Finance of 17th March 2008. 8.27
State-Regions Agreement no. 255/CSR of 20th December 2012 (Official Gazette General Series no. 32 of 7-2-2013, ordinary integration no. 9

1057 Legislative Decree no. 286 of 25th July 1998 and State-Regions Agreement no. 255/CSR of 20th December 2012


1059 Ministerial Decree of 1st February 1991

1060 State-Regions Agreement no. 255/CSR of 20th December 2012
mandatory for Italian citizens too, pursuant to the Leg. Decree no. 286 of 25th July 1998, art.35 par. 5.

**Undocumented pregnant women**

Pregnant women up to six months after the child’s birth can register under the RHS and receive free health care related to pregnancy and maternity.

**Children of undocumented migrants**

Health services to children (0 to 17 years of age\(^{1061}\)) of irregular migrants are provided through the registration under the Regional Health Service (RHS), pursuant to the State-Regions Agreement no. 255/CSR of 20th December 2012.

All foreign minors aged 0 to 6 are not submitted to co-payment, as the Italian citizens\(^{1062}\), as stated in the Leg. Decree no. 286 of 25th July 1998, art 35, par. 3, item b and in the State-Regions Agreement no. 255 CSR, of 12th December 2012, page 20 and page 37.

**Minors aged 14 to 17**

Children of undocumented migrants aged from 14 to 17 years old are generally excluded from health services.

For irregular minors, a privileged health assistance is in place, with the registration under the NHS, compared to that for adults (using the STP or ENI code). In fact, 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 17 is excluded\(^{1063}\). The reason for this exclusion could be the difficulty to identify the exact age sometimes, since no evidence document is available. The Cross-Regional Migration and Health Services Commission (of the Health Commission Coordination at the Conference of Regions) issued a document to this purpose (on 30th October 2014) entitled ‘Protocol for the identification and holistic multidisciplinary ascertainment of the age of minors without parents’. However, the procedure – rather difficult in itself – 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 17 is excluded almost everywhere from the opportunities to access health services for minors.

**EU citizens**

The law makes a difference between EU citizens and extra EU citizens.

The X01 exemption code, that cancels co-payment for the services that would require it and that applies when the patient cannot pay, can be used for Extra-EU citizens only and does not apply for EU 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 ERs that often – however not always – meet those requirements without being able to guarantee continuous treatment. In Puglia, a recent regional resolution (20th December 2015) abolished the ENI code ‘limiting it to February 1993 art. 8 par. 16 and the following modifications).

\(^{1061}\)The Law no. 176 of 27th May 1991: Ratification and execution of the New York Convention on the Rights of Children of 20th November 1989, art. 1:‘…children as intended as all human beings aged below 18 …’

\(^{1062}\)At 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 EUR36,151.98 per year (N. L. no. 537, of 24th February 1993 art. 8 par. 16 and the following modifications).

\(^{1063}\)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.
urgencies only’, thus putting this region in a situation which is similar to that of Lombardy and Umbria.

The right to register under the RHS 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 RHS 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…’. The right to register under the RHS for the EU minor (not meeting the requirements) is confirmed in art. 1 par. 2 of the Consolidated Text no.189/02 too.

Implementing the national health legislation for undocumented migrants

The national health legislation guarantees access to health care for irregular 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.

Indeed, the constitutional law no. 3 of 18th 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 20th December 2012. The implementation of this Agreement is however currently incomplete, which causes differences in the implementation.

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 NHS. 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 NHS.

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 irregular adults and minors, at public or private hospitals under agreement with the NHS. Essential medicine health services to irregular 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.
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