Accessing HIV prevention, testing, treatment care and support in Europe as a migrant with irregular status in Europe: A comparative 16-country legal survey

Updated and extended edition (November 2017) of the original version March 2018

European HIV Legal Forum (EHLF), November 2015

Gaia Inverardi, lawyer in Milan

February 2016

Co-funded by the Health Programme of the European Union

The European HIV Legal Forum (EHLF) is a project coordinated by AIDS Action Europe (AAE). The project was co-funded by the Health Program of the European Union and Positive Action of ViiV Healthcare UK Ltd. (ViiV)

Contributors:

Sepideh Hassani and Katja Grafl, Aids Hilfe Wien, Austria

Sini Pasanen, HIV Finland, Finland

Nicolas Klausser and Richard Stanz, AIDES, France

Tanja Gangarova, Deutsche AIDS-Hilfe e V., Germany

Marianella Kloka, Apostolos Kalogiannis, PRAKSIS, Greece

Márton Asbóth and Rita Bence, Hungarian Civil Liberties Union, Hungary

Lella Cosmaro, LILA Milano ONLUS, Italy

Sanja Jovanovik, STRONGER TOGETHER, Macedonia

Ronald Brands, Soa Aids Nederland, the Netherlands

Wojciech Tomczynski, SIEC PLUS, Poland

Érica Almeida Postiço, GAT, Portugal

Nicoleta Andreescu, Nicoleta Dascalu, ARAS, Romania

Nenad Petkovic, Q-CLUB, Serbia

Ramón Espacio, CALCSICOVA, Spain

Arda Karapinar, RED RIBBON ISTANBUL, Turkey

Sarah Radcliffe and Christopher Hicks, NAT (National AIDS Trust), UK

Michael Krone and Ferenc Bagyinszky, AIDS Action Europe

A special thanks to Paulette Brombard

Table of Contents

Essential Acronyms

AAE: AIDS Action Europe

CJEU: The Court of Justice of the European Union

ECHR: The Convention for the Protection of Human Rights and Fundamental Freedoms

ELHF: The European HIV Legal Forum

ESC: European Social Charter

ESC(r): The European Social Charter (Revised)

EU Charter: The Charter of Fundamental Rights of the European Union

TFEU: The Treaty on the Functioning of the European Union

Introduction

This work is part of AIDS Action Europe's (AAE) project, "The European HIV Legal Forum" (EHLF), launched in 2012. Its purpose is to give an updated picture of how migrants with irregular status access testing, treatment, care, and support in 10 European countries. In each country, this document reviews relevant laws, policies and European law cases, in order to evaluate how effective and available treatment and care is for people with HIV, regardless of their residency status.

Given the persistence of poverty in many countries and its association with demographic change, the presence of migrants with irregular status in Europe will continue to increase, irrespective of factors related to conflicts and/or environmental conditions. It is thus increasingly urgent to improve access to healthcare, a task that cannot be delegated to non-governmental organizations (NGOs) or civil society alone. Many international instruments refer to the universal right to healthcare, regardless of one's status. "The range of international texts that ensure people's basic and universal right to healthcare is impressive. They include binding state commitments under the United Nations, the Council of Europe and European Union agreements, and an even greater body of 'soft' recommendations issued by their respective institutions and agencies. However (*editor's note*) in practice, these texts often remain just words rather than effective guarantees for universally accessible healthcare system."[1] People without documents face tremendous difficulty accessing healthcare systems. As such, in each of the selected countries, this study analyses the primary barriers that exist when attempting to access healthcare. Often, the most limiting barriers include restrictive national or regional regulations, high financial costs of care, bureaucratic and administrative obstacles, etc., This study also outlines procedures and policies that facilitate access to HIV healthcare regardless of legal status.

[1] MdM International network, Legal report on access to healthcare in 12 countries, 8th June 2015.

Denying treatment to migrants with irregular status perpetuates HIV transmission and undermines efforts aimed at controlling the HIV/AIDS epidemic. Furthermore, interruptions to HIV treatment can lead to illness, the development of drug resistance and death[2].

Methodological Considerations

Migrants with irregular status refer to third-country nationals who do not have the required permit authorizing them to regularly stay in the surveyed country.

This study will review migrants with irregular status' access to healthcare in the following 10 nations: France, Germany, Greece, Hungary, Italy, the Netherlands, Poland, Serbia, Spain and United Kingdom. These countries were chosen because they are considered representative of the epidemiological, political, geographical and economic diversity of Europe. All states, with the exception of Serbia, are members of the European Union (EU). Note that the present study does not specifically consider asylum seekers, refugees, European Union (EU) citizens or other subgroups of migrants, such as pregnant women or children, who represent a lower percentage of the migratory population in Europe. In addition, it does not specifically consider existing regional laws and rules that are in force in various areas in a given country.

[2] Discrimination, Denial, and Deportation, Human Rights Abuses Affecting Migrants Living with HIV, Human Rights Watch, 2009.

Main international regulations in favour of the right to healthcare

An individual's right to health care is anchored in numerous international human rights treaties, which span time and place. Combined, these regulations consider the right to healthcare to be an absolute value that belongs to the natural heritage of any individual. It is a human right not connected to nationality or citizenship.

The following treaties and articles are foundational to this assertion:

-Art. 25 of the Universal Declaration of Human Rights (UDHR), General Assembly of the United Nations, 10th December 1948. (Appendix 1)
-Art. 12 of the International Covenant on Economic, Social and Cultural Right (ICESCR), General Assembly of the United Nations, 16th December 1966. (Appendix 2)

Additionally, the following specific regulations deal with the elimination of discrimination:

-Art. 5 of the International Convention on the Elimination of All Forms of Racial Discriminations (ICERD), General Assembly of the United Nations, 21th December 1965; (Appendix 3)
-Art. 10 and 12 of the I.L.O. Convention n. 143 Concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers, 24th June 1975; (Appendix 4)
-Art. 11 and 12 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), General Assembly of the United Nations, 18th December 1979; (Appendix 5)
- Art. 24 of the Convention on the Rights of the Child (CRC), General Assembly of the United Nations, 20th November 1989; (Appendix 6)
-Art. 25 of the Convention on the Rights of Persons with Disabilities (CRPD), General Assembly of the United Nations, 13th December 2006; (Appendix 7)
-Principles 17 and 18 of The Yogyakarta Principles on the Applications of Human Rights Law in Relation to Sexual Orientation and Gender Identity, International Service of Human Rights, 26th March 2007. (Appendix 8)

Leading European Laws Related to the Right to Healthcare

In addition to aforementioned international laws, conventions and articles, the following regional laws are essential to the European Union (EU) context.

1. The Charter of Fundamental Rights of the European Union (EU Charter),
2. The Treaty on the Functioning of the European Union (TFEU),
3. The European Social Charter (revised) (ESC(r))
4. The European Convention on Human Rights (ECHR).

The Charter of Fundamental Rights of the European Union (EU Charter)

The EU Charter is an internal set of rules that are legally binding within the EU. All institutions and bodies of the EU cannot violate the rights contained in the Charter when they negotiate or implement EU law and policy. The Charter specifically incorporates the right to healthcare in Article 35 (Appendix 9) and does not limit this right to health prevention and medical treatment. It states that access to a high level of human health protection is integral to all EU policies and actions.

The Charter can be used during the negotiation, implementation and litigation of EU laws and policies. During the negotiation process, The Charter can influence the development of laws and policies that are in line with human rights standards.

Once legislation or policy has been adopted, the Court of Justice of the EU (CJEU) can enforce The Charter. In 2012, CJEU declared that restrictions applicable to other liberties ensured by the Charter in the name of protecting human health were legitimate (CJEU September 6th 2012, case C-544d/10 Deutsches Weintor and G.) [3] On a national level, The Charter can ensure local and national authorities and courts appropriately implement legislation. That said, it does allow for variation between the laws and practices of national systems. National laws establish a minimum standard, but Article 52 on the scope of the Charter remains applicable, which shall not prevent

[3] Trattati dell'Unione Europea, a cura di Antonio Tizzano, II edizione, Le Fonti del Diritto Italiano, Giuffrè Editore, pag. 2610;

Union law to provide protection that is more extensive. CJEU may review national laws and measures in this regard.

During litigation, The Charter may be used to argue breaches human rights standards[4] by a created law or policy – or the means in which laws and policies are implemented by the EU or a member state. The application of The Charter is limited to those matters that fall within the scope of EU law. Although it does not make any distinction on grounds of nationality, it does make exercising the right to healthcare subject to national laws and practices.

The Treaty on the Functioning of the European Union (TFEU)

The Treaty on the Functioning of The European Union (TFEU) addresses public health in Article 168 (2012/C/326/01) (Appendix 10). In the field of health care, the EU plays a coordinating role that excludes, in principle, the possibility of adopting harmonizing regulations within the Union (final part of par. 5). The EU cannot intervene on behalf of national authorities in all cases when fundamental rights are violated, nor can the EU adopt legally binding acts that require member states to harmonize their laws and regulations. However, The EU can support, coordinate or supplement the actions of the member states (Article 6 TFEU). Given this, and given this document's area of focus, the EU's influence is derived from launching and funding programs that fight AIDS and other infectious diseases.

European institutions can also adopt, through ordinary legal procedures, incentives to protect and improve human health and the Council, upon the Commission's proposal, can give its recommendation. Art. 168, par. 7, provides a host of supportive services and opportunities to EU member states when defining health policy, organizing and supplying health services and medical assistance and allocating resources they are entitled to. These services and opportunities should be considered part of the encouraging action that art. 168 par. 2 comma 2 proposes with the aim to favour a major integration between national health systems at least in the border regions.[5]

[4] I. Butler, Background paper, Open society European Policy Institute, February 2013.
[5] Trattati dell'Unione Europea, a cura di Antonio Tizzano, II edizione, Le Fonti del Diritto Italiano, Giuffrè Editore, pag. 1518 e ss;

Secondary EU law regulates access to health care for individuals affiliated with a national health scheme in their EU Member States or in another state of the European Economic Area (EEA).

For migrants in an irregular situation who have been given either a period of voluntary leave or whose removal was formally postponed, Directive 2008/115/EC (Return Directive) 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, at art. 14 par. 1 b) is relevant. This directive confirms a state obligation to protect the health of irregular migrants (Appendix 11), guaranteeing emergency health care and essential treatment of illness. This directive further states that particular attention must be paid to vulnerable persons.

Other EU law instruments regulate access to health care for other categories of people. For people intercepted/rescued at sea by Frontex, Regulation EU n. 656/2014 (Rules on Frontex-coordinated sea operations) states, "participating units shall address the special needs of (…) persons in need of urgent medical assistance."[6]

The European Social Charter (ESC)

The European Social Charter (ESC) is a Treaty of the Council of Europe that guarantees social and economic human rights. It was adopted in 1961 and revised in 1996. It expressly guarantees the right to health in Article 11[7].

European Convention on Human Rights (ECHR)

The Convention for the Protection of Human Rights and Fundamental Freedoms, more commonly known as the European Convention on Human Rights (ECHR), states that the right to health protection is linked to the right to life, the prohibition of

[6] Article 4 par. 4.

[7] **Article 11ESC(r):** "…. The Parties undertake, either directly or in cooperation with public or private organizations, to take appropriate measures designed *inter alia:*

1. To remove as far as possible, the causes of ill-health;
2. 2. To provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. 3. To prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

torture and inhuman or degrading treatment or punishment. The ECHR protects this right indirectly.

Article 2 states that:

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
   (a) in defence of any person from unlawful violence;
   (b) in order to effect a lawful arrest or to prevent escape of a person lawfully detained;
   (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

Article 3 of the ECHR further states that:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

And Article 8 of the ECHR states that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others[8].

[8] For the interpretation of the ECHR, the international treaty in which all Council of Europe member states are party, see paragraph 5).

Country Profiles

Austria

Constitutional basis

In Austria *the Charter of Fundamental Rights of the European Union* and *the European Convention for the Protection of Human Rights* have constitutional ranks. *The Austrian Federal Hospitals Law (Bundesgesetz über Krankenanstalten und Kuranstalten – KAKug)* is another relevant legislation. Pursuant to paragraph 23 (1) KAKuG absolutely necessary medical assistance shouldn't be denied to anybody in public hospitals.

Main characteristics of national health system

The Austrian health care system is based on compulsory social insurance. Access to services is regulated by law, the most important legislative basis being the General Social Insurance Law (ASVG)" (Federal Ministry of Health and Women's Affairs). This federal law implements several European Union directives.

Austria has a very good health care system. Insurance is linked to employment/income, recipients of transfer payments, status of asylum seekers and recognised refugees.

Health insurance covers a broad range of services such as primary health care services, emergency care, ambulance services, dental services, maternity services, prescription medicines[9], mobile care and home care[10], preventive services, rehabilitation, care for people with disabilities and many more.

The Federation of Austrian Social Insurance says in its Report from March 2017 (38th edition) that, 99,9% of the population is protected by social health insurance.

---

[9] One has to pay a prescription charge (Rezeptgebühr) of 6€ for every medicine. One gets automatically exempted from it if the paid amount exceeds more than 2% of one's net income of the actual year. Additionally, people with low income can apply for exemption of this prescription fee. And PLHIV are automatically exempted. These regulations should make the system more equal for people who need a lot of medicines.

[10] Only medical services like wound care are covered. Basic care services are not included. Therefore, it is possible to apply for care allowance (Pflegegeld) for people in need of care. There are several care levels depending on the necessary amount of care time which has to be determined by a qualified physician. Nevertheless the care allowance does not come close to covering all costs of caring.

The financing of health care system consists of income-based social insurance contributions, public income generated through taxes and private payments in the form of direct and indirect co-payments. Social insurance is regulated by law and linked to employment. Health insurance is compulsory for all employees. The employer has to make sure that their employees are registered for social insurance. In case of self-employment, the insurance has to be applied for. The insurance contribution depends on the income level and is paid by payroll taxes, half by employers and half by employees. Close dependents are insured free of charge if they fulfil the requirements (Information from *Federal Ministry of Health and Women's Affairs*).

The public health insurance (*Gebietskrankenkasse - GKK*) provides self-insurance for those who are not insured via employment or via being a close dependent of someone insured and have their place of residence within Austria. For this, a residence registration (*Meldezettel*), a photo ID and a valid residence permit (not for EU citizens) has to be submitted. The monthly contribution is currently € 418,69 (01.01.2018). A decrease of this contribution can be applied for by form together with the insurance application. Within the first 6 months - regarded as a waiting period - no insurance benefits are paid. This waiting period does not apply in case of maternity care (8 weeks before the estimated date of childbirth) and if a compulsory insurance had existed in the last 12 months for 26 weeks or the person has had at least 6 weeks of insurance within the general social insurance immediately before the application for self-insurance. These exceptions are valid for Austrian citizens and citizens of an EU member state.

Access to healthcare for migrants with irregular status

The number of irregular migrants in Austria in 2015 is estimated between the maximum of 254.000 and a minimum of 95.000, which represents max. 2,9% and min.1,1% of the total residential population. The Migration council (*Migrationsrat*) made this estimation in their report in 2016. The Migration council is defined as an autonomous and independent board of experts and was originated by the former minister of interior Johanna Mikl-Leitner in 2014.

Migrants with irregular status have no access to the public health care system as it is always connected to a valid insurance.

Migrants with irregular status have access to treatment in case of a medical emergency, but have to cover the costs by themselves. The exceptions are pregnant women with irregular status, who have access to maternity care (§ 22 (4) KAKuG).

Certain infectious diseases however, are covered by the federal government if the person has no insurance.

The costs of a required TB treatment are covered, and during the period of TB treatment other existing diseases are treated as well (also HIV) but this stops with the termination of the TB treatment. (§38 Tuberculosis Law)

Pursuant to paragraph 10 (1) of the Law on sexually transmitted diseases, costs of the communicable diseases of gonorrhoea, syphilis, cancroid, LGV (§1) are covered if the patient is destitute and uninsured. The sexually transmitted diseases law appears somehow antiquated although it is still valid. For instance, it says that the welfare federation (*Fürsorgeverband*), which does not exist in this form anymore, has to cover the costs if there is no insurance existing. It also refers to a paragraph in the criminal law, which does not exist anymore. Nevertheless, a hospital is not allowed to reject people with the above-mentioned STI's. In practice, uninsured people with the above-mentioned STIs repeatedly receive an invoice from the hospital for the treatment costs. Due to the antiquated law and missing information of who is in charge of assumption of the costs, the invoice remains.

Prevention, testing, treatment and care of HIV for migrants with irregular status
Migrants with irregular status do not have legal access to HIV treatment and care within the official Austrian health care system.

Issues
Aids Hilfe Wien as an NGO provides HIV treatment for people without insurance. There are also some hospitals in Austria who try to provide treatment and care to people without insurance. These services are voluntary and have no legal basis.
Nationals without insurance also cannot access the public health system free of charge.

Good practices

NGOs, church institutions and committed physicians try to fill the gap due to the lack of access to public health services. These are helpful services but unfortunately, they are not sufficient, from some regions of Austria, people without insurance need to travel to Vienna to access health care services.

The AIDS support organizations (Aids Hilfen) in Austria are advocating for ensuring access to treatment for uninsured PLHIV and also help them by supporting their (re)integration into the insurance system, their application for self-insurance and/or refer them to organizations that are specialized on asylum law as asylum seekers are insured as well.

Finland

Constitutional basis

Section 19 of the Constitution of Finland ensures the right to social security. Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider.

Public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population.

Moreover, public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the wellbeing and personal development of the children. Public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing.

Main characteristics of national health system

In Finland there is a public healthcare system and there are also private health care providers.

Public healthcare is available to all permanent residents in Finland regardless of their financial situation. Primary health care services are provided by

municipal health centres and specialized medical care is provided by district hospitals. EU/EEA nationals on a temporary stay in Finland are entitled to state-provided medical treatment on provision of a European health insurance card, and can get information on accessing services from the Contact Point for Cross-Border Healthcare.

Travellers and visitors from outside EU or EEA country needing medical care can access health care via payment or travel insurance, at a private healthcare provider., Private healthcare is also available for those who prefer it.

The Finnish healthcare financing system is mostly taxed-based. Public services are complemented by private healthcare services and most of the regularly employed people are covered by occupational healthcare services.
Public healthcare in Finland is not totally free, though charges are very reasonable. Besides taxation, public healthcare is also funded by patient fees.

The maximum fees municipalities can charge are stipulated in the Act and Decree on Social and Health Care Client Fees. In 2016 the maximum out-of-pocket fee for treatment in primary health care ex. seeing a doctor at a health centre, is €20.90; this may be charged a maximum of three times per year. Fees for public healthcare have an upper limit per calendar year; beyond which clients are no longer required to pay (this does not apply to short-term institutional care). Maximum patient fees, including hospital and dental fees can be found at Ministry of Social Affairs and Health. (691 euros in 2016 / calendar year)

If the standard fees will undermine statutory maintenance obligations of clients or their families, municipalities must determine charges according to clients' ability to pay.

Access to healthcare for migrants with irregular status
The number of migrants with irregular status in Finland is estimated around 3000 - 3500. Migrants with irregular status can access all services but they are charged for them. Treatment and care of communicable diseases are exceptions in case of pregnancy and/or under the age of 18.

Prevention, testing, treatment and care of HIV for migrants with irregular status
Testing and diagnosis are provided free of charge but treatment is only provided in case of pregnancy and/or under the age of 18.

Issues
Migrant with irregular status cannot access the public healthcare where patient fees are regulated and limited to a maximum amount per year. Although private healthcare is available for anyone, it is too expensive and thus not accessible for migrants with irregular status.

Good practices
Services are provided by volunteers at Global Clinic and NGOs. These include legal, mental health, dental, housing (temporary) and other social services (food, clothes etc.) Education is also accessible until the age of 16 due to “Person's liability to participate in compulsory education”.
Some cities / municipalities provide treatment and care in case of pregnancy and/or under the age of 18, also in some cases hospitals might provide care and treatment for short period of time. Care is provided in most of the cases, but accessing medication for longer period is almost impossible.
NGOs working in the field of HIV also provide anonymous and free HIV testing and harm reduction services that is also accessible for migrants with irregular status.

France

Constitutional Basis

The preamble to the 1946 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.” Moreover, the Charter for the Environment

of 2004 [11] declares that “everyone has the right to live in a balanced environment which shows due respect for health”.

Main characteristics of national health system

The healthcare system in France is a social security system with a compulsory national insurance scheme providing universal coverage to individuals, based largely on the professional categories to which they belong. Article L 1110-1 of the Public Health Code states “health providers [and] health facilities (…) contribute to (…) guaranteeing equal access to healthcare for each individual as required by their health condition.” The system, managed almost entirely by the state, is complemented by elements of tax-based financing and complementary individual health insurance.

In January 2000, with adoption of the CMU Law of 27 July 1999 (Universal Health Coverage Act), France instituted basic universal medical coverage (CMU) and a complementary program (CMU – C), in order to provide statutory health insurance coverage to all individuals who meet the following criteria:

- The individual must have a low income (CMU-C is for those with the lowest incomes).
- The individual must be a French citizen, have a residence permit or have started the regularization process with proof of continuous residence for more than three months in France or French overseas departments/territories.

With this change, individuals who meet these criteria became eligible for health coverage, regardless of their employment status, for a period of up to one year. However, this scheme does not account for migrants with irregular status.

France also offers supplementary health insurance assistance (ACS), also valid for one year, which provides coverage to those not eligible for CMU and who have a lower income. Those who access ACS receive financial support (€100 – €150/year depending on age) for supplementary health insurance.

[11] Constitutional Act No. 2005-205 of 1 March 2005.

In July 2013 and again in May 2015, eligibility requirements for CMU and ACS were re-evaluated. These reforms initially broadened coverage to more than 500,000 individuals, a number that has expanded eight-fold over the following nine years[12].

Access to healthcare system for migrants with irregular status

According to Article L251-1 of the Social Action and Family Code, migrants with irregular status who have been residents in France for more than three months and who have low resources – a threshold which changes annually - are entitled to State Medical AID (AME). In order to receive coverage, individuals must prove their identity, their address and proof of residence for a minimum of three months. AME, which is financed through state taxes, gives qualifying individuals access to free health care for up to one year. Medical costs are fully covered, with the exception of prosthesis (dental, optical, etc.), medically assisted reproduction and medicines with limited therapeutic value.

Adult migrants with irregular status who do not comply with AME-requirements only receive state-sponsored emergency care. Those with resources above the threshold must pay for healthcare.

The PASS system

In 1998, France established the hospital PASS system through the Fight Against Exclusion Act of 29 of July – a law against social exclusion. This system aims to give anyone, even those without health coverage, access to free outpatient hospital care.

The DASEM (residence permit for medical reasons)

Foreign nationals who have resided in France since 1998 may be entitled to a residence permit for medical reasons and protection from expulsion in accordance with the Code of Entry and Residence of Foreign Nationals and Right of Asylum (CESEDA, now Article L.313-11 *Loi* n. 2007-1631). To qualify, the foreign national must reside in France, have a health condition that requires medical care in order to

[12] M. Crivellini, M. Galli, Sanità e salute, due storie diverse Sistemi sanitari e salute nei paesi industrializzati, p. 272, Franco angeli, 2011.

avert health consequences of exceptional gravity, and must demonstrate that access to the appropriate treatment cannot be guaranteed in their country of origin.

The permit for “private and family life” is for one year (renewable) if they have been in France for more than one year. If the foreign national has only been in France for a short period, they can apply for a provisional residence permit that gives care for a six-month maximum.

Normally, as long as a migrant has a proof of seeking a resident permit, or has a resident permit, they are eligible to the public health insurance, as French citizens (and not to State Medical AID, who concerns migrant in irregular situation). But due to the Bill named “Puma” that was voted in the end of 2015, there is a restrictive interpretation by administration of the list of documents that proved the process of regularization. The consequence of those practices for migrants is an increase of the difficulties to obtain a public health insurance.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

HIV testing, diagnosis (test + confirmatory test), treatment and care are provided free of charge in France. All migrants with irregular status have free access to public information centres, anonymous testing and diagnosis of sexually transmitted infections through the Centre Gratuit d’Information Dépistage et de Diagnostic, where people can receive information on sexually transmitted diseases and their prevention and testing.

France considers a seropositive status a medical emergency. Treatment costs for patients with no health coverage are covered by the PASS system or the Fund for Vital and Urgent Care (FSVU). This fund, created through Article L254-1 of the social Action and Family Code, finances essential care for people who do not meet the conditions for AME.

Pre-Exposure Prophylaxis (PrEP) for the prevention of HIV is available for all. However, being at risk of HIV infection, i.e. the rationale for using PrEP, does not qualify migrants with irregular status for residency permit for health reasons. In case

of a pending asylum requests etc. they have access to PrEP, similar to other health services.

Until 2016, migrants in irregular situation who had State Medical AID had a reduction for transport fees. After the regional elections of December 2015, right-wing regional government was elected in Île-de-France (Paris's region, with the highest density within France). The newly elected regional president decided to exclude migrants with such health insurance of the transportation fee reduction.

Issues

About AME:

A high percentage of migrants with irregular status residing in France, though technically entitled to AME coverage, do not receive it. As a result, there are numerous of illegal failures observed with regional variation across the country.

1. Documentation**.** Proving residency and information on economic resources is an obstacle for migrants with irregular status attempting to access AME. The documents required to prove these conditions are not consistent between social security agencies across the country.

2. Duration**.** Although AME is technically valid one year, in practice its duration is shortened by slow processing times. The one-year period begins on the date of submission, but often approval is not received for several months.

3. Renewal. AME can be renewed, and requests for renewal can be submitted two months before AME expires. However, the renewal process often takes more than two months, leaving a gap in coverage.

4. Identity Documents. Some migrants do not possess an identity document, meaning they cannot submit an AME request. Should they have these documents in another language, an official translator must translate them, which is not easily accessible and inexpensive.

About PASS system:

The application of this system is imperfect and varies in each hospital. There are no guarantees that people can find the needed service and it works only for outpatient care.

About DASEM:

The statement “absence of appropriate treatment” in the country of origin is subject to arbitrary and vague interpretation. As a result, the Ministry of Health made extensive clarification on 10 November 2011. Unfortunately, this clarification is not always followed.
However, the greatest challenges come from the system’s complexity. The temporary residence permit requires in individual to submit an appropriate identity document, evidence of their medical condition and evidence of a lack of adequate treatment in their country of origin. These challenges are further exacerbated by discriminatory practices, whereby some professionals and pharmacies deny treatments or medicines to migrants with irregular status.

About resident permit for medical reasons:

France has the particularity of having a resident permit for medical reasons for people who cannot have access to health care in their home country. This legal framework exists since 1998, and until 2017 the medical evaluation of applications was made by doctors of the Health Ministry. In parallel, Home Office services also checked the administrative conditions, as the lack of threat for public order. Since the 1st of January 2017, medical evaluation is made by doctors from the Home Office. Civil society fears that immigration control issues take the lead over medical and public health ones. Besides, the procedure has become more complicated. Its impact on the resident permit effectiveness should be evaluated in the following months after introduction.

Good practices

In addition to AME and FSVU, the PASS system and DASEM, NGOs in France (i.e. AIDES, Médecins du Monde France - MdM), are available to solve problems that arise during the administrative process.

Project “PARCOURS

In 2016 the National Research Agency on AIDS published its study, showing that 49% of people living with HIV within sub-Saharan community who reside in Île-de-France had contracted HIV **after** their arrival in France. These infections often have a link with the precariousness of life in France. This study exposes the importance of access to health insurance and a resident permit as soon as possible, for public health interest.

National law cases

Resident permit for medical reasons in France: Synthesis of two cases[13],[14] *- Protection against deportation for ill migrants*

Case reference: Conseil d’Etat, réf. 11 juin 2015, M. X., n° 390705

Summary

The *Conseil d’Etat* stated that the Regional Health Agency doctor’s (MARS) medical advice was unfavourable to the deportation of a migrant in irregular situation that could not have access to care in his country of origin. The Conseil stated this constituted a new element related to access to the procedure, which they termed “*référé-liberté”* (an emergency procedure when a fundamental right is about to be violated by a state measure). Although the administrative tribunal had already ruled on the obligation to leave French territory (“L’obligation de quitter le territoire francais”), the prefecture and the tribunal were not aware of this circumstance when they ruled on the person's situation.

Fact and procedure

[13] Edited by Nicolas Klausser, *Chargé de projet – Doctorant*, Aides, France.
[14] **Note : the pathology concerned in those cases is not HIV, but those « good practices » and the legal procedures described here concerned every pathologies.**

The police arrested a Georgian in irregular situation, who had been in France for a couple of months. Because of his irregular situation, he faced a deportation measure, and he was placed in an administrative retention centre in advance of deportation.

During his detention, he appealed the deportation measure based on illness; however, the administrative tribunal had already approved the deportation. The Regional Health Agency doctor then stated that because of this person's medical situation (Hepatitis C), he could not be deported to Georgia given that he could not access to the medical care needed. The Regional Health Agency Doctor's position permitted this person to legally remain in the country, because both prefecture (who decided the deportation in the first place) and the administrative tribunal were unaware of this element when they made their decisions.

It is important to note that the home office contested the medical advice of the Regional Health Agency doctor during the judicial debate in order to deport the individual.

-Counter-medical investigation from prefecture and the judge's control - Cour d'appel de Bordeaux, 3 février 2014, n° 13BX01932.

Summary

The medical advice of MARS was favourable for the delivery of a resident permit for medical reasons to a person who could not access medical care in his country of origin. Despite this advice, the prefecture of Dordogne denied the delivery of the resident permit because, contrary to MARS, it stated that medical care is accessible in the country of origin. The person concerned appealed this decision. The administrative tribunal of Bordeaux confirmed the prefecture decision, but the Appeal Court of Bordeaux did not. The Appeal Court of Bordeaux stated that the prefecture has not sufficiently demonstrated the existence of appropriate health care in the country of origin.

Fact and procedure

A migrant from Kosovo sought a resident permit for medical reasons (depression). MARS provided favourable advice for the delivery of this permit, but the prefecture did not. For motivation, the prefecture provided a letter from French embassy in Kosovo from 2010, alleging that medical care is available in Kosovo. The Appeal Court judged that with only this document, the prefecture had not proven the existence of appropriate health care in Kosovo for this individual.

Interestingly, the Court did not cancel the administrative measure, given that the prefecture is not competent for medical evaluation. Rather, the administrative measure was cancelled because the prefecture did not provide sufficient proof of available of medical care.

AIDES and several other associations specialize in the defence of the rights of migrants with health problems. They observed that in 63 cases related to counter-evaluation from prefecture when MARS evaluation was favourable to a resident permits, 62 judgments cancelled the denial of resident permit because the prefectures did not sufficiently prove the accessible medical care in the country of origin.

Germany

Constitutional basis

In Germany, the state's obligation to guarantee unhindered access to proper medical services is derived from the constitution. It declares human rights inviolable and inalienable, and dictates that the state must take active measures to ensure that people are able to make effective use of their fundamental rights.

The right to "physical integrity" is one of the fundamental rights of a human being within the scope of the Basic Law (*Grundgesetz,* 1949) for the Federal Republic of Germany. This fundamental right protects the physical and mental health of a human being, but it does not include social wellbeing.

Main characteristics of national health system

Germany is a Federal Republic and the regulation of health services is shared between the federal government, 16 federal states *(Länder)* and civil society organizations. In short, the federal government's role is to check and fix general rules, while the *Länder* work more closely with service management. Germany's healthcare system is funded by a statutory contribution system, organized through a contribution-financed obligatory health insurance system.

Germany has two insurance systems: a public statutory health insurance (GKV) made of health insurance funds (*Krankenkassen*), and private health insurance (PKV). In both systems, employees and employers share insurance payments. Compulsory insurance 'for long term care' (public or private) was introduced in 1995.

In 2009, the Statutory Health Insurance and Healthcare Competition Strengthening Act of 25 October 2006, was enforced, making it compulsory for all German citizens and long-term legal residents to have health insurance. Citizens and long-term residents can select either the public scheme (mandatory as of 2007), or the private scheme (mandatory as of 2009).

This change meant that people who were once excluded from the health insurance system had to be reintegrated. Though there is now universal coverage, some individuals had to write off unpaid healthcare service costs from before 2007 (public system) or 2009 (private system). Because many individuals struggled to repay their debt, Germany introduced a new law on August 11 2013 that reduced this debt.

The GKV provides insurance to nationals and non-German residents who earn less than a given threshold (€56 250 annually in 2016). To qualify, these individuals must also prove that they have a job in Germany and earn more than €451 Euro/month as of 2016. All others must activate a private health insurance.

GKV provides coverage for: preventive services, inpatient and outpatient hospital care, physician services, mental healthcare, dental care, optometry, physiotherapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, sick leave compensation. It does not cover all costs related to medical services. In some cases, small supplementary payments are requested for medications.

Access to healthcare system for migrants with irregular status

Those in Germany without documentation cannot receive insurance from a health insurance provider. Nevertheless, according to the Asylum Seekers Benefit Act of 1 November 1993 and successive amendments (AsylbLG), migrants with irregular status have a right to medical care. However, this stipulation only covers: treatment for acute illness and severe pain, antenatal and postnatal care, recommended immunizations, preventive medical tests, anonymous counselling and screening for infectious diseases. Migrants with irregular status are also legally entitled to access the emergency system (StGB 13 November 1998 and successive amendments).

However, with an evident legal contradiction, the Residence Act of 30 July 2004 *(Aufenthaltsgesetz-AufenthG),* Section 87(2) 2, states that "any public institution shall notify the competent foreign nationals registration authority forthwith, if, in discharging their duties, they obtain the 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 Code" (commonly referred to as *'Denunziationsparagraphen'*, Duty to Denounce). This means that whenever a migrant with irregular status enters a doctor's office, they risk being reported to immigration authorities, and possible deportation. In September 2009, in an effort to limit this duty to report, *Bundesrat* issued an instruction ("verlängerte Geheimnisschutz"), which binds hospital administrative and medical staff and social services departments with medical confidentiality, should they obtain information on the status of a migrant with irregular status in hospital emergency department. The regulation only takes effect in cases of emergency treatments and it is not well known in Germany and non-binding. In practice, health coverage for migrants with irregular status is limited to emergency services, and access to this coverage is still threatened by the medical professional's duty to report.

The German Residence Act [15] allows foreign nationals, including migrants with irregular status, to have a residence permit. [16] Pursuant to Article 25 (3) and in conjunction with Article 60 (7) of the Residence Act, a residence permit shall be granted to a foreigner facing a serious and concrete risk against their life and physical integrity or freedom if returned to the country of origin. Article 25(4) of the Residence Act deals with temporary residence permits on urgent humanitarian or political grounds and can inter alia be applied to cases in which urgent personal grounds arise. The granting of a residence permit, where judicial or *de facto* reasons render the departure of the migrant impossible, is allowed under Article 25 (5).

In case of chronic diseases, such as HIV/AIDS, a doctor's declaration of the following conditions can lead to the issuance of a residence permit for humanitarian reasons:

1. The applicant is unable to travel or cannot stop treatment in Germany.
2. The applicant is able to travel but the treatment required by their condition is not possible in their country of origin or not available to them due to lack of financial resources.
3. The applicant is able to demonstrate that there is a serious risk to his health in his country of origin.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

The Law on Preventing and Combating infectious diseases in humans of 20 July 2000 (Protection against Infection Act) stipulates in section 19 that migrants with irregular status are entitled to counselling and testing for transmissible diseases and outpatient care. Theoretically, the law also provides free HIV/AIDS treatment if the patients cannot bear the costs. In order to receive public subsidies from the social welfare office, the patient must apply for an illness certificate (*Krankenscheien)*. However, the duty of denounce still prevents effective access to care. In practice,

---

[15] *Aufenthaltsegestz vom* 30 July 2004 (BGBl. I S. 1950) *zuletzt geändert durch das Gesetz zur Umsetzung aufenthalts-* und *asylrechtlicher Richtlinien der Europäischen Union vom* 19 August 2007 (BGBl. I S. 1970). Retrieved on 1 June 2008.

[16] **Article 25 Residence Permit**
(3) "A foreigner should be granted a residence permit if the conditions for a prohibition of deportation are fulfilled in accordance with Section 60 (2) (3), (5) or (7)."
(4) "A foreigner, who is not subject to a final deportation order, may be granted a residence permit for a temporary stay if his or her continued presence in the Federal territory is necessary on urgent humanitarian or personal grounds or due to substantial public interests."
(5) "A foreigner who is subject to a final deportation order may be granted a residence permit if his or her departure is impossible in fact or in law and the obstacle to deportation is not likely to be removed in the foreseeable future."

only those who can demonstrate a serious risk to their health in their country of origin can apply for *duldung* and get access to treatment.

HIV testing and diagnosis are anonymous and free of charge. In every large German city, there are medical centres (Gesundheitszentren or Gesundheitsämter) that are accessible to all and offer anonymous services (testing and counselling). Tests are either free or only cost a small amount (usually around 10 or 15 Euro) and people do not need to provide their names.

Issues

1. Insurance Providers. If citizens (or long term residents) want to be insured by a private health insurance provider, they will have to answer many questions or be examined by a doctor. They will be asked whether they were sick in recent years, took medications or drugs and whether they are HIV-positive. The health insurance provider is entitled to charge extra premiums or reject a standard application depending on the state of health. However, private health insurance providers must accept anyone who is not eligible for statutory health insurance and whose medical costs are not covered by the state. If citizens have a chronic illness (such as HIV), they can only be insured at a more expensive rate called *"Basistarif".*

2. Regional Variation. National regulations are often interpreted and implemented in very different ways in different German states, making it very difficult to generate general statements.

3. Duty to Denounce. AsylbLG technically guarantees limited access to medical provisions for migrants with irregular status. However, in practice the Duty to Denounce limits access, given that procedures for reimbursing emergency medical costs is confidential, but non-emergency reimbursement is not. As a result, migrants with irregular status can only access outpatient services from either independent physicians who would waive their fees or from health providers who refuse to report migrants with irregular status to the immigration authorities.

About the residence permit

Article 5 of the Residence Act stipulates general requirements for residence permits, which includes confirmed identity, sufficient means of subsistence and appropriate standard of accommodation. While the residence permit mentioned under Article 25 (3) is exempted from compliance with all requirements, the other two residence permits (Article 25 (4) and (5) may be exempted from all or some requirements only at the discretion of the issuing authority.

Good practices

In addition to the resident permit, migrants with irregular status who are not in touch with medical professionals offering free treatments can rely on assistance provided by non-governmental organizations, such as locally based AIDS service organizations, *Büro für medizinische Flüchtlingshilfe, Malteser Migranten Medizin, Ärzte der Welt*. Their contribution is remarkable – they often negotiate with insurance companies and authorities giving migrants with irregular status access to treatment – but they certainly cannot compensate the inaccessibility of the public healthcare system. Their restricted resources mean that they cannot sustain the cost of intensive or in-patient treatment.

Some existing models do try to improve medical care and treatment for migrants with irregular status in Germany, such as the case of *"Anonymer Krankenschein" in Lower Saxony (Hannover and Göttingen)* and the *Münchener Modell*. However, they largely focus on acute illness and pain. None of them can cover the cost of HIV therapy on the long term.

Recently, local authorities, health professionals and NGOs have called on the German government to change law on reporting migrants with irregular status[17].

[17] See htt://picum.org/en/news/picum-news/48359.

National law cases

About the residence permit under Article 25 (3)

According to the prevailing case law of the Federal Administrative Court (*Bundesverwaltungsgericht*) these conditions are *inter alia* applicable should the person concerned face a grave and serious health impairment shortly after return because the illness cannot be adequately treated in the country of origin. Once these requirements are met, the applicant is entitled to obtain a residence permit. With the exception of atypical and exceptional circumstances, the competent authority is obliged to come to a positive decision[18].

Greece

Constitutional basis

Article 21 Par. 3 of the Constitution of Greece of 1975 states that "the State shall care of the health of the citizens and shall adopt special measures for the protection of youth, old age, disability and for the relief of the needy." Article 5 further states that everyone has the right to health protection and genetic identity (par. 5) and that everyone within the Greek territory shall enjoy full protection of their life and their dignity without distinction of nationality, race, language, religion or other belief (par, 2). As it is accepted according to this article, it is prohibited to discriminate in the health sector – an obvious and necessary prerequisite for the preservation of life.

Main characteristics of national health system

Law 1397/1983 is the basis for the Greek health care system, as it introduced the notion of the National Health System. Article 1 states that health is a social good that the state should equitably provide free of charge at the point of delivery, regardless of social and economic status.[19] Law 3918/11, which created the National Organization

[18] So, Undocumented And Seriously Ill: Residence Permits For Medical Reasons In Europe, PICUM, *Brusseles,* 2009, p.21.
[19] C. Economou, Greece: health system review, Health system in transition, 2010, vol 12, n. 7.

for Healthcare Provision and Law 4238/14 on primary healthcare reformed the system, creating a central health fund, *EOPYY.*

The Greek healthcare system is a mix of public and private sectors. The public healthcare system (ESY) is based on social insurance and is primarily financed through a mandatory contribution related to worker's insurance. The private sector is financed from out-of-pocket payments and by private health insurance. Today, out-of-pocket expenditures are increasing because of austerity measures and the for-profit restructuring of the health care system.

All Greek citizens and non–national legal residents are entitled to access to free healthcare services from the National Health System, assuming they have registered employment and regular status. Because this coverage has been related to employment, uninsured people – both nationals and non-nationals – have had difficulties accessing healthcare.

EOPYY guarantees free primary care services for citizens with insurance and it is obliged to cover all citizens, including the unemployed. The public budget or the European Social Fund can provide coverage to those without health insurance, but this is an option available to few people.[20]

The Common Ministerial Decree n. 48985/2014 has improved access to healthcare for nationals and non-nationals who hold regular status but no health coverage. However, these improvements apply only under certain conditions.

A hospital committee decides who has the right to free medical aid on a case-by-case basis. In practice, this acts as a barrier to healthcare.

Law 4368/16 has delinked access to free/affordable healthcare and medicines from employment status, giving access to uninsured Greek citizens and non-national legal residents. In practice, many components remain to be implemented.

[20] The proportion of the yearly average of ESF beneficiaries in Greece in relation to the total population between 15-64 years was a little bit more than 4%, fifth highest in the EU (2000-2006). [European Union, The European Social Fund and Health, 2010, p.5]

HIV-specific services and medicines delivery are state-funded and administrated for free. However, there is a recent trend to move into co-payment schemes regarding monitoring of HIV (i.e. viral load RNA tests).

Budgets for antiretroviral medicines are part of the general pharmaceutical budget of each hospital hosting an HIV unit. The Government has announced working on a new model of closed independent budgets for ARV medicines.

Access to healthcare system for migrants with irregular status

In Greece, adult migrants with irregular status are not entitled to healthcare, except in cases of emergency. In fact, the recently introduced Law 4251/2014 (the new Migration Code) prohibits healthcare for migrants with irregular status.[21]

A recent legal provision (Law 4368/2016 expands access to the state healthcare system through a parallel registration system to undocumented residents, (KYPA – Foreigner's Healthcare Card), yet to be implemented.

In early 2018 both laws are still in place. Since KYPA is not implemented yet, the contradiction between the 2014 code law and 2016 application law has not been dealt with. In the meantime, existing legislation provides access to migrants with irregular status depending on their health status.

Only in cases of emergency - and the concept of urgency is a medical-technical definition decided by attending physician – does the state provide hospitalization, financed healthcare and treatment for infectious diseases including HIV. This lasts only until stabilization of the health condition is achieved.

A Common Ministerial Decision (GG 1453 of 5 June 2015) – and before the Law 3907/2011, amending Law 3386/2005 - provides that persons suffering from serious

[21] See Article 26§1 that states: "Public services, legal entities of public law, local authorities, public utilities and social security organizations shall not provide their services to third-country nationals who do not have a passport or any other travel document recognized 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".
And see also Article 26.2a (As Law 2910/2001) that contains an exception for minors and pregnant women.

health problems, including foreigners, are entitled to have a residence permit for humanitarian reasons.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

Greece provides HIV testing, diagnosis (test + confirmatory test), treatment and care free of charge for migrants with irregular status. Specifically, a Common Ministerial Decision, (93443 of 18 August 2011) foresees that all people living in Greece, including migrants with irregular status, have access to testing and treatment for HIV and other infectious diseases 'until their health condition is stabilized'. As a result, migrants with irregular status who do not have access to ARV therapy in their home country are entitled both to treatment and a temporary residence permit for the duration of their treatment.

Law 4268/2016 provisions that in order for a migrant with irregular status to have access to the healthcare system and medicines it requires certified disability of 67% and above. With the implementation of the KYPA card the prerequisite of disability for migrants with irregular status will be seemingly revoked, showcasing an internal inconsistency of the law. Since the KYPA card system is not implemented yet, migrants with irregular status have limited access to care for acute medical conditions and primary care.

Diagnostics and medicines for conditions other than HIV are harder to access for migrants with irregular status, since they have no access to co-payment schemes outside the state health system.

Issues

1. Non-Emergency Access. Foreigners with irregular status are deprived of the right to healthcare and are not admitted to hospitals and clinics for non-emergencies. In addition, they do not qualify for coverage as uninsured or under the social protection certificate.

2. Social Insurance for HIV Testing. Although HIV testing is free for everyone, some HIV healthcare services demand social insurance in order to provide free testing. This practice makes testing either non-free or non-anonymous.

3. Regional differences. Greece has a national health system, which is supervised by the central government and not by the regional or local authorities and, in practice HIV services are centralized around the capital (Athens). Northern Greece has only one big HIV unit and access to HIV services - especially for people living in the islands - demands travelling. Patients living outside Athens, Thessaloniki and Patras usually pay couriers to have their ARV medicines delivered.

Good practices

In addition to the resident permit for humanitarian reasons, mobile units and stable structures of NGOs (e.g. PRAKSIS, Checkpoints etc.) offer free and anonymous testing for HIV in collaboration with some communities of migrants in the centre of Athens, Piraeus, Thessaloniki and Patras. These clinics provide information on HIV, condoms, counselling, and free and anonymous rapid testing.

Greece's legal frame became problematic in 2013 when the Ministry of Health re-established Decree 39a, giving authorities the option to enforce mandatory HIV testing among migrants, drug users and sex workers. Fortunately, this decree was repealed in April 2015 by the subsequent government, partly in response to civil society's pressure and continuous action.

Hungary

Constitutional basis

The Fundamental Law of Hungary (2011), Article XX Paragraph (1) declares, "Everyone shall have the right to physical and mental health." The Healthcare Act, which sets general rules in the field of healthcare, emphasizes the importance of equal access and equal treatment.

Main characteristics of national health system

In 1990, Hungary introduced a compulsory state health insurance system. To access free healthcare services, one must have a valid national health insurance, which can be obtained through employment or as a pensioner or student. Those that do not fall under one of these categories must personally pay for insurance. The National Health Insurance Fund (HIF) provides universal population coverage throughout the country, without disparities. The Act on Local Governments assigns responsibility for arranging the provision of primary healthcare services to local governments.

Certain health care services fall under the category “urgent need,” defined by a Ministerial Act. In these cases, healthcare is provided to all – even those without health insurance. Several diseases and conditions are listed under urgent need, including ‘infectious diseases/conditions that by themselves or as a result of their complications cause a life threatening conditions’. However, the State Secretary of Health and the HIF do not consider HIV/AIDS to be categorized as “urgent need.” As such, HIV-care and antiretroviral therapy are not considered urgent lifesaving health services.

Access to healthcare system for migrants with irregular status

Migrants with irregular status are not entitled to coverage under the Hungarian health insurance scheme. They do not have access to any free healthcare services besides emergency care, which is immediately provided free of charge to citizens and non-citizens under the Health Act.

Since it does not provide any conditions on grounds or residence status, it can be assumed that migrants with irregular status are covered by this provision and the costs are covered by the HIF. In terms of other medical services, migrants with irregular status must pay. If they cannot, the costs of the health care provider are reimbursed by HIF.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

HIV testing is free of charge, for treatment see above.

Issues

1. Defining Urgent Need and Emergency Care. In the absence of a clear definition of urgent need/emergency care, health providers interpret what constitutes as urgent and an emergency. This results in many differences of interpretation among hospitals and competent authorities, and variation in reimbursement.

2. Xenophobia. The recent waves of xenophobia in Hungary are another obstacle when trying to extend healthcare for people with irregular status.

Good practices

The OLTALOM – Hospital in Budapest is a private hospital that provides free direct medical assistance to uninsured people (homeless and migrants with irregular status). Many other NGOs (the Hungarian Civil Liberties Union, the Hungarian Helsinki Committee, Menedék- Hungarian Associations for Migrants) also try to help migrants with irregular status.

Italy

Constitutional basis

The Italian Constitution states, in Article 32, that: “the Republic protects health as a fundamental right of each individual and as the interest of the community, and guarantees free assistance and treatment to the poor.” Furthermore, in Article 2 it states, “The Republic recognizes and guarantees the inviolable rights of the person, as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled.”

DPCM of Jan 12, 2017 (the President of the Council of Ministries' Decree) has established the LEA (Livelli Essenziali di Assistenza – Essential Health Assistance Levels). Art. 63 par. 4 of the LEA states that "foreign minors present on the national territory are eligible for enrolment in the National Health System and can access health services benefitting of the same terms and conditions offered to Italian citizens, even if undocumented".

Main characteristics of national health system

The Italian National Health Service (SSN) was founded with Law n. 833/1978 and later reformed in 1992-1993. Based on the model of the UK National Health Service, a public system aims to grant universal access to an equitable level of health care throughout the country.

The SSN operates at three levels: a central level, a regional level and a local level. The central government (central level) and 20 regions (regional level) share the responsibility to provide health care. The State guarantees access to healthcare for everyone throughout the country with general health laws. The regions, which have exclusive competence to regulate and organize the health care system, must implement the general aim with regional health law. Local Health Administrations (ASLs) in turn provide health care services at the local level.

The system is financed through general taxation (direct and indirect). The ASLs also receive payment of 'tickets' - moderate fees proportional to one's income and social or health status.

The Italian health system provides universal access for nationals, residents and regular migrants.

Access to healthcare system for migrants with irregular status

Migrants with irregular status do not have the right to register with the Italian National Health Service. However, in 1998, health care became ensured to migrants with

irregular status in particular areas as a result of the *Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e sulla condizione dello straniero (T.U.),* (Single Text on the provisions governing immigration and the status of foreigners) - the basic law on immigration (D.L.vo 286/1998).

Testo Unico regulates the access of foreign citizens staying in Italy who do not comply with entry and residency regulations. According to Art. 35 3. they are entitled to urgent or otherwise essential care in public outpatient health facilities and in hospitals, even when in need of continuous care, for illness and injury, and they can benefit from health prevention programs to safeguard individual and public health. The following services are ensured:
a) social protection of pregnancy and maternity; b) protection of the child's health; c) vaccinations; d) international prophylactic interventions; e) prophylaxis, diagnosis and treatment of infectious diseases.
Benefits described in paragraph 3 shall be offered without any charge to applicants in case they do not have sufficient economic resources, with the exception of the shares of equal participation with the Italian nationals. Access to healthcare facilities by foreigners not complying with residency legislation cannot involve any kind of reporting to the authority, except in those cases in which the report is mandatory, on equal terms with Italian citizens.
In some Regions, undocumented migrants can also access public facilities providing primary care (GPs). In other Regions, primary care is guaranteed only by NGOs. In some instances, access to health care is more difficult for foreigners who come from another EU country but do not have the European Card for Health Insurance (Tessera Europea Assicurazione Malattia) than for undocumented migrants.

Article 1 of T.U. 286/1998 ensures that foreign nationals, when in Italy, have access to fundamental human rights. Article 35 T.U. 286/1998 ensures that irregular foreign nationals in Italy have access to outpatient and hospital urgent and essential medical care, which includes continual treatment, preventive care, and care provided for public health reasons. This includes prenatal and maternity care on an equal basis with Italian citizens, care for minors, vaccinations, activities of international prevention, and the diagnosis and treatment of infectious diseases.

In Italy, migrants with irregular status are defined as *"Stranieri Temporaneamente Presenti"* (temporarily residing foreigners). Article 43 of D.P.R. 349/1999 *"Assistenza sanitaria per gli stranieri non iscritti al Servizio Sanitario Nazionale"* (Health care for foreigners not registered in the Italian national health care system), provides these individuals with an anonymous "STP code" that guarantees access to some of the aforementioned treatments free of charge, in addition to the attribution of "indigence status". A public health authority – either the hospital administration or the local health administrators – issues this STP code. It is provided free of charge and valid throughout Italy for a renewable period of up to 6 months. Worth noting is that different regions enforce national laws differently and thus provide different coverage.

The Ministry of the Interior covers the costs incurred for providing urgent and essential health care to migrants with irregular status. The National Health Fund covers costs for other care services, as mentioned in article 35 T. U. 286/1998). Article 35 of T.U. 286/1998 clearly states that authorities should not be informed when migrants with irregular status seek health care. Article 36 of this same law states that migrants and foreign nationals can request and obtain a specific visa and the related residence permit for health care.

Moreover, Article 5 (6) of the T.U. 286/1998, defines the scope under which a residence permit may be refused by the Italian state. It stipulates that revocation or refusal can be based on conventions or international agreements should the applicant not satisfy the conditions of stay in one of the contracting states. However, cases will be exempt when serious matters of humanitarian character or individual rights arise from constitutional or international obligations. This text serves as a legal basis for residence permits on humanitarian or constitutional grounds. It provides the possibility of granting an atypical residence permit to severely ill migrants with irregular status already residing in Italy. However, Italian authorities have ample margins of discretion when granting it.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

HIV testing, diagnosis (test + confirmatory test), treatment and care, in addition to hospitalization in inpatient and outpatient clinics are ensured at the same conditions guaranteed to Italian citizens.

Issues

1. Regional Variation. Although the Italian health care system provides equitable health coverage to migrants with irregular status, in practice the law is not evenly implemented throughout the country or in all circumstances. Important differences still exist among the twenty regions and among the different hospitals and ASLs.

Naga- Associazione volontaria di assistenza socio sanitaria per i diritti di stranieri e nomadi, is an organization based the Lombardy region that provides social and health assistance to foreigners and temporarily residing persons. It recently conducted a survey to document and denounce cases of inequitable application of the law[22]. The results of this survey are discouraging: a large gap exists between law and practice, and the general legislation on health care for migrants with irregular status is not rightfully applied in Lombardy. There is evidence of failures to comply with current legislation and extremely different procedures are adopted in the hospitals, at the discretion of the hospital management or of individual healthcare staff.[23]

2. Lack of Knowledge. The lack of knowledge about current legislation does not only affect healthcare providers. Evidence shows that in Italy, many migrants with irregular status are not aware of their rights. Differences between legal citizens and migrants with irregular status persist, particularly in regards to difficulties faced when trying to access testing and treatment services. Often, these difficulties stem from a lack of information, ignorance, cultural and language barriers, and fear of being arrested.

Besides lack of information, ignorance, cultural and language barriers, frequent moves and short stay in the different cities/areas also contribute to the difficulties for migrants with irregular status when accessing health care services and retention in care.

[22]Naga, Health is (not) permitted. Survey on access to health care for undocumented migrants in hospitals in Milan, from January 9, 2014 to February 28, 2015.
[23] Cfr. Abstract of Naga, Health is (not) permitted. Survey on access to health care for undocumented migrants in hospitals in Milan, from January 9, 2014 to February 28, 2015.

Good practices

As in many other countries, Italy assists unregistered migrants within the national health care service, as documented by local level experiences with voluntary organizations, community groups and NGOs. Italy also issues residence permits for humanitarian reasons.

NGOs (Naga, Caritas, LILA) give support and provide basic social and health care and some specialized care. They try to bridge the gap between law and practice, making efforts to address these issues by publishing and disseminating guides, and targeting specific groups[24].

National law cases

The Italian Constitutional Court has defined the right to health as a "primary and fundamental right that (…) requires full and comprehensive protection." It must be provided to anyone, and therefore considered as a public service for every person[25].

The Constitutional Court stated in decision n. 309/1999, that the right to health protection warrants specific and central focus, as it is related to the deep substance of human dignity. The Court also ruled that the alien citizen has a basic right to health, which must be extended to foreigners, no matter their legal residency status in Italy. Furthermore, the expulsion of a severely ill migrant is detrimental to each person in Italy's right to access essential and continuous health care pursuant to Article 2 and 32 of the Constitution (Constitutional Court, judgment 252/2001 but see also decisions 269/2010, 299/2010 and 61/2011).

The administrative courts (Tar of Lombardy and of other Italian regions as Piemonte, Lazio and Sicily) state that requests for residency permits must be assessed and released even if the request has been presented by a migrant with irregular status[26].

[24] 'It seems useful to mention the case of the *Centro di Salute Internazionale e Medicina Transculturale* (Centre for International Health and Transcultural Medicine) established by the Local Health Care Office (ASL) of Brescia, which recently also developed a local Epidemiological Observatory of Immigrants. The structure not only provides health care benefits to legal and illegal immigrants, but also monitors the health conditions and the most common diseases of the migrant population.': A. De Petris, Constitutional provisions and health care services for illegal immigrants in some federal and regional EU member states: looking for best practices, Working Paper 6/2014, Luiss Guido Carli, Dipartimento di Giurisprudenza, Roma;
[25] Constitutional Court, decision 992/1988; see also decisions 88/1979, 132/1985, 61/1987.
[26] Lastly, T.A.R. Palermo, May 28 2015, sentence n. 1252.

A person suffering from severe illness who does not have the possibility to obtain adequate medical treatment in the country of origin should not be expelled.

The Supreme Italian Court of Cassation *(Corte di Cassazione)* has defined the right to health as an "absolute and primary right" that cannot be conditioned nor influenced by any legal status[27]. Furthermore, it stated that HIV positive migrants with irregular status cannot be expelled from Italy if they are undergoing treatment with 'lifesaving medicines' or 'in any case necessary to avoid the worsening of one's health conditions'[28]. HIV treatment falls into these categories.

Republic of Macedonia

Constitutional basis

There are several legal documents that guarantee the right to health in Macedonia: the Constitution, Health Protection Law, Patients' Rights Law, Law on protection of the population from infectious diseases, and Health Insurance Law.

Article 39 of the Constitution of Republic of Macedonia prescribes: The right to health care is guaranteed to every citizen. The citizen has the right and the obligation to protect and promote their own health and the health of others.

The Patients' Rights Law also proclaims the principle of availability of health services for all patients equally and without discrimination.

Additionally, the Health Insurance Law also prescribes that the right to health insurance can also be exercised by refugees and people under subsidiary protection (as specified in the Convention relating to the status of the refugees and its Protocol).

Main characteristics of national health system

By the law, every citizen is entitled to mandatory health insurance. However, in practice, according to statistical data, this provision is not fully implemented. According to the State agency for statistics, the population of Macedonia is 2.072.490.[29] According to the date from the State Fund of Health Insurance, the

[27] Cass. S.U. 796/1973 and S.U. 999/1973.
[28] Cass cases n. 7615/2011 I civil section e n. 145000/2013 S.U..
[29] http://www.stat.gov.mk/

number of users of health insurance is 1.870.761[30]. The missing people do not have health insurance due to administrative obstacles, loopholes in the laws of employment, unregistered childbirths etc.

In Republic of Macedonia, healthcare is financed by mandatory contribution for all citizens of the country. This covers a certain set of health services prescribed in the Health Insurance Law. The law allows insurance of dependents: spouse, children born both out and in wedlock, as well as adopted children.

Lately, besides mandatory state insurance, citizens can additionally opt for an optional insurance by private insurance companies for services not included in the mandatory insurance, but this is still not very popular among the population.

In the country, there are state health institutions as well as private health institutions; also some of them function as a public – private partnership.

There is a special National HIV Program (officially: Program for the protection of the population from HIV/AIDS) financed by the state budget (and not by the State Health Insurance Fund) through which antiretroviral treatment and basic monitoring tests (CD4 count and VL) are provided.

All the other health services related to HIV care are covered by the health insurance as specified in the Law on Health Insurance. Normally, for all services that are covered by the health insurance patients in general are required to pay a co-payment. However, the co-payment for most of the services related to the HIV care for people living with HIV are covered through a separate program of the Ministry of Health (Program for participation in the use of health protection for certain diseases), which prescribes that people living with HIV are exempted from the co-payment only for services related to their HIV care.

However, in practice people living with HIV can use this exemption only when using HIV related health services at the University Clinic for Infectious Diseases and Febrile Conditions, as the only center for HIV care and not from other health institutions, even when the services they are receiving are part of their HIV care.

Access to healthcare for migrants with irregular status

Migrants with irregular status do not have state health insurance thus cannot access healthcare services within the public healthcare.

[30] http://www.fzo.org.mk/default.asp?ItemID=8754C32D4C42FE4DAE4394F4D7584EB6

Prevention, testing, treatment and care of HIV for migrants with irregular status

Access to HIV testing, diagnosis and treatment for migrants with irregular status is not specifically regulated by the law. In practice, HIV testing is available as anonymous in non-governmental organizations and in state public health centres across the country, so no ID or proof of citizenship is needed. Since this is available free of charge for citizens, non-citizens can also obtain these services due to the anonymity.

Also, in the State Program for protection of the population from HIV/AIDS there is no restriction regarding the users of antiretroviral therapy, so it can be interpreted that any person with HIV, including irregular migrants who do not have any documents, would be able to receive antiretroviral therapy and CD4 count and VL test. However, the implementation of this in practice would be very difficult, considering that all other related services (including the consultation with a specialist and other tests performed) would require a health insurance or would need to be charged the full price.

However, in practice, so far there are no officially recorded cases in which migrants with irregular status attempted to access HIV care.

Off the official record, the Association for support of people living with HIV - Stronger Together, Skopje is familiar with a case when a person without citizenship asked for health services related to HIV few years ago. The person did receive HIV care over a period of 1 year and more, but this was achieved due to the good will of the medical specialists who found a way to use specific loopholes in the procedures back then, and not through a regular procedure.

Issues

As there is only one specialized health institution for HIV treatment and care, located in the capital city, Skopje, there are regional differences in accessing HIV care and treatment services for people with HIV living outside the capital city.

Good practices

NGOs provide legal, social, and housing services for anyone regardless of their status.

The Netherlands

Constitutional basis

According to the Dutch Constitution, the Government has a duty to ensure social security for all, the distribution of wealth (Article 20), and public health (Article 22). Article 1 (equal treatment), Article 10 (the right to respect and protection of personal privacy) and Article 11 (the right to the inviolability of one's person) are also relevant to the right of health.

Main characteristics of national health system

Since 2006, The Netherlands has had a single compulsory health insurance scheme, operated by a series of private health insurance companies. Competing insurers negotiate with providers on price and quality, and patients are free to choose the provider and policy that best suits their needs and preferences. The government's responsibility is to control quality, accessibility and affordability of healthcare.

All regular residents in the Netherlands are obliged to take out health insurance that covers a standard package of essential health care, determined by the government. This includes visits to general practitioners (GPs) or specialists, outpatient treatments in hospital, hospitalization, emergency treatment, transport to the hospital, maternity care, obstetrics, and mental healthcare. To cover costs beyond the standard package, regular residents can purchase supplementary insurance. Private insurers, entitled to pursue profits, freely determine the associated premiums.

Insurers negotiate with health care providers on price and quality. They offer competing health insurance policies. The nationals / citizens are free to choose the health insurer they prefer and join the one which best fits their personal situation. Your own risk – the amount that has to be covered out of pocket – is €385 in 2017.

Insurance holders have to pay a fixed (elevated) monthly premium, which currently ranges between €82 and €112. In addition, they must pay an elevated fee for actually accessing healthcare services and treatments. Following these two payments,

individuals pay no additional costs for services included in the government-defined standard package.

Although the government claims this system to be an effective balance between social need and free market dynamics, there is an increasing number of patients facing poverty who struggle to pay the service fees. In order to pay lower monthly premiums, they often opt for a higher franchise.

Authorized residents on a low income have a right to financial help.

Access to healthcare system for migrants with irregular status

Migrants with irregular status are not entitled to take out health insurance in the Netherlands. The Linkage Act of 26 March 1998 (or the Benefit Entitlement Act) linked certain rights, including the right to state medical insurance, with the condition of authorized residence. As a result, non-residents are not allowed to the Dutch social insurance scheme. However, following the Aliens Act (2000), migrants with irregular status gained the right to emergency care, "care that is medically necessary," and care needed "in situations that would jeopardize public health." [31]

In the event that a migrant with irregular status does not have alternate healthcare insurance – as is often the case – the migrant is expected to personally pay for health services rendered. In theory, if they are able to prove that they cannot pay, health care providers, hospitals and pharmacies will provide care or treatment and then seek reimbursement from a specific public financial arrangement of the Central Administration Office for persons that cannot be insured. GPs can recover 80% of their consultation costs, but in the case of secondary care, medical costs are only reimbursed for the hospitals that previously entered into an agreement with the healthcare authorities.

Article 64 of the Aliens Act 2000, in conjunction with Article 3.46 of the Aliens Decree 2000, states that the expulsion of a migrant with irregular status can be suspended

[31] In 2007, an independent commission of medical (and social and legal) experts, clearly defined 'medically necessary care': doctors must provide adequate and appropriate care by following the same guidelines, protocols and code of conduct that medical and academic professional organizations adhere to in care for any other patient. Healthcare should not be affected by uncertainty about the duration of the patient's stay in the Netherlands and cannot be influenced by financial aspects. Cfr. MdM International Network, Legal report on access to healthcare in 12 countries, 8th June 2015, p. 83

as long as his state of health would make it 'inadvisable' for him to travel.[32] This suspension is only applicable in emergency cases. Usually, it is granted for 6 months but departure can be postponed for a maximum of one year, after which patients can file for a residence permit for medical treatment (Article 64).

Article 14 of the Aliens Act 2000, in conjunction with Article 3.4 (1.o) of the Aliens Decree 2000, states that a temporary residence permit may be granted if medical treatment is needed and the Netherlands is the only country in which the special treatment can take place. This permit is valid for one year, although exceptional cases may grant residence for up to five years. Patients must prove that they can cover their living and treatment costs during their stay and they must have obtained an advance authorization to enter the country.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

HIV testing and diagnosis (test + confirmatory test) can be done at a GP's office. Furthermore, the national 'complementary sexual healthcare subsidies' system offers anonymous and free of charge screening to most at risk populations. These populations are broadly defined, and can include migrants with irregular status.

HIV treatment is part of the 'medically necessary care' to which migrants with irregular status are entitled, but in practice, many barriers remain. Among the primary barriers is the fact that only hospitals previously holding a contract with the National Healthcare Institute can apply for compensation for the costs of HIV care given to migrants with irregular status.

Issues

1. General Practitioner Variability. There are reports of GPs refusing to treat patients who are migrants with irregular status. This may be because the practitioner refuses to activate the reimbursement scheme, because the patient cannot pay the outstanding 20% of the consultation fee, or because the GP is unfamiliar with the scheme. Furthermore, for GPs to be reimbursed, they must provide the identity of the patient and evidence of the patient's insolvency. Further difficulty arises from the fact

[32] This means that 'termination of medical treatment would lead to death, disability or another form of serious psychological or physical damage within three month' Article B8/9.1.3. of the Aliens Circular 2000.

that medical professionals do not have a recognized right to claim a refund. Overall, there is a general lack of information about how the system works.

2. Residence Permit Requirements. In regards to the residence permit for medical reasons after one year of postponed departure (Article 64), it should be noted that the application process is particularly long and difficult[33], which limits effective protection. .

In 2013[34] and 2015[35], the National Ombudsman condemned the many obstacles surrounding access to healthcare and treatment. The Ombudsman also criticized the State Medical Service (BMA) regarding the accessibility and availability of care in the country of origin.

Good practices

Many NGOs (like Soa Aids Nederland, the HIV Association, Lampion-Pharos, and Doctors of the World) together with the Central Administration Office and their Helpdesk, make remarkable efforts to provide medical assistance, accessible information to all, to set up prevention activities, for uninsurable persons and help migrants with irregular status to healthcare access.

Poland

Constitutional basis

The Constitution of Republic of Poland of 1997[36] guarantees all citizens the right to equal access to health services financed by public sources, irrespective of their ability to pay.

---

[33] E.g., the need for formal proof of identity and medical declarations from all healthcare providers involved issued within the last six weeks, etc.
[34] Letter from the National Ombudsman to the Secretary of State for Security and Justice, 4 September 2013.
[35] Report further to a complaint against the Medical Advisors Office, BMA, National Ombudsman, 19 March 2015.

[36] **Article 68**

1.Everyone shall have the right to have his health protected.

Main characteristics of national health system

The Polish healthcare system is a decentralized mandatory insurance-based system. Voluntary health insurance (VHI) does not play an important role; healthcare is largely provided by medical subscriptions offered by employers in the context of occupational health.

Compulsory health insurance, complemented with financing from state and regional government budgets, covers the majority of the population and guarantees, at least in theory, access to a broad range of health services.

The National Health Fund (NFZ) is responsible for health care financing and contracts with public and non-public health care providers. The Ministry of Health is the key policy maker and regulator in the system. NFZ covers medical benefits according to the list prepared by the Ministry of Health and the patient must cover any additional benefits. Certain health care tasks and regulatory functions have been decentralized. Other tasks, such as health care promotion and prevention, have been transferred to local governments. The NFZ recently attempted to increase efficiency by shifting funds to primary care and introducing new payment mechanisms.

Access to healthcare system for migrants with irregular status

There is no specific legislation in Poland addressing migrants with irregular status. The only care migrants with irregular status can access free of charge is care provided by rescue teams outside hospitals in the event of an emergency. Article 7 of the Law of Health Protection obligates healthcare providers to provide assistance in the case of immediate danger to life or health. As such, migrants with irregular status can be treated in the emergency units, but they will bear the total cost of the care.

2.Equal access to health care services, financed from public funds, shall be ensured by public authorities to citizens, irrespective of their material situation. The conditions for, and scope of, the provision of services shall be established by statute.

3.Public authorities shall ensure special health care to children, pregnant women, handicapped people and persons of advanced age.

4.Authorities shall combat epidemic illnesses and prevent the negative health consequences of degradation of the environment.

5.Public authorities shall support the development of physical culture, particularly amongst children and young persons.

No duty to denounce exists for Polish health workers.

The law contemplates a residence permit due to humanitarian reasons and consent for tolerated stay.

Foreigners unwilling to return to their country of origin for important reasons may be granted consent to stay in Poland based on humanitarian reasons or consent for tolerated stay.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

HIV testing and diagnosis (test + confirmatory test) are free of charge. Seropositive individuals must pay for antiretroviral treatment and care.

Only immigrants with health insurance can take full advantage of the medical services in Poland. This insurance is near impossible to obtain, especially for those with irregular status

The new national HIV/AIDS Strategy of Poland for 2018-2021 lists providing access to ARV treatment for migrants with irregular status but legislations and regulations have not been adjusted accordingly yet.

Issues

1. Financial. In general, financial obstacles seem to be the greatest barrier in improving the accessibility of health care services. Migrants with irregular status face discrimination in Poland, given that they can access only a few types of health care free of charge.

2. Access to Insurance. In regards to HIV, the primary concern is that antiretroviral treatment and full constant medical care is only provided for free only to individuals with health insurance – and this is near impossible for migrants with irregular status to obtain.

Good practices

NGOs roles (like Helsinki Foundation for Human Rights Warsaw and SIEC PLUS) are very important. Caritas Polska, '*Punkt Pomocy Medycznej'* (Point of Medical Help) and Doctors of Hope are charity organizations geared mostly at providing medical care for Warsaw's homeless population and people with irregular status. These organizations have limited resources and can provide very basic care.

Portugal

Constitutional basis

The article 64 of the Portuguese constitution recognizes the right of provision of healthcare to all "through a universal and general national health service and that, by taking into account the economic and social conditions of the citizens, is prone towards gratuity".

Main characteristics of national health system

Portugal´s health system provides universal coverage, but is prone to exclude poor and/migrant people due to financial constraints related to transportation to and from healthcare settings and, in case of migrants due to accumulating debts towards the state, such as hospital bills, as it is an obstacle to getting a residency permit.

Portugal's Serviço Nacional de Saúde (National Health Service) is funded by direct and indirect taxation. However, per each health service and complementary act (e.g. lab tests), the user must pay a "moderating fee": these fees are, in theory, just a tool to deter people from making abusive use of the services, and not (much of) a financing source.

The fees can go up to 18€ (for SNS beneficiaries: nationals and regular migrants) in emergency services. They can also be calculated in terms of income or health status (people with low income or with certain diseases conditions can be exempt from payment). Some consultations, complementary analysis, and/or treatments are accessible free of charge by all SNS beneficiaries and, in some cases, also by migrants with a regular status.

Access to healthcare for migrants with irregular status

Migrant with irregular status in Portugal have legal entitlement to access to care and treatment of communicable diseases. However, the law is no clear and the clarification issued by the Justice Ombudsperson is often ignored; clarification by National Health Authority is often misinterpreted.

Irregular migrants residing for more than 90 days in Portugal must obtain a certificate from sub municipal district governing body in order to exercise to their right to healthcare. For medical appointments or services, the person has to pay the costs incurred (lab tests, first consultations); the person becomes exempt only after being diagnosed with HIV.

Prevention, testing, treatment and care of HIV for migrants with irregular status

Once diagnosed with HIV any person, regardless of their legal status, have access to HIV care and treatment. Some services even accept a reactive rapid test result as evidence enough that the person is (likely) HIV+, and therefore they become exempt, when creating a personal file in the National [Public Healthcare] Users Registry.

Issues

Although there is legal entitlement to access free HIV care and treatment, healthcare providers often misinterpret the law and ignore the clarification by the Ombudsperson. The reluctance of healthcare providers to provide treatment and care and the sometimes high costs of travelling to treatment centres prevent migrants with irregular status but also people with no or low income from accessing services.

Good practices

GAT

Group of Activists in Treatments (GAT) is a non-profit non-governmental organization (NGO) based in Portugal and aims to improve coverage and access (fast track) to prevention, harm reduction, early diagnosis and treatment services to tackle HIV/sexual transmitted infections/viral hepatitis/tuberculosis by enhancing local community response and key populations participation in tailoring favourable environments, peer-led services delivery, policy decision-making, human rights advocacy and second generation surveillance/granular evidence/research production.

Among its several projects, Espaço Intendente is the one that addresses some of the populations most vulnerable to HIV and other STIs, including migrants.
Its main objective is to raise awareness to the prevalence of STIs in some of the most vulnerable populations through the implementation of a screening and production service and the dissemination of information about them. It helps migrants, regardless of the legal status, to navigate the Portuguese national health service.
Another project, Anti-Discrimination Centre (CAD), developed a program of training and awareness sessions for people potentially interacting with PLHIV, aimed at employers, labour and employment authorities, unions, health professionals, teachers, social workers, social security services, civil society organizations and activists, in general. There is no other program/project or service, in Portugal, focused specifically on discrimination and promotion of the rights of PLHIV and viral hepatitis, so CAD is complementary to other community or governmental services and projects that only address those issues on a non-systematic, case by case basis and are focused essentially on migrants and women.
The work developed by CAD is focused specifically in reducing stigma and discrimination towards people living with HIV and viral hepatitis, particular the most vulnerable groups, and in supporting people that have gone through these situations. Several PLWHIV are trained and empowered by CAD to perform support and counselling functions, either at CAD or at network members.

Romania

Constitutional basis

The Constitution of Romania states that Art. 34 (1) „The right to the protection of health is guaranteed." and Art. 47 (2)" Citizens have the right (…) to medical care in public health centres."

Main characteristics of national health system

The Romanian health system is built on mandatory contributions paid by both employees and employers (private or public) and by a part of retired individuals –

those with a pension over €500. Insured people are those who contribute and all children (under the age of 18).
There is a National Health Insurance House that collects all the contributions and then reimburses the expenditures of the health service providers (public or private) through the regional branches (42 branches: 41 counties and Bucharest – capital city). If not insured an individual can only access emergency health care.
HIV is considered a priority so everyone who has an HIV diagnosis is included in the national program on HIV/AIDS of the Ministry of Health and automatically becomes insured even if they do not contribute. The ministry program pays for their medication and the Insurance House reimburses costs incurred from tests and all the other services needed.

Access to healthcare for migrants with irregular status

Only treatment and care for medical emergencies is provided. In general migrants with irregular status keep a low profile because the law stipulates the obligation of the healthcare provider to report them.

For emergency care one does not need to show any formal identification thus it is accessible for anyone without and insurance, including migrant with irregular status.

However, migrants who are detained due to their irregular status (those identified and awaiting their return) become automatically insured and have the same level of access to health services as insured nationals.

Prevention, testing, treatment and care of HIV for migrants with irregular status
Anyone diagnosed with HIV becomes automatically insured and receive care and treatment. However, for a test and diagnosis, a valid ID is needed. For migrants with irregular status this means that they have to apply for asylum or other form of protection to regulate that status in Romania.

Issues
The situation of a migrant with irregular status and of an individual without an ID is the same in regard to accessing healthcare services, including HIV services. Official data form May 2016 showed that there were more than 160.000 people in Romania without any form of identification. The majority of this people are poor people of

Roma origin. The differences in accessing health care services and HIV services derive from one´s legal status in Romania.
Also the health care system is seriously underfunded in Romania; € 814 per capita is allocated for health spending, which is below the European average of € 2,500. At the same time 361 euros, compared to 429 euros as the European average is spent on medication.

About 2.500.000 Romanians out of 20.000.000 are uninsured. The Euro Health Consumer Index has placed Romania on one of the last places among European states with a very large gap in indicators such as patients 'waiting time for accessing innovative medicines, patients' rights and the general level of information among patients, as well as the general health condition of the population. (http://www.healthpowerhouse.com/files/EHCI_2016/EHCI_2016_report.pdf

Serbia

Constitutional basis

Article 68 of the Constitution of the Republic of Serbia guarantees the right to health: 'Everyone has the right to protection of their physical and mental health…´. The human rights protection framework within the European Convention of Human Rights and the national Health Protection Act and Patient's Rights Act, both of which are included in the Serbian legal system, further emphasize the right to health and healthcare.

Main characteristics of national health system

In the Republic of Serbia, health care is provided by both the state and private sector. The Law on Health Insurance regulates compulsory and voluntary health insurance.

Health care services are financed through the National Health Insurance Fund (HIF), the compulsory state healthcare insurance. This fund is responsible for financing the

system and voluntary insurance may be obtained through private insurance. Employees and employers pay contributions to the compulsory state health insurance plan and, as a result, health care is provided free of charge to patients at the point of use. Private health insurance can be purchased on an individual or group basis, in order to provide safety in case of illness. The private health sector is developed, but not incorporated into the national health system.

Access to healthcare system for migrants with irregular status

Healthcare for migrants with irregular status is only covered in the event of medical emergencies and lifesaving interventions. In these situations, the HIF Fund finances care. It is near impossible for migrants with irregular status to obtain health insurance in Serbia and without this insurance, healthcare services are unavailable.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

HIV testing is free of charge and anonymous, and is available to all people regardless of documentation or insurance. However, a test for confirmation of HIV status is only available to those with health insurance. There is no national legal entitlement to HIV treatment for migrants with irregular status.

Issues

In Serbia, migration has, and will continue, to demand adjustments in the healthcare field and the associated legal frameworks. Depending on the evolving trends in migration, there may be an increased demand for HIV treatment and support.

Good practices

Although doctors are not legally required to provide HIV treatment to migrants with irregular status, there have been examples where doctors at HIV clinics provide urgent care to patients who do not have the necessary documentation.

In Serbia, an HIV positive status is listed as a public health measure that can be insured. Because of this, every HIV positive person who legally resides in the country can obtain health insurance.

NGOs like Q-CLUB and Belgrade Centre for Human Rights and Asylum Protection Centre also play an important role in the provision of healthcare services to migrants with irregular status.

Spain

Constitutional basis

Article 43 of the Spanish Constitution of 1978 recognizes the 'right to health protection' and healthcare for all citizens. It that 'it is incumbent upon the public authorities to organize 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'.

Main characteristics of national health system

The main principles governing the right to health protection are regulated by the General Health Act of 25 April 1986, which created the National Health System (*Sistema Nacional de Salud,* SNS). The Act 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'.

The Spanish healthcare system is a decentralized tax-based system. The SNS encompasses the public healthcare administration of both the Central Government Administration and the Autonomous Communities (AC). The Ministry of Health defines minimum standards and requirements for health care provision, and AC health departments organize and provide the health services and implement national legislation. Public financing is complemented by out-of-pocket payments into the public system, and by voluntary private sector insurance.

On 28 May 2003, Law 16/2003 was approved on the cohesion and quality of the National Health System (*Ley de Cohesiòn y Calidad*). Article 3 governs the access to health care within Spanish National Health System. This law considers all people residing in Spain, irrespective of their financial resources or legal status, to be entitled to universal health protection and healthcare.

In 2012, the Spanish Parliament radically reformed health coverage by adopting two new Decree-Laws. The first was Royal Decree-Law 16/2012, 'on urgent measures to ensure sustainability of the National Health System and to improve the quality and safety of its services'. The second was Royal Decree-Law 1192/2012, 'regulating insured and beneficiary status for the purposes of healthcare in Spain, charged to public funds through the National Health System'.

Decree-Law 1192/2012 established a new form of healthcare for individuals without an insured condition. Those who make less than €100 000 annually, who do not have health insurance, and who have been residents of Spain for a minimum of 1 year must now register to pay an amount related to their age. Prior to April 2012 Spanish law guaranteed real access to care for all people residing in the country, whatever their financial resources or legal status. The adoption of this Decree is a radical structural transformation that considerably reduces access to healthcare.

Both Decrees are "Real Decreto Ley" rather than laws, meaning they were executive decisions that avoided parliamentary debate. They were both made because of austerity measures, and contain wording that is vague and confusing. They link the right to healthcare and publically financed medicine with the administrative and employment status of citizens, and they limit uninsured assistance to emergencies and to pregnant women and minors. Patients who cannot claim 'insured' status (as defined by Decree) can only access healthcare services if they pay for it themselves or if they are eligible for a 'special provision', which includes a basic package of services.

The Royal Decree Law has been the subject of six appeals of unconstitutionality by several AC, alleging a breach of universality as a principle. The ACs has also alleged procedural issues and breaches to regional competencies.

Access to healthcare system for migrants with irregular status

Before 2012, access to the Spanish National Health System was almost universal and free of charge for everyone, including migrants with irregular status.

The *Ley Organica de Extranjería* no. 4 of the year 2000 introduced important innovations in this field. It recognized that illegal immigrants have a right to health care services, which was previously not accounted for in Spanish law. The Act also introduced a mandatory minimum level of health care protection, recognizing emergency treatments to all foreigners without restrictions or limits based on nationality or legal status. Any refusal by medical professionals to care for people without a health insurance card or residence permit results in the initiation of disciplinary proceedings.

However, following the adoption of the Royal Decree Law 16/2012, migrants with irregular status became completely excluded from healthcare system, unless there is an emergency or if they are children under 18 or pregnant women. This Decree does state that migrants with irregular status can obtain personal public health insurance (special agreement) after one year of residence in Spain, assuming they can afford the costs. This health insurance costs between €60 and €157 per month depending on age, but this way of getting access to health has been used by few people most of whom have residence permits. If the individual cannot afford to pay for health insurance and/or has not been in Spain for a minimum of one year, they do not have access to healthcare. In Many ACs in Spain have rejected the Royal Decree and have developed different laws or regulations in order to allow migrants with irregular status access to healthcare.

Royal Decree 557/2011 Article 126 states that a temporary residence permit on humanitarian grounds can be granted to a foreign national if:

- The individual is affected by a serious disease after arrival in Spain, 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.

This permit is valid for 1 year and is renewable so long as the conditions are demonstrated through a clinical report to the authority.

Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status

The adoption of Royal Decree Law 16/2012 excluded almost all people with irregular status from the National Health System. The new provision abolished the health care card previously granted to illegal immigrants, which had given them access to free health care.

In February 2014 the Ministry of Health, Social Services and Equality, with approval from all ACs, published a document entitled 'Healthcare interventions in situations of public health risk'. This document establishes that all individuals have the right to healthcare (preventative, follow-up and monitoring) whenever an infectious disease subject to epidemiological control and/or elimination at a national or international level is suspected. This right also extends to cases where individuals have infection diseases that require long term and chronic medical treatment, such as HIV. But taking the findings of this document into practice has been weak as there has been an agreement that it would not be developed into a law.

In summary, the legislative change produced in 2012 (Royal Decree-Law 16/2012, and Royal Decree-Law 1192/2012) reverted the previous situation limiting the access to public healthcare of immigrants whose immigration status is irregular to urgencies, pregnant women and minors.
Subsequently, most Spanish Autonomous Communities (AC), with the exception of Castile and León, La Rioja and the autonomous cities of Ceuta and Melilla, passed orders, instructions or decrees intended to counteract the public healthcare reform. Nevertheless, this created situations of violation of the right to public healthcare due to the complicated administrative requirements and misinformation among immigrants, health workers and administrative staff. For instance, REDER (Network of denunciation and resistance against RDL16/2012,) since 2014 has gathered 3784 (38 HIV+) notifications of cases in which immigrants in irregular situation in Spain were refused medical assistance, even though many of them had legal right to this assistance according to Royal Decree (minors, urgencies, pregnant women) or autonomic regulations. The situation in the autonomous city of Melilla is especially dramatic.

It should be noted that an appeal of unconstitutionality of the RDL 16/2012 was brought by the Autonomous Community of Navarre. However, the Constitutional court declared, against the Autonomous Community appeal, that the RDL 16/2012 is Constitutional (July, 2016).

Moreover, at the end of 2016, the Popular Party (PP) government, in spite of being a minority government, vetoed a law proposal brought by the Socialist Party (PSOE) to repeal the Royal Decree 16/2012 on the grounds of Article 134.6 of the Constitution, which requires government compliance in all those law proposals that may have an impact on state budgets.

Finally, in December 2017 and January 2018, the Constitutional Court issued sentences against the legislative measures that the Autonomous Communities of the Basque Country, Comunidad Valenciana and Extremadura had put in place to provide public health care to people excluded by the state law, mainly irregular migrants. Although the autonomous governments have expressed their willingness to continue offering assistance to this group, these sentences are a serious blow to the universality of public health care in these territories.

To sum up, since 2012 Spain has been suffering a situation of legal and administrative confusion that hinders real access to health care to the population in an irregular situation.

Issues

1. Healthcare System Reform. The reform of 2012 has had a severe impact on disadvantaged and vulnerable groups, especially individuals with low income and/or without residence permits. These reforms excluded many people from the healthcare system, which has had a real and dangerous effect on the population's health, 'specifically concerning infectious diseases like (…) HIV- infected patients (…)'[37]. Furthermore, the 2012 reforms have led to the saturation of accident and emergency

[37] H. Legido-Quigley, 'Erosion of universal health coverage in Spain', The Lancet, 2013.

wards in hospitals[38], without producing substantial savings for the Spanish economy[39].

2. Regional Variation. AC rejection of the Royal Decree has also created confusion and inequality across Spain's 17 different health systems. Their varying rejection and regional implementation of regulations has created a conflict of competence, administrative confusion and inequality in access to care depending on where someone lives.

3. Administrative Understanding. Finally, many specialists in infectious diseases say that in practice they have difficulty treating HIV-positive patients who are migrants with irregular status, because of a lack of information on the part of the administrative workers.

Good practices

Since 2012 there has been and a strong movement of civil society both at national level; REDER (Network of denunciation and resistance against RDL16/2012,) Yo si Sanidad Universal, and at regional level (ODUSALUD, PASU-CAT...) in order to promote the universal access to health care.

In most cases, the intervention of NGOs (CALCSICOVA, *Médicos del Mundo, Mèdicos sin Fronteras*) is fundamental in helping migrants with irregular status[40].

Turkey

Constitutional basis

Rights to health of the citizens in Republic of Turkey (or individuals who temporarily have the equal status regarding the local legislation) are regulated under the title of

[38] See Spain to allow illegal immigrant to access free public healthcare, www.telegraph.co.uk

[39] S. M.J. CALDES, *Controriforma sanitaria in Spagna. Nel mirino anche gli immigrati*, 4/12/2012, avail. in: http://www.saluteinternazionale.info/2012/10/controriforma-sanitaria-in-spagna-nel-mirino-anche-gli-immigrati/ (30/3, 2014).

[40] 'In Barcelona, for example, in 2006 a special "Plan for Immigration in the health care sector" was issued, which expressly regulates the practices adopted to allow full protection of the right to health, including that of the illegal immigrants living in the Catalan capital. The Barcelona City Council has also entered into an agreement with a local non-governmental organization (NGO) active in the field of migration and health protection. The program identifies illegal immigrants who may not have access to health care services and hospital treatment because of their inability to get a national health card. The city tries to fill the absence of the national health service in the provision of medical treatments for illegal immigrants.': A. De Petris, Constitutional provisions and health care services for illegal immigrants in some federal and regional EU member states: looking for best practices, Working Paper 6/2014, Luiss Guido Carli, Dipartimento di Giurisprudenza, Roma;

Standards of Health Rights, article No.12 in Economic, Social and Cultural Rights Agreement.

In addition, article No.56 of the current Constitution dated 1982 states that “A general health insurance system may be constituted by order in law to provide better health service in a wider network in accordance with the needs”. Regarding this article, back in 2006, a new law called *Social Security and General Health Insurance Law* was made and all the citizens in Republic of Turkey (and those individuals who temporarily have the equal status) have been guaranteed to get any health services in everywhere in the country, even though they are unemployed. (1)

Main characteristics of national health system

All the citizens of Republic of Turkey are automatically registered to General Health Insurance system. With the general health insurance, everybody can apply to all public health institutions for free, maybe sometimes for very little additional costs (around € 5). PLHIVs are exempt from any extra costs including doctor visits, treatment tests and the medications.

To access healthcare services for free, one must provide a Turkish ID or temporary Turkish ID number which is issued for residency permit owners, refugees and migrants in regulated situations.

If a person is an employee, social security and health insurance of the person is paid by the employer; but if a person is an unemployed, then they need to pay their own general health insurance contribution, which costs around € 15 (2). The cost may rise up to € 150 for those who have temporarily equal status regarding the reason of their stay in the state such as for study, research, diplomacy etc. and the amount of payment is regulated by the legislation for each stay status (e.g. payments for refugees are covered by the state; payments for international students are listed as €100 per month).

Access to healthcare for undocumented migrants/ refugees with irregular status

There is no legal entitlement to access any healthcare services for migrants with irregular status. If they are officially recognised as asylum seekers or refugees by UN then their healthcare costs will be covered by the state on behalf of UN.

Prevention, testing, treatment and care of HIV for undocumented migrants/ refugees with irregular status

HIV testing is not anonymous but free of charge for everyone, so migrants with irregular status can also access HIV testing and prevention services but they have no entitlement to HIV care and treatment services as long as their status is irregular.

Issues

When a person is diagnosed with HIV and has no insurance, NGOs are able to provide him/her temporary treatment (for a couple of weeks/months). Some generic medication is available and cheap but there is no permanent access secured.

Good practices

Good practices in Turkey include NGOs providing free and anonymous HIV testing. With the support of the Embassy of the USA, Red Ribbon Istanbul could provide around 1000 tests in less than 6 months, 20% of these tests were provided for individuals who are migrants.

Another example of good practise is NGOs working actively in HIV field cooperated to help migrants in irregular status and refugees diagnosed with HIV during their stay in Turkey to access viral load and CD4 tests, and also acute healthcare service when needed. In 2017, 51 migrants in irregular situation and refugees received support to access treatment and later getting temporary legal status to maintain accessing healthcare.

United Kingdom

Constitutional basis

The United Kingdom (UK) does not have a written constitution and as such, there is no right to health beyond the possible health-related implications of the European Convention on Human Rights, which is enshrined in domestic law through the Human Rights Act of 1998. The Human Rights Act established the principle of the

precedence of human right considerations in the development and implementation of policy and practice in public services and allowed UK courts to make ruling on its applicability.

Main characteristics of national health system

The UK's health care system is called the National Health Service(NHS). It was established by the National Health Service Act of 1946 - the first of its kind worldwide – and it was introduced two years later and subsequently amended by law.

Healthcare is a devolved matter in the UK, meaning each of the four nations has separate health laws. The NHS is managed separately in England (NHS England), Scotland (NHS Scotland), Wales (NHS Wales) and Northern Ireland Health and Social Care (Northern Ireland-HSCNI). In spite of some differences, they are generally similar – though there are differing approaches in each nation in respect to migrant healthcare access.

The Health Act 2009 established the NHS Constitution, which has some legal status in England. The Health and Social Care Act 2012 and the Care Act 2014 have reaffirmed it. The Act brings together the principles, values, rights and pledges of the NHS in England. In Scotland, the Patient Rights Act includes similar content.

The UK government funds the NHS for each of the four nations through a central taxation revenue composed of a combination of direct and indirect sources of taxation (income tax, national insurance contributions paid by employees and VAT). The NHS is intended to provide universal health coverage to the entire UK population, based on clinical need. It is, with but a few exceptions, free at the point of use. While healthcare is predominately financed by general taxation and national insurance contributions (98.8%), there are service user charges for certain aspects of healthcare such as dentistry and prescriptions which equate to 1.2% of funding for the NHS. There is no difference in access to healthcare dependent upon how much taxation someone contributes, so people who receive state benefits or are not in employment still have equal access to the NHS.

Access to NHS services for UK/EEA nationals those with permission to reside

As the NHS is not an insurance-based system, entitlement to services depends on residency status.

Primary care is free to all residents, regardless of nationality or immigration status. Everyone present in the UK is entitled to register with a GP, and may receive primary services free of charge. It is possible to be registered on a temporary basis if an individual is present in the UK for 3 months or less. Most are liable for a fixed prescription charge (£8.05 per item), but there are some exemptions for pregnant women, children and people aged over 60.

Secondary care is free at the point of use for all people defined as 'ordinarily resident' in the UK. This is a test specific to NHS access, and should not be confused with any other residency tests in immigration, tax or benefits law. Ordinary residence has not been formally defined in law. In practice, to be considered 'ordinarily resident', the patient must be: "living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being."[41] It is possible for someone to be a UK citizen or permanent resident and not be found to be 'ordinarily resident' (i.e. a UK citizen who resides in the USA and is in London for a holiday). In this case, they may be considered a chargeable patient for secondary care. Conversely, it is possible for someone who has recently arrived in the UK to be considered 'ordinarily resident' (i.e. an EEA national who has recently moved to Birmingham to take up a job and is planning to live in the UK for the foreseeable future).

The Immigration Act 2014, Section 39, which came into force on 6 April 2015, introduced a partial definition of 'ordinary residence'. It excludes all those who do not have indefinite leave to remain in the UK. This includes those who need leave to enter or remain, and those who currently live and work in the UK with limited leave to remain (i.e. anyone who is subject to immigration control).

In addition, non-nationals subject to immigration control (visa holders, nationals of countries from outside the EEA) who are staying the UK for longer than six months

[41] The concept of settled purpose' has been developed by the courts: "There must be an identifiable purpose for their residence here, there can be one purpose or several, and it may be for a limited period. The purpose for living in the UK must have a sufficient degree of continuity to be properly described as 'settled'."

must pay a 'health surcharge' as a part of the visa application process. The health surcharge (£200 per year and £150 per year for students) must be paid in advance for each of the years covered by the relevant visa[42]. This is intended as a contribution to the costs of their healthcare while they are resident in the UK. This fee is additional to any taxes they pay while resident. Third-country nationals already in the UK and who apply to extend their stay will also pay this health surcharge. Once the individual has paid this surcharge, non-nationals may access all NHS services for free on the same basis as nationals who are 'ordinarily resident'.

In summary, the following groups may access NHS secondary care for free:

0. Nationals/citizens who are ordinarily resident.
1. Non-nationals who are permanent residents (with indefinite leave to remain) and who are ordinarily resident.
2. Non-nationals who have paid the NHS surcharge.
3. EEA nationals/citizens who are ordinarily resident.
4. EEA nationals/citizens with a European Health Insurance Card for their country of residence.
5. Asylum seekers with an open claim.
6. Refugees (those whose asylum claim has been successful).

Access to healthcare system for migrants with irregular immigration status

Primary care, and accident and emergency (A&E) care are free of charge to all patients. As such, in accessing these services, migrants with irregular status should have the same entitlements as other NHS patients.

The Secretary of State for Health (Health Minister) says that there is no formal requirement to provide documentation when registering with a GP, and that GPs receive the same amount for overseas patients and for the other patients. There is no minimum period that a person needs to have been in the UK before a GP can register them.

[42] A typical work visa is for up for 5years.

'Chargeable migrants' - those who are not ordinarily resident and/or who have not paid the migrant surcharge, which includes migrants with irregular status - will be asked to pay directly for secondary care treatment.

The standard of care, access to clinicians, testing and medications are the same for all patients regardless of migration status[43].

The NHS uses the terms 'immediately necessary' and 'urgent care' to describe treatment which should never be denied or delayed due to charging concerns. This is linked to human rights obligations. However, migrants with irregular status may be billed for such treatment and care after it is completed. The charge will be the standard tariff for that service, as paid by NHS commissioners. That said, certain types of treatment and care are always provided free to all patients, regardless of residency status or whether they are subject to immigration control. This includes testing and treatment for HIV and all other sexually transmitted infections, as well as a range of specified diseases.[44]

In addition, some groups of migrants are considered vulnerable and are therefore provided free treatment. This includes victims of violence (FGM, domestic violence), unaccompanied children in local authority care, and disabled and seriously ill adults in local authority care. *Prevention, testing, treatment and care of HIV/AIDS for migrants with irregular status*

Since 1 October 2012, England has offered free access to HIV treatment and care services, regardless of residency status. This was promoted in recognition of the significant public health benefits[45] that arise from ensuring universal access to HIV treatment, in addition to testing, which has always been free. Scotland introduced the same access in law in 2014, and Northern Ireland followed in 2015. In Wales, treatment is provided without charge in practice. Even if a patient in Wales could be charged for HIV treatment, it should never be denied. Welsh law also provides free

[43] Guidance issued to HIV clinics recommends that when patients is believed to be a short-term visitor they may be given prescriptions of shorter duration (e.g. 1 month rather than 3), and asked to return the clinic within the time in order to have further medication dispensed.

[44] Acute encephalitis; Acute poliomyelitis; Anthrax; Botulism; Brucellosis; Cholera; Diphtheria; Enteric fever (typhoid and paratyphoid fever); Food poisoning; Haemolytic uraemic syndrome (HUS); Human immunodeficiency virus (HIV) Infectious bloody diarrhoea; Invasive group; Invasive meningococcal disease (meningococcal meningitis, meningococcal septicaemia and other forms of invasive disease); Legionnaires' disease; Leprosy; Leptospirosis; Malaria;Measles; Mumps; Pandemic influenza (defined as the "Pandemic Phase") or influenza that might become pandemic (defined as the "Alert Phase");Plague;Rabies; Rubella; Severe Acute Respiratory Syndrome (SARS;) Smallpox; Tetanus; Tuberculosis; Typhus; Viral haemorrhagic fever;Viral hepatitis; Whooping cough; Yellow fever

[45] Adherence to HIV treatment reduces the risk of HIV transmission and therefore prevents new HIV infections.

healthcare of all kinds to refused asylum seekers (those with appeal rights exhausted). In practice, this may extend to other migrants with irregular status.

While in policy there is no fundamental difference in access to HIV testing or treatment between nationals and irregular migrants, the impact of charging upon health seeking behaviour may mean that migrants choose not to interact with the healthcare system for fear of being charged. Some migrants with irregular status are also concerned that accessing public services may lead to identification of their whereabouts by immigration authorities.

Issues

1. Emphasis on Chargeable Migrants. The universal nature of the NHS, specifically the open-access model of sexual health and HIV clinics, facilitates treatment and care access for migrants with irregular status. Irregular migrants may access HIV clinics directly, without the need to be referred by a GP or hospital. However, increasing emphasis is placed on pursuing revenue from 'chargeable' migrants for other hospital services, as part of a government-wide attempt to create a 'hostile environment' for migrants with irregular status[46]. There is also a renewed attempt to recoup costs from other EEA member states for non-HIV hospital treatment provided to EEA nationals who hold an EHIC card. These trends are likely to lead to new barriers to access for EEA nationals who are not insured in their home state or who cannot prove they are ordinarily resident in the UK and exercising treaty rights.

New regulations that came into force in April 2017 extend the areas of the NHS for which migrants can be charged for in England, which now includes non-NHS providers of NHS care such as the voluntary sector or community services funded by the NHS. It has been confirmed that drug treatment services are now required to charge migrants. Migrants will now also be charged upfront for secondary care, and where they cannot pay in advance they will be denied treatment unless the care is

[46] In May 2014 , with the introduction of a new Immigration Act, came into force in April 2015, the Government expressly stated that it was designed to make it 'more difficult for illegal immigrants to live in the UK'. The Act 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; prevent illegal immigrants accessing and 'abusing' public services or the labor market.

deemed ‘immediately necessary’ or ‘urgent’. The Government has looked at extending charging into primary care though they will take a phased approach to implementing this policy and primary care remains free for the time being. Overall, while migrants can access free HIV treatment, the effects of charging of migrants in other areas of the NHS may be having a detrimental impact upon health seeking behaviours generally.

2. Identification of Migrants with Irregular Status. With the requirement for providers to now charge patients upfront, identification of patients who are not eligible for free NHS care is a process that will need to be engrained further into the health system, only meaning more people will be deterred from accessing healthcare. There is already a policy in place that allows the Home Office to request data such as name and address from the NHS in order to identify the whereabouts of migrants with irregular status for the purposes of immigration enforcement.

3. Lack of Information. The British Medical Association notes ‘considerable confusion about overseas visitors’ eligibility for NHS primary medical services … largely because of a lack of clarity in the NHS regulations’.[47] NHS England recently published clarification on universal free entitlement to GP registration.[48] However, in the same month, the Department of Health announced a public consultation on the possibility of charging migrants with irregular status for A&E and certain primary healthcare services.[49]

4. Secondary Care Costs**.** Migrants with irregular status are often without a legal source of income and many struggle to afford prescribed medications, secondary care and hospitals bills. These bills can often be extortionately high, and act as a deterrent themselves, for if a migrant is in more than £500 worth of debt to the NHS then applications for leave to enter, leave to remain or indefinite leave to remain can be refused.

Good practices

[47] See BMA, General Practitioners Committee, Overseas Visitors- Who is eligible for NHS Treatment, London, 2006, p.1;
[48] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf
[49] https://www.gov.uk/government/consultations/overseas-visitors-and-migrants-extending-charges-for-nhs-services

The National AIDS Trust, (as well as other NGOs) successfully campaigned to exempt HIV treatment and care from charges (in 2012) and continue to campaign for wider healthcare access for migrants, focusing on, for example, ensuring that GP consultations are exempt from any future extension of charging in primary care. NAT are also now advocating for drug treatment services to be exempt from charging.

European Case Law

This section presents a brief review of interesting cases of the European Courts and of the European Committee of Social Rights.

European Court of Human Rights (ECHR)

As it is known, the ECHR pronounces itself on individual or state appeals inherent to alleged violations of civil and political rights established by the European Convention of Human Rights. The Court's sentences are binding, and states must modify legislation and their administrative praxis to conform to the Court's decision.

The ECHR does not contain an Article dedicated to health. However, it indirectly protects the right to healthcare by way of Articles 2, 8 and 3 which detail the right to life, the right to respect for private and family life and the prohibition of torture and inhuman or degrading treatment or punishment. These articles developed rich case law on the influence of the medical state of an applicant and the individual possibilities of return to his/her country of origin. It approaches this issue from the perspective of the rights granted by the ECHR in the abovementioned articles.

The ECRH has found on many occasions that, considering a state's obligation to make healthcare available to the whole population, their acts and omissions regarding healthcare policy engage their responsibility.

On denial of healthcare (violation of Article 2 ECHR) see:

- Application N. 45305/99, Powell v. UK, decision 4 May 2000;
- Application N. 65653/01 Nitecki v. Poland, decision 21 March 2002;
- GC Cyprus v. Turkey, 10 May 2001,§ 219;
- GC Öneryldiz v. Turkey, 30 November 2004, § 71, 90, 94-96.

The right to respect for private life (Article 8 of ECHR) includes the right to physical and moral integrity. This article can be invoked if removal from the country would cause acute physical and mental suffering. Unlike Article 3 of the ECHR, this right is

not absolute nor is it subject to proportionality. The article allows contracting states to interfere with the right if in accordance with the law and necessity of a democratic society. The threshold for an Article 8 of the ECHR claim on medical grounds is equally high as for an Article 3 of the ECHR claim. Normally the European Court of Human Rights does not raise separate issues under Article 8 of the ECHR when assessing applications against expulsion on medical grounds[50].

On violation of Article 3 ECHR see:

-**Application N. 46553/99 SCC v. Sweden**, in which the Court recalls that "at the outset that Contracting States have the right, as a matter of well-established international law and subject to their treaty obligations including the Convention, to control the entry, residence and expulsion of aliens. However, in exercising their right to expel such aliens Contracting States must have regard to Article 3 of the Convention, which enshrines one of the fundamental values of democratic societies. The Court has repeatedly stressed in its line of authorities involving extradition, expulsion or deportation of individuals to third countries that Article 3 prohibits in absolute terms torture or inhuman or degrading treatment or punishment."

-**Application N. 30240/96 D. v. the United Kingdom,** in which the Court established a broad interpretation of Article 3.

The applicant was in an advanced stage of AIDS and his short life expectancy was contingent on the continuation of the medical treatment available to him in the UK. He was close to death and had formed a bond with the care providers who supported him through the end of his life. Given that in his country of origin, St. Kitts, the patient had no familiar, social or other support, and that there was no medical treatment available for his illness, the ECHR held that his deportation would violate Article 3.

"… the Court must reserve to itself sufficient flexibility to address the application of that Article (Art. 3) in other contexts which might arise. It is not therefore prevented from scrutinising an applicant's claim under Article 3 where the source of the risk of proscribed treatment in the receiving country stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of that

[50] See Undocumented And Seriously Ill: Residence Permits For Medical Reasons In Europe, PICUM, Brusseles, 2009, p. 14.

country, or which, taken alone, do not in themselves infringe the standards of that Article (Art. 3). To limit the application of Article 3 in this manner would be to undermine the absolute character of its protection. In any such contexts, however, the Court must subject all the circumstances surrounding the case to a rigorous scrutiny, especially the applicant's personal situation in the expelling State.
Against this background the Court will determine whether there is a real risk that the applicant's removal would be contrary to the standards of Article 3 in view of his present medical condition. In so doing the Court will assess the risk in the light of the material before it at the time of its consideration of the case, including the most recent information on his state of health."(§ 49)

This case is the only case[51] where the ECHR found the circumstances sufficiently exceptional to conclude that the applicant's removal would be contrary to Article 3. It stands in contrast to subsequent medical asylum cases where the ECHR found that the circumstances of the applicants were not sufficiently distressing for an issue under Article 3 to arise if they were expelled.

About this, see Application **N. 26565/05, N. v. the United Kingdom,** in which the Court, in a situation relating to the expulsion of a person with a HIV and AIDS-related condition, stated that *"[a]liens who are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance and services provided by the expelling State. The fact that the applicant's circumstances, including his life expectancy, would be significantly reduced if he were to be removed from the Contracting State is not sufficient in itself to give rise to breach of Article 3.*

The decision to remove an alien who is suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness are inferior to those available in the Contracting State may raise an issue under Article 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling." (§42)

[51] But see also BB v. France (9 March 1998, RJD 1998-VI, p. 2596) where the Commission found that the deportation of a national from the Democratic Republic of Congo whose HIV/AIDS illness had stabilized due to the therapy he was receiving would amount to a violation of Article 3 ECHR, since adequate medical treatment and family support were unavailable in his country of origin.

-**Application N. 34724/10 E.O. v. Italy,** the case regards an appeal against expulsion made by a Nigerian woman affected by HIV and illegitimately present on the Italian territory. The Court, recalling one of its previous rulings, (N. v. United Kingdom Application n. 26565/05) declared the appeal unfounded and explained its refusal to accept it because the health condition of the subject had been stabilized thanks to the treatment received in Italy.
Thus, her expulsion was not contrary to Art. 3 as it was not characterized by urgent humanitarian considerations.

-**Application no. 70055/10 S.J. v. Belgium**.
This case originated with the Belgian Alien Office's decision to expel Ms. S.J., a young Nigerian mother. Upon her arrival in Belgium in 2007, Ms. S.J. was diagnosed with a serious immune system deficiency requiring antiretroviral treatment. She was closely monitored for the following years and as a result, her state of health was stabilized. As she had no realistic prospect of obtaining access to the appropriate medical treatment in Nigeria, Ms. S.J. requested ECHR to declare that her deportation would violate Article 3 of the ECHR, as it would expose her to a premature death in conditions of acute physical and mental suffering. On 27 February 2014, relying on the principle established in N. v. UK, the ECHR Chamber ruled that Ms. S.J.'s expulsion would not breach Article 3.

In his dissent to the Grand Chamber decision, Judge Pinto de Albuquerque strongly criticized the ECHR's approach in medical asylum cases and called upon the Court to revisit, after six years, the 'unfortunate principle' laid down in N. v. UK.

In these last three cases, the applicants' situations were distinguished from D. v. UK on the basis that their illness had not reached a critical stage or that family members could take care of them in their country of origin.

This case law suggests that the expulsion of seriously ill aliens only raises an issue under Article 3, in situations where their illness is so advanced that their death is imminent. So long as their health condition is stable and they are fit to travel at the time of the propose removal, the ECHR does not consider the impossibility of accessing adequate medical treatment in the receiving state to be a relevant factor, even if removal would likely cause the applicant's premature and painful death.

It is hoped that the ECHR will align its medical asylum case law with the protective standard of Article 3 as elaborated in other removal cases. However, recently the Court has pronounced very interesting judgments.

-**Application N. 2700/10 Kiyutin v. Russia**.

In this case, the Court held that Russia could not deny a residence permit to an individual exclusively because of the person's HIV positive status. However, the particular outcome does not make this case significant – it is the precedent that it sets.

Ensuring protection against discrimination to persons in poor health affects a substantial population worldwide. This ruling represents a significant step forward for the often-ostracized HIV-positive community. The Kiyutin Court ruling under the ECHR grants seropositive individuals protection against differential treatment as a result of their health status. It provides this population with some international legal protection and support. [52].

A broad reading of the ECHR extends this much-needed protection to virtually all realms of life and grants significant political influence across the world.

European Union Court of Justice (ECJ, "The Court")

The ECJ guarantees the respect of EU regulations and monitors the interpretation and application of the founding treaty of the EU. The Court has always protected health matters in an ancillary and indirect way.

Migrants suffering from life-threatening conditions are not only excluded from the protection of Article 3 ECHR, they are also excluded from the protective regime granted to refugees and persons otherwise in need of international protection by the EC Directive 2004/83/EC.

In **M'Bodj v. Belgian State** (C-542/13) the Belgian Constitutional Court requested a preliminary ruling by the ECJ on the question whether aliens suffering from a serious

[52] S. Levitan, Kiyutin: Protecting the Human Rights of Person Living with HIV/AIDS Beyond Immigration, Boston College International and Comparative Law Review, 35, 49 (2013);

health condition should be included in the category of persons protected by the Directive 2004/83/EC.

The ECJ ruled that "*None the less, the fact that a third country national suffering from a serious illness may not, under Article 3 ECHR as interpreted by the European Court of Human Rights, in highly exceptional cases, be removed to a country in which appropriate treatment is not available does not mean that that person should be granted leave to reside in a Member State by way of subsidiary protection under Directive 2004/83. In the light of the foregoing, Article 15(b) of Directive 2004/83 must be interpreted as meaning that serious harm, as defined by the directive, does not cover a situation in which inhuman or degrading treatment, such as that referred to by the legislation at issue in the main proceedings, to which an applicant suffering from a serious illness may be subjected if returned to his country of origin, is the result of the fact that appropriate treatment is not available in that country, unless such an applicant is intentionally deprived of health care.*"

Conversely, in another judgement delivered on the same day, the Luxembourg Court, adopted a markedly broad interpretation of Articles 5 and 13 of 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.

In **Centre Public d'Action Sociale d'Ottignies-Louvain-La-Neuve v. Moussa Abdida** (C-562/13), there was criticism surrounding national legislation that did not endow with suspensive effect an appeal against a decision ordering a third country national suffering from a serious illness to leave the territory of a member state. The enforcement of that decision could expose the third country national to serious risk of grave and irreversible deterioration of his health, and it did not allow for the basic provision of emergency healthcare and essential illness treatment during the period in which the member state was required to postpone the individual's removal following the lodging of the appeal.

Consequently, member states are required to provide the basic needs of a third country national suffering from a serious illness who has appealed against a return decision and whose enforcement may expose him to a serious risk of grave and irreversible deterioration in his state of health.

The contradictory approach of the Luxembourg Court reflects the current contradiction in the Strasbourg Court's case law itself, which has simultaneously sustained an unreasonably restrictive interpretation of the Article 3 substantive guarantee, (i.e. N. v. the United Kingdom), and a reasonably broad procedural interpretation of the right to an effective remedy as elaborated in other removal cases (Application n. 27765/09 Hirsi Jamaa and Others v. Italy, Application n. 22689/07 De Souza Ribeiro v. France)[53].

The situation of illegal migrants suffering from life-threatening conditions is precarious. However, rather than extending the protective scope of human rights and EU law to afford a minimum level of protection to those vulnerable people, sometimes the ECHR and the ECJ have accepted that European member states have the right to deport them even when this course of action would, in all likelihood, bring about their death in dire conditions.

European Committee of Social Rights

The protection of health, stated in Article 11 of ESC(r), is connected to the right to life and the prohibition of torture and inhuman or degrading treatment or punishment, as described by the European Convention on Human Rights (ECHR) in Article 2 and 3. The ECSR has repeatedly ruled on the interpretation of Article 11 of the ESC(r).

In FIDH (International Federation of Human Rights) v. France, the ECSR stressed the connection between the right to healthcare and the fundamental value of human dignity. It states that the protection of health is a "*prerequisite for the preservation of human dignity."*
Moreover, ECSR believes that Article 11.1, which is related to the obligation to remove the causes of ill health, establishes the right to the best possible standard of health for the population, and the right to access to healthcare without distinguishing between nationals and non-nationals[54].

[53] In these terms, the opinion of Judge Pinto de Albuquerque in the ECtHR's case S.J. v. Belgium.
[54] See ECSR, "Conclusions 2004", 'General introduction', pp. 10.

The European Committee of Social Rights, in a case related to State Medical Aid in France, states that "*a practice or a legislation who denies the right to a medical assistance for migrants, on the territory of a member State, even if they are in irregular situation, is contrary to the Chart*".

The right to access to healthcare has been interpreted to require that cost not constitute an excessive financial burden to individuals. The European Committee of Social Rights specifically stated in November 2014, with regards to a case concerning Spain, 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".* This means that states have the obligation to assist citizens regardless of their residence status.

Pursuant to Article 11.2 of ECS(r), nations have to provide advisory and educational facilities that promote health and encourage of individual responsibility for their health. In the interpretation of the ECS(r), this means that states have an obligation to raise awareness through education, information and public participation. It also means a state obligation to carry out screening and provide counselling by way of free and regular consultations and medical checks[55].

The third obligation that the ESC(r) imposes (Article 11.3), in relation to the right to protection of health, is a series of measures that parties are required to take [56] and also checks whether specific awareness activities concerning migrants[57].

[55] See ECSR "Conclusions 2009", German and Denmark, pp84-85.
[56] See ECSR "Conclusions 2009", German and Denmark, pp85-88
[57] See ECSR "Conclusions 2007" Ireland.

Conclusions

This document provides evidence that access to healthcare for migrants with irregular status is not completely guaranteed in any of the examined countries and that health care procedures are heterogeneous among them. While migrants with irregular status often receive the same health services as nationals, the condition of access to these services varies depending on the country. Furthermore, while the law provides comprehensive health coverage to migrants with irregular status, there are many gaps between theory and practice, especially at local level.

At the same time, the right to healthcare is a basic social right, protected and recognized regardless of administrative status through international instruments ratified by various European countries. This presents a paradox for healthcare providers: if they provide care, they may act against legal and financial regulation, but if they do not provide care, they violate human rights and exclude some of the most vulnerable populations. This paradox cannot be resolved at a practical level. It must be managed such that neither human rights nor national regulations are violated.[58]

In each country reviewed, civil society, NGOs and some healthcare professionals, many of whom work in a voluntary capacity, play a significant role in helping migrants with irregular status know their rights, access assistance and support, and access to health care. However, the responsibility in providing healthcare ultimately rests on each national government.

The climate of repression and xenophobic pressures[59], which find fertile ground in the terrible recent acts of terrorism, is a major obstacle when working to comply with

[58] C. Björngren Cuadra Policies on Health Care for Undocumented Migrants in EU27, Health Care in NowHereland, improving services for undocumented migrants in the EU, Country Report, Poland, , April 2010, p. 3.

[59] See the latest amendments to the Hungarian Health Care Act regarding mandatory screening. This amendment came into force 28, October 2015 in relation to the legislative changes regarding the refugee crisis enacted in September, 2015. One of these amendments introduced the notion of *crisis situation caused by mass immigration,* which was declared for six counties of Hungary in September, 2015. This is still in force. The new provisions of the Health Care Act authorize the chief medical officer (head of healthcare management) to order certain screenings mandatory for asylum seekers during a crisis situation caused by mass immigration and in other healthcare crisis situations. However, the same amendments also declare this authorization almost unnecessary when setting out that if the crisis situation caused by mass immigration is declared on almost any ground, there is no need for the chief medical officer order. These "certain screenings" - the law is not specified further - take place at a location assigned by the asylum authority. If the asylum seeker is in the transit zone, the screening shall be carried out before entering the territory of Hungary if entrance permit is granted. The chief medical officer has not publicly declared any screening mandatory. Therefore, there is little room for advocacy at the moment on national level.

international human right obligations. A recent Italian study[60] illustrates a deep correlation between cultural and political attitudes towards foreigners and access to healthcare for migrants with irregular status. In states where there are higher numbers of xenophobic parties, access to healthcare for migrants with irregular status is lower.

Cost is another obstacle when providing healthcare services to migrants with irregular status. Although economic considerations cannot justify a lack of compliance with fundamental rights, cost effectiveness is an important issue in the debate on access to healthcare for migrants with irregular status. In spite of this debate, a recent study published by the FRA European Union Agency for Fundamental Rights[61] illustrates that it is more cost-effective to provide regular access to healthcare than it is to limit the access migrants in irregular situations to emergency healthcare only.

Finally, some policy makers and health professionals fear that greater access to healthcare would represent a pull factor for migration, and that restrictive health policies will help enforce restrictive migration policies. However, several studies show that the number of 'medical refugees' is in fact very small[62].

In speaking specifically about access to HIV/AIDS prevention and treatment, migrants with irregular status continue to face many barriers. In practice, insurance-based systems (France, Germany, Hungary, Netherland, Poland, Serbia) seem to offer less access to free HIV treatment, when compared to direct taxation/national health systems (Italy, Spain, before the Royal Decree Law 16/2012, and UK). Greece is a combination of the two systems.

Numerous health care professionals indicate that it is imperative to ensure information is adequately provided, in order to provide migrants with irregular status access to health care treatments. Social and language barriers often result in a lack of awareness and stigma. Legal, financial and administrative barriers further result in

[60] A. Rosano A. Spagnolo, Access to health services of undocumented migrants and xenophobic attitudes in EU countries, 4th Conference on Migrant and Ethnic Minority Health in Europe, 21-23 June 2012, Milan.
[61] FRA European Union Agency for Fundamental Rights, Cost of exclusion from healthcare The case of migrants in a irregular situation, 2015. The results of the research show that, in case of hypertension and prenatal care, the governments would save money by providing access to primary regular preventive healthcare to migrants in a irregular situation.
[62] Parliamentary Assembly Council of Europe, Migrants and refugees and the fight against AIDS, Doc. 13391 , 22 January 2014 and documented cited.

delayed diagnoses, fear of seeking treatment and higher HIV-related morbidity and mortality[63]. This ultimately leads to serious problems for individual and public health.

Recommendations

In light of these conclusions, this paper proposes the following recommendations to the studied states, in order to bridge the identified gaps:

1. Comply with international obligations at the legislative level, reviewing and/or revising national and regional legislation, and adopting a human right-based approach to healthcare and to fighting HIV/AIDS.

2. Ensure that information about what treatment is available to migrants with irregular status is made accessible to these individuals and to healthcare providers.

3. Abolish every kind of healthcare provider or public official duty to denounce, as this regulation makes healthcare inaccessible to migrants with irregular status for fear of deportation.

4. Protect seriously ill foreigners, including migrants with irregular status, from deportation through domestic laws. Ensure that foreigners are granted an effective permit to stay in the host nation if they are unable to receive effective access to treatment in their country of origin.

5. Eliminate or reduce the cost of services.

6. Simplify administrative procedures for access to healthcare services.

7. Ensure privacy and autonomy of every patient.

Judge Pinto de Albuquerque's notable dissenting opinion[64] in the ECHR's case S.J. v. Belgium, and the Application N. 2700/10 Kiyutin v. Russia, gives some hope that

[63]Parliamentary Assembly Council of Europe, Migrants and refugees and the fight against AIDS, Doc. 13391 ,22 January 2014.

[64] "Six years have passed since the N. judgment. When confronted with situations similar to that of N., the Court has reaffirmed its implacable position, feigning to ignore the fact that the Grand Chamber sent N. to her death. Too much time has elapsed since N.'s unnecessary premature death and the Court has not yet remedied the wrong done. I wonder how many N.s have been sent to death all over Europe during this period of time and how many more will have to endure the same fate until the "conscience of Europe" wakes up to this brutal reality and decides to change course. Refugees, migrants and foreign nationals are the first to be singled out in a dehumanised and selfish society. Their situation is even worse when they are seriously ill. They become pariahs whom Governments want to get rid of as quickly as possible. It is a sad coincidence that in the present case the Grand Chamber decided, on the World Day of the Sick, to abandon these women and men to a certain, early and

the right to healthcare may find effective protection in the European Courts, at a minimum. Lowering the threshold required for Article 3 to be engaged in medical asylum cases could also have an impact on the ECJ's interpretation of serious harm under Directive 2004/83/EC and 2008/115/EC and on the domestic law of Convention states.

painful death alone and far away. I cannot desert those sons of a lesser God who, on their forced path to death, have no one to plead for them".

Bibliography

-MdM International Network, Legal report on access to healthcare in 12 countries, 8th June 2015;

-Discrimination, Denial, and Deportation, Human Rights Abuses Affecting Migrants Living with HIV, Human Rights Watch, 2009;

-I. Butler, Background paper, Open Society European Policy Institute, February 2013;

-Trattati dell'Unione Europea, a cura di Antonio Tizzano, Le Fonti del Diritto Italiano, II edizione, Giuffrè Editore;

-M. Crivellini, M.Galli, Sanità e salute, due storie diverse, Sistemi sanitari e salute nei paesi industrializzati, p. 272, Franco Angeli, 2011;

-Undocumented and Seriously Ill: Residence Permits for Medical Reasons In Europe, Brussels, PICUM, 2009;

- C. Economou, Greece: health system review, Health system in transition, 2010, vol 12, n. 7;

-Naga, Health is (not) permitted. Survey on access to health care for undocumented migrants in hospitals in Milan, from January 9, 2014 to February 28, 2015;

-A. De Petris, Constitutional provisions and health care services for illegal immigrants in some federal and regional EU member states: looking for best practices, Working Paper 6/2014, Luiss Guido Carli, Dipartimento di Giurisprudenza, Roma;

-Letter from the National Ombudsman to the Secretary of State for Security and Justice, 4 September 2013;

-Report further to a complaint against the Medical Advisors Office, BMA, National Ombudsman, 19 March 2015;

-Spain to allow illegal immigrant to access free public healthcare, www.telegraph.co.uk;

-H. Legido-Quigley, 'Erosion of universal health coverage in Spain', The Lancet, 2013;

-S. M.J. CALDES, Controriforma sanitaria in Spagna. Nel mirino anche gli immigrati, 4/12/2012, http://www.saluteinternazionale.info/2012/10/controriforma-sanitaria-in-spagna-nel-mirino-anche-gli-immigrati/ (30/3, 2014);

-S. Levitan, Kiyutin: Protecting the Human Rights of Person Living with HIV/AIDS Beyond Immigration, Boston College International and Comparative Law Review, 35, 49(2013);
-C. Björngren Cuadra, Health Care in NowHereland, Improving services for undocumented migrants in the EU, Policies on Health Care for Undocumented Migrants in EU27, Country Report Poland, April 2010;
Luglio 2013;
-A. Rosano A. Spagnolo, Access to health services of undocumented migrants and xenophobic attitudes in EU countries, 4th Conference on Migrant and Ethnic Minority Health in Europe, June 21-23 2012, Milan;
-FRA European Union Agency for Fundamental Rights, Cost of exclusion from healthcare The case of migrants in an irregular situation, 2015;
-Health Care in NowHereland, Improving services for undocumented migrants in the EU, Policies on Health Care for Undocumented Migrants in EU27: Towards a Comparative Framework, Summary Report, Carin Björngren Cuadra, July 2010;
-EuroHiv Edat- Aides, Synthesis- National Reports;
-Organization for Economic Co-operation and Development. Report by the Global Commission on International Migration OECD, in Access to healthcare for undocumented migrants in Europe, Brussels, PICUM, 2007;
-Local authorities, health professionals and NGOs call on German government to change law on reporting undocumented migrants, htt://picum.org/en/news/picum-news/48359;
-L'accesso alle prestazioni sanitarie per gli i presenti sul territorio italiano. Il nucleo irriducibile dei diritti fondamentali rende irrilevante la distinzione tra immigrato regolare e immigrato irregolare, www.lavocedeldiritto, 11 febbraio 2015;
-Health Systems in Transition, Vol. 13 No. 8 2011, Poland Health System Review, European Observatory on Health Systems and Policy;
-HUMA Network, Are undocumented migrants and asylum seekers entitled to access health care in the EU?, A comparative overview in 16 countries, November 2010;
-We're Treating Them As Homeless: Health Care Access for Undocumented Migrants in Poland, B. Larson, P. Sypniewska, www.humanityinaction.org;
-A.Gavrilović – S. Trmčić, Health Insurance System in Serbia – Quality, Reform, Financial Sustainability;

-British Medical Association BMA, General Practitioners Committee, Overseas Visitors- Who is eligible for NHS Treatment, London, 2006;
-Protecting Migrants under the European Convention on Human Rights and the European Social Charter, A handbook for legal practitioners, Y. Ktistakis, Council of Europe Publishing, 2013;
-Parliamentary Assembly Council of Europe, Migrants and refugees and the fight against AIDS, Doc. 13391, January 22 2014;
-A. Spagnolo, Il diritto alle cure degli stranieri irregolari, Salute Internazionale, 4
-Health Care for Undocumented Immigrants: A View from Europe, NESRI Media Center;
-J. Close, Human rights outcasts: seriously-ill migrants as beyond the reach of European protective legal regimes, April 20, 2015, International Law Blog;
-The protection of seriously ill migrants and the “unfortunate principle” of N.v. the United Kingdom, www.ein.or.uk, March 19 2015;
-B. Catallo, Il diritto alla salute nel contest delle migrazioni e la protezione sussidiaria: l’orientamento della Corte di giustizia dell’Unione europea nella sentenza n. c-542/13 del 18 dicembre 2014.

List of Appendix

Appendix 1
Article 25
(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Appendix 2
Article 12
1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
The content of this article has been clarified by the UN Committee on Economic, Social and Cultural Rights (CESCR) in his General Comment n. 14: " States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal migrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy…".

Appendix 3
Article 5
In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:
(a) The right to equal treatment before the tribunals and all other organs administering justice;
(b) The right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution;

(c) Political rights, in particular the right to participate in elections-to vote and to stand for election-on the basis of universal and equal suffrage, to take part in the Government as well as in the conduct of public affairs at any level and to have equal access to public service;
(d) Other civil rights, in particular:
(i) The right to freedom of movement and residence within the border of the State;
(ii) The right to leave any country, including one's own, and to return to one's country;
(iii) The right to nationality;
(iv) The right to marriage and choice of spouse;
(v) The right to own property alone as well as in association with others;
(vi) The right to inherit;
(vii) The right to freedom of thought, conscience and religion;
(viii) The right to freedom of opinion and expression;
(ix) The right to freedom of peaceful assembly and association;
(e) Economic, social and cultural rights, in particular:
(i) The rights to work, to free choice of employment, to just and favorable conditions of work, to protection against unemployment, to equal pay for equal work, to just and favorable remuneration;
(ii) The right to form and join trade unions;
(iii) The right to housing;
(iv) The right to public health, medical care, social security and social services;
(v) The right to education and training;
(vi) The right to equal participation in cultural activities;
(f) The right of access to any place or service intended for use by the general public, such as transport hotels, restaurants, cafes, theatres and parks.

Appendix 4
Article 10 Each Member for which the Convention is in force undertakes to declare and pursue a national policy designed to promote and to guarantee, by methods appropriate to national conditions and practice, equality of opportunity and treatment in respect of employment and occupation, of social security, of trade union and cultural rights and of individual and collective freedoms for persons who as migrant workers or as members of their families are lawfully within its territory.
Article 12 Each Member shall, by methods appropriate to national conditions and practice--
(a) seek the co-operation of employers' and workers' organizations and other appropriate bodies in promoting the acceptance and observance of the policy provided for in Article 10 of this Convention;
(b) enact such legislation and promote such educational programs as may be calculated to secure the acceptance and observance of the policy;
(c) take measures, encourage educational programs and develop other activities aimed at acquainting migrant workers as fully as possible with the policy, with their rights and obligations and with activities designed to give effective assistance to migrant workers in the exercise of their rights and for their protection;
(d) repeal any statutory provisions and modify any administrative instructions or practices which are inconsistent with the policy;
(e) in consultation with representative organizations of employers and workers, formulate and apply a social policy appropriate to national conditions and practice which enables migrant workers and their families to share in advantages enjoyed by

its nationals while taking account, without adversely affecting the principle of equality of opportunity and treatment, of such special needs as they may have until they are adapted to the society of the country of employment;
(f) take all steps to assist and encourage the efforts of migrant workers and their families to preserve their national and ethnic identity and their cultural ties with their country of origin, including the possibility for children to be given some knowledge of their mother tongue;
(g) guarantee equality of treatment, with regard to working conditions, for all migrant workers who perform the same activity whatever might be the particular conditions of their employment.

Appendix 5
Article 11
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:
(a) The right to work as an inalienable right of all human beings;
(b) The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;
(c) The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;
(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;
(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;
(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.
2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:
(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;
(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
(c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;
(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.
3. Protective legislation relating to matters covered in this article shall be reviewed periodically in the light of scientific and technological knowledge and shall be revised, repealed or extended as necessary.

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Appendix 6
Article 24
1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(a) To diminish infant and child mortality;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and post-natal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Appendix 7
Article 25 - Health
States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:
Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programs;
Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as

appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
Provide these health services as close as possible to people's own communities, including in rural areas;
Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Appendix 8

PRINCIPLE 17. THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity. Sexual and reproductive health is a fundamental aspect of this right.

States shall:
a) Take all necessary legislative, administrative and other measures to ensure enjoyment of the right to the highest attainable standard of health, without discrimination on the basis of sexual orientation or gender identity;
b) Take all necessary legislative, administrative and other measures to ensure that all persons have access to healthcare facilities, goods and services, including in relation to sexual and reproductive health, and to their own medical records, without discrimination on the basis of sexual orientation or gender identity;
c) Ensure that healthcare facilities, goods and services are designed to improve the health status of, and respond to the needs of, all persons without discrimination on the basis of, and taking into account, sexual orientation and gender identity, and that medical records in this respect are treated with confidentiality;
d) Develop and implement programs to address discrimination, prejudice and other social factors which undermine the health of persons because of their sexual orientation or gender identity;
e) Ensure that all persons are informed and empowered to make their own decisions regarding medical treatment and care, on the basis of genuinely informed consent, without discrimination on the basis of sexual orientation or gender identity;
f) Ensure that all sexual and reproductive health, education, prevention, care and treatment programs and services respect the diversity of sexual orientations and gender identities, and are equally available to all without discrimination;
g) Facilitate access by those seeking body modifications related to gender reassignment to competent, non-discriminatory treatment, care and support;
h) Ensure that all health service providers treat clients and their partners without discrimination on the basis of sexual orientation or gender identity, including with regard to recognition as next of kin;
i) Adopt the policies, and programs of education and training, necessary to enable persons working in the healthcare sector to deliver the highest attainable

standard of healthcare to all persons, with full respect for each person's sexual orientation and gender identity.

PRINCIPLE 18. PROTECTION FROM MEDICAL ABUSES

No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity. Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed.

States shall:
a) Take all necessary legislative, administrative and other measures to ensure full protection against harmful medical practices based on sexual orientation or gender identity, including on the basis of stereotypes, whether derived from culture or otherwise, regarding conduct, physical appearance or perceived gender norms;
b) Take all necessary legislative, administrative and other measures to ensure that no child's body is irreversibly altered by medical procedures in an attempt to impose a gender identity without the full, free and informed consent of the child in accordance with the age and maturity of the child and guided by the principle that in all actions concerning children, the best interests of the child shall be a primary consideration;
c) Establish child protection mechanisms whereby no child is at risk of, or subjected to, medical abuse;
d) Ensure protection of persons of diverse sexual orientations and gender identities against unethical or involuntary medical procedures or research, including in relation to vaccines, treatments or microbicides for HIV/AIDS or other diseases;
e) Review and amend any health funding provisions or programs, including those of a development-assistance nature, which may promote, facilitate or in any other way render possible such abuses;
f) Ensure that any medical or psychological treatment or counselling does not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed.

Appendix 9
Article 35
Health care
Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.
A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Appendix 10
PUBLIC HEALTH
Article 168
(ex Article 152 TEC)
1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.
The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention. C 326/122 EN Official Journal of the European Union 26.10.2012
2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programs in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organization of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.
3. The Union and the Member States shall foster cooperation with third countries and the competent international organizations in the sphere of public health.
4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:
(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;
(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;
(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.
5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonization of the laws and regulations of the Member States.
6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.
7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The 26.10.2012 EN Official Journal of the European Union C 326/123 responsibilities of the Member States shall include the management of health services and medical

care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Appendix 11

Article 14

Safeguards pending return

1. Member States shall, with the exception of the situation covered in Articles 16 and 17, ensure that the following principles are taken into account as far as possible in relation to third-country nationals during the period for voluntary departure granted in accordance with Article 7 and during periods for which removal has been postponed in accordance with Article 9:

L 348/104 EN Official Journal of the European Union 24.12.2008

(a) family unity with family members present in their territory is maintained;

(b) emergency health care and essential treatment of illness are provided;

(c) minors are granted access to the basic education system subject to the length of their stay;

(d) special needs of vulnerable persons are taken into account.

2. Member States shall provide the persons referred to in paragraph 1 with a written confirmation in accordance with national legislation that the period for voluntary departure has been extended in accordance with Article 7(2) or that the return decision will temporarily not be enforced.