
LEGAL REPORT ON ACCESS TO HEALTHCARE IN 12 COUNTRIES



BELGIUM - CANADA - FRANCE - GERMANY - GREECE - LUXEMBOURG - NETHERLANDS - SPAIN - SWEDEN -
SWITZERLAND - TURKEY - UNITED-KINGDOM

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Foreword

The range of international texts that ensure people's basic and universal right to healthcare is impressive. They include binding State commitments under UN, Council of Europe and EU agreements and an even greater body of 'soft' recommendations issued by their respective institutions and agencies. Yet, the most recent MdM report¹ shows how, in practice, these texts often remain just words rather than effective guarantees for universally accessible healthcare systems. Among the people seen in 2014 in nine European countries, Turkey and Canada, 68.7% had no healthcare coverage when they first came to MdM programmes.

Access to healthcare is defined by many intertwined and interacting factors. According to the European Commission², access includes health system coverage (who is entitled to healthcare, what share of the population), depth of coverage (what basket of care people are entitled to), affordability (the level of co-payment for care and treatment) and availability (healthcare workforce, distance, waiting times, etc.). In this legal report on access to healthcare, we systematically address these four aspects from the specific point of view of people facing multiple health vulnerabilities. The analysis is a legal

¹ Chauvin P, Simonnot N, Vanbiervliet F, Vicart M, Vuillermoz C. [Access to healthcare for people facing multiple vulnerabilities in health in 26 cities across 11 countries. Report on the social and medical data gathered in 2014 in nine European countries, Turkey and Canada](#) Paris: Doctors of the World – Médecins du monde international network, May 2015.

² European Commission [Communication on effective, accessible and resilient health](#)

one, but written deliberately from the concrete bottom-up point of view of patients. In order to evaluate effective availability of care, the theoretical legal frameworks concerning access have been compared to the situation in practice.

The most important barrier to healthcare that people seen in MdM programmes face in the surveyed countries is restrictive national laws. These restrictions are often linked to patients' administrative status: asylum seekers, citizens of non-EU countries without permission to reside, EU migrants with no permission to reside, and unaccompanied minors. Consequently, the report systematically focusses on the respective entitlements of these four groups.

Financial problems in paying for care – whether it concerns charges for consultations and treatment, upfront payments or the prohibitive cost of healthcare coverage contributions – are equally an important barrier, including for destitute nationals. It was cited by 27.9% of MdM patients in the nine European countries surveyed. Hence, affordability of care and treatment is transversally present throughout the chapters.

We have analysed the consequences of legal and financial barriers on the accessibility of screening, treatment and care for HIV, hepatitis and STIs, on sexual and reproductive healthcare services, and on vaccinations and paediatric care.

Finally, a small number of migrants become seriously ill after arriving in Europe and for them going back to their home country is not an option because they are not able to effectively access healthcare there. Even in those

countries where there is a legal framework concerning protection against expulsion, there are numerous barriers to obtaining effective protection, including barriers to access the procedure and incomplete evaluations of effective access to care and treatment in the country of origin.

MdM calls on States to offer universal public health systems built on solidarity, equality and equity, open to everyone living on their territory. All children should have the same access to national immunisation programmes and to paediatric care. Similarly, all pregnant women must have access to contraceptions, termination of pregnancy, antenatal and postnatal care and safe delivery. In order to respect the ban on the death penalty, seriously ill migrants should never be expelled to a country where effective access to adequate healthcare cannot be guaranteed.

We hope this tool can be useful to other non-profit organisations, researchers, policy makers and other stakeholders, as long as their aim is to improve and enlarge the access to healthcare for those facing multiple health vulnerabilities.

June 3rd 2015,
Anne-Laure Macherey
for Doctors of the World – Médecins du monde International Network

Acronyms

AC	Autonomous Community ES	CDAG	Free and anonymous testing centre (<i>Centre de dépistage anonyme et gratuit</i>) FR
ACS	Supplementary Health Insurance Assistance Scheme (<i>Aide Complémentaire Santé</i>) FR	CCG	Clinical Commissioning Group UK
ALD	Long-term chronic illnesses (<i>Affection de Longue Durée</i>) FR	CEPS	Economic Committee for Healthcare products (<i>Comité Economique des produits de Santé</i>) FR
AME	Medical Aid (<i>Aide Médicale de l'Etat</i>) FR	CH	Switzerland
AMU	Urgent Medical Aid (<i>Aide Médicale Urgente</i>) BE	CHST	Canadian Health and Social Transfer CA
ARS	Regional Health Agencies (<i>Agence Régionale de Santé</i>) FR	CESEDA	Code on Entry and Residence of Foreign Nationals and Right of Asylum (<i>Code de l'entrée et du séjour des étrangers et du droit d'asile</i>) FR
ASE	Child welfare services (<i>Aide Sociale à l'Enfance</i>) FR	CIRE	Certificate of Inscription in the Register of Foreign Nationals (<i>Certificat d'Inscription au Registre des Étrangers</i>) BE
ASEM	Association for Solidarity and Support for Migrants TR	CGIDD	Information centre for free testing and diagnosis of sexually transmitted infections (<i>Centre gratuits d'information, de dépistage et de diagnostic</i>) FR
AufenthG	Residence Act DE	CIDDIST	Information centre for testing and diagnosis of sexually transmitted infections (<i>Centre d'information, de dépistage et de diagnostic des infections sexuellement transmissibles</i>) FR
AsylbLG	Asylum Seekers' Benefits Law DE	CLAT	Centre for Fighting Tuberculosis (<i>Centre de Lutte Anti Tuberculeuse</i>) FR
BBI	Blood-Borne Infections	CLSC	Local Community Services Centre (<i>Centre</i>
BE	Belgium		
BIM	Increased refund of the healthcare insurance (<i>Bénéficiaire de l'Intervention Majorée</i>) BE		
BMA	State Medical Service NL		
CA	Canada		
CAAMI	Auxiliary Illness and Disability Insurance Fund (<i>Caisse Auxiliaire d'Assurance Maladie-Invalidité</i>) BE		
CCAS	Communal Centre for Social Support (<i>Centre Communal d'Action Sociale</i>) FR		

	Local de Services Communautaires) CA		(Département Fédéral de l'Intérieur) CH
CMU	Universal Medical Coverage (<i>Couverture Maladie Universelle</i>) FR	DH	Department of Health UK
CMUc	Complementary Universal Medical Coverage (<i>Couverture Maladie Universelle complémentaire</i>) FR	DOM	French overseas departments (<i>Département d'Outre- Mer</i>) FR
COA	Central Agency for the Reception of Asylum Seekers (<i>Centraal Orgaan opvang asielzoekers</i>) NL	EEA	European Economic Area
CoE	Council of Europe	EL	Greece
COMEDE	Medical Committee for Exiles (<i>Comité Médical pour les exilés</i>) FR	EHIC	European Health Insurance Card
CNAMTS	National Health Insurance Fund for Salaried Workers (<i>Caisse Nationale d'Assurance Maladie des Travailleurs Salariés</i>) FR	EOPYY	National Organisation for Healthcare Provision EL
		EPIM	European Programme for Integration and Migration
		ES	Spain
		ESY	National Healthcare System (<i>Ethniko Systima Ygeias</i>) EL
		EU	European Union
		FADSP	Associations Defending Public Health (<i>Federacion de Asociaciones en Defensa de la Sanidad Publica</i>) ES
CNS	National Health Fund (<i>Caisse Nationale de Santé</i>) LU	FARES	The Respiratory Diseases Fund (<i>Fonds des Affections Respiratoires</i>) BE
CPAM	Primary Health Insurance Funds (<i>Caisse Primaire d'Assurance Maladie</i>) FR	FOSI	Federal Office for Social Insurance CH
CPAS	Public Social Welfare Centre (<i>Centre Public d'Action Sociale</i>) BE	FR	France
CRAM	Regional Health Insurance Funds (<i>Caisses Régionale d'Assurance Maladie</i>) FR	FSUV	Fund for Vital and Urgent Care (<i>Fonds pour les soins urgents et vitaux</i>) FR
CRC	Convention on the Rights of the Child	GIS	Guaranteed Income Supplement CA
DCO	Designated Country of Origin	GHIS	General Health Insurance System TR
DE	Germany	GP	General Practitioner
DFI	Federal Department of the Interior	GKV	Statutory Health Insurance (<i>Gesetzliche Krankenversicherung</i>) DE

HAS	High Authority for Health (<i>Haute Autorité de Santé</i>) FR		(<i>Office luxembourgeois de l'accueil et de l'intégration</i>) LU
HIV	Human Immunodeficiency Virus	ONSS	National Social Security Office (<i>Office National de Sécurité Sociale</i>) BE
HTP	Health Transformation Programme CH	OPAD	Public Employees' Fund EL
IFHP	Interim Federal Health Program CA	NL	The Netherlands
IHC	Individual Healthcare Card ES	PASS	Free Medical Centre (<i>Permanence d'accès aux soins de santé</i>) FR
IKA	Private Employees' Fund EL	PCT	Primary Care Trust UK
INAMI	National Institute for Health and Disability Insurance (<i>Institut National d'Assurance Maladie-Invalidité</i>) BE	PICUM	Platform for International Cooperation on Undocumented Migrants
IND	Immigration and Naturalisation Service NL	PKV	Private Health Insurance (<i>Private Krankenversicherung</i>) DE
INSS	National Institute of Social Security NL	PMI	Mother and child health centre (<i>Protection maternelle et infantile</i>) FR
IRB	Immigration and Refugee Board CA		
LAMal	Federal Law on Compulsory Healthcare CH	PRAIDA	Regional Programme for the Settlement and Integration of Asylum Seekers (<i>Programme Régional d'Accueil et d'Intégration des Demandeurs d'Asile</i>) CA
LAsi	Asylum Law CH		
LETr	Federal Act on Foreign Nationals CH		
MARS	Doctor from the Regional Health Agency (<i>Médecin de l'ARS</i>) FR	RAMQ	Quebec's health insurance board (<i>Régie de l'Assurance Maladie du Québec</i>) CA
MdM	Doctors of the World (<i>Médecins du monde – MdM</i>)		
MSA	Agricultural scheme (<i>Mutualité Sociale Agricole</i>) FR	RIZIV	National Institute for Health and Disability Insurance (Rijksinstituut voor ziekte- en invaliditeitsverzekering) BE
MOI	Ministry of Interior		
NHS	National Health System UK – SE	RSI	Scheme for the self-employed (<i>Régime Social des Indépendants</i>) FR
NEF	Network of European Foundations		
OAMal	Health Insurance Ordinance CH		
OGA	Farmers' Fund EL	SE	Sweden
OLAI	Luxembourg Reception and Integration Agency		

SIDEP	Integrated services for screening and prevention CA
SMR	Therapeutic benefit evaluation system (<i>Service Médical Rendu</i>) FR
SSI	Social Security Institution (<i>Sosyal Güvenlik Kurumu</i>) TR
STI	Sexually Transmitted Infections
TB	Tuberculosis
TLV	Dental and Pharmaceutical Benefits Agency SE
ToP	Termination of pregnancy
TPS	Third-party Social Payment (<i>tiers-payant social</i>) LU
TR	Turkey
UK	The United Kingdom
UKBA	United Kingdom Border Agency UK
UNCAM	National Union of Health Insurance Funds (<i>Union Nationale des Caisses d'Assurance Maladie</i>) FR
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
VRGT	The Respiratory Healthcare and Tuberculosis Association (<i>Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding</i>) BE

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>

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*”³.

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 package⁴.

The national health system consists of a mix of private and public actors and is funded by employer and employee

³ *Constitution of Belgium 1994* (last updated 8 May 2007),

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

⁴ S. Gerken and S. Merkur, “Belgium: Health system review”, *Health Systems in Transition*, vol. 12, No. 5, xvi, 2010,

contributions, and federal government subsidies. Social security contributions are deducted automatically from salaries and are paid to the National Social Security Office⁵.

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-INAMI⁶.

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,

⁵ <http://belgium.angloinfo.com/money/social->

[http://www.euro.who.int/data/assets/pdf_file/](http://www.euro.who.int/data/assets/pdf_file/0014/120425/E94245.PDF)

[0014/120425/E94245.PDF](http://www.euro.who.int/data/assets/pdf_file/0014/120425/E94245.PDF)

[security/](#)

⁶ Op. cit. note 4

BELGIUM

patients are only responsible for small co-payments for drugs and transport⁷.

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 2010⁸, which came into effect on 1 January 2012, individuals affiliated to one of the mutuels 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 insurance⁹. Moreover, the annual contribution may

vary from one mutual health coverage fund to another, from €30 to €250¹⁰.

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 services¹¹.

Accessing Belgium healthcare system

Nationals and authorised residents in Belgium must register with a health insurance company of their choice. They pay contributions for their membership as well as a fixed amount established by law for the cost of the services.

Nationals and authorised residents must pay in advance for the medical consultation fees charged by the doctor or hospital. They must submit their receipts for reimbursement and the money is then paid directly into the claimant's bank account. In general, the cost of a GP consultation is €24.48. The health insurance company reimburses €18.48 leaving €6 paid by the patient¹². It should be noted that some individuals, depending on their means, pay less for most medical services: “*BIM status*” and “*OMNIO status*”¹³. The local public social welfare centre (*Centre Public d'Action*

⁷ W. Van Biesen, N. Lameire, P. Peeters, R. Vanholder, “Belgium’s mixed private/public health care system and its impact on the cost of end-stage renal disease”, *the International Journal of Health Care Finance and Economics*, 2007, <http://www.dopps.org/doppscd/pdf/VanBiesen-ISHCOF-Belgium-2007.pdf>, (accessed 25 March 2015).

⁸ *Law of 26 April 2010*, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2010042607&table_name=loi

⁹ *Law of 14 July 1994*, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1994071438&table_name=loi

¹⁰ L. Baekelandt, « La cotisation de mutuelle est désormais obligatoire », *Plusmagazine.be*, 26 January 2012, <http://plusmagazine.levif.be/fr/011-1548-La-cotisation-de-mutuelle-est-desormaisobligatoire.html>

¹¹ <http://www.caami-hziv.fgov.be/Model4-10-F.htm>

¹² *Ibid.*

¹³

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

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Sociale – CPAS) may also decide – in their internal policy – to contribute to the medical costs of authorised residents who are too destitute to pay for important health expenses.

To join a health insurance company, a membership application must be submitted to one of the mutuels or the CAAMI. Being private organisations, the mutuels may refuse membership to an applicant. The public fund, however, may not refuse membership to an applicant. This guarantees the availability of health insurance to all Belgians. The individual is bound by their choice of mutual or the CAAMI for a one-year period. Obviously, one advantage is that if affiliated members become undocumented, they keep their healthcare coverage for up to a year after their last payment. Dependent children are bound by their parents' choice.

The contents of the mandatory health insurance organised by RIZIV-INAMI is determined by the RIZIV-INAMI nomenclature¹⁴, 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)¹⁵ and has also frozen the prices of essential drugs. Thus, six

categories of drugs have been defined¹⁶.

Access to healthcare for migrants

Asylum seekers, refugees and those eligible for subsidiary protection¹⁷

The 2007 law on the reception of asylum seekers and other categories of foreign nationals and stateless people defines the entitlement of asylum seekers to medical care. According to this law, all asylum seekers are entitled 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.)

¹⁴

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

¹⁵ I. Cleemput and al., « Détermination du ticket modérateur en fonction de la valeur sociétale de la prestation ou du produit », Health Services Research (HSR), Bruxelles : Centre Fédéral d'Expertise des Soins de Santé (KCE), KCE Report 186BS, 2012.

https://kce.fgov.be/sites/default/files/page_documents/KCE_186B_determination_ticket_modérateur_synthese_second_print_0.pdf

¹⁶ 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 cost of D medication, whatever aid mechanism they benefit from.

¹⁷ 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.

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- 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.).

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")¹⁸, 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*"¹⁹. They receive a Certificate of Inscription in the Register of Foreign Nationals (*Certificat d'Inscription au Registre des Étrangers – CIRE*) which remains valid for one year and is renewable on request²⁰. The CIRE gives them entitlement to health insurance under the RIZIV-INAMI scheme²¹.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum or who have obtained refugee status have access to antenatal, delivery and

¹⁸ Asylum seekers who are not living in a reception structure are called "no shows".

¹⁹

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

²⁰ Ibid.

²¹ Op. cit. note 19

postnatal care as authorised residents. They also have access to free termination of pregnancy (ToP) 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 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*"²². 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 is subject to three conditions. The individual must:

- Obtain a medical certificate proving health needs signed by a doctor;
- Prove their place of residence in a municipality;
- After having obtained a medical certificate, prove 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.)

²² *Royal Decree of 12 December 1996*, <http://www.miis.be/sites/default/files/doc/KB%201996-12-12.pdf>

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and on administrative formalities in Belgium (request for regularisation, asylum, etc.). Questions may vary considerably from one CPAS to another. Next the CPAS will claim the medical certificate (template document) in order to prove health needs. This document is compulsory in order for the health provider/pharmacist to obtain reimbursement. The CPAS must check the place of stay through a home visit.

The circular of 25 March 2010²³ 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.

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). Obviously, many health problems will have become much 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 residence²⁴.

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 there is systematic discrimination, based on where in Belgium an undocumented patient lives.

Based on the above, 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. At the same time, the CPAS, such as the one in Antwerp, often refuses 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 three months of continuous care), 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 health professionals by the CPAS. Afterwards, the federal authorities reimburse the CPAS for all medical treatments except for those which do not have a RIZIV-INAMI nomenclature code.

²³ *Circular of 25 March 2010*, <http://www.ejustice.just.fgov.be/cgi/api2.pl?lg=f&pd=2010-05-06&numac=2010011203>

²⁴ European Union Agency for Fundamental Rights (FRA), *Migrants in an irregular situation: access to healthcare in 10 European Union Member States*, Luxembourg, 2011.

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Often healthcare providers refuse to treat an undocumented migrant who has a medical card granted from a CPAS in another region, because the CPAS might not reimburse the costs of care²⁵. 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 in order to make the process easier for patients but others do not make such an effort²⁶.

In addition, the Law of 30 December 2009²⁷, followed by the circular quoted above, 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*”²⁸.

Undocumented pregnant women

As mentioned above, the Royal decree refers to “urgent care”, a term that might well be misleading as they encompass 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. Postnatal follow-up care is financed and organised by the federated entities: the Birth and Childhood Office (*Office de la Naissance et de l’Enfance* in the French community) and Child and Family (*Kind en Gezin*) in the Flemish Community). Access to Community-financed postnatal consultations is free of charge for all women. However, this does not include antenatal ultrasound, blood tests, nor curative interventions, which all require AMU. The same barriers apply for pregnant women and children as for other AMU claimants.

The CPAS, often due to unwillingness or lack of awareness, impede access to health services for undocumented migrants, including pregnant women, when they refuse 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 well as academics, under the leadership of Doctors of the World – Médecins du Monde (MdM), 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.

²⁵ Ibid.

²⁶ Platform for International Cooperation on Undocumented Migrants (PICUM), *Undocumented Migrants’ Health Needs and Strategies to Access Health Care in 17 EU countries, Country Report Belgium*, June 2010, <http://files.nowhereland.info/706.pdf>

²⁷ *Law of 30 December 2009*, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2009123001&table_name=loi

²⁸ Ibid.

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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 later²⁹. 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 scheme³⁰.

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 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 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

²⁹

<http://www.viefeminine.be/spip.php?article270>

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³⁰ INAMI, Kluwer a Wolters Kluwer Business, Médecins du Monde, *Livre vert sur l'accès aux soins en Belgique*, Waterloo, 2014.

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 2012³¹ 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 1976³² 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 2014³³, 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

³¹ Law of 19 January 2012, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2012011913

³² Law of 8 July 1976, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1976070801&table_name=loi

³³ Judgement of the Constitutional Court, 30 June 2014, <http://www.const-court.be/public/f/2014/2014-095f.pdf>

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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 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 2014³⁴ 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 follow:

- 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.

Therefore, in the light of this judgment, EU migrants in Belgium must have access to AMU during the first three months of their stay. In practice, the CPAS are still not applying the new interpretation of Article 57quinquies and are thus violating the Belgian Constitution.

So, in practice, pregnant women and children who are EU citizens should

have access to AMU as 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.

Moreover, regarding access to termination of pregnancy for pregnant women who are EU citizens, this seems to be a veritable obstacle course. For the first three months of their stay they are considered as tourists; they quickly 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 pay for a termination out of their own 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 18₃₅ 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-

³⁴ *Circular of 5 August 2014*, http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl

[?sql=%28text%20contains%20%28%27%27%29%29&language=fr&rech=1&tri=dd%20AS%20RANK&value=&table_name=loi&F=&cn=2014080501&caller=image_a1&fromtab=loi&la=F](http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl?sql=%28text%20contains%20%28%27%27%29%29&language=fr&rech=1&tri=dd%20AS%20RANK&value=&table_name=loi&F=&cn=2014080501&caller=image_a1&fromtab=loi&la=F)

³⁵ *Law of 12 May 2014,*
http://www.ejustice.just.fgov.be/mopdf/2014/11/21_1.pdf#Page18

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

³⁶ *Programme Law of 24 December 2002,*

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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 since 2014):

- 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, the government excludes unaccompanied minors, especially older ones, because they have to wait three months before accessing to healthcare.

Protection of seriously ill foreign nationals

In Belgium, by law, seriously ill foreign nationals benefit from special protection which prevents the authorities from expelling them to their

country of origin or the country where they are resident.

Indeed, according **Article 9ter** of the Law of 15 December 1980 on access to Belgium, residence, establishment and return of foreign nationals³⁷, “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

³⁷ Law of 15 December 1980, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1980121530&tab

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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 Aliens Law Litigation (*Conseil du Contentieux des Etrangers*).

In the judgment of the Court of Justice of the European Union (Grand Chamber) of 18 December 2014³⁸, the Court rules that Article 9ter of the Law of 15 December 1980 violates Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

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

³⁸ *Centre public d’action sociale d’Ottignies-Louvain-la-Neuve v Moussa Abdida*, 18 December 2014, Judgement of the Court of Justice of the European Union (Grand Chamber), <http://curia.europa.eu/juris/celex.jsf?celex=620>

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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 during the appeal.

observed undocumented pregnant women who have failed to overcome these hurdles, despite being Human Immunodeficiency Virus (HIV) positive.

Prevention and treatment of infectious diseases

The Royal Decree of 1 March 1971 on the prevention of contagious diseases covers the list of notifiable diseases on Belgian territory.

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

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

A number of referral centres offer Sexually Transmitted Infections (STI) screening upon request. Although screening is free (and anonymous) for anyone without medical insurance, these centres are now 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 already

CANADA (QUEBEC)

National Health System

Organisation and funding of Canadian healthcare 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 levels³⁹. 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 applicants⁴⁰.

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”⁴¹.

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 Police⁴².

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 territory⁴³.

However, the main constraint for new residents is the waiting period that

³⁹<http://www.hc-sc.gc.ca/index-eng.php>

⁴⁰ <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php>

⁴¹

<http://www.cic.gc.ca/english/newcomers/after-health.asp>

⁴² <http://www.canadian-healthcare.org/>

⁴³ Ibid.

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generally takes **three months**⁴⁴ 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; antenatal care, for example in the Quebec province, is covered during the waiting period).

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 services⁴⁵. 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 medicines⁴⁶. The province of Quebec does not provide dental healthcare 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,⁴⁷ such as drugs prescribed outside hospitals, ambulance costs, and hearing, vision and dental care that are not covered under the Canada Health Act⁴⁸.

⁴⁴ 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.

⁴⁵ Op. Cit. note 42

⁴⁶ Op. Cit. note 42

⁴⁷ Op. cit. note 40

⁴⁸ Op. cit. note 40

Accessing Quebec healthcare system

In order to ensure free access to healthcare in Quebec, the provincial government created Quebec's health insurance board (*Régie de l'Assurance Maladie du Québec – RAMQ*). The government's goal was to respond to the needs of its citizens and residents, and implement its own health and social welfare policies in line with the spirit of the federal policies⁴⁹.

Quebec's health insurance board administrates the public health and prescription drug insurance plans.

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 origin⁵⁰. 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

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<http://www.ramq.gouv.qc.ca/en/regie/Pages/mi-ssion.aspx>

⁵⁰ Ibid.

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their health insurance card from that province when receiving healthcare from a doctor in Quebec⁵¹. 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 origin⁵². In Quebec, a general practitioner's consultation fees vary from €50 to €140.

If an individual is covered by public or private health insurance, they do not pay 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 plans⁵³.

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. 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 €430 from 1 July 2014 to 30 June 2015)⁵⁴, whether or not they purchase prescription drugs⁵⁵.

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)⁵⁶;
- holders of a claim slip and their children under the age of 18⁵⁷;

⁵⁴ If a summary of costs is necessary, please see <http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/summary-costs.aspx>

⁵⁵ <http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/annual-premium.aspx>

⁵⁶ The Guaranteed Income Supplement (GIS) is an amount added to the Old Age Security Pension (OASP) and is paid at the same time as that pension to certain people age 65 or over. A person may receive the maximum GIS (100%), a partial GIS or no GIS (0%), depending on the family income. In each case, the contribution to the public plan differs (GIS).

⁵⁷ This specific benefit is delivered to the beneficiary of a claim slip renewable every month. The beneficiary can obtain the prescription drugs that he/she or his/her family needs, presenting this diary to a pharmacist of his/her choice. Specific benefits 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, <http://www.mess.gouv.qc.ca/regles-normatives/b-aides-financieres/05-prestations-speciales/05.01.05.html>

⁵¹ Op. cit. note 49

⁵² Op. cit. note 49

⁵³ Op. cit. note 49

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- newborn children whose parents are covered by the public plan.

Access to healthcare for migrants

Asylum seekers and refugees

It should be noted that 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.

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 people⁵⁸, such as protected persons⁵⁹, asylum seekers, rejected refugee claimants before their expulsion date⁶⁰, etc.

The IFHP offers six types of coverage:

- Type 1, Basic, Supplemental and Prescription Drug Coverage
- Type 2, Basic and Prescription Drug Coverage

⁵⁸

<http://www.cic.gc.ca/english/information/applications/guides/5568ETOC.asp#5568E2>

⁵⁹ *Immigration and Refugee Protection Act*, 2001, section 95(2): "A protected person is a person on whom refugee protection is conferred under subsection (1), and whose claim or application has not subsequently been deemed to be rejected under subsection 108(3), 109(3) or 114(4)".

<http://laws-lois.justice.gc.ca/eng/acts/I-2.5/>

⁶⁰ It means a person:

- whose claim for refugee protection has been finally rejected by the Immigration Refugee Board and whose right to judicial review, or any appeal of that judicial review, in respect of that claim has been exhausted; or
- whose claim is deemed to be rejected under subsections 105(3), 108(3) or 109(3) of the *Immigration and Refugee Protection Act*.
<http://www.cic.gc.ca/english/department/laws-policy/ifhp.asp>

- Type 3, Basic and Public Health or Public Safety Prescription Drug Coverage
- Type 4, Public Health or Public Safety Basic Coverage and Public Health or Public Safety Prescription Drug Coverage
- Type 5, Coverage for persons detained under the *Immigration and Refugee Protection Act*
- Type 6, Coverage for the *Immigration Medical Examination*

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.

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 hospitals and doctors refuse to treat individuals with a valid IFHP or require payment in advance. Asylum seekers also have to deal with IFHP renewal issues. They lose access to public healthcare as soon as their IFHP document expires.

Pregnant asylum seekers

All pregnant women eligible for the IFHP can benefit from Type 2 coverage, which includes basic coverage⁶¹ and prescription drug

⁶¹ In-patient and outpatient hospital services, services of medical doctors, registered nurses and other health-care professionals licensed in

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coverage⁶². This coverage lasts for the term of the pregnancy plus an additional two months. They also have the same access to pregnancy termination as nationals with health coverage.

Children of asylum seekers

Children eligible for the IFHP who are less than 19 years old can benefit from Type 1 coverage which includes basic coverage⁶³, supplemental coverage⁶⁴ and prescription drug coverage⁶⁵. This coverage, which also includes vaccination, lasts for as long as they remain eligible for the IFHP and are under 19 years of age.

Reforms

IFHP reforms background

In April 2012, the federal government announced changes to the IFHP,

Canada, including pre and postnatal care, laboratory, diagnostic and ambulance services. <http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp>⁶²

<https://www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobheader=application/pdf&blobheadername2=MDT-Type&blobkey=id&blobwhere=1187213211285>

⁶³ In-patient and outpatient hospital services, services of medical doctors, registered nurses and other health care professionals licensed in Canada, including pre and postnatal care laboratory, diagnostic and ambulance services. <http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp>

⁶⁴ Limited dental and vision care, home care and long-term care services by allied health-care practitioners, including clinical psychologists, occupational therapists, speech language therapists, physiotherapists assistive devices, medical supplies and equipment, including: orthopedic and prosthetic equipment, mobility aids, hearing aids, diabetic supplies, incontinence supplies, and oxygen equipment.

<http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp>

⁶⁵ Op. cit. note 62

which provides temporary health benefits to asylum seekers, rejected refugee claimants, etc. in Canada. The drastic changes to the IFHP, which came into effect on 30 June 2012, considerably limited access to healthcare for the groups concerned⁶⁶.

First of all, protected persons and refugee claimants where a decision has not yet been made or is under appeal and who are not nationals of a designated “safe” country of origin (non- DCO) continued to receive basic health coverage. Medications and immunisations were covered only if they were required to prevent or treat diseases which pose a risk to public health or safety⁶⁷.

Secondly, rejected refugee claimants (even those who cannot be expelled from Canada) and refugee claimants where a decision has not yet been made and who are nationals of a designated “safe” country of origin (DCO)⁶⁸, including those whose initial claims have been rejected and still have appeal options, which may take several years, were not eligible to basic healthcare, including emergency care⁶⁹. They only had access to

⁶⁶ R. Goel, “Federal reversal of refugee health cuts still leaves many uncovered”, *Health Debate*, 2014, <http://healthydebate.ca/opinions/reversal-of-refugee-health-cuts>

⁶⁷ List of infectious diseases, please see this document in French, Note 3 <https://www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobheader=application/pdf&blobheadername2=MDT-Type&blobkey=id&blobwhere=1187213211399>

⁶⁸ List of countries, <http://www.cic.gc.ca/english/refugees/reform-safe.asp>

⁶⁹ L. Samson and C. Hui, “Cuts to refugee health program put children and youth at risk”, Canadian Paediatric Society, 2012, http://www.cps.ca/advocacy/CPS_RefugeeHealth.pdf

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healthcare or medications if these were required to prevent or treat a disease posing a risk to public health⁷⁰.

Finally, at the discretion of the Immigration Minister, some people could be granted special dispensation for health services⁷¹. This happens in very rare and exceptional circumstances.

As a result, ending coverage for basic healthcare impeded many pregnant women from having access to antenatal and obstetric care; as well as children from having access to the diagnosis and treatment of common illnesses, including infections which commonly affect children in their early years⁷². Moreover, chronic medical conditions that routinely present themselves in early childhood, such as asthma, may be diagnosed late or not at all⁷³.

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 have access to the same healthcare and services as before the government's cuts.

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 deemed the cuts to the refugee health programme "*cruel and unusual*" treatment. Indeed, the 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"⁷⁴.

The federal government was given four months, until 4 November 2014, to reinstate the original programme⁷⁵. On 4 November 2014, the government announced what it calls "*Temporary measures for the Interim Federal Health Program*"⁷⁶ which is not quite a full reversal of the cuts of 2012⁷⁷. These measures will be in force until the end of the trial.

It should be noted that the government has restored access to healthcare and medications through IFHP for children, pregnant women and asylum seekers from designated countries of origin.

The government has not restored access to medications for all other active refugee claimants, privately-sponsored refugees in case of resettlement⁷⁸ or rejected claimants until the date of expulsion, who were provided with access to medications through the IFHP before the 2012 cuts.

[Bill C-31](#)⁷⁹

⁷⁴ *Canadian Doctors for Refugee Care, the Canadian Association of Refugee Lawyers, Daniel Garcia Rodriques, Hanif Ayubi and Justice for Children and Youth v Attorney General of Canada and Minister of Citizenship and Immigration*, 2014, Federal Court <http://cas-ncr-nter03.cas-satj.gc.ca/rss/T-356-13%20Cdn%20Doctors%20v%20AGC%20Judgment%20and%20Reasons.pdf>

⁷⁵ Op. cit. note 66

⁷⁶

<http://www.cic.gc.ca/english/department/media/notices/2014-11-04.asp>

⁷⁷ Op. cit. note 66

⁷⁸

<http://www.cic.gc.ca/english/refugees/sponsor/index.asp>

⁷⁹ *Statutes of Canada 2012*, Chapter 17 2012, <http://www.parl.gc.ca/HousePublications/Public>

⁷⁰ Ibid.

⁷¹ Op. cit. note 69

⁷² Op. cit. note 69

⁷³ Op. cit. note 69

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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 (IRB), 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 IRB's Refugee Protection Division. Unsuccessful claimants are sometimes detained before being removed from Canada; however, they may apply to the Federal Court of Canada for a judicial review.

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 treatment⁸⁰. 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.

[ation.aspx?Language=E&Mode=1&DocId=5697417](#)

⁸⁰
http://www.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_ls.asp?ls=c31&Parl=41&Ses=1

Undocumented migrants

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 fail 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*⁸¹ determined that an undocumented immigrant was properly excluded from a federal health insurance programme and held that benefits under that programme 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 authorities⁸².

In practice, there is no overarching legal duty in Canada for doctors in clinics or hospitals to treat patients⁸³. However, doctors' codes of conduct

⁸¹ *Nell Toussaint v Attorney General of Canada and the Canadian Civil Liberties Association*, 2011, Federal Court of Appeal, http://www.law.yale.edu/documents/pdf/Intellectual_Life/Toussaint_v_Canada.pdf

⁸² P. Glen, "Health Care and the Illegal Immigrant", *Health Matrix: Journal of Law-Medicine*, vol. 23, 2013, <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1788&context=facpub>

⁸³ A. Sikka and al., "Access to Health Care and Workers' Compensation for Precarious Migrants in Québec. Ontario and New Brunswick", *McGill Journal of Law and Health*, Vol 5(2), 2011, <http://mjlh.mcgill.ca/pdfs/vol5-2/MJLH%20Vol%20V,%20No.%202%20-%20Sikka.pdf>

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and provisions in provincial legislation point to the existence of duties to treat some people, including undocumented migrants who may not be otherwise covered for medical services, under some circumstances⁸⁴.

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"⁸⁵. 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"⁸⁶. 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 presents with a condition that could entail serious consequences if immediate medical attention is not given"⁸⁷.

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*⁸⁸.

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 price⁸⁹.

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

⁸⁴ Ibid.

⁸⁵ 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."

⁸⁶ *An Act Respecting Health and Social Services*, Updated to 1 April 2015, http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S4_2/S4_2_A.html

⁸⁷ *Code of Ethics of Physicians*, Updated to 1 April 2015, http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=3&file=/M_9/M9R17_A.HTM

⁸⁸ Op. cit. note 86

⁸⁹ Our teams are working on it and are collecting official documents about this controversy.

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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 €140; 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 child⁹⁰.

The average bill for delivery services ranges from €5,000 to €7,000,

depending on the institution, but fees

are often higher if there are complications and if more complex

medical attention is needed⁹¹.

This amount includes hospital fees for the mother (between €1,700 and €2,500 per day, depending on the hospital) and the baby (between €700 and €1,000 per day), as well as the doctor's fees (between €1,000 and €2,000)⁹². For women who need it, an epidural adds between €350 and €650 to the bill⁹³. These costs are a direct obstacle to healthcare services that are essential to maternal health.

Furthermore, new practices have recently been introduced in some hospitals requiring pregnant women to pay all or part of these amounts before

delivery⁹⁴. This leads women to seriously consider home delivery and to renounce antenatal care.

The constant fear of being reported to the immigration authorities and expelled is another significant barrier in

accessing healthcare. Therefore,

many pregnant women prefer to pay fees to private practitioners rather than go to public health structures⁹⁶.

For those who can afford private practitioners' 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. In

some cases, this leads to medical complications that could have been

avoided.

As for **pregnancy termination**⁹⁹, 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:

- €425 (stage between 12 and 13 weeks)
- €550 (stage between 14 and 16 weeks)
- €700 (stage between 17 and 20 weeks)
- €1,200 (stage between 20 and 23 weeks)

[insecure-access-to-health-care-in-montreal](#)

⁹¹ Ibid.

⁹² Op. cit. note 90

⁹³ Op. cit. note 90

⁹⁰ Doctors of the World – Médecins du Monde Canada, *Women with precarious status and maternal health: Insecure access to health care in Montreal*, 2013, <http://www.solidarityacrossborders.org/solidarity-city/solidarity-city-journal/women-with-precarious-status-and-maternal-health->

⁹⁴ C. Rousseau, "Perinatal health care for undocumented women in Montreal: When sub- standard care is almost the rule", *Journal of Nursing Education and Practice*, Vol. 4, No. 3, 2014,
<http://www.sciedu.ca/journal/index.php/jnep/article/viewFile/3326/2325>

⁹⁵ Ibid.

⁹⁶ Op. cit. note 94

⁹⁷ Op. cit. note 94

⁹⁸ Op. cit. note 94

⁹⁹

<http://www.educaloi.qc.ca/en/capsules/abortion-no-legal-time-limits>

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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 is a Canadian citizen or permanent resident, the child has the right to a RAMQ card from birth.

If one of the parents is in a status regularisation process (e.g. refugee claimant, 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 are temporary residents or undocumented migrants, the child does not have the right to be covered by the RAMQ even if they are technically considered to be a Canadian citizen.

Even though the Canadian courts have consistently recognised that most provisions of the Canadian Charter of Rights and Freedoms, 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 (*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, they ask undocumented parents to pay €100 per vaccine.

The only way to access free healthcare for Canadian-born children is through the application of their parents to obtain a legal and permanent status. During the waiting period after the application is submitted, their children will be eligible for the RAMQ until the application is processed. If the application is refused, children are no longer eligible for the RAMQ. It should be noted that most 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

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lower rate of success in their asylum claims than accompanied children or adults. However, they also have a lower expulsion rate¹⁰⁰.

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 more than 93,000 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).

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.

¹⁰⁰ S. Grover, “Denying the right of trafficked minors to be classed as convention refugees: The Canadian case example”, *International Journal of Children's*, Volume 14, Issue 3,

Protection of seriously ill foreign nationals

The Immigration and Refugee Protection Regulations of 2001, last amended on 21 February 2015, foresees 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:

- 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 their application), if returned to their home country, would be subject to a risk to life caused by the inability of their country (or countries) of nationality, or former habitual residence if they do not have a nationality, to provide adequate health or medical care.

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

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health insurance card because they do not know the rights of patients.

Treatment for STIs and BBIs is not accessible without a health insurance card.

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National Health System

Constitutional basis

The Preamble to the Constitution of 27 October 1946¹⁰¹, the Declaration of the Rights of Man and of the Citizen of 26 August 1789 as well as the Charter for the Environment of 2004¹⁰² 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*”¹⁰³.

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*”¹⁰⁴.

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*”¹⁰⁵.

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 security¹⁰⁶.

The health insurance system is dominated by the National Health Insurance Fund for Salaried Workers (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés – CNAMTS*)¹⁰⁷. It covers the majority of the population, including beneficiaries of universal medical coverage (*Couverture d'Assurance Maladie – CMU*).

Other basic funds cover specific occupational groups: for instance, the agricultural scheme (*Mutualité Sociale*

¹⁰¹ *Preamble to the Constitution 1946*, http://www.conseil-constitutionnel.fr/conseil-constitutionnel/root/bank_mm/anglais/cst3.pdf

¹⁰² *Constitutional Law of 2 March 2005 related to the 2004 Charter for the Environment*, <http://www.legifrance.gouv.fr/Droit-francais/Constitution/Charte-de-l-environnement-de-2004>

¹⁰³ Op. cit. note 101

¹⁰⁴ Op. cit. note 102

¹⁰⁵ *Article L. 1110-1 of the Public Health Code*,
<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIARTI000006685741&dateTexte=&categorieLien=cid>

¹⁰⁶ The Commonwealth Fund,
INTERNATIONAL PROFILES of Health Care Systems, Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States, New-York, 2013.

¹⁰⁷ Civitas, *Health care Systems: France*, updated by Emily Clarke (2012) and Elliot Bidgood (January 2013), Based on the 2001 Civitas Report by David Green and Benedict Irvine,
<http://www.civitas.org.uk/nhs/download/france.pdf>

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Agricole – MSA) or the scheme for the self-employed (*Régime Social des Indépendants – RSI*)¹⁰⁸.

These three main schemes (CNAMTS, MSA and RSI) were federated into a National Union of Health Insurance Funds (*Union Nationale des Caisses d'Assurance Maladie – UNCAM*) by the 2004 health insurance reform¹⁰⁹. This new federation has become the sole representative of the insured in negotiations with healthcare providers.

The Primary Health Insurance Funds (*Caisses Primaire d'Assurance Maladie – CPAMs*) are responsible for the reimbursement of claims and benefits¹¹⁰. They also manage preventive services and general health and social care in their area¹¹¹.

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 area¹¹².

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 occupation¹¹³. 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 people¹¹⁴. In addition, universal access is guaranteed for those on low incomes and/or with chronic conditions¹¹⁵ 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 coverage¹¹⁶. 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 . This card is not a means of payment, but it does facilitate a quicker reimbursement and simplifies the procedure (electronic treatment form) 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*¹¹⁸), such as diabetes and HIV/AIDS, or those who are entitled to supplementary universal medical

¹⁰⁸ Ibid.

¹⁰⁹ K. Chevreul et al., “France: Health system review”, *Health Systems in Transition*, Vol 12, No 6, 2010,

<http://www.euro.who.int/0008/135809/E94856.pdf>

¹¹⁰ Ibid.

¹¹¹ Op. cit. note 109

¹¹³ Op. cit. note 106

¹¹⁴ Op. cit. note 106

¹¹⁵ Op. cit. note 106

¹¹⁶ Op. cit. note 107

¹¹² Op. cit. note 109

¹¹⁷ Op. cit. note
107

¹¹⁸ List of long-
term chronic
illnesses (ALD
30+1),
[http://www.fonds
hs.fr/Media/Defa
ult/Images/R
essources-
Allocations/Liste
des_ALD_30.p
df](http://www.fonds
hs.fr/Media/Defa
ult/Images/R
essources-
Allocations/Liste
des_ALD_30.p
df)

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coverage (CMU-C) or pregnant women from the first day of the sixth month of their pregnancy¹¹⁹.

Statutory health insurance funds cover:

- Hospital care and treatment in public or private rehabilitation or physiotherapy institutions;
- Outpatient care provided by general practitioners (GPs), specialists, dentists and midwives;
- Diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals (nurses, physiotherapists, speech therapists, etc.);
- Prescription drugs, medical appliances and prostheses that have been approved for reimbursement; and
- Prescribed healthcare-related transport¹²⁰.

Statutory health insurance also partially covers long-term and mental healthcare and provides minimal coverage of outpatient vision and dental care¹²¹.

CMU scheme

In January 2000 (CMU Law, 27 July 1999¹²²) basic universal medical coverage (CMU) and supplementary CMU (CMU-C) were created in order to enable people who are not covered by the health insurance scheme to have

access to healthcare. This major change in health coverage system in

France allowed all persons authorised to reside in France to obtain a health coverage (not any more related to employment). However, this scheme did not include undocumented migrants. They are therefore covered by a specific scheme (see below).

Basic CMU

Basic CMU enables those eligible to be covered for health expenses under the same conditions as other individuals, provided they have been resident in France for three months, but with no condition of employment. In practice, the patient pays health expenses (medical consultations, medication, etc.) but doesn't have to pay the full amount. For a GP consultation, 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).

To be entitled to free basic CMU, an individual must be on a low income (below €9,610 per year). If an individual earns more than this annual threshold, the basic CMU is not free. The individual must pay a contribution based on 8% of their income.

Moreover, the individual must be a French citizen, have a residence permit or have started the regularisation process, and must have been living in France (mainland

France or the French overseas departments (*Départements d'Outre-Mer – DOM*), with the exception of

¹¹⁹ <http://www.ameli.fr/assures/soins-et-remboursements/ce-qui-est-a-votre-charge/le-ticket-moderateur.php>

¹²⁰ Op. cit. note 106

¹²¹ Op. cit. note 106

¹²² *Basic Universal Coverage (CMU) Law of 27 July 1999,*

<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000198392>

¹²³ The country of France comprises metropolitan France, including the islands around its coast and Corsica, and a number

of overseas departments and territories outside the continent of Europe. In this report the term "mainland France" is used to describe all of France excluding the overseas departments and territories.

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Mayotte where the scheme is different (see below)) continuously for more than three months. Asylum seekers who have fully started their claim process can also request this coverage.

CMU-C

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

To be entitled to CMU-C, an individual must be on a low income: below €720.42 per month (€8,644.52 per year) in mainland France or below €801.75 per month (€9,621 per year) in the overseas departments (except Mayotte)¹²⁴. The same conditions of residency must be met as for CMU.

Supplementary health insurance assistance scheme (*Aide Complémentaire Santé - ACS*)

ACS 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 age¹²⁵.

To be entitled to ACS, an individual must have an income which does not exceed the threshold for access to CMU-C by more than 35%¹²⁶ (€720.42 (in mainland France) or €801.75 (DOM, except Mayotte)). The ACS is valid for one year.

¹²⁴

<http://vosdroits.servicepublic.fr/particuliers/F1073.xhtml>

<http://vosdroits.servicepublic.fr/particuliers/F13375.xhtml#N10237>

¹²⁶ Ibid.

It should be noted that reforms to the ACS scheme are to be undertaken from July 2015. Users of this scheme will not need to pay for their medical expenses upfront (full third-party payer).

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

The law against social exclusion of 29 July 1998¹²⁷ 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

¹²⁷

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

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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 PASS¹²⁸ created a regional coordination structure with a PASS framework which details every PASS in France and evaluate them. 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. The PASS systems are not all the same and not all of them offer actual access to healthcare for people in vulnerable situations. The system is often insufficient to meet the needs.

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

Positive reform

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% (€972.5¹²⁹ in May 2015). This revaluation should enable more than 750,000 additional individuals to have full health coverage. The full extent of this

¹²⁸ Circular of 18 June 2013,
http://www.sante.gouv.fr/fichiers/bo/2013/13-07/ste_20130007_0000_0078.pdf

¹²⁹ <http://www.cmu.fr/acs.php>

measure is expected at the end of 2015.

In May 2014 (figures last consulted on 22/02/2015), 920,000 people were using ACS, compared with 826,257 before the widening of the eligibility criteria (an additional 93,743 people).

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).

This means that so far, 539,307 additional people have obtained coverage thanks to this positive measure (not including those covered by State Medical Aid (*Aide Médicale Etat – AME*)).

New healthcare Bill

A new healthcare bill is currently debated in the Parliament. According to MdM FR, there are many progresses to consolidate by vote:

- the new definition of harm reduction policy and the implementation of safe supervised injection centers unlock new opportunities regarding drug users' care and treatment;
- the progressive spread of the third party payment system in order to get free access to care at point of use to reduce the amount of patients giving up seeking care;
- the acknowledgement of the need to provide interpreters and health mediators in health structures in order to facilitate access to care;
- associations can call upon the High Authority for Health (*Haute Autorité de Santé – HAS*);
- the Economic Committee for Healthcare products (*Comité*

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Economique des produits de Santé – CEPS) can make a framework agreement with registered associations;

However, there are also many loopholes:

- 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.
- No change to reduce refusal of healthcare: still monitored by the Medical order council 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 refusals of healthcare through a situational test;
- New healthcare bill is still missing the opportunity to match up law in Mayotte with mainland law regarding medical protection, leaving many people with no access to care and social help.

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 CMU scheme (basic CMU and CMU-C). To be entitled to basic CMU, they must have earned less than €9,534 the year

before their application for social security. If they have no official documentation, they can make a sworn statement regarding their financial resources. They are exempt from the condition of residence (three months) but they must prove that they are in the country legally¹³⁰.

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 to be entitled to CMU and CMU-C they need to have an address, after which they can submit their asylum application to the prefecture; this procedure then eventually entitles them to health coverage. 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.

However, some asylum seekers are excluded from the general legal system by local prefectures.

- There are those who are subject to the Dublin III regulation¹³¹.

¹³⁰ <http://www.cmu.fr/resider-en-france-stable-regulier.php>

¹³¹ This Regulation establishes the principle that only one Member State is responsible for

examining an asylum application. It temporarily

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This Regulation establishes the principle that only one Member State is responsible for examining an asylum application. The French authorities are temporarily forbidden from considering the asylum application while they wait for a decision by the Member State responsible for considering the individual's asylum application. These people, according to circular n° DSS/2A/2011/351 of 8 September 2011 are therefore not entitled to social security but to AME (for undocumented migrants).

- There are those from safe countries 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 (15 days for the Office for the Protection of Refugees and Stateless Persons (OFPRA) and four days for people in an administrative detention centre). These people are also not entitled to health coverage under the CMU scheme like other asylum seekers.

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.

forbids the examining of the asylum application by French authorities while waiting for determining the Member State responsible for examining an asylum application.
http://europa.eu/legislation_summaries/justice_freedom_security/free_movement_of_persons

[_asylum_immigration/l33153_en.htm](http://europa.eu/legislation_summaries/justice_freedom_security/free_movement_of_persons_asylum_immigration/l33153_en.htm)

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 residents.

- 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

According to Article L251-1 of the Social Action and Family Code, an undocumented individual who has been resident for more than three months in France and whose

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resources are less than €720 per month is entitled to AME¹³².

This 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*¹³³) 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, they can request a renewal of AME. In theory, they 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 government, was repealed by the new socialist one in 2012 as one of the 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 document¹³⁴ and can therefore not submit a request.

To give yet another example of the administrative barriers, if a migrant wants to prove their identity with a birth certificate, said document will have to be translated by an official translator¹³⁵, 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. The situation is that undocumented migrants 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

¹³² <http://vosdroits.service-public.fr/particuliers/F3079.xhtml#N10118>

¹³³ The SMR is a criteria used in public health to classify drugs or medical devices according to their therapeutic or diagnostic utility.

¹³⁴

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

¹³⁵ Ibid.

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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, the circular DHOS/DSS/DGAS adopted in 2005 (Article L254-1 of the Social Action and Family Code¹³⁶) created the Fund for Vital and Urgent Care (*Fonds pour les soins urgents et vitaux – FSUV*). This is now the urgent care scheme, 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. With the urgent care scheme, healthcare is always considered as essential care for pregnant women and children.

Undocumented pregnant women

¹³⁶ Article 254-1 of the Social Action and Family Code,
http://legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006074069&idArticle=L_EGIARTI000006797164&dateTexte=&categorieLien=cid

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 above-mentioned 2005 circular 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 the law, only adults' undocumented migrants are concerned by the authorisation to stay. Thus, children of undocumented migrants in France do not need a permit to reside, they are not considered as undocumented migrants. In principle, children of undocumented migrants are entitled to the AME scheme upon arrival in France (without the three-month residence condition), even if their parents are not eligible. The right is granted for one year¹³⁷.

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. Then they are only entitled to the PASS system and 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

¹³⁷ Circular of 8 September 2011,
http://www.sante.gouv.fr/fichiers/bo/2011/11-10/ste_20110010_0100_0055.pdf

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children is considered as emergency care.

Moreover, children can receive vaccinations against all the principal diseases free of charge¹³⁸. In accordance with the general health system, all children have access to immunisations at PMI centres¹³⁹.

EU citizens

Destitute EU citizens are considered as undocumented migrants (no health coverage, insufficient financial resources)¹⁴⁰ and they can access AME under the same conditions as any other undocumented migrant¹⁴¹ (DSS/DACI/2011/225 9 June 2011¹⁴²).

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 barrier¹⁴³. Some CPAMs also ask EU citizens to request CMU first before they can apply for AME, even if they will clearly not obtain it,

¹³⁸ <http://www.ameli.fr/assures/prevention-sante/la-vaccination.php>

¹³⁹ Comité Médical pour les Exilés (COMEDE), *Migrants/étrangers en situation précaire*, 2008, <http://www.comede.org/IMG/pdf/guide-comede08.pdf> and

<http://www.immigration.interieur.gouv.fr/Asile/L-accueil-des-demandeurs-d-asile/Les-droits-sociaux-des-demandeurs-d-asile>

¹⁴⁰ These are conditions to be authorized to reside in France for inactive individuals.

¹⁴¹ Op. cit. note 134

¹⁴² *Circular of 9 June 2011*, http://circulaire.legifrance.gouv.fr/pdf/2011/07/cir_33406.pdf

¹⁴³ Doctors of the World International Network, *Access to healthcare for vulnerable populations – Update of legislation in 10 countries*, 2013,

<http://www.medecinsdumonde.org/content/download/14823/174607/file/legal%20update%20full%20v06042013.pdf>

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 which apply.

However, since the circular DSS/2A/DGAS/DHOS, adopted on 7 January 2008¹⁴⁴, 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.

Unaccompanied minors

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

The care of unaccompanied minors falls under Child Protection which is the responsibility of the departmental council through child welfare services (*Aide Sociale à l'Enfance – ASE*). Children taken into care by social services can benefit from accommodation, socio-educational measures, counselling, 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

¹⁴⁴ *Circular of 7 January 2008*, <http://www.sante.gouv.fr/fichiers/bo/2008/08-02/a0020048.htm>

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people seeking protection are under the age of majority and unaccompanied.

However, 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 FR strongly criticises these practices, especially because they are imprecise, unethical and unreliable. MdM is 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.

MdM further 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.

Protection of seriously ill foreign nationals

From 1998, in accordance with the Code on Entry and Residence of Foreign Nationals and Right of Asylum (CESEDA), foreign nationals ordinarily residing in France could obtain a residence permit for medical reasons and protection from expulsion if:

- Their state of health required medical assistance i.e. if they could not access healthcare, it could produce consequences of exceptional gravity.
- They would not be able to benefit from appropriate care in their home country.

Despite strong and intense opposition from organisations and some members of parliament, a reform related to immigration, integration and nationality was promulgated on 16 June 2011 (“*Loi Besson*”)¹⁴⁵. This reform modifies the text guaranteeing the right to stay for ill foreign nationals.

Now, the criterion for an ill foreign national being permitted to remain is the absence in their country of return of appropriate treatment, except in exceptional humanitarian circumstances. Thus, the verification of the existence of appropriate treatment in the country of return would be sufficient to decide that the individual can return to their home country to be treated.

A seriously ill foreign national 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 time¹⁴⁶.

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*)¹⁴⁷. However, the

¹⁴⁵ Law of 16 June 2011, <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000024191380&categorieLien=id>

¹⁴⁶ <http://www.interieur.gouv.fr/A-votre-service/Mes-demarches/Etranger-Europe/Etrangers-en-France/Titres-documents-de-sejour-et-de-circulation-des-etrangers-non-europeens/Questions-Reponses/Quelle-procedure-s-applique-au-sejour-des-etrangers-malades>

¹⁴⁷ Observatoire du Droit à la Santé des Etrangers (ODSE), *Les personnes étrangères malades et leurs proches ont le droit de vivre dignement en France*, 2015,

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Ministry of the Interior **often becomes involved** in the medical advice scheme, despite the fact that competence in this area belongs exclusively to the Ministry of Health¹⁴⁸. Thus, management of migration interferes with health policies.

This involvement occurs at different levels of the procedure: breach of medical confidentiality at the prefecture, a medical second opinion conducted by the prefect disregarding the opinion of the MARS; some prefects consider that they are not bound by the opinion of the MARS¹⁴⁹.

The prefecture must then consider administrative conditions (ordinary residence i.e. over one year, threat to public order) to determine the type of protection to be granted (temporary residence permit (one year) or provisional residence permit (six months)). However, it does not intervene in the assessment of medical conditions (Articles L.313-11 and R.313-22 du CESEDA).

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. The prefect undertakes 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 2013, 6,006 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.

http://www.odse.eu.org/IMG/pdf/Recommandations_ODSE_projet_de_loi_immigration_22_janvier_2015.pdf

¹⁴⁸ Ibid.

¹⁴⁹ Op. cit. note 147

According to 1,398 patients followed by some NGOs, the rate of positive decisions was 85%¹⁵⁰.

In order to avoid a restrictive and arbitrary interpretation of this ambiguous concept of “*absence of appropriate treatment*”, the Ministry of Health provided clarification in an instruction of 10 November 2011¹⁵¹. 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.)¹⁵².

However, according to the Medical Committee for Exiles (*Comité Médical pour les exilés – COMEDE*)¹⁵³, 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.

¹⁵⁰ Comité pour la Santé des Exilés (COMEDE), *Rapport COMEDE 2014*, <http://www.comede.org/IMG/pdf/RapportComede2014.pdf>

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

¹⁵² AIDES, *Observatoire des étrangers malades - Droit au séjour pour soins*, 2012, http://www.aides.org/sites/default/files/doc/120418_Rapport_EMA.pdf

¹⁵³ Op. cit. note 150

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It should also be noted that MdM FR strongly criticised the “Country fact files” for 30 countries produced by the Inter-ministerial Committee for the Management of Immigration in 2007. This committee recommended not taking into account the effective accessibility of treatment in these countries.

Prevention and treatment of infectious diseases

Sexually Transmitted Infections

Currently, there are two types of facility holding information on sexually transmitted infections and their prevention and testing.

- Free and anonymous testing centres (*Centres de dépistage anonyme et gratuit – CDAG*) for HIV and hepatitis, created in 1988, authorised by the ARS and funded by health insurance;
- Information centres for testing and diagnosis of sexually transmitted infections (*Centres d'information, de dépistage et de diagnostic des infections sexuellement transmissibles – CIDDIST*) where testing is carried out for specific sexually transmitted infections. Since the recentralisation introduced by the 2004 Law related to local freedoms and responsibilities, they have been managed either by the general councils by agreement with the State or through structures authorised by the ARS and funded by the State.

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 2015¹⁵⁴ 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 (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

¹⁵⁴ Law of 22 December 2014, <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000029953502>

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(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

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 reside¹⁵⁵, 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). In Mayotte, CMU, CMU-C and AME do not exist.

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).

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

[20080126](#)

¹⁵⁵ Order of 20 December 1996,
<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=LEGITEXT000005622330&dateTexte=>

expensive in relation to their financial resources (one in five inhabitants earns less than €100 per month¹⁵⁷).

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 amount¹⁵⁸. 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 has **until now not been applied in Mayotte**.

¹⁵⁶ Order of 21 July 2014,
http://www.gisti.org/IMG/pdf/arrete_ars-mayotte_no182_2014-07-21.pdf

¹⁵⁷ The average monthly income of the French-born Mayotte (Mayotte) is only 290 euros monthly (190 euros for foreign nationals), 5 times less than French do not originate in Mayotte.

http://www.insee.fr/fr/insee_regions/mayotte/themes/infos/insee_infos_28.pdf

¹⁵⁸ This amount is not set by any law.

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Exceptional 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.

For instance, a foreign national in mainland France who is ordered to leave French territory has at least 48 hours to challenge the order and obtain an action of annulment from the Administrative Court. Then the execution of the expulsion is suspended until the decision by the judge. In Mayotte, a foreign national can be expelled in a few hours.

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National Health System

Organisation and funding German healthcare system

German laws regarding access to healthcare are made at the national level. However, as a federal country, responsibilities for the healthcare system in Germany are shared between the Länder (federal states), the federal government and civil society organisations¹⁵⁹ (i.e. important competencies are legally delegated to membership-based, self-regulated organisations of payers and providers)¹⁶⁰, thus combining vertical implementation of policies with strong horizontal decision-making¹⁶¹.

Healthcare in Germany is funded by a statutory contribution system that ensures mostly free healthcare for citizens and authorised residents at the point of use via health insurance

funds¹⁶². There are two insurance systems: public statutory health insurance (*Gesetzliche*

<http://www.civitas.org.uk/nhs/download/germany.pdf>

¹⁵⁹ For instance, there are “Kassenärztliche Vereinigung” (represents the interests of approximately 24.000 registered doctors) or “Bundesärztekammer” (umbrella organization which represents political interests of almost half a million doctors) or “Deutsche Patientenvereinigung” (organization for patients).

¹⁶⁰ R. Busse and J. Wasem, “The German Health Care System – Organization, Financing, Reforms, Challenges...”, *European Observatory on Health Systems and Policies*, Brussels, 2013. https://www.mig.tuberlin.de/fileadmin/a38331600/2013.lectures/Brussels_2013.02.13.rb_GermanyHealthCareSystem-FINAL.pdf

¹⁶¹ Civitas, *Health care Systems: Germany*, updated by Emily Clarke (2012) and Elliot Bidgood (January 2013), Based on the 2001 Civitas Report by David Green and Benedict Irvine,

Krankenversicherung – GKV) and private health insurance (*Private Krankenversicherung – PKV*).

For both systems, insurance payments are shared between employees and employers¹⁶³. Approximately 85% of all citizens belong to the public statutory health insurance scheme, whereas only 10% have private health insurance. The remaining 5% are covered by special regimes (e.g. for soldiers).

As of 2009, it is compulsory for all German citizens and long-term residents to have health insurance. For those earning less than €54,900 per year, insurance is provided by the public statutory health insurance scheme (GKV). Anyone earning more than €54,900 per year has the option to purchase a private health insurance plan.

The GKV is operated by approximately 150 competing sickness funds. This means that citizens and long-term residents choose to which sickness fund they want to belong.

Since 2009, a uniform contribution rate has been set by the government (and has been set in federal law since 2011)¹⁶⁴. As of 2011, employees or pensioners with health coverage contribute 8.2% of their gross incomes, while the employer or pension fund adds another 7.3%¹⁶⁵. Within the GKV, this contribution also covers

¹⁶²

<http://www.bundesaerztekammer.de/page.asp?his=4.3571>

¹⁶³ Ibid.

¹⁶⁴ Op. cit. note 106

¹⁶⁵ Op. cit. note 106

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dependents (non-earning spouses and children)¹⁶⁶.

For destitute nationals, it depends on the individual's situation. Those with health coverage must pay the compulsory insurance (*Pflichtversicherung*). This costs a minimum of €135 per month, depending on the individual's income. If they receive welfare benefit, then the social welfare office (*Sozialamt*) normally pays. However, if the person has had a "gap" in 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).

The GKV does not cover all the costs related to medical services. In most cases, small co-payments must be made, that is patients must pay on top of their payroll contributions. For instance, there are co-payments for inpatient services (€10 per day), for certain treatments such as physiotherapy or specific dental care

and for certain medicines patients also have to pay €5. However, measures have also been put in place to prevent extreme financial burdens e.g. recipients of unemployment benefit and those on low incomes, individuals injured at work and pregnant women. For them, there is an upper threshold for the financial burden. Regarding co-payments, only children under 18 years old are completely exempt.

The problem is that there are gaps in the system, such as the complexity of filling out forms and complying with all the rules of the welfare benefits system. Another issue is that, even though the monthly rates may be paid,

many people without health insurance previously applied for welfare benefits and are still in debt with the insurance for this gap period. This often leads to a situation where individuals still do not have health coverage due to the debt, even though their current monthly fees are being paid by the social welfare office.

Accessing Germany healthcare system

Health insurance is provided by competing, not-for-profit, non-governmental health insurance funds (called "sickness funds" (*Krankenkassen*); there were 134 as of

January 2013) through the statutory

health insurance scheme or by voluntary substitutive private health insurance (PKV)¹⁶⁸.

Regarding payments for healthcare (individual co-payments), until the end of 2012 the patient had to pay €10 per quarter if they went to the doctor. As of 1 January 2013, this provision no longer applies. It was eliminated by Section 1 G. v. 20.12.2012 BGBl. I S.

2789 , and patients no longer have to

¹⁶⁶ Op. cit. note 106

pay anything for medical consultations. For medication, on the other hand, patients will continue to be responsible for a co-payment of 10% of the cost of the medication. This co-payment will continue to be at least €5 and at most €10 per prescription (Section 61 SGB V).

Only children under 18 years old are completely exempt from co-

payment.

¹⁶⁷ There are many differences between them: some illness funds offer additional services such as home-based care programs for isolated patients. Others offer specific care for patients with chronic diseases.

¹⁶⁸ Op. cit. note 106

¹⁶⁹

<http://www.buzer.de/s1.htm?g=SGB%2BV%2B31.12.2012&a=28>

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Prior to 2004, people on welfare benefits and on low incomes were also exempt. This provision was eliminated in 2004 and since then, the annual expenditure on medication co-payments for any German citizen and authorised resident could not exceed 2% of their gross annual household income. This limit was established to prevent unreasonable costs for those on low incomes. The 2% calculation is based on the head of household's income. In addition, people with chronic illnesses do not have to pay more than 1% of their gross annual household income.

In case of emergency, a person with health coverage (public/private) does not have to pay in advance.

With the 2009 reform, health insurance became mandatory for all citizens and permanent residents in Germany (previously, certain groups could choose not to have insurance, although few did so)¹⁷⁰.

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 compensation¹⁷¹.

Recent reforms

On 25 October 2006, the German government presented a comprehensive healthcare reform bill,

¹⁷⁰ Op. cit. note 106

¹⁷¹ Op. cit. note 106

entitled the Statutory Health Insurance Competition Strengthening Act¹⁷². 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 care¹⁷³. The law stipulates that any permanent resident or citizen must be covered by the public health insurance. It should be noted that 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 public health insurance and if they are on a high income.

Since these reforms, individuals who were previously excluded from the public 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 who have not been covered since 2007 (public insurer) or 2009 (private insurer), have had to settle their debts, namely retroactively pay all their contributions.

For example, a permanent resident who became affiliated to the public insurer in 2010 has had to repay their debt (absence of monthly contributions) from 2007 to 2010. Regarding the public insurer, the debt must be paid from April 2007, adding a 5% rate of interest. The same rule applies for any private insurer, but only

¹⁷² M. Lisac, "Health care reform in Germany: Not the big bang", *Health Policy Monitor*, Germany, 2006, http://www.hpm.org/de/Surveys/Bertelsmann_Stiftung_-_D/08/Health_care_reform_in_Germany_Not_the_big_bang.html

¹⁷³ Ibid.

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debts incurred since 2009 have to be reimbursed.

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 debt¹⁷⁴.

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 31 December 2013, the incurred debt is cancelled.
- If an individual subscribed from April 2007 to 31 December 2013, 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.

Our 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.

With regard to private insurances, this is a system of packages (minimum or maximum health coverage). There are three cases:

- If an individual had subscribed before 31 December 2013 and did not pay their contributions, they had a debt with a private insurer. This assumes that they

had subscribed to minimum health coverage since 2009. The debt is equivalent to the monthly contributions for minimum health coverage, which is around €100-125 per month.

- If an individual was not yet insured but decided to subscribe before 31 December 2013, the debt from 2009 to the date of their subscription is cancelled.
- If an individual decided to subscribe to a private insurer after 31 December 2013, they have to pay 15 times the amount of their monthly contributions, so between €1,500 and €2,000.

Access to healthcare for migrants

Asylum seekers and refugees

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

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

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 the allowance for asylum seekers, which is 40% lower

¹⁷⁴ Law of 15 July 2013, <http://www.dghm.org/krankenhaushygieneinfek>

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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 of €359 instead of €224 per month, until the German Parliament enacted a new law.

Since 1 March 2015, asylum seekers and refugees are entitled to welfare benefits 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*)¹⁷⁵. Asylum seekers and refugees may have access to healthcare under the same conditions that apply to German citizens who receive welfare benefits¹⁷⁶. 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*”¹⁷⁷.

For the first 15 months, these services cover “*treatment for severe illnesses or acute pain and everything necessary for curing, improving or relieving the illnesses and their consequences, antenatal and postnatal care, vaccinations, preventive medical tests and anonymous counselling and screening for infectious and sexually transmitted diseases*” (Section 11.5 AsylbLG and Section 19 Infektionsschutzgesetz).

In emergency situations, asylum seekers and refugees can go directly

to the emergency department for care. For non-emergency situations, asylum seekers 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 law on asylum seekers (AsylbLG); the care provider is then reimbursed directly.

It is the municipal departments, which do not have medical expertise, that decide whether or not to authorise reimbursement for care. In practice, this is a problem, because municipal departments may interpret the law differently. For example, some departments will not issue a health voucher to people with chronic illnesses unless there is a severe deterioration in their health.

In contrast, some municipalities (Bremen and Hamburg, in particular) have agreements with public 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.

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

¹⁷⁵

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

¹⁷⁶ Ibid.

¹⁷⁷ Op. cit. note 175

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

Pregnant asylum seekers and refugees

The Asylum Seekers Benefits Act (Section 4) contains a special provision for pregnant women and for women who have recently given birth. 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 normal access to health coverage for antenatal and postnatal care.

Children of asylum seekers and refugees

Children of asylum seekers and refugees are subject to the same system as adults. However, the law stipulates that children can receive other care meeting their specific needs (Section 6 AsylbLG), although this provision does not specify the particular treatments that children may receive. As discussed above, Section 4 AsylbLG stipulates that asylum seekers and refugees who have been in Germany for less than 15 months are entitled to vaccinations¹⁷⁸. However, vaccinations (Section 4.3 AsylbLG) are not compulsory in Germany, but merely recommended. 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

¹⁷⁸ List of vaccinations
<http://www.bmg.bund.de/themen/praevention/frueherkennung-und-vorsorge/impfungen.html>

German peers, due to discrimination in health and education services¹⁷⁹. 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)¹⁸⁰.

Undocumented migrants

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 months¹⁸¹.

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

- 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.

According to the Residence Act of 30 July 2004 (*Aufenthaltsgesetz – AufenthG*), Section 87(2)2, which goes completely against medical providers and social services ethics, “Public bodies [with the exception of schools and other educational and care

¹⁷⁹ Z. Dogusan, “Refugee children discriminated against in Germany, UNICEF says”, *Daily Sabah*, 10 September 2014
<http://www.dailysabah.com/europe/2014/09/10/refugee-children-discriminated-against-in-germany-unicef-says> (accessed 15 March 2015).

¹⁸⁰ Ibid.

¹⁸¹ Op. cit. note 24

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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 or;
- concrete facts which justify the assumption that the conditions exist for the authorities' right to contest pursuant to Section 1600 (1), no. 5 of the Civil Code¹⁸²."

This means that public bodies, with the exceptions mentioned above, including public hospitals, have an obligation to report any undocumented migrants encountered in the course of their work to the immigration authorities.

It should be noted that, in September 2009, thanks to intensive civil society advocacy, the *Bundesrat* issued an instruction¹⁸³ on the application of the duty to report. Hospital administrative and medical staff are bound by medical confidentiality, as are social services departments, if they obtain information on the status of an undocumented migrant in hospital emergency departments.

Even though, in principle, health coverage for undocumented migrants should extend 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 that used for non-emergency care is not.

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).

For non-emergencies, undocumented migrants seeking reimbursement must themselves approach the social welfare office, whose staff then have a duty to report them to the administrative authorities and/or the police¹⁸⁴. This risk renders access to non-emergency healthcare meaningless¹⁸⁵. As a result, undocumented migrants often choose not 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 office¹⁸⁶. Office staff are required to report the status of undocumented migrants to the police, hindering in practice their access to cost-free medication¹⁸⁷. Hence, only those with a "temporary tolerated stay"¹⁸⁸ are

¹⁸² *Residence Act of 30 July 2004*, http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html#p1120

¹⁸³ <http://dip21.bundestag.de/dip21/brd/2009/0669-09.pdf>

¹⁸⁴ Op. cit. note 24

¹⁸⁵ Op. cit. note 24

¹⁸⁶ Op. cit. note 24

¹⁸⁷ Op. cit. note 24

¹⁸⁸ Op. cit. note 182 - Section 60 a (2) 3rd sentence (pregnancy is considered – with discretion – as urgent personal grounds).



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likely in reality to be able to access medicines free of charge¹⁸⁹.

In practice, undocumented migrants do not have real access to healthcare because they are stopped by the so-called duty to report them. They can only have access to outpatient services from health providers who would waive their fees, would be willing to work without being paid and would refuse to report undocumented migrants.

Undocumented pregnant women

In principle, undocumented pregnant women should have access to healthcare services in the same way as women seeking asylum. 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 (Duldung) is only granted for a limited time period, when the woman is considered “unfit to travel” (generally, according to maternity leave law, six weeks before and 12 weeks after delivery)¹⁹⁰. With this document, they do not have to pay the costs of antenatal and postnatal care.

However, for the first six months of their pregnancy, the women are not covered so they do not get appropriate antenatal care (starting at 12th 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 entitled to 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 Code¹⁹¹ 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

¹⁸⁹ Op. cit. note 24

¹⁹⁰ Op. cit. note 24

¹⁹¹ *Criminal Code* s218a, <http://www.gesetze->

im-internet.de/stgb/_218a.html

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- the procedure is performed within 12 weeks of conception (even after a rape with a medical certificate from a psychiatrist).

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.

According to the Ministry for Family Affairs, Senior Citizens, Women and Youth, in Germany the cost of termination of pregnancy is borne entirely by the patient and is not reimbursed.

However, women whose income is below €1,033 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.

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. They have to obtain health coverage through private insurance if they can afford the contributions.

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 organised, 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 them¹⁹². "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 52¹⁹³ of the

Social Security Code Book XII . The health benefits granted must meet all of the requirements in each individual

¹⁹² A. Muller, "Unaccompanied Minors in Germany Focus-Study by the German National Contact Point for the European Migration Network (EMN)", *Federal Office for Migration and Refugees*, Nuremberg, 2014, <http://www.bamf.de/SharedDocs/Anlagen/EN/Publikationen/EMN/Nationale-Studien-WorkingPaper/emn-wp60-minderjaehrige-in-deutschland.pdf?blob=publicationFile>

¹⁹³ Ibid.

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case¹⁹⁴. They shall cover any additional charges and contributions.“ (Section 40 Social Security Code Book VIII) This also covers any need for psychological care¹⁹⁵.

If an unaccompanied minor has already been recognised as an asylum seeker or has been granted subsidiary protection, has been granted refugee status or a prohibition of expulsion has been established, they 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 Office¹⁹⁶.

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 Office¹⁹⁷. They are merely entitled to medical care under the Asylum Seekers Benefits Act¹⁹⁸. Therefore, they have access to health packages as quoted above.

Protection of seriously ill foreign nationals

According to **Section 60a of the Residence Act**, a foreign national may be granted a temporary permit to reside if their continued presence in Germany is necessary on urgent humanitarian or personal 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.

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.

In addition, if the patient is considered able to travel despite their illness, but the treatment required by their condition is not possible their country of origin or not available to them due to lack of financial resources, 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 their health in their country of origin. Data on the national health system and the person's economic and social situation must be presented.

Prevention and treatment of infectious diseases

According to the Section 19 of the law on infectious diseases¹⁹⁹, undocumented migrants are entitled to counselling and testing for transmissible diseases and to

¹⁹⁴ Op. cit. note 192

¹⁹⁵ Op. cit. note 192

¹⁹⁶ Op. cit. note 192

¹⁹⁷ Op. cit. note 192

¹⁹⁸ Op. cit. note 192

¹⁹⁹ *Law on Preventing and Combating infectious diseases in humans of 20 July 2000 (Protection against Infection Act)*, http://www.gesetze-im-internet.de/ifsg/_19.html

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outpatient care (for STIs, TB, hepatitis, etc.). The law also provides for free HIV/AIDS treatment if the patient cannot bear the costs. But the duty to report prevents effective access to care and, in practice, only those with temporary residence permits have access.

In most large German cities, such as Cologne or Munich, however, 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 in practice (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*”²⁰⁰.

Historical background

The founding law of the Greek health system (Law 1397/1983) 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 system²⁰¹. This law can be characterized as the foundation of the Greek healthcare system²⁰².

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 status²⁰³. According to its provisions, there should be universal coverage, equal access to health services and the State should be fully responsible

²⁰⁰ *Constitution of Greece of 1975* (last amendment of 2008), <http://www.hri.org/MFA/syntagma/artcl25.html>

²⁰¹ C. Economou, “Greece: Health system

review”, *Health Systems in Transition*, 2010, vol. 12, No. 7,

for the provision of services to the population.

Organisation and funding of Greek healthcare system

The Greek health care system comprises elements from both the public and private sectors . In

relation to the public sector, elements of the Bismarck and Beveridge models coexist²⁰⁵.

The Greek public healthcare system (*Ethniko Systima Ygeias – ESY*) is financed by a mix of public and private resources. Public statutory funding is based on social insurance. The primary source of revenue for the social insurance funds is the contributions of employees and employers (including contributions by the State as an employer)²⁰⁶. The State budget, via direct and indirect tax revenues, is responsible for covering administration expenditures, funding health centres and rural surgeries, providing subsidies to public hospitals and insurance funds, investing in capital stock and funding health education²⁰⁷.

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

Recent reforms

Before 2011, there were a lot of insurance funds providing coverage for primary, secondary and pharmaceutical care and in some cases also coverage for glasses, diagnostic and laboratory tests. The

http://www.euro.who.int/data/assets/pdf_file/0004/130729/e94660.pdf

²⁰² Ibid.

²⁰³ Op. cit. note 201

²⁰⁴ Op. cit. note 201

²⁰⁵ Op. cit. note 201

²⁰⁶ Op. cit. note 201

²⁰⁷ Op. cit. note 201

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Private Employees' Fund (*Idryma Kinonikon Asfaliseon – IKA*) was the largest social health insurance fund, offering the most comprehensive package, which included almost everything except cosmetic surgery. In addition, most of the funds provided income allowances for lost income due to illness, maternity benefits and others²⁰⁸.

The establishment of the National Organisation for Healthcare Provision (EOPYY) (Law 3918/11) was approved by Parliament on 11 February 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), based on the core values of the Declaration of Alma-Ata, to ensure better health of the Greek people²⁰⁹. With this law, Greece intends to build a comprehensive and strong nation-wide primary healthcare service²¹⁰.

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

²⁰⁸ Op. cit. note 201
²⁰⁹

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

²¹⁰ Ibid.

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 EOPYY²¹¹.

Functioning of Greek healthcare system

Primary healthcare (PHC) is a key element of the Greek health system, acting both as a point of first contact and a gatekeeping mechanism²¹². PHC in Greece is provided by both National Health System and EOPYY units. However, a large number of self-employed health professionals exist²¹³.

More specifically, PHC 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 EOPYY²¹⁴. The current scheme allows free choice of

²¹¹ N. Polyzos et al., "The introduction of Greek Central Health Fund: Has the reform met its goal in the sector of Primary Health Care or is there a new model needed?", *BMC Health Services Research*, 2014,

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

²¹² Ibid.

²¹³ Op. cit. note 211

²¹⁴ Op. cit. note 211

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provider but free choice of insurer is prohibited²¹⁵.

Structurally, there is a shortage of general practitioners (GPs) in Greece compared to specialists, there are few nurses per thousand people and urban areas attract most providers and patients²¹⁶.

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 provision²¹⁷.

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)²¹⁸.

As a result, EOPYY covers over 98% of people with health coverage²¹⁹. This model is similar to the French National Union of Health Insurance Funds (UNCAM).

For primary healthcare, EOPYY also undertakes the operational coordination and cooperation between

(public and private) healthcare units and health professionals constituting the primary healthcare network²²⁰.

Generally, Greek citizens seem to prefer inpatient/hospital PHC services, as they consider them more effective²²¹. In Greece, the system is based on a "free-choice" model, which means each patient can choose freely any healthcare provider of the National Health System or EOPYY²²².

In theory, undocumented migrants and individuals without health coverage may receive public care²²³.

Accessing Greece healthcare system

All Greek citizens are entitled to access healthcare free at the point of delivery. Authorised residents in Greece are entitled to the same access to healthcare as Greek citizens. Formal access to the free services of the National Health System is dependent on registered employment and regular status.

Although the EOPYY could theoretically reduce administrative costs and improve access to healthcare, a series of immediate measures transferred to a portion of

costs to the insured population. For example, EOPYY immediately restricted access to many essential health services, such as medical aids,

²¹⁵ S. Karakolias and N. Polyzos, "The Newly Established Unified Healthcare Fund (EOPYY): Current Situation and Proposed Structural Changes, towards an Upgraded Model of Primary Health Care, in Greece", *Scientific Research*, 2014, <http://www.scirp.org/journal/PaperDownload.aspx?paperID=44338>

²¹⁶ Ibid.

²¹⁷ Op. cit. note 215

²¹⁸ Op. cit. note 215

²¹⁹ Op. cit. note 211

²²⁰ Op. cit. note 211

²²¹ Op. cit. note 211

²²² Op. cit. note 211

²²³ Op. cit. note 211

²²⁴ D. Niakas, "Greek economic crisis and health reforms : correcting the wrong prescription", *International Journal of Health Services*, Vol 43, No 4, 2013, <http://www.iatronet.gr/photos/enimerosi/niakas.pdf>

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glasses, dental care and physiotherapy services²²⁵.

Meanwhile, it imposed a 10-25% medication co-payment for patients with various chronic illnesses and a €25 charge for each hospital admission²²⁶. On 1 April 2015, the €5 fee at public hospitals and the €1 fee per prescription were removed²²⁷.

The new fund has also increased co-payments for private hospital services, starting at 20% and reaching 50% for farmers. These measures will increase the insured population's out-of-pocket participation at a time when their total income has decreased by about 35%²²⁸.

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 body²²⁹.

EOPYY provides free primary care services to the insured population in urban areas through its salary-based healthcare professionals (some professionals serve on a contractual basis)²³⁰.

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 basis²³¹. However, these budgets targeted only a small part of this population group.

Positive reform

Common ministerial decree no Y4α/ΓΠ/οικ.48985

According to the Common ministerial decree no Y4α/ΓΠ/οικ.48985/2014, access to healthcare for individuals without health coverage but with a regular legal status has been improved under certain conditions.

According to Paragraph 8 of this text, people entitled to free medical care in hospitals are:

- uninsured people from Greece or people of Greek origin (expatriates), EU citizens or citizens of non-European countries, who live permanently and legally in Greece, lack the prerequisites in order to obtain a health booklet and have no medical coverage through public or private insurance;
- people who had health insurance before but lost it due to debts to their insurance fund.

Who is entitled to benefit from the provisions of Paragraph 8 is determined by a three-member committee of the hospital. Thus, in each hospital there is a three-member committee which involves the following sectors: GP, surgical and psychiatric sector. They base their decision on a medical report presented by the patient.

In practice, the fact that a committee has to decide on a case-by-case basis who has the right to free medical care

²²⁵ Ibid.

²²⁶ Op. cit. note 224

²²⁷

[http://www.tovima.gr/files/1/2015/04/01/docum ent%20\(1\).pdf](http://www.tovima.gr/files/1/2015/04/01/docum ent%20(1).pdf)

²²⁸ Op. cit. 224

²²⁹ Op. cit. 224

²³⁰ Op. cit. note 224

²³¹ Op. cit. note 224

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is a considerable barrier. It requires a long time to process all the files. Therefore, this new health regulation does not mean that all individuals without health coverage now have access to care. Access to healthcare is still not granted for many people. Moreover, hospital emergency departments decide whether a patient's case should be described as an emergency or not.

Repeal of measure 39A of the Health Act

A Ministerial Decision published in the Government Gazette on 17 April 2015²³² finally repeals 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. In fact, the law 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 (April 2015) have decided to repeal this measure which violates human rights and affects human dignity.

Access to healthcare for migrants

Asylum seekers and refugees

In theory, refugees and asylum seekers have equal access to healthcare to Greek citizens. A Common ministerial decision KYA Y4α/48566/05 foresees free healthcare for asylum seekers and refugees without health coverage who cannot cover the related expenses. To access free healthcare, asylum seekers must hold a special asylum seeker's card and refugees must hold a special ID card for political refugees²³³. The same applies (Presidential Decree 266/1999) for foreign-born individuals whose stay in Greece has been permitted on humanitarian grounds and has not yet expired²³⁴.

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, states 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*

²³²

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

²³³ D. Balourdos, "Making a success of integrating immigrants into the labour market", *National Centre for Social Research (EKKE)*, 2010,

<http://ec.europa.eu/social/BlobServlet?docId=8213&langId=en>

²³⁴ Ibid.

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*cases, emergency aid shall be provided to applicants free of charge (...)*²³⁵.

Thus, in principle, asylum seekers and refugees who are destitute and without health coverage have free access to hospitals and medical care. However, in addition to the negative repercussions of the financial crisis on the health sector in Greece, asylum seekers who seek access to health services require, in some cases, prior approval by a committee.

In practice, this has led to significant administrative barriers, including more stringent procedures for undergoing surgery and to access other medical supplies, and refusal or restriction of the provision of health services to asylum seekers by the public hospitals.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum and pregnant refugees should have access to antenatal and postnatal care. It should include pregnancy termination.

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.

The new Migration Code, implemented by Law 4251/2014 and repealing Law 3386/2005, continues to prohibit

healthcare for undocumented migrants²³⁶.

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”*.

Thus, according to the circular of the Ministry of Health (OIK/EMΠ 518,2/2/2005) undocumented migrants in Greece are not entitled to healthcare, with the exception of emergency situations and until stabilisation of their health is achieved²³⁷. It should also be noted

²³⁵ Presidential Decree of 2007, <http://www.refworld.org/docid/49676abb2.html>

²³⁶ A. Triandafyllidou, “Migration in Greece Recent Developments in 2014”, *Hellenic Foundation For European and Foreign Policy*, 2014, http://www.eliamep.gr/wp-content/uploads/2014/10/Migration-in-Greece-Recent-Developments-2014_2.pdf

²³⁷ I. Kotsioni and P. Hatziprokopiou, “STATE OF THE ART REPORT ON THE GREEK CASE”, *Mighealthnet: Information network on good practice in health care for migrants and minorities*, <http://www.mighealth.net/el/images/f/f7/Greek>

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that Law 2910/2001 expressly excludes minors so they should have access to healthcare.

The circular Y4α/οικ 93443/11 of 18 August 2011 states that patients who present at a hospital are first examined by doctors from the emergency departments who decide on whether a patient's case is an emergency or not. The decision is then at the discretion of the medical professionals whether or not access to healthcare is granted.

Undocumented pregnant women

By law (Article 26.2 of Law 4251/2014), undocumented pregnant women have access to care during delivery. However, they do not have access to antenatal and postnatal care. Since the article explicitly includes only delivery care, they do not have access to pregnancy termination.

Thus, undocumented pregnant women do not have access to antenatal care and postnatal care. For pregnancy termination, they have to pay approximately €340 in public hospitals.

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.

Children of undocumented migrants

In theory, children of undocumented migrants should have access to healthcare as they are explicitly not included in the law prohibiting access to care for undocumented adults beyond emergencies. However, it also

means that there is no specific legislation explicitly providing them with healthcare.

[State of the Art Report English Summary.pdf](#)

In practice, they mostly only have access to emergency care. They may also have free access to vaccination at those Mother and Child Protection Centres which have not closed down during the social and economic crisis.

EU citizens

In accordance with Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004, after three months destitute EU citizens are considered to be undocumented migrants. They have the same access to healthcare as third-country nationals. This means Law 4251/2014 (Article 26.1 and 26.2) applies to them and they only have access to emergency care.

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 the new Directive 2013/33/EC which provides for a general ban on detaining minors except under "exceptional circumstances" (Article 11, paragraph 3).

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 guardian²³⁸. Given the particular characteristics of unaccompanied children, as well as their numbers, the

²³⁸ United Nations High Commissioner for Refugees Greece, *Current Issues of Refugee Protection in Greece*, July 2013, https://www.unhcr.gr/fileadmin/Greece/News/2013/PCjuly/Greece_Positions_July_2013_EN.pdf

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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 CRC²³⁹.

The large influx of asylum seekers to Greece has overwhelmed existing centres, so that minors are held in inappropriate facilities for long periods of time. As noted by representatives of the Ombudsman and the Marangopoulos Foundation for Human Rights, who visited the Amygdaleza detention centre in Athens on 9 October 2014, the conditions of the detention of unaccompanied minors at this centre failed to comply with even the most basic European standards, since unaccompanied minors are held together with adults and hygiene and medical services are non-existent²⁴⁰.

Greek law does not prohibit or regulate the administrative detention of children who enter Greece without valid papers and 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 months²⁴¹. These situations happen

²³⁹ Ibid.

²⁴⁰ MARANGOPOULOS FOUNDATION FOR HUMAN RIGHTS, *Visit-Autopsy of the MFHR delegation to the Immigration Pre-removal Detention Centre (YFEKA), Amygdaleza, Athens, Greece*, http://www.antigone.gr/files/news/MFHR%20Report_Visit-Autopsy%20at%20Immigration%20Pre-removal%20Detention%20Centre.pdf

²⁴¹ Platform for International Cooperation on Undocumented Migrants (PICUM), *Recommendations to the European Union to Urgently Address Criminalisation and Violence Against Migrants in Greece*, Brussels, 2014, http://picum.org/picum.org/uploads/publication/Recommendations%20to%20address%20criminalisation%20and%20violence%20against%20migrants%20in%20Greece_Reprint%20May%202014_2.pdf

despite the fact that Article 32 of Law No 3907/2011 (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. The reasons for detaining children for longer or shorter periods appear to be arbitrary²⁴².

When arriving in Greece, unaccompanied children are not accurately or adequately identified (including through proper age assessment procedures)²⁴³.

Reception capacity for children is insufficient (currently there are nine special centres for unaccompanied children, with capacity for approximately 400 persons and no reception facility to provide for the special needs of children under the age of 12)²⁴⁴. 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 CRC²⁴⁵. 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 law²⁴⁶.

The new Government, elected on 25 January 2015, particularly the Minister of Migration Policy, Tasia Christodouloupoulou has announced that minors will no longer be held in

²⁴² Ibid.

²⁴³ Op. cit. note 238

²⁴⁴ Op. cit. note 238

²⁴⁵ Op. cit. note 238

²⁴⁶ Op. cit. note 238

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detention centres and that reception centres for children will improve.

Protection of seriously ill foreign nationals

Article 44.1e of Law 3386/2005²⁴⁷ of June 2005 was amended by Article 42 of Law 3907/2011²⁴⁸.

The latter states that *“by decision of the Ministers of Interior, Public Administration and Decentralization and of Employment and Social Protection, residence permits may be issued for humanitarian reasons to (...) persons suffering from serious health problems. Serious health problems and the length of treatment shall be verified by a recent certificate from a public hospital or IKA clinic. In the event that the health problem relates to an infectious disease, the consent of the Minister of Health and Social Solidarity that they pose no threat to public health shall be required for the issuance of the said decision. For the issuance of the permit in [this case], the applicant must hold a prior residence permit. The length of the permit shall be up to one year and may be renewed for an equal period each time”*.

Prevention and treatment of infectious diseases

Detention on public health grounds

Law 4075 of April 2012 providing for the detention of migrants and asylum seekers on public health grounds is still in force. The law permits the detention for up to 18 months of a migrant or asylum seeker who represents a danger to public health: 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 hygiene²⁴⁹. 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 2011 was adopted, HIV testing and treatment are free for all people living in Greece, regardless of their legal status and health coverage. Thus, it includes Greek citizens without health coverage and undocumented migrants.

²⁴⁷ Law of June 2005, <http://www.refworld.org/docid/4c5270962.html>

²⁴⁸ Law of 26 January 2011, <http://www.refworld.org/docid/4da6ee7e2.html>

²⁴⁹ Op. cit. note 238

LUXEMBOURG

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*”²⁵⁰.

Organisation and funding of Luxembourgish 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 income²⁵¹.

The necessary financial resources to fund the health system are based on contributions, except for the financing of maternity care paid by the State²⁵².

In practice, all employees automatically contribute 5.44% of their gross income on average (with a maximum contribution of €6,225) to the National Health Fund (*Caisse Nationale de Santé – CNS*). The contribution is deducted directly from

their salaries with half paid by the employer²⁵³.

Long-term care is financed through separate insurance called “*assurance dépendance*”²⁵⁴. This is funded

through by contributions from all active workers and retired individuals. They all pay a 1.4% contribution on all their professional and real estate incomes. These contributions are also complemented by State and electricity sector funding²⁵⁵.

Accessing Luxembourg healthcare system

According to Article 1 of the Social Security Code, health insurance is compulsory in Luxembourg²⁵⁶.

The system allows access for basic healthcare free at the point of entry to all citizens²⁵⁷. 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 beneficiary²⁵⁸.

All dependent family members are covered by contributing family members²⁵⁹. Students and

²⁵³

²⁵² Ibid.

²⁵⁰ *Constitution of Luxembourg of 1868* (last updated 1 August 2013), <http://www.legilux.public.lu/leg/textescoordonnes/recueils/Constitution/Constitution.pdf>

²⁵¹ <http://www.sante.public.lu/fr/systeme-sante/financement/>

<http://www.europe-cities.com/en/633/luxembourg/health/>
²⁵⁴

<http://www.sante.public.lu/fr/remboursements-indemnite/assurance-dependance/index.html> ²⁵⁵ Op. cit. note 254
²⁵⁶ *Social Security Code,*

<http://www.legilux.public.lu/leg/textescoordonnes/codes/code securite sociale/code securite sociale.pdf>

²⁵⁷ Op. cit. note 250

²⁵⁸ Op. cit. note 253

²⁵⁹ Op. cit. note 256

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unemployed children are covered up until 27 years of age²⁶⁰.

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 hospitalisation²⁶¹.

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 system²⁶².

The patient must pay all costs and then submit receipts to the CNS 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%²⁶³.

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%²⁶⁴.

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 €100²⁶⁵.

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*)²⁶⁶.

According to the law, TPS can be granted to any resident in Luxembourg. The Social Welfare Office is the only body which is competent to assess whether or not an individual should benefit from it²⁶⁷.

When a person is granted TPS, they are given a certificate and a book of labels²⁶⁸. 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 payment²⁶⁹.

The aim of TPS is to facilitate access to healthcare for people with limited income²⁷⁰. 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 extension²⁷¹.

²⁶⁰ Op. cit. note 256

²⁶¹

<http://www.pacificprime.com/country/europe/luxembourg-health-insurance-pacific-prime-international/>

²⁶² Op. cit. note 253

²⁶³ Op. cit. note 253

²⁶⁴ Op. cit. note 253

²⁶⁵ <http://www.cns.lu/>

²⁶⁶ <http://www.cns.lu/assures/?m=97-0-0&p=281>

²⁶⁷ Ibid.

²⁶⁸ Op. cit. note 265

²⁶⁹ Op. cit. note 265

²⁷⁰ Op. cit. note 265

²⁷¹ Op. cit. note 265

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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 available and about 75% of the population purchases additional health insurance coverage, which is mostly used to pay for services categorised as non-essential under the compulsory schemes and provided by non-profit agencies or mutual associations (*mutuelles*), which are also allied to the Ministry of Social Security²⁷².

However, 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 emergency²⁷³. 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 large hospitals and is free at the point of use²⁷⁴. 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

²⁷²

<https://healthmanagement.org/c/it/issuearticle/overview-of-the-healthcare-system-in-luxembourg>

²⁷³ Ibid.

²⁷⁴ Op. cit. note 272

available for consultation but an appointment is necessary²⁷⁵.

Prescription drugs can only be prescribed by doctors and consultants and the costs are also reimbursed by the *Caisse Nationale de Santé*. Non-prescription drugs are priced much higher and are generally not reimbursed²⁷⁶.

Access to healthcare for migrants

Asylum seekers

According to Article 6 of the Law on asylum and other complementary forms of protection of 5 May 2006, anyone seeking protection may present their asylum claim at the border or when they already are inside the country²⁷⁷.

This law was modified by the regulation on the conditions and details for accessing social aid for asylum seekers on 8 June 2012²⁷⁸.

Article 1 §3 of this legislation provides that asylum seekers are entitled to free access to basic healthcare and that their insurance fee is paid by the State, which allows them to have the same access to healthcare as any other citizen²⁷⁹.

Also, asylum seekers are entitled to free housing and food distribution, as well as a monthly allocation of €25 for adults, €12.50 for minor children and

²⁷⁵ http://www.expatica.com/lu/visas-and-permits/Healthcare-in-Luxembourg_105466.html

²⁷⁶ Ibid.

²⁷⁷ Law of 5 May 2006,

<http://eli.legilux.public.lu/eli/etat/leg/loi/2006/05/05/n1>

²⁷⁸ Regulation of 8 June 2012,

<http://www.refworld.org/docid/3df5ff614.html>

²⁷⁹ Ibid.

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€25 for unaccompanied minors aged between 16 and 18 years²⁸⁰.

In cases where it is not possible to provide access to food, the monthly allocation is €225 for adults, €300 for couples, €200 for additional adults, €173 for teenagers between 12 and 18 years old, €140 for children under 12 years of age and €225 for unaccompanied minors between 16 and 18 years of age²⁸¹.

In the first three months of their stay, asylum seekers may apply to the Luxembourg Reception and Integration Agency (*Office luxembourgeois de l'accueil et de l'intégration – OLAI*) which will pay for all emergency care through a system of tickets²⁸².

From the fourth month onwards, the National Health Fund will pay for the insurance as mentioned above²⁸³.

Undocumented migrants

Undocumented migrants include visa or permit “overstayers”, rejected asylum seekers and individuals who have entered the country without a permit. In Luxembourg, undocumented migrants have no access to healthcare²⁸⁴.

²⁸⁰ Op. cit. note 278, Article 8.

²⁸¹ Op. cit. note 278, Article 8.

²⁸² Guide to access medical healthcare to applicants for international protection, rejected asylum seekers and undocumented migrants in Luxembourg, http://www.asti.lu/media/asti/pdf/guide_msf.pdf

²⁸³ Luxembourg Red Cross, Nadia Conrardy, Luxembourg report, http://www.roteskreuz.at/fileadmin/user_upload/PDF/Site/Mental_Health/Luxembourg.pdf

²⁸⁴ Bernd Rechel et al., “Migration and health in the European Union”, *European Observatory on Health Systems and Policies*, 2011,

http://www.euro.who.int/data/assets/pdf_file/0019/161560/e96458.pdf

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 care²⁸⁵.

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 Charter²⁸⁶. These conclusions are quite revealing concerning undocumented migrants’ access to emergency care.

The report concludes that Luxembourg’s legislation and practice do not guarantee that all foreign nationals in an irregular situation can benefit from emergency care for as long as they may need to. The Committee notes that there is no specific legislation concerning undocumented migrants’ access to health. Moreover, their access to emergency care has been limited to two or three days²⁸⁷.

Nevertheless, the Committee underlines the fact that “medical aid

²⁸⁵ Platform for International Cooperation on Undocumented Migrants (PICUM), *Preventing undocumented pregnant Women and Children from Accessing health Care: fostering health inequalities in Europe*, March 2011, http://picum.org/picum.org/uploads/publication/Public%20hearing%20on%20access%20to%20health%20care%20for%20undocumented%20pregnant%20women%20and%20children%20-%208%20December%202010_1.pdf

²⁸⁶ European Social Charter, European Committee of social rights, Conclusions, Conclusions XX-2 (2013), (LUXEMBOURG) Articles 3, 11, 12, 13 et 14 of the 1961 Charter, March 2014, <http://www.coe.int/t/dghl/monitoring/socialchart>

er/Conclusions/State/LuxembourgXX2_fr.pdf

²⁸⁷ Ibid.

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covering all urgent care is ensured and that a “street ambulance” provides all needed diagnosis, advice, treatment and medication all year round to people without health insurance, including undocumented migrants”²⁸⁸. We have no evidence that it is sufficient to cover all the needs.

Termination of pregnancy

A reform was passed on 21 December 2012, since when the termination of pregnancy system in Luxembourg has been centred on the provision of information and advice to pregnant women²⁸⁹.

Termination of pregnancy is legal in Luxembourg up to 12 weeks from the date of conception²⁹⁰, provided that:

- The woman has obtained a certificate, 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 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 service²⁹¹.

Protection of seriously ill foreign nationals

In Luxembourg, the Immigration Medical Department makes sure that the organisation of the medical part of the 2008 law on the free circulation of people and immigration is properly implemented²⁹².

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 Luxembourg²⁹³.

According to the Law of 26 June 2014²⁹⁴, the Immigration Medical

<http://luxembourg.angloinfo.com/information/healthcare/pregnancy-birth/termination-abortion/>

²⁸⁸ Op. cit. note 286

²⁸⁹

<http://www.luxembourg.public.lu/fr/actualites/2012/12/21-avortement/index.html>

²⁹⁰

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 deferred²⁹⁵.

²⁹¹ Ibid.

²⁹² <http://www.sante.public.lu/fr/impacts-milieu-vie/sante-travail/007-service-medical-immigration/>

²⁹³ Ibid.

²⁹⁴ *Law of 26 June 2014*,
<http://eli.legilux.public.lu/eli/etat/leg/loi/2008/08/29/n1>

²⁹⁵ <http://www.sante.public.lu/fr/impacts-milieu-vie/sante-travail/007-service-medical-immigration/020-sursis-eloignement/index.html>

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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 health²⁹⁶.

It is also necessary to prove that the person concerned is not able to get the treatment in the country they are about to be sent back to²⁹⁷.

If all the requirements are met, the individual will obtain a deferment of expulsion for a maximum of six months²⁹⁸, with the possibility of renewal not exceeding two years²⁹⁹.

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 reasons³⁰⁰.

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 aid³⁰¹.

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 length³⁰².
- A certificate from the medical authorities from their country of origin proving that the person

cannot receive the treatment in their country³⁰³.

- An agreement from the health establishment for the admission of the patient on a certain date, signed by the head of the service which will treat the patient³⁰⁴.
- An estimate of the cost of the treatment and proof that the financing of it are guaranteed by the person³⁰⁵.

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)³⁰⁶.

In this plan, it is stated that migrants face multiple vulnerabilities such as increased³⁰⁷ risk to infectious

diseases . The government has assessed the need to raise awareness regarding these diseases and the necessity for these migrants³⁰⁸ to access

free HIV screening tests . No specific

³⁰⁰ Op. cit. note 294, Article 131.

³⁰¹ Op. cit. note 294, Article 132.

³⁰² Op. cit. note 294, Article 130.

²⁹⁶ Ibid.

²⁹⁷ Op. cit. note 295

²⁹⁸ Op. cit. note 294, Article 131.

²⁹⁹ Op. cit. note 294, Article 131.

mention is made for undocumented migrants.

There are national health facilities which provide such services for free

³⁰³ Op. cit. note 294, Article 130.

³⁰⁴ <http://www.sante.public.lu/fr/impacts-milieu-vie/sante-travail/007-service-medical-immigration/030-soins-etrangeurs-luxembourg/>

³⁰⁵ Ibid.

³⁰⁶ Ministry of Health of the Grand Duchy of Luxembourg, *National strategy and action plan regarding the fight against HIV/AIDS 2011-2015*,

<http://www.sante.public.lu/publications/rester-bonne-sante/sida-prevention/strategie-plan-action-vihsida-2011-2015/strategie-plan-action-vihsida-2011-2015.pdf>

³⁰⁷ Ibid.

³⁰⁸ Op. cit. note 306

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and anonymously. There are six of them throughout Luxembourg³⁰⁹.

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 it³¹⁰. Nonetheless, the Ministry of Health has recognised that a number of administrative barriers often impede vulnerable groups in accessing treatment when they need it³¹¹.

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 infections³¹². This Committee will be 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 diseases³¹³.

³⁰⁹ <http://www.dimps.lu/files/mds-sida-annoncea4-hd-.pdf>

³¹⁰ Op. cit. note 306

³¹¹ Op. cit. note 306

³¹² Regulation of 27 February 2015, A-n°47 du 13 mars 2015, Règlement du Gouvernement en Conseil du 27 février 2015 portant institution d'un Comité de surveillance du syndrome d'immunodéficience acquise (SIDA), des hépatites infectieuses et des maladies sexuellement transmissibles

³¹³ Op. cit. note 312, Article 1.

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National Health System

Constitutional basis

According to the Dutch Constitution, the government has a duty to ensure social security for all and to ensure the distribution of wealth (Article 20), as well as public health (Article 22)³¹⁴. 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.

Organisation and funding of Dutch healthcare system

Since 2006, a dual system of public and private insurance for curative care has been replaced by a single compulsory health insurance scheme. Competing insurers (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 healthcare³¹⁵.

According to Statistics Netherlands, the total expenditure for health in the

³¹⁴

http://wetten.overheid.nl/BWBR0001840/geldigheidsdatum_21-05-2015

³¹⁵ W. Schäfer et al., "Germany: Health system review", *Health Systems in Transition*, vol 12, No 1, 2010,

http://www.euro.who.int/data/assets/pdf_file/0008/85391/E93667.pdf

Netherlands in 2012 amounted to €92.7 billion³¹⁶, while the Dutch health administration estimates the total expenditure for the health scheme for undocumented migrants in 2013 to be €29.8 million, i.e. still far below 0.0005% of total health expenditure.

Accessing the Netherlands healthcare system

Taking out standard (private) health insurance is obligatory for authorised residents³¹⁷. 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 profile³¹⁸. 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)³¹⁹. Contraception is not included in the basic package. Pregnancy termination is not included

³¹⁶ <http://www.cbs.nl/NR/rdonlyres/B3173C43-368C-4190-8D9C-88E6BBF2CBE8/0/2013c156puberr.pdf>

³¹⁷ *Health Insurance Act of 16 June 2005*, Article 2,

http://wetten.overheid.nl/BWBR0018450/Hoofdstuk2/Paragraaf21/Artikel2/geldigheidsdatum_06-02-2015

³¹⁸ 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>

³¹⁹ <http://www.rijksoverheid.nl/onderwerpen/zorgverzekering/vraag-en-antwoord/basispakket-zorgverzekering-2015.html>

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either, but is fully reimbursed under the Law on Long-term Healthcare³²⁰.

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. However, they do need to pay elevated **monthly premiums** for health insurance. These currently 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. Single people with yearly incomes lower than €26,316 have a right to financial help; for couples the income ceiling is €32,655. A single person can receive monthly help up to €78, couples up to €149 a month. Only people with limited capital have a right to these benefits³²¹. In 2015, benefits

³²⁰

<http://www.rijksoverheid.nl/onderwerpen/zorg-in-zorginstelling/wet-langdurige-zorg-wlz>

³²¹ The ceiling has been systematically lowered, thereby limiting the number of people with a right to benefits. e.g. for a single person,

have been raised for the lowest incomes, although the average Dutch citizen will have to pay for a larger part of their insurance themselves³²². In July 2014, the Ministry of Health denied the trend of increased avoidance of seeking healthcare³²³ that was denounced by the national GP association³²⁴.

When accessing healthcare services and treatment, people first need to pay a **franchise** (their “own risk”), which is currently – as defined by law – at least €375 a year, but can go up to €875 depending on their chosen insurance formula³²⁵. 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

the income ceiling was €35.059 in 2012 and €30.939 in 2013.

<http://www.rijksoverheid.nl/onderwerpen/zorgtoeslag/vraag-en-antwoord/wanneer-heb-ik-recht-op-zorgtoeslag.html>.

³²²

<http://www.zorgkeus.nl/zorgverzekering/zorgtoeslag-10-euro-omhoog-voor-laagste-inkomens>
³²³ <http://www.rijksoverheid.nl/ministeries/vws/docu-ocumenten-en-publicaties/kamerstukken/2014/07/28/beantwoording-kamervragen-over-onderzoek-huisartsen.html>

³²⁴

<https://www.lhv.nl/actueel/nieuws/zorgmijden-neemt-steeds-zorgwekkender-vormen-aan>

³²⁵ 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. Reforms of the insurance systems have been announced by the Ministry of Health in February 2015, in order to improve the “quality and affordability of healthcare”, that will include encouraging insurance providers to offer insurance packages with a lower franchise (e.g. interesting for the chronically ill)

<http://www.rijksoverheid.nl/ministeries/vws/docu-ocumenten-en-publicaties/kamerstukken/2015/02/06/kamerbrief-over-verbeteren-kwaliteit-en-betalbaarheid-zorg.html>

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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)³²⁶. Vaccinations are freely accessible for all children through preventive frontline infant consultations (0-4 years), and according to the national immunisation calendar³²⁷.

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 individual³²⁸. Those who do not pay their monthly premiums face financial penalties.

Pregnancy termination

For residents authorised to reside, pregnancy termination is free at the point of delivery under the Act on Long-term Healthcare³²⁹. 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

³²⁶

<http://www.independen.nl/zorgverzekering/info/eigen-risico.aspx>

³²⁷

http://www.rivm.nl/Onderwerpen/R/Rijksvaccinatieprogramma/De_inenting/Vaccinatieschema

³²⁸

<http://www.rijksoverheid.nl/onderwerpen/zorgverzekering/vraag-en-antwoord/wat-gebeurt-er-als-ik-niet-verzekerd-ben-voor-de-zorgverzekering.html>

³²⁹

<http://www.rijksoverheid.nl/onderwerpen/zorg-in-zorginstelling/wet-langdurige-zorg-wlz>

determined by the 1981 Termination of Pregnancy Act³³⁰). The gestational limit stated in the Law is 24 weeks (based on foetal viability), but according to a 2012 International Planned Parenthood Federation report, clinics “stick to 22 weeks”³³¹.

In case a late termination is needed – after 24 weeks – doctors are obliged to report these to a central committee³³². Under the Directions on the Non-Prosecution of Cases of Euthanasia and Late Abortions, 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”³³³.

Access to healthcare for migrants

³³⁰

http://wetten.overheid.nl/BWBR0003396/geldigheidsdatum_22-04-2015

³³¹ International Planned Parenthood Federation (IPPF) European Network, *Abortion Legislation in Europe*, Belgium, 2012,

http://www.ippfen.org/sites/default/files/Final_Abortion%20legislation_September2012.pdf

³³²

<http://www.rijksoverheid.nl/onderwerpen/leven-seinde-en-euthanasie/late-zwangerschapsafbreking-en-levensbeeindiging-bij-pasgeborenen>

³³³ *The Termination of Pregnancy Act of 1 May 1981*, Article 5(2a),

http://wetten.overheid.nl/BWBR0003396/geldigheidsdatum_21-05-2015

Asylum seekers, refugees and persons eligible for subsidiary protection

As authorised residents, recognised refugees and people who have obtained subsidiary protection have the same duties and rights as Dutch citizens. Asylum seekers access healthcare through a parallel scheme of primary care contracting, organised by Menzis, a non-profit insurance company commissioned by the Central Agency for the Reception of Asylum Seekers (*Centraal Orgaan opvang asielzoekers – COA*). On the one hand, this means that they can only turn to GPs, physiotherapists, dentists, hospitals and pharmacies that are contracted. On the other hand, no out-of-pocket payment at all (not even a franchise) is required³³⁴.

As for Dutch residents, GPs are the gatekeepers of access to other healthcare services. The basket of care is similar to that of the basic package for authorised residents (but, for example, dental care for adults is also accessible in case of pain or chewing problems³³⁵). Upon entry, asylum seekers undergo compulsory TB screening. Asylum seekers coming from high-risk countries are offered voluntary follow-up screening for a period of two years³³⁶.

Pregnant asylum seekers and refugees

Pregnant asylum seekers and refugees have access to antenatal,

³³⁴ <http://www.rzasielzoekers.nl/home/zorg-voor-asielzoekers.html>

³³⁵ http://www.rzasielzoekers.nl/dynamic/media/28/documents/rzaenbijlagen/Bijlage_5_noodhulp_ijst_2015.pdf

³³⁶ http://www.rzasielzoekers.nl/dynamic/media/28/documents/overige_documenten/2012_factsh_eet_Menzis_HR.pdf

delivery and postnatal healthcare free at the point of delivery. Because of their specific vulnerabilities, those women are entitled to more intensive antenatal care (with more consultations). They are also entitled to access to pregnancy termination services free of charge. However, asylum seekers and refugees aged 21 and over have to pay for contraceptives themselves³³⁷.

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 insurance³³⁸. 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”. In 2007, an independent commission of medical (and social and legal) experts, clearly defined “medically necessary care”³³⁹: doctors must provide adequate and appropriate care by following the same guidelines,

³³⁷ S. Goosen, “Induced abortions and teenage births among asylum seekers in the Netherlands: analysis of national surveillance data”, *Journal of Epidemiology and Community Health*, 2009,

http://www.ggdghorkennisnet.nl/?file=1204&m=1310635532&action=file_download

³³⁸ *The Linkage Act of 26 March 1998*,

http://wetten.overheid.nl/BWBR0009511/geldigheidsdatum_02-06-2015

³³⁹

http://www.pharos.nl/documents/doc/webshop/arts_en_vreemdeling-rapport.pdf

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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 authorities³⁴⁰, 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, lacking knowledge of the reimbursement scheme etc.). In 2014, the authorities drafted a short document to help healthcare professionals determine who is undocumented³⁴¹, although the

language used is rather stigmatising³⁴². The barriers to healthcare for undocumented people were also confirmed by the National Ombudsman in 2013³⁴³.

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, Amsterdam signed a covenant with pharmacies and support organisations (including Doctors of the World) to manage this fund (in 2015) 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.

In July 2014, 132 municipalities still remained without a contracted pharmacy (including a number of medium-sized cities).

In 2014, the European Committee of Social Rights ruled 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

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<http://www.zorginstituutnederland.nl/verzekering/onverzekerbare+vreemdelingen>

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<http://www.zorginstituutnederland.nl/binaries/content/documents/zinl-www/documenten/rubrieken/verzekering/onverzekerbare-vreemdelingen/1307-hoe-stel-ik-vast-dat-iemand-illegaal-in-nederland->

[verblijft/Hoe+stel+ik+vast+dat+iemand+illegaal+in+Nederland+verblijft.pdf](http://www.zorginstituutnederland.nl/binaries/content/documents/zinl-www/documenten/rubrieken/verzekering/onverzekerbare-vreemdelingen/1307-hoe-stel-ik-vast-dat-iemand-illegaal-in-nederland-)

342

http://picum.org/picum.org/uploads/file/_Leaflet_NL_forPrinting_7Nov.2014.pdf

343 [Medische zorg vreemdelingen. Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers](http://www.zorginstituutnederland.nl/binaries/content/documents/zinl-www/documenten/rubrieken/verzekering/onverzekerbare-vreemdelingen/1307-hoe-stel-ik-vast-dat-iemand-illegaal-in-nederland-)

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seekers whose applications for protection have been rejected³⁴⁴. The Dutch Association of Municipalities (*Vereniging Nederlandse Gemeenten*) has taken the same view concerning rejected asylum seekers³⁴⁵. At the time this report was drafted (April 2015), the government proposed making access to food, water and shelter accessible in some cities, but only provided that the rejected asylum seekers would commit to returning to their country of origin. Most Dutch municipalities are strongly opposed and declared that they will keep their emergency shelters for ex-asylum seekers open.

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, in practice, undocumented women are often urged to pay straight away in cash, persuaded to sign up for payment by instalments or receive a bill and reminders at home, and 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

³⁴⁴ EUROPEAN COMMITTEE OF SOCIAL RIGHTS, *Conference of European Churches (CEC) v the Netherlands*, 1 July 2014, http://www.coe.int/t/dghl/monitoring/socialchart er/Complaints/CC90Merits_en.pdf

³⁴⁵ <https://www.vng.nl/onderwerpenindex/integratie-en-asiel/vreemdelingenzaken/nieuws/gemeenten-willen-uitgeprocedeerde-asielzoekers-opvang-kunnen-bieden>

Aliens 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.

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. Unlike in Belgium or in France, the care scheme for undocumented third-country nationals is not applicable to EU citizens without authorisation to reside. If the latter do not have a European Health Insurance Card (EHIC), they only have free access to emergency care³⁴⁶. There are no specific legal provisions for children of destitute EU citizens.

Unaccompanied minors

Unaccompanied children seeking asylum have access to healthcare

³⁴⁶

http://www.pharos.nl/documents/doc/pharos_v_erslag_expertmeeting_gezondheid_en_zorggebruik_midden-en_oost-europese_migranten-8juni2012.pdf

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services on the same basis as adult asylum seekers. They receive extra assistance in separate reception facilities³⁴⁷. 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 (Article 6 of the Measures regarding asylum seekers and other categories of foreign nationals³⁴⁸). Unethical medical examination methods (X-rays of the wrist and collarbone) are used in order to determine minors' age³⁴⁹.

Protection of seriously ill foreign nationals

Postponed departure from the Netherlands due to medical emergencies

According to Article 64 of the Aliens Act 2000³⁵⁰, in conjunction with Article 3.46 of the Aliens Decree 2000³⁵¹, 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

³⁴⁷ <http://www.coa.nl/nl/asielzoekers/wonen-op-een-azc/kind-in-de-opvang>
³⁴⁸

http://wetten.overheid.nl/BWBR0017959/geldigheidsdatum_22-04-2015#HoofdstukIII_Artikel6

³⁴⁹ <http://www.vluchtelingenwerk.nl/feiten-cijfers/alleenstaande-minderjarigen>
³⁵⁰

http://wetten.overheid.nl/BWBR0011823/Hoofdstuk6/Afdeling2/Artikel64/geldigheidsdatum_27-04-2015
³⁵¹

http://wetten.overheid.nl/BWBR0011825/Hoofdstuk3/Afdeling2/Paragraaf1/Subparagraaf5/Artikel346/geldigheidsdatum_27-04-2015

of the Aliens Circular 2000³⁵²). As this suspension of expulsion is only applicable in emergencies, it is usually granted for six months. However, the text does state 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 Aliens Act 2000³⁵³ in conjunction with Article 3.4 (1.o) of the Aliens Decree³⁵⁴, a temporary residence permit may be granted if medical treatment is needed in the Netherlands as the only country

³⁵²

http://wetten.overheid.nl/BWBR0012289/B8/9/91/913/Tekst/geldigheidsdatum_27-04-2015
³⁵³

http://wetten.overheid.nl/BWBR0011823/Hoofdstuk3/Afdeling3/Paragraaf1/Artikel14/geldigheidsdatum_23-04-2015
³⁵⁴

http://wetten.overheid.nl/BWBR0011825/Hoofdstuk3/Afdeling2/Paragraaf1/Subparagraaf1/Artikel34/geldigheidsdatum_23-04-2015

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in which the special treatment can take place³⁵⁵. 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 Netherlands³⁵⁶.

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 application³⁵⁷ 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). According to the Platform for

International Cooperation on Undocumented Migrants (PICUM) in 2009, the country of origin information is primarily received from International SOS and from specially appointed doctors who are working in the countries of origin³⁵⁸. 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 facility³⁵⁹

for asylum seekers, this is often not the case.

In 2013, the National Ombudsman³⁶⁰ 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 new report from March 2015³⁶¹, the Ombudsman also holds a critical

³⁵⁵ Platform for International Cooperation on Undocumented Migrants (PICUM), *Undocumented and seriously ill: Residence permits for medical reasons in Europe*, Brussels, 2009, http://picum.org/picum.org/uploads/publication/Undocumented_and_Seriously_Ill_Report_Picum.pdf

³⁵⁶

<http://www.stichtinglos.nl/content/verblijfsvergu>

[ning-medische-behandeling](http://www.stichtinglos.nl/content/verblijfsvergu)
³⁵⁷ <https://ind.nl/documents/7050.pdf>

³⁵⁸ Op. cit. note 355
³⁵⁹

[https://www.ind.nl/EN/Documents/2009%20EA
UT%20Motie-Spekman.pdf](https://www.ind.nl/EN/Documents/2009%20EA%20UT%20Motie-Spekman.pdf)

³⁶⁰ Letter from the National Ombudsman to
the Secretary of State for Security and
Justice, 4

September 2013,

[http://www.inlia.nl/uploads/File/Brief%20aan%
20staats%20Teeven%204%20sep%202013%
20zorgen%20over%20motie_spekman%20opv
ang%20voor%20zieke%20asielzoekers.pdf](http://www.inlia.nl/uploads/File/Brief%20aan%20staats%20Teeven%204%20sep%202013%20zorgen%20over%20motie_spekman%20opvang%20voor%20zieke%20asielzoekers.pdf)

³⁶¹

<https://www.nationaleombudsman.nl/uploads/r>

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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 should be more critical about BMA decisions as well.

The statistics given by the Dutch Secretary of State for Security and Justice for the period from 1 January 2010 to 31 March 2013 reveal that, of the 670 requests for protection, 420 were denied due to the incompleteness of the application, 200 requests were denied because access to healthcare was deemed sufficient in the country of origin and 40 requests were approved (half of these because the BMA did not respond in a timely manner)³⁶².

Prevention and treatment of infectious diseases

HIV and hepatitis screening and treatments are included in the basic package of the compulsory health insurance³⁶³. 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). Destitute 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: 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 25³⁶⁴. However, in the future, the number of groups who can access these services could be restricted³⁶⁵.

[apport/Rapport%202015-053%20BMA%20en%20IND%20webversie.pdf](https://www.nationaleombudsman.nl/uploads/apport/Rapport%202015-053%20BMA%20en%20IND%20webversie.pdf)

³⁶² Letter from the Secretary of State to the Dutch National Parliament, 27 May 2013, <https://www.nationaleombudsman.nl/uploads/apport/Rapport%202015-053%20BMA%20en%20IND%20webversie.pdf>

³⁶³ <https://www.soa aids.nl/nl/professionals/interventies/structurele-interventies/toegang-soa-en-hiv-zorg>

[nties/structurele-interventies/toegang-soa-en-hiv-zorg](https://www.soa aids.nl/nl/professionals/interventies/structurele-interventies/toegang-soa-en-hiv-zorg)

³⁶⁴ <https://www.soa aids.nl/nl/professionals/interventies/structurele-interventies/aanvullende-seksuele-gezondheidszorg>

³⁶⁵ <http://www.ggdghorkennisnet.nl/?file=13972&m=1375704358&action=file.download>



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National Health System

Constitutional basis

The Spanish Constitution of 1978 recognises in Article 43 the “*right to health protection*”³⁶⁶ and healthcare for all citizens. 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*”³⁶⁷.

Organisation and funding of Spanish healthcare system

The Spanish healthcare system is based on solidarity. It aims to redistribute income amongst Spanish citizens³⁶⁸. 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 responsible³⁶⁹.

Accessing Spain healthcare system after 2012 Royal-Decree

General Health Law No. 14/1986 of 25 April 1986³⁷⁰ 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 2003³⁷¹ 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.

Article 1 of Royal Decree-Law 16/2012³⁷² (which came into force on 1 September 2012) modifies Article 3 of Law 16/2003³⁷³ and Article 12 of Organic Law 4/2000³⁷⁴. 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 16/2003³⁷⁵):

- workers, retired people and beneficiaries of social security services (e.g. unemployment benefits);

³⁶⁶ Constitution of Spain of 1978, https://www.essex.ac.uk/armedcon/world/europe/western_europe/spain/SpainConstitution.pdf

³⁶⁷ Ibid.

³⁶⁸ Health Information Institute, *National Health System of Spain*, Madrid, 2010, <http://www.msssi.gob.es/organizacion/sns/doc/s/sns2010/Main.pdf>

³⁶⁹ Ibid.

³⁷⁰ Law of 25 April 1986,

<http://www.boe.es/buscar/doc.php?id=BOE-A-1986-10499>

³⁷¹ Law of 28 May 2003,

http://www.boe.es/diario_boe/txt.php?id=BOE-A-2003-10715

³⁷² Royal Decree-Law of 20 April 2012,

http://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

³⁷³ Op. cit. note 371

³⁷⁴ Organic Law of 11 January 2000,

<http://www.boe.es/buscar/act.php?id=BOE-A-2000-544>

³⁷⁵ Op cit. note 371

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- people who have “exhausted” their right to unemployment benefits and do not benefit from any other allowances;
- spouses, dependent ex-spouses, descendants or dependants under 26 years old (or older in the case of people with disabilities categorised as equal to or over 65%) of an insured person.

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 AC³⁷⁶.

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 System³⁷⁷, 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 medicines³⁷⁸ which are included in the catalogue of medicines covered by the social security system (others are not covered)³⁸⁰.

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

³⁷⁶ Health For Undocumented Migrants and Asylum seekers (HUMA) Network, *Accès aux soins des personnes sans autorisation de séjour et des demandeurs d’asile dans 10 pays de l’UE – Législation et Pratique*, 2009, http://www.aedh.eu/plugins/fckeditor/userfiles/file/Asile%20et%20immigration/Legislation_et_pratique_rapport_HUMA_FR.pdf

³⁷⁷ Royal Decree of 3 August 2012,

http://www.seg-social.es/Internet_1/Normativa/169476

³⁷⁸ Op. cit. note 372;
http://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403;
<http://www.ocu.org/salud/derechos-paciente/noticias/reforma-sanitaria-copago> ³⁷⁹ There are more than 15 000

medicines covered,
<http://www.msssi.gob.es/profesionales/nomenclator.do>
³⁸⁰ List of medicines which have been excluded in 2012,
<http://www.msssi.gob.es/profesionales/farmacologia/pdf/BOEA201210952.pdf>

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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];
- 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 insurance³⁸¹.

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 coverage³⁸². 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 §Section 2-4 of Article 3 of Law 16/2003 mentioned above) can only access healthcare services if they pay for it themselves or if they are eligible for a "special provision". Furthermore, the services included in this special provision (which, in reality, is the same as private insurance) are limited to the "basic package of services" of the National Health System, meaning that expenses such as non-urgent medical transportation, drugs or external prosthesis (e.g. a wheelchair) are not included in the package. However, emergency transportation is included in the "basic package" (Article 8bis of Law 16/2003).

The change in the law motivated six AC to appeal to the Constitutional

³⁸¹ Europe Public Health Alliance (EPHA), *EPHA Press Release: Spain on brink of failing its most vulnerable via new health law - A law bringing to an end decades-long free and universal health care does not benefit*

anybody, Brussels, 2012, <http://www.ephah.org/a/5161>

³⁸² Op. cit. note 372

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Court, alleging a breach of universality as a principle. The appeals were also submitted on the grounds of procedural issues (e.g. the Government had not justified the “extraordinary and urgent necessity” required to use legal terms of the Royal Decree), as well as a breach of regional competences (the management of healthcare is an issue of regional domain). These processes are still pending a verdict.

The European Committee of Social Rights stated in November 2014 that “*the economic crisis cannot serve as a pretext for a restriction or denial of access to healthcare that affects the very substance of the right of access to healthcare*”, meaning that states have the obligation to provide assistance to citizens regardless of their residency status³⁸³.

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 healthcare³⁸⁴. It constitutes a structural transformation

MdM ES have documented at least “2,000 people who could not access healthcare because of a lack of proper

documentation, conflicts in the interpretation of the Royal Decree and, for some, discrimination or racism”.

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”³⁸⁵.

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.

An article published by *The Lancet*³⁸⁶ concludes that austerity measures in Spain affect children in particular, with nearly 30% being at risk of poverty or social exclusion³⁸⁷.

MdM ES report 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 annulled³⁸⁸.

Access to healthcare for migrants

³⁸³ EUROPEAN SOCIAL CHARTER
European Committee of Social Rights
Conclusions XX-2 (ESPAGNE) Articles 3, 11,
12, 13 and 14 of the 1961 Charter, November
2014,

http://www.coe.int/t/dghl/monitoring/socialchart er/Conclusions/State/SpainXX2_en.pdf

³⁸⁴ Doctors of the World – Médecins du Monde
ES, *Dos años de reforma sanitaria : más vidas
humanas en riesgo*, April 2014,

http://www.medicosdelmundo.org/index.php/mod.documentos/mem.descargar/fichero.documentos.Impacto-Reforma-Sanitaria-Medicos-del-Mundo_3ec0bdf9%232E%23pdf

³⁸⁵ H. Legido-Quigley, “Erosion of universal health coverage in Spain”, *The Lancet*, 2013.

³⁸⁶ <http://www.lamarea.com/2013/12/16/un-articulo-en-lancet-alerta-sobre-las-posibles-consecuencias-de-la-exclusion-sanitaria-en-espana/>

³⁸⁷ Ibid.

³⁸⁸ Op. cit. note 384

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 12/2009³⁸⁹ as well as by the fourth additional provision of Royal Decree 1192/2012³⁹⁰. 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 permit³⁹¹. As asylum seekers, they have the same access to healthcare as nationals and authorised residents.

In order to obtain their IHC, they have to register with their municipality under the same conditions as prior to the 2012 reform.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum or with refugee status have the same access to healthcare as nationals and authorised residents. They have access to antenatal, delivery and postnatal care and pregnancy termination.

Children of asylum seekers and refugees

By law, children of asylum seekers and refugees have the same access to healthcare as the children of nationals

³⁸⁹ Law of 30 October 2009,

<http://www.boe.es/buscar/act.php?id=BOE-A-2009-17242>

³⁹⁰ Op. cit. note 377

³⁹¹ Op. cit. note 389

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 16/2012³⁹² 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.

³⁹² Op. Cit. note 372

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It must be stressed that each AC in Spain can implement specific regulations regarding access to and costs of healthcare for undocumented migrants³⁹³. This situation creates administrative confusion and therefore inequality in access to healthcare depending on where someone lives³⁹⁴.

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 system³⁹⁵. It also added that times of economic crisis cannot be an excuse to deny or restricting the right to health to this vulnerable group³⁹⁶.

Undocumented pregnant women

Article 1 of Royal Decree-Law 16/2012 introducing the new Article 3ter states that foreign nationals who are neither registered nor authorised to reside in Spain will be covered for antenatal, delivery and postnatal care.

However, since the 2012 reform, a number of Non-Governmental Organisations (NGOs) and media have reported how pregnant women often struggle to gain access to medical care³⁹⁷. Indeed, women are asked to present their IHC and if they do not

have one, they are instructed to go to the emergency department³⁹⁸.

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 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 €3,300³⁹⁹.

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

³⁹³ J. A. Pérez-Molina and F. Pulido, "¿Cómo está afectando la aplicación del nuevo marco legal sanitario a la asistencia de los inmigrantes infectados por el VIH en situación irregular en España?", *Elsevier*, 2014, [http://apps.elsevier.es/watermark/ctl_servlet?_f=10&pident_articulo=0&pident_usuario=0&pcornactid=&pident_revista=28&ty=0&accion=L&origen=zonadelectura&web=www.elsevier.es&lan=es&fichero=S0213-005X\(14\)00362-0.pdf&eop=1&early=si](http://apps.elsevier.es/watermark/ctl_servlet?_f=10&pident_articulo=0&pident_usuario=0&pcornactid=&pident_revista=28&ty=0&accion=L&origen=zonadelectura&web=www.elsevier.es&lan=es&fichero=S0213-005X(14)00362-0.pdf&eop=1&early=si)

³⁹⁴ Ibid.

³⁹⁵ Op. cit. note 384

³⁹⁶ Op. cit. note 384

³⁹⁷ Op. cit. note 384

³⁹⁸ Yosi - sanidad universal, *Un año de exclusión sanitaria, un año de desobediencia, Campaña de desobediencia al Real Decreto-Ley 16/2012*, 2013,

<http://yosisanidaduniversal.net/media/blogs/ma-teriales/DossierAniversarioRDL.pdf>; I. Benitez, "Health Care for Immigrants Crumbling in Spain", *Inter Press Service News Agency*, 24 May 2013, <http://www.ipsnews.net/2013/05/health-care-for-immigrants-crumbling-in-spain/>

³⁹⁹ G. Sanchez, "Embarazadas, menores y urgencias: los incumplimientos de una ley sanitaria discriminatoria", *eldiario.es*, 31 August 2013, http://www.eldiario.es/desalambre/inmigracion-sanidad-sin-papeles-un-ano-sin-sanidad-universal_0_170433089.html

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provides that “*in any case, foreign nationals who are less than 18 years old receive healthcare under the same conditions as Spanish citizens*”⁴⁰⁰.

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 provides for the basic health services package which includes prevention services⁴⁰¹. 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 IHC. 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 CA⁴⁰².

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 misinformation⁴⁰³, they can be denied care and sent to the emergency department in the meantime⁴⁰⁴.

EU citizens

Directive 2004/38 was transposed into the Spanish legal framework by Royal Decree 240/2007 of February 16, on the entry, free movement and residence in Spain of citizens of the

Member States of the European Union and other states parties to the agreement on the European Economic Area.

Royal Decree 240/2007 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 EHIC⁴⁰⁵. European patients who hold an EHIC have been denied access to public healthcare⁴⁰⁶.

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

⁴⁰⁰ Op. cit. note 372

⁴⁰¹ Op. cit. note 372

⁴⁰² Op. cit. note 372; Op. cit. note 143

⁴⁰³ Op. cit. note 384

⁴⁰⁴ Op. cit. note 24

⁴⁰⁵ European Commission, *European Health Insurance Card: Commission expresses concerns about refusals by Spanish public hospitals to recognise EHIC*, Brussels, 30 May 2013, http://europa.eu/rapid/press-release_IP-13-474_en.htm?locale=en

⁴⁰⁶ Ibid.

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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 after⁴⁰⁷ 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 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

⁴⁰⁷ Mostly, it is very difficult for doctors to attest if the disease occurred after or before arrival.

of undocumented migrants from the National Healthcare System.

Concerning the specific medical attention to be given to undocumented migrants (excluding those under 18 years old and pregnant women), some ACs in Spain have developed different laws or regulations in order to allow undocumented migrants access to healthcare⁴⁰⁸ and, in particular, regarding the treatment of infectious diseases⁴⁰⁹.

In six ACs (**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.⁴¹⁰ The undocumented migrants must be registered in the locality and be able to prove their lack of resources⁴¹¹ 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 agreement⁴¹²).

There is no information on specific provisions to guarantee access to

⁴⁰⁸ Op. cit. note 384

⁴⁰⁹ Op. cit. note 393

⁴¹⁰ Op. cit. note 384

⁴¹¹ Op. cit. note 393

⁴¹² Op. cit. note 384

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treatment for those with infectious diseases.

Cantabria

Cantabria's Programme of Social Protection and Public Health 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), granting any resident in Navarre – including undocumented ones – the right to free and public healthcare. This law has been appealed before the Constitutional Court. While the verdict is pending, the section related to pharmaceutical benefits has been temporarily suspended. This means that all those without health coverage cannot access free drugs and there is no information about people with infectious diseases.

Castile and Leon – Castile-La Mancha – La Rioja

With regards to Castile and Leon, Castile-La Mancha 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 reform⁴¹³.

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 Decree . Nonetheless, in Madrid, this treatment is charged to the patient. In the Balearic Islands, the treatment is free and the same is true for Catalonia⁴¹⁵.

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

⁴¹³ Op. cit. note 393

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CAs⁴¹⁶. This document does not specifically refer to undocumented migrants, but broadly to any person who does not benefit from the National Health System⁴¹⁷.

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 treatment⁴¹⁸.

Various diseases are included such as HIV, hepatitis B and C, tuberculosis⁴¹⁹.

Nevertheless, even though specific regulation may be established in Spain, 37% of doctors who are specialists in infectious diseases say that they have real difficulties “always or most of the time” in treating HIV positive patients who are undocumented migrants⁴²⁰.

⁴¹⁶ Ministerio de Sanidad, servicios sociales e igualdad, *Intervencion sanitaria en situaciones de riesgo para la salud publica*, 18 de diciembre de 2013,

<http://www.msssi.gob.es/profesionales/saludPublica/docs/IntervencionSanitariaRiesgoSP.pdf>

⁴¹⁷ Ibid.

⁴¹⁸ Op. cit. note 416

⁴¹⁹ Op. cit. note 416

⁴²⁰ <http://www.chueca.com/articulo/la-exclusion-de-migrantes-de-la-sanidad-impide-el-control-de-las-enfermedades-infecciosas>

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National Health System

Constitutional basis

The Constitution of the Kingdom of Sweden of 1974, in 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 [...]”*⁴²¹.

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 [...]”*⁴²².

Organisation and funding of Swedish healthcare system

The Swedish healthcare system has an explicit public commitment to ensure the health of all citizens. The Health and Medical Services Act 1982⁴²³ not only incorporated equal

access to services on the basis of need, but also emphasises a vision of “equal health for all”⁴²⁴.

It is organised into three levels: the national, regional and local. Predominantly, these three entities handle the funding of the National Health System (NHS). Government funding comes mainly from income taxes levied by county councils/regions and municipalities, and some national and indirect tax revenues. As in the UK, a small proportion of the population has private health insurance, which is usually paid by their employer.

With primary responsibility for the delivery of good 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 services⁴²⁵.

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 municipalities⁴²⁶. The Act is designed to give county councils and

⁴²¹ Constitution of the Kingdom of Sweden of 1974,

<http://www.parliament.am/library/sahmanadrutyunner/Sweden.pdf>

⁴²² Ibid.

⁴²³ The Health and Medical Service Act of 1982,

<http://www.ilo.org/dyn/travail/docs/1643/health%20a%20nd%20medical%20insurance%20act.pdf>

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<http://www.euro.who.int/en/countries/sweden>

⁴²⁵ OECD Reviews of Health Care Quality, Sweden 2013 - Raising Standards, http://www.nsd.mn.no/filarkiv/File/Eksterne_rappporter/OECD_rapport_Sverige_1_.pdf

⁴²⁶ Op. cit. note 106

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municipalities 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 country⁴²⁷.

The 209 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 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 care⁴²⁸.

The Swedish health system does not provide medicines free of charge to

individuals with health coverage. However, according to the Law on Pharmaceutical Benefits⁴²⁹, the State subsidises the cost of certain medicines.

The Dental and Pharmaceutical Benefits Agency (TLV) is a central government agency which determines whether a pharmaceutical product (or dental care procedure) should be subsidised by the State⁴³⁰.

There is a high-cost threshold that reduces patient costs for prescription medicines. The high-cost threshold applies for a 12-month period from the first purchase. It starts to apply after purchases amounting to around €115 (1,100 SEK) for prescription medicines during a 12-month period. The maximum cost for a patient for prescription medicines in the high-cost threshold system is around €235 (2,100 SEK) during a 12-month period.

In practice, the patient pays the full price for their medicines up to around €115 (1,100 SEK). Following this, a discount system comes into effect:

- between 1,101 SEK and 2,100 SEK, the patient pays 50% of the cost of the medicine;
- between 2,101 SEK and 3,900 SEK (around €415), the patient pays 25% of the cost of the medicine;
- between 3,901 SEK and 5,400 SEK (around €575), the patient

⁴²⁷ Op. cit. note 106

⁴²⁸ Op. cit. note 106

⁴²⁹ *Law on Pharmaceutical Benefits of 2002*, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2002160-om-lakemedelsfo_sfs-2002-160/

⁴³⁰ <http://www.tlv.se/In-English/in-english/>

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pays 10% of the cost of the medicine⁴³¹.

If a patient has bought medicines on prescription for 2,200 SEK within a 12-month period then they do not pay any more for their medicines during the remaining time in that period⁴³².

For asylum seekers and undocumented migrants, the situation is slightly different but more advantageous. 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 per prescribed drug⁴³³. This applies to medicines subsidised by the State.

In addition, anyone with health coverage who has a medical consultation with a GP has to pay a fee of €21 directly upfront or ask for a bill.

Within a 12-month period after their first visit to a GP, an individual with health coverage never has to pay more than around €120. Indeed, after having paid €120, the patient can obtain a card that gives them access to free healthcare until 12 months have passed since the first visit.

Access to healthcare for migrants

Asylum seekers and refugees

⁴³¹ <http://www.tlv.se/In-English/medicines-new/the-swedish-high-cost-threshold/how-it-works/>

⁴³² Ibid.

⁴³³ Regulation on care fees for foreign nationals staying in Sweden without the necessary permits of 2013, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Forordning-2013412-om-varda_sfs-2013-412/

According to the Law on Health and Medical Services for Asylum Seekers and Others⁴³⁴, all asylum seekers are entitled to subsidised health and dental care that “cannot be postponed”⁴³⁵, maternity care, pregnancy termination and contraceptive advice.

The Swedish Migration Agency provides them with a personal card (LMA card) which is valid for a certain period (three, four or six months⁴³⁶). This card must be presented when seeking care⁴³⁷.

For any visit to a health centre or hospital, adult asylum seekers pay around €5 for the visit or examination and around €5 when buying a prescribed medicine from the pharmacy⁴³⁸. For medical transport they pay a maximum of €4.30⁴³⁹. According to the law regulating the reception of asylum seekers⁴⁴⁰, asylum seekers who are registered are entitled

⁴³⁴ Law on Health and Medical Services for Asylum Seekers and Others of 2008, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2008344-om-halso--och-s_sfs-2008-344/

⁴³⁵ Ibid.

⁴³⁶

http://plus.rjl.se/info_files/infosida31671/imakort.pdf

⁴³⁷ C. Björngren Cuadra, “Policies on Health Care for Undocumented Migrants in EU27, Country Report, Sweden”, *Healthcare in NOWHERELAND improving services for undocumented migrants in the EU*, 2010, <http://files.nowhereland.info/692.pdf>

⁴³⁸ G. Abraha, “A Handbook for Asylum Seekers in Sweden”, *Asylum Reception in Focus - A series from NTN-asylum & integration* No. 5, 2007

<http://www.temaasyl.se/Documents/NTG-dokument/A+Handbook+for+Asylum+Seekers+in+Sweden.pdf>

⁴³⁹ Ibid.

⁴⁴⁰ Law on the reception of asylum seekers and others of 1994,

http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-1994137-om-mottagande-a_sfs-1994-137/

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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 them for costs over €43⁴⁴¹. The county administrative board receives payment for medical examinations and medical care from the Migration Board⁴⁴². The county administrative board can, following an application, receive payment for special costly care⁴⁴³.

Asylum seekers and refugees also have access to emergency care but this is not free of charge. Each medical consultation in case of emergency costs around €40. According to the Regulation on foreign nationals and care fees⁴⁴⁴, 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.

Pregnant asylum seekers and refugees

Pregnant women seeking asylum have the right to receive maternity care under the conditions detailed above. They can have a pregnancy termination as well as receive contraceptive advice services free of charge.

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. Therefore, they have access to immunisation.

This is regulated by the Law on Health and Medical Care for Asylum Seekers and Others (2008:344).

Undocumented migrants

Prior to the implementation of the Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (2013:407)⁴⁴⁵ in July 2013, in contrast to Swedish citizens and authorised residents, undocumented migrants had to pay full fees for receiving healthcare, even in cases of emergency.

Since July 2013, this law grants undocumented migrants the same access to healthcare as asylum seekers and refugees i.e. subsidised healthcare "*that cannot be postponed*". It includes medical examination and medicine covered by the Pharmaceutical Benefits Act, dental care "*that cannot be deferred*", maternity care and pregnancy termination, contraceptive counselling and sexual and reproductive care⁴⁴⁶. 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 residents⁴⁴⁷. Similarly to asylum

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http://www.1177.se/Dokument/Stockholms_lan/Regler_och_rattigheter/V%C3%A5rd%20f%C3%B6r%20dig%20som%20befinner%20dig%20i%20Sverige%20utan%20tillst%C3%A5nd/Fojder%20A4_engelska.pdf

⁴⁴⁶ Ibid.

⁴⁴⁷ Platform for International Cooperation on Undocumented Migrants (PICUM), *Guaranteeing Access to Health Care for Undocumented Migrants in Europe: What Role Can Local and Regional Authorities Play?*,

⁴⁴¹ Op. cit. note 438

⁴⁴² Op. cit. note 438

⁴⁴³ Op. cit. note 438

⁴⁴⁴ Op. cit. note 433

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seekers, at least in theory, undocumented migrants can also apply for the compensation of costs over €43.

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*”⁴⁴⁸.

In practice, this is how the National Board of Health and Welfare defines what care is included in the terms:

- acute care and treatment (emergency care);
- treatment of diseases and injuries where even a moderate delay can have serious consequences for the patient;
- care that can counteract a more serious medical condition;
- care to avoid more comprehensive care and treatment;
- care to reduce the use of more costly emergency treatment measures;
- psychiatric care;
- maternal health (antenatal, delivery and postnatal care);
- contraceptive advice;
- termination of pregnancy;
- medicines covered by the Pharmaceutical Benefits Act;
- disease control measures;
- a health check-up (if the individual has not already received one)

Brussels, 2013,
http://picum.org/picum.org/uploads/publication/CoR%20Report%20Access%20to%20Healthcare%20EN_FR_IT_ES%202013.pdf

<http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19381/2014-2-28.pdf>

- disability aids (unless the patient can get access to such items otherwise)
- medical travel / transport in connection with the care episode
- interpreter in connection with the care.

Since the July 2013 law came into force, 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, €45 for a GP consultation, whereas it should cost around €5.

Moreover, many undocumented migrants are still denied access to healthcare. Of the undocumented migrants whom the organisation referred to public healthcare in the course of 2014, 19% (30 out of 162) were at some point denied subsidised healthcare that they should have been entitled to.

Undocumented pregnant women

Undocumented pregnant women pay a patient fee of around €5 when they seek a medical consultation. The July 2013 Law states that undocumented pregnant women have the right to obtain maternal healthcare free of charge, including delivery care⁴⁴⁹. Regarding pregnancy termination⁴⁵⁰, the care related to the procedure is

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http://www.vardgivarguiden.se/Patientadministration/Ta-betalt/Asyl_Utan_tillstand/Personer-utan-tillstand/Artiklar/Patientavgifter/

450 *Law on care fees for certain foreign nationals staying in Sweden without the necessary permits of 2013*,
https://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2013407-om-halso--och-s_sfs-2013-407/?bet=2013:407

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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

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 nationals⁴⁵¹.

In addition, according to the July 2013 Law, minor children of undocumented migrants have the same rights to medical and dental care as the children of Swedish nationals.

EU citizens

The EU directive 2004/38 transposed into the Aliens Act (2005:716), Chapter 3a⁴⁵², 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.

The July 2013 Law is not clear on whether destitute EU citizens who

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<http://www.socialstyrelsen.se/smittskydd/vaccination/barnvaccinationer/allmantprogram>;
<http://www.1177.se/Stockholm/Regler-och-rattigheter/Vard-for-dig-som-befinner-dig-i-Sverige-utan-tillstand/>

⁴⁵² Aliens Act of 2005,

<http://www.government.se/content/1/c6/06/61/>

have lost the right to reside are currently able to access healthcare on the same basis as undocumented migrants (third-country nationals).

The government bill 2012/13:109⁴⁵³ 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 receiving healthcare in most hospitals and health centres.

Unaccompanied minors

Since the 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 responsible for providing the same level of health service, including healthcare, for children seeking asylum under the age

⁴⁵³ Government Bill on healthcare for people staying in Sweden without permission of 2013, [22/bfb61014.pdf](http://www.government.se/content/1/c6/06/61/22/bfb61014.pdf)

http://www.riksdagen.se/sv/Dokument-Lagar/Forslag/Propositioner-och-skrivelser/Halso--och-sjukvard-tillperso_H003109/

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<http://www.socialstyrelsen.se/vardochomsorgforasyksokandemedflera/halso-ochsjukvardochtandvard/vilkenwardskaerbjudas>

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of 18 as for other children who are citizens or residents in Sweden, including child psychiatric and dental care⁴⁵⁵. 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 asylum⁴⁵⁶. According to the 1949 law (Chapter 19), the chief guardian is elected by the city council⁴⁵⁷. They are elected for a four-year period.

Protection of seriously ill foreign nationals

According to the Aliens Act (Chapter 5, Section 6) of 29 September 2005⁴⁵⁸, a residence permit on grounds of exceptionally distressing circumstances can be granted.

Section 6 states that if a residence permit cannot be awarded on other grounds, it may be granted to a foreign national if, on an overall assessment of their situation, there are such **exceptionally distressing circumstances** that they should be allowed to stay in Sweden. In making this assessment, particular attention should be paid to the foreign national's health, their integration in Sweden and their situation in their country of origin. Children may be granted residence permits under this section, even if the

⁴⁵⁵ U. Wernesjo, "Conditional Belonging Listening to Unaccompanied Young Refugees' Voices", *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Social Sciences* 93. Uppsala, 2014, http://www.diva-portal.org/smash/get/diva2:689776/FULLTEXT_01.pdf

⁴⁵⁶ Ibid.

⁴⁵⁷ *The Children and Parents Code of 1949*, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Foraldrabalk-1949381_sfs-1949-381/#K19

⁴⁵⁸ Op. cit. note 452

circumstances that come to light do not have the same seriousness and weight that is required for a permit for adults.

Section 9 specifies that "a residence permit that is granted pursuant to Section 6 on ground of sickness shall be for a limited time if the [foreign national's illness] or need of care in Sweden is of a temporary nature".

In MdM SE's experience, it is very difficult for seriously ill individuals to obtain a residence permit. The patient must be more or less fatally ill to obtain residency, and even in such cases the residency is often temporary.

Prevention and treatment of infectious diseases

Infectious diseases are covered by the Diseases Act (*Smittskyddslagen*⁴⁵⁹) which states that testing and treatment are free of charge for residents in Sweden and for those who are covered by EU regulation 883/2004. Since the 2013 law which grants the same access to healthcare for undocumented migrants as asylum seekers and refugees, undocumented migrants also have access to free testing and treatment free of charge. Diseases such as tuberculosis, HIV and hepatitis are covered by the law.

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.

⁴⁵⁹ *Diseases Act of 2004*, http://www.riksdagen.se/sv/Dokument-Lagar/Ovriga-dokument/Ovrigt-dokument/_sfs-2004-168/

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National Health System

Constitutional basis

The Federal Constitution of the Swiss Confederation, adopted on 18 April 1999, enshrines the right to health. Article 12 establishes that *“persons in need and unable to provide for themselves have the right to assistance and care, and to the financial means required for a decent standard of living”*⁴⁶⁰. 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”*⁴⁶¹.

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 (...)”*⁴⁶².

In addition, Article 118 enshrines the protection of health, for which *“the Confederation shall, within the limits of its powers, take measures”*⁴⁶³.

Organisation and funding of Swiss healthcare system

The Swiss Federal Law on Compulsory Health Care (LAMal) entered into force on 1 January

1996⁴⁶⁴. 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 confederation⁴⁶⁵.

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 package⁴⁶⁶. 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 basis⁴⁶⁷.

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);

⁴⁶³ Ibid.

⁴⁶⁰ *Federal Constitution of the Swiss Confederation of 1999* (last updated 18 May 2014), <http://www.admin.ch/ch/e/rs/1/101.en.pdf>

⁴⁶¹ Ibid.

⁴⁶² Op. cit. note 460

<https://www.eda.admin.ch/missions/mission-onu-omc-aele-geneva/en/mission-geneva/manual-regime-privileges-and-immunities/manual-insurance/manual-insurance.html>

⁴⁶⁵ 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>

⁴⁶⁶ Ibid.

⁴⁶⁷ Op. cit. note 464

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- social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance and military insurance⁴⁶⁸.

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 varies between €286 and €2,390 for adults (€0 to €574 for children) and must also contribute up to 10% (proportional share) of the cost of the services provided⁴⁶⁹.

This proportional share is capped at €669 per adult and €334 per child⁴⁷⁰. In other words, in addition to the monthly premium, an adult who has opted for a €286 franchise will pay a maximum of €955 (€286 + €669) 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)⁴⁷¹ 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

⁴⁶⁸ Op. cit. note 106

⁴⁶⁹ In January 2015, the Swiss National Bank (SNB) left the floor rate between the euro and the Swiss franc (CHF) ; € 1 is now between 1 CHF and 1.05 CHF and while it traded at 1.20 CHF before.

⁴⁷⁰

http://www.guidesocial.ch/fr/fiche/55/%23som_134251

⁴⁷¹ *Federal Law on health insurance of 1994*, <http://www.admin.ch/opc/fr/classified-compilation/19940073/index.html#a64a>

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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 end the health insurance (Article 9, OAMal)⁴⁷².

A partial reduction or full exemption from monthly premiums is foreseen in Article 65(1) LAMal 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)⁴⁷³ 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). Social assistance is granted if a person in need cannot be looked after by their family⁴⁷⁴ or cannot claim other

legal services to which they have a right (principle of subsidiarity)⁴⁷⁵.

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 insurance⁴⁷⁶.

The healthcare services covered by the compulsory (basic) health insurance are indicated in Articles 24 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 disease⁴⁷⁷. 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 Code⁴⁷⁸ (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

⁴⁷² Op. cit. note 470

⁴⁷³ *Federal Law on assistance of 1977*, <http://www.admin.ch/opc/fr/classified-compilation/19770138/index.html#id-1>

⁴⁷⁴ W. Schmid and D. Maravic, “The new CSIAS standards relative to the obligation to provide care under the terms of family rights”, *The fiduciary Expert*, 2009, http://www.trex.ch/custom/trex/pdfarchiv/TREX_2009/Edition_4/Articles_specialises/Walter_Schmid_Danie.pdf

⁴⁷⁵

http://www.fr.ch/sasoc/fr/pub/aide_sociale/buts_aide_sociale.htm

⁴⁷⁶ <http://csias.ch/>

⁴⁷⁷ *Healthcare Benefits Ordinance of 1995*, <http://www.admin.ch/opc/fr/classified-compilation/19950275/index.html>

⁴⁷⁸ *Swiss Criminal Code of 1937*, <http://www.admin.ch/opc/fr/classified-compilation/19370083/index.html#a119>

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- 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)⁴⁷⁹. 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 refugees⁴⁸⁰.

Thus, asylum seekers and statutory refugees have to take out compulsory health insurance as they are “*persons*

domiciled in Switzerland within the

⁴⁷⁹ Op. cit. note 473

⁴⁸⁰ V. Bilger and C. Hollomey, “Policies on Health Care for Undocumented Migrants in Switzerland, Country Report”, Healthcare in NOWHERELAND improving services for undocumented migrants in the EU, 2011, http://chm.com/country_report_Switzerland.pdf

meaning of Articles 23-26 of the Swiss Civil Code”⁴⁸¹.

They can make a claim for premium reductions if they are “*on a low income*”⁴⁸². They can also benefit from social assistance at the level provided by their canton, as foreseen in Articles 80-81⁴⁸³ of the Asylum Act. This social assistance covers basic medical care, including compulsory insurance (especially the amount remaining after premium reductions and franchises).

According to the LAsi, asylum seekers who receive a negative asylum decision or a rejection of their application still benefit from ordinary social assistance.

In order to revise the LAsi⁴⁸⁴, three projects were launched to change measures applying to asylum seekers and refugees. The first one, which concerned changes to the allocation of social assistance to asylum seekers, came into force on 1 February 2014. It includes, in particular, an amendment to Article 82(1) and 82(2).

Under this scheme, social assistance is automatically withdrawn from individuals who receive a removal decision with a fixed departure deadline (Article 82(1)). Those who receive a removal decision may only have access to emergency care on request (Article 82(2)). This barrier to accessing care goes against the rights of asylum seekers appealing a decision i.e. who are still in the asylum process.

⁴⁸¹ *Swiss Civil Code of 1907*, <http://www.admin.ch/opc/fr/classified-compilation/19070042/index.html>

⁴⁸² <https://www.geneve.ch/assurances/maladie/su-bsides-assurance-maladie-2015.asp#a14>

⁴⁸³ Op. cit. note 473

⁴⁸⁴ <http://www.odae-romand.ch/spip.php?article244>

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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 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 Constitution⁴⁸⁵.

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. Indeed, most cantons ask for proof of income tax in order to grant access to premium reductions.

⁴⁸⁵ Op. cit. note 460

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 nationals⁴⁸⁶, 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 franchise⁴⁸⁷, around €2,390 per year. It means that they have to cover the first €2,390 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

⁴⁸⁶ *Federal Law on Foreigners of 2005*, <https://www.admin.ch/opc/fr/classified-compilation/20020232/index.html>

⁴⁸⁷ The franchise or deductible is the amount which has to be paid by the patient before the insurance starts paying.

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“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 reported. Insurers must maintain confidentiality with regard to third parties⁴⁸⁸ 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

⁴⁸⁸ *Federal Law on the general section of social insurance of 2000*, Article 33, 84, 92, c <http://www.admin.ch/opc/fr/classified->

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 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.

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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. In practice, to

avoid them accessing social assistance, cantons are authorised to remove their residence permit if they lose their job and do not have enough resources to stay in Switzerland. In the

Vaud canton, regional social centres which have responsibility for assistance often report those who ask for help shortly after their arrival to the Cantonal Office for Population and Migrants⁴⁸⁹.

Termination of pregnancy

According to Article 119 of the Criminal Code⁴⁹⁰, 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 doctor considers that there is physical danger for the pregnant woman. Terminations of pregnancy are included in the basic health insurance services and are therefore entirely reimbursed for insured persons (Article 30 LAMal)⁴⁹¹.

Unaccompanied minors

⁴⁸⁹ M. Danesi, "L'aide sociale au coeur des crispations", *Le Temps*, 4 February 2014, (accessed 18 April 2015), <http://www.letemps.ch/Page/Uuid/0713c18e->

In certain cantons, unaccompanied minors should be taken into establishments which assist them and ensure their protection. Those who seek asylum have the same access to healthcare as children of asylum seekers.

According to state regulations, the right to seek asylum is guaranteed for all unaccompanied minors in

Switzerland⁴⁹². This right is strictly personal, therefore whether

unaccompanied minors reach the age of discernment, they can make an application for asylum personally, or they will have to be represented by a

"trustworthy person"⁴⁹³. These persons are assigned by the canton authorities⁴⁹⁵.

It is important to stress that even if an unaccompanied minor reaches the age of discernment and is able to fill out an asylum application on their own, they will have to be assisted by a "trustworthy person" representative during the procedure⁴⁹⁶.

Therefore, the issue of this representative is crucial regarding asylum requests by unaccompanied minors. On 4 February 2015, the United Nations Committee on the Rights of the Child addressed a number of recommendations to Switzerland, one of which relates to the rights of unaccompanied minors⁴⁹⁷. Indeed, the United Nations experts are

⁴⁹² Op. cit. note 490, Article 19 al. 2
⁴⁹³

8d1e-11e3-a0c7-33a92f4fec1d/Laide sociale au c%C3%83%E2%80%A6%C3%A2%E2%82%AC%C5%93u r des crispations

⁴⁹⁰ Op. cit. note 478

⁴⁹¹ Op. cit. note 471

<https://www.bj.admin.ch/content/dam/data/bfm/asy/verfahren/hb/c/hb-c10-f.pdf>

⁴⁹⁴ Ibid.

⁴⁹⁵ Op. cit. note 493

⁴⁹⁶ *Asylum Law of 1998*,

<http://www.admin.ch/opc/fr/classified-compilation/19995092/index.html#a82a>

⁴⁹⁷ [http://www.asile.ch/vivre-](http://www.asile.ch/vivre-ensemble/2015/02/07/odae-romand-lonu-sinquiete-des-conditions-daccueil-des-enfants-migrants-en-suisse/)

[ensemble/2015/02/07/odae-romand-lonu-sinquiete-des-conditions-daccueil-des-enfants-migrants-en-suisse/](http://www.asile.ch/vivre-ensemble/2015/02/07/odae-romand-lonu-sinquiete-des-conditions-daccueil-des-enfants-migrants-en-suisse/)

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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 procedure⁴⁹⁸.

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 activity⁴⁹⁹.

A serious health condition for which no treatment in the country of origin exists is not sufficient in itself as a criterion, as the person’s level of integration into

⁴⁹⁸ Ibid.

⁴⁹⁹ *Ordinance on admission, residence and gainful employment of 2007*, <http://www.admin.ch/opc/fr/classified-compilation/20070993/index.html#a31>

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 insurance⁵⁰⁰. 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

⁵⁰⁰ *Order of the Interior Federal Department (DFI) of 1995*, Article 12d

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to pay around €60 for HIV screening (€30 for those under 20 years old) and around €40 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.

TURKEY

National Health System

Constitutional basis

Article 56 of the Constitution of Turkey of 1982, amended in 2010, states, “*that it is the duty of the state (...) to ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through the economy and increased productivity, the state shall regulate the central planning and functioning of the health services*”⁵⁰¹. Article 60 explains that “everyone has the right to social security”⁵⁰².

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)⁵⁰³.

In 2006, the parliament ratified the Law on Social Insurance and Universal Health Insurance (Law No. 5510 – GHI Law)⁵⁰⁴. With this law, the three separate schemes (Bağ-Kur, SSK and

GERF⁵⁰⁵) 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 facilities⁵⁰⁶. The SSI is funded through payments by employers and employees and government contributions in cases of budget deficit⁵⁰⁷.

The Ministry of Health is the main actor in planning and supervising health services⁵⁰⁸.

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 sources⁵⁰⁹. Social health insurance contributions take the lead, followed by government sources, out-of-pocket payments and other private sources⁵¹⁰.

The SSI finances the cost of healthcare services provided by health service providers through the premiums collected from universal insurance holders.

⁵⁰¹ Constitution of the Republic of Turkey of 1982,

http://www.hri.org/docs/turkey/part_ii_3.html#article_56

⁵⁰² Ibid.

⁵⁰³ R. Hunter, “TURKEY’S HEALTH CARE REFORM: THE 2023 CHALLENGE”,

TURKISH POLICY Quarterly, Vol. 12 No. 2, 2013, http://turkishpolicy.com/pdf/vol_12-no_2-hunter.pdf

⁵⁰⁴ *Social Insurance and Universal Health Insurance Law of 2006*,

⁵⁰⁵ M. Tatar et al., “Turkey: Health system review”, *Health Systems in Transition*, Vol. 13 No. 6, 2011,

<http://turkishlaborlaw.com/images/turkish-social-security-law/social-security-law-5510.pdf>

<http://www.euro.who.int/0006/158883/e96441.pdf>
⁵⁰⁶ Ibid.

⁵⁰⁷ Op. cit. note 505
⁵⁰⁸ Op. cit. note 505
⁵⁰⁹ Op. cit. note 505
⁵¹⁰ Op. cit. note 505

[data/assets/pdf_file/](#)

TURKEY

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 share⁵¹¹.

Accessing Turkey healthcare system

In theory, as introduced by the GHI Law, the GHIS provides individuals residing in the country with comprehensive, fair and equitable access to healthcare services, regardless of their economic situation.

The system is available to foreign residents paying social security contributions. With the Social Insurance and General Health Insurance, everybody residing in the country legally is included in the health system. In addition to this, the new system extended free health coverage for children below 18⁵¹². 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.⁵¹³.

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 year⁵¹⁴. Self-employed people (formerly covered by the Bağ-Kur) and those who were not previously covered by any other scheme must have paid at least 60 days of contributions⁵¹⁵.

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 reason⁵¹⁶. 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 year⁵¹⁷.

In accordance with Article 60 of the GHI Law⁵¹⁸, 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

⁵¹¹ <http://www.invest.gov.tr/en-us/investmentguide/investorsguide/employeesandsocialsecurity/pages/turkishsocialsecuritysystem.aspx>

⁵¹² O. Karadeniz, "Extension of Health Services Coverage for Needy in Turkey: From Social Assistance to General Health Insurance", *Journal of Social Security*, 2012, <http://www.acarindex.com/dosyalar/makale/acarindex-1423911988.pdf>

⁵¹³ Op. cit. note 505

⁵¹⁴ Op. cit. note 505

⁵¹⁵ Op. cit. note 505

⁵¹⁶ Op. cit. note 505

⁵¹⁷ Op. cit. note 505

⁵¹⁸ Op. cit. note 504

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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 €430⁵¹⁹, so destitute citizens have less than approximately €143 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 from a primary care physician (GP); patients pay €5 to public hospitals. However, inpatient services are fully covered⁵²⁰. Visits to primary care facilities do not require a co-payment⁵²¹.

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 revenues⁵²². 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

⁵¹⁹ <http://www.fedee.com/pay-job-evaluation/minimum-wage-rates/>

⁵²⁰ Op. cit. note 505

⁵²¹ Op. cit. note 505

⁵²² R. Atun, et al., "Universal health coverage in Turkey: enhancement of equity", *the Lancet*, Vol 382, No 9886, 2013.

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 is supposed to be free without any distinction between private or public healthcare institutions⁵²³.

Asylum seekers and refugees

Turkey was one of the original signatories to the 1951 Refugee Convention. However, it adopted the Convention with a "geographical limitation".

⁵²³ <http://www.admdlaw.com/health-care-services-for-foreigners-in-turkey/#.VOCdrku6w7s>

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This means that Turkey assumes responsibility for refugees coming from countries that are members of the Council of Europe (CoE). For those coming from outside this zone, Turkey offers limited protection in the form of temporary asylum. This means that those found to be refugees from outside Europe can stay only temporarily and must find a long-term solution outside Turkey⁵²⁴.

Moreover, it is important to bear in mind that in Turkish regulations the terms “*refugee*” and “*asylum seeker*” are defined differently from the established definitions based on international law. Therefore, a refugee is defined as a foreign national or stateless person of European origin who has been recognised as such according to the criteria within Article 1 of the Refugee Convention by the Ministry of the Interior (MOI). An asylum seeker is defined in Turkish regulations as a foreign national or stateless person of non-European origin whose status as an asylum seeker has been recognised by a decision of the MOI that they meet the criteria within Article 1 of the Refugee Convention.

The GHI Law that came into force in 2008 represented a step forward, as it entitled “refugees and stateless [individuals]” to universal health insurance under its Article 60.

Therefore, according to Turkey’s regulations and particular use of terminology, Article 60 of this law seemed to consider asylum seekers as individual holders of the universal health insurance.

⁵²⁴

<http://www.refugeesolidaritynetwork.org/learn-more/turkey-asylum-basics/>

The amended Article 60 of the GHI Law grants public health insurance to those recognised as asylum seekers or stateless persons⁵²⁵. However, under the definition used by the Ministry of the Interior, only United Nations High Commissioner for Refugees (UNHCR) - recognised, non-European refugees are regarded as “asylum seekers”⁵²⁶. Since the Ministry of the Interior does not issue any documentation indicating that a person is an “asylum seeker”, this provision within the law has no practical use⁵²⁷.

Moreover, different reports show how in practice this law is not properly implemented and does not guarantee access to healthcare for asylum seekers. Indeed, it has been reported that only seven asylum seekers and 598 stateless individuals in Turkey were covered under universal health insurance as of July 2011, according to data from the Ministry of Interior⁵²⁸. In addition, over 25,000 “refugees and asylum applicants”, as they are currently defined in Turkish law, lack universal health insurance⁵²⁹.

Recently, the Law on Foreigners and International Protection, which was passed by parliament in April 2013 and came into force in April 2014, makes certain changes to the asylum system in Turkey, even though the geographical limitation remains in

⁵²⁵ Amnesty International, “STRANDED Refugees in Turkey denied protection”, United Kingdom, 2009,

<https://www.amnesty.org/download/Documents/48000/eur440012009en.pdf>

⁵²⁶ Ibid.

⁵²⁷ Op. cit. note 525

⁵²⁸ Op. cit. note 525;

<http://www.bianet.org/english/other/139208-new-legislation-to-ease-foreigners-access-to-healthcare-in-turkey>

⁵²⁹ Op. cit. note 525;

<http://www.bianet.org/english/other/139208-new-legislation-to-ease-foreigners-access-to-healthcare-in-turkey>

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place under the new law. For example, the section entitled “Rights and Obligations” under this law, specifically, Article 89, does include in the national healthcare system asylum applicants who are not mentioned in the GHI Law⁵³⁰.

Refugees and asylum seekers must prove their lack of resources as destitute nationals. They have to submit a claim to the Social Aid and Solidarity Foundation. However, only an “ikamet” (a kind of residence permit)

can give them access to a “citizen number” which is necessary to initiate the procedure for fee exemptions and only a few asylum seekers and refugees can obtain one⁵³¹. Thus, mostly, the healthcare requirements of the claimants are not covered.

Therefore, in practice, access to healthcare for asylum seekers and refugees is denied or takes too long to be really effective. This means they usually have to pay out-of-pocket for health services, be it antenatal and postnatal care for pregnant women or children’s vaccinations.

In addition, a new legislative arrangement was made last year in relation to refugees from Syria and Iraq, whose numbers in Turkey are gradually increasing. Under this arrangement, introduced by the Temporary Protection Regulation, hospital-based medical examinations, treatment bills and medicine cost-sharing by refugees from Syria are covered by the Prime Minister’s Disaster and Emergency Management Authority. However, since this agency takes a long time to make payments,

pharmacists refuse to supply free medicine to refugees. This arrangement excludes refugees from Iraq.

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

hospitals⁵³². Moreover, the amount charged 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 hospitals⁵³³.

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

⁵³⁰ *Law on Foreigners and International Protection of 2014*,

<http://www.refworld.org/pdfid/5167fbb20.pdf>

⁵³¹ M. Blézat and J. Burtin, « Soigner le mal par le rien », *Plein droit*, juin 2012, No 93.

⁵³² Ibid.

⁵³³ Op. cit. note 531

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hospitalised and then taken and interned in Kumkapi detention centre. This phenomenon has been observed since at least 2010⁵³⁴. In most cases, these arrests break the continuity of care and they also demonstrate the cooperation which exists between the police and hospital staff⁵³⁵.

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 weeks⁵³⁶.

The minor children of undocumented migrants also have no access to healthcare. They may have access to vaccination at a primary healthcare centre but these centres usually require the child to be registered with the authorities. Each vaccine costs around €18, added to the medical consultation which costs around €40.

Unaccompanied minors

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 Agency⁵³⁷.

⁵³⁶ Abortion in Turkey is legal until the 10th week after the conception, although that can be extended to the 20th week if the pregnancy threatens the woman’s mental and/or physical health, or if the conception occurred through rape.

⁵³⁷ Global Detention Project, Immigration Detention in Turkey, April 2014, http://www.globaldetentionproject.org/fileadmin/docs/Turkey_report.pdf

⁵³⁴ Op. cit. note 531

⁵³⁵ Op. cit. note 531

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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 documentation⁵³⁸. 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 crimes⁵³⁹.

Moreover, there is no margin of error applied to the result of the tests, as recommended by international standards⁵⁴⁰. 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 applied⁵⁴¹.

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 child⁵⁴².

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))⁵⁴³.

The law states that unaccompanied minors who apply for international protection are not to be detained⁵⁴⁴. 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)⁵⁴⁵.

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 may be detained⁵⁴⁶.

Protection of seriously ill foreign nationals

Law no. 6458 on Foreigners and International Protection of April 2013⁵⁴⁷ 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

⁵³⁸ Refugee Advocacy & Support Program, *Unwelcome Guests: The Detention of Refugees in Turkey's "Foreigners' Guesthouses*, November 2007, http://www.hyd.org.tr/staticfiles/files/rasp_detention_report.pdf

⁵³⁹ Ibid.

⁵⁴⁰ Op. cit. note 538

⁵⁴¹ Op. cit. note 538

⁵⁴² Op. cit. note 538

⁵⁴³ Op. cit. note 537

⁵⁴⁴ Op. cit. note 537

⁵⁴⁵ Op. cit. note 537

⁵⁴⁶ "During his visit, the Special Rapporteur on the Human Rights of Migrants expressed concern about the situation of children at both the Kumkapi and Edirne removal centres. Boys over the age of 12 apprehended with their mothers were automatically separated from their mothers and placed in orphanages (SRHRM 2012)", <http://www.globaldetentionproject.org/countries/europe/turkey/introduction.html>

⁵⁴⁷ Op. cit. note 530

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maximum duration of one year at a time may be granted and renewed by the governorates without seeking the conditions for other types of residence permits: a) where the **best interest of the child** is of concern; b) where, notwithstanding a removal decision or ban on entering Turkey, **foreign nationals cannot be removed from Turkey or their departure from Turkey is not reasonable or possible**; [(...)] e) in cases when foreign nationals should be allowed to enter into and stay in Turkey, **due to emergency** or in view of the protection of the national interests as well as reasons of public order and security, in the absence of the possibility to obtain one of the other types of residence permits due to their situation that precludes granting a residence permit; f) in **extraordinary circumstances**".

In these cases, seriously ill foreign nationals can obtain a humanitarian residence permit and not be expelled to their country of origin or to their country of former usual residence.

Prevention and treatment of infectious diseases

The treatment of infectious diseases is covered by the guarantee package of the GHIS. In medical examinations, STIs such as HIV/AIDS and syphilis as well as tuberculosis are checked free of charge. Tuberculosis is also checked during employment recruitment processes and for other people who may have contact with infected people (also free).

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.

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National Health System

Organisation and funding of British healthcare system

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.

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*⁵⁴⁸ 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 staff⁵⁴⁹. 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 situations⁵⁵⁰.

The NHS is intended to provide universal health coverage to the population in the UK. All those “ordinarily resident” (see definition below) in the UK are automatically entitled to healthcare that is largely free at the point of use through the NHS⁵⁵¹, 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, 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.

From April 2013, in England, all GP practices belong to a Clinical

⁵⁴⁸ The NHS Constitution for the England of 26 March 2013, <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf>

⁵⁴⁹ K. Grosios et al., “Overview of healthcare in the UK”, *EPMA Journal*, 2010, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405352/pdf/13167_2010_Article_50.pdf

⁵⁵⁰ Ibid.

⁵⁵¹ Op. cit. note 106

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Commissioning Group (CCG)⁵⁵² which commissions most health services for the population in its area, including:

- planned hospital care;
- rehabilitative care;
- urgent and emergency care;
- most community health services;
- maternity services; and
- mental health and learning disability services⁵⁵³.

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 not “ordinarily resident” in the UK for health services. The powers were first used in 1982 to make Regulations in relation to NHS hospital treatment (now consolidated as the NHS (Charges to Overseas Visitors) Regulations 2015).

Since 1982, anyone not ordinarily resident in the UK has not been entitled by right to free NHS hospital treatment. An exemption from charges within the Charging Regulations must apply to someone who is not ordinarily resident in the UK, otherwise they will be liable for charges for NHS hospital 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

⁵⁵² <http://www.patient.co.uk/doctor/clinical-commissioning-groups-ccgs>

⁵⁵³ Guide to the Healthcare System in England Including the Statement of NHS Accountability for England, May 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF

being⁵⁵⁴. 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”⁵⁵⁵.

That definition was later applied by the Court of Appeal in the context of the entitlement of rejected asylum seekers to free NHS secondary care, with the caveat that in order to be ordinarily resident one must have a legal right or explicit permission from the immigration authorities to remain in the UK. The Court went on to find that “temporary admission” (a form of entry to the UK granted pending an immigration decision, to people liable to detention and removal) does not amount to residence⁵⁵⁶.

In May 2014, the government published a new Immigration Act 2014 explaining that it was designed to make it “*more difficult for illegal immigrants⁵⁵⁷ to live in the UK*”.

⁵⁵⁴ Department of Health, *Internal review of the overseas visitor charging system - Part 2 Analysis of the overseas visitor charging system*,

<https://fullfact.org/sites/fullfact.org/files/782677/R%20Chap%20%20of%20Review%20pages%201-52.pdf>

⁵⁵⁵ *R v Barnet LBC, ex parte Shah*, 1983, House of Lords,

<http://www.bailii.org/uk/cases/UKHL/1982/14.html>

⁵⁵⁶ *R v Secretary of State for Health*, 2009, Court of Appeal,

<http://www.refworld.org/docid/49d1fca62.html>

⁵⁵⁷ Please note that MdM and its partners, especially PICUM, absolutely disagree with the use of « illegal » designating a person. Only the laws saying that a person is illegal are illegal. **No one is illegal.** <http://picum.org/en/our-work/terminology/>

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According to the Government⁵⁵⁸, the Act is intended to:

- introduce changes to the removals and appeals system, making it easier and quicker to remove those with no right to be in the UK;
- end the “abuse” of Article 8 of the European Convention on Human Rights – the right to respect for family and private life; and
- prevent illegal immigrants⁵⁵⁹ accessing and “abusing” public services or the labour market⁵⁶⁰.

Provisions in the Immigration Act 2014 regarding entitlement to National Health Service treatment came into force in April 2015 (see further details below).

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 split 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 including primary and Accident and Emergency

⁵⁵⁸ Race Equality Foundation, Access to services: the Immigration Act 2014 and key equality impacts, 2014, <http://www.edf.org.uk/blog/wp-content/uploads/2014/09/Equality-impacts-IA-Sepp2014-final.pdf>

⁵⁵⁹ Please note that MdM and its partners, especially PICUM, absolutely disagree with the use of « illegal » designating a person. Only the laws saying that a person is illegal are illegal.

No one is illegal. <http://picum.org/en/our-work/terminology/>

⁵⁶⁰ Op. cit. note 558

care. Extension of charging to these areas will be subject to a further consultation, which is not likely to take place before autumn 2015.

Accessing the NHS

Primary care

As of 1 April 2014⁵⁶¹, patients in England pay €11.30 per prescription, but patients who need more than 13 prescriptions per year or four prescriptions in three months can obtain reductions through a prescription prepayment system⁵⁶². In Wales⁵⁶³, Scotland⁵⁶⁴ and Northern Ireland⁵⁶⁵, 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, under 16 years of age (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

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http://www.nhsbsa.nhs.uk/HealthCosts/Documents/HealthCosts/HC11_April_2014.pdf

⁵⁶²

<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/PPC.aspx>

⁵⁶³

<http://www.wales.nhs.uk/nhswalesaboutus/budgetcharges>

⁵⁶⁴

<http://www.psd.scot.nhs.uk/prescriptioncharges.html>

⁵⁶⁵

<http://www.nhs.uk/ipgmedia/national/Asthma%20UK/Assets/Prescriptionchargesandasthma.pdf>

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who receive some form of means-tested social security benefit⁵⁶⁶.

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 the date of issue and must be produced each time when collecting a prescription or receiving treatment, e.g. dental care, glasses, etc.

In England, Section 3 NHS Act 2006 as amended by Section 13 Health & Social Care Act 2012⁵⁶⁷ states that 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 (Clinical Commissioning Groups (CCGs) – Disapplication of Responsibility) Regulations 2013⁵⁶⁸ specifies that people are to be treated as "usually resident" at the address given by them (or by someone on their behalf), and if they give no address then they are to be treated as usually resident wherever they are present, thereby formally unlinking immigration status from eligibility for primary care.

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<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx>

⁵⁶⁷ *National Health Service Act of 2006*, <http://www.legislation.gov.uk/ukpga/2006/41/section/3>; *Health and Social Care Act of 2012*, <http://www.legislation.gov.uk/ukpga/2012/7/section/13>

⁵⁶⁸ *The National Health Service (Clinical Commissioning Groups— Disapplication of Responsibility) Regulations of 2013*, <http://www.legislation.gov.uk/uksi/2013/350/regulation/3/made>

Regulation 2 of the NHS (General Medical Services Contracts) Regulations 2004⁵⁶⁹ (GMS Regs) which govern the delivery of many NHS primary medical services⁵⁷⁰, defines "patient" as including temporary residents. Paragraph 16 of Schedule 6 GMS Regs⁵⁷¹ 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".

GPs have a general discretion to register or refuse to register anyone in their geographically-defined catchment area⁵⁷², but can only refuse applications for inclusion in the patient list on reasonable grounds (e.g. the list is closed, the patient does not live in the GP's catchment area). Refusals must not be related to the applicant's ethnic origin, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition⁵⁷³. Under equality laws race includes nationality and ethnic or national origins⁵⁷⁴, so in the absence of

⁵⁶⁹ *The National Health Service (General Medical Services Contracts) Regulations of 2004*,

<http://www.legislation.gov.uk/uksi/2004/291/regulation/2/made>

⁵⁷⁰ Many 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.

⁵⁷¹ Op. cit. note 569

⁵⁷² Op. cit. note 569

⁵⁷³ Op. cit. note 569

⁵⁷⁴ *Equality Act of 2010*,

<http://www.legislation.gov.uk/ukpga/2010/15/section/9>

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eligibility criteria for primary care that are based on immigration status, a refusal of primary care for these reasons is likely to be unlawfully discriminatory.

Secondary care

Ordinarily resident

All those “*ordinarily resident*” in the UK are automatically entitled to secondary healthcare that is largely free at the point of use through the NHS⁵⁷⁵. 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 categories of people who are exempt from charges.

Section 39 Immigration Act 2014, which came into force on 6 April 2015, introduced a partial definition of “*ordinary residence*” which excludes all those who do not have indefinite leave to remain in the UK⁵⁷⁶. This includes those who need leave to enter or remain but also those currently living and working in the UK with limited leave to remain⁵⁷⁷.

Other provisions in the Immigration Act 2014 that also came into effect on 6 April 2015 mean that nationals of countries from outside the EEA coming to the UK for longer than six months will be required to pay a “health surcharge” when they make their

immigration application⁵⁷⁸. It will also be paid by third-country nationals already in the UK who apply to extend their stay.

The health surcharge will be €270 per year and €200 per year for students, payable upfront and for the total period of time for which migrants are given permission to stay in the UK.⁵⁷⁹

Reciprocal healthcare agreements

Under Regulation 14 NHS (Charges to Overseas Visitors) Regulations 2015⁵⁸⁰, “no charge may be made or recovered in respect of any relevant services provided to an overseas visitor where those services are provided in circumstances covered by a reciprocal agreement with a country or territory specified in Schedule 2” of the Regulations⁵⁸¹.

Exemptions

Some NHS services are free to everyone regardless of the status of the patient:

- Services provided for the treatment of a condition caused by (i) torture; (ii) female genital mutilation; (iii) domestic violence; or (iv) sexual violence, provided that the overseas visitor has not travelled to the United Kingdom for the purpose of seeking that treatment⁵⁸².
- **Accident and emergency services**, whether provided at a hospital accident and emergency department, a minor

⁵⁷⁵ Op. cit. note 106

⁵⁷⁶ *Immigration Act of 2014*, <http://www.legislation.gov.uk/ukpga/2014/22/section/39>

⁵⁷⁷ *Immigration Act of 2014 - Summary of Provisions*, <http://www.jcwi.org.uk/sites/default/files/Immigration%20Act%202014%20Summary%20Provisions.pdf>

⁵⁷⁸ Op. cit. note 576

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<https://www.gov.uk/government/news/migrant-health-surcharge-to-raise-200-million-a-year>

⁵⁸⁰ *The National Health Service (Charges to Overseas Visitors) Regulations of 2015*, <http://www.legislation.gov.uk/uksi/2015/238/regulation/14/made>

⁵⁸¹ Ibid.

⁵⁸² Op. cit. note 580

injuries unit, a walk-in centre or elsewhere; but not including any services provided after the overseas visitor has been accepted as an inpatient or at an outpatient appointment, in other words no emergency treatment given elsewhere in the hospital⁵⁸³.

- **Family planning services and treatment for sexually transmitted infections**⁵⁸⁴ – 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 tests⁵⁸⁵, as well as testing for STIs.
- **Diagnosis and treatment for communicable diseases** such as influenza, measles, mumps, tuberculosis and viral hepatitis⁵⁸⁶.

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 treatment⁵⁸⁷. Hospitals are required to inform the Home Office of patients who owe the NHS more than €1,350 and such people may be refused visa renewals or regularisation of their immigration status until the debt is paid⁵⁸⁸.

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 processed⁵⁸⁹.

⁵⁸³ Op. cit. note 580

⁵⁸⁴ Op. cit. 580

⁵⁸⁵ <http://www.nhs.uk/Conditions/contraception-guide/Pages/contraception-clinic-services.aspx>

⁵⁸⁶ 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 and scarlet fever, invasive meningococcal disease (meningococcal meningitis, meningococcal septicemia and other forms of invasive disease), legionnaires' disease, leprosy, leptospirosis, malaria, measles, mumps, influenza that might become pandemic, plague, rabies, rubella, Severe

Acute Respiratory Syndrome (SARS), smallpox, tetanus, tuberculosis, typhus, viral hemorrhagic fever, viral hepatitis, whooping cough, yellow fever and... thanks to the 2012 amendment, also HIV/AIDS.

⁵⁸⁷ Department of Health, *Guidance on implementing the overseas visitor hospital charging regulations 2015*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418634/Implementing_overseas_charging_regulations_2015.pdf

⁵⁸⁸ Ibid.

⁵⁸⁹ *The National Health Service (Charges to Overseas Visitors) Regulations of 2011*, <http://www.legislation.gov.uk/uksi/2011/1556/regulation/11/made>

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This exemption will apply to the family of the asylum seeker if they are living in the UK with that person on a permanent basis. In practice, asylum seekers can register with a GP; the National Asylum Support Service, a section of the United Kingdom Border Agency, usually applies for an HC2 certificate valid for six months for asylum seekers⁵⁹⁰. Asylum seekers and rejected asylum seekers who are not entitled to free prescriptions under these categories have to make a Low Income Scheme HC1 claim⁵⁹¹.

Regulation 15 also exempts from charges rejected asylum seekers receiving support under Section 95 of the Immigration and Asylum Act 1999⁵⁹²; and people who have made an application to be granted temporary protection, asylum or humanitarian protection under the immigration rules which was rejected and who are supported under Section 4(2) of the 1999 Act (e); or Section 21 of the National Assistance Act 1948.

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 prior to treatment⁵⁹³. 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 can therefore differ from country to country within the UK⁵⁹⁴.

Focus on pregnant women and children

Under this scheme, pregnant women 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 should have access to 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 patients⁵⁹⁵. Finally, there is no minimum period that a person needs to have been in the UK before a GP can register them⁵⁹⁶.

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.

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<http://www.nhsbsa.nhs.uk/HealthCosts/1136.aspx>

⁵⁹¹ BMA Ethics, *Access to health care for asylum seekers and refused asylum seekers – guidance for doctors*, November 2012,

<http://bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/asylumseekeraccessguidancenovember2012.pdf>

⁵⁹² <http://www.legislation.gov.uk/ukpga/1999/33/section/95>

⁵⁹³ Op. cit. note 556

⁵⁹⁴ Op. cit. note 591

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<http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm121026/text/121026w0001.htm>

⁵⁹⁶ Op. cit. note 587

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Adults over 60 have automatic free prescriptions and eye tests. They can obtain free dental treatment with an HC2 certificate. 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 (see below).

Regarding access to secondary care, as mentioned above, 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.

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 €4,000 if there are no complications.

The Department of Health has stressed repeatedly that providers also have human rights obligations, meaning that treatment considered by clinicians to be immediately necessary (including all maternity treatment) must never be withheld from chargeable patients, even if they have not paid in advance.

Children of undocumented migrants

Vaccination is available for all children and adults through their GP and baby clinics. In practice, children are only accepted by GPs if at least one of their parents is already registered. 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 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 for more than a short period and intend to remain.

If insured, an EEA national is exempt from charges for "all medically necessary treatment", i.e. treatment that it is medically necessary during their temporary stay in, with a view to preventing them from being forced to return home for treatment before the end of their planned duration of stay. For instance, regarding England, this means⁵⁹⁷:

- 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

⁵⁹⁷ Op. cit. note 587

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- exacerbated without
treatment; plus
- the treatment of chronic, or pre-existing, conditions, including routine monitoring.

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 law⁵⁹⁸.

Termination of pregnancy

Termination of pregnancy is possible during the first 24 weeks of pregnancy (and in certain circumstances thereafter) 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).

Two doctors must agree that a termination would cause less damage to a woman’s physical or mental health than continuing with the pregnancy⁵⁹⁹. According to the MdM UK team in

London, it may be difficult to obtain a termination of pregnancy free of charge without a referral from a GP. In addition, in some areas, termination of pregnancy is seen as an elective

⁵⁹⁸ Op. cit. note 580

⁵⁹⁹ *Abortion Act of 1967*,

<http://www.legislation.gov.uk/ukpga/1967/87/contents>;
<http://www.nhs.uk/conditions/Abortion/Pages/introduction.aspx>

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 charges⁶⁰⁰. 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 Remain⁶⁰¹.

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

⁶⁰⁰ J. Simmonds and F. Merredew, “The Health Needs of Unaccompanied Asylum Seeking Children and Young People”, *EP23 - LAC 9.4 Unaccompanied asylum seeking children*, <https://www.nice.org.uk/guidance/ph28/evidence/looked-after-children-ep23-unaccompanied-asylum-seeking-children-john-simmonds-and-florence-merredew2>

⁶⁰¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/312346/discretionaryleave.pdf

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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”⁶⁰². 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. 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”⁶⁰³.

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 time⁶⁰⁴. 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 get it in the UK.

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 and on 1 October 2012 screening and treatment was made free to anyone in the UK⁶⁰⁵.

In 2004, free HIV treatment was made 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

⁶⁰² *N. v United Kingdom*, 2008, European Court of Human Rights, [http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-86490#{"itemid":\["001-86490"\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-86490#{)

⁶⁰³ *N. v Secretary of State for the Home Department*, 2005, House of Lords, <http://www.bailii.org/uk/cases/UKHL/2005/31.html>

⁶⁰⁴ Op. cit. note 601

⁶⁰⁵ <http://www.aidsmap.com/HIV-treatment-and-care/page/2526102/>

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for legal residence) had to pay to receive antiretroviral HIV treatment through the National Health Service⁶⁰⁶.

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 rights⁶⁰⁷. In March 2009, though, 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 status⁶⁰⁸.

⁶⁰⁶ *The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations of 2004*,

<http://www.legislation.gov.uk/ukxi/2004/614/contents/made>

⁶⁰⁷ S. Boseley, "Asylum seekers have right to full NHS care, high court rules, but government considers appeal"; *The Guardian*, 2008,

<http://www.theguardian.com/uk/2008/apr/12/migration.publicservices>

⁶⁰⁸ <http://www.avert.org/hiv-treatment-uk.htm>

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