



Models of Child Health Appraised

(A Study of Primary Healthcare in 30 European countries)

Migrant Children in Europe: Entitlements to Health Care



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Executive Summary

The Models of Child Health Appraised (MOCHA) is a European project, funded by European Union (EU) within the Horizon 2020 program, and studying the 30 EU and EEA countries of Europe. MOCHA is performing a systematic, scientific evaluation of the different models of primary health care for children that exist in Europe. In this report we focus on the national health care policies for migrant children that define entitlement to primary health care. The report primarily covers entitlement on a policy level. To what extent these policies have been implemented could not be comprehensively covered within the framework of this project, and to a large extent remains to be investigated.

Migrant children live on the margins of European societies. They may have applied for asylum in a European country, may be on the move from the southern borders of Europe to more northern destinations, or may live in an irregular legal situation, and are undocumented. In 2015 alone, more than 300,000 children applied for asylum in Europe, with one out of five arriving unaccompanied without the support of an adult carer.

Research has shown that asylum-seeking and newly-settled refugee children have high rates of stress-related mental health problems during the first years after resettlement, with unaccompanied minors having the highest rates of symptoms. Infectious diseases and poor dental health are more common in these children than in settled European populations and many have an accumulated need of preventive and basic health. Thus, access to health care is a major concern for migrant children.

This report is based on the information from the MOCHA country agents, the European Network of Ombudspersons for Children and non-governmental organisations (NGOs) as well as official documents from national governments. It has a human rights framework, with the United Nations Convention on the Rights of the Child (UNCRC) as a fundamental guiding document. All EU/European Economic Area (EEA) countries have signed this Convention. Its second article clarifies that it applies to *“all children within the jurisdiction of the State, without discrimination of any kind”*, which includes the protection of the rights of children in marginalised and irregular situations, such as migrant children. It implies that migrant children, regardless of their legal status, have the right to health care on equal terms with resident children.

The entitlements to care for different categories of migrant children in EU/EEA are summarised in Table 1. A migrant child who is legally categorised as an asylum seeker is more likely to be entitled to health care on equal terms with a resident child than other migrant children without permanent residency. Twenty out of the 30 states have a policy to care for an asylum-seeking child in the same way as they do for the host population. Only 11 states have similar arrangements for irregular migrant or undocumented children from non-EU/EEA countries (See Table 1). Eight countries have similar entitlements for asylum-seeking children to that of the host population in a parallel primary care organisation outside of the general primary health care.

Health care policies in the EU/EEA frequently do not address the rights of migrant families from other EU countries, who have overstayed the three-month period of free mobility; or who lack identification. These migrants fall outside the defined categories of a migrant in many national as well as European policies.

Table 1: Levels of equality regarding entitlements to health care for three groups of migrant children compared to national children. (no data =no data was available)

Colour code			
Entitlements equal to nationals regarding coverage and cost and included in same health care system			
Entitlements equal to nationals regarding coverage and cost but enrolled in parallel health care system			
Entitlements restricted compared to nationals/No legal entitlements			
Unclear legal provision			
	Equality dimension		
	Child asylum seekers	Children of irregular third-country migrants	Children of irregular migrants from other EU countries
Austria			
Belgium			
Bulgaria			
Croatia			no data
Cyprus			no data
Czech Republic			no data
Denmark			
Estonia			no data
Finland			
France			
Germany			
Greece			
Hungary			
Iceland			
Ireland			
Italy			
Latvia			no data
Lithuania			
Luxembourg			
Malta			no data
Netherlands			
Norway			
Poland			
Portugal			
Romania			
Slovakia			
Slovenia			
Spain			
Sweden			
UK			no data

In at least 12 countries, unaccompanied children have broader entitlements to health care than accompanied children. Although this is certainly beneficial for this most vulnerable group of children, it is also a policy that discriminates migrant children by family status.

Germany and Slovakia stand out as the countries with the most restrictive policies. They are the only countries that have policies that restrict health care for asylum-seeking children as well as for irregular migrant children originating outside of the EU/EEA area. The German case is particularly troublesome, since it applies to so many migrant children, and in the case of irregular migrants is tied to a reporting duty.

The system used to fund health care differs considerably in Europe. Some countries have a tax based system while others are funded by insurances. Although the insurance-based system is more administratively complicated when it comes to funding health care for migrant children, the good solutions to this challenge in insurance funded countries like France and the Netherlands show that there is no obvious relationship between the funding system and health care policy for migrant children in Europe.

A number of countries use concepts like “basic”, “necessary” or “emergency” care to define entitlements to health care that for migrants. These vague definitions make access to healthcare, and in particular primary and psychological care, arbitrary and dependent upon the judgement of individual health care providers, and thereby foster inequity. Primary care should be the pillar of health care for all children, as laid out in the WHO declaration of Alma Ata of 1978. Health care provided in a primary care setting is in most societies the most cost-effective way of providing the psychological support which is the most pressing health care need for migrant children, and particularly for victimised children who has a specific right to rehabilitation according to article 39 in the UNCRC. It also has the potential for early detection of communicable disorders and the provision of preventive interventions like vaccinations and screenings for malformations and disabilities. The link of primary care to the community is particularly valuable in the work with migrant populations where collaboration with other segments of the community is often important for preventive as well as curative purposes. Thus, policies that do not explicitly provide full access to primary care for migrant children do not fulfil the requirement of article 24 of UNCRC of the “highest attainable standard of health care”, thus implying that the country is breaching its legal and ethical duty.

In all but four countries in the EU/EEA there are systematic health examinations of newly settled migrants of some kind. In most eastern European countries and Germany this health examination is mandatory; while in the rest of western and northern Europe it is voluntary. All countries that have a policy of health examination aim to identify communicable diseases, so as to protect the host population. Almost all countries with a voluntary policy, also aim to identify a child’s individual health care needs, but this is rarely the case in those countries that have a mandatory policy.

During the autumn of 2015, unprecedented numbers of asylum seekers overwhelmed the system for asylum applications in many European countries; leaving many children in irregular situations, and with an unclear provision of health care, before their asylum applications could be filed. Access to psychological services was minimal, and access to physical services was also limited in countries on the border of EU, as well as in temporary shelters in countries further away from the EU borders such as Sweden and the Netherlands.

Implications

Action is needed to improve entitlements to primary health care for migrant children in Europe. The EU Reception Conditions Directive sets the standard for the reception of migrants in Europe. This directive cites some principles of the UN Convention of the Rights of the Child, but avoids the important principle of non-discrimination. A clarification on this point could be one important step towards a policy that provides entitlement on equal terms to nationals for primary care for all migrant children in the EU.

- The legal situation of irregular and destitute EU migrants needs to be clarified in European as well as in national legislation.
- The purpose of health examinations of migrants should be extended to identify the health care needs of the individual child in all EU/EEA countries. A closer collaboration on a European level, coordinated by an EU body such as the European Centre for Disease Prevention and Control, has the potential to improve the quality and cost effectiveness of health examinations of migrants.
- European governments need to consider how health care can be delivered in a context that allows migrant children to access health care without fear.
- The experience of a “health care crisis” within the so-called “refugee crisis” during the autumn of 2015 needs to be evaluated on a national as well as on a European level, so that more effective policies can be implemented when extraordinary migrant situations such as this occur again.

In conclusion, in many European countries today migrant children’s rights to health care, as defined in UNCRC, are violated with limited access to primary care as a consequence, with potential dire consequences on their short and long term health and development. Action is urgently needed by European and national governments to implement a children’s rights perspective in health care policy for migrants.

Key terms and definitions

Migrant

We define a migrant as *“a person who changes his or her country of usual residence”*.

Child

We define a child as *“every human being below the age of 18 years”*. In countries where children’s entitlements do not apply until 18 years of age, this will be made clear.

Child asylum seekers

Child asylum seekers constitute children of persons who are in the process of applying for refugee status under the 1951 Geneva Refugee Convention. Persons under Dublin regulation are asylum seekers.

Children of irregular third-country migrants

Children in this category are also referred to as *“undocumented migrants”* or *“unregistered migrants”*. This group of children is a large, varied and highly vulnerable group in Europe. They include children:

- Who live without a residence permit;
- Who have overstayed visas or were refused immigration applications as a family and who have not left the territory of the destination country subsequent to receipt of an expulsion order;
- Who have entered a country irregularly either alone or as a family.
- Who are passing through or residing temporarily in a country without seeking asylum

Children of irregular migrants from other EU countries

EU citizens, who make use of the right to free movement, but lack resources, health coverage, valid identification papers or have not registered with the authorities for various reasons, are not automatically granted the same entitlements as irregular third-country nationals. The category of irregular migrants that are EU nationals encompasses groups such as beggars, homeless and minority groups such as Romani people, who have EU citizenship, but fall outside EU social security regulations, and whose rights are largely determined by national legislation.

Unaccompanied minors

Unaccompanied minors are defined as children: *“who have been separated from both parents and other relatives and are not being cared for by any adult who, by law or custom, is responsible for doing so”*.

Emergency care, Primary care, Secondary care

Emergency care includes life-saving measures as well as medical treatment necessary to prevent serious damage to a person’s health. Primary, secondary and tertiary care refers to different levels of care in a health care organisation with increasing degrees of specialised care. The care provided on the primary level varies considerably between different health care organisations. See text below in the introduction.

Health examinations of newly arrived migrants

Health examinations in this report are defined as targeted intervention offered to new migrants only, to identify communicable disorders and unmet needs of medical care.

Introduction

The right to health is a universal, basic social right inscribed in various international treaties and texts. These texts include binding State commitments under the United Nations and the Council of Europe as well as within EU agreements and 'soft' recommendations issued by their respective institutions and agencies.

Children's right to health and health care is codified in the Convention on the Rights on the Child (UNCRC), which considers a child as a child first and foremost and is underpinned by a principle of non-discrimination, meaning that the rights in the convention applies to all children regardless of race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status (UN General Assembly, 1989).

The EU-funded MOCHA project, studying the 30 European countries in the EU and EEA, focuses primarily on primary health care for children. It appraises the different models of primary health care for children in Europe in Europe, and will make recommendations on the optimum model features available to all children. Primary health care has many different definitions in different contexts. Everyone would agree that primary care is the first level of care in health care in a hierarchical health care organisation, where secondary and tertiary care refers to increasing levels of specialised care. But the definition of what is primary care varies greatly between health care organisations. In the Alma Ata declaration, the World Health Organization defined primary health care as "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage." It addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and well-being. It integrates care when more than one health problem exists, deals with the context in which illness exists and influences people's responses to their health problems (WHO, 2004). In evaluation research primary care has been demonstrated to contribute to improved access to care for deprived populations, to increase cost-effectiveness and to enable detection of health problems before they are severe enough to demand hospital care (Starfield et al, 2005).

The UNHCR estimates that in 2015, there were 21.3 million refugees worldwide, out of which children aged below 18 years of age constituted more than half. This is the highest figure in more than a decade (UNHCR, 2016). During 2015 Eurostat reported a record high number of 1.3 million asylum seekers in the 28 EU Member States. Preliminary data showed that 337,000 of these asylum applicants were children below 18 years of age, and 88 700 were unaccompanied minors (Eurostat, 2016).

Migrant children are an especially vulnerable group of children. Migration is often a means to escape war, poverty and/or discrimination. In cases where children travel alone, either as unaccompanied or separated children, they are extremely vulnerable to abuse and exploitation. The migration process and the living conditions children and young migrants experience, can carry exceptional risks to their physical and mental well-being; this is linked to factors such as unequal access to health care and services, marginalization, discrimination and poor socio-economic conditions (Anderson, Ascher, Björnberg, Eastmond, & Mallander, 2005).

Thus, it is not surprising that surveys have shown that asylum-seeking and newly-settled refugee children have high rates of mental health problems, particularly depression and post-traumatic stress disorder (PTSD) during the first years after resettlement (Fazel, Wheeler, & Danesh, 2005; Montgomery, 1998; Reed et al., 2012), with unaccompanied minors having the highest rates (Eide & Hjern, 2013). Infectious diseases such as hepatitis B and tuberculosis are more common in these children than in settled European populations, as is poor dental health (Hjern et al., 1991). The war situation in the countries of origin and the hardships during the migration process is particularly difficult for the few children with chronic disorders and severe disabilities, but also create an accumulation of health care needs in many other children.

Health examinations after resettlement can be important to identify health care needs, so that they can be adequately addressed (Frederiksen, Kamper-Jørgensen, Agyemang, Krasnik, & Norredam, 2013). According to the European Union Fundamental Rights office in Vienna, the majority of the 28 member states conduct health screening for migrants in need of international protection. In some countries however, the screening procedures aim only to identify communicable diseases in order to protect the host population (FRA, 2016).

Not only are migrant children vulnerable and at risk, but they cannot advocate for themselves, thus migrant children and their right to health care in the EU is a subject that is of high priority for many organisations, NGOs and researchers. Recent projects focusing on services, protection and justice for children of asylum seekers and of irregular migrants have been conducted by organisations including the Platform for International Cooperation on Undocumented Migrants (PICUM, 2008a, 2008b, 2015), the Health for Undocumented Migrants and Asylum seekers Network (HUMA, 2009, 2010, 2011), Médecins du Monde (Medecins du Monde, 2013, 2014, 2015a, 2015b), the European Union Agency for Fundamental Rights (FRA, 2010, 2011a, 2011b, 2013), the International Organisation for Migration (IOM, 2009a, 2009b, 2009c, 2013b) and the Centre on Migration, Policy and Society (COMPAS, 2015a, 2015b). The Nordic Network for research on Refugee Children has described the reception conditions for asylum-seeking and refugee children in country reports entitled 'Reception of refugee Children in the Nordic Countries' (Brendler-Lindquist & Hjern, 2010; Gunnlaugsson, 2010; Jessen & Montgomery, 2010; Lutine de Wal Pastoor, Eide, & Mekonen, 2010). Projects and reports concerning the health conditions for unaccompanied children have been conducted by the European Migration Network (EMN, 2010); the European Network of Ombudspersons for Children (ENOC, 2016) and Save the Children. Health care entitlements for children of irregular EU nationals are a topic that has received less attention and discussion. However, a recent report from UNICEF Sweden focuses on this group of children and also discusses their entitlement to health care – or lack thereof – in the Swedish context (UNICEF Sweden, 2015).

There are increasing numbers of online databases and platforms related to migrants and health. The project "Asylum Information Database" (AIDA, 2015) is an online mapping of asylum procedures, reception conditions and detention in Europe, which peripherally touches upon the health care entitlements for asylum-seeking children. The Migrant Integration Policy Index (MIPEX, 2015e) is another online database that among other things rates health care for adult migrants in the EU countries and also peripherally touches upon the entitlements to health care for children of asylum-seekers and irregular migrants.

Legal framework for children's health care

Legal instruments and policy initiatives aimed at protecting the right to health and health care for migrants, including children, are primarily found at international and national level. National governments have a legal obligation to follow the international and European laws that they have ratified or formally consented to and made valid. This means that any national law, policy or practice, which is contrary to these, can be challenged as unlawful.

An impressive range of International and European treaties and commitments concern the basic and universal right to health and healthcare, and applies to individuals irrespective of their legal or administrative status.

Relevant United Nations texts regarding health rights include the ***Universal Declaration on Human Rights***, the ***International Covenant of Economic, Social and Cultural Rights***, ***International Convention on the Elimination of all Forms of Racial Discrimination*** and the ***UN Convention on the Rights of the Child***.

Relevant law texts on an EU level include the ***European Convention on Human Rights***, the ***European Social Charter***, the ***Treaty on the European Union***, and the ***EU Charter on Fundamental Rights***.

Children's rights to health and health care are directly enshrined in ***the Treaty on the European Union***. Children's right to health is indirectly addressed in ***The EU Charter on Fundamental Rights*** which states that: "*children shall have the right to such protection and care as is necessary for their well-being*" and "*in all actions relating to children, the child's best interest must be a primary consideration*" (European Commission, 2000, art. 24). However, the most comprehensive rights complex protecting the rights of the child and promoting children's health and lives is the ***United Nations Convention on the Rights of the Child***¹ (UNCRC).

The UN Convention on the Rights of the Child (UNCRC)

The UNCRC (1989) is ratified by all members of the United Nations (193 countries), except for the United States and Somalia. States party to the UNCRC must ensure that its provisions and principles are fully reflected and given legal effect in relevant domestic legislation. Policies must be guided by the four general principles of: non-discrimination; the best interests of the child; the right to life, survival and development; and the rights of the child to express their views, and be heard, in all matters affecting them (see elaboration below).

The UNCRC marks an important change in the legal perception of a child. It considers a child as a child first and foremost and children as people in their own right (Waterston & Goldhagen, 2007 p. 176; Wolfe, 2015 p. 15). Furthermore, the Convention has a holistic nature and addresses children's rights as indivisible and interrelated, which makes the UNCRC a useful framework for the protection of all children, in particular vulnerable children (IOM, 2009a). The Convention applies to all children within the jurisdiction of the ratifying State and recognises the civil and legal status of children as laid out in children's rights to healthcare, education, social and civil services.

¹ Other relevant international instruments and recommendations for the protection and promotion of migrant children's right to health are: The resolution of the sixty-first session of the World Health Assembly (2008), and the report of the WHA's secretariat on 'the Health of Migrants' together with the WHO executive board on 'Reducing health inequities through action on the Social Determinants of Health' (2009). For elaboration see IOM's 'Ensuring the Rights of Migrant children to Health Care' (IOM, 2009a).

A body of 18 independent experts - the Committee on the Rights of the Child (CRC) - monitors the implementation of the treaty and has interpreted the Convention in its General Comments. Several of the ratifying countries of the UNCRC have established means by which the Convention can be translated into national policy and implemented in practice, and several of the countries have established advocacy committees, children's commissioners and children's ombudspersons under the European Network of Ombudspersons for Children (ENOC)².

The Convention is partly based on the *United Nations Universal Declaration on Human Rights*, according to which children are entitled to special care and assistance. The UNCRC also takes account of the *Declaration of Rights of the Child* adopted by the United Nations General Assembly on the 20th November 1959 in that the child due to physical and mental immaturity needs special safeguards and care, including appropriate legal protection, before and after birth.

To single out specific parts of the Convention relevant to children's health is difficult, because the rights are interrelated and health is seen in the context of the environmental and social factors that affect a child's life. However, Table 2 depicts the articles most relevant to migrant children's right to health grouped into three brought classes of rights as developed by Waterston & Goldhagen, 2007. It is followed by a discussion of the central articles for migrant children's health.

Table 2: Articles of the Convention on the Rights of the Child that are particularly important when addressing migrant children health

Child rights of Protection	<p><u>Article 2</u>: Right to non-discrimination</p> <p><u>Article 6</u>: Right to life</p> <p><u>Article 9</u>: Right not to be separated from parents (except to protect the child)</p> <p><u>Article 19</u>: Right to be protected from all forms of abuse</p> <p><u>Article 20</u>: Right to special attention</p> <p><u>Article 22</u>: Right to protection while seeking refugee status or when considered a refugee</p> <p><u>Article 25</u>: Right to periodic review of treatment provided</p>
Child rights of Provision	<p><u>Article 24</u>: Right to the highest attainable standard of health care</p> <p><u>Article 27</u>: Right to a standard of living adequate for a child's physical, mental, spiritual, moral and social development</p> <p><u>Article 39</u>: Right to rehabilitation for children who have been victims of neglect and abuse, including armed conflict.</p>
Child rights to Participation	<p><u>Article 12, 13</u>: Right to express views freely and to be listened to</p> <p><u>Article 17</u>: Right to access information</p>

Based on Waterston & Goldhagen 2007 and Wolfe 2015.

² For elaboration on the development of the Convention of The Rights of the Child see Wolfe, 2015 p. 16.

The central provision of the Child Convention regarding the right to health is Article 24, which states ***“the right of the child to the enjoyment of highest attainable standard of health”*** and commits state parties to ***“ensure that no child is deprived of his or her right of access to such healthcare services”***. The right to the highest attainable standard of health draws from the International Bill of Human Rights as well as definitions and principles from organisations such as WHO and the United Nations Children’s Fund (UNICEF). In the general comments no. 15 the Committee on the Rights of the Child sets out four elements of care which are necessary for realising the health goals of the Convention: *availability, accessibility, affordability and quality* of care. Furthermore, components of the right to health include: health education, preventive and primary healthcare, family planning and education. The right to health should be understood and implemented in light of the general principles below:

Guiding general principles (Articles 2, 3, 6, 12):

- **Article 2** addresses the ***right to non-discrimination***. The fact that the CRC applies to *all children within the jurisdiction of the State* implies that all migrant children, regardless of their legal status, have the right to exercise their right to health on an equal basis as national children. This also implies that States should respect the right to health by not implementing measures that may prevent some children from exercising this right.
- **Article 3** addresses the ***best interest of the child***. The Convention recognises that in *“all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be a primary consideration.”* The best interest of the child shall be considered in all actions affecting his or her well-being and as being different from child to child in accordance with their specific situation, including health and migration status, cultural background and particular individual needs. The International Organisation for Migration (IOM) stresses that this right entails governments, through legislation and practice at health service level, to implement guidelines from international organisations such as the World Health Organisation (WHO) and UNICEF; set up monitoring and evaluation mechanisms to assess the respect, protection and fulfilment of migrant children’s right to healthcare, including assessment of their health status and to take up appropriate measures to their specific needs³.
- **Article 6** concerns ***the right to life, survival and development*** and obliges States Parties to ensure children’s’ survival and development to the maximum extent of their resources. The right to life and health is not only about ensuring mere survival of the child, but also about providing services that promotes the realisation of a child’s physical, mental, cultural, social and spiritual wellbeing and their full human potential.
- **Article 12** recognises ***the right to express views freely***. In health care settings this relates to children being seen and heard in matters affecting health and health care and child-friendly and supportive environments are created around the child.

EU Reception Conditions Directive

³ For elaboration on “the best interest of the child” see Alston, 1994 and Detrick, 1999 p. 85-99.

In past years, there have been many new laws to better protect children and promote children's rights at the EU level⁴.

One such document is the ***EU Reception Conditions Directive***, which was adopted in 2003 and establishes common standards of living conditions for asylum applicants. The directive aims to ensure that applicants have access to housing, food, health care and employment, as well as medical and psychological care. The Directive was amended in 2013, and the obligation to conduct an individual assessment in order to identify the special reception needs of vulnerable persons, including accompanied and unaccompanied minors, was clarified (European Parliament, 2013 Ch. 4).

In Articles 23 and 24 the Directive specifically addresses minors and unaccompanied minors and applies the "the best interests of the child" perspective to address reception conditions for children. However, children's health care needs are not specifically addressed. It states that: *"Member States shall ensure a standard of living adequate for the minor's physical, mental, spiritual, moral and social development"* and further take into account the child's background when assessing the best interest of the child and ensuring the child's well-being and social development (European Parliament, 2013 Art. 23 (1,2)).

The Directive provides asylum seekers with certain minimum reception standards regarding access to health care. Article 19 states that: *"Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders"* and *"Member States shall provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care where needed"* (European Parliament, 2013 Art. 19 (1,2)). Article 13 states that EU Member States may require health screenings for applicants for international protection on public health grounds. There is, however, no obligation to undertake such screenings.

The general terminology within the articles allow member states to maintain very different national policies, that in some cases may fall short of an adequate standard of health care. The Directive does not address children outside the asylum system and defines a minor as *'a third-country national or stateless person below the age of 18 years'* (European Parliament, 2013 Art. 2, d). However, the Directive does relate to the UNCRC as it emphasizing the best interest of the child and by seeing children as a vulnerable group whose needs and reception conditions should receive special attention.

Rights of all children in the context of migration

The CRC recognizes that in all countries in the world there are children living in exceptionally difficult conditions and that such children need special consideration. Migrant children belong to this group and the Committee on the Rights of the Child has made explicit that: *"The enjoyment of rights stipulated in the Convention is not limited to children who are nationals of a State Party and must therefore, if not explicitly stated otherwise in the Convention, also be available to all children – including asylum-seeking, refugee and migrant children – irrespective of their nationality, immigration status or statelessness"* (Committee on the Rights of the Child, 2005, Ch. IV, a12).

This statement is backed up by the Committee on Economic, Social and Cultural Rights who notes the State obligation to respect the right to health by, *"inter alia, refraining from denying or limiting equal*

⁴ For a comprehensive overview of EU laws on child protection see European Commission, 2015 p. 3.

access for all persons, including ... asylum seekers and illegal immigrants, to preventive, curative and palliative health services” (Committee on Economic Social and Cultural Rights, 2000, Chp. II, 34). The committee further emphasises the principle of non-discrimination and affordable health care for all.

The Committee on the Rights of the Child has dedicated specific attention towards children in the context of migration and devoted its Day of General Discussion in 2012 to the rights of all children in the context of international migration. On this background the committee issued a report with 36 recommendations for States Parties to implement a systematic, comprehensive child-rights approach to migration. This report states that:

“States should ensure that all children in the context of migration have equal access as national children to economic, social, and cultural rights and to basic services regardless of their or their parent’s migration status, making their rights explicit in legislation. In doing so, States are strongly encouraged to expeditiously reform legislation, policies and practices that prevent or discriminate against children affected by migration and their families, in particular those in an irregular situation, from effectively accessing services and benefits such as health care, education, long-term social security and social assistance, among others” (Committee on the Rights of the Child, 2012, Chp. IV, 86).

The CRC report also addresses the administrative and financial barriers migrant children face in accessing services such as health care. The Committee advocates that alternative means of providing identity and residence, such as testimonial evidence, should be accepted and that mechanisms such as a duty for health care staff, for example, to report irregular migrants should be abandoned:

“States should ensure effective safeguards on information sharing between civil registries, public-service providers and immigration authorities to ensure that this is not contrary to the best interests of the child and does not expose them or their families to potential harm or sanctions. These safeguards must be implemented in law and in practice, including through issuing clear guidance for service providers and awareness-raising programmes on these safeguards amongst persons in irregular migration situations” (Committee on the Rights of the Child, 2012, Chp. IV, 87)

The importance of migrant children’s rights have also been recognised by the Council of the European Union, which in their Council Conclusions on unaccompanied minors notes that: *“the EU Charter for Fundamental Rights and the United Nations Convention on the Rights of the Child establish that children should be treated as such regardless of their migratory status, nationality or background” (Council of the European Union, 2010, para. c.)*

Furthermore, in its draft conclusions on the promotion and protection of the Rights of the Child, the Council invites member states to: *“ensure in practice that all children, are protected from discrimination and enjoy equal opportunities in order to allow them to develop their full potential”, and invites member states and the European Commission to “give full recognition to children as rights holders and to ensure respect for the principle of the best interests of the child in all policies affecting children” (Council of the European Union, 2014, para 5 and 13).*

In the European Parliament’s motion to a resolution on the 25th anniversary of the UN Convention on the Rights of the Child, the parliament reiterates that every child is first and foremost a child whose

rights should be fulfilled without discrimination, regardless of their or their parents' ethnic origin, nationality or social, migration or residence status (European Parliament, 2014,); and that more needs to be done to ensure that the rights of migrant children are fully respected across the EU.

Many migrant children have escaped armed conflicts in the country of origin and deal with mental health problems as a consequence of their war experiences. Paragraph 39 of the UNCRC addresses the right of these children to “all appropriate measures to promote physical and psychological recovery and social reintegration” ... “in an environment which fosters the health, self-respect and dignity of the child”.

United Nations High Commissioner for Refugees – the United Nations Refugee Agency (UNHCR)

In response to the “refugee crisis” in Europe during the fall of 2015 the United Nations Refugee Agency (UNHCR) suggested a regional public health strategy. Central to this strategy was access to essential health care services at “equal levels to that of nationals”. This refers primarily to “comprehensive primary care” including vaccinations, breastfeeding support and brief evidence based psychological treatments for mild-moderate mental health problems (UNHCR, 2015).

The legal texts highlighted above emphasise the need for governments and national health systems to recognise and address the specific needs of vulnerable groups of the population, hereunder migrant children, and put in place implementation and monitoring systems that contribute to equitable health system for all children. In particular, the articles in the EU Reception Condition Directive and the CRC regarding vulnerable groups and health care provides a rights-based approach to strengthening migrant children's health systems and a provides an important framework and motivation for action.

Aim

The aim of this report is to compare national legal entitlements to healthcare for three groups of migrant children across the EU/EEA countries; namely child asylum seekers, irregular third-country migrants and irregular migrants from other EU countries, in a human rights framework.

Methodology

Categories of migrant children included in the study

In the report we have chosen to include three categories of migrant children, which are in separate ways vulnerable and exposed populations. The report compares these children's entitlements to those of national resident children and also compares entitlements across the different categories of migrant children. This illustrates how legal rights are in many instances bound to migrant status rather than to the fact of being a child. The report only peripherally addresses unaccompanied children and issues related to age determination⁵. Furthermore, it is outside the scope of this report to include families and children in detention. The three categories of migrant children considered by this report are:

Asylum seekers

These children are very vulnerable, whether accompanied or alone. Many of these children have experienced war, violence, acts of cruelty and similar traumas. While seeking asylum they live in circumstances characterized by their temporary nature and uncertainty about their situation and future. If they are with their parents, they are also exposed to the parents' traumatizing experiences and stressful situation. Special care directed towards this group is therefore crucial.

Irregular third-country migrants

These children are in a position of triple vulnerability: they are children; they are migrants; and they are in an irregular migrant position. Despite the many legal protections in international and regional human rights instruments that guarantee all children access to civil, economic, social and cultural rights, irregular migrant children still face countless barriers to exercising their fundamental rights to access healthcare, housing and education.

Irregular migrants from other EU countries

These children have only recently started to gain attention and their legal entitlements in many countries are unclear. They are children of EU citizens, who have made use of the right to free movement⁶, but cannot make use of the Directive on cross border-health care (EU Parliament, 2011) because they have either overstayed the three months legal residency period, they lack resources, health coverage (non-holders of the EHIC card), valid identification papers, or have not registered with the authorities for various other reasons. These children may have travelled with their parents to another EU country to beg, and they live in isolation, they are not included in the school system and are not even automatically granted the same entitlements as irregular third-country migrants. In many countries such children are in a legal vacuum as they have EU citizenship, but fall outside EU social security regulations.

⁵ For a recent report on age determination see: <https://www.easo.europa.eu/sites/default/files/public/EASO-Age-assessment-practice-in-Europe1.pdf>

⁶ According to EU directive 2004/38/EC on Free Movement EU citizens can reside legally up to three months in another EU country as long as they have a valid ID-card or passport. Economically non-active persons (e.g. unemployed, students, retired, etc.) have the right to reside for longer than this period if they: *"have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State during their period of residence and have comprehensive sickness insurance cover in the host Member State"* (European Parliament, 2004, Art. 7b).

Data collection

The data used in this report is based on a combination of surveys and desk research.

Surveys

Questionnaires were circulated to MOCHA National Country Agents and members of the European Network of Ombudspersons for Children (ENOC) as well as members of the European Council of Refugees and Exiles (ECRE). The data was collected between November 2015 and February 2016.

Questionnaires focusing on national legal entitlements to health care for different groups of migrant children were prepared and circulated to National Country Agents⁷ and members of the European Network of Ombudspersons for Children (ENOC). The questionnaires were of an open ended form to enable respondents to place attention to issues they found relevant within the overall theme.

In order to ensure that sufficient information was obtained from each country, members of the ENOC were also asked to complete the questionnaire. The members of the network were contacted by phone to obtain personal email addresses and contact persons where possible, and the questionnaire was sent and received via email. For countries that are not members of ENOC, National Ministries responsible for migrant children's health care were contacted. Depending on the country, the ministries were related to interior affairs, health, social affairs, immigration, or foreign affairs. Questionnaires were also circulated to members of the European Council of Refugees and Exiles (ECRE). The obtained information was triangulated and coherence tested. The final mapping of entitlements was re-circulated to the national Country Agents and doubled checked and approved.

Desk research

A *Database search* was conducted to identify academic literature using the Google Scholar and PubMed databases, and using the key words: migrants, children, health care, access, entitlements, EU, policies.

A *Google search*, using the same keywords as above, was used to identify grey literature in the field such as reports, government information, law texts and guidelines, as well as to identify relevant organisations working in the field.

Publications from international and regional organisations specifically concerning migrants, entitlements to health care and children were identified. Publications from the following organisations were used as baseline studies and inspiration: World Health Organisation (WHO), International Organisation for Migration (IOM), Platform for International Cooperation on Undocumented Migrants (PICUM), Centre on Migration, Policy and Society (COMPAS), Health for Undocumented Migrants and Asylum seekers Network (HUMA), Médecins du Monde (Médecins du Monde), European Union Agency for Fundamental Rights (FRA), United Nations Children Fund (UNICEF), Save the Children, United Nations High Commissioner for Refugees (UNHCR).

Online platforms and EU projects regarding migrants, health and health policies were identified such as: MigHealthNet, NowHereland, Health Systems in Transition (HiTs), MIPEX, EquiHealth, AIDA, and Pucafreu.

Webpages from National Ministries related to health, migrants and social issues were scrutinised.

⁷ The National Country Agents are local experts involved directly in the MOCHA research project and regular rounds of questions addressed to the Country Agents were planned from the project start.. For a list of country agents see: <http://www.childhealthservicemodels.eu/partnerlisting/country-agents/>

PICUM monthly bulletins is a bi-monthly publication, which provides up-to-date news and information on issues related to the situation of undocumented or irregular migrants in Europe. These bulletins were read regularly to check on any updates on national developments and laws in Europe concerning migrant children and health care. Search words used were: European policy development, National developments, Healthcare, and Undocumented children and their families.

Entitlements: Definition and focus

In this report we use the term '*entitlement*' rather than '*access*' to explain migrant children's rights to health care as defined in national laws. The term '*entitlements*' describes the *potential entry* of a given population group to the health care delivery system. Whereas '*access*' relates more to *actual entry* where implementation gaps and barriers such as refusal of access by service providers or administrative staff; lack of knowledge about entitlements and the health care system from the migrant and migrant families' side; and language barriers to mention a few, are important factors for consideration⁸. The access barriers faced by migrants in accessing health care in practice have been the focus of a number of studies including PICUM, HUMA, FRA and Médecins du Monde. Access barriers in practice remains an important topic to address, and the absence of legal restrictions to access does not necessarily imply equity in access as practical barriers may hinder this (Norredam, Mygind, & Krasnik, 2006 p. 287).

However, the focus of this report is the extent to which national laws are congruent with international treaties signed by Member States regarding equal access to health care for all children. To this effect, the report will investigate entitlements described in national laws and guidelines regarding migrant children's rights to health care services. We will both include explicit entitlements given to *specific groups* of migrant children, and implicit entitlements in countries where it is stated that *all* children have access to specific services. To the greatest extent possible we will describe whether migrant children are explicitly mentioned in law or not, and the level of detail regarding their access to health care. We will also take into account the formal mechanisms which in effect limit potential entitlements; for example a significant requirement to pay, complicated documentary requirements, or administrative procedures or service providers' duty to report undocumented or irregular migrants to the authorities.

When mapping entitlements in table 1-3 we use the following components, namely:

- *Coverage* (the range of services covered – emergency care or care beyond emergency care including primary and secondary care) and *Cost-Sharing* (the level of co-payment and out-of-pocket financial contribution required from the service user – free of charge, co-payment, full charge)
- *System barriers to entitlements* (formal mechanisms or conditions which in effect limit entitlements)
- *UAMs* (Special entitlements for unaccompanied minors)
- *Financing* (universal state scheme, insurance scheme or other)
- *Equality dimension* (Level of care compared to national children)

Levels of health care compared to national children

⁸ For more on potential and actual entry to healthcare systems and on definitions of access and entitlements see: Aday, Andersen, & Fleming, 1984.

There is no one clear-cut definition of equitable access to health services (Allin, Masseria, Sorenson, Papanicolas, & Mossialos, 2007). Most commonly, it is described as equal access to treatment for those in equal medical need, irrespective of other characteristics, such as income. This principle is also known as 'horizontal equity' of health care delivery (Wagstaff & Doorslaer, 2000). In contrast, the concept of 'vertical equity' refers to the extent to which individuals on unequal incomes are treated proportionately to achieve equity ('fairness') in health care finance (Tamsma & Berman, 2004). This report investigates the horizontal dimension, also referred to as equality in health, whereas the vertical dimension refers to equity in health. When analysing equality we investigate if migrant children and national children according to national legislation have equal rights to health care services. We divide migrant children's entitlements to health care compared to national children into four categories:

Entitlements equal to nationals regarding coverage and cost and included in same health care system (Equal entitlements regarding coverage, cost-sharing and included the same health care system)

Entitlements equal to nationals regarding coverage and cost but enrolled in parallel health care system
(Entitlements are close to those of nationals, but parallel health systems are used)

Entitlements restricted compared to nationals
(Entitlements restricted either due to lack of legal provision which causes differences in coverage or cost sharing, or very complicated administrative procedures, a duty to report or other conditions which in effect nullifies entitlements)

Unclear legal provision
(Entitlements are unclear and ambiguous)

Results

In the following sections entitlement to health care services for each group of migrant children is presented in separate sections; asylum seekers, irregular third-country migrants, and irregular migrants from other EU countries. Each section is summarised in a table which provides a country overview of which health care services the children are entitled to and on which terms (full cost, co-paid, free of charge), any formal conditions tied to the entitlements, sources of financing, special entitlements for unaccompanied minors and levels of equity in entitlements compared to national children. For more specific details on sources and legislation in each country, see the annex section.

Child asylum seekers

Table 3 displays health care entitlement for asylum-seeking children and compare these to those of national children.

Table 3: Health care entitlements of Child asylum seekers																																		
<div>Colour code</div> <table><tr><td colspan="7">Entitlements equal to nationals regarding coverage and cost and included in same health care system</td></tr><tr><td colspan="7">Entitlements equal to nationals regarding coverage and cost but enrolled in parallel health care scheme</td></tr><tr><td colspan="7">Entitlements restricted compared to nationals</td></tr><tr><td colspan="7">Unclear legal provision</td></tr></table>							Entitlements equal to nationals regarding coverage and cost and included in same health care system							Entitlements equal to nationals regarding coverage and cost but enrolled in parallel health care scheme							Entitlements restricted compared to nationals							Unclear legal provision						
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Unclear legal provision																																		
	Coverage and cost sharing		System barriers to entitlements	Financing	UAMs *	Equality dimension																												
	Emergency care	Care beyond emergency care		of Sources financing	Special entitlements for unaccompanied	Level of care compared to national children																												
Austria	Free of charge	Free of charge	Entitlements are conditioned upon the families not leaving their designated quarters for several nights	The costs are shared between Federal Government (60 %) and the Länder (40 %). After 1 year the costs are undertaken by the Federal Government completely.	No																													
Belgium	Free of charge	Free of charge	For those residing outside the centres, the administrative procedures for accessing health care are complicated as a complex parallel administrative system has been put in place	Healthy baby clinics is paid for via taxes, while GP, emergency and secondary is social security (National Institute of Health and disability) and paid for by compulsory participation of employers and employees in an insurance scheme (Bismarkian system)	Yes																													
Bulgaria	Free of charge	Free of charge	Long administrative procedures	The State covers the health insurance of all children in Bulgaria through the National Health Insurance Fund.	No																													
Croatia	Free of charge	Free of charge		The service provider claims expenses from the Ministry of Health which uses funds from	No																													

				the state budget to pay for them.		
Cyprus	Free of charge	Free of charge		Tax based State-funded public health system	No	
Czech Republic	3 euro Service fee	Free of charge	Small out-of-pocket amount for outpatient services	The provided care is reimbursed by insurance; user is entitled to claim the paid amount from the Ministry of Health of the Czech Republic.	No	
Denmark	Free of charge	Free of charge	Only “necessary care”	Red Cross funded by the state via taxes.	No	
Estonia	Free of charge	Free of charge		Health insurance fund or state budget	Yes	
Finland	Free of charge	Free of charge		The Ministry of the Interior's branch of government	No	
France	Free of charge	Free of charge	In order to receive CMU ⁹ they need to provide an address, which is often complicated, as their accommodation is often precarious	No data	Yes	
Germany	Free of charge	Free of charge after 15 months of residence	Medical interventions are only allowed in cases of acute diseases and pain during the first 15th months of their stay.	No data	Yes	
Greece	Free of charge if cannot pay	Free of charge if cannot pay	Prescription of pharmaceuticals is performed only through an electronic prescription system using a person's unique security number, which the asylum-seeking child lacks.	Tax based State-funded public health system	No	
Hungary	Free of charge	Free of charge	Access to health care depends on application phase, residency and schooling	Through National Health Insurance Fund, however when handling people in phase with no submitted application, all health providers are obliged to examine whether expenses are recoverable or not.	Yes	
Iceland	Free of charge	Free of charge		Care is funded by the state treasury. Emergency care is funded according to Regulation no. 1142/2015 on health care services to those not covered by the National Health insurance. The municipalities that receive asylum seekers are paid an index-linked daily fee for each asylum seeker and utilize it to provide housing, food, general health care, education and various other services.	No	
Ireland	Free of charge	Free of charge		Tax based State-funded public health system	No	

⁹ CMU (Couverture d'Assurance Maladie) and CMU-C are basic and supplementary universal medical coverage created in 2000 in order to enable people who are not covered by the health insurance scheme to have access to healthcare.

Italy	Free of charge	Free of charge		The payment of the fixed fee normally payable for access to health care (out-of-pocket portion of the service, Ticket) is excluded for people with income of less than 8.263,31 euros. The urgent or essential hospital services are paid by the Ministry of the Interior, while other benefits are covered by the National Health Fund	No	
Latvia	Free of charge	Free of charge	No data	No data	No	
Lithuania	Free of charge	Free of charge		State budget, via allocations to the Budget of Compulsory Health Insurance Fund	No	
Luxembourg	Free of charge	Free of charge after 90 days	Complex bureaucratic system	Public healthcare insurance	Yes	
Malta	Free of charge	Free of charge if cannot pay		Tax based State-funded public health system		
Netherlands	Free of charge	Free of charge	Only "necessary care"	Menzis COA Administration financed by the state	Yes	
Norway	Free of charge	Free of charge		Primary care is financed by the municipality by taxes, block grants from the central government and earmarked grants for specific purposes. A major source of financing is also the National Insurance System (through a fee-for-service payment and reimbursement of user's fees) administered through HELFO The Norwegian Health Economics Administration. Secondary care is funded through the state, which owns and runs the hospitals All funding through state or municipality is tax based.	No	
Poland	Free of charge	Free of charge	Access to services in selected health facilities (having signed an agreement with Central Clinical Hospital of the Ministry of Internal Affairs).	Tax based State-funded public health system through contract with Central Clinical Hospital of the Ministry of Internal Affairs	No	
Portugal	Free of charge	Free of charge		Tax based State-funded public health system	No	
Romania	Free of charge	Free of charge		General Inspectorate for Immigration whose funds are coming from the European Fund for Refugees. Provides coverage for the Health Insurance for the children.	No data	
Slovakia	Free of charge	Unclear		If without health insurance, the Migration Office of the Ministry	Yes	

	if cannot pay			of Interior finance health care via contracted health institutions		
Slovenia	Free of charge	Free of charge	No data	No data	Yes	
Spain	Free of charge	Free of charge		Tax based State-funded public health system	No	
Sweden	Free of charge	Free of charge		The care is funded via taxes by the state through a fixed amount per child and month. For more costly care extra funding is available, but has to be asked for and approved by a special state office.	No	
UK	Free of charge	Free of charge	To access primary care children and young people require an NHS number – to obtain an NHS number a child or young person must be registered with a GP	No data	Yes	

*UAM=Unaccompanied minors

Entitlements equal to nationals regarding coverage and included in the same health care scheme

Table 3 shows that in 20 countries¹⁰, child asylum seekers are entitled to an equal level of care to that of national resident children including emergency, primary and secondary health care and enrolled in the national health system.

However in a number of countries, system constraints may effectively limit these entitlements. In *Austria*, child asylum seekers are entitled to basic services, including access to health care and all health services. However, entitlements are dependent upon the families not leaving their designated quarters for several nights. In countries such as *Belgium* and *Finland*, asylum seekers can choose if they want to live in asylum centres or reside outside these centres. However, in Belgium those residing outside the centres face complex administrative procedures to access health care, because of a complex parallel administrative system that has been put in place. Children aged from 0-6 can access the healthy child clinics. Here, immunization, screening, and prevention programmes are offered free of charge. *France* and *Greece* suffer from overcrowded asylum centres, forcing some families to sleep on the streets, and have to wait a long time before accessing any asylum procedure. The situation in Greece is especially worrying because of the financial crisis, and the high pressure on the Greek asylum system. Due to resource constraints, specialized care for children is currently limited. NGOs are the principal service provider, and many of these organizations have withdrawn from the country in protest at the living conditions of asylum seekers. Furthermore, in Greece, pharmaceutical prescribing is performed solely through an electronic prescription system, which uses a person's unique security number, which the asylum-seeking child lacks. In these cases, pharmaceuticals can be obtained only by NGOs or other private initiatives. Immunizations are in principle provided for free, but currently there are vaccine shortages in the country. In *Luxembourg* child asylum seekers benefit from public healthcare insurance, but they must contribute to costs in a small way, which is eventually refunded to

¹⁰ Austria, Belgium, Croatia, Cyprus, Czech Republic, France, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, Norway, Portugal, Romania, Spain, Sweden, UK.

them. The procedure to reclaim expenses is quite bureaucratic, and one that constitutes an important and unnecessary workload for social workers. Public health care insurance only becomes effective after a period of 90 days, during which health care is provided through a voucher system.

In countries such as *Hungary, Iceland and Ireland* asylum-seeking children's entitlements to health care are not directly addressed in legislation; but it is assumed they have equal entitlements to those of nationals. In Hungary, asylum seekers waiting for acknowledgement of their application for asylum are eligible for same level of health care as nationals for a one year period. Access to healthcare for children (aged under 18) depends on their status of residency and on their education status. In *Malta* applicants are provided with emergency health care, including essential treatment of illness and serious mental disorders. Medical and other assistance is provided to applicants who have special reception needs, including mental health care. However, it is not clearly defined what services this includes.

In the *UK*, in order to access primary care children and young people require a National Health Service (NHS) number. In order to obtain an NHS number a child or young person must be registered with a general practitioner (GP). Anecdotal feedback indicates that there can be difficulties in registering children and young people with GPs, which can lead to delays in receiving non-urgent care. There is limited data identify exactly how many children have experienced delays in access as a result of being of an asylum seeker.

In *Croatia*, asylum seekers' entitlements to health care were reduced in 2013 from 'necessary' to emergency care only. However, children were not included in these restrictions and are fully insured and have the same entitlements as nationals.

In the *Czech Republic*, asylum seekers have to pay a small amount for outpatient services, which is similar to that of nationals. However, as highlighted elsewhere, even small amounts of co-funding can have an impact on low income groups, such as most asylum seekers.

Entitlements equal to nationals regarding coverage and cost, but enrolled in parallel health care system

In another group of countries¹¹, the child asylum seekers are entitled to similar health care to that of nationals; but not on the same terms. They are enrolled in parallel health care schemes. Services are primarily located at the asylum centres or reception facilities and designated health care staff assigned to the families.

In *Bulgaria* the State Agency for Refugees (SAR) is responsible for providing the health care for asylum seekers at designated centres. Problems have been reported, regarding long administrative procedures which are meant to transfer insurance-related data from the SAR to the National Revenue Agency and from there on to general physicians.

In countries such as *Estonia, the Netherlands and Denmark*, child asylum seekers have a right to *necessary* medical care and it is up to individual service providers to determine what necessary care is for each child. In Estonia, asylum seekers are included in the system of health care coverage if they are accommodated by a reception or detention centre; and the centre chooses the particular health care provider, as well as the time and location of treatment. Families living outside such centres are not

¹¹ Bulgaria, Denmark, Estonia, Finland, Lithuania, Netherlands, Poland, Slovenia.

included in health care coverage. In Denmark, health care is outsourced by contract between the Danish Immigration Service and operators of the asylum camps (the Red Cross). Prior to 2014, the well-being of asylum children was the responsibility of the Danish municipalities, who were obliged under the Service Law to protect children exposed to vulnerability. These children have now been excluded from this law, and asylum-seeking children, including unaccompanied children, are now solely under the responsibility of the Danish Immigration Services. In the Netherlands, asylum seekers access healthcare via a parallel scheme of primary care contracting, which is organised by Menzis, a non-profit insurance company commissioned by the Central Agency for the Reception of Asylum seekers (Centraal Orgaan opvang asielzoekers – COA). On the one hand, this means that they can only turn to GPs, physiotherapists, dentists, hospitals and pharmacies who are contracted to Menzis. On the other hand, no out-of-pocket payments are required, not even a franchise.

In *Poland*, health care services are provided in selected health facilities and primary health care is provided by doctors working in centres for refugees. Asylum-seeking families and their children cannot choose a doctor. Emergency care is provided without preconditions. To access diagnostic tests, specialist care or hospital treatment, a child must obtain a referral from a doctor working in a refugee centre.

In *Lithuania*, child asylum seekers are covered by the same compulsory health insurance system as that which grants medical care to resident children. Costs are covered by the state budget by means of allocations to the Budget of Compulsory Health Insurance Fund. Primary health care for asylum seekers is provided by the Ministry of the Interior, in clinics at the Foreigners Registration Centre. If these clinics are unable to provide treatment, health care institutions within the Lithuanian national health system can be used.

In *Slovenia*, asylum seekers aged under 18, have the same entitlements to the health care system as nationals. However, research and experiences of the NGO sector, show that implementation of this legal provision is not always successful in practice. This is because a special procedure is required in order to obtain health insurance on this legal basis. Outpatient clinics are located at asylum centres. In the event of serious health problems, the asylum seekers are examined at a nearby health care centre, and urgent cases are treated at the emergency department of the Ljubljana University Medical Centre.

Entitlements restricted compared to nationals

In *Germany* and *Slovakia* entitlements to health care for asylum-seeking children are formally restricted, compared to nationals.

In Germany, the same general rules apply for children and adult asylum seekers. Medical interventions are only allowed in cases of acute disease and pain, during the first 15 months of their stay. However, legally, children can receive other care which meets their specific needs; although this provision does not specify the particular treatments that children may receive.

In Slovakia, child asylum seekers have the same entitlements as adults, which is only free emergency care. Some NGOs are active in providing other care to these children, but the legal entitlements to care are limited. Furthermore, many health-care providers are reluctant to accept migrant patients, because it involves extra administration.

Unaccompanied asylum-seeking children

In nine countries,¹² unaccompanied minors (UAMs) have special entitlements to health care when enrolled in the asylum procedure and placed in state custody. In *Belgium, France* and *Estonia*, UAMs are included in the insurance system and thus avoid complex administrative procedures in order to access health care. In *Croatia*, in general they are given more attention by health care providers compared to accompanied migrant children, and are subject to targeted health promotion campaigns and programmes.

In *Germany*, asylum-seeking UAMs' health care is based on the child's individual needs, including access to psychological care. In *Luxembourg*, the probation period of three months before gaining health care insurance does not apply to UAMs. They are covered immediately. In *Slovakia* and *Slovenia*, UAMs should be covered by the public health insurance system and have their health insurance paid by the State, unlike asylum-seeking accompanied children. In the *UK*, UAMs in the asylum system are entitled to NHS treatment on the same terms as national children and other children in care facilities. Services include trained and independent interpreters, counselling, health services (medical and sexual) and mental health services.

¹² Belgium, Estonia, Germany, Hungary, Luxembourg, Netherlands, Slovakia, Slovenia, UK.

Irregular third-country migrants

Table 4 displays health care entitlement for children of irregular third-country migrants and compares these to those of national children.

Table 4: Health care entitlements for children of irregular third-country migrants						
Colour code <div> Entitlements equal to nationals regarding coverage and cost and included in same health care system Entitlements equal to nationals regarding coverage and cost but enrolled in parallel health care scheme Entitlements restricted compared to nationals Unclear legal provision </div>						
	Coverage and cost sharing		System barriers to entitlements	Financing	UAMs*	Equality dimension
	Emergency Care	Care beyond emergency care		Sources of financing	Special entitlements for	Level of care compared to national children
Austria	Free of charge if cannot pay	Full cost			Yes	
Belgium	Free of charge	Free of charge	Obtaining from the municipality document for Urgent Medical Aid	Healthy child clinics by taxes; for GP, secondary, emergency and hospitalization, the care for irregular migrants in the curative streamline is reimbursed to the hospitals by the Ministry of Social Integration, not the Ministry of Health.	Yes	
Bulgaria	Full cost (rates established by health providers)	Full cost	A duty to report to the authorities for health care staff	-	No	
Croatia	Free of charge if cannot pay	Free of charge if cannot pay		The service provider claims expenses from the Ministry of Health which uses funds from the state budget to pay for the expenses.	Yes	
Cyprus	Free of charge	Unclear		Tax based government funded	No	
Czech Republic	Free of charge if cannot pay	Full cost		Emergency care is reimbursed by the VZP - General Health Insurance Company which claims expenses from the Ministry of Health of the Czech Republic.	No	

Denmark	Free of charge if cannot pay	Unclear		The region or the Danish Immigration Service reimburses	Unclear	
Estonia	Free of charge	Free of charge		No data	No data	
Finland	Free of charge	Full cost except for municipalities like Helsinki and Turku		Care beyond emergency care paid by migrants themselves, except in a few municipalities which funds care beyond emergency care.		
France	Free of charge	Free of charge			Yes	
Germany	Free of charge	Full cost	A duty to report to the authorities for health care staff			
Greece	Free of charge	Free of charge	Currently prescription of pharmaceuticals is performed only through an electronic prescription system using a person's unique security number, which the irregular child lacks. In these cases, medicines and pharmaceuticals can be obtained only by NGOs or other private initiatives	By the Greek state and social security funds	Yes	
Hungary	Free of charge if cannot pay	Full cost		The healthcare provider may ask for reimbursement for its services. If a patient fails to pay for the treatment received, the treatment's costs shall be reimbursed from the central budget through the National Health Insurance Fund, after concluding the relevant proceedings.	Yes	
Iceland	Free of charge if cannot pay	Unclear		Emergency care is funded by the state treasury.	Unclear	
Ireland	Free of charge if cannot pay	Full cost	However, there is no duty to report a child/family purely on the basis of being an irregular migrant.	The cost of urgent medical treatment is dependent on the providers' discretion. Patients are eligible to apply for reduced or waived hospital charges if they will incur a 'financial hardship'. If an irregular migrant does not pay for the care, the cost is covered by the state	Yes	
Italy	Free of charge if cannot	Free of charge if cannot pay		The benefits shall be provided without cost to the applicants if lacking	No	

	pay			sufficient resources. The urgent or essential hospital services are paid by the Ministry of the Interior, while other benefits are covered by the National Health Fund.		
Latvia	Free of charge	Full cost				
Lithuania	Free of charge	Full cost		Sometimes the fees are covered by NGO's, but it is not officially regulated and is on a voluntarily basis only.	Yes	
Luxembourg	Free of charge	Full cost				
Malta	Unclear	No entitlement	-	-	Yes	
Netherlands	Free of charge if cannot pay	Free of charge if cannot pay (and to protect public health)		Depends on the medical diagnosis. The Healthcare Insurance Board (CVZ) website lists the contracted providers for reimbursement of costs of indirectly accessible care for uninsured illegal immigrants - pharmacies, hospitals and the ambulance service. For care that is covered by the Exceptional Medical Expenses Act (EMEA) (AWBZ) and for mental health care, the CVZ states that a contract will be formed with the institutions concerned. Youth health care is financed via municipal funds. Whether or not health care to children/young people without a residence permit will be reimbursed depends on the policy of the individual municipality.	Yes	
Norway	Free of charge	Free of charge	Lack of financial funds may hinder access to medication. The healthcare centre for undocumented migrants in Oslo will provide medication free of charge (for children and adults), but is hardly accessible for all	Funded by the state/municipality/HEL FO system as resident children	No	
Poland	Unclear	Full cost for most services.	School attendance	Funded by the state	Yes	

		Preventive check-ups free of charge if attending school. Secondary care related to infectious diseases also free of charge.				
Portugal	Free of charge	Free of charge		State budget	No	
Romania	Free of charge	Free of charge	A requirement for health care is a personal identification number. Despite the legal statement of equal access to health care for all children, the absence of a personal identification number seriously limits irregular migrant children's access to the primary care services, to specialized medical services and to medication or other treatment; particularly costly treatments and medications. .	General Inspectorate for Immigration, funded by the European Fund for Refugees	No	
Slovakia	Free of charge	Full cost		Emergency care is paid by the State budget. Primary and special care is paid via "private" and mainly 3rd sector-NGOs, CBOs, FBOs organisations involved in social work and comprehensive care (e.g. Slovak Catholic charity, HIA, St. Elizabeth university, other bodies from this category e.g. UNICEF) for vulnerable children, OVCs and migrants' protection.	Yes	
Slovenia	Free of charge	Full cost (extended access if attaining school)	Complicated bureaucratic procedures	No data	No	
Spain	Free of charge	Free of charge	In order to receive care beyond emergency care, irregular migrants must obtain a health card, and therefore need to be registered at the city			

			council. To do that, they need an official identity document. Moreover, they have to prove they have an official resident address in order to be registered at the city council.			
Sweden	Free of charge	Free of charge				
UK	Free of charge	Primary care free of charge, secondary care full cost	In order to access primary care children and young people require an NHS number – to obtain an NHS number a child or young person must be registered with a GP. Anecdotal feedback indicates that there can be difficulties in registering children and young people with GPs which can lead to delays in receiving non-urgent care.		No data	

* UAMs=Unaccompanied minors

Entitlements equal to nationals regarding coverage and included in the same health care scheme

In 11 countries¹³, migrant children in irregular third country families are entitled by law to receive the same health care as national children. However, the level of specific entitlements defined in law varies. In *Estonia* and *Romania*, entitlements are implicit, as legislation states that all children are covered by state or health insurance fund including dentistry. However, in Romania a precondition for health care is the existence of a personal identification number, which seriously limits the access of irregular child migrants to the services of a primary care physician, to specialized medical services and also to costly medications. In *Sweden*, the rights of irregular migrant children to health care were made explicit in law in 2013, after years of advocacy and political discussions. Irregular third-country children now have the same entitlements to health care as nationals. In *Spain*, health care entitlements for irregular adult migrants were restricted in 2012, while irregular migrant children are still entitled to a level of care equal to that of national children. In *Croatia*, irregular migrant children have access to emergency medical assistance, general/family medicine services and hospital treatment if the child's medical condition requires. Services for irregular children are mostly related to paediatric trauma, dehydration, wound infections, fatigue, posttraumatic stress, pneumonia, hypothermia and frostbite. In addition to a medical check-up and primary health care services, all children are provided with necessary medicines. In *Portugal*, access to health services for irregular migrants is organized through the assignment of a temporary code at first contact with health centres. The II National Plan for the Integration of Immigrants (2010-2013) embodies several measures to improve an immigrant's access to the NHS. One measure is a practical manual to manage diverse situations, such as the procedures to implement in the case of an irregular migrant child receiving health care in the NHS. This requires a formal communication to the National Immigrant Support Centre. In *Greece*, the law is explicit about irregular third-country minors' entitlements to health care regardless of status; as the law that limits health care for irregular third-country nationals excludes minors. However, it does not specify to

¹³ Belgium, Croatia, Estonia, France, Greece, Italy, Norway, Portugal, Romania, Spain, Sweden.

which services the children are entitled. In *Belgium* and *France*, children of irregular third-country migrants are, in principle, entitled to the same health care as national children; but they do not qualify for national health insurance. In Belgium, irregular migrants are eligible for Urgent Medical Assistance (Aide Médicale Urgente – AMU/DMH) free of charge. In France, irregular migrant children must qualify for the state medical aid (AME), while unaccompanied irregular migrant children have access to universal health coverage (CMU).

Entitlements restricted compared to nationals

In 15 countries¹⁴, entitlements for children of irregular migrants are restricted, compared to those of national children. In most of these countries care beyond emergency care is only available at full cost. In other countries, entitlements beyond emergency care are provided, but not equally to that of national children. In *Austria*, irregular children are entitled to emergency and “basic services” without further clarifications. In *Poland*, irregular migrant children who attend school are entitled to preventive check-ups, including immunization. In *Ireland*, children of irregular third country migrants are linked to public health nursing from birth, and are entitled to access optical, dental and hearing screening via school health screening programmes. A ‘catch-up’ immunisation programme has been developed by the Health Protection Surveillance Centre (2015) based on National Immunisation Guidelines.

In the *UK* irregular migrant children have free access to emergency and primary care, but have to pay full cost for non-urgent secondary care and dental care.

In Germany, in cases of emergency care, such as that provided by emergency hospital departments, the health care provider has to apply for reimbursement from the social welfare office (Sozialämter). This extends medical confidentiality to the welfare office. However, any other care must first be approved and the welfare office has a potential duty to share undocumented patients’ data with the relevant authorities. As for health care professionals, medical confidentiality applies. However, in combination with distrust in these rules this means that in effect irregular children have limited access to health care.

In *Finland*, irregular migrants are not mentioned in any legislation; and it is assumed that irregular migrant children are entitled to emergency care only. Some municipalities, including Helsinki, for example, have decided to provide all health care services for irregular migrant children and pregnant women.

In *The Netherlands*, irregular migrants have no rights to public services, with the exception of legal assistance, education (for children between 5 and 16), medically necessary care and preventive health care in the context of protecting public health. Treatment under these conditions is reimbursed by a special government fund, which allows reimbursement without formally establishing the identity of the irregular migrant (otherwise default, identification is obligatory, based on a national individual identifying code (‘BSN’)). In all other cases, irregular migrants must pay medical care costs themselves. In practice, however, some doctors are willing to treat irregular migrants free of charge. In April 2008, the Parliament approved proposals to make medical care for this group more available, including full

¹⁴ Austria, Bulgaria, Czech Republic, Finland, Germany, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Netherlands, Poland, Slovakia, Slovenia, UK.

reimbursement of costs related to pregnancy and childbirth. The law was enacted on January 1st, 2009. An 'illegal' child cannot get health insurance, for that you have to be a legal resident of the Netherlands.

In *Poland*, health care is normally given to all children who attend school until the age of 18, however for irregular migrant children who do not attend school access to health care is very difficult.

In *Slovakia*, care beyond emergency provision is available only at full cost to the migrant. Health care staff are not obliged to report irregular migrants to the police or other authorities. However, staff occasionally report to authorities as they mistakenly believe that they are required to do so. Many physicians and mainly private health centres do not accept irregular migrants from fear of transmissible diseases or losing clients.

Unclear legal provision

In the last group of countries: Denmark, Cyprus, Iceland and Malta, legislation on health care for irregular children is very unclear. According to *Danish* law all children below school attendance age have the right to seven preventive examinations by a general practitioner. This includes a health care examination and childhood vaccinations. This assumes that children of irregular migrants have the same entitlements to health care as national children. However, the legislation is unclear, and in reality entitlement depends on assessments from individual doctors. In *Malta*, there is no legal basis for care for irregular migrant children, except for an operational policy of the Department of Health, which supports health care for irregular migrants. However, in practice, all care in the community is provided free of charge at the government health centres to all who attend, because there is no billing and payment system in place. The legislation in *Iceland* regarding irregular migrant children is unclear, but individuals without national health insurance who are not covered by international agreements only have rights to emergency care in the public health system. In reality, children are treated, and if the parents are in an irregular migrant situation, health care personnel are obligated to inform child protection authorities if illegality prevents the child from receiving necessary services and security.

Unaccompanied irregular migrant children

In at least 12 countries unaccompanied minors (UAMs) have more entitlements to health care than accompanied minors. In some countries, irregular UAMs have the same entitlements as asylum-seeking children, whereas accompanied children face restrictions. In Belgium and France, unaccompanied children have access to health insurance, whereas more complicated and different administrative procedures are used for accompanied irregular minors. However, in some countries the procedures aimed at strengthening entitlements for UAMs, such as the implementation of the EU Reception Directive, do not always include irregular UAMs.

Irregular migrants from other EU countries

Table 5 displays entitlements to health care for children of irregular migrants from other EU countries and compare these to those of national children. Seven countries¹⁵ are not included in this table due to ambiguous answers.

Table 5: Health care entitlements for children of irregular migrants from other EU countries						
Colour code						
Entitlements equal to nationals regarding coverage and cost and included in same health care system						
Entitlements equal to nationals regarding coverage and cost but enrolled in parallel health care scheme						
Entitlements restricted compared to nationals						
Unclear legal provision						
	Coverage and cost sharing		Formal barriers to entitlements	Financing	UAMs*	Equality dimension
	Emergency Care	Care beyond emergency care	Formal barriers to entitlements	Sources of financing	Special entitlements for unaccompanied minors	Level of care compared to national children
Austria	Free of charge if cannot pay	Full cost		Emergency care Reimbursed by Social Services	Yes	
Belgium	Free of charge	Free of charge after 3 months	Must register with the commune where they reside. They will then have three months of no access to UMA (Urgent Medical Aid), and after 3 months they have same entitlements as irregular third-country nationals.	For healthy child clinics see asylum-seeker chapter; for GP, secondary, emergency and hospitalization, the care for irregular migrants in the curative streamline is reimbursed to the hospitals by the Ministry of Social Integration, not the Ministry of Health.	Yes	
Bulgaria	Free of charge	Full cost			No	
Denmark	Free of charge	Unclear			Unclear	
Finland	Free of charge	Full cost		Emergency assistance is covered by the Ministry of Health	No	
France	Free of charge	Free of charge	Three months residence condition before obtaining AME (State Medical Aid) and prove that they do not have health coverage in their country of origin.		Yes	

¹⁵ Croatia, Cyprus, Czech Republic, Estonia, Latvia, Malta and the UK.

			However, as children in France are not considered as “irregular” and do not need a permit to reside, children of irregular EU nationals should be entitled to the AME scheme upon arrival in France (without the three-month residence condition).			
Germany	Free of charge	Unclear				
Greece	Free of charge	Unclear	Destitute EU families and children need to meet a set of stringent preconditions to qualify for free health care (welfare card) etc.	-	Yes	
Hungary	Free of charge if cannot pay	Full cost			Yes	
Iceland	Free of charge	Unclear			Unclear	
Ireland	Free of charge if cannot pay	Full cost			Yes	
Italy	Free of charge	In some regions primary care free of charge			No	
Lithuania	Free of charge	Full cost			Yes	
Luxembourg	Free of charge	Free of charge				
Netherlands	Free of charge	Full cost			Yes	
Norway	Free of charge	Free of charge			No	
Poland	Unclear	Full cost for most services			Yes	
Portugal	Free of charge	Free of charge			No	
Romania	Free of charge	Free of charge			No	
Slovakia	Free of charge	Full cost			Yes	
Slovenia	Free of charge	Full cost			No	
Spain	Free of charge	Free of charge				
Sweden	Free of	Unclear				

	charge					
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* UAMs=Unaccompanied minors

Entitlements equal to nationals regarding coverage and cost and included in same health care system

Out of the 23 countries included in the Table 5, only five countries, namely Norway, France, Portugal, Romania and Spain offer equal entitlements to health care for migrant children, compared to nationals, regardless of administrative status. In *Spain*, the recent health reform explicitly excluded EU citizens from obtaining a health card, if they are not permitted to Spanish residency. However, all children below 18 remain entitled to equal rights to health care. In *Romania*, this group is implicitly entitled to health care, as the law grants equal rights to health care for all children. However, entitlements for ethnic Roma citizens, born in Romania, depend on their birth registration. If they have a birth certificate, they can register with a family physician, which entitles them to the same services as any other child. In reality, there is an unknown proportion of undocumented minors born in Romania, whose parents may also lack documents; in these cases the National Insurance does not cover health services.

In *France*, irregular EU nationals are included in the health care system for irregular third-country migrants. They must be resident for three months before they can obtain AME (State Medical Aid), and they must prove that they do not have health coverage in their country of origin. However, as children in France are not considered as “irregular” and do not need a permit to reside, children of irregular EU nationals should be entitled to the AME scheme upon arrival in France (without the three-month residence condition).

Entitlements restricted compared to nationals

In 15 countries¹⁶ entitlements for children of irregular migrants from other EU countries are restricted compared to national children. In most countries, this is due to the fact that there is no legislation for this group, and therefore we assume they have minimum entitlements to health care, which is emergency care. In *Belgium*, irregular EU citizens have been included in health care legislation for irregular third-country migrants; but this group of EU-nationals face several administrative barriers, which limit their access to health care. In the *Netherlands*, unlike in Belgium or France, the care scheme for irregular third-country nationals is not applicable for EU nationals who have no authorisation of residence. They are omitted from legal regulation and have no entitlements beyond emergency care. In *Italy*, EU citizens without health coverage in their home state and in the national territory can receive urgent and essential care from the national health services. In some regions such as Tuscany, they can obtain an ENI code (which is given to European Citizens not Registered in the National Health Service) allowing access primary and secondary care.

Unclear legal provision

In three countries¹⁷, legislation regarding this group of children is very unclear. In *Ireland* all persons are entitled to access urgent medical treatment, and there is a statutory requirement to provide care to all children, irrespective of their status under the Child Care Act. However, there is no explicit reference to the group of irregular EU-nationals in the regulatory framework for healthcare, and it is

¹⁶ Austria, Belgium, Bulgaria, Finland, Greece, Germany, Hungary, Ireland, Italy, Lithuania, Luxembourg, Netherlands, Poland, Slovakia, Slovenia.

¹⁷ Denmark, Iceland, and Sweden.

unclear what their entitlements are. In *Sweden* there is confusion around the right for health care for this group of migrants, which primarily consists of Roma people from Romania and Bulgaria. Entitlements for irregular third-country migrants have recently been made explicit, and there have been various attempts to clarify that these entitlements also apply to irregular EU-nationals if they overstay the three-month limit. However, the legal situation remains unclear, and reports show that many caregivers are unaware of the entitlements for this group and restrict their access to care.

Targeted health examinations of newly arrived asylum-seeking and refugee children

Table 6 displays an overview of targeted medical examinations of newly arrived migrant children. Two countries¹⁸ are not included in this table due to ambiguous answers.

Table 6: Health examinations of newly arrived asylum-seeking and refugee children							
	Mandatory	Voluntary	No systematic health examinations upon arrival	Directed towards health care needs of migrant children	Directed towards protecting resident population against communicable diseases	Directed both towards health care needs and resident population	Migrant groups covered
Austria	✓					✓	All migrants in need of international protection
Belgium		✓			✓		Asylum seekers
Bulgaria	✓				✓		Asylum seekers
Croatia	✓				✓		All migrants in need of international protection
Cyprus	✓				✓		All migrants in need of international protection
Czech Republic	✓				✓		Asylum seekers
Denmark		✓				✓	Asylum seekers and people granted refugee status
Finland		✓				✓	Asylum seekers
France		✓		No data	No data	No data	
Germany	✓				✓		Foreigners in accommodation or reception centres
Greece			✓	-	-	-	All migrants in need of international protection after registration process is completed in the hotspots
Hungary	✓				✓		All migrants in need of international protection
Iceland	✓					✓	Everyone that is applying for permanent residency and comes from Central and South America, European countries that are not part of the EEA, Asia and Africa. If these individuals have a ratified medical

¹⁸ Estonia and Luxembourg excluded due to ambiguous answer.

							certificate that was issued less than 3 months ago, they are exempt from such examination.
Ireland		✓				✓	All migrants, including returning emigrants, those who come voluntarily to work, Asylum seekers undocumented or irregular migrants
Italy	✓			-	✓	-	All migrants in need of international protection incl. migrants arriving by sea
Latvia	✓				✓		Third-country citizens applying for residency and Asylum seekers
Lithuania	✓				✓		All migrants in need of international protection
Malta	✓					✓	All migrants in need of international protection incl. migrants arriving by sea
Netherlands		✓*				✓	Third-country citizens applying for residency and Asylum seekers. Tuberculosis screening of the Municipal Public Health Service will be held for special groups, such as illegal immigrants and the homeless.
Norway		✓*				✓	Asylum seekers
Poland	✓					✓	Asylum seekers
Portugal			✓	-	-	-	
Romania	✓				✓		All migrants in need of international protection
Slovakia	✓				✓		Asylum seekers and migrants requesting work permit with tolerated residency or regular residency.
Slovenia	✓				✓		Asylum seekers
Spain			✓	-	-	-	
Sweden		✓				✓	Asylum seekers refugees and family relations to these groups.
UK		✓				No data	Asylum seekers

*Mandatory screening for tuberculosis

In 16 countries¹⁹ newly arrived migrants undergo a mandatory health examination upon arrival

(primarily Eastern European countries), whereas in nine countries²⁰ (primarily Scandinavia and Northern Europe) voluntary examinations are offered. In two of these countries, namely Norway and the Netherlands, screening for tuberculosis is mandatory. In three countries²¹ (Southern European) no systematic examinations are offered.

In the majority of the countries that have mandatory examinations, these examinations are primarily directed towards protecting the *resident population* against communicable diseases, whereas in other countries the examinations are directed *both* towards the health care needs of migrant children and the resident population. In none of the countries included, the initial examinations are directed primarily towards the need of the migrant child.

In most Eastern European countries, health examinations are mandatory and primarily aimed at protecting the host population. In *Hungary* the Chief Medical Officer of the district orders the medical examinations required by a given epidemiological situation. Such screenings usually cover a predefined scope of illnesses (for instance, tuberculosis, HIV infection, syphilis, typhoid fever, hepatitis B). In *Lithuania*, all newly arrived migrants are referred to the State Border Guard Service under the Ministry of the Interior where they have a mandatory health examination. The Foreigners Registration Centre has a primary health care centre, where one family physician works part-time (two days a week), and three nurses are present.

Scandinavian and northern European countries who offer health examinations on a voluntary basis, direct the examinations both towards protecting the host population against communal diseases and addressing the health needs of the migrant children. There is variation in the description of the purposes of these examinations. In *Ireland*, the position on screening is outlined in the Health Protection Surveillance Centre's guidance document, Infectious Disease Assessment for Migrants (2015) which states that: *These guidelines are not proposing a formal screening programme, but offer best practice advice for infectious disease assessment in migrants. The guidelines facilitate opportunistic assessment, and participation on the part of the migrant is on a voluntary basis. In using these guidelines consideration should be given to the individual migrant, their needs and their country of origin. The guidelines are intended to benefit both migrants and the host population.*

In most Southern European countries no systematic health examinations take place. The reasons for this range from a lack of resources (such as in Greece) to more conscious public health considerations related to ethical issues and the doubts about the effectiveness of such examinations (as is the case in Spain).

The content of these examinations varies a great deal. In countries where the health examination is mandatory, they typically consist of an examination of urine, blood, heart and lungs in order to detect communal diseases such as tuberculosis and hepatitis. Furthermore, vaccination status established. In countries such as *Croatia*, *Czech Republic*, *Lithuania* and *Slovakia* newly arrived migrants are held in quarantine until the results from the examination are obtained. In *Slovakia*, migrants who test positive for certain diseases, such as TB or STDs, are usually immediately sent back to country of origin.

¹⁹ Austria, Bulgaria, Croatia, Cyprus, Czech Republic, Germany, Hungary, Iceland, Latvia, Lithuania, Malta, Poland, Romania, Slovenia, Slovakia.

²⁰ Belgium, Denmark, Finland, France, Ireland, Netherlands, Norway, Sweden, UK.

²¹ Greece, Portugal, Spain.

In the group of countries where health examinations upon arrival are optional, examinations typically consist of a review of the child's medical history; a physical examination aimed at evaluating the health needs of the child in terms of acute or chronic conditions; and to some extent screening for mental health problems. Identification of communicable diseases and immunization status will also be included. Usually treatment is provided for the identified diseases.

In most Member States, health screenings target asylum seekers; in a few Member States they target all newly-arrived migrants in need of protection or those applying for job/residence.

Discussion

This report describes policies for entitlement to health care and targeted health examinations for migrant children in the EU/EEA, based on official documents and surveys to Children's Ombudspersons, NGOs and the MOCHA country agents. It is clear that entitlement to health care varies greatly between countries, and by legal status, even within many countries. Thus, in many countries the status of being a migrant is more important than being a child when it comes to policy for health care.

This report has a human rights framework, with the UN Convention on the Rights of the Child as the core document. All EU/EEA countries have signed this Convention. The UN Convention was designed to protect the rights of children in marginalised and irregular situations, such as the migrant children in this report. It implies that migrant children, regardless of their legal status, have the right to health and health care on an equal basis as national children. The content of this report demonstrates that currently this important basic principle of the Convention is violated in all but a handful of EU/EEA countries.

'Asylum seeker' is the legal category of children, which most often is entitled to health care on equal terms with resident children. Twenty out of 30 states have entitlements to care for asylum-seeking children on equal terms with the host population; while only 11 States have such entitlements for irregular or undocumented children from non-EU/EEA countries.

Eight countries have similar entitlements for asylum-seeking children to the host population in a parallel primary health care organisation outside of the general primary health care. Providing care in this manner potentially provides easier access to interpreters and gives health care professionals a better understanding of the context of the needs and living conditions of migrants. Such a system can also facilitate the implementation of health examination programs. However, this type of organisation is often built on a small staff, has problems recruiting qualified staff and insufficient funding, which makes it vulnerable and may even create barriers to care on equal terms. This model can also deepen isolation and marginalization of asylum-seeking children and their family from the surrounding society (Sandahl et al, 2013).

The report demonstrates that health care policies in the EU/EEA often do not address the rights of migrant families from other EU countries that have overstayed the 3 months period of free mobility, or who lack formal identification. This group primarily encompasses groups such as beggars, homeless and minority groups such as the Roma. This group is potentially extremely marginalised in that policy makers have identified that this population falls outside of the categories defined in most migrant policy documents; as well as outside current EU regulations aimed at providing better health care to migrants, such as the reception Directive, the Directive on Free Movement, and the Directive on Cross-border Healthcare.

In at least 12 countries, unaccompanied migrant children have broader entitlements to health care than accompanied migrant children. Although this is certainly beneficial for this most vulnerable group of children, it is also a policy that discriminates children by family status.

Germany and Slovakia stand out as the countries with the most restrictive policies. They are the only countries that have policies that restrict health care for asylum-seeking children, as well as for

irregular third-country migrant children. Germany is the country that received the highest number of asylum seekers within the EU/EEA area by far in 2015, at 441,800 individuals. The fact that the German policy restricts access to health care has implication for tens of thousands of asylum-seeking and irregular minors. In contrast the country with the highest per capita reception of asylum seekers in the EU/EEA during 2015, Sweden, has equal entitlements to care for asylum-seeking and irregular third-country migrant children. France, Spain, Portugal, Romania and Norway stand out because they have explicit policies that aim to provide care on equal terms to the host population for all categories of migrant children, displaying a view of children as children first and foremost instead of migrants with different legal status.

The EU produces a Migrant Integration Policy Index (MIPEX) with indicators of national immigration policy (MIPEX, 2015e). Based on these indicators European countries can be divided into three different categories (Borrell et al, 2015): inclusive, assimilationist and exclusionist. With this categorisation countries with quite diverse entitlements to health for migrant children are found in the same category; for example France with its generous entitlements and Germany with its restricted entitlements are both considered assimilative countries, thus child health care policy for migrants cannot be understood solely as a component of national immigration policy in Europe, underlining that such broad classifications can overlook a key area such as the basic primary healthcare of children, indicating that children rights policy is a policy arena of its own.

Article 24 in the UN Convention on the Rights of the Child recognises the right to highest attainable standard of health care for children. A health reception of newly settled migrants that includes a health examination by a physician or a nurse can facilitate the integration into the primary health care services and thus the attainment of this right (Frederiksen et al., 2013). This report shows a quite diverse pattern with regards to health examinations for migrant children. In all but four countries in the EU/EEA there is a policy of systematic health examinations of some kind. In most eastern European countries this health examination is mandatory, while in western and northern Europe it is usually voluntary. All countries with a policy of health examinations have the ambition to identify communicable disorders to protect the host population. Almost all countries with a voluntary policy also aim to identify individual health care needs, while this is rarely the case in countries with a mandatory policy.

A number of countries use concepts like “basic”, “necessary” or “emergency” care to define the entitlements to care for migrants. These vaguely defined entitlements makes decisions on access to healthcare arbitrary and dependent on the judgement of individual health care providers, and often have the consequence of excluding children from full access to primary care. Decentralised economic responsibility in combination with these vague definitions can be a real problem, creating incentives for limiting access to care, particularly when the inflow of migrants increases rapidly in small communities with limited resources.

There is no doubt that recognising the right to the highest attainable standard of health care for all children also should include equal access to primary care as nationals. Primary care should be the pillar of health care for all children, as laid out in the WHO declaration of Alma Ata of 1978 (WHO, 2004). Access to primary care is particularly important for marginalised populations like asylum seekers and irregular migrants (Starfield et al, 2005). Health care provided in a primary care setting is in most societies the most cost-effective way of providing the psychological support which is the most

pressing health care need for refugee children and their parents, and a specific right for victimised children according to article 39 of the UNCRC. Primary care also has the potential for early detection of communicable disorders and the provision of preventive interventions such as vaccinations and screenings for malformations and disabilities. The link of primary care to the community is particularly valuable in the work with migrant populations where collaboration with other segments of the community is often important for preventive as well as curative purposes (Hjern & Jeppson 2005). Thus, policies that do not explicitly provide full access to primary care for migrant children do not fulfil the requirement of article 24 of UN Convention of the Rights of the Child o highest attainable standard of health care for children.

Fear of police or immigration authorities is a major barrier for irregular migrants to access the care to which they are entitled. Thus, to make health care truly accessible for irregular migrants, health services should be entirely independent from immigration authorities, and the principles of medical confidentiality should be upheld for these patients. It is often easier to create this needed sense of safety in a primary care setting than among the multitude of people in hospitals. In this sense the policy in Germany and Bulgaria of a legal duty for health services to report irregular migrants stand out as the most obvious negative example of policy.

Several good examples of policy were identified in the report, examples that could lead the way for better policy on migrant children in the EU/EES. In Italy the equal right of all children to health care has been applied differently across regions. On this background an agreement adopted by the Italian State-Regions Permanent Conference on 20 December 2012 aims to ensure that the legislation is applied equally throughout the country, and reiterates that irregular migrant children should have full access to health care and will be assigned a paediatrician (necessary for continuity of care and access to secondary health services), and should have access through the National Health System (NHS) (mainstream administrative procedure). The benefits should be provided without cost to the applicants if lacking sufficient resources. In Portugal The II National Plan for the Integration of Immigrants (2010-2013) embodied several measures to improve immigrant's access to the National Health System (NHS). One of those measures was the institutionalization of procedures to better manage health agreements and promote the immigrants access to health care. In this regard the Portuguese Health authorities, with the collaboration of the High Commission for Migration, designed a practical manual to manage diverse situations such as the procedures to implement in the case of irregular children receiving health care in the NHS.

The way health care is funded differs considerably in the EU/EEA. Some countries have a tax-based system while others are funded via insurance schemes. Although it is often more administratively complicated to fund health care for migrant children in insurance-based systems, there is no obvious relationship between the funding system and health care policy for migrant children in Europe. The Netherlands, for instance, has overcome this administrative challenge in an innovative way by the creation of a national fund where costs for irregular migrants can be reimbursed by health care providers. In France children in irregular migrant situations are eligible for State Medical Assistance (Aide Médicale Etat - AME) free of charge which covers all kinds of health care. These children have the right to AME immediately without any administrative requirements.

Economic arguments are often raised to defend restricted entitlements to health care for migrants, particularly in times of economic crisis (Suess, Ruiz Pérez, Ruiz Azarola, & March Cerdà, 2014). On a

national level, however, even in countries with high numbers of asylum seekers, such as Germany and Sweden, this expense is nothing but marginal in relation to the total national health care budgets. The European Union Agency for Fundamental Rights has also pointed to the economic incentives for providing health care on equal terms for migrants in an irregular situation. Not providing care in the early stages of a disease, or excluding migrants from preventive programs can lead to very high costs for hospital care (FRA, 2015). A report from Médecins du Monde shows that only 60% of irregular migrant children who were cared for in their clinics in London and Belgium had been vaccinated against MMR, tetanus and HBV. This puts these children at risk of developing these disorders, and, in the case of measles, also puts the host population at risk (Medecins du Monde, 2013), with very large potential costs involved.

During 2015, hundreds of thousands of refugees arrived on the shores of southern Greece. Around 25% were children, with unprecedented high numbers arriving unaccompanied by adults. UNHCR formulated a strategy for providing health care to these vulnerable migrants based on equal access to primary care. In a recent report, the European Network of Ombudspersons for Children has identified a major problem in the health care service response and provision of care according to the needs of these children (ENOC, 2016). The large numbers of asylum seekers overwhelmed the system for asylum applications in many countries; leaving many children in irregular situations with unclear provision of health care before an asylum application could be filed. The ombudspersons point to a lack of psychological services as the most pressing problem; but access to physical services was also limited in a few countries, such as Greece, but also in temporary shelters in countries further away from the EU borders such as Sweden and the Netherlands. In Greece and several other countries, provision of health care for the children and other migrants during the autumn and winter of 2015-16 depended a great deal on volunteers and NGOs. The effort of these organisations and individuals are highly valued; but if health care is not guaranteed by the state, it is a fragile situation. This was illustrated in the spring of 2016, in Greece, when many NGOs decided to move out from the border areas in protest over the new EU policy for refugees. Thus, the UNHCR strategy for providing health care for refugees in transition was not successfully implemented on the southern borders of Europe or in the destinations of the refugees in northern Europe.

A parallel report from Australia (Little & Goldfeld, 2016) shows that restriction of health care as a component in migration policy is not a uniquely European phenomenon. In Australia, irregular migrants, children as well as adults are only entitled to emergency care. For asylum seekers there is distinction between those that are detained off-shore and those who reside within the community, with a lower quality health care offered to those in off shore detention. Since similar off-shore detention centres have been discussed within the EU as well, in the Mediterranean, the reported high levels of mental health problems in such detention centres (Silove et al, 2000) in combination with the low quality of the health care provided in the Australian setting should be of concern also in Europe.

Limitations

The results in this report are based on simple comparisons of different, complex health systems. Moreover, laws related to immigrants and health care are multifaceted and continually changing within the EU countries. Thus, the report provides a rough picture of entitlements to health care in the EU/EEA for different groups of migrant children.

The report primarily covers entitlement to care for migrant children on the policy level. To what extent these policies have also been implemented could not be comprehensively covered within the framework of this project and to a large extent remains to be investigated. It seems possible that access to care could be greater than that provided according to official policy in some countries. Health care professionals may stretch the rules to provide care according to medical ethics rather than policy. The opposite is also possible, when the funding made available for this care is insufficient for large numbers of migrants. The latter is, for example, known to be the case in Greece. Thus, further studies that investigate the actual access to care based on interviews with migrant are needed to better understand the actual access to care for migrant children.

Implications

This report demonstrates that there is a diverse pattern of policies for health care for children who are asylum seekers or irregular migrants in Europe. No more than a handful of EU/EEA member states have a policy that provides entitlement of care in an equal manner to children in the host population for all migrant children. This is an obvious breach of the non-discrimination principle in article 2 of the UN Convention on the Rights of the Child, which has been signed by all Member States. Considering the large number of migrant children who have arrived in the Member States during recent years, this gap leaves a large number of children with unmet needs for of basic health care in violation of their rights.

Thus, action is needed to improve entitlements to care for migrant children in Europe. On a European level, the EU Reception Conditions Directive sets the standard for the reception of migrants in Europe. The general nature of the recommendations in the directive allows member states to maintain very different policies with regards to entitlements for health care. The directive cites some principles of the UN Convention on the Rights of the Child, but avoids the important principle of non-discrimination. A clarification on this point could be one important step towards a better policy for health for migrant children in the EU.

The legal situation of irregular and destitute EU migrants has not been sufficiently addressed on the European level or in national legislation. This leaves some of the most vulnerable children in Europe without entitlement to health care. We therefore encourage national governments and the EU to clarify these children's rights in health care policies and include all children, regular or irregular, EU nationals and non-EU-nationals.

A policy of mandatory or voluntary health examinations of migrant children are currently in place in all but a few countries in the EU/EEA area. In many countries these examinations only serve the purpose of protecting the host population from communicable diseases. Extending the purpose of such health examinations to also identify the needs of health care in the individual child would facilitate the integration of these children into the primary health care services in the receiving country. It would thus allow these children the chance to attain good health as stated in article 24 of the UN Convention on the Rights of the Child. A closer collaboration on the European level, coordinated by an EU body such as the European Centre for Disease Prevention and Control, has a potential to improve the quality and cost effectiveness of health examinations of migrants.

The cross-country comparisons of this report call for action on the national level in many countries. This is particularly pertinent for Germany, the economic pillar of the EU and the country that absorbed the largest numbers of asylum seekers in 2015. Germany limits access to care for asylum-seeking

through a policy with a restrictive entitlement to care and for irregular migrants also by the legal duty of health services to report irregular migrants. In German health care policy, a distinction between adult and child migrants is rarely made. Thus, the German government has yet to accommodate their legislation and policies on health care for migrant children to the UN Convention of the Child.

Fear of immigration authorities or police is a major barrier for irregular migrants to seek health care in all countries. Providing health care in primary care settings makes it easier for migrants to access care without this fear.

The so-called “refugee crisis” during the autumn of 2015 demonstrated how local health care facilities can be overwhelmed when large numbers of migrants arrive during a short period of time. An ambitious health care strategy, based on equal access to primary care, formulated by the UNHCR seems to have had little influence on the care provided in many countries. This experience needs to be evaluated on the national as well as on a European level; so that more effective policies can be implemented when extraordinary migrant situations occur. The situation of children, as the most vulnerable in these situations, should always be given special consideration in these policies.

In conclusion, this report demonstrates that in most European countries today children’s rights to health care as defined in the United Nations Convention on the Rights of the Child (UNCRC) are violated. This limits access to primary health care for tens of thousands of migrant children with potential dire consequences on their short and long term health and development. Action is urgently needed by European and national governments to implement a children’s rights perspective in health care policy for migrants.

Annexes

Situation per country

Annex 1: Child asylum seekers

In **Austria** children of asylum seekers are entitled to Basic Welfare Services (Grundversorgung) and in principle all insured and basically get the same medical treatment as national children²². However, entitlements are conditioned upon the families not leaving their designated quarters for several nights²³. If they leave, they have to apply for a renewal of "Grundversorgung", which takes a minimum of several weeks to take up again.

They may have a choice about registering with a GP or primary care paediatrician and treatment are done in doctor offices or outpatient ambulatory centres in hospitals. Children up to 5 years of age are enrolled in the 'Mutter-Kind-Pass' programme, which provides certain child examinations, including immunizations.

Interpreters are assigned according to hospital law. Health care is financed by the Ministry of Interior at the initial asylum procedure, and at the main asylum procedure split between the Ministry of Interior and the (regional) Länder (60% to 40%)²⁴.

Unaccompanied minors who are accommodated in facilities of the Children and Youth Service Authorities are usually covered by the general health insurance (Koppenberg, 2014 p. 57), while unaccompanied minors who do not fall under the basic welfare system only have access to emergency healthcare. Furthermore, the law states that: *"such persons shall be assisted by initial clarification and stabilization measures whose purpose should be to strengthen their emotional state and create a basis of trust"*²⁵. Access to psychological care and its quality depend on each accommodation facility (EMN, 2010 p. 59).

In **Belgium** asylum-seeking children are entitled to same level of health care as nationals and for emergency, primary and secondary care all patient participation fees are waived²⁶. Primary care for children of asylum seekers include access to "Healthy Child Clinics" [Kind&Gesein / ONE /DKF] and GP care. The Healthy Child Clinics (0-6 years), offers immunizations, screening, prevention and nurse home visits. The Healthy Child Clinics are in effect free for anyone who turns up and are financed by the region or the community. Secondary care and emergency care are organized and financed at the federal level. The organization responsible for asylum seekers is Fedasil (Federal Agency for the Reception of Asylum Seekers). Asylum seekers can either live in centres or reside outside these centres. In the centres there is direct access to all forms of care (primary, secondary, etc.). Outside the centres, families will have to return to Fedasil authorities for care. This will always be a bit more complex than referring directly to the medical staff of the centre.

Unaccompanied minors who stay in a reception centres in Belgium have access to medical care, with costs covered by the centre. Under certain conditions, they have the right to medical insurance and can register with a health insurance provider. During the initial stages of their reception, a social worker at the Observation and Orientation Centres (OOCs) draws up a medical, social and psychological report with the aim of orienting the unaccompanied minor towards an appropriate second stage, including for treatment (EMN, 2010 p. 59). If they

²² Basic welfare support agreement (Grundversorgungsvereinbarung) BGBl.1 Nr. 80/2004 Art. 6 para 1 subpara 5; which guarantees by law the right of health, the access to health care and all health services considering the appropriate ethical and clinical standards.

²³ Other exceptions are no organ transplantations during the time where the asylum status has not yet been decided upon and restrictions in entitlements to rehab. Other minor differences concern the possibilities of transportation to the nearest doctor (can be difficult for rural Austrians, too) and the reimbursement of e.g. dental prostheses (Questionnaire Caritas Austria).

²⁴ Questionnaire MOCHA Country Agent Austria.

²⁵ Basic welfare support agreement Nr. 80/2004 Art. 7 (1).

²⁶ Law of 12 January 2007 Concerning the Reception of Asylum seekers and certain other Categories of Foreigners.

are living outside a centre, they are covered by health insurance (mutuelle) if they have been attending school in Belgium for at least three months²⁷. Otherwise, they are treated like adult migrants in an irregular situation (FRA, 2011 p. 79).

In **Bulgaria** children of asylum seekers are not specifically addressed in legislation. Health-care access for asylum seekers in general is regulated by the Health Act 2005 and the Health Insurance Act and all asylum seekers living in reception centres are entitled to health insurance, accessible medical assistance and free of charge medical care under the conditions and the procedures applicable for Bulgarian citizens²⁸. The Health Insurance Act states that the obligation of the State Agency for Refugees (SAR) to insure an asylum seeker starts at the moment of the asylum procedure launch. Then the SAR is supposed to cover the health insurance of asylum seekers by sending funds to the National Revenue Agency, which in turn transfers the money to the National Insurance Fund. However, problems have been reported regarding long administrative procedures meant to transfer insurance related data from the SAR to the National Revenue Agency and from there on to general physicians (ECRE, 2016b). Furthermore, financial resources are very limited and the response to migrant influxes has been highly dependent on European Union funds (WHO Regional Office for Europe, 2015). There is also a lack of interpreters in the centres and no guides explain the health care rights and obligations of the asylum seekers. After being registered as insured, asylum seekers are entitled to: access medical care within the framework of the medical procedures guaranteed by the budget of the National Health Insurance Fund; choose and register at a personal general physician; receive a document needed to exercise their entitlement to medical care (health insurance card). Primary care is provided in health care offices in transit centres, registration centres and reception centres ruled by the State Agency for Refugees (SAR) by designated doctors and nurses. Children are vaccinated according to the national immunization schedule and receive a personal immunization card (WHO Regional Office for Europe, 2015).

Unaccompanied minors are entitled (like asylum seekers) to health insurance, accessible medical care and free health care and mental health support similarly to all Bulgarian citizens (IOM, 2015)²⁹.

In **Croatia** asylum seekers' entitlements to health care was reduced in November 2013 from "necessary treatment of illness" to emergency health care only. However, children are entitled to health care as nationals and are fully insured³⁰. The service provider claims expenses from the Ministry of Health which uses funds from the state budget to pay for the expenses. Croatian authorities do not provide free services of an interpreter, which is problematic as most of the applicants are not able to pay for such assistance on their own (ECRE, 2016b).

Unaccompanied minors have entitlements to healthcare identical to that of insured persons from compulsory health insurance³¹. They generally have more attention from health care providers compared to accompanied migrant children and targeted health promotion campaigns and programmes³².

In **Cyprus** all asylum seekers are entitled to free medical care in all public institutions, "*if they do not have sufficient resources*"³³. Minors are entitled to medical card A³⁴, which gives access free of charge to the public health system and to emergency, primary and secondary care, medicines and treatment of serious infectious diseases (HUMA, 2011).

All unaccompanied minors are registered as asylum seekers and are under the care of the Social Welfare Office, which, under the 2000 Refugee Law, ensures their access to free healthcare (FRA, 2011b). They are entitled to medical card A, which gives access free of charge to primary and secondary care, tests, diagnosis and

²⁷ Health law dated 13th December 2006 art. 120, 22 ° and Law on health insurance and compensation, consolidated on 14 July 1994, art. 32.

²⁸ Law on Asylum and Refugees State gazette N 54/22.05.2002 art. 29, p. 5, last amendment from 22 of December 2015; Health Act 2005 and the Health Insurance Act.

²⁹ The Asylum and Refugees Act. Art 29 (4,5).

³⁰ Compulsory Health Insurance Act 2013 (Official Gazette 80/13 to 137/13) (Zakon o obveznom zdravstvenom osiguranju NN 80/13 do 137/13).

³¹ The Act on Compulsory Health Insurance and Healthcare of Foreigners in the Republic of Croatia (Official Gazette number 80/13) 2013.

³² Questionnaire Country Agent Croatia.

³³ §11 and §15 of the Oi peri Prosfigon (Sinthikes Y podohis Aititon) Kanonismoi tou 2005 (on Asylum Seekers' Reception Conditions).

³⁴ Regulation 15(2) of the Prosfigon of 2005.

prevention, all necessary medicines for treatment prescribed for a doctor, dental treatment. Chronic psychiatric care is excluded, but compulsory psychiatric care by court order in a public psychiatric institution is included and is free of charge in all circumstances (HUMA, 2011).

In the **Czech Republic** asylum seekers are entitled to public health insurance and thus have access to the same type of preventative and curative care as Czech nationals³⁵. Although exempt from payments, whenever they seek medical help, they must pay, as well as all other insured persons, from 1 January 2015 the "regulatory fee for ambulance service" in the amount of CZK 90 (approx. 3 Euro) per treatment in the case of emergency (out of regular office hours) outpatient services. During the first year in the Czech Republic asylum seekers are not allowed to work and do not even receive social benefits support. In addition, asylum seekers do not receive a regular insurance card, but only a paper certificate the "substitute insurance card", which proves entitlement to free health care to the extent of care covered by health insurance the VZP (Všeobecná zdravotní pojišťovna - General Health Insurance Company). The provided care is reimbursed by the VZP (Všeobecná zdravotní pojišťovna - General Health Insurance Company) which then is entitled to claim the paid amount from the Ministry of Health of the Czech Republic. Currently several legislations related to health care of foreigners are undergoing amendments/changes³⁶.

Unaccompanied minors get full medical service as soon they are placed in the facility for unaccompanied minors. It's in the same range as for Czech kids (including prevention and immunization) and its covered from the health insurance system. Their psychological care relies on NGO support since it is not covered by public health insurance³⁷.

In **Denmark** children of asylum seekers are not specifically addressed in health legislation³⁸. According to the National Council for Children in Denmark, asylum-seeking children are entitled to 'necessary treatment' and according to a publication by the Danish Ministry of Health, Children of asylum seekers are entitled to the same healthcare as children who are residents of Denmark (Danish Ministry of Health, 2014). Asylum seekers in general are not included in the National Health Insurance system and in the general health care system for nationals. Instead, health care during the asylum period is performed at the asylum camps and outsourced in a contract between the Danish Immigration Service and the operators of the asylum camps – the Red Cross (Sandahl et al., 2013). According to Sandahl et al. (2013) children have free access to a general practitioner and five consultations with a private practicing specialist doctor, and three consultations with a psychiatrist or psychologist. To receive prolonged mental health care, the asylum centre must contact the municipality, who decides whether the child needs extra care according to the principles outlined in the Service Law. Expenses for their healthcare are covered by the Danish Immigration Services. Emergency care is paid by the municipality. According to the contract between the Immigration Service and the Danish Red Cross, treatment other than this, such as non-acute hospitalization and prolonged specialist treatment, must be approved by the Danish Immigration Service. Since 2014 asylum children's legal status has been weakened after they are no longer included under the Service Law, which aims at protecting children who are in exposed positions. This includes unaccompanied children. Thus, asylum-seeking children are now solely under the responsibility of the Danish Immigration Services and social authorities in the municipalities no longer have a duty of care asylum-seeking children who are not thriving.

Unaccompanied minors' entitlements to health care are not clearly stated in legislation. As also pointed to in the section on asylum-seeking children, the Danish Service Law, which obliges the municipalities to support children who are not thriving, was amended in 2014 as to no longer include children without a legal residence permit in Denmark or children in the asylum process. Thus, both unaccompanied children without legal residence permit or in the process of applying for asylum are not covered by this law anymore, but solely under the responsibility of the Immigration Services (Danish Ministry of Social Affairs and Integration, 2012).

In **Estonia** asylum seekers are included in the system of health care coverage if they are accommodated in the reception centre or detention centre³⁹. Health service providers contracted by the asylum centre decides upon the necessity of health services and medicines. Centre chooses the particular provider, time and location of

³⁵ Charter of Fundamental Rights and Freedoms contained in the Constitutional Law No.23 / 1991 Coll., which declares the right of every citizen to health, Law No. 48/1997 Coll., On Public Health Insurance, Act No.108 / 2006 Coll., on social services.

³⁶ Questionnaire Country Agent Czech Republic.

³⁷ Questionnaire Country Agent Czech Republic.

³⁸ Consolidation Act on Social Services 2009, the Danish Healthcare Act §8, §80; the Danish Aliens Act § 42a, 1.

³⁹ Health insurance act; social security act; Act on Granting International Protection to Aliens

treatment. Funding is organised through the centre. In cases where asylum seekers are financially capable of paying himself/herself for the health care services or medicines, he/she is required to do so. In cases where asylum seeker does not live in the collective centre, he/she is not included in the health care coverage. Expenses are covered by health insurance fund or state budget⁴⁰.

Unaccompanied minors are entitled to same level of health care as insured persons in accordance with the Health Insurance Act.

In **Finland** adult asylum seekers are entitled to urgent health care as well as necessary health care⁴¹. Children of asylum seekers are entitled to same health care services as nationals (Ministry of Social Affairs and Health, 2016). Care is funded by the state, including cost of medication (Keskimäki, Nykänen, & Kuusio, 2014).

The reception centres operate under the guidance of the Immigration Service and organise the necessary reception services, including health services. Social services are also available in reception centres. Most asylum seekers stay at reception centres while their asylum applications are being processed. However, many also make their own accommodation arrangements. There are reception centres throughout Finland. They each observe an open-door policy and asylum seekers staying in them are not obliged to report on their movements to the centre's personnel.

Unaccompanied minors applying for asylum have equivalent rights to public health care as minor Finnish citizens who have a municipality of residence in Finland. The availability of mental health care services is not up to standards and only about a third of them have received treatment for their symptoms. Free health care does not apply for unaccompanied minors who are not enrolled in the asylum system. However, in Helsinki, minors are entitled to all public health care services in exchange for the municipal resident's client fee (EMN, 2014c).

In **France** children of asylum seekers have the same access to health care as the resident children. They can access Mother and Child Health Centres (Protection maternelle et infantile – PMI) without any status requirements and for free⁴². The PMI centres offer preventive care, follow-up and vaccination for babies and children up to six years old and can be accessed before the parents receive their Universal Health Care Cover (CMU) (Ministère de l'intérieur, 2013). Even before starting the asylum process, minors should in theory have access to AME⁴³ health coverage (State Medical Aid – Aide Médicale Etat) as soon as they arrive in France. In practice, their parents lack information and often don't request AME before they have been in the country for at least three months, and actually obtaining AME takes several months (Médecins du Monde, 2015b). Children can receive vaccinations against all the principal diseases at PMI centres free of charge (Medecins du Monde, 2015b).

Unaccompanied children are eligible for the mainstream health insurance through the universal Health Coverage Act (CMU). The care of unaccompanied minors falls under Child Protection which is the responsibility of the departmental council through child welfare services (Aide Sociale à l'Enfance – ASE) (Medecins du Monde, 2015).

In **Germany** children of asylum seekers are subject to the same system as adults, namely that during their first 15 months in the country they are entitled only to basic healthcare services defined as emergency medical care, treatment for acute and painful conditions, care during pregnancy and childbirth, vaccinations and other "necessary preventive measures"⁴⁴. Further benefits may be granted if they are indispensable in the individual case to secure health or to cover special needs of children¹.

These legal restrictions have been coupled with administrative barriers which have been recently reduced in

⁴⁰ Regulation of the Minister of Social Affairs, 13.12.2013.

⁴¹ Law on reception of a person requesting for international protection and on identification and help for victims of trafficking 17.6.2011/746; Barnskyddslag.

⁴² Social Security Code, Article R. 380-1

⁴³ State Medical aid (AME) allows undocumented/irregular migrants to benefit from access to healthcare. Once assigned, the AME is granted for 1 year. The renewal must be requested each year (<https://www.service-public.fr/particuliers/vosdroits/F3079>).

⁴⁴ Asylum Seekers Benefits Law (Asylbewerberleistungsgesetz, AsylbLG) of 5 August 1997, last change 11.3.2016, Section 2, 4 and 6.

² Wächter, M.: Einführung der Gesundheitskarte für Asylsuchende und Flüchtlinge Der Umsetzungsstand im Überblick der Bundesländer, Bertelsmann Stiftung, Gütersloh, 2016, accessed online July 15th, 2016: https://www.bertelsmann-stiftung.de/fileadmin/files/BSt/Publikationen/GrauePublikationen/Studie_VV_Gesundheitskarte_Fluechtlinge_2016.pdf

some Federal Länder by introducing an electronic health card for refugees, e.g. in Schleswig-Holstein. In others, a framework contract with health insurances, has been settled, e.g. in North Rhine Westfalia. The latter however, has to be joined on individual decision of the municipalities resulting in heterogeneous access within one Federal Land. Other Federal Länder decided to currently keep the system of medical treatment vouchers². Except for the health care provided in reception centres and for emergencies, service providers grant access to any type of ambulatory or specialist care only to AS&R who hold a valid healthcare-voucher. These healthcare-vouchers are valid for a limited period of time (e.g. three months), and are required to access any type of health care service and are a substitute for insurance cards used by the general population who are members of a Statutory Sickness Fund. To obtain a health-care-voucher, asylum seekers must make a personal request at the local welfare agency, sometimes several times at different agencies, and repeatedly for every subsequent visit to a service provider (Medecins du Monde, 2015b). There is no right to free medical interpretation in care (Fox, 2015). After 15 months of residence in Germany asylum seekers are integrated into the mainstream system and entitled to social benefits as regulated in the Twelfth Book of the Social Code.

However, the law stipulates that children can receive other care meeting their specific needs, although this provision does not specify the particular treatments that children may receive (Medecins du Monde, 2015b). In these cases, e.g. local welfare agencies may ask for expert opinions of the local Child and Youth Public Health Service, e.g. in case of elective surgery. In a report from 2014 UNICEF strongly criticizes the conditions in Germany for these children and points to the fact that most children in asylum-seeking families have fled traumatic circumstances and are often in dire need of counselling or other medical services. Furthermore, children suffering from chronic illnesses might not be attended to. The report emphasize that children's treatment in Germany is not adequate to the standards prescribed by the UN Convention on the Rights of the Child and to national children in Germany (Berthold, 2014).

Asylum-seeking unaccompanied minors fall in the responsibility of the youth welfare office (Jugendamt) for the assistance for children and young people (Kinder- und Jugendhilfe). Health care is based on the minors' individual needs, and they also have access to psychological care. Other groups of UAMs are entitled to medical care under the Asylum Seekers' Benefits Act (Müller, 2014).

In **Greece** children of asylum seekers have access free of charge to emergency, primary and secondary health care⁴⁵, whereas families of national children have to pay a percentage of these services as well as a percentage of prescribed medicine. This does not apply for asylum seekers as far as primary and secondary healthcare services are concerned. Vaccines are subsidized 100% by the state for resident children, which is not the case for children in asylum-seeking families. The care is funded by the Greek state and takes place in health care clinics or hospitals. Due to the financial crisis and high pressure on the Greek asylum system, specialised care for children is currently limited by resource constraints given that NGOs are the principal service provider (ECRE, 2016b). Medicines and pharmaceuticals from hospital pharmacies are difficult to obtain as prescription of pharmaceuticals is performed only through an electronic prescription system using a person's unique security number, which the asylum-seeking child lacks. In these cases, medicines and pharmaceuticals can be obtained only by NGOs or other private initiatives⁴⁶.

All unaccompanied minors are entitled to full health care services (EMN, 2014b) including immunizations (in practice currently this is not the case for immunizations due to vaccine shortages). Since unaccompanied asylum seekers are often under the responsibility of shelters, a written statement indicating that the minor is under the responsibility of a specific facility is needed to access free health care⁴⁷. However, there is a lack of interpreters for communicating with health personnel and a lack of special psychological care. Specialised treatment is entrusted to local mental health care services which, however, are not often specialised on juvenile or intercultural issues (EMN, 2010).

In **Hungary** Children of asylum seekers are not specifically addressed in legislation but according to Decree 301/2007, asylum seekers with special needs are "*eligible for free of charge health care services, rehabilitation, psychological and clinical psychological care or psychotherapeutic treatment required by the person's state of health.*" Foreigners staying in Hungary for more than 3 months shall receive age-appropriate vaccination as it is prescribed by the Hungarian vaccination schedule. The paediatrician initiating the vaccination of the child records the 3-months residence time thereby he examines the child at least 2 times within a year and between

⁴⁵ Ministerial Decision 139491/2006

⁴⁶ Questionnaire Country Agent Greece.

⁴⁷ Ministerial Decision 139491/2006.

the two visits, at least, 2 months shall be omitted. Care is funded through the National Health Insurance Fund. Unaccompanied minors applying for asylum are considered to require special treatment and are entitled to health services equivalent to Hungarian minors⁴⁸, rehabilitation, psychological and psychotherapeutic support. Healthcare is usually provided by the Reception Centre. Co-operation has been developed with the Cordelia Foundation, which provides psychological support and psycho-therapy for traumatised unaccompanied minors, including provision of native interpreters (EMN, 2010). However, UAMs outside the asylum system are not included in the care agreement and in principle only entitled to emergency care (EMN, 2014a).

In **Iceland** healthcare for asylum-seeking children is integrated into the general healthcare for residents provided by the state and municipalities⁴⁹. The laws and regulations do not mention children specifically when it comes to rights to health care, but The Act on Foreigners 96/2000 art. 47 b states that asylum seekers are entitled to “necessary health care services”. A recent agreement between the municipalities Reykjanesbær and Reykjavik and the Ministry of the Interior on services to asylum seekers, states that asylum seekers are entitled to general health care and medicine that is prescribed during that care. They shall have the opportunity to seek treatment with a psychiatrist or psychologist, e.g. regarding post-traumatic stress disorder and other ailments. Other medical services have to be approved by a consulting physician who determines if the treatments and procedures are necessary⁵⁰. According to Sandahl et al. 2013 and the Ombudsperson for Children, asylum-seeking children are entitled to the same healthcare services, including preventive healthcare examinations for children and vaccinations, as resident children. Secondary care is also free of charge, but must go through The Directorate of Immigration.

Unaccompanied minors are placed in care of child protection services should be provided with all health care needed⁵¹.

Access to health services in **Ireland** for asylum seekers is provided on the same basis as for Irish citizens through the state funded public health system⁵². There is little explicit recognition of the rights of children within Irish asylum legislation. Asylum seekers will generally qualify for a medical card which entitles them to free access to a wide range of health services including General Practitioner (GP) and Primary Care services, as well as Inpatient / day-care / outpatient services in public hospital in-patient and out-patient services (as a public patient) (Health Service Executive Ireland, n.d.). If the asylum seeker’s financial means or assets exceed the income threshold for the medical card, he/she and the family may be entitled to a GP Visit Card which covers free access to GP visits. Access to hospital services is then provided through the public health system which incurs a maximum annual fee (Citizens Information Board Ireland, n.d.-a). According to the General Practitioner Service Act 2014, If the family are not entitled to this, all children aged under 6 years are automatically entitled to a GP Visit card, which is equivalent to the entitlements of resident children.

Asylum-seeking children are entitled to immunisation programme free of charge similar to resident children – ‘catch-up’ immunisation programme developed by Health Protection Surveillance Centre (2015) based on National Immunisation Guidelines (Health Protection Surveillance Centre Ireland, 2015).

No specific legislative instrument deals with unaccompanied minors in Ireland, including with regard to their reception and care. The main legislative instrument relevant to the care of unaccompanied minors in Ireland is the Child Care Act 1991. This piece of primary legislation governs the care and protection of all children in Ireland, including unaccompanied minors, but does not refer specifically to this group. Children under the age of 18 who arrive in Ireland and who are not in the custody of an adult will be placed in the care of TUSLA, which is the Child & Family Agency. The Refugee Act 1996 states that in cases where it appears that a minor presenting at the border or within the state is ‘not in the custody of any person’, the Immigration Officer or other authorised office must contact TUSLA, and thereafter the provisions of the Child Care Act 1991 apply⁵³. TUSLA is responsible for the general care, health care and well-being of the minor and will provide assistance to that minor. Foster care may be sought for that child. Health Care is provided through the public health system. TUSLA may decide that an application for a declaration as a refugee should be made on behalf of the minor.

⁴⁸ Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services, §16

⁴⁹ The Act on Foreigners 96/2000; Regulation 1142/2015 on Health Services to those that are not insured.

⁵⁰ Viðauki um þjónustu við hælisleitendur samkvæmt samningi Útlendingastofnunar & Reykjavíkurborgar.

⁵¹ Questionnaire Country Agent Iceland.

⁵² Legislation relevant for this section: Health Act 1970 with subsequent amendments; The Refugee Act 1996 with subsequent amendments.

⁵³ Refugee Act 1996 Section 8 (5)(a)).

In **Italy** all migrant children are entitled to same health care services as nationals including primary care, secondary care, emergency care, immunizations and screenings and preventive child health examinations⁵⁴. Asylum seekers are given a free mandatory insurance and enrolled in the National Health Service⁵⁵ system, which they register for in the offices of the local health board (ASL)⁵⁶. Once registered, a temporary health card ("*tessera sanitaria*") is delivered to the asylum seeker, which entitles the asylum seeker to the following health services: free choice of a general doctor from the list presented by the ASL and choice of a paediatrician for children (free medical visits, home visits, prescriptions, certification for access to nursery and maternal schools, obligatory primary, media and secondary schools); Special medical assistance through a general doctor or paediatrician's request and on presentation of the health card; Midwifery and gynaecological visits at the "family counselling" ("*consultorio familiare*") to which access is direct and does not require doctors' request; and free hospitalisation in public hospitals and some private subsidised structures (ECRE, 2016a). The benefits shall be provided without cost to the applicants if lacking sufficient resources. The payment of the fixed fee normally payable for access to health care (out-of-pocket portion of the service, ticket) is excluded for people with income of less than 8.263,31 euros⁵⁷. The urgent or essential hospital services are paid by the Ministry of the Interior, while other benefits are covered by the National Health Fund. The equal right to health care remains applicable even in the process of renewal of the permit to stay (ECRE, 2016a).

Unaccompanied minors are entitled to registration in the National Health Services (SSN) and entitled to all medical care granted by the National Healthcare System on the same terms as national children⁵⁸. However, unaccompanied minors without a residence permit cannot be registered in the SSN and may only benefit from ambulatory and day hospital care, if urgent or continuative, as well as preventive medicine programmes⁵⁹ (EMN, 2010).

In **Latvia** minor asylum seeker has a right to receive all medical assistance at public expenses (i.e. free of charge, failure of which may provide a threat to a child's development and health, taking into account the asylum seeker's special reception needs⁶⁰. Location of treatment depends on the type of the necessary treatment. Might be provided in state or/and municipal hospitals or by doctor in the asylum centre.

Unaccompanied minors applying for asylum are accommodated in reception centres or a day-care centre (for example, orphanage) and entitled to goods of hygiene and emergency medical help and primary health care, and primary medical inspection (EMN, 2014f).

In **Lithuania** children of asylum seekers are covered by the compulsory health insurance system that grants the medical care the same as for the resident children (emergency, primary, secondary, immunizations, preventions)⁶¹. The costs are covered by the state budget via allocations to the Budget of Compulsory Health Insurance Fund. Primary health care is placed under the Ministry of the Interior in clinics at the Foreigners Registration Centre. If these clinics are not able to provide the treatment, health care institution of the Lithuanian national health system can be used. Primary health care physicians can refer the children to any secondary health care institution of the Lithuanian national health system, if the health care centres operating in the Foreigners Registration Centre or Refugee Reception Centre are not able to provide necessary treatments. The Law on Health Insurance was amended in 2005 to include unaccompanied minors in the Compulsory Health Insurance Fund and benefit from state-financed health care regardless of their legal status. Unaccompanied minors residing in Refugees' Reception Centre receive medical services at the centre's medical facility, which employs a general practitioner and a nurse. This centre has signed an agreement on provision of

⁵⁴ Decree 25/07/1998, n. 286 (art 34); Decree 18/08/2015 n. 142. Consolidated Act on Immigration; Law 537/1993 Art. 8 § 16 and subsequent amendments and additions.

⁵⁵ Article 34 paragraph 1 b of the Immigration Act, the Ministry of Health memorandum of 24 March 2000 n 5. - Art. 27 Legislative Decree 251/2007, Legislative Decree 18/2014- State-Regions Agreement 20/12/2012

⁵⁶ See Ministry of Health Circular No. 5, 24/03/2000

⁵⁷ Article 8 paragraph 16 of Law 537/1993 and subsequent amendments and additions.

⁵⁸ Legislative Decree 25/07/1998, n. 286; State Region Agreement dated 20. December 2012.

⁵⁹ Consolidation Act on Immigration 286/98, Art. 35, § 3.

⁶⁰ In accordance with article 18 part 2 paragraph 8 of the new Asylum law of the Republic of Latvia (came into force on 19 January 2016).

⁶¹ Law of health insurance 21 May 1996 – No I-1343 (As last amended on 10 July 2014 – No XII-1001); law on the legal status of aliens, 29 April 2004 No IX-2206 Vilnius. Article 71. Rights and Duties of an Asylum Applicant in the Republic of Lithuania Pending the Examination of His Application for Asylum.

healthcare services with the company “Achema” outpatient clinic; and in the case of serious health problems, unaccompanied minors are sent for consultations to Kaunas city clinics. Unaccompanied minors are also provided with psychological assistance at the centre, if suggested by their guardians, together with other social workers from the centre. The types of treatment provided include consultations, relaxation, autogenic training (music, art therapy, film screenings) and group sessions with other minors (EMN, 2010).

In **Luxembourg** asylum seekers have equal entitlements regarding coverage as nationals. All asylum seekers are submitted to medical screening and the necessary immunizations. Asylum seekers benefit from the public healthcare insurance, but they have to participate in the costs with a small amount, which is refunded to them through a quite bureaucratic procedure, that constitutes an important and unnecessary workload for the social workers. This insurance becomes only effective after a period of 90 days, during which health care is provided through a voucher system.

For unaccompanied minors this probation period of three month does not exist, they benefit from the beginning of the healthcare insurance⁶².

In **Malta** applicants shall be provided with emergency health care and essential treatment of illness and serious mental disorders⁶³. Medical and other assistance shall be provided to applicants who have special reception needs, including mental health care and pregnant women and minors have free access to health care services and vaccinations (IOM, 2013a). If applicants have sufficient resources, the asylum seeker may be asked for a refund. Care is funded through the general health care budget for public health services. Revenue is obtained through general taxation.

Unaccompanied minors are provided humanitarian protection until 18, so have access to the same level of services as nationals (PICUM, 2015). Their care falls under the responsibility of the state and they are also provided with free medication. They have access to the General Practitioner (GP) in the health centres and in one of the residential homes and a private GP assist them regularly on a voluntary basis. In general, access to mental health care is very restricted in the public sector and only those displaying severe symptoms of mental health disturbance are referred (EMN, 2009). Furthermore, there is a lack of interpreters available in the hospitals (IOM-UNHCR, 2014).

In the **Netherlands** asylum seekers access healthcare through a parallel scheme of primary care contracting organised by Menzis, a non-profit insurance company commissioned by the Central Agency for the Reception of Asylum Seekers (Centraal Orgaan opvang asielzoekers – COA). On the one hand, this means that they can only turn to GPs, physiotherapists, dentists, hospitals and pharmacies that are contracted. On the other hand, no out-of-pocket payment at all⁶⁴ (not even a franchise) is required. According to The Regulation Care on Asylum Seekers (in Dutch: RZA) primary, secondary and emergency care provided to children in an asylum-seeking situation is mostly similar to the care provided children with permanent residency. However, they only have a right to necessary medical care which excludes for instance cosmetic surgery or prevention with only long-term effects. It is up to the individual health care providers to determine what is “necessary” health care. Care is organized in Health Centres for Asylum seekers (in Dutch: GCA’s) at or near the asylum seekers centres. The Municipal Health Service is responsible for providing public healthcare to Dutch residents and asylum seekers. The care focuses on prevention, providing information and screening, and follows the routine preventive child healthcare scheme. Moreover COA contacts Youth social care and Youth mental health care providers if needed. Unaccompanied minors in the Netherlands are entitled to the same medical facilities as for other asylum applicants. In December 2006 a law was passed which stated that unaccompanied minors (both documented and undocumented) would be able to obtain insurance. The law took effect in May 2008. The result is that unaccompanied children are now treated at the same level and have the same (health care) rights as national children (PICUM, 2009). The Central Agency for the Reception of Asylum Seekers (COA) has medical services (nurses and a general practitioner) at each location, including for those who require special treatment (e.g. post-traumatic stress syndrome (PTSS), schizophrenia, psychoses, anxiety disorders and depression). If an unaccompanied minor has psychiatric problems accompanied by inappropriate behaviour, which causes a

⁶² Questionnaire Ombudsperson for Children Luxembourg.

⁶³ Refugees Act 2001 Cap 420 Article 13 (2); Subsidiary legislation 420.06; Amended by: L.n. 417 of 2015. Reception of asylum seekers regulations, art. 11(2, 5).

⁶⁴ Asylum seekers are exempted from paying personal contribution or own risk for health care (all adult citizens in the Netherlands have to pay the own risk, that is (in 2016) the first 385 euro of their healthcare costs as far as it does not regard GP care; GP care is always excluded from the own risk.

nuisance to the co-occupants and employees at the reception centre, then they would be placed in a special reception centre. Elsewhere, support for the provision of healthcare is available from *Pharos*, which is a national expert centre that specialises in areas including health promotion of aliens, in particular with respect to refugees, and the accessibility to, alignment with and quality of care for these groups (EMN, 2010). COA has contracted the foundation *NIDOS* to provide guardians for UAMs. UAMs outside the asylum system do not have any specific protection, their access to healthcare depends on their residence status (Medecins du Monde, 2015b).

In **Norway** all children have full legal entitlements to healthcare⁶⁵. They do, however, not have the right to transport and to have a designated GP in primary health care. Health care for asylum-seeking children is free. The consultation is free, but medication must usually be paid for, unless it is for specified contagious disease like TBC and HIV or medication on the so-called “blue list”, which are free for children. These medications are usually for chronic diseases, so for instance asthma medication may be covered, but not antibiotics for a UVI. All children are offered MMR and polio immunization by the health centre for mother and children. Vaccination depends on age and medical history but normally BCG, and “triple immunization” in accordance with national vaccination programme. Screenings and preventive child health examinations – Regular controls for infants and small children in municipalities. Primary care is financed by the municipality by taxes, block grants from the central government and earmarked grants for specific purposes. A major source of financing is also the National Insurance System (through a fee-for-service payment and reimbursement of users fees) administered through The Norwegian Health Economics Administration (HELFO). Secondary care is funded through the state, which owns and runs the hospitals. All funding through state or municipality is tax based.

Unaccompanied minors have the same access to health care as Norwegian children. Access to secondary health care is also in principle equal, but not always in practice⁶⁶. Municipalities have differing practices, especially when it comes to psychiatric health issues for UAMs who are in the Dublin procedure and for those with temporary or no residence permit (Lidén, Eide, Hidle, Nilsen, & Wærdahl, 2013; Staver & Lidén, 2014).

In **Poland** asylum seekers and their children have the same access to health care regarding coverage as Polish citizens that are insured⁶⁷. Health care services are, however, provided in selected medical institutions having signed an agreement with Central Clinical Hospital of the Ministry of Internal Affairs (except for emergency care). Access to primary care is free, but services are provided only by doctors working in centres for asylum seekers and asylum seekers are not allowed to choose a specific doctor. Access to secondary care is free of charge regardless of the type of care. Health care services are provided in selected health facilities having an agreement from Central Clinical Hospital of the Ministry of Internal Affairs and Administration (Centralny Szpital Kliniczny Ministerstwa Spraw Wewnętrznych i Administracji, CSK MSWiA) and on the basis of a referral issued by a doctor working in a refugee centre. A significant difference between people with status of ‘asylum-seeking’ and Polish citizens is that applicants for refugee status and their children have free access to all medicines, while Polish citizens only to some extent. Health care costs are covered by the Polish State. Unaccompanied minors under the supervision of ‘Care and Educational Institution’ (placówka opiekuńczo-wychowawcza), which deals with unaccompanied children in Poland, are entitled to free health care services covered by public funds. For children outside this institution, their situation is the same as the children of irregular migrants with regards to health care access and types of care.

In **Portugal** every child and pregnant women are entitled to free full access to health care and to the National Health Services funded by the state budget⁶⁸. Same free full access to the Portuguese National Immunisation Programme which follows the Portuguese immunization calendar. Children up to 12 years of age are exempted from paying a general small fee to access NHS services (WHO Regional Office for Europe, 2014). Every child

⁶⁵ Regulation on the right to health and other care services for persons without legal residence status (Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket) section 4; Act on the rights of patients and users (Pasient- og brukerrettighetsloven) section 2-1 a and 2-1 b; The Municipal Health and Care Act; Specialist Care Act.

⁶⁶ Circular RS I5/2011 from the Ministry of Health and Care Services leaves local health care provides to assess asylum seekers’ and irregular migrants’ requirements for care.

⁶⁷ 2004 Law on medical treatment financed by public fund (access to publicly financed medical treatment provided to refugees and subsidiary protection holders, authority: National Health Fund)); 2003 Law on granting protection to foreigners on Polish territory (Access to free medical treatment for asylum seekers (authority: Office for foreigners)).

⁶⁸ Specific situation related to foreigners are specified in the ‘Manual de Acolhimento no Acesso ao Sistema de Saúde de Cidadãos Estrangeiros’ from the Portuguese Ministry of Health.

born in Portugal, is entitled to be included in the neonatal screening programmes and when on a Family Practitioner's list or when enrolled in school, to the paediatric screening and prevention programmes. In this case, the official status of asylum seeker or refugee is required. All children are entitled to the same level of health care regardless of their administrative status⁶⁹.

In **Romania** children in asylum-seeking families have the same rights as Romanian citizens including primary care by family physicians, free medical assistance and treatment for emergencies and chronic disease who endanger the child's life⁷⁰. Children of asylum seekers are included in the category of vulnerable persons. Their needs should be evaluated, and if the assessment reveals special needs, they are entitled to special services⁷¹. Medical services are available in some reception/asylum centres⁷² or at other accredited medical clinics. The General Inspectorate for Immigration (GII)⁷³ assigns asylum seekers a personal identification numbers (CNP) and a family physician. GII funds the health care and monitors the situation of those who receive the status of immigrants and asylum seekers. GII will provide coverage for the Health Insurance for the children, but parent/s need to register by a family physician. This way, children receive medical assistance and vaccination as long as the procedures of asylum continue. There are reportedly problems regarding reluctance from the medical staff to treat asylum seekers and language barriers are also presented as important barriers. A valuable resource for improving communication is represented by the ethnic communities already settled in Romania (they often act as mediators when a health issue arise). Moreover, within a framework of a project financed by the EU programme for solidarity and management of migration flows for the period 2007-2013, a network of intercultural mediators was created in Romania covering many different migrant communities⁷⁴. From 2008, within the EU Framework programme on solidarity and management of migration flows for the period 2007-2013 a series of projects were implemented at national level by various NGOs. A part of them included a facilitation component for the different categories of migrants (asylum seekers, recognized refugees and third country nationals) to access health services. E.g., activities as counselling and information about health system in Romania, mediation of the relation between migrants and family medical doctors, subsidies for accessing different medical services through private medical system⁷⁵.

Unaccompanied minors have the same entitlements to health care as national children.

In **Slovakia** asylum seekers are not included in the public health insurance and are entitled to "necessary care" which includes at least emergency care⁷⁶. Besides from an initial health "test" that has to be passed in order to get out of quarantine, health care provision is not guaranteed. However, if an individual is identified as having special reception needs they are placed in the accommodation centre in Opatovska Nova Ves and have access to additional medical treatment (EU, 2015). NGOs such as the Slovak Catholic Charity and Health Initiatives Association contributes to paying to the extent possible. Psychological care for minors is provided by the NGO, the Slovak Humanitarian Council who have been visiting the centres in the western part of Slovakia since November 2005. In special circumstances defined in law parent who have lived more than 1 year in Slovakia whose child are less than 3 years old can get "contribution" to care from healthcare insurance company. Currently there is pressure from doctors and NGOs to change the political view and society perspectives on migrant and refugee's issues and healthcare delivery⁷⁷.

According to legislation every child found on the territory of Slovakia without a parent or person responsible

⁶⁹ Questionnaire Country Agent Portugal.

⁷⁰ Asylum Law 122/2006; Article 67(2) of the Law on the protection of foreigners.

⁷¹ Governmental Order 44/2004 art. 5 and its methodological norms.

⁷² At national level are 6 reception/accommodation centres for refugees and asylum seekers (Bucharest, Giurgiu, Galati, Radauti, Somcuta Mare, Timisoara). The asylum seeker is accommodated where the asylum procedure was initiated. In practice, at the level of these centres there is a lack of medical staff especially in terms of medical doctors.

⁷³ GII is funded by the European Fund for Refugees. Since 2008, within the EU Framework programme on *solidarity and management of migration flows* for the period 2007-2013 a series of projects were implemented at national level by various NGOs. A part of them included a facilitation component for the different categories of migrants (asylum seekers, recognized refugees and third country nationals) to access health services. This includes activities such as counselling and information about the health system in Romania, mediation of the relation between migrants and family medical doctors, subsidies for accessing different medical services through private medical system.

⁷⁴ For more information please follow the link <http://www.migrant.ro/mediatori>.

⁷⁵ Questionnaire Country Agent Romania.

⁷⁶ These provisions are included in the Act on Asylum (No. 480/2002).

⁷⁷ Questionnaire Country Agent Slovakia.

for the child are placed in a children's home. These children should be covered by the public health insurance system and have their health insurance paid by the State⁷⁸. These children should have the same access to health care as Slovak children including emergency, primary and secondary health care. Even if the UAM do not apply for asylum, they get tolerated residence status, which is guaranteed to him/ her until he reaches the age of majority (18 years of age) and guarantees free health care. Unaccompanied children are protected from deportation and detention by law. According to legislation every child found on the territory of Slovakia without a parent or person responsible for the child and placed in a children's home based on the court's decision is covered by the public health insurance system and his health insurance is paid by the State. This child should have the same access to health care as Slovak children⁷⁹.

In **Slovenia** asylum seekers in general are not included in the system of health care coverage. They are only entitled to emergency health care. National legislation extends the right to health care to all children of up to 18 years that are enrolled in educational system in Slovenia, even if they do not have any health insurance, citizenship or permanent residency status⁸⁰. Moreover, underage asylum seekers have the same access to health care system as nationals (PIC, 2013). However, research and experiences of NGO sector show that implementation of this legal provision is not always successful in practice since a special procedure is required in order to obtain health insurance on this legal basis⁸¹. Outpatient clinics are located at the asylum centres. In the event of serious health problems the asylum seekers are examined at the nearby health care centre and urgent cases are treated at the emergency department of the Ljubljana University Medical Centre. All costs of medical services and issued medications are covered by the budget of the Republic of Slovenia. As a consequence of the immense influx of refugees in Slovenia in 2015 the army have had medical units with vehicles in the field, as well as many volunteers from Slovenia and abroad (Government of the Republic of Slovenia, 2015).

Unaccompanied minors applying for asylum in Slovenia are entitled to medical care under the same criteria as nationals (the costs are covered by the Ministry of Health) and to the supplementary health insurance in cases when they do not possess any means of survival or their living is not provided for in some other way (the costs of this insurance are covered by the Ministry of Interior). If an unaccompanied minor has special needs (e.g. if they are victims of any forms of abuse, neglect, exploitation, torture, cruel, inhumane and demeaning behaviour or have been affected by military conflicts), they are again granted access to adequate healthcare under the same criteria as nationals. The existence of special needs is established by a commission on grounds of the person's application or upon a proposal of the staff employed in organisations active in the field of integration assistance. UAMs outside the asylum system are entitled to emergency care only (EMN, 2014d).

In **Spain** entitlements to health care for some groups of migrants were reduced in 2012 as a consequence of the economic crises. However, asylum seekers still have full access to the health system⁸². Given their status as a vulnerable group, they are not required to be insured by the Social Security System. Asylum seekers receive a health certificate (instead of a health card), which enables them to access the Public Health System and enjoy the same rights as any other citizen. There are no healthcare costs for asylum seekers. In fact, they pay less than nationals, as they are exempt from Social Security System payments, which nationals must pay. Nevertheless, problems have been reported regarding documentation and status of asylum seekers. There are three different stages in the achievement of the asylum seekers' documentation: (1) Register with the municipality; (2) Obtain a temporary ID card (3) Obtain an asylum seeker ID Card. Health assistance should be provided from the first stage.

All minors, irrespective of their administrative status, are guaranteed universal health care.

In **Sweden** asylum-seeking children are entitled to the same level of care as resident children, and enrolled in the national health care system⁸³. They have the right to seek any health care institution (primary, secondary, emergency, children health centre) of their own choice. For adults the care is restricted to care "that cannot wait". Treatment is provided at health centres and hospitals, dental clinics etc. Treatment is funded by the state

⁷⁸ Act on Health Insurance No. 580/2004 Coll.

⁷⁹ Questionnaire Country Agent Slovakia.

⁸⁰ Point 24 of article 15 of the Health Care and Health Insurance Act (ZZVZZ)

⁸¹ Unpublished research, project: Skupaj za zdravje, <http://www.skupajzazdravje.si/projekt/>

⁸² Law 12/2009, Articles 16, §2 and 18§1; Royal Decree 1192/2012 fourth additional provision.

⁸³ Lag (2008:344, 347) om hälso- och sjukvård åt asylsökande m.fl.; Förordning (1996:1357) om statlig ersättning för hälso- och sjukvård till asylsökande.

through the Migration Board (Migrationsverket) who pays the municipality a fixed amount per child monthly. For more costly care extra funding is available, but has to be asked for and approved by a special state office. In order to receive health care you must present the special ID awarded to asylum seekers (the LMA card).

Unaccompanied minors in Sweden have the right to health, dental and medical services on the same terms as other minors (EMN, 2014e). However, personnel in housing facilities in many cases do not know about these children's right to health care, which results in them not taking the children to hospitals when they have non-acute conditions⁸⁴. The County Councils are responsible for providing any physical and psychological care that may be needed, with their costs covered by the State (EMN, 2010). There are, however, regional shortcomings in the access to health care, especially in mental health services and psychiatric care (The National Board of Health and Welfare, 2013). UAMs outside the asylum system should have the same access as national children too. However, during 2015 there was an unprecedented inflow of unaccompanied minors to Sweden, altogether 35,000. Many of these minors were housed in emergency shelters during their first months in Sweden, before they even had a chance to file an application for asylum. The Children's Ombudsman in Sweden, after having inspected some of these shelters, reported that access to health care was in fact quite limited, primarily due to poor knowledge of the existing rules by the staff at these shelters (Barnombudsmannen, 2016).

In the **UK** all asylum seekers are entitled to free healthcare from all National Health Services (NHS) while they are waiting for the outcome of their asylum application and appeals⁸⁵. In order to access primary care children and young people require a unique patient identifier (NHS) number – to obtain an NHS number a child or young person must be registered with a GP. Anecdotal feedback indicates that there can be difficulties in registering children and young people with GPs which can lead to delays in receiving non-urgent care. There is limited data to know exactly how many children have experienced delays in access as a result of being of refugee background.

Unaccompanied minors in the UK in the asylum system or if they are identified as needing to be under the care of the local authority, or are (suspected) victims of trafficking are entitled to National health Services (NHS) on the same terms as national children and other children in care facilities (EMN, 2015). Services include trained and independent interpreters, counselling, health services (medical and sexual) and mental health services. If an UAM applying for asylum is assessed as needing psychological or medical care, then the *Local Authority Children's Services* will provide them with access to a number of such services. *The Medical Foundation for the Care of Victims of Torture* and *The Helen Bamber Foundation* are two independent voluntary organisations who provide care for children who have been child soldiers or victims of torture.

In England and Wales unaccompanied children and young people are entitled to the same rights as all looked-after children and young people, including accommodation, some finance, education, statutory health assessments, support and reviews. Statutory guidance in England sets out the rights of looked after children in relation to health care – *Promoting the health and wellbeing of looked-after children*. Practice guidance is also available in Wales, *Safeguarding and Promoting the Welfare of Unaccompanied Asylum-seeking Children and Young People*. In Northern Ireland asylum seekers who are unaccompanied minors are placed in the care of Social Services. In Scotland, unaccompanied children and young people are given provision as part of the Scottish Guardianship Service.

⁸⁴ Questionnaire, Swedish Ombudsman for Children.

⁸⁵ England and Wales: The Immigration (Health Charge) Order 2015, Schedule 2. Scotland: The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989/ 364 (as amended). Northern Ireland: The Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015, Schedule 9.

Annex 2: Irregular third-country migrants

In **Austria** there is no specific regulation governing health care provision for irregular third-country migrants, including minors (Potkanski, 2015). Exceptions apply for children whose removal has been suspended or postponed who according to the Basic Care Agreement (2004) are entitled to a range of health care services (FRA, 2011a). Other irregular migrants are excluded from the insurance system and from the state-funded scheme for uninsured persons and must therefore pay full expenses of services. However, irregular migrants can access emergency care at federal hospitals free of charge (in terms of the KAKuG 2008) and irregular children can access the public vaccination program free of charge as well as “basic services”⁸⁶. Some hospitals – often with a confessional background, like the hospital of the Barmherzigen Brüder (“brothers of mercy”) offer free treatment for people without health insurance, many of them migrants. The hospital offers the whole range of outpatient and inpatient services of a public hospital. It is funded by the provincial health fund of Vienna and by donations. Medical care for persons without health insurance is also provided by NGOs. The two largest of them active throughout Austria are AMBER-MED and the Marienambulanz (Kraler, Edthofer, Enzenhofer, & Perchinger, 2014).

In **Belgium**, irregular children are entitled to the same health care as irregular adults⁸⁷. They cannot access the national health insurance system (Universal Medical Coverage - CMU) but have access to health care through the Urgent Medical Aid (Aide Médicale Urgente – AMU⁸⁸) granted by the Centre Public d’Action Sociale (CPAS) to foreign nationals residing in Belgium illegally⁸⁹. Despite its name, AMU covers both preventive and curative care, and individuals entitled to this medical coverage must be granted access to health services beyond emergency care. Children of irregular migrants have access to vaccinations and preventive care through the Birth and Childhood office or Child and Family Services (ONE/Kind&Gezin) until the age of six. For the healthy child clinics costs are paid by the region; for GP, secondary, emergency and hospitalization, the care for irregular in the curative streamline is reimbursed to the hospitals by the Ministry of Social Integration, not the Ministry of Health (Medecins du Monde, 2015b; PICUM, 2015).

In **Bulgaria** there is no specific legislation for irregular migrants in relation to healthcare, and children of irregular migrants are not mentioned in the law. Therefore conclusions are deduced from the general laws and the practice (IOM, 2015). Irregular migrants living outside detention centres have the same entitlements as uninsured Bulgarian citizens and have access to emergency care, but have to pay afterwards on rates defined by each health care establishment⁹⁰.

In **Croatia** the health system ensures free access to all health services for migrant children and provides health care to all children needing it by inclusion in the compulsory insurance scheme⁹¹. Services include emergency medical assistance, general/family medicine services and hospital treatment if the child’s medical condition requires it. Documentation on treatment of irregular migrant children shows that care provided are mostly related to paediatric trauma, dehydration, wound infections, fatigue, posttraumatic stress, pneumonia, hypothermia and frostbites. In addition to the medical check-up and primary health care services, all children are provided with necessary medicines. The service provider claims expenses from the Ministry of Health which uses funds from the state budget to pay for the expenses.

⁸⁶ Basic Care Agreement, art. 2(6) §§ 2,4; Austrian Federal Hospital act, BGBl. 1 no. 80/200.

⁸⁷ Royal Decree of 12 December 1996; Loi relative à l’assurance obligatoire soins de santé et indemnités 14 juillet 1994 art. 32, 1st alinea no. 22.

⁸⁸ Obtaining AMU is subject to three conditions: The individual must obtain a medical certificate proving health needs signed by a doctor; prove their place of residence in a municipality; after having obtained a medical certificate, prove lack of financial resources through a mandatory social inquiry from the CPAS. Belgium’s National Agency for Health Technology Assessment, the KCE, has recently drafted a document on care to undocumented persons. The conclusion is that there is a strong commitment to keeping the generous “AMU”, but to make it more efficient, more user-friendly, and to have greater consistency between boroughs in terms of social enquiry and access (Questionnaire). More information on this see: (Belgian healthcare knowledge centre, 2015).

⁸⁹ Royal Decree of 12 December 1996 relating to medical assistance.

⁹⁰ Asylum and refugee act; 2004 Health act art. 82 (1), 99 (1), 100(1).

⁹¹ Compulsory health insurance and health protection of foreigners in the Republic of Croatia law (OG80/13).

In **Cyprus** emergency health care and specific services (such as for infectious diseases) are free for all patients, including irregular migrants⁹², aside from a registration fee (10 euros, foreseen for all apart from welfare beneficiaries)⁹³. In addition, irregular migrant children attending school may have access to vaccinations. Circular Y.Y. 11.11.09(4) specifically addresses medical care of irregular children and gives access to “necessary care” free of charge if cannot pay. While said to have the force of law the Circular has not been officially published (PICUM, 2015).

In the **Czech Republic** irregular migrants, including highly vulnerable groups such as children or pregnant women in the do not have free access to any health services⁹⁴. They must pay the full cost of any kind of care without exception. However, if they cannot pay, they cannot be denied immediate (urgent, emergency) care (which is usually interpreted as care in life-threatening situations) and treatment of infectious diseases, including HIV. These types of services for them are accessible (valid legal acts requires all health care providers to treat all persons who need urgent care or treatment of infectious diseases). Currently several amendments are being made related to foreigners and healthcare⁹⁵.

In **Denmark** all non-residents staying in Denmark are entitled to emergency hospital care free of charge “*in the event of an accident, childbirth, acute illness or sudden aggravation of a chronic disease*”⁹⁶. Further, irregular migrants are entitled to “necessary healthcare” free of charge if the foreigner cannot pay defrayed by the Danish Immigration Service⁹⁷. However, residence must be known to the authorities (Danish Ministry of Health, 2014). According to Danish law⁹⁸ all children below school attendance age have the right to seven preventive examinations at a general practitioner, which include health care examination and children's vaccinations (Cuadra, 2010a). Hereby, one could assume that children of irregular migrants have the same entitlements to health care as national children (Danish Medical Association; Danish Red Cross; Danish Refugee Council, 2010). However, the legislation is not clear and in reality it depends on assessments from individual doctors. The expenses are to be paid by the region in which the child resides in accordance with agreement between the regions and the general practitioners organization. Although there is no official duty, there is widespread assumption among health care staff that you have to report people without legal stay to the authorities (Danish Medical Association; Danish Red Cross; Danish Refugee Council, 2010).

In **Estonia** there is no specific legislation regarding access to health care for irregular migrants (Cuadra, 2010b). However, every person inside Estonian territory has the right to receive emergency care and the state must cover cost of emergency care provided to uninsured persons⁹⁹. Although not specifically addressing irregular children, Estonian law defines all children as insured. Therefore irregular migrant children are implicitly entitled to same level of care as nationals (PICUM, 2015).

⁹² Revision of Health Care Scheme in Public Hospitals 1.8.13; Ministerial Circular dated 2011 (Y.Y.11.11.09(4)); 2000 Refugee Law.

⁹³ Revision of Healthcare Scheme in Public Hospitals from 1/8/2013

⁹⁴ Act No. 372/2011 Collection of Laws on health services and the conditions of their provision; Charter of Fundamental Rights and Freedoms contained in the Constitutional Law No.23 / 1991 Coll., which declares the right of every citizen to health, Law No. 48/1997 Coll., On Public Health Insurance, Act No.108 / 2006 Coll., on social services.

⁹⁵ The amendments concerns the following laws: Modification of private health insurance for foreigners, amendment to Act no. 326/1999 on the residence of foreigners in the Czech Republic; Defining the categories of foreigners covered by public health insurance, amendment to Act no. 48/1997 on public health insurance; Defining the categories of foreigners for which the medical services covered by the state, namely the Ministry of Health, amendment to the foreigners Act and Act no. 325/1999, Asylum, and Law no. 221/2003, on temporary protection of foreigners.

⁹⁶ § 80 in the Health Act 2014 (Sundhedsloven) and Executive Order on the Right to Hospital Treatment (Sygehusbekendtgørelsen) § 5 and http://www.im.dk/artikler_im_dk/Files/Fil1/3857.pdf

⁹⁷ The Danish Aliens Act § 42a, 2.

⁹⁸ Chapter 36 in the Health Act 2014 (Sundhedsloven) and §7 in Law on Preventive Examinations for Children and Youth (Bekendtgørelse om forebyggende sundhedsydelser for børn og unge).

⁹⁹ The Health Services Organisation Act, para. 6 (2); The Health Insurance Act, para. 86 (4); Health Insurance Act (Ravikindlustuse seadus) §5(4), RT I 2002, 62, 377.

In **Finland** irregular migrant and migrant children are not mentioned explicitly in any legislation. Emergency care is provided for patients regardless of their place of residence and paid by the municipalities¹⁰⁰. Some municipalities, including for example Helsinki and Turku, have decided to provide all health care services for irregular migrant children and pregnant women (Paperittomuudesta, n.d.). Other than this, health care of irregular migrants relies largely on voluntary activities outside society's official service structure, where health care services are offered by clinics for irregular migrants.

In **France**, children of irregular migrants are entitled to State Medical Assistance (Aide Médicale État - AME) free of charge, which covers most kind of health care. Unlike adult irregular migrants, children have the right to AME immediately (adults must wait three months), without any administrative requirements except to prove their identity. They have access to AME in their own right, do not have to wait for their parents to prove that they are eligible, and can continue to have access even if the parents are found not to be eligible. AME is granted for one year. All types of health care should also be available to children in hospitals, regardless of status, ensuring health care for children outside the AME system¹⁰¹. While various practical barriers remain, many children of irregular migrants receive health care through the AME system (PICUM, 2015).

In **Germany** irregular migrants are afforded by law the same access to health services as asylum seekers who have been in Germany for less than 15 months, namely basic healthcare services defined as emergency medical care, treatment for acute and painful conditions, care during pregnancy and childbirth, vaccinations and other "necessary preventive measures"¹⁰². However, in order to receive health care they need to request a health insurance voucher from the social welfare office (Sozialämter) which is obliged to notify the authorities¹⁰³. In theory, immunisations for children of irregular migrants must be provided free of charge¹⁰⁴. However, due to the duty to report, there is no direct access to vaccination. One way for children of irregular migrants to be vaccinated is by paying the costs of the medical consultation and the costs of the vaccines per vaccine (Medecins du Monde, 2015a). Therefore irregular migrants, including children, are in effect only entitled to emergency care. Increasingly, Some Public Health Services establish consultation hours offering vaccinations and medical consultations, which applies, too, to consultations offered by NGOs like Medinetz, Medibüro. In addition, partly anonymized health insurance vouchers allowing access health care services without being reported have been established as pilot projects at city and federal states levels.

In **Greece** adult irregular immigrants have very restricted rights to health care¹⁰⁵. This is not the case though for children with irregular status, who are explicitly addressed in legislation which states that services can be provided to minors whose access to regular and emergency health care should be fully ensured¹⁰⁶. However, which services are offered is not clear. The care is funded by the Greek state and social security funds. Currently prescription of pharmaceuticals is performed only through an electronic prescription system using a person's unique security number, which the irregular migrant child lacks. In these cases, medicines and pharmaceuticals can be obtained only by NGOs or other private initiatives. Children who are accommodated in shelters for minors are entitled to free healthcare by the national health care system upon demonstration of a statement issued by the shelter verifying that the patient is under their responsibility¹⁰⁷. While this is not a provision targeting migrants it can be used in the case of unaccompanied minors who are accommodated in shelters

¹⁰⁰ Health Care Act (1326/2010) Section 50.

¹⁰¹ Code on Social Action and Families (Code de l'action sociale et des familles – CASF) Loi No 99 641 of July 1999; Decree of the Council of State of 7 June 2006 (Arrêt du Conseil d'Etat du 7 juin 2006); Circulaire DSS/2A no 2011-351 du 8 Septembre 2011.

¹⁰² Asylum Seekers Benefit Act 1997 (AsylbLG) § 1, 4 and 6.

¹⁰³ The German Residence Act requires all civil servants (except educational institutions) to notify the authorities when they obtain information about someone without valid residence permit (PICUM, 2015).

¹⁰⁴ Infektionsschutzgesetz § 7, 19.

¹⁰⁵ Codification of Legislation on the Entry, Residence and Social Integration of Third-Country Nationals on Greek Territory, Law 3386/2005 (Government Gazette GG A 212), Article 84(1), amended by Directive of 2 May 2012; Ministerial Decision 139491/2006.

¹⁰⁶ Codification of Legislation on the Entry, Residence and Social Integration of Third-Country Nationals On Greek Territory, Law 3386/2005 (Government Gazette GG A 212), Art. 84(1), amended by Directive Of 2 May 2012 and Circular Y4α/οικ.45610, issued by the Minister of Health on 02/05/2012.

¹⁰⁷ Ministerial Decision 139491/2006.

(MIPEX, 2015a).

In **Hungary** irregular migrant are entitled to emergency care only¹⁰⁸ and excluded from compulsory insurance. Even in cases of emergency care, the medical service provider shall examine whether the costs can be enforced towards the irregular migrant. In case of non-enforceable payment, the State budget will cover the costs. Irregular migrant children are not specifically addressed in legislation and not covered by social security. Mandatory vaccinations are provided to everyone free of charge. Irregular migrant children taken into child care institutions can benefit from free primary care and secondary care¹⁰⁹; furthermore, people asking help from any homeless institution (rehabilitation centres, night shelters, day shelters) are entitled to health care services in the social security system as “homeless” for six months¹¹⁰ (in this case there is a duty to report for the health care providers). Mandatory immunizations are considered as part of emergency care and provided free of charge¹¹¹.

In **Iceland** irregular migrants are not addressed in legislation and not included in the public health insurance system. They are therefore assumed to have the same entitlements as individuals without health insurance. According to Icelandic health care legislation these individuals are entitled to emergency care in the public health sector¹¹². They will be expected to pay for the cost of the care, but if they are unable to pay the cost, the health care institution that provided the care will cover the cost from its own budget (MIPEX, 2015b). In cases of emergency care, children will receive treatment and if the parents are in an illegal situation the health care personnel are obligated to inform child protection authorities if illegality prevents the child from receiving necessary services and security. For services beyond emergency care, parents that are not registered in the social security system will be asked about health insurance or guarantee for payment of services when children arrive at health care centres. Unaccompanied children are in care of child protection services and should be provided with all health care needed.

In **Ireland**, the law excludes irregular migrants from the entitlement to access all but urgent medical treatment where such is deemed appropriate by the provider¹¹³. If an irregular migrant does not pay for the care, the cost is covered by the state. There are no regulations specifically targeting children of irregular migrants. According to current regulations all infants can be visited by a public health nurse during the first 6 weeks, free of charge and families can apply for a GP visit card which gives access to free visits to a GP for children under the age of 6 years old (Citizens Information Board Ireland, n.d.-b). These consultations are preventive checks that include charting age, weight and height and taking appropriate follow up action. However, in order to receive this service the parents and child must have a Personal Public Service (PPS) number which in effect excludes irregular migrant families. In circumstances where a child is born in Ireland of parents with irregular migrant status, the child may receive a PPS number, in which case the child will then be able to access these services. All personnel in services engaged with children have a legislative duty to report any child protection concerns to TUSLA, the Child & Family Agency. However, there is no duty to report a child/family purely on the basis of being irregular or undocumented. All children are entitled to ‘catch-up’ immunisation programme developed by Health Protection Surveillance Centre based on National Immunisation Guidelines (Health Protection Surveillance Centre Ireland, 2015). Children under the age of 18 who arrive in Ireland and who are not in the custody of an adult will be placed in the care of TUSLA, which is the Child & Family Agency¹¹⁴. Health care is

¹⁰⁸ Act CLIV of 1997 on Health, § 142 on the healthcare services provided without any preliminary examination of social security coverage; 52/2006. (XII. 28.) EüM rendelet (regulation of the Ministry of Health) on the Emergency healthcare services.

¹⁰⁹ Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services, § 16(1)(m).

¹¹⁰ Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services, § 44/A(10)-(11) (on the certificate of homeless people).

¹¹¹ Act CLIV of 1997 on Health, especially § 142 (2)(a)(aa).

¹¹² Regulation no. 1088/2014 on health services for persons who are not health insured in Iceland, art. 15

¹¹³ Health Act 1970 (as amended by the Health (Amendment) Act 1991. The cost of urgent medical treatment is dependent on the providers’ discretion. Patients are eligible to apply for reduced or waived hospital charges if they will incur a ‘financial hardship’ (e.g. when they cannot pay). But these decisions are made at board level and on a case by case basis (regardless of the immigration status of the person). If the patient is not exempted, he or she will be charged the full rate, which is 2.5 times higher than the statutory rate for “ordinary residents”.

¹¹⁴ Refugee Act 1996 Section 8 (5)(a).

provided through the public health system. TUSLA may decide that an application for a declaration as a refugee should be made on behalf of the minor.

In **Italy** all care is provided free of charge to children under the age of 6, on equal terms with nationals¹¹⁵. Regional health cards are provided by the Local Health Authorities offices (ASL). After this age, children have access on the same terms as irregular adults, to urgent and essential care. This is defined as including health care for children in accordance with the Convention on the Rights of the Child (CRC)¹¹⁶. But according to PICUM the right of irregular children to health care is much less protected by Italian law than the right to education, with very serious violations of the rights provided for by the CRC, as they cannot register with the National Health System and do not have access to specialists (such as paediatricians, dentists, etc.)(PICUM, 2009). However, irregular children's entitlements to health care have been applied differently in the different regions. An agreement adopted by the Italian State-Regions Permanent Conference on 20 December 2012¹¹⁷ aims to ensure that the legislation is applied equally throughout the country, and reiterates that irregular migrant children should have full access to health care and will be assigned a paediatrician (necessary for continuity of care and access to secondary health services), and should have access through the NHS (mainstream administrative procedure) as unaccompanied children do. The benefits shall be provided without cost to the applicants if lacking sufficient resources. The payment of the fixed fee normally payable for access to health care (out-of-pocket portion of the service, ticket) is excluded for people with income of less than 8.263,31 euro¹¹⁸. The urgent or essential hospital services are paid by the Ministry of the Interior, while other benefits are covered by the National Health Fund.

In **Latvia** there is no specific legislation regarding health care for irregular migrants, including children. According to Latvian legislation, everyone have access to emergency care¹¹⁹. However, irregular migrants are not authorized to receive the emergency care funded by the State budget (Cudra, 2010). Thus, no irregular migrant (without a valid personal code given by the Latvian Ministry of Interior) has guaranteed access to medical services, unless they are detained. Access to primary care and anything beyond emergency care is available only for insured persons or if persons pay out-of-pocket for such services. In principle, an irregular migrant can purchase private insurance. Health care staff are not obliged to report irregular migrants to the police or other authorities (MIPEX, 2015c).

In **Lithuania** there is no specific legislation regarding health care for irregular migrants, including children. The law does not cover, and subsequently compulsory health insurance fund does not reimburse, health services for irregular children. Persons who are not covered by the obligatory health insurance are exempted from payment for emergency care¹²⁰. Unless referred to the State Border Guard Service under the Ministry of the Interior of the Republic of Lithuania and placed in detention in Foreigners Registration Centre, irregular migrants are only entitled to emergency health care services¹²¹. For all unaccompanied children health care services are covered by the Budget of Compulsory Health Insurance Fund financed by the State (MIPEX, 2015d).

In **Malta** no legal provisions cover health care rights for irregular migrants, including children, unless in detention (IOM, 2013a). There is an official policy document that states that *"the Ministry for the Family and Social Solidarity is responsible for the social welfare of all irregular immigrants"* and *"shall liaise with other*

¹¹⁵ State-Regions Agreement no. 255/CSR of December 2012, which expressly refers to the Convention on the Rights of the Child, as well as the Resolution A7-0032 / 2011, Sections 5 and 22 of the European Parliament on 8 February 2011. In regions that do not apply the State-Region agreement, health care is provided according to Legislative Decree 25.7.1998, n. 286, art. 35.

¹¹⁶ National Immigration Law T.U. Legislative Decree No. 286/98 as amended, Article 35(3).

¹¹⁷ Italian State Regions Permanent Conference, Agreement No.255/CSR of 20 December 2012.

¹¹⁸ Law 537/1993, Art. 8 §16 and subsequent amendments and additions.

¹¹⁹ Latvian legislation relevant for this section: Latvian Constitution (para. 11) on emergency care; Medical Treatment Act (2009), Sections 16, 17 and 18 (1998, as amended).

¹²⁰ Lithuanian legislation relevant for this section: Order of the Minister of Interior No. IV-340, 4 October 2007; Law on Health Insurance (2008, as amended in 2012), Article 8; LAW of HEALTH INSURANCE 21 May 1996 – No I-1343 (As last amended on 10 July 2014 – No XII-1001).

¹²¹ Questionnaire Country Agent Lithuania.

*Ministries and as much as possible (to): provide shelter and welfare support services to irregular immigrants released from closed centres”*¹²². In practice, irregular children are usually provided necessary health services and not charged, but no legal entitlement or official policy regarding irregular migrants access to public health services exist (PICUM, 2015).

In **Norway** all children, including children of irregular migrants, are entitled to health care and preventive services like resident children and through regular channels (GP offices, health stations, school health services etc.)¹²³. Children that do not meet the criteria for full access to health care as defined in “Regulation on the right to health and other care services for persons without legal residence status” § 2, are entitled to emergency care and “necessary” care. It is further stated that all children, i.e. persons under 18, residing in Norway almost has full right to health care, regardless of the residence grounds or length¹²⁴. Financing of health care to children that are here without legal permit (irregular migrant children) is not regulated. In practice the service provider (municipality or regional specialized health provider) finance this help to children.

In the **Netherlands** irregular migrants have no right to benefit from public services¹²⁵, with the exception of legal assistance, education (for children between 5 and 16), medically “necessary care” and preventive health care in the context of protecting public health¹²⁶. Doctors and nurses are always obliged to offer assistance if someone needs medical care. Without the consent of the person receiving the help they can’t give information to others. Treatments under these conditions are reimbursed by a special government fund, which allows reimbursement without formally establishing the identity of the irregular migrant (otherwise default identification is obligatory, based on a national individual identifying code (‘BSN’). In all other cases, they have to pay the medical care costs themselves. In practice, however, sometimes doctors are willing to treat these people free of charge. In April 2008, the parliament approved some proposals that make medical care for this group more available (including full reimbursement of costs related to pregnancy and childbirth). The law was enacted in January 1st, 2009. As an ‘illegal’ child, you can’t get a health insurance, for that you have to be a legal resident of the Netherlands which has a ‘BSN’ (Questionnaire). All children can access free vaccination at preventive frontline infant consultations (0-4 years), including children of irregular migrant parents. For curative care and for vaccinations after the age of 4, the children of irregular migrants face the same barriers to care as their parents (Medecins du Monde, 2015b).

In **Poland** children of irregular migrants are entitled only to emergency care and medical assistance under the same conditions as irregular adults and uninsured Polish citizens except for medical and dental prophylactics – including mandatory vaccinations, medical check-ups, screening tests – which are free of charge whilst they are attending public school¹²⁷. However, for irregular children that do not attend school access to health care is very difficult¹²⁸. While it is clear that emergency care provided by rescue teams is free of charge to everyone, it is not clear whether such care would be free of charge in hospital emergency departments, as there is no legislation establishing who would bear the costs. Therefore, irregular migrants may be liable to pay the full costs for

¹²² Maltese legislation relevant for this section: *Ministry for Justice and Home Affairs and Ministry for the Family and Social Solidarity, Irregular Immigrants, Refugees and Integration – Policy Document, 2005, p.19.*

¹²³ Regulation on the right to health and other care services for persons without legal residence status” (Forskrift om rett til helse og omsorgstjenester til personer uten fast opphold i riket) § 2; Patient Rights (Lov om pasient- og brukerrettigheter) Chp. 2; Veileder for helsetilbudet til flyktninger, asylsøkere og familiejenforente.

¹²⁴ Exceptions are entitlements to treatment from a private service or service provider outside the realm, see Patient Rights § 2-1 fourth and fifth paragraphs and deadline determination under § 2-1, third paragraph, third sentence, and § 2-2 second paragraph. Moreover, sick-transportation is not covered and entitlements to see a doctor regularly.

¹²⁵ On 1 July 1998, “the Benefit Entitlement Residence Status Act” (commonly known as the “Linking Act”) came into effect across the Netherlands. This law effectively linked the right to social services in the Netherlands to the possession of a valid residence status.

¹²⁶ Foreigners Act 2000 (Vreemdelingenwet) Art 10, S2; Amendment to the Health Insurance Act 31249, 2008; Linking act 1998 (Koppelingswet) Art. 122.

¹²⁷ Law on Healthcare Services Financed by Public Funds, 2004 (Ustawa z dnia 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych); Law on education system (7 September 1991) (Ustawa z 7 września 1991 roku o systemie oświaty), Articles 92 (1) and (2); Regulation of the Minister of Health on the organisation of the prophylactic health care for children and youths of 28 August 2009 (Rozporządzenie Ministra Zdrowia z 28 sierpnia 2009 r. w sprawie organizacji profilaktycznej opieki zdrowotnej nad dziećmi i młodzieżą).

¹²⁸ Questionnaire country Agent Poland.

emergency care in hospitals (after treatment) (PICUM, 2015).

In **Portugal** all children until 16 years of age are entitled to the same level of health care and enrolled in the National Health Services (NHS) despite their legal status¹²⁹. They have access free of charge to primary, secondary and emergency care, immunization and screening and prevention programmes. Irregular migrant children are specifically addressed in the law, and a register of foreign minors with an irregular status, managed by the High Commission for Migration, has been uniquely designed to ensure their access to health care, pre-school and school education. The II National Plan for the Integration of Immigrants (2010-2013) embodied several measures to improve immigrant's access to the NHS. One of those measures was the institutionalization of procedures to better manage health agreements and promote the immigrants access to health care. In this regard the Portuguese Health authorities, with the collaboration of the High Commission for Migration, designed a practical manual to manage diverse situations such as the procedures to implement in the case of irregular children receiving health care in the NHS¹³⁰.

In **Romania** all children are covered by the National Health Insurance, without paying contributions or co-payments¹³¹. Therefore irregular migrant children are implicitly entitled to the same level of care as nationals (PICUM, 2015). However, a precondition for health care is the existence of a personal identification number. In practice, in spite of the general law that states equal access to health care for all children, the absence of the personal identification number might seriously limit the access of irregular children to the services of primary care physician, or specialized medical service and also to medication and other treatment, especially the costly treatments and medications, that cannot be afforded easily by services¹³².

In **Slovakia** emergency care is to be provided free of charge to every patient by law¹³³. There are no specific regulations for non-removed persons or for children in an irregular situation. If a migrant does not have commercial insurance, then direct payment is necessary. Only foreigners with permanent residence and employed migrants with temporary residence can (must) have a public insurance¹³⁴ (PICUM, 2015). All children between 2-15 can receive immunizations free of charge¹³⁵.

The Republic of **Slovenia** provides budget funding for the emergency health treatment of irregular migrants. In case the treatment is regarded as non-urgent a person needs to pay for the service out of pocket¹³⁶. According to national legislation children up to 18 years of age and enrolled in the educational system have extended access to health care, even if they do not have health insurance, citizenship or permanent residency¹³⁷. However, a complicated administrative procedure is required in order to obtain this access (MIPEX 2015).

In **Spain** entitlements to health care for irregular migrants were modified in 2012. As a consequence of the economic crisis and to avoid "health care tourism" the Royal decree-law 16/2012 was enacted, which modifies Ley Orgánica 4/2000 and limits health care of irregular migrants to emergency services and to the process of

¹²⁹ Circular Informativa nº 65/DSPCS de 26/11/2004

¹³⁰ The model for this communication is available at the page 44 of this link: <http://www.acss.min-saude.pt/Portals/0/MANUALDEACOLHIMENTONOACESSOAOSISTEMADESA%C3%9ADEDECIDAD.pdf>

¹³¹ Romanian Law on the protection and promotion of the rights of the child/ 272/2004, art. 43; Law 95/2006 on healthcare reform as amended, art. 213.

¹³² Questionnaire Country Agent Romania.

¹³³ Act No. 576/2004 Coll. on Healthcare; Decree of the Ministry of Health No. 585/2008 Coll. on the Prevention and Control of Infectious Diseases; Act on Health Insurance No. 580/2004 Coll.

¹³⁴ Act No. 576/2004 Coll. on Healthcare, Healthcare Related Services and on amendments and supplementation of certain Acts.

¹³⁵ Based on the Decree of the Ministry of Health No. 585/2008 Coll. on the Prevention and Control of Infectious Diseases, children of asylum seekers should be vaccinated only against measles and poliomyelitis. However, on October 2015, as the reaction to migrant crisis, the Public Health Authority of the Slovak Republic did issue a recommendation to vaccinate all migrant children arriving to Slovakia at the age between 2 and 15 against long list of infectious diseases, including tuberculosis, hepatitis type A, measles, mumps, rubella, flu, diphtheria, tetanus, pertussis, poliomyelitis, and pneumococcus. This recommendation applies to all migrant children, not just asylum seekers. The recommendation does not specify any legal status of these migrant children; therefore it should apply also to undocumented migrant children.

¹³⁶ Health Care and Health Insurance Act art. 7; 2011 amendment to the Health Care and Health Insurance Act, ZZZZZ, art 15 (24).

¹³⁷ 2011 amendment to the Health Care and Health Insurance Act, ZZZZZ, art 15 (24). For more info see: (OHCHR, 2013).

pregnancy, natal and post-natal care. Only in the case of migrants aged <18 years, the principle of equal terms in the access to health care is maintained. However, problems of accessing health care for irregular migrant children have been reported. In order to receive care beyond emergency care, irregular migrants must obtain a health card, and therefore need to be registered at the city council. To do that, they need an official identity document. Moreover, they have to prove to have an official living address in order to be registered at the city council. The administrative requirement to get the health card also varies between regions, which complicated the process. However, these issues are often solved by involving social services that together with the support of the NGOs will help migrants to solve administrative barriers (MIPEX, 2015f).

In **Sweden** all children below 18 years of age are entitled to same health care as nationals¹³⁸. The rights of irregular migrant children to health care were made explicit in law in 2013¹³⁹. According to this law adult irregular migrants are entitled to necessary health care and children of irregular migrants to same conditions as nationals. Thus, irregular children can access any health care institution (primary, secondary, emergency, children health centre) of own choice and are entitled to free of charge vaccinations in accordance with the national vaccination programme. Funding authority is the counties, who receive earmarked money from the Swedish government. For youth without ID, who cannot prove that they have an age below 18, some caregiver may refuse them care that is not included in the concept “care that cannot wait”. Reporting to the police is a breach of the code of silence in Swedish health care law, but has nonetheless occurred¹⁴⁰.

In the **UK** all migrants whether lawfully in the UK or not, are eligible to register with a GP practice to receive free primary care, even if they are not eligible for secondary care services. Access to primary care in England is set out in the Standard Operating Principles for Primary Medical Care (General Practice). They are also entitled to free urgent and emergency care. Vaccination is available for all children and adults through their GP and baby clinics. In practice, children are only accepted by GPs if at least one of their parents is already registered. Children also have free access to dental care. Charges for secondary care are applied to irregular children in the same ways as adults¹⁴¹. One of the most difficult barriers for irregular children to overcome is the need to provide personal information to public authorities such as general practitioners and school administrators through registration. This information is a necessary requirement for access, however it is information that can be used to detect, track or even expel migrants from the country. Therefore it is mostly out of fear of detection and possible removal that many irregular children go without access to these services (PICUM, 2009).

¹³⁸ Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd; Förordning (2013:412) om vårdavgifter m.m. för utlänningar som vistas i Sverige utan nödvändiga tillstånd

¹³⁹ Law 2013:407 <https://lagen.nu/2013:407>.

¹⁴⁰ Questionnaire Country Agent Sweden.

¹⁴¹ National Health Service (Charges to Overseas Visitors) Regulations Updated 2013. Guidance on Implementing the Overseas Visitors Hospital Charging Regulations, Department of Health, 2013.

Annex 3: Irregular migrants from other EU countries

Austria EU citizens who are not insured can receive emergency care in all circumstances. It will be reimbursed by social services.

In **Belgium** destitute EU migrants are included in the healthcare system for irregular migrants. Yet, according to Médecins du Monde, this right remains merely theoretical, as EU citizens are faced with several administrative barriers (Medecins du Monde, 2015b). In theory EU migrants in Belgium must have access to Urgent Medical Aid (Aide Médicale Urgente – AMU) granted by the Centre Public d'Action Sociale (CPAS) to foreign nationals residing in Belgium illegally after the first three months of their stay. In practice, CPAS are still not applying a new interpretation of Article 57 quinquies and are thus violating the Belgian Constitution (Medecins du Monde, 2015b). Children, who are EU citizens, in theory have access to UMA as irregular migrants and access to vaccinations and preventive care through the Birth and Childhood office or Child and Family Services (ONE/Kind&Gezin) until the age of six¹⁴².

Bulgaria for those who are not insured, emergency assistance is covered by the Ministry of Health¹⁴³.

Croatia No data

Cyprus No data

Czech Republic No data

In **Denmark**, children of destitute EU citizens are not described in law. It is assumed they are entitled to the same health care as irregular migrants, since these are only entitled to emergency care.

Estonia No data

In **Finland** destitute migrants from other EU Member States fall outside of the current health care regime in Finland; by not having health care insurance from their homeland (e.g. Romania or Bulgaria), several thousand Romani beggars and short-term workers lack access to health benefits (Finnish National Institute for Health and Welfare, 2014).

In **France** destitute EU migrants are included in the healthcare system for irregular migrants. Destitute EU citizens are considered as irregular migrants and they can access AME (State Medical Aid - aide médicale de l'état – AME), after three months of residence in France under the same conditions as any other irregular migrant. They must prove to the CPAMs that they do not have health coverage in their country of origin. Circular of 7 January 2008 states that destitute EU citizens can benefit from the FSUV and have access to emergency care. This circular specifies that while EU citizens have the right to move and reside freely within the territory of a member state, they do not have full freedom to settle and reside in France. Therefore, they can be considered as irregular migrants regarding provisions governing entry and stay on French territory. However, as children in France are not considered as irregular and do not need a permit to reside, children of irregular EU citizens should be entitled to the AME scheme upon arrival in France (without the three-month residence condition), even if their parents are not eligible. The AME is granted for one year¹⁴⁴.

In France, children can get vaccination for all principal diseases free of charge.

¹⁴² Questionnaire Country Agent Belgium.

¹⁴³ <http://ec.europa.eu/social/main.jsp?catId=1103&langId=en&intPageId=2425>

¹⁴⁴ Circular DSS/2A no 2011-351 of September 8, 2011.

In **Germany** irregular EU citizens are entitled to assistance in case of emergencies, according to the 12th book of the German Social Security Code. This can mean, depending on the circumstances, that the costs for an urgent operation might be reimbursed by social services¹⁴⁵.

In **Greece** in accordance with Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004, after three months irregular EU citizens have the same access to healthcare as third-country nationals. For adults this means that law 4251/2014 (Article 26.1 and 26.2) applies to them and they only have access to emergency care. Irregular EU families and children need to meet a set of stringent preconditions to qualify for free health care (welfare card) etc.¹⁴⁶. For children, in theory they should have access to healthcare as they are explicitly not included in the law prohibiting access to care for irregular adults beyond emergencies. However, it also means that there is no specific legislation explicitly providing them with healthcare (Medecins du Monde, 2015b).

Regional health authorities, in cooperation with KEELPNO and the Ministry of Health and Social Solidarity, have developed and implemented a comprehensive immunization programme, aiming to “bring” healthcare services to Roma populations, who have low levels of social insurance coverage, lack identity papers or citizenship documents. Through the provision of immunization services at their place of residence data are collected on which children have been vaccinated against which diseases, and healthcare needs are identified. Such information is recorded on special “health cards” that form a rough “medical record” for these children. Routine health monitoring programmes are established mainly for the monitoring of children’s health and the organization of health education and health prevention programmes. In addition, mobile health units visit Roma camps and provide health promotion and preventive services, including pap-tests amongst others. In some camps, social and health centres staffed by a social worker, a psychologist and a nurse have also been established (European Observatory on Health Systems and Policies, 2016).

In **Hungary** irregular EU citizens have the same entitlements as irregular third-country migrants.

In **Iceland** article 36 in the Act on Foreigners declares that citizens of countries in the EEA that can provide a ratified passport or identification have the right to stay in Iceland for up to three months from arrival, as long as they’re not an unreasonable burden on the Icelandic social system. Nothing is said about the citizens of these nations that lack passports or other identifications¹⁴⁷. These individuals are not covered by the public health insurance system nor international agreements. They therefore only have a right to emergency care in the public health sector, that is, health care that the government is obligated to give according to health care legislation¹⁴⁸. For children, if parents are not able to pay, child protection will be involved to guarantee necessary treatment. Health care personnel are obligated to inform child protection authorities if illegality prevents the child from receiving necessary services and security¹⁴⁹.

In **Ireland**, under the terms of the Health Act 1970 (as amended by the Health (Amendment) Act 1991) all persons are allowed access to urgent medical treatment, which includes children of irregular migrants. Explicit reference to this group is not made in the regulatory framework for healthcare. However, there is a statutory requirement to provide care to all children in Ireland, irrespective of their status under the Child Care Act (1991, Section 3.1) which states that *‘It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection’*. They may qualify for a Medical Card¹⁵⁰, if they fulfil the criteria for habitual residence in Ireland and/or if they are in receipt of social security payments / worked / paid social insurance in another EU state.

In **Italy** EU citizens without health coverage in their home state and in the national territory can receive urgent

¹⁴⁵ <https://mdmeuroblog.files.wordpress.com/2014/01/legal-update-full-v06042013.pdf>

¹⁴⁶ Questionnaire Country Agent Greece.

¹⁴⁷ Act on Foreigners, article 36

¹⁴⁸ Reglugerð um heilbrigðisþjónustu við þá sem ekki eru sjúkratryggðir samkvæmt lögum um sjúkratryggingar og greiðslur þeirra fyrir heilbrigðisþjónustuna nr. 1142/2015

¹⁴⁹ Questionnaire ECRE.

¹⁵⁰ Medical Card entitles holders to free access to a wide range of health services including General Practitioner (GP) and Primary Care services, as well as Inpatient / day-care / outpatient services in public hospitals Hospital in-patient and outpatient services (as a public patient)

and essential care from the National Health Service (NHS). In some regions such as Tuscany the ENI code (European Citizens not Registered in the National Health Services) gives access free of charge to:

- outpatient and hospital care, urgent or essential, although continuing, due to illness and injury;
- interventions of preventive medicine and nursing care services related to them¹⁵¹.

The ENI code is issued following verification that the citizen has no medical coverage from the country of origin and is not eligible for registration with the National Health Services (Pratomigranti, 2013).

Latvia No data

In **Lithuania** children of irregular EU citizens (except unaccompanied children) are entitled only to emergency care of the same scope as resident children, as they do not have legal status.

In **Malta** No data

In the **Netherlands** unlike in Belgium or in France, the care scheme for irregular third-country nationals is not applicable to EU citizens without authorisation to reside. If the latter do not have a European Health Insurance Card (EHIC), they only have free access to emergency care. There are no specific legal provisions for children of destitute EU citizens who have lost their right to reside and have no health insurance (Medecins du Monde, 2015b).

In **Norway** all children are entitled to same level of care. Destitute migrants may have problems buying necessary medication. There is a health care centre in Oslo (funded by Red Cross and Inner city mission) which may offer also free medication. The financing of health care to children that are here without legal permit is not regulated, in practice the provider (municipality or regional specialized health provider) finance this help to children¹⁵².

In **Poland** irregular EU citizens have the same entitlements as irregular third-country migrants.

In **Portugal** every child (under the age of 18 years old) is entitled to free full access to health care. Both the National Programme of Child and Youth Health, from the National Directorate of Health, and the law establishing the exception from fees to every child or adolescent, regulate this access. Specific situation related to foreigners are specified in the "Manual de Acolhimento no Acesso ao Sistema de Saúde de Cidadãos Estrangeiros", from the Portuguese Ministry of Health.

In **Romania** this group of children is implicitly entitled to health care, as the law grants equal rights to health care for all children. However, entitlements for ethnic Romani citizens, born in Romania, depend on their birth registration. If they have a birth certificate, they can register with a family physician, and then they are entitled to all services for any other child. The reality is that there is an unknown proportion of undocumented minors, born in Romania, whose parents might also lack documents, and in this case the National Insurance House does not cover their health services¹⁵³.

In **Slovakia** this group is entitled to emergency health care only, or they do have to pay in cash, if possible, every health treatment provided to them and all the medicaments prescribed to them, similarly to other irregular migrants.

In **Slovenia** pursuant to Article 7 of the Health Care and Health Insurance Act, the Republic of Slovenia provides budget funding for the emergency health treatment of persons with unknown places of residence, aliens from countries with which Slovenia has not entered into an international treaty, foreigners and citizens of the Republic of Slovenia who have their permanent residences abroad but are temporarily staying in or travelling through the Republic of Slovenia and for whom no other payment for health services could be provided, as well as for other persons who are not included in the compulsory health insurance scheme in accordance with the provisions of the Act and are not insured by a foreign insurance institution.

¹⁵¹ State-Region Agreement dated 20 December 2012.

¹⁵² Questionnaire Country Agent Norway.

¹⁵³ Questionnaire Country Agent Romania.

In **Spain** for children of irregular EU citizens the same entitlements to health care applies as for irregular third-country migrants¹⁵⁴. Groups of destitute EU migrants, such as foreign Roma populations, have been particularly hard hit by the financial crisis and the related limitations in entitlements to health care. Due to high levels of unemployment, informal economy, and poverty, these groups rely more heavily on public services that are more seriously affected by government cuts. The Progress Report from a multi-stakeholder perspective on the implementation of the NRIS (National Roma Integration Strategy) in Spain explains in detail the problems faced by Roma populations regarding access to health care. For example, to obtain a certificate from their countries of origin to prove that they do not receive free medical assistance there has become an insurmountable obstacle to access healthcare in Spain, especially due to the long and complex bureaucratic procedures and excessive fees imposed by consulates. In this regard, the Progress Report from a Multi-stakeholder Perspective on the Implementation of the NRIS (National Roma Integration Strategy) and other National Commitments in Spain (EquiHealth Roma Health, 2014) states that legal hindrances make it virtually impossible for Roma people to obtain entitlement (MIPEX 2015). Regarding children, some Roma children are not vaccinated, do not get regular paediatric check-ups, and have a deficient or unbalanced diet. Furthermore, lack of healthcare centres in segregated areas and the absence of public transport make it more difficult for Roma people, including children, to get the necessary documents to register with and access healthcare system.

In **Sweden** there is a lack of clarity regarding health care entitlements for children of destitute EU citizens. The July 2013 Law which grants health care rights to irregular migrant children is not clear on whether irregular EU citizens, including children, who have lost the right to reside are currently able to access healthcare on the same basis as irregular third-country nationals (UNICEF Sweden, 2015)¹⁵⁵. The government bill 2012/13:109453 merely stipulates that this is possible “only in a few cases”¹⁵⁶ without further precision. However, in December 2014, the National Board of Health and Welfare publicly announced that irregular EU citizens should have the same access to care as asylum seekers and irregular third-country nationals. It then made a new statement in April 2015 and reiterated the fact that EU citizens who stay longer than three months may in certain cases have access to healthcare on the basis of the 2013 law (Socialstyrelsen, n.d.). In practice, they remain in the former system and have to pay full fees for receiving healthcare in most hospitals and health centres. There is a clinic run by the Médicins du Monde in Stockholm that sees many patients from this group that have been refused care elsewhere¹⁵⁷.

In **UK** No data

¹⁵⁴ Royal Decree 240/2007 states that EU citizens have the right to reside only if they have health coverage and have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State. This provision excludes destitute EU citizens. EU nationals who have lost their authorization to reside in Spain must apply for a “special provision”, under the same conditions as undocumented migrants, to be readmitted into the Spanish National Health System and are entitled only to emergency care free of charge.

¹⁵⁵ Lag (2013:407) om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd; Förordning (2013:412) om vårdavgifter m.m. för utlänningar som vistas i Sverige utan nödvändiga tillstånd explicitly addresses undocumented.

¹⁵⁶ Government Bill on healthcare for people staying in Sweden without permission of 2013.

¹⁵⁷ Questionnaire Country Agent Sweden.

Annex 4: Health examinations of newly arrived asylum-seeking and refugee children

In **Austria** asylum seekers undergo a mandatory health examination for tuberculosis and polio and a voluntary check of the immunization status with free immunizations if required and wished. The health check is performed after the asylum application has been lodged.

In **Belgium** No targeted health examination of newly arrived migrants are in place. The three agencies for child welfare (K&G, ONE, DKF) will attempt to identify them and send them to the well-baby clinic if they are less than 6 years of age. School health will assess the others. FEDASIL centres offer care.

In **Bulgaria** the law on Asylum and Refugees specifies that medical screenings must be provided to all asylum seekers at registration. The health services in the migrant reception and detention centres and the Medical Institute of the Ministry of the Interior are responsible for this examination. Migrants are in quarantine until the results from the examinations are ready. In 2013, most health services were provided by non-governmental organizations, including Médecins Sans Frontières and the Bulgarian Red Cross, but in 2014 control of food and medical services was handed over to the State Agency for Refugees (WHO Regional Office for Europe, 2015).

In **Croatia** the Communicable Diseases Population protection Act 2007 states that asylum seekers should be examined for Communicable Diseases and vaccination status after seven days of initial reception. If necessary, vaccinations should be given during these examinations against diseases established under the Compulsory Programme of Vaccination of School Children and Children of Preschool Age. Supplementary medical examinations are performed with the purpose of determining chronic infections diseases and acquiring health certificate needed for their application procedure. The examinations is not intended to determine special needs of the children, but to protect the resident population against health conditions which might be brought into the country (IOM, 2014). However, in practice health threats are low and examinations are focused above all on the needs of the migrant child. UAMs Protocol on dealing with children separated from their families presumes medical examinations for UAMs before they are accommodated in social care institutions. Reception conditions for unaccompanied and separated children have been pointed to as not adequate by the CRC and HRW. These examinations should be performed by a physician specialized in Family Medicine, paediatric ambulatory or a general practitioner besides the family doctor (IOM, 2014).

In the **Czech Republic** newly arrived asylum seekers undergo a medical examination comprised of a comprehensive examination of urine, blood, heart and lung X-ray and of detecting potential danger of contagious infections, including family, social and professional history. Input procedure or the so called "quarantine" lasts an average of three weeks and is mandatory for all new asylum seekers¹⁵⁸.

In **Cyprus** asylum seekers undergo a mandatory health examination and undergo the following screenings: Mantoux test; HIV; HBV; HCV; Syphilis test. Aimed at protecting the resident population against health conditions which might be brought into the country.

In **Denmark** asylum seekers go through a voluntary health examination at the asylum camps performed by a nurse and under Red Cross auspices. From primarily focusing on communal diseases, these examinations have become more focused on the needs of the asylum seekers, on prevention and information about the Danish health care system (Frederiksen & Norredam, 2012). According to the Danish Immigration service, migrant children should be offered a health examination within ten days of arrival. However, due to limited resources and staff at the reception centres many children are not seen by a doctor or nurse accordingly (DR.DK, 2016). Newly settled refugees are also offered health care examinations in the municipalities. These examinations are currently being debated, as the municipalities wants to stop them due to related expenses.

In **Estonia** an official may arrange for health checks UAMs in order to determine any medical needs as soon as possible. Furthermore, the Illuka Reception Centre for Asylum Seekers has the obligation to organise emergency

¹⁵⁸ Czech Republic Act no. 326/1999 Coll.

care and health checks for applicants.

In **Finland** all asylum seekers are advised to have an interview within two weeks after they have arrived. This includes evaluation of their health risks before arrival, symptoms, previous vaccinations, previous diseases and their care and current medication, as well as for children length and weight. Thorax x-ray will be carried out for people with symptoms or asymptomatic persons arriving from high-risk countries for tuberculosis. Laboratory tests for infectious diseases are taken within three months from arrival. All children below 7 year will have a medical check-up, including vaccinations. The primary focus is the needs of the migrant child.

In **France** a health check is offered in reception centres and accepted by nearly all asylum seekers (not everybody is granted access to reception facilities)(ECRE, 2007).

In **Germany** all asylum seekers should undergo a medical examination, which usually takes place shortly after the registration of the asylum application in the initial reception centre¹⁵⁹. The supreme health authority of the Land or an authority designated by it shall determine the extent of the medical examination and the physician to conduct the examination. The examination is focused on the detection of communicable diseases and, starting at the age of 15 including an x-ray of the respiratory organs. The examination does not include a screening for potential vulnerabilities. Sometimes medical personnel or other staff members working in the reception centres inform the BAMF if they recognise symptoms of trauma, but there is no systematic procedure in place ensuring that such information is passed on (ECRE, 2015). Catch up vaccinations are offered in case of need.

Some Federal Länder, e.g. Hesse, North Rhine Westfalia, Saarland established legal frames for examinations covering all immigrant children by the Paediatric Public Health Service. These focus on conditions of school relevance and the perspective of potential needs of support for a successful participation in school, including e.g. chronic conditions or disabilities.

In **Greece** no systematic health care examinations are provided and no legal framework exists regarding screening of newly arrived children (or migrants). Health care services are provided to some extent to newly arrived migrants from various stakeholders (NGOs, local activists, local authorities, the national public health institute etc.) in first reception camps.

In **Hungary** the Chief Medical Officer may order healthcare examination for all migrants In case of massive migration to Hungary or other case of necessity¹⁶⁰. Every check-point has its own military surgeon for first contact physical examination entering Hungarian territory. Such screenings usually cover a predefined scope of illnesses (tuberculosis, HIV infection, syphilis, typhoid fever, hepatitis B); however, the Chief Medical Officer of the District may make a different decision in accordance with the epidemiological situation. Unaccompanied minors are granted such services in the procedure of child care by the authorities¹⁶¹.

In **Iceland** Individuals who apply for a residence permit must undergo a physical examination that is aimed at catching infectious diseases. This applies to everyone from Central and South America, European countries that are not part of the EEA, Asia and Africa. If these individuals have a ratified medical certificate that was issued less than 3 months ago, they are exempt from such examination¹⁶². The assessment is done to exclude contagious diseases, tuberculosis and hepatitis. Blood samples are drawn, urine samples collected and x-rays taken of lungs to exclude tuberculosis. Furthermore, children must submit a stool sample to exclude diseases caused by parasites in the digestive tract. If a disease is detected that health care workers are required to report according to Icelandic law, it is recommended that outpatient units are responsible for the care and treatment needed. Immunization records are viewed and if there is a lack of these it is made sure that the individual is offered vaccination in their primary care facility¹⁶³. If the examination casts light on anything abnormal the children are given relevant treatment and follow up is done via the outpatient unit. The service is focused on both the needs of the migrant child and the protection of the resident population¹⁶⁴.

¹⁵⁹ According to Section 62 fin Asylum Procedure Act (AsylVfG)

¹⁶⁰ Act CLIV of 1997 on healthcare, § 74/A

¹⁶¹ Questionnaire Country Agent Hungary.

¹⁶² Verklagsreglur um læknisrannsókn á fólki sem flyst til landsins

¹⁶³ Reglugerð um skýrslugerð vegna sóttvarna nr. 221/2012 og Reglugerð um sóttvarnarráðstafanir nr. 817/2012

¹⁶⁴ Verklagsreglur um læknisrannsókn á fólki sem flyst til landsins.

In **Ireland** initial screenings for infectious diseases is available to all migrants – this may be accessed through any medical setting where migrants present for healthcare, for example, primary care, specialist services for migrants, antenatal clinics, prison medical services or hospitals (Health Protection Surveillance Centre, 2015). Health screening is available for asylum seekers in Reception Centres – voluntary and confidential. Screening covers Hepatitis, TB, HIV, immunisation status and any other ailments or conditions that the medical officers feel require further investigation and/or treatment. Screening staff also check the vaccination needs of the resident and their family. The position on screening is outlined in the Health Protection Surveillance Centre's guidance document, Infectious Disease Assessment for Migrants which states that: *These guidelines are not proposing a formal screening programme but offer best practice advice for infectious disease assessment in migrants. The guidelines facilitate opportunistic assessment, and participation on the part of the migrant is on a voluntary basis. In using these guidelines consideration should be given to the individual migrant, their needs and their country of origin. The guidelines are intended to benefit both migrants and the host population* (Health Protection Surveillance Centre, 2015 p. 9).

In **Italy** no targeted health examination of newly arrived migrants are in place.

In **Latvia** All third-country citizens should undergo a mandatory TB screening after they have received a positive decision on issuance of a residence permit. All asylum seekers are tested as well (EMN, 2012).

In **Lithuania** all newly arrived migrants are referred to the State Border Guard Service under the Ministry of the Interior where they have to go through a health examination (mandatory). There is a primary health care Centre in Foreigners Registration Centre, where one half-part time works family physician (two days per week) and three nurses. All newly arrived migrants there have to pass health examination (mandatory). This service delivery is mainly focused to protect the resident population against health conditions which might be brought into the country, for prevention and control of uncommon communicable diseases.

In **Malta** health examinations are mandatory to all newly arrived migrants. First screening is done at disembarkation where all migrants are screened for emergency cases to be referred to the hospital, and a second screening is done within the policy HQ for dermatological or infectious disease (IOM, 2013a).

In the **Netherlands** asylum seekers undergo a medical screening in the Netherlands before submitting their asylum application. A compulsory check is carried out for tuberculosis and all other medical checks. The aim is to see all the asylum seekers (on a voluntary basis), with priority given to the 0-19 year olds, pregnant women, the disabled, those with a medical case history and other at risk groups (UNHCR, 2015). The Municipal Public Health Service (GGD) is responsible and provides asylum seekers with routine vaccinations, according to the national vaccination scheme, with corrections and extensions if needed. The latter depends on the country of origin and what already has been received by the child, according to the available documentation. For some diseases additional checks are provided. For example, tuberculosis (TB) and mange (scabies) and in certain risk groups x-rays of the lungs are made and in some cases examinations are done at a hospital for the presence of the bacterium MRSA. Treatment is provided if necessary. Moreover, the child receives an extended scheme of the routine well-baby and well-child assessments. Sometimes there is an additional offer depending on the country of origin and associated risks. This e.g. regards Hepatitis B, which is not part of the routine vaccination scheme in the Netherlands.

In **Norway** asylum seekers go through a mandatory test for tuberculosis and are offered an initial health examination in transit centres which includes: medical screening to detect need of treatment for diseases as well as health conditions requiring immediate attention; optional HIV and hepatitis test. If tuberculosis is detected, treatment is initialized immediately. There is no screening process for vulnerable asylum seekers. However, upon arrival at an ordinary reception centre, UAMs will generally have a meeting with the local public health nurse (helsesøster) to map their possible healthcare needs (Staver & Lidén, 2014). Municipalities are advised to offer a full medical examination to all asylum seekers within three months of arrival (Lutine de Wal Pastoor et al., 2010).

In **Poland** asylum seekers must go through mandatory health examination. It is primarily to protect the resident population, but the Head of the *Foreigners' Affairs Unit* may order a medical or psychological examination (covered by public funds) of a person who may require special treatment. In *The Act of 13 June 2003 on granting protection to foreigners on Polish territory* there are listed some categories of migrants that

should be especially taken into consideration, e.g. children and youth.

In **Portugal** no targeted health examination of newly arrived migrants are in place. Voluntary health checks are provided at the Institute of Tropical Medicine in Lisbon (ECRE, 2007).

In **Romania** newly arrived migrants must go through a medical examination prescribed for them¹⁶⁵. Practice of vaccination follows the regulations of the law and is delivered at the request of the General Inspectorate for Immigrations, addressed to the County Directorates of Public Health or the Bucharest Municipality Public Health.

On arrival in **Slovakia** asylum seekers must undergo a medical examination, which includes blood tests, lung x-rays and tests for HIV, syphilis and hepatitis. These examinations are obligatory and without them an asylum seeker cannot be discharged from quarantine (usually within 30 days). The doctor contracted by the Migration Office carries out the examinations; the asylum seekers are taken to a hospital for the x-ray accompanied by officers of the Migration Office. The examinations are primarily focused on the prevention of transmittable diseases to the inhabitants and citizens in Slovakia, not for protection (and further treatment) of the migrant child. Children, youth or adult who is found to be positive e.g. due to TB or STDs are usually immediately sent back to their country of origin¹⁶⁶.

In **Slovenia** medical examination for international protection applicants is done in Centre for Foreigners or in Asylum Centre, both are under authority of Ministry of Internal Affairs. Examination is made by a doctor that works under contract for Asylum Centre. Occurs before every application for international application. Medical history of contagious diseases contacts with infected persons; Information on vaccinations and medication; Basic medical exam (skin, mucosa, throat, lymph nodes) for potential contagious diseases; Other urgent examinations regarding medical situation of patient (EMN, 2012). Refugees and migrant undergo a preventative medical examination in reception centres, where medical staff have basic medical equipment and medicine. The examination includes an enquiry about medical history with regard to contagious disease and a physical examination. Patients with contagious diseases are processed in separate rooms (Government of the Republic of Slovenia, 2015).

In **Spain** no targeted health examination of newly arrived migrants are offered. Reasons are that, apart from the ethical issues involved, such practices are not effective from the public health point of view.

In **Sweden** the law states that asylum seekers, refugees and family relations to these groups, of all ages, should be provided a health examination by the counties where they reside, paid for by the Swedish state. This examination is not mandatory and participation is around 40-50%. The main reasons for the low participation rights are administrative, and vary greatly between counties, with particularly low rates in the bigger cities. The health examination, according to the law has two purposes; identifying needs of care for the refugees and identifying communicable diseases that could be a danger to the rest of the society. The content of this health examination is not defined in the law and differs greatly between counties. It almost always consists of an interview by a nurse accompanied by some blood tests for communicable disease and a PPD (tuberculosis) test.

In the **UK** asylum seekers are sent to initial accommodation centres where a preliminary health assessment is carried out to assess any immediate health needs, as well as provide a medical history for when they register with a GP (if they are dispersed to accommodation around the UK – though some individuals may be detained whilst their application is considered).

¹⁶⁵ Law 122/4 May 2006, re-actualised 24th December 2015, article 17.

¹⁶⁶ Questionnaire Country Agent Slovakia.

Annex 5: Questionnaire

Policy for health care for migrant children

1. Entitlements to health care for children in asylum-seeking families

1. a. Does the service delivery regulatory or commissioning framework for health care for children in your country include **children in asylum-seeking** equally in the entitlements to care that are granted to children with permanent residency? Please answer in terms of:

- Primary care (including type of care / location of treatment)?
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

1.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.

1.c. Are there any differences compared with resident children with regard to fees paid when accessing such health care?

1.d. How is this care funded?

1.e. Are there any conditionalities tied to receiving healthcare for children in this category e.g. administrative barriers etc.?

1.f Are unaccompanied children in this category awarded special entitlements to health care?

2. Entitlements to health care for undocumented children

2.a. Does the service delivery regulatory or commissioning framework for health care for children in your country include **undocumented children, including children residing temporarily or passing through your country**, and treat them equally with children granted permanent residency? Please answer in terms of:

- Primary care (including type of care / location of treatment)
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

2.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.

2.c. Are there any differences compared with resident children with regard to fees paid when accessing health care?

2.d. How is this care funded?

2.e. Are there any conditionalities tied to receiving healthcare for undocumented children, such as a duty to report to the authorities for health care staff, school attendance, administrative barriers etc.?

2.f Are unaccompanied children in this category awarded special entitlements to health care?

3. Entitlements to health care for children of destitute EU citizens

3.a. Does the service delivery regulatory or commissioning framework for health care for children in your country include **families or children of destitute EU migrants** and treat them equally with children having permanent residency? Please answer in terms of:

- Primary care (including type of care / location of treatment)
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

3.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.

3.c. Are there any differences compared with resident children with regard to fees paid when accessing health care?

3.d How is this care funded?

3.e. Are there any conditionalities tied to receiving healthcare for children in this category e.g. administrative barriers etc.?

3.f Are unaccompanied children in this category awarded special entitlements to health care?

4. Health examinations of newly arrived migrants

4.a. Does the legal framework for health care for children in your country include any health examination/assessment for newly arrived children from other countries? If yes,

4. b. Which categories of migrants are covered (e.g. asylum-seeking, undocumented)?

4.c. Is it mandatory?

4.d. Is this service delivery focused above all on the needs of the migrant child, or is it adapted primarily to protect the resident population against health conditions which might be brought into the country?

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