2019 OBSERVATORY REPORT

LEGAL REPORT ON ACCESS TO HEALTHCARE IN BELGIUM, GERMANY, SWEDEN AND THE UNITED KINGDOM

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FOREWORD

The law determines, in conjunction with other factors, the scope of health coverage in a country. The law protects and authorizes. The law constraints and limits. The legislator has constantly extended citizens' rights in order to achieve health protection that is often satisfactory in terms of public health and national cohesion. What about foreigners and those we do not see or cannot make their voices heard? Three thoughts come to mind around this question.

Recent history and future prospects attest to the rise in migratory movements. The question of the portability of migrants' rights from one country to another will become ever more acute. This portability, often recognized in its principles at the global level, is confronted with the primacy of the nation-state, which continues to be the guarantor but also the gatekeeper. It is absolutely certain that one day we will succeed in protecting the standard of living of our citizens while guaranteeing the universality of fundamental rights to the citizens of other countries that cross our borders. The question is when and how.

We are clearly not there yet and, on the contrary, we are increasingly committed to the principle of "less eligibility". This principle is defined as the limitation of the welfare state in such a way as to encourage the poorest to get up again or to punish the precarious to prevent them from settling in the welfare state. This principle is based on the belief that the precariousness of the Other is born of his irresponsibility or lack of foresight. Thus, for example, it is not possible to grant equal rights to non-citizens because their non-citizenship is an irresponsibility that they will become aware of if their rights are limited. In terms of health, this means denying a treatment adapted to the needs and building a punitive response based on status. How else can we interpret the gaps that persist in Europe, for example in the care of pregnant migrant women?

The third reflection that comes to us on the question of laws is linked to the ever-increasing use of computerization of systems to limit rights. Digitisation in health is an explicit policy of the Union. It enchants us as much as it worries us because it allows us to reform a series of situations and thus to exclude people, pathologies, reimbursements, and sometimes even medical appointments.

This publication is therefore necessary to understand the niches of non-rights and vectors that Europe can mobilise for the inclusion of all people in healthcare systems. The *Legal Report* also remains an excellent tool for field practitioners, doctors, health care workers, social workers and advocacy officers negotiating the reintegration of patients excluded from the health care system.

Knowing and making known the rights of users who attend Médecins du Monde consultations remains our priority.

Pierre Verbeeren.

Executive Director of Médecins du Monde Belgium.

ACRONYMS

BE	Belgium
CoE	Council of Europe
CRC	Convention on the Rights of the Child
DE	Germany
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EEA	European Economic Area
EFTA	European Free Trade Association
EHIC	European Health Insurance Card
EPIM	European Programme for Integration and Migration
ETHOS	European Typology of Homelessness and Housing Exclusion
EU	European Union
FEANTSA	Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abris
FGM	Female Genital Mutilation
GP	General Practitioner
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
MDM	Doctors of the World (*Médecins du monde – MDM*)
NEF	Network of European Foundations
NGO	Non-governmental organisation
NHS	National Health System
OHCHR	Office of the High Commissioner for Human Rights
SRHR	Sexual and Reproductive Health Rights
SE	Sweden
SEK	Swedish krona
SHI	Social Health Insurance
STIs	Sexually Transmitted Infections
UHC	Universal Health Coverage
UK	The United Kingdom
UN	United Nations
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organisation

INTRODUCTION

Access to health care is commonly defined as health services being available, adequate, accessible, appropriate and affordable[1]. Patients can seek quality healthcare they need in an informed and patient-centred fashion without suffering financial hardship nor delays. The notion of access to healthcare can also be understood through the concept of coverage, as provided by the World Health Organization (WHO)[2]. In 2005, the World Health Assembly (WHA) adopted a resolution on universal health coverage (UHC) and urged Member States to "*plan the transition to universal coverage of their citizens*"[3], which was thus included in the United Nations (UN) sustainable development goal 3 in 2015[4]. The WHO usually presents the UHC as a three-dimension concept that reflects the quantity of population covered, the services provided and the financial protection (i.e. level of out-of-pocket payments). A large majority of European countries claim they have successfully achieved universal health coverage or have engaged in policies converging towards UHC. However, some groups of people are still excluded from health coverage[5]. Indeed, in some national healthcare systems, access to healthcare for asylum seekers, refugees and undocumented migrants is restricted, and even if they have access on the same basis as nationals, there may still be barriers to effective access to healthcare[6]. It is established that people can be excluded from healthcare due to social, economic or cultural factors[7], but the purpose of this report is more to focus on the deprivation of their right to access to healthcare through legislation and its implementation.

Presentation of the project

The European Observatory is a consortium financed by the Open Society Foundation (OSF) and the European Platform for the Integration of Migrants (EPIM), and which brings together seven chapters of Médecins du Monde (MDM), in Belgium, France, Germany, Luxembourg, Sweden, Switzerland and the United Kingdom. The purpose of the Observatory is to contribute to reducing inequalities in Europe by advocating the right to access affordable, timely and good quality healthcare. To achieve this objective, several instruments exist, including the Legal Report. The Observatory Report, which is an evidence-based analysis report regarding barriers in access to healthcare for categories of population excluded from healthcare, serves as the main instrument. It compiles data from more than 58.000 medical consultations in MDM clinics.

The Legal Report is a research project, which aims to describe four national healthcare systems, in Belgium (BE), Germany (DE), Sweden (SE) and the United Kingdom (UK), using both legal expertise and feedback from what MDM observes in the field. It addresses the difficulties in accessing the public healthcare system for specific categories of people in Europe. This report details the legal aspects necessary for the staff engaged in advocacy for people excluded from healthcare. This concerns not only MDM staff but also all our partners involved in the field, and enables them to understand the legal framework. It also provides a basis for reflection of the restrictions to access to healthcare for certain categories of people. This creates a platform for claiming better access to healthcare in order to achieve universal coverage.

Working methodology

[1] European Patients Forum, "Defining and Measuring Access to Healthcare : the Patients' Perspective", Position Statement, March 2016, http://www.eu-patient.eu/globalassets/policy/access/epf_position_defining_and_measuring_access_010316.pdf.

[2] David B Evans, Justine Hsu,Ties Boerma, *Bulletin of the World Health Organization 2013*, Volume 91, Number 8, August 2013, pp. 546-546A, https://www.who.int/bulletin/volumes/91/8/13-125450.pdf..

[3] Resolution WHA58.33, 58th World Health Assembly, May 2005, WHA58/2005/REC/1.

[4] WHO, "SDG 3: Ensure healthy lives and promote wellbeing for all at all ages", SDG 3.8, https://www.who.int/sdg/targets/en/.

[5] Communication from the Commission on effective, accessible and resilient health systems, COM(2014) 215, https://ec.europa.eu/health//sites/health/files/systems_performance_assessment/docs/com2014_215_final_en.pdf.

[6] Rita Baeten, Slavina Spasova, Bart Vanhercke and Stéphanie Coster, *Inequalities in access to healthcare: A study of national policies 2018*, European Social Policy Network, European Commission, 2018, p. 39 https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8152&furtherPubs=yes.

[7] D. Doumont, I. Aujoulat, A. Deccache, "L'exclusion de la santé: Comment le processus se construit-il et quels facteurs y contribuent-ils?", Série de dossiers documentaires, UCL, December 2000, https://cdn.uclouvain.be/public/Exports%20reddot/reso/documents/dos10.PDF.

The report is based on the research work carried out in the last few years by MDM teams on 16 countries. It reworks this research and includes present legislative and regulatory developments in the four countries under review.

In the report, the public healthcare system of each country is described as a whole through its organisation, access and funding. Then, different categories of people are highlighted, namely European Union (EU) / European Economic Area (EEA) migrants, asylum seekers and refugees, undocumented migrants, unaccompanied minors, seriously ill foreign nationals and homeless people. The choice of these categories was dictated by the fact that specific provisions apply to them, generally restricting their access to the public healthcare system. They can also face barriers in accessing healthcare. Particular attention is also given to access to sexual and reproductive health rights (SRHR). As many more specific rights are encompassed by this notion, for the relevance of the report, we chose to focus on access to maternity care, termination of pregnancy and family planning services, access to treatment for sexually transmitted infections (STIs) and female genital mutilation (FGM), and services provided to female victims of violence. Ultimately, the methodology used is to combine both legal expertise (with literature review) and relevant information observed by MDM in the field (through reports and interviews).

Historical context of access to healthcare

Universal health coverage does not only (?) depend on public health priorities. It also follows the evolution of political objectives to achieve social protection for the many. Social security, including State health insurance, has been recognised as a human right in the 1948 Universal Declaration of Human Rights[8] and has a great importance in reducing inequalities and exclusion.

Gradually, governments came to realise that at one crucial time in history, be it the unification of a nation, the hardship or the immediate rebuilding period of a world conflict, cohesive societies must be built on solidarity. Thus, no citizen could ever face exclusion because of the consequences of ominous events such as the occurrence of disease and poor health coverage. Historically in Europe, the states had little role in providing health services. In 1883, Otto von Bismarck, the German chancellor, instigated the first social health insurance (SHI) system in creating a compulsory social insurance programme for sickness, for accident at work one year later and for old age and disability in 1889. This system is based on work and financed by contributions. Adopted by other Western European countries, the SHI system has been and is still a model in several countries across the world. But it is during World War II that other countries moved for social security. France Resistance governments paved the way for De Gaulle's temporary government to establish a universal insurance-based social security system but it was in the UK that a National Health Service (NHS) was first created, based on the William Beveridge's report of 1942[9]. In the Beveridge system, access to healthcare is universal and free at the point of service. Health services are provided and financed by the government through taxes so the government acts as the single-payer. The principle of this system is that no one should live below a minimum standard throughout his/her lifetime. These are the two main social security systems but some other countries have adopted a mixed or a private system.

Each State then establishes its own social security system and there is no unified model across the EU but only cooperation between Member States[10]. The government, from a political point of view, defines the scope of the healthcare coverage, leading to the coverage of vast segments of its population but also deprives categories of people of their right to health.

The international and European context of access to healthcare

At the international level, the WHO Constitution states in its Preamble that health is a fundamental right of every human being[11]. According to the WHO, the right to health is not the right to be healthy but refers to the right to enjoy the highest attainable standard of health and

[8] OHCHR, *Universal Declaration of Human Rights*, 1948, Art. 22, https://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf.

[9] ILO, "From Bismarck to Beveridge: Social security for all", December 2009, https://www.ilo.org/global/publications/world-of-work-magazine/articles/ilo-in-history/WCMS_120043/lang--en/index.htm.

[10] EU, *Treaty on the Functioning of the European Union*, 2007, Art. 168(2).

[11] WHO, *Constitution of the WHO*, 1946, Preamble.

benefit from health goods, facilities and services[12]. The right to health is protected by several international legal instruments, the main one being the International Covenant on Economic, Social and Cultural Rights (ICESCR), which requires States to take steps within their means to progressively achieve the right to health[13]. Thus, as health is considered a human right, there is a legal obligation on States to ensure access to timely, acceptable and affordable healthcare[14]. The implementation of the right to health is monitored by international mechanisms, for example the Committee on Economic, Social and Cultural Rights related to the ICESCR can engage in a constructive dialogue with each State.

The right to health is also recognised in European instruments. At the EU level, the right to access healthcare is proclaimed in the Charter of Fundamental Rights[15] and has been included more recently into the European Pillar of Social Rights stating that "*[e]veryone has the right to timely access to affordable, preventive and curative health care of good quality*" [16]. Even if the European Pillar is not legally binding, it is an important step for public health and access to healthcare.

The European Health Insurance Card

With the freedom of movement in the EU, the European Economic Area (EEA) and Switzerland, the mobility of EU citizens has increased and they need access to proper healthcare while travelling. The first introduction of the European Health Insurance Card (EHIC) in 2004 simplified the procedures to access healthcare for citizens staying in another State, by eliminating the need to complete a new form (E111, E110, E128 or E119) for each trip. The EHIC is a free card giving access to the healthcare necessary on a temporary stay abroad by the host country's public healthcare system on the same basis and at the same cost as nationals of that country under EU law[17]. This card is not an alternative to travel insurance, does not cover the costs for planned medical international and does not guarantee free services, as the reimbursement will depend on the rules and rates of the host country[18]. Anyone who is insured or covered by a state social security system in a Member State of the EU, the EEA or in Switzerland is eligible to receive the card, no matter his/her nationality[19]. In case the person does not have his/her EHIC, s/he cannot be refused treatment but may have to pay and claim reimbursement once at home[20]. However, the person can do so only for the treatment s/he is entitled to receive at home and up to the cost of treatment in the home country[21]. However, if the person is not insured in his/her home country, s/he cannot apply for an EHIC.

Concerning the UK and the Brexit, the UK government issued detailed advice on the EHIC. If the UK leaves the EU without a deal on 31 January 2020, the EHIC will no longer be valid after this date. In this case, the government advises its citizens who intend to travel in Europe to buy travel insurance to get healthcare treatment[22]. If there is a deal, the EU law will continue to apply in the UK and people will still be able to use their European card.

The European Convention on Human Rights

The European Convention on Human Rights (ECHR) has no provision about the right to health but the European Court of Human Rights (ECtHR) is developing case law about quality and access to healthcare issues based

[12] OHCHR, WHO, "The Right to Health", Fact Sheet No. 31, June 2008, p. 5, https://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

[13] OHCHR, *International Covenant on Economic, Social and Cultural Rights*, 1966, Art. 12.

[14] WHO, "Human rights and health", 29 December 2017, https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

[15] EU, *Charter of Fundamental Rights*, 2000, Art. 35.

[16] EU, *European Pillar of Social Rights*, 2017, Principle 16.

[17] See EU, *Regulation (EC) No. 883/2004*, European Parliament and Council, 29 April 2004, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:en:PDF.

[18] European Commission, "European Health Insurance Card", https://ec.europa.eu/social/main.jsp?catId=559&langId=en.

[19] European Commission, "Frequently asked questions – The European Health Insurance Card", https://ec.europa.eu/social/main.jsp?catId=857&langId=en&intPageId=1304.

[20] EU, "Health cover for temporary stays", 8 May 2019, https://europa.eu/youreurope/citizens/health/unplanned-healthcare/temporary-stays/index_en.htm.

[21] EU, "Unplanned healthcare: payments and reimbursements", 23 March 2019, https://europa.eu/youreurope/citizens/health/unplanned-healthcare/payments-reimbursements/index_en.htm.

[22] NHS, "Travelling in the EU, EEA and Switzerland", 8 February 2019, https://www.nhs.uk/using-the-nhs/healthcare-abroad/healthcare-when-travelling-abroad/travelling-in-the-european-economic-area-eea-and-switzerland/.

mainly on Articles 2, 3, 8 and 14 of the Convention[23]. Then, over the last decades, the Court has ruled several times in cases related to the expulsion of seriously ill foreign nationals. The access to healthcare for this specific category of people will be discussed later on for each country. But the ECHR and the case law of the Court applies for all States of the Council of Europe (CoE) (including the States under review) so we chose to set out this case law at this point of the report.

Under Article 3 ECHR, a person is protected from being expelled when there are substantial grounds for believing that there is a real risk of being subject to an inhuman or degrading treatment in the country of expulsion. In its case law, the ECtHR first applied Article 3 in cases concerning the removal of a foreigner suffering from serious illness "*only in a very exceptional case*"[24] when the person facing expulsion is exposed to an imminent risk of dying. But the Court departed from this excessively restrictive approach in the case *Paposhivili v. Belgium* of 13 December 2016[25]. In this case, the Court considered that the terms "very exceptional cases" refer to "*situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she, although not at imminent risk of dying, would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy*"[26]. The returning State must verify that the care is sufficient and appropriate for the treatment of the applicant's illness in the receiving State but "*[t]he benchmark is not the level of care existing in the returning State*"[27] so the quality of the treatment is not taken into account. Also, "*[w]here, after the relevant information has been examined, serious doubts persist regarding the impact of removal on the persons concerned – on account of the general situation in the receiving country and/or their individual situation – the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the persons concerned so that they do not find themselves in a situation contrary to Article 3*"[28]. Thus, the States, by signing the ECHR and accepting the jurisdiction of the ECtHR, have the legal obligation to follow the interpretation of the Convention by the Court. They cannot remove a seriously ill foreigner if his/her state of health is in serious risk of declining in the receiving State according to threshold given by the Court.

[23] CoE/ECtHR, "Health-related issues in the case-law of the European Court of Human Rights", Thematic Report, June 2015, p. 5, https://www.echr.coe.int/Documents/Research_report_health.pdf.

[24] ECtHR, *N. v. The United Kingdom*, 27 May 2008, No. 26565/05, §42.

[25] ECtHR, *Paposhvili v. Belgium*, 13 December 2016, No. 41738/10.

[26] *Idem*, §183.

[27] *Idem*, §189.

[28] *Idem*, §191.

Comparative tables on access to healthcare

In order to facilitate the reading of the report, the following five summary tables give a quick overview of access to healthcare for five categories of persons, which will be further developed in the Report.

Note: These are concise tables and may not accurately represent the complexity of the situation and the law for each country. Thus, you can refer to the detailed chapters for a more in-depth legal analysis.

The first one gives an overview of access to healthcare for asylum seekers. In Germany, access to healthcare depends on the duration of their stay.

ACCESS TO HEALTHCARE FOR ASYLUM SEEKERS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS AUTHORISED RESIDENTS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS AUTHORISED RESIDENTS WITH RESTRICTIONS	ACCESS TO LIMITED[29] HEALTHCARE
BELGIUM		✓	
GERMANY		✓ [30]	✓ [31]
SWEDEN			✓
UNITED KINGDOM	✓ [32]		

The second table provides an overview of access to healthcare for children of asylum seekers.

ACCESS TO HEALTHCARE FOR CHILDREN OF ASYLUM SEEKERS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS CHILDREN OF AUTHORISED RESIDENTS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS ADULTS ASYLUM SEEKERS
BELGIUM		✓
GERMANY		✓
SWEDEN	✓	
UNITED KINGDOM	✓	

The third table provides an overview of access to healthcare for undocumented migrants.

ACCESS TO HEALTHCARE FOR UNDOCUMENTED MIGRANTS	ACCESS TO A SPECIFIC HEALTHCARE SCHEME UNDER CERTAIN CONDITIONS	ACCESS TO LIMITED HEALTHCARE
BELGIUM	✓ [33]	
GERMANY		✓ [34]

[29] Regarding the duration of their stay or the type of health services people can access.

[30] After 15 months, asylum seekers can have access to healthcare on the same basis as authorised residents in Germany but with conditions.

[31] During the first 15 months of their stay in Germany, asylum seekers have access to limited healthcare.

[32] Asylum seekers have free access to NHS services on the same basis as "ordinarily resident".

[33] Belgium grants undocumented migrants access to a specific healthcare scheme under certain conditions (e.g. resources, residence, application).

[34] Undocumented migrants have access to healthcare on the same basis as asylum seekers who have been in Germany for less than 15 months.

SWEDEN		✓
UNITED KINGDOM		✓ [35]

The fourth table provides an overview of access to healthcare for children of undocumented migrants.

ACCESS TO HEALTHCARE FOR CHILDREN OF UNDOCUMENTED MIGRANTS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS CHILDREN OF AUTHORISED RESIDENTS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS ADULTS ASYLUM SEEKERS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS UNDOCUMENTED ADULT MIGRANTS
BELGIUM			✓
GERMANY		✓	
SWEDEN	✓		
UNITED KINGDOM			✓

The fifth table provides an overview of access to healthcare for unaccompanied minors. In some countries, access to healthcare depends on whether unaccompanied minors have applied for asylum or have been granted asylum.

ACCESS TO HEALTHCARE FOR UNACCOMPANIED MINORS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS AUTHORISED RESIDENTS	ACCESS TO HEALTHCARE ON THE SAME BASIS AS AUTHORISED RESIDENTS WITH CONDITIONS	ACCESS TO LIMITED HEALTHCARE
BELGIUM		✓	
GERMANY	✓ [36]		✓ [37]
SWEDEN	✓		
UNITED KINGDOM	✓ [38]		

[35] Undocumented migrants not "ordinarily resident" in the UK have access to free primary care but only to limited free secondary care.

[36] For unaccompanied minors recognised as asylum seekers, who have been granted subsidiary protection or refugee status.

[37] For unaccompanied minors whose permission to remain is pending the asylum decision, who have a suspension of removal or a special residence permit, and who are not accommodated in a residential youth welfare institution.

[38] Unaccompanied minors are exempt from charges if they have made an asylum application, and usually also if they have not done so or if their application has been refused.

GLOSSARY

Access to healthcare

The WHO gives three dimensions to access to healthcare:

- *"Physical accessibility. This is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organisation and delivery that allow people to obtain the services when they need them.*
- *Financial affordability. This is a measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work). Affordability is influenced by the wider health financing system and by household income.*
- *Acceptability. This captures people's willingness to seek services. Acceptability is low when patients perceive services to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services."*[39]

Asylum seekers

Asylum-seekers are individuals seeking international protection. "*In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker*".[40]

EU/EEA migrants

Citizens from one EU/EEA country staying in another EU/EEA country.

Female genital mutilation

Female genital mutilation comprises "*all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons*"[41].

Healthcare

Healthcare refers to the "*services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health*"[42].

Homeless people

According to definition and classification under the European Typology of Homelessness and Housing Exclusion (ETHOS), different living situations amount to homelessness or housing exclusion[43]:

- Rooflessness: refers to people living rough and people in emergency accommodation;
- Houselessness: refers to people in accommodation for the homeless, in women's shelters, in accommodation for immigrants, people due to be released from institutions and people receiving long-term support due to homelessness;
- Living in insecure housing: refers to people living in insecure tenancies, under threat of eviction or violence;
- Living in inadequate housing: refers to people living in temporary/non-conventional structures,

[39] David B Evans et al., "Universal health coverage and universal access", *op. cit.* note 2, p. 546.

[40] UN High Commissioner for Refugees, *UNHCR Master Glossary of Terms*, June 2006, Rev. 1, p. 4, https://www.refworld.org/docid/42ce7d444.html.

[41] WHO, "Female genital mutilation", 31 January 2018, https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation.

[42] WHO Centre for Health Development, "A glossary of terms for community healthcare and services for older persons", *Ageing and Health Technical Report*, Volume 5, 2004, https://apps.who.int/iris/bitstream/handle/10665/68896/WHO_WKC_Tech.Ser._04.2.pdf?sequence=1&isAllowed=y.

[43] Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abris AISBL (FEANTSA), *ETHOS – European Typology of Homelessness and Housing Exclusion*, https://www.feantsa.org/download/en-16822651433655843804.pdf.

in unfit housing or in situations of extreme overcrowding.

Maternity care

Maternity care encompasses health services provided during pregnancy (prenatal or antenatal care) and delivery and, after delivery (postnatal care).

Primary care

Primary care is "*first-contact, accessible, continued, comprehensive and coordinated care. First-contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person rather than the short duration of the disease; comprehensive care is a range of services appropriate to the common problems in the respective population and coordination is the role by which primary care acts to coordinate other specialists that the patient may need*"[44].

Refugees

"*A refugee is someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries.*"[45]

Reproductive and sexual health rights

Reproductive health is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases*"[46].

Third-country nationals

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

Unaccompanied minors

Unaccompanied minors are "*persons below the legal age of majority who are not in the company of an adult who, by law or custom, is responsible to do so, such as parents, guardians or primary caregivers*"[47].

Undocumented migrants

"*Undocumented [...] migrants are persons who do not fulfil the requirements established by the country of destination to enter, stay or exercise an economic activity*"[48].

Universal health coverage

There is Universal Health Coverage when "*all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the*

[44] WHO/Europe, "Primary health care, Main terminology", 2004, http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/main-terminology.

[45] USA for UNHCR - The UN Refugee Agency, "What is a refugee?", https://www.unrefugees.org/refugee-facts/what-is-a-refugee/.

[46] UNFPA, "Report of the International Conference on Population and Development, Programme of Action", Cairo, 1994, §7.2, https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.

[47] UNHCR, *UNHCR Master Glossary of Terms*, *op. cit.* note 38, p. 21.

[48] International Conference on Population and Development, Programme of Action, Cairo, September 1994, p. 112, https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.

use of these services does not expose the user to financial hardship"[49].

Violence against women

Violence against women refers to "*any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"*[50].

[49] WHO, "What is health financing for universal coverage", https://www.who.int/health_financing/universal_coverage_definition/en/.

[50] UNGA, *Declaration on the Elimination of Violence against Women*, New York, 23 February 1993, A/RES/48/104, Article 1, https://undocs.org/en/A/RES/48/104.

BELGIUM

Main legal changes

In March 2018, the House of Representatives (*Chambre des Représentants*) approved a bill about the AMU/DMH for undocumented migrants (see below: Undocumented migrants). Under this new text, a monitoring procedure is established in order to ensure that medical assistance is provided only in case of emergency. Thus, the medical officer of the CAAMI/HZIV must check if the healthcare provided corresponds to the emergency criteria. If it is not the case, the cost will not be reimbursed by the CPAS/OCMW[51]. The problem is that the text does not clarify what those criteria[52] are and the definition used is not the one based on the Royal Decree of 12 December 1996, stating that the AMU/DMH can cover preventive and curative healthcare[53] and not only emergency care. Moreover, the 2015 KCE report highlights that the AMU/DMH covers only 10 to 20% of undocumented migrants[54]. Ultimately, for MDM Belgium, the effect of this reform is to delay access to healthcare for undocumented migrants.

Since January 2019, a waiting period of 24 months (and not only 6 months) applies to people who did not pay their contribution for the supplementary insurance.

National Health System

Constitutional basis

Article 23 of the Belgian Constitution of 1994 states that "*[e]veryone has the right to lead a life in keeping with human dignity. To this end, the laws, federate laws and rules referred to in Article 134 guarantee economic, social and cultural rights, taking into account corresponding obligations, and determine the conditions for exercising them. These rights include among others: [...] the right to social security, to health care and to social, medical and legal aid*"[55].

Organisation and funding of the Belgian healthcare system

Belgium has a Bismarckian-type of compulsory national health insurance through a reimbursement system based on the principles of equal access and freedom of choice (regarding health providers, mutual insurance plans)[56]. It achieves almost universal health coverage of the population (99%)[57].

The National Health System is organised at the federal and regional levels with a complex division of responsibilities[58]. The federal government deals with compulsory healthcare insurance, the financing of hospitals and heavy medical care units, and with the registration of pharmaceutical products and their price control. At the regional level, the three regions and the three communities[59] are responsible for health promotion, preventive health, elderly care, organisation of healthcare and support to federal bodies in the financing of hospitals[60].

[51] Le Guide Social, "La réforme de l'AMU a été adoptée", 16 March 2018, https://pro.guidesocial.be/articles/actualites/la-reforme-de-l-amu-a-ete-adoptee.html.

[52] CIRÉ, "Aide médicale urgente; un projet de réforme qui fait mal!", 15 March 2018, https://www.cire.be/aide-medicale-urgente-un-projet-de-reforme-qui-fait-mal/.

[53] *Royal Decree on urgent medical assistance granted by the public social welfare centres to foreign nationals residing illegally in the Kingdom (Arrêté royal relatif à l'aide médicale urgente octroyée par les centres publics d'aide sociale aux étrangers qui séjournent illégalement dans le Royaume)*, 12 December 1996, No. 1996022721, Article 1, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1996121237&table_name=loi.

[54] See Belgian Health Care Knowledge Centre (KCE), "What health care for undocumented migrants in Belgium?", KCE Report 257, 2015, https://kce.fgov.be/sites/default/files/atoms/files/KCE_257_Health_care_Migrants_Scientific%20Report_0.pdf.

[55] *The Belgian Constitution*, 17 February 1994 (as updated following the constitutional revision of 24 October 2017), Article 23, https://www.dekamer.be/kvvcr/pdf_sections/publications/constitution/GrondwetUK.pdf.

[56] V. Buffel and I. Nicaise, "ESPN Thematic Report on Inequalities in access to healthcare, Belgium", European Commission, *European Social Policy Network*, 2018, p. 5.

[57] OECD/European Observatory on Health Systems and Policies, *Belgium: Country Health Profile 2017, State of Health in the EU*, OECD Publishing, Paris / European Observatory on Health Systems and Policies, Brussels, p. 6, https://www.oecd-ilibrary.org/docserver/9789264283299-en.pdf?expires=1568193268&id=id&accname=guest&checksum=877B284D5CD6546F57083ED90A0F3C84.

[58] V. Buffel and I. Nicaise, "ESPN Thematic Report on Inequalities in access to healthcare, Belgium", *op. cit.* note 56, p. 4.

[59] The Flemish region, the Walloon region and the region of Brussels-Capital; and the Flemish community, the French community and the German community.

[60] V. Buffel and I. Nicaise, "ESPN Thematic Report on Inequalities in access to healthcare, Belgium", *op. cit.* note 56, p. 5.

The details of the health services covered by the mandatory health insurance is managed by the National Institute for Health and Disability Insurance (*Institut national d'assurance maladie-invalidité – INAMI* (in French) / *Rijksinstituut voor ziekte- en invaliditeitsverzekering – RIZIV* (in Dutch)) and determined by a scale, the INAMI/RIZIV nomenclature. INAMI/RIZIV oversees the general organisation of the compulsory health insurance however, the task of actually providing insurance falls to the sickness funds (*mutualités / ziekenfonds*). Indeed, compulsory health insurance is organised through six private, non-profit national associations of sickness funds and one public sickness fund called the Auxiliary Illness and Disability Insurance Fund (*Caisse Auxiliaire d'Assurance Maladie-Invalidité – CAAMI / Hulpkas voor Ziekte en Invaliditeitsverzekering – HZIV*). Nationals and authorised residents must be affiliated to one sickness fund of their choice[61]. The auxiliary fund is available for people who do not wish to join one of the other private sickness funds.

The health system is mostly funded by employer and employee contributions and, to a lesser extent, by federal government subsidies[62].

For the general scheme for employed persons, the National Social Security Office (*Office National de Sécurité Sociale – ONSS / Rijksdienst voor Sociale Zekerheid – RSZ*) collects from salaries employer and employee social contributions. Then, the ONSS/RSZ distributes the contributions between the sickness funds[63]. These sickness funds have the responsibility to reimburse health service benefits to their members and represent them in the INAMI/RIZIV[64].

Although there are several sickness funds, the social security system reimburses them equally for medical services. Competition between mutual health insurance funds, therefore, is based on the quality of services provided and on the supplementary services offered.

Since 2012, individuals affiliated to one of the sickness funds are obliged to subscribe to supplementary insurance by paying a contribution if these services are offered by the sickness fund[65]. It will cover situations not covered by the compulsory insurance (e.g. orthodontic treatments, homeopathic care, birth grants). From January 2019, in the absence of contribution to a supplementary insurance, the person is subject to a waiting period of 24 months, and not only 6 months anymore, in order to benefit from the supplementary insurance[66]. It means that during this period, the person will pay contributions without benefiting from advantages and services provided by the sickness fund.

Article 67 of the 2010 Law mentions that no segmentation of contributions is allowed but there can be differentiation based on household composition or social status, in accordance with Article 37 of the Law of 14 July 1994 on Compulsory Medical Care and Sickness Benefit Insurance[67]. Moreover, the annual contribution may vary from one sickness fund to another, from €80 to €130[68]. However, if the person does not need a supplementary insurance or cannot to pay for it, s/he can join for free the CAAMI/HZIV which provides access to all services covered within the INAMI/RIZIV nomenclature, but does not provide supplementary services[69].

Accessing the Belgium healthcare system

To join a health insurance company, a membership application must be submitted to one of the private sickness funds or to the CAAMI/HZIV. Being private organisations, the sickness funds may refuse membership to an applicant. The public sickness fund, however, may not refuse membership to an applicant. This guarantees

[61] *Ibidem*.

[62] *Ibid*.

[63] Service public fédéral – Sécurité sociale, "Office national de Sécurité sociale (ONSS)", https://socialsecurity.belgium.be/fr/reseau/office-national-de-securite-sociale-onss.

[64] S. Gerkens and S. Merkur, "Belgium: Health system review", *Health Systems in Transition*, Vol. 12, No. 5, 2010, p. 16, http://www.euro.who.int/__data/assets/pdf_file/0014/120425/E94245.PDF.

[65] *Law on the organisation of supplementary health insurance (Loi portant des dispositions en matière d'organisation de l'assurance maladie complémentaire (I))*, 26 April 2010, No. 2010024147, Article 67, al. 1, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2010042607&table_name=loi.

[66] Mutualité chrétienne, "Cotisations: des réponses à vos questions", https://www.mc.be/la-mc/cotisations/faq#!#utilite.

[67] *Law on the organisation of supplementary health insurance*, *op. cit.* note 65, Article 67, al. 1(e).

[68] Bruxelles-J, "La mutualité, combien ça coûte?", 23 August 2019, https://www.bruxelles-j.be/ta-sante/mutuelle-et-prix-des-soins-de-sante/la-mutualite-combien-ca-coute/.

[69] CAAMI, "Devenir membre", https://www.caami-hziv.fgov.be/fr/devenir-membre.

the availability of health insurance to all Belgians. The individual is bound by his/her choice of sickness fund for a one-year period. One advantage is that if affiliated members become undocumented, they keep their healthcare coverage for up to a year after their last payment. Dependent children are bound by their parents' choice.

The content of the mandatory health insurance organised by INAMI/RIZIV is determined by the INAMI/RIZIV nomenclature[70], which provides a comprehensive list of partially or fully reimbursable medical services. Those services are divided into categories, the main ones being[71]:

- Visits and consultations to GPs and specialist doctors;
- Physiotherapist care;
- Nurse care and home nursing services;
- Dental care;
- Childbirth care;
- Prostheses, bandages and implants;
- Hospital care;
- Care in nursing home for the elderly;
- Functional rehabilitation care.

Nationals and authorised residents must pay in advance for the medical consultation fees charged by the doctor or hospital. They must submit their receipts for reimbursement and the money is then paid directly into the patient's bank account. For a GP consultation, the sickness fund will reimburse the consultation fees but the potential excess fees are paid by the patient[72].

Several measures and initiatives have been introduced to limit the amount of the patient's contributions. For example, some individuals have a right to increased health insurance reimbursement (*intervention majorée* / *verhoogde tegemoetkoming*) depending on their social status or income[73]. It gives them preferential tariffs so that they pay less for most medical services[74]. Also, if the household's medical expenses reach a certain amount during the year, the sickness fund will cover the additional costs (*maximum à facturer* / *maximumfactuur*) for the rest of the year. The maximum amount differs according to the type of maximum à facturer/maximumfactuur. For example, for a household benefiting from the increased reimbursement, the annual maximum amount is €450[75]. The local public social welfare centres (*Centre Public d'Action Sociale – CPAS / Openbaar Centrum voor Maatschappelijk Welzijn – OCMW*) may also decide, in their internal policy, to contribute to the medical costs of authorised residents who are too destitute to pay for important health expenses.

INAMI/RIZIV also contributes to the cost of medication to different degrees. Sickness funds reimburse in part or in full some medicines whose list is established by INAMI/RIZIV[76]. Eight categories of drugs that determine the reimbursement have been defined[77]. Also, for each category, the cost paid by the patient is limited to a maximum amount[78].

[70] INAMI, "Nomeclature – Textes", http://www.inami.fgov.be/fr/nomenclature/nomenclature/Pages/default.aspx#.VL5oNkeG_94.

[71] RIZIV, "De geneeskundige verstrekkingen die uw ziekenfonds terugbetaalt", 31 January 2018, https://www.riziv.fgov.be/nl/themas/kost-terugbetaling/door-ziekenfonds/Paginas/default.aspx.

[72] Belgium.be, "Honoraires médicaux", https://www.belgium.be/fr/sante/cout_des_soins/honoraires_medicaux.

[73] V. Buffel and I. Nicaise, "ESPN Thematic Report on Inequalities in access to healthcare, Belgium", *op. cit.* note 56, p. 7.

[74] Belgium.be, "Remboursements spécifiques", https://www.belgium.be/fr/sante/cout_des_soins/remboursements_specifiques.

[75] INAMI, "Types de maximum à facturer (MAF)", 30 July 2019, https://www.inami.fgov.be/fr/themes/cout-remboursement/facilite-financiere/Pages/types-maximum-facturer-(MAF)-.aspx#Le_MAF_social.

[76] INAMI, "Liste des spécialités pharmaceutiques remboursables", 24 June 2019, https://www.inami.fgov.be/fr/themes/cout-remboursement/par-mutualite/medicament-produits-sante/remboursement/specialites/Pages/default.aspx.

[77] Category A: drugs of vital importance (cancer or diabetes treatment); Category B: therapy treatment (antidepressant); Category C: drugs for symptomatic treatment; Category Cs: vaccine against flu and allergy; Category Cx: contraceptives; Category Fa: drugs of vital importance for which the reimbursed part is fixed; Category Fb: essential drugs for which the reimbursed part is fixed; Category D: drugs considered not "essential" and consequently not reimbursable such as vitamins, but also paracetamol. All patients, including those on a low income, must pay the full cost of D medication, whatever aid mechanism they benefit from. INAMI, "Liste des spécialités pharmaceutiques remboursables : les categories de remboursement", 2 May 2019, https://www.inami.fgov.be/fr/themes/cout-remboursement/par-mutualite/medicament-produits-sante/remboursement/specialites/Pages/liste-specialites-pharmaceutiques-remboursables-categories-remboursement.aspx.

[78] INAMI, "Montants maximum à payer par le patient pour une spécialité pharmaceutique", 19 December 2018,

Regarding vaccination, in Belgium only the polio vaccination is mandatory. For other vaccines, a vaccination schedule is established by the Health Council (*Conseil Supérieur de la santé / Hoge Gezondheidsraad*). The vaccination costs are partially reimbursed within the INAMI/RIZIV nomenclature and some sickness funds intervene in addition[79]. But for children under 6 years old, the Birth and Childhood Offices (*Office de la Naissance et de l'Enfance / Kind en Gezin*) provides free vaccination[80].

Sexual and reproductive health rights

Maternity care

Antenatal and postnatal care as well as childbirth provided by midwives to authorised residents are covered within the INAMI/RIZIV nomenclature. The cost are reimbursed in full if the service provider is "*conventionné*" and 75% if s/he is not[81].

Termination of pregnancy

Termination of pregnancy is allowed by law since 1991. The law of 15 October 2018 sets out the conditions that must be respected to perform an abortion[82]:

- The termination must be performed up to 12 weeks of pregnancy;
- A period of six days must be respected between the first medical consultation and the day of the termination. This period of time may be reduced in case of urgent medical reason;
- The termination must be performed in a hospital or outpatient centre.

Between 12 and 14 weeks of pregnancy, termination of pregnancy is authorised if the health of the woman is in danger or if the unborn child will be affected by a serious incurable disease[83].

The cost of a termination of pregnancy is partially covered by INAMI/RIZIV and pregnant women only have to pay €1.80 for the preliminary examination and €1.80 for the medical procedure. But if the person does not have health insurance, the cost is about €450 for the termination[84]. In this case, she can request AMU/DMH to cover the cost (see below: Undocumented migrants).

Family planning services

Contraception are partially reimbursed under the INAMI/RIZIV nomenclature. Also, since 2004, women under 21 years old are entitled to an additional reimbursement from the INAMI/RIZIV of €3 per month for their prescribed contraceptives[85].

Sexually transmitted infections

A number of referral centres offer STIs screening upon request. Although screening is free (and anonymous) for anyone with medical insurance, these centres are obliged to check whether the patient has medical insurance, which is an additional threshold. Furthermore, most of these referral centres cannot guarantee the provision of the treatment if the individual does not have access to health insurance.

Female genital mutilation

FGM has been criminalised in 2001 under Belgian law. The Penal Code provides that the perpetrator can be punished with 3 to 5 years of imprisonment[86].

Since 2014, two referral centres (CHU St-Pierre/UMC Sint-Pietr and UZ Gent) offer multidisciplinary care (psycho-

https://www.inami.fgov.be/fr/themes/cout-remboursement/par-mutualite/medicament-produits-sante/remboursement/specialites/Pages/specialite-pharmaceutique-montants-maximum-payer-patient.aspx.

[79] Vaccination-info, "Quelle est la politique de vaccination en Belgique?", 16 April 2019, https://www.vaccination-info.be/quelle-est-la-politique-de-vaccination-en-belgique/.

[80] ONE, "La vaccination", https://www.one.be/public/1-3-ans/sante/la-vaccination/.

[81] *Circular to insurers (Circulaire OA)*, 19 December 2018, No. 2018/374, in force since 1st January 2019, https://www.riziv.fgov.be/SiteCollectionDocuments/tarif_sages_femmes_20190101.pdf.

[82] *Law on the voluntary termination of pregnancy (Loi relative à l'interruption volontaire de grossesse, abrogeant les articles 350 et 351 du Code pénal et modifiant les articles 352 et 383 du même Code et modifiant diverses dispositions législatives)*, 15 October 2018, No. 2018014460, Article 2, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2018101503&table_name=loi.

[83] *Idem*, Article 2§5.

[84] Bruxelles-j, "Interrompre sa grossesse – IVG", 30 August 2019, https://www.bruxelles-j.be/amour-sexualite/interrompre-sa-grossesse/.

[85] Bruxelles-j, "Que coûte la contraception?", 30 August 2019, https://www.bruxelles-j.be/amour-sexualite/que-coute-la-contraception/.

[86] *Penal Code (Code pénal)*, 8 June 1867, No. 1867060850, Article 409, http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl?language=fr&caller=list&cn=1867060801&la=f&fromtab=loi.

sexo-medical care) for excised women[87]. All these care, including surgery, are free for women with health insurance. Women asylum seekers can access for free to psychological and medical follow-up as well as surgery (except clitoral reconstruction) after request to their CPAS/OCMW[88].

Violence against women

Women victims of violence can have support from specialised organisations. For example, a Centre taking care of victims of sexual violence exist in few hospitals in Belgium. The victim can receive medical and psychological care and follow-up, along with legal assistance[89]. Indeed, it is recommended that each victim receives this kind of care provided by specialists as soon as possible to have better chance of recovery and be less likely to experience further violence[90].

Access to healthcare for EU/EEA migrants

EU/EEA migrants insured in their country of origin can be reimbursed by the CAAMI/HZIV on the same basis as insured Belgian individuals for healthcare services provided in Belgium, if they can present an EHIC[91].

For destitute EU/EEA migrants with no health insurance, they are included in the healthcare system for undocumented migrants (see below: Undocumented migrants) who have access to healthcare through the Urgent Medical Aid (Aide Médicale Urgente – AMU / Dringende Medische Hulpverlening – DMH).

The right to AMU/DMH comes from the Organic Law on the CPAS/OCMW centres of 8 July 1976[92], and has been specified in the Royal Decree of 12 December 1996[93]. However, the law of 19 January 2012[94] restricted access to healthcare for destitute EU migrants. This law modified the Organic Law and according to Article 57 quinquies added by Article 12 of the 2012 law, the CPAS/OCMW were not obliged to provide social assistance to EU nationals or members of their families during the first three months of their stay[95].

However, in 2014 the Constitutional Court partially abolished the interpretation of Article 57 quinquies. The Court ruled that Article 12 of the Law of 2012 breaches Article 10 and 11 of the Constitution in that it allows CPAS/OCMW to refuse AMU/DMH to EU citizens during the first three months of their stay in Belgium. Indeed, the Court considered that the measure creates a difference of treatment, which is unjustified[96], between EU citizens and their family members that cannot claim for AMU/DMH to CPAS/OCMW, and extra-European undocumented migrants that can benefit from AMU/DMH.

Therefore, the AMU/DMH is also guaranteed to some categories of EU/EEA migrants during the first three months of their stay[97]:

- EU/EEA citizens who are jobseekers, and their family members;
- EU/EEA citizens who are students or economically inactive citizens, and their family members;
- EU/EEA citizens who are family members of a Belgian citizen.

[87] Institut pour l'Egalité des Femmes et des Hommes, "Mutilations génitales féminines", https://igvm-iefh.belgium.be/fr/activites/violence/mutilations_genitales_feminines.

[88] Fédération des Centres de Planning familial des FPS, "Les mutilations génitales féminines : des informations complètes et pratiques pour mieux la comprendre, l'appréhender et y faire face", https://www.planningsfps.be/nos-dossiers-thematiques/dossier-violences-sexuelles/les-mutilations-genitales-feminines-mgf/.

[89] Violences sexuelles, "Centres de prise en charge des violences sexuelles: quoi, pour qui et où?", https://www.violencessexuelles.be/centres-prise-charge-violences-sexuelles.

[90] *Ibid*.

[91] CAAMI, "Temporary residence", https://www.caami-hziv.fgov.be/en/temporary-residence.

[92] *Organic Law on the CPAS/OCMW (Loi organique des [centres publics d'action sociale])*, 8 July 1976, No. 1976070810, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1976070801&table_name=loi.

[93] *Royal Decree on urgent medical assistance granted by the public social welfare centres to foreign nationals residing illegally in the Kingdom, op. cit.* note 53.

[94] *Law amending the legislation regarding the reception of asylum seekers (Loi modifiant la législation concernant l'accueil des demandeurs d'asile)*, 19 January 2012, No. 2012000102, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2012011913.

[95] *Idem*, Article 57 quinquies.

[96] *Constitutional Court*, Decision No. 95/2014, 30 June 2014, at B.55.11-B.55.12., https://www.const-court.be/public/f/2014/2014-095f.pdf.

[97] Medimmigrant, "L'Aide Médicale Urgente", 11 April 2019, https://medimmigrant.be/L-Aide-Medicale-Urgente.

Focus on pregnant women and children of EU/EEA migrants

Pregnant women and children who are EU/EEA migrants should have access to AMU/DMH as other undocumented migrants. For women with EHIC, maternal care are covered.

Pregnancy termination is also covered by the AMU/DMH. However, pregnant women must respect the legal period of 12 weeks of pregnancy for termination, even though the CPAS/OCMW response to the AMU/DMH application usually comes one month later. In practice, between the pregnancy being certified and the AMU/DMH being granted, those 12 weeks have already passed[98].

Access to healthcare for third-country nationals

Asylum seekers and refugees

According to the 2007 Law on the reception of asylum seekers and other categories of foreign nationals and stateless people, all asylum seekers are entitled, free of charge, to health services in order to guarantee them a life in conditions of human dignity[99]. Access to healthcare services is based on the INAMI/RIZIV nomenclature but exceptions are allowed by Royal decree[100]. Indeed, some healthcare services listed in the INAMI/RIZIV nomenclature are not applicable to asylum seekers because they are not considered as obviously necessary[101]:

- Orthodontics;
- Infertility investigation and treatment;
- Dental prostheses, when there is no chewing problem, regardless of the age;
- Cosmetic procedures, except reconstruction after surgery or trauma;
- Dental care and/or dental extractions under general anaesthesia.

On the contrary, some healthcare services not covered within the INAMI/RIZIV nomenclature are granted to asylum seekers as part of daily life[102]:

- Category D drugs if prescribed by a doctor on the basis of a generic prescription, taking into account the recommendations of the referral reimbursement and except substances against impotence;
- Category D drugs: antacids, spasmolytics, antiemetics, anti-diarrheals, analgesics, antipyretics and drugs for oral or throat disorders;
- Dental extraction;
- Dental prostheses, only to restore the chewing function;
- Children's glasses, prescribed by an ophthalmologist, except bi- or multifocal glasses or tinted lenses;
- Adult glasses prescribed by an ophthalmologist, as soon as the correction index of the best eye reaches at least 1D, except bi- or multifocal lenses or tinted lenses;
- Appropriate infant milk when breastfeeding is not possible.

While living in a reception centre, asylum seekers' medical expenses are normally covered by the federal agency for the reception of asylum seekers (Fedasil) (*Agence fédérale pour l'accueil des demandeurs d'asile / Federaal agentschap voor de opvang van asielzoekers*) or one of its reception partners. If they do not live in a centre and have a 207 code "no show" or "WSP", they must obtain a "payment warranty" (*"réquisitoire"*) from Fedasil before they can receive care and treatment, without having to pay. In case of emergency, if it is impossible to obtain the "réquisitoire" in advance, the doctor must attach an urgent care certificate[103] to the bill. This administrative

[98] Vie féminine, "L'aide médicale urgente : quelques critiques féministes", http://www.viefeminine.be/spip.php?article2701.

[99] *Law on the reception of asylum seekers and other categories of foreign nationals (Loi sur l'accueil des demandeurs d'asile et de certaines autres catégories d'étrangers)*, 12 January 2007, No. 2007002066, Article 23, http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl?language=fr&la=F&cn=2007011252&table_name=loi&&caller=list&F&fromtab=loi&tri=dd+AS+RANK&rech=1&numero=1&sql=(text+contains+(%27%27))#LNK0018.

[100] *Idem*, Article 24.

[101] *Royal decree determining the medical aid and care to the beneficiary of the reception (Arrêté royal déterminant l'aide et les soins médicaux manifestement non nécessaires qui ne sont pas assurés au bénéficiaire de l'accueil et l'aide et les soins médicaux relevant de la vie quotidienne qui sont assurés au bénéficiaire de l'accueil)*, 9 April 2007, No. 2007002076, Articles 2 and N1, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2007040946&table_name=loi.

[102] *Idem*, Articles 3 and N2.

[103] Medimmigrant, "Fedasil", 11 April 2019, https://medimmigrant.be/Fedasil.

procedure is quite complicated and many healthcare providers are unfamiliar with it.

Fedasil is competent to cover the medical expenses of the asylum seekers until they receive refugee status or subsidiary protection, or until they receive order to leave the territory[104]. In the case where they obtain a Certificate of Inscription in the Register of Foreign Nationals (*Certificat d'Inscription au Registre des Étrangers – CIRE / Bewijs van inschrijving in het vreemdelingenregister – BIVR*), they are entitled to health insurance under the INAMI/RIZIV scheme.

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

Focus on pregnant women and children of asylum seekers and refugees

Pregnant women seeking asylum or who have obtained refugee status have access to antenatal, delivery and postnatal care in the same conditions as authorised residents.

They also have access to free termination of pregnancy within the legal period (up to 12 weeks).

Children have access to the same healthcare as adult asylum seekers, but also to vaccinations as authorised residents under the INAMI/RIZIV scheme.

Undocumented migrants

As stated above, undocumented migrants have access to healthcare through the AMU/DMH. AMU/DMH covers both preventive and curative care, and individuals entitled to this medical coverage must be granted access to inpatient and outpatient healthcare[105]. Thus, it is not limited to emergency healthcare but there is no regulation specifying the scope of healthcare services covered. In general, every intervention within the INAMI/RIZIV nomenclature is eligible for AMU/DMH reimbursement if the conditions are met (see below). The CPAS/OCMW may also decide to cover healthcare or medication not reimbursed within the INAMI/RIZIV nomenclature on its own funds[106].

AMU/DMH is provided by the CPAS/OCMW of the person's usual place of residence[107]. To obtain AMU/DMH coverage, the undocumented migrant must go to his/her local CPAS/OCMW and ask for the coverage of the healthcare costs. The person must prove his/her place of residence and this can be done by the CPAS/OCMW through home visits or visits at the sleeping place for homeless people. Then, an administrative procedure is led by the competent CPAS/OCMW during one month. It will assess if certain conditions are met[108]:

- The claimant must have no right of residence (or be an EU citizen as described above);
- The claimant must be destitute so without sufficient financial means to pay for his/her healthcare;
- The doctor must provide a certificate stating that the care is under the scheme of AMU/DMH so that the medical intervention is covered by the State.

During the administrative procedure, a social investigation must be performed in order to establish the destitute situation of the claimant[109]. For example, the CPAS/OCMW must verify that the claimant is not already insured in his/her country of origin and analyse his/her financial resources[110]. Also, a house visit can be made by a social assistant. However, the procedure may vary considerably from one CPAS/OCMW to another as the

[104] *Ibid*.

[105] *Royal Decree on urgent medical assistance granted by the public social welfare centres to foreign nationals residing illegally in the Kingdom, op. cit.* note 53, Article 1.

[106] Medimmigrant, "L'Aide Médicale Urgente", *op. cit.* note 97.

[107] *Law on emergency services granted by public social welfare centres (Loi relative à la prise en charge des secours accordés par les centres publics d'aide sociale)*, 2 April 1965, No. 1965040210, Article 2, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=1965040201&table_name=loi.

[108] Medimmigrant, "L'Aide Médicale Urgente", *op. cit.* note 97.

[109] *Circular on the social investigation required for the reimbursement of medical charges (Circulaire sur l'enquête sociale exigée pour le remboursement des frais médicaux)*, 25 March 2010, No. 2010011203, http://www.ejustice.just.fgov.be/cgi/article_body.pl?language=fr&caller=summary&pub_date=10-05-06&numac=2010011203.

[110] Belgian Health Care Knowledge Centre (KCE), "Synthèse: Quels soins de santé pour les personnes en séjour irrégulier?", Report 257Bs, 2015, pp. 12-13, https://kce.fgov.be/sites/default/files/atoms/files/KCE_257B_Soins_de_sante_migrants_Synthese.pdf.

CPAS/OCMW may conduct their investigation by the means they judge appropriate[111].

This mandatory social investigation is very intrusive in the claimant's life and in the life of those who host them. It often prevents individuals entitled to the AMU/DMH from submitting a request to benefit from it. Furthermore, a CPAS/OCMW can refuse AMU/DMH due to the applicants' alleged refusal to collaborate with the social investigation[112].

Usually, the person must go to his/her CPAS/OCMW before the appointment so before the healthcare is provided. In case of emergency, the individual can go directly to the hospital's accident and emergency department. The hospital's social services will inform the competent CPAS/OCMW and launch the procedure for AMU/DMH, with proxy of the patient[113]. According to MDM team, this procedure often leads to a negative decision, leaving the patient and/or the hospital with very high costs for which no reimbursement is possible.

If the CPAS/OCMW renders a positive decision regarding the attribution of AMU/DMH, the person will be granted a "*réquisitoire*" or an individual medical card that gives access to a GP or pharmacy. For hospital care, an electronic notification is addressed to all hospitals[114]. However, the scope of healthcare services that undocumented migrants can have access to depends on the specific policy of each CPAS/OCMW.

Some CPAS/OCMW have put in place a system with a free first consultation in order to make the process easier for patients. For example, the CPAS/OCMW in Molenbeek pays the first medical consultation as soon as the person registers and requests medical assistance, and without requiring that the administrative conditions are met[115]. However, this is rather an exception as in most cases, the patient will have to pay for the first consultation or find an organisation or practitioner willing to offer free consultation, which constitutes an important barrier.

The AMU/DMH is usually granted for 92 days, but the duration depends on each CPAS/OCMW, ranging from one day to one year for chronically ill patients [116].

The healthcare expenses are directly reimbursed to health professionals by the State, except if they are not included within the INAMI/RIZIV nomenclature. In this case, they will be covered by the CPAS/OCMW on its own funds[117].

Focus on pregnant women and children of undocumented migrants

Undocumented pregnant women must have full free access to antenatal and postnatal care as authorised residents if they have obtained the AMU/DMH. However, they still have to meet the conditions for receiving the AMU/DMH. For MDM Belgium, it is therefore not exceptional to see undocumented pregnant women without any kind of reimbursement because they received a negative response from the CPAS/OCMW.

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

Children are entitled to the same healthcare as undocumented adults. Under the age of six, they have free access to vaccinations through the Birth and Childhood Office[118]. After the age of six, they must obtain AMU/DMH like adults for all curative and preventive care.

Unaccompanied minors

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

[111] *Circular on the social investigation required for the reimbursement of medical charges*, *op. cit.* note 109, Article 2.

[112] KCE, "Synthèse: Quels soins de santé pour les personnes en séjour irrégulier?", *op. cit.* note 110, p. 20.

[113] Medimmigrant, "L'aide médicale du CPAS (en general)", 11 April 2019, https://medimmigrant.be/L-aide-medicale-du-CPAS-en-general.

[114] *Ibid*.

[115] PICUM, "Cities of rights: Ensuring health care for undocumented residents", Belgium, 2017, p. 15, https://picum.org/wp-content/uploads/2017/11/CityOfRights_Health_EN.pdf.

[116] KCE, "Synthèse: Quels soins de santé pour les personnes en séjour irrégulier?", *op. cit.* note 110, p. 21.

[117] Medimmigrant, "L'Aide Médicale Urgente", *op. cit.* note 97.

[118] ONE, "La vaccination", https://www.one.be/public/1-3-ans/sante/la-vaccination/.

But since the law of 12 May 2014 which added a new Article 5/1 to the Programme Law of 24 December 2002[119], the guardianship service (*services des Tutelles / dienst Voogdij*) in charge of setting up specific guardianship for unaccompanied minors must also be intended for "*nationals of European Economic Area countries or Switzerland*"[120]. The guardianship service will designate a guardian who will take care of the minor whilst in Belgium. Under the 2014 law, "*the guardian ensures that the minor goes to school and receives psychological support and appropriate medical care*"[121]. Thus, regardless of whether the unaccompanied minors are EU citizens or not, they are entitled to access to healthcare under the INAMI/RIZIV scheme.

According to the 18 October 2010 circular[122], unaccompanied minors recognised as such by the guardianship service can register to healthcare insurance without paying contributions but under certain conditions[123]:

- For children not required to go to school because they are under 6 years old, they must be declared at the Birth and Childhood Office;
- For children in compulsory education age, they must either go to school for three consecutive months at an educational establishment recognised by a Belgian authority; or be exempted by the competent regional service to go to school.

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

Protection of seriously ill foreign nationals

In Belgium, by law, seriously ill foreign nationals can benefit from special protection, which prevents the authorities from expelling them to their country of origin. Indeed, according to Article 9ter of the Law of 15 December 1980, a foreign national residing in Belgium legally or not, can request a residence permit if s/he "*suffers from a disease which causes a real risk to his/her life or physical integrity, or a real risk of inhuman or degrading treatment when there is no adequate treatment in his/her country of origin or stay*" [124].

The individual must send his/her application to the Immigration Office (*Office des Étrangers / Vreemdelingenzaken*), including proof of identity, an effective address of residence, a medical certificate issued less than three months ago clearly indicating the severity of the condition and any relevant and recent information regarding the availability and accessibility of appropriate treatment in the country of origin. Once this has been completed,, the Immigration Office can launch the procedure.

The admissibility of the application

In the first instance, representative of the Immigration Office examines whether the formal requirements for the submission of the application are met. In addition, since the introduction of a medical filter in February 2012, the medical officer of the Immigration Office is responsible for assessing whether the illness is serious enough. If the health condition clearly does not meet the threshold of seriousness, the application of Article 9ter may be declared inadmissible[125].

If the application is deemed complete, passes the medical filter and the residential investigation conducted by the municipality is positive (it means that homeless people

[119] *Law modifying the Programme Law of 24 December 2002 (Loi modifiant le titre XIII, chapitre VI, de la loi-programme (I) du 24 décembre 2002 en ce qui concerne la tutelle des mineurs étrangers non accompagnés)*, 12 May 2014, No. 2014009398, Article 3, http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2014051231.

[120] *Programme Law (Loi-programme (I) (art. 479) - Titre XIII - Chapitre VI: Tutelle des mineurs étrangers non accompagnés)*, 24 December 2002, No. 2002A21488, Article 5/1, https://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2002122445.

[121] *Idem*, Article 10 §1er.

[122] *Circular to insurers (Circulaire OA)*, 18 October 2010, No. 2010/386, https://medimmigrant.be/IMG/pdf/20101018_omza3fa.pdf.

[123] Medimmigrant, "Assurance-maladie", 5 September 2019, https://medimmigrant.be/Assurance-maladie.

[124] *Law on access to the territory, residence, settlement and removal of foreigners (Loi sur l'accès au territoire, le séjour, l'établissement et l'éloignement des étrangers)*, 15 December 1980, No. 1980121550, Article 9ter, http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl?language=fr&la=F&cn=1980121530&table_name=loi&&caller=list&F&fromtab=loi&tri=dd+AS+RANK&rech=1&numero=1&sql=(text+contains+(%27%27))#LNK0006.

[125] Medimmigrant, "Autorisation de séjour pour raison médicale (art. 9ter)", 27 February 2019, https://medimmigrant.be/Autorisation-de-sejour-pour-raison?lang=fr.

cannot apply for Article 9ter), the Immigration Office declares Article 9ter admissible and issues a certificate of registration, known as the "Orange Card" for three months. This certificate can be renewed three times for a further three months and then every month until the Immigration Office takes a substantive decision[126]. This card does not entitle the holder to access a health insurance fund or employment. However, the holder can request AMU/DMH from the CPAS/OCMW of his/her place of residence.

The substantive decision

In the second instance, the Immigration Office asks the medical officer to make a full evaluation of the state of health of the individual and of the availability of the treatment in the country of origin. The medical officer may also ask a specialist to assess the health status of the applicant and summon him/her to medical examination. If the administration and the medical officer judge that the treatment is not available or not accessible in the country of origin, a one-year residence permit is granted[127].

This residence permit enables the holder to join a health insurance fund, to access the labour market and to benefit from social assistance from the CPAS/OCMW if s/he is destitute. After five years since the submission of the application, the residence permit becomes permanent[128].

When medical reasons no longer prevail because the state of health has radically and durably improved, the Immigration Office may withdraw the residence permit and issue an order to leave the territory[129].

If the individual is not granted a residence permit, s/he can appeal the negative decision within 30 days to the Council for Foreigners Law Litigation (*Conseil du Contentieux des Étrangers – CCE / Raad voor Vreemdelingenbetwistingen – RvV*). The appeal is not automatically suspensive so the claimant must request suspension to the CCE/RvV[130]. This way, the seriously ill foreign national who appeal the decision must still benefit from AMU/DMH and can stay in Belgium during the appeal.

It must be noted that, as mentioned in the introduction of the report, in the case *Paposhvili v. Belgium* of 2016, the ECtHR ruled that States cannot remove a seriously ill foreign national if due to the removal, his/her state of health would face a real risk to decline, and not only when the individual is at an imminent risk of dying[131]. Since then, the CEE/RvV has quashed various decisions based on this new jurisprudence[132].

Access to healthcare for homeless people

Homeless people can receive assistance from the CPAS/OCMW, including the AMU/DMH when they are undocumented. However, they usually face several barriers to access healthcare due to their situation. Indeed, the administrative procedure of the CPAS/OCMW is complex for homeless people and it can be difficult to establish the territorially competent CPAS/OCMW when the person does not stay at the same place.

Indeed, homeless people may need to have a strong network of organisations willing to provide them with attestations stating that they are effectively living on the territory of the specific CPAS/OCMW. They can also have found temporally an owner willing to provide them with a place to sleep but refusing any kind of home visit, forcing them to choose between a shelter and medical aid. Also, the complexity of the procedure to obtain the AMU/DMH and the delay of one month (minimum) between the application and the decision are highly inadequate to the needs and living conditions of homeless people.

Political perspective

The Health Committee of the House approved on 12 March 2019 a bill that raises the age of contraceptive reimbursement to 25 years and makes the morning-after

[126] *Ibid*.

[127] Medimmigrant et al., "Livre blanc sur l'autorisation de séjour pour raisons médicales (9ter)", 2015, pp. 20-21, https://medimmigrant.be/IMG/pdf/livre_blanc_b1f0.pdf.

[128] *Law on access to the territory, residence, settlement and removal of foreigners*, *op. cit.* note 124, Article 13.

[129] Medimmigrant, "Autorisation de séjour pour raison médicale (art. 9ter)", *op. cit.* note 125.

[130] *Ibid*.

[131] *Paposhvili v. Belgium, op. cit.* note 25, §183.

[132] Ligue des droits humains, Commission Étrangers, "Addendum au "Livre blanc sur l'autorisation de séjour pour raisons médicales (9ter)"", May 2019, p. 5, https://medimmigrant.be/IMG/pdf/addendum_9te9ae7.pdf.

pill free regardless of the woman's age. The bill must now be adopted in plenary session, so it will be up to the new government to decide whether to pass the bill or not[133].

[133] *RTBF*, "La gratuité de la contraception étendue jusqu'à l'âge de 25 ans? Le prochain gouvernement décidera", 13 March 2019, https://www.rtbf.be/info/belgique/detail_la-gratuite-de-la-contraception-sera-etendue-jusqu-a-l-age-de-25-ans?id=10168500.

GERMANY

Main legal changes

On 1 January 2019, a new law entered into force, the insured persons relief law (*GKV - Versichertenentlastungsgesetz – GKV-VEG*) It reintroduced the principle of equal share between employer and employee of the contributions to the statutory health insurance and lowered the fictive minimum income of those "voluntarily insured" (see below), thus lowering the contributions for self-employed with little income.

However, the law also introduced provisions that people who do not pay their contributions, do not use any health services and cannot be reached (e.g. by letter or phone call) can lose their insurance. This has negative impact on some groups, e.g. people with mental health problems or homeless people.

National Health System

Organisation and funding of the German healthcare system

German laws regarding access to healthcare are made at the national level. However, as a federal republic, responsibilities for the healthcare system in Germany are shared between the Länder (federal states), the federal government and legitimised civil society organisations[134]. Indeed, important competencies are legally delegated to membership-based, self-regulated organisations of payers and providers[135], thus combining vertical implementation of policies with strong horizontal decision-making[136]. The legal framework is defined by the federal government but the regulatory details are set by the Federal Joint Committee (*Gemeinsamer Bundesausschuss*). The Länder supervise self-governing bodies and are responsible for hospital planning and medical education[137].

The German healthcare system is made up of two insurance systems, statutory health insurance (*Gesetzliche Krankenversicherung - GKV*) and private health insurance (*Private Krankenversicherung - PKV*). Since 2009, it is compulsory for all German citizens and long-term residents to have health insurance[138]. Employees earning less than €60,750 per year or €5,063 per month (as of 2019) are mandatorily covered by the statutory health insurance scheme (GKV)[139]. Anyone earning more than this opt-out threshold can choose to be covered either by private health insurance (PKV) or by statutory health insurance[140]. In 2017, approximately 89% of the population were registered on the GKV scheme, whereas 11% were using PKV[141]. Therefore, the majority of the population is covered by statutory or private health insurance but part of the population remains uninsured (79,000 according to the last census of 2015).

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

Since 2009, the government has set a uniform contribution rate to the GKV. As of 2019, employees or

[134] For instance, there are the German Medical Association (*Bundesärztekammer*), umbrella organisation that represents political interests of half a million doctors or the Association of Statutory Health Insurance Physicians (*Kassenärztliche Vereinigung*) which represents the interests of registered doctors and psychological psychotherapists.

[135] R. Busse and M. Blümel, "Germany: Health system review", *Health systems in transition*, Vol. 16, No. 2, 2014, p.17, http://www.euro.who.int/__data/assets/pdf_file/0008/255932/HiT-Germany.pdf?ua=1.

[136] Civitas, "Healthcare Systems: Germany", updated by E. Clarke (2012) and E. Bidgood (January 2013), Based on the 2001 Civitas Report by D. Green and B. Irvine, http://www.civitas.org.uk/content/files/germany.pdf.

[137] OECD/European Observatory on Health Systems and Policies, *Germany: Country Health Profile 2017, State of Health in the EU*, OECD Publishing, Paris / European Observatory on Health Systems and Policies, Brussels, p. 6, https://read.oecd-ilibrary.org/social-issues-migration-health/germany-country-health-profile-2017_9789264283398-en#page8.

[138] *Act to Strengthen Competition in SHI (Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung (GKV-Wettbewerbsstärkungsgesetz GKV - WSG))*, No. 11, 2007, https://www.bgbl.de/xaver/bgbl/text.xav?SID=&tf=xaver.component.Text_0&tocf=&qmf=&hlf=xaver.component.Hitlist_0&bk=bgbl&start=%2F%2F*%5B%40node_id%3D'363805'%5D&skin=pdf&tlevel=-2&nohist=1.

[139] Bundesministerium für Gesundheit, "Neuregelungen im Jahr 2019 in Gesundheit und Pflege", Press release, 14 December 2018, https://www.bundesgesundheitsministerium.de/presse/pressemitteilungen/2018/4-quartal/neuregelungen-2019.html.

[140] R. Busse and M. Blümel, "Germany: Health system review", *op. cit.* note 135, p.121.

[141] T. Gerlinger, "ESPN Thematic Report on Inequalities in access to healthcare, Germany", European Commission, 2018, p. 5.

pensioners with health coverage contribute 7.3% of their gross incomes, while the employer or pension fund adds another 7.3%[142]. In addition, supplementary premiums of between 0.3% and 1.9% are collected, also paid equally by employer and employee since the insured persons relief law (*GKV - Versichertenentlastungsgesetz – GKV-VEG*)[143] which came into force on 1st January 2019.

Those who are self-employed can choose between GKV and PKV. If they are insured with the GKV (in a so-called "voluntary insurance"), they have to pay both the employer and the employee contribution to the GKV which represents 14.6% of their gross income. In 2019, the GKV-VEG reduced the "fictive" monthly minimum gross income to €1,038.88 so that contributions can be very high for those earning less.

Within the GKV, the contribution also covers dependents i.e. non-earning spouses and children[144].

The social welfare office pays the contribution to the health insurance for destitute legal residents.

In the GKV scheme, not-for-profit statutory health insurance funds (*Krankenkassen*) finance and deliver benefits covered by GKV within the legal framework[145]. As of 2019, there are 109 those health insurance funds from which citizens and long-term residents can choose anyone.

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

It is not easily possible to change to the GKV after one has been insured by the PKV. People over 55 years old cannot enter into the GKV.

If insurance contributions are not paid (both when a person is voluntarily insured with the GKV or in the PKV), the health insurance only covers healthcare for acute illness, pregnancy and preventive measures until the debt is paid. For destitute persons, the social welfare office does not cover the debt.

MDM DE teams treat many German citizens at MDM's programmes. Most of them were privately insured or voluntarily insured in the GKV but cannot afford the monthly fees anymore. Some again do not have a health insurance and would have to pay contributions retrospectively for the past five years to enter a health insurance.

Until recently, people would not easily fall out of the health insurance system completely. Even if they did not pay contributions, they would remain insured and healthcare would be provided in all acute cases, pregnancy and preventive measures. With the new law GKV-VEG however, people who do not pay their contributions, do not use any services and cannot be reached (e.g. by letter or phone call) can lose their insurance. This has negative implications, for example for people with mental health problems or for homeless people.

Accessing the German healthcare system

Statutory health insurance covers[146]:

- Preventive services (including regular dental check-ups, child check-ups, basic immunizations, check-ups for chronic diseases, and cancer screening at certain ages);
- Inpatient and outpatient hospital care;
- Physician services;
- Mental healthcare;
- Dental care;
- Optometry;
- Physical therapy;
- Prescription drugs;
- Medical aids;
- Rehabilitation;

[142] M. Blümel and R. Busse, "The German Health Care System", In E. Mossialos et al. (Ed), "International Profiles of Health Care Systems", *The Commonwealth Fund*, May 2017, p. 69, https://www.commonwealthfund.org/sites/default/files/documents/__media_files_publications_fund_report_2017_may_mossialos_intl_profiles_v5.pdf.

[143] *Law on insured persons relief (GKV – Versichertenentlastungsgesetz)*, 11 December 2018, https://www.bgbl.de/xaver/bgbl/start.xav?startbk=Bundesanzeiger_BGBl&jumpTo=bgbl118s2387.pdf#__bgbl__%2F%2F*%5B%40attr_id%3D%27bgbl118s2387.pdf%27%5D__1568641971387.

[144] M. Blümel and R. Busse, "The German Health Care System", *op. cit.* note 142, p. 69.

[145] R. Busse and M. Blümel, "Germany: Health system review", *op. cit.* note 135, p.17.

[146] M. Blümel and R. Busse, "The German Health Care System", *op. cit.* note 142, p. 70.

- Regenerative therapies for mothers or fathers;
- Hospice and palliative care;
- Sick leave compensation (70% of income before tax).

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

Some health services, such as medical cosmetic procedures or acupuncture, have been excluded from the statutory health insurance scheme by the Federal Joint Committee[147], as they go beyond what is defined by law as sufficient, appropriate and economic patient care. Thus, these "individual health services" (*Individuelle Gesundheitsleistungen - IGel*) have to be paid by the patient and are usually not reimbursed[148].

For medication, patients have to pay 10% of the cost of the medication. This co-payment amounts to at least €5 and at most €10 per prescription[149].

The Standing Committee on Vaccination (STIKO), an independent expert panel set up by the Federal Ministry of Health, issues vaccination recommendations. Persons insured by the GKV can receive the recommended vaccines free of charge[150] and the vaccines recommended by the WHO are free of charge[151].

Measures have also been put in place to prevent extreme financial burden. Annual expenditure on co-payments for any German citizen must not exceed 2% of gross annual household income[152]. This limit was established to prevent unreasonable costs for those on low incomes. The 2% calculation is based on the household income, from which an allowance for each household member is subtracted. In addition, people with chronic illnesses do not have to pay more than 1% of gross annual household income[153]. Persons receiving social aid (*Sozialhilfe*) pay a maximum of €50.88 (if chronically ill) or €101.76 (if not) per year. Children under 18 are exempt from any co-payment[154].

PKV can be more attractive for young people with good income as they can be offered contracts with more ranges of services and lower premiums[155]. PKV plays a role of complementary but also supplementary insurance in covering minor benefits not covered by GKV and some co-payments (e.g. for dental care) and gives access to better amenities[156].

Sexual and reproductive health rights

Maternity care

Under Book XII of the German Social Security Code, during pregnancy and after birth, women are entitled to medical treatment and care, as well as midwife assistance. They can also benefit from supply of medicines, bandages and remedies and the costs of an inpatient delivery facility are covered[157]. The costs of antenatal and postnatal care and obstetric care are fully covered by the health insurance fund[158].

Termination of pregnancy

Generally, termination of pregnancy is illegal in Germany. Section 218a of the Criminal Code[159], which resulted from the adoption of the 21 August 1995 law on antenatal

147 *Social Security Code (Sozialgesetzbuch (SGB))*, Book V, 20 December 1988, Section 92, https://www.gesetze-im-internet.de/sgb_5/__92.html.

148 Kassenärztliche Bundesvereinigung, "Individuelle Gesundheitsleistungen", http://www.kbv.de/html/igel.php.

149 *Social Security Code*, *op. cit.* note 148, Section 61, http://www.gesetze-im-internet.de/sgb_5/.

150 List of recommended vaccinations: c.f. Federal Ministry of Health, "Vaccinations", 26 January 2018, https://www.bundesgesundheitsministerium.de/en/topics/prevention/vaccinations.html.

151 Federal Ministry of Health, "Vaccinations", 26 January 2018, https://www.bundesgesundheitsministerium.de/en/topics/prevention/vaccinations.html.

152 M. Blümel and R. Busse, "The German Health Care System", *op. cit.* note 142, p. 70.

153 *Ibid*.

154 *Ibid*.

155 *Idem*, p. 69.

156 *Idem*, p. 70.

157 *Social Security Code (Sozialgesetzbuch (SGB))*, Book XII, 27 December 2003, Section 50, http://www.gesetze-im-internet.de/sgb_12/__50.html.

158 Federal Office for Migration and Refugees, "Pregnancy and maternity leave", 13 December 2016, http://www.bamf.de/EN/Willkommen/KinderFamilie/Mutterschutz/mutterschutz-node.html.

159 *Criminal Code (Strafgesetzbuch – StGB)*, 13 November 1998, Section 218a, http://www.gesetze-im-internet.de/stgb/__218a.html.

assistance and aid to families, indicates the conditions under which termination of pregnancy is not punishable.

This section specifies that termination of pregnancy is not punishable if all of the following conditions are met[160]:

- The pregnant woman explicitly requests the abortion;
- The pregnant woman demonstrates to the physician by certificate that she had obtained the mandatory counselling by an approved counselling centre at least three days before the operation;
- The abortion is performed by a physician;
- At the time of the abortion not more than twelve weeks have elapsed since conception.

In other cases, the termination of pregnancy is not considered illegal if it is performed by a physician with the consent of the pregnant woman and, considering the present and future living conditions of the pregnant woman, the abortion is medically necessary to avert a danger to the life or the danger of grave injury to the physical or mental health of the pregnant woman provided that, from her point of view, the danger cannot reasonably be averted in another way[161].

Moreover, the termination of pregnancy is also not considered illegal in cases where according to medical opinion a woman is a victim of rape or sexual abuse, there is strong reason to support the assumption that the pregnancy was caused by the act, and not more than twelve weeks have elapsed since conception[162] .

Pregnant women are not punishable for an abortion performed by a physician after mandatory consultation and within 22 weeks of pregnancy. The operating physician, however, can make himself punishable. If the pregnant woman was in particular distress at the time of the operation, the court can order a discharge of the physician[163].

In case of termination of pregnancy without criminal or medical indication, the cost of the abortion is borne by the patient and is not reimbursed. For an outpatient abortion, the costs are between €350 and €600, depending on the method chosen[164]. The costs of medical consultation, for the necessary examinations before and after the termination and the possible follow-up treatment if complications are however, covered by the statutory health insurance. Cost of termination is covered by the health insurance in case of medical indication or rape/sexual abuse[165]. It is covered by the social welfare office for women with low income.

For women whose income minus rent is below €1,216 per month (as of July 2019), pregnancy termination is fully covered. It increases by €288 if underage children are living in the household[166]. According to the law, female asylum seekers and undocumented women are also entitled to coverage. However, access remains very difficult for undocumented women, due to the need for a health voucher and the risk of being reported, as discussed below.

Family planning services

Family planning methods are generally not part of the service coverage of health insurances. Under the Book XII of the German Social Security Code, the medical consultation, the necessary examination and the prescription of the contraceptive means are provided. The costs of contraceptives are also covered if they have been prescribed by a doctor for medical reasons (e.g. acne)[167]. The costs of prescription family planning methods (e.g. the pill) are covered by the GKV for all women up to the age of 22. Many municipalities also provide free access to family planning for women without means.

Sexually transmitted infections

According to the Section 19 of the Law on infectious diseases, everyone, including undocumented migrants, is

[160] *Idem*, Section 218a(1).

[161] *Idem*, Section 218a(2).

[162] Familien Planung, "Schwangerschaftsabbruch: Rechtslage, Indikationen und Fristen", 4 April 2018, https://www.familienplanung.de/beratung/schwangerschaftsabbruch/rechtslage-und-indikationen/#c5916.

[163] *Criminal Code*, *op. cit.* note 160, Section 218a(4).

[164] Familien Planung, "Die Kosten eines Schwangerschaftsabbruchs", 25 July 2019, https://www.familienplanung.de/beratung/schwangerschaftsabbruch/kosten-schwangerschaftsabbruch/.

[165] *Ibid*.

[166] *Ibid*.

[167] *Social Security Code*, *op. cit.* note 158, Section 49, https://www.gesetze-im-internet.de/sgb_12/__49.html.

entitled to counselling and testing for sexually transmitted diseases[168].

In most large German cities, such as Munich[169] or Leipzig[170], the authorities set up special counselling services for people with STIs, accessible to all, regardless of legal status. These services were launched many years ago, at first for sex workers and drug users. They offer anonymous services, generally free testing and counselling and sometimes consultation with a doctor.

The cost of HIV and hepatitis treatment is covered by the GKV and the PKV insurance schemes. There is, however, no clear and explicit provision entitling asylum seekers and undocumented migrants for cost coverage of HIV and Hepatitis C treatment.

Female genital mutilation

Since 2013, female genital mutilation is a criminal offence and can be punished with a prison sentence of not less than one year, in less severe cases between six months and five years[171]. Diagnosis and treatment of FGM are covered by GKV.

The German Medical Association has issued recommendations on the management of patients with a history of FGM[172]. Indeed, it points out that those patients require special medical and psychological care and counselling. The doctor-patient interactions must also be the time when patients are made aware of the consequences of FGM from a medical, psychological, social and criminal point of view.

Violence against women

Violence against women including domestic violence and sexual offences are punishable according to the Criminal Code[173]. The Federal Ministry for Family , Seniors, Women and Youth has issued multilingual information for both survivors and medical personnel on healthcare for survivors. It is based on the experience of the project called Medical intervention against violence (*Medizinische Intervention gegen Gewalt* – MIGG) which developed unified standards for the treatment of women victims of violence and created a medical intervention model to improve healthcare treatment for women victims of domestic violence[174].

Access to healthcare for EU/EEA migrants

Access to healthcare coverage and welfare benefits for EU/EEA citizens depends on their employment situation and on the reason of their stay in Germany:

- EU/EEA citizens temporarily staying in Germany and insured in their country of origin can get an EHIC. This allows them to get medical care that is necessary when taking into account the duration of the stay. This can thus also cover treatment of chronic conditions;
- EU/EEA citizens working in Germany can be covered by the same health insurance scheme as German nationals. They can be covered by the GKV and if they are self-employed or above a certain income, by the PKV. If they are insured with the GKV and have worked for a certain period of time, they remain insured and receive unemployment benefits when they lose their job;
- Since 2017, a new Act on access to social welfare (*Gesetz zur Regelung von Ansprüchen*

[168] *Law on Preventing and Combating infectious diseases in humans (Infektionsschutzgesetz - IfSG)*, 20 July 2000, http://www.gesetze-im-internet.de/ifsg/__19.html.

[169] Stadt München, "Beratungsstelle zu sexuell übertragbaren Infektionen einschließlich AIDS/ STI Ambulanz", https://www.muenchen.de/rathaus/Stadtverwaltung/Referat-fuer-Gesundheit-und-Umwelt/Infektionsschutz/Aids/Aidsberatung_STI-Ambulanz.html

[170] Stadt Leipzig, "Beratungsstelle für sexuell übertragbare Infektionen und AIDS - Gesundheitsamt", https://www.leipzig.de/buergerservice-und-verwaltung/aemter-und-behoerdengaenge/behoerden-und-dienstleistungen/dienststelle/beratungsstelle-fuer-sexuell-uebertragbare-krankheiten-und-aids-53202/.

[171] *Criminal Code*, *op. cit.* note 160, Section 226a, http://www.gesetze-im-internet.de/stgb/__226a.html.

[172] Bundesärztekammer, "Recommendations on the management of patients with a history of female genital mutilation (FGM)", April 2016, https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/G/Genitalverstuemmelung/Recommendations-Patients-History-Genital-Mutilation_FGM.pdf.

[173] *Criminal Code*, *op. cit.* note 160, https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html#p0012.

[174] European Institute for Gender Equality, "Combating violence against women – Germany", 24 November 2016, https://eige.europa.eu/publications/combating-violence-against-women-germany.

ausländischer Personen)[175] has reduced the rights of some EU/EEA citizens. Indeed, unemployed EU citizens who have legally resided in Germany for less than five years, who are not insured through a family member and whose right of residence results solely from the purpose of finding work or from Article 10 of the EU Regulation No. 492/2011[176] are not entitled to social services including healthcare. They can only have access to "bridging benefits" that include basic health services required for the treatment of acute illnesses and pain[177]. They are provided for a period of one month, and only once every two years. After receiving these reduced benefits for one month, the affected groups of EU migrants have no entitlement to the coverage of any healthcare services (even emergency care) within the next 23 months. Hospitals and other providers are thus reluctant to offer such care because it is not refunded.

Focus on pregnant EU/EEA migrants

For pregnant EU/EEA migrants with an insurance, all antenatal, postnatal and obstetric care are covered by the GKV. All necessary care for those EU/EEA citizens temporarily staying in Germany who have an EHIC are also covered by the GKV, as those receiving "bridging services". However, there is no entitlement to coverage for those who have already received bridging services for one month within the last two years or for those who are staying in Germany temporarily and have no insurance in their country of origin.

Access to healthcare for third-country nationals

Asylum seekers and refugees

The Asylum Seekers Benefits Act[178] (*Asylbewerberleistungsgesetz* - AsylbLG) regulates the entitlement to state coverage for medical care of refugees, asylum seekers, people who hold a certain residence permit for humanitarian reasons, people with a "temporary tolerated stay" (*Duldung*) and for those who are obliged to leave (e .g . undocumented migrants). Below, for better legibility we will refer to this very heterogenous group as "asylum seekers".

Unlike in most European countries, asylum seekers and refugees living in Germany do not have the same access to healthcare as nationals.

During their first 18 months on the German territory, asylum seekers and refugees are only entitled to limited healthcare services determined in Section 4(1) of the AsylbLG. They only have access to healthcare in case of acute diseases and painful conditions for which necessary medical and dental treatment must be granted, including the supply of medicines, bandages and other necessary services[179]. They are also entitled to vaccinations and "necessary preventive medical check-ups" for the prevention and early detection of diseases[180]. Other healthcare services (e.g. psychological care or treatment of chronic conditions) can be granted according to Section 6 of the AsylbLG if they are indispensable to secure health of the patient[181]. There is no definition of the term "necessary treatment" and it is interpreted differently amongst social service departments.

Asylum seekers holding a residence permit and suffering from trauma, or victims of torture, can benefit from specialised treatment provided by specialised doctors in specialised institutions[182] but the number of places is

[175] *Act on the Settlement of Claims of Foreign Persons (Gesetz zur Regelung von Ansprüchen ausländischer Personen in der Grundsicherung für Arbeitssuchende nach dem Zweiten Buch Sozialgesetzbuch und in der Sozialhilfe nach dem Zwölften Buch Sozialgesetzbuch*), 22 December 2016, Bundesgesetzblatt Jahrgang 2016, Teil I, Nr. 65, https://www.bgbl.de/xaver/bgbl/start.xav?start=%2F%2F*%5B%40attr_id%3D%27bgbl116s3155.pdf%27%5D#__bgbl__%2F%2F*%5B%40attr_id%3D%27bgbl116s3155.pdf%27%5D__1565615932555.

[176] EU, *Regulation No. 492/2011*, 5 April 2011, Article 10, https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:141:0001:0012:EN:PDF.

[177] "Parallel report to the CESCR on the right to health for non-nationals", Doctors of the World Germany, July 2018, p. 7, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCESCR%2fCSS%2fDEU%2f32476&Lang=en.

[178] *Asylum Seekers benefit Act (Asylbewerberleistungsgesetz - AsylbLG)*, 30 June 1993, http://www.gesetze-im-internet.de/bundesrecht/asylblg/gesamt.pdf.

[179] *Idem*, Section 4(1), http://www.gesetze-im-internet.de/asylblg/__4.html.

[180] *Ibid*.

[181] *Idem*, Section 6, http://www.gesetze-im-internet.de/asylblg/__6.html.

[182] *Ibid*.

limited and their access to medical treatment is not always guaranteed[183].

The period of time during which asylum seekers are entitled to access only limited healthcare services was reduced in 2015 from 48 to 15 months. However, before 1996, this period of time was 12 months and before the introduction of the AsylbLG in 1993, there was no such restriction [184]. In 2019, the period was again prolonged to 18 months,

After 18 months, asylum seekers are entitled to social welfare benefits and thus have access to healthcare under the same conditions as German citizens under the Social Security Code Book XII[185]. However, a reduction in benefits may be applied for more than 18 months (i.e. without any time limit) to people who have abused the law to affect the duration of their stay[186]. Thus, they can be denied full access to healthcare services if they are considered to have seriously hampered their expulsion from German territory by, inter alia, reporting a false nationality or having not provided accurate information on their identity[187].

In emergency situations, asylum seekers can go directly to the emergency department for care. For non-emergency situations, asylum seekers in many federal states and municipalities must first request a health voucher (*Krankenschein*) or health insurance certificate from the municipal social services department in order to gain access to healthcare. The health voucher is valid for three months for all primary and specialized medical care. It allows free access to the medical services they are entitled to under the AsylbLG. The care provider is then reimbursed directly. If the doctor prescribes medication, the prescription states that the patient is exempt from co-payments.

Some federal states (Berlin, Brandenburg, Bremen, Hamburg, Schleswig-Holstein and Thuringia) have agreements with statutory health insurance funds and issue health insurance cards to asylum seekers. While the service coverage is the same, this saves asylum seekers from having to request a health voucher every time they need access to care[188]. It is also much easier for health providers.

Focus on pregnant women and children of asylum seekers and refugees

The Asylum Seekers Benefits Act contains a special provision for pregnant women and for women who have recently given birth. They are entitled to "medical and nursing help and support", including midwifery assistance[189]. Therefore, they have the same access to health coverage for antenatal and postnatal care as German citizens covered by statutory health insurance.

Children of asylum seekers and refugees are subject to the same system as adults. However, the law stipulates that children can receive additional care meeting their specific needs, although this provision does not specify the particular treatments that children may receive[190]. As discussed above, Section 4 AsylbLG stipulates that asylum seekers and refugees who have been in Germany for less than 18 months are entitled to vaccinations and "necessary preventive medical check-ups" (e.g. preventive check-up examinations for children).

For the first time, the Standing Committee on Vaccination has included in its Recommendations for 2018/19 vaccination recommendations for migrants and asylum seekers arriving in Germany. Regarding children, the Committee drew up a list of recommended vaccinations[191].

Undocumented migrants

According to the AsylbLG, undocumented migrants are entitled to the same health services as asylum seekers

[183] Informationsverbund Asyl und Migration, "Country Report: Germany", *Asylum Information Database*, 2018, p. 86, http://www.asylumineurope.org/reports/country/germany.

[184] "Parallel report to the CESCR on the right to health for non-nationals", *op. cit.* note 178, p. 11.

[185] *Asylum Seekers benefit Act*, *op. cit.* note 179, Section 2(1), http://www.gesetze-im-internet.de/asylblg/__2.html.

[186] *Ibid*.

[187] "Parallel report to the CESCR on the right to health for non-nationals", *op. cit.* note 178, p. 11.

[188] Informationsverbund Asyl und Migration, "Country Report: Germany", *op. cit.* note 184, p. 85.

[189] *Asylum Seekers benefit Act*, *op. cit.* note 179, Section 4(2), http://www.gesetze-im-internet.de/asylblg/__4.html.

[190] *Idem*, Section 6, http://www.gesetze-im-internet.de/asylblg/__6.html.

[191] Robert Koch-Institut, "Recommendations of the STIKO for the Robert Koch Institute", *Epidemiologisches Bulletin 34/2018*, No. 34, 21 August 2018, p. 359, https://www.rki.de/DE/Content/Infekt/EpidBull/Archiv/2018/Ausgaben/34_18.pdf?__blob=publicationFile.

who have been in Germany for less than 18 months[192] (see above: Asylum seekers).

In order to access financial coverage of non-emergency care and treatment, a healthcare voucher must be obtained from the social service department. However, according to Section 87(2) of the Residence Act (*Aufenthaltsgesetz – AufenthG*), the officials have the obligation to report individuals who cannot provide a valid residence permit to the competent foreign nationals' registration authority[193]. This means that social service departments have an obligation to report to the immigration authorities, if or when they encounter any undocumented migrants in the course of their work. Thus, undocumented migrants, de facto, do not have access to financial coverage of non-emergency healthcare.

In cases of emergency, undocumented migrants will be treated in the hospital without a health voucher. In theory, the hospital can request reimbursement from the social service department[194] after an emergency. In practice, however, hospitals are rarely reimbursed because the patient needs to prove his/her neediness for which many documents are required, and the social service department only reimburses services that were provided before the social service department was informed. Hospitals thus sometimes put pressure on patients and their families to pay for the treatment[195].

Administrative and medical staff of non-state hospitals are bound by rules of medical confidentiality. The same applies to social services departments if they receive information from hospital staff after an emergency. They must not report the information about the status of an undocumented migrant to the immigration authority. However, it still remains that in practice, many undocumented migrants cannot be certain that medical confidentiality will be respected and fear that their data will be disclosed to the immigration authorities[196].

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

Focus on pregnant women and children of undocumented migrants

According to the law, undocumented pregnant women have access to healthcare services in the same way as German women covered by statutory health insurance. In practice, however, the duty to report also applies to pregnant women. For the first six months of their pregnancy, undocumented women risk expulsion when applying for cost reimbursement so they often do not get appropriate antenatal care (starting at the 14th week at the latest).

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

The children of undocumented migrants are concerned by the provisions of the Asylum Seekers Benefit Act, so they should have the same access to healthcare as the children of asylum seekers, including free access to immunisations. However, due to the duty to report, undocumented families refrain from seeking non-emergency healthcare.

Unaccompanied minors

Unaccompanied minors have access to healthcare for their care needs under Book VIII of the Social Security Code. Nevertheless, the extent of the healthcare services differs depending the situation of the unaccompanied minor.

Healthcare must be provided by the youth welfare office during preliminary taking into care and regular taking into

[192] *Asylum Seekers benefit Act*, *op. cit.* note 179, Section 2(1), http://www.gesetze-im-internet.de/asylblg/__2.html.

[193] *Residence Act, (Aufenthaltsgesetz - AufenthG)*, 25 February 2008, Section 87(2), http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html#p1120.

[194] *Asylum Seekers benefit Act*, *op. cit.* note 179, Section 6a, http://www.gesetze-im-internet.de/asylblg/__6a.html.

[195] "Parallel report to the CESCR on the right to health for non-nationals", *op. cit.* note 178, p. 16.

[196] Bundesarbeitsgruppe Gesundheit/Illegalität, "Notfallhilfe im Krankenhaus für Menschen ohne Papiere", August 2019, p. 8, https://www.diakonie.de/fileadmin/user_upload/Diakonie/PDFs/Broschuere_PDF/BAG_Gesundheit_Illegalitaet_Arbeitspapier_Notfallhilfe_im_Krankenhaus_August_2019_Web.pdf.

care[197]. If unaccompanied minors are accommodated in residential youth welfare institutions, healthcare services must also be provided[198], including preventive healthcare, assistance in case of illness and assistance for family planning, for pregnancy and maternity and for sterilisation[199].

Unaccompanied minors who have been granted subsidiary protection or refugee status and those for whom a prohibition of expulsion has been established, are entitled to health benefits based on the sections of the Social Security Code, commensurate with their situation, even if it has been established that they do not need assistance from the youth welfare office[200].

The situation is different in respect of unaccompanied minors who have a permission to remain pending the asylum decision, a suspension of removal or a special residence permit, and who are not accommodated in a residential youth welfare institution. These unaccompanied minors are not entitled to medical care under Book VIII of the Social Security Code but under Section 4 of the Asylum Seekers Benefits Act on the same basis as adult asylum seekers living in Germany for less than 18 months and adult undocumented migrants[201]. Consequently, those unaccompanied minors find it difficult to access medical benefits beyond services to heal or alleviate acute illnesses and pain[202].

Protection of seriously ill foreign nationals

According to the Residence Act, a foreign national may be granted a temporary suspension of deportation (*Duldung*) if his/her continued presence in Germany is necessary on urgent humanitarian or personal grounds (including medical grounds) or due to substantial public interests[203]. As a result, the expulsion of a foreign national must be suspended for as long as expulsion is impossible in fact or in law. However, no residence permit is granted. Since March 2016 with the *Asylpaket II and August 2019 with the Migrationspaket*, stricter regulations are applied for proving that a medical condition makes an expulsion impossible[204], thus making it easier for German authorities to expel seriously ill foreigners.

In the case of chronic diseases, the foreign nationals' registration office (*Ausländerbehörde*) may grant a temporary residence permit if a specialist doctor declares in a detailed certificate that a person is unable to travel or cannot stop treatment in Germany[205]. The temporary permit to reside ceases to apply once the patient is fit to travel again.

In addition, if the patient is considered able to travel despite his/her illness but the treatment required by his/her condition is not possible anywhere in the country of origin, a residence permit for humanitarian reasons can be issued, in accordance with Section 25(3) AufenthG and Section 60(7) AufenthG.

To obtain a residence permit on humanitarian grounds, the applicant must demonstrate to the relevant authorities that there is a serious concrete risk to his/her health if s/he is deported in his/her country of origin. Data on the national health system and the person's economic and social situation must be presented.

An accelerated asylum procedure can be carried out for asylum seekers from a "safe country of origin" and in this case, the Federal Office for Migration and Refugees can

[197] *Social Security Code (Sozialgesetzbuch (SGB))*, Book VIII, 26 June 1990, Sections 42 and 42a, https://www.gesetze-im-internet.de/sgb_8/BJNR111630990.html#BJNR111630990BJNG000805140.

[198] *Idem*, Section 40, https://www.gesetze-im-internet.de/sgb_8/__40.html.

[199] *Social Security Code*, *op. cit.* note 158, Sections 47 to 51, http://www.gesetze-im-internet.de/sgb_12/BJNR302300003.html#BJNR302300003BJNG000900000.

[200] A. Müller, "Unaccompanied Minors in Germany", Focus-Study by the German National Contact Point for the European Migration Network, Working Paper 60, *Federal Office for Migration and Refugees*, 2014, p. 40, https://www.bamf.de/SharedDocs/Anlagen/EN/Publikationen/EMN/Studien/wp60-emn-minderjaehrige-in-deutschland.pdf?__blob=publicationFile.

[201] J. Tangermann, P. Hoffmeyer-Zlotnik, "Unaccompanied Minors in Germany – Challenges and Measures after the Clarification of Residence Status", Focused Study by the German National Contact Point for the European Migration Network, Working Paper 80, *Federal Office for Migration and Refugees*, 2018, pp. 42-43, https://ec.europa.eu/home-affairs/sites/homeaffairs/files/11a_germany_uam_2018_en.pdf.

[202] *Idem*, p. 43.

[203] *Residence Act*, *op. cit.* note 194, Section 60a(2), http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html#p1140.

[204] *Idem*, Section 60a(2)(c) and (d).

[205] *Idem*, Section 25(5), http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html#p0550.

take a decision within one week[206]. This short time makes it extremely difficult for asylum seekers to present the information about their health status in time. Several countries have been classified as "safe countries of origin", increasing the number of asylum seekers affected by the accelerated asylum procedure.

Access to healthcare for homeless people

Homeless people are entitled to basic social services and health insurance according to the Social Security Code. However, a number of them lack health insurance and even if they are insured, they face barriers to access healthcare[207].

[206] *Asylum Act (Asylgesetz – AsylG)*, 2 September 2008, Section 30a, http://www.gesetze-im-internet.de/englisch_asylvfg/englisch_asylvfg.html#p0016.

[207] H. Kaduszkiewicz, B. Bochon, H. van den Bussche, J. Hansmann-Wiest, C. van der Leeden, "The Medical Treatment of Homeless", *Deutsches Ärzteblatt International*, Vol. 117, 2017, p. 675, https://www.aerzteblatt.de/pdf.asp?id=193682.

SWEDEN

Main legal changes

Since 2016, only temporary residence permits are issued for people who have been granted subsidiary protection. The permits are valid for 13 months, whereas before this Act, foreign nationals could be granted a permanent residence permit. This law was extended in 2019 until July 2021.

National Health System

Constitutional basis

The Constitution of Sweden in the Instrument of Government states that "*Public power shall be exercised with respect for the equal worth of all and the liberty and dignity of the individual. The personal, economic and cultural welfare of the individual shall be fundamental aims of public activity. In particular, the public institutions shall secure the right to employment, housing and education, and shall promote social care and social security, as well as favourable conditions for good health […]*"[208].

Organisation and funding of the Swedish healthcare system

The Swedish healthcare system has an explicit public commitment to ensure the health of all citizens. Under the Health and Medical Services Act 2017, equal access to health and medical services must be ensured to the entire population based on their needs[209].

The Swedish healthcare system is organised in three levels[210].

At the national level, the Ministry of Health and Social Affairs (*Socialdepartementet*) is responsible for overall health and healthcare policy. It establishes principles and guidelines for care and sets the political agenda for health and medical care. Eight national government agencies are directly involved at this level.

At the regional and local levels, the Health and Medical Services Act specifies that the responsibility for ensuring that everyone living in Sweden has access to good healthcare lies with the county councils and municipalities[211] which have considerable freedom regarding the organisation of their health services.

At the regional level, the 21 county councils and the regional bodies are responsible for the funding and provision of healthcare services to the population, especially primary care, through a national network of 1,185 public and private primary healthcare centres covering the country. But there are also about 70 hospitals at the county level and seven regional/university hospitals for highly specialised healthcare[212].

At the local level, the 290 municipalities are responsible for long-term care for older people living at home, in care homes or nursing homes, and for those with disabilities or long-term mental health problems.

All county councils and municipalities are represented by a collaborative national organization, the Swedish Association of Local Authorities and Regions (*Sveriges Kommuner och Landsting* - SALAR)[213].

Predominantly, these three entities handle the funding of the National Health System. The Government funding comes mainly from proportional income taxes levied by county councils/regions and municipalities on their population, and from some national and indirect tax revenues[214].

Accessing the Swedish healthcare system

Health coverage is universal and granted to all legal residents in Sweden.

[208] *Constitution of Sweden, Instrument of Government*, 2016, Chapter 1, Article 2, https://www.riksdagen.se/globalassets/07.-dokument--lagar/the-constitution-of-sweden-160628.pdf.

[209] *Health and Medical Service Act (Hälso- och sjukvårdslag)*, 2017:30, 9 February 2017, Section II, Chapter 3, Article 1, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag_sfs-2017-30.

[210] A. H. Glenngård, "The Swedish Health Care System", In E. Mossialos et al. (Ed), "International Profiles of Health Care Systems", *The Commonwealth Fund*, May 2017, p. 147, https://www.commonwealthfund.org/sites/default/files/documents/__media_files_publications_fund_report_2017_may_mossialos_intl_profiles_v5.pdf.

[211] *Health and Medical Service Act*, *op. cit.* note 212, Section III, Chapter 8 and Section IV, Chapter 12.

[212] J. Agerholm, J. Friszell, "ESPN Thematic Report on Inequalities in access to healthcare – Sweden", European Commission, *European Social Policy Network*, 2018, p. 5.

[213] *Ibid*.

[214] A. H. Glenngård, "The Swedish Health Care System", *op. cit.* note 213, p. 147.

Only a minor proportion of the population has private health insurance, which is usually paid by the employer. This private insurance is generally purchased to avoid the problem of waiting times[215].

The publicly financed health system covers[216]:

- Public health and preventive services;
- Primary care;
- Inpatient and outpatient specialized care;
- Emergency care;
- Inpatient and outpatient prescription drugs;
- Mental health care;
- Rehabilitation services;
- Disability support services;
- Patient transport support services;
- Home care and long-term care, including nursing home care and hospice care;
- Dental care and optometry for children and young people; and, with limited subsidies, adult dental care.

Services can vary throughout the country as county councils and municipalities are responsible for the organisation and financing of healthcare at the regional and local levels[217].

Other healthcare services require out-of-pocket payments but there are separate regulations for medical and dental care[218].

The fees for GP consultations are set by each county and vary between SEK 140 and 300 (€13-28[219]) across the country, although one county council has abolished fees[220]. For specialist care, fees vary between SEK 200 and 400 (€18-37)[221]. Annual out-of-pocket payments for healthcare visits are capped nationally at SEK 1,100 (€103) per individual[222]. After reaching this threshold, the patient can obtain a card that gives him/her access to free healthcare until 12 months have passed since the first visit.

The Swedish health system does not provide medicines free of charge to individuals with health coverage. However, according to the 2002 Law on Pharmaceutical Benefits[223], the State subsidises the cost of certain medicines. For instance, since 1 January 2016, certain prescribed drugs in the reimbursement system are free for children under 18 years old[224].

The Dental and Pharmaceutical Benefits Agency (*Tandvårds- och Läkemedelsförmånsverket* – TLV) is a central government agency, which determines whether a pharmaceutical product, medical device or dental care procedure is to be subsidised by the State[225]. If it is the case, they will be included in the high-cost threshold which reduces patient costs for prescription medicines. The high-cost applies for a 12-month period, starting after purchases amounting to SEK 1,150 (€ 108) for prescription medicines. In practice, the patient pays the price for his/her medicines up to SEK 1,150 (€ 108)[226]. Following this, a discount system comes into effect[227]:

- Between SEK 1,150 (€108) and SEK 2,195 (€206), the patient pays 50% of the cost of the medicine;
- Between SEK 2,196 (€206) and SEK 4,078 (€383), the patient pays 25% of the cost of the medicine;
- Between SEK 4,079 (€383) and SEK 5,645 (€530), the patient pays 10% of the cost of the medicine.

Patients who bought medicines on prescription for SEK 2,300 (€ 216) within a 12-month period do not pay any more for their medicines during the remaining time in that

[215] J. Agerholm, J. Friszell, "ESPN Thematic Report on Inequalities in access to healthcare – Sweden", *op. cit.* note 215, p. 6.

[216] A. H. Glenngård, "The Swedish Health Care System", *op. cit.* note 213, pp. 147-148.

[217] *Idem*, p. 148.

[218] J. Agerholm, J. Friszell, "ESPN Thematic Report on Inequalities in access to healthcare – Sweden", *op. cit.* note 215, p. 5.

[219] Exchange rate as of September 2019.

[220] Sveriges Kommuner och Landsting, "Patientavgifter i hälso- och sjukvården 2019", 21 January 2019, https://skl.se/halsasjukvard/patientinflytande/patientavgifter.14668.html.

[221] *Ibid*.

[222] J. Agerholm, J. Friszell, "ESPN Thematic Report on Inequalities in access to healthcare – Sweden", *op. cit.* note 215, p. 5.

[223] *Law on Pharmaceutical Benefits*, 2002:160, 11 April 2002, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2002160-om-lakemedelsfo_sfs-2002-160/.

[224] *Idem*, Article 19.

[225] Tandvårds- och Läkemedelsförmånsverket, "Welcome to the TLV", https://www.tlv.se/in-english.html.

[226] Tandvårds- och Läkemedelsförmånsverket, "High-cost threshold - How it works", 23 May 2019, https://www.tlv.se/in-english/medicines/what-is-the-high-cost-threshold/how-it-works.html.

[227] *Ibid*.

period[228]. Prescribed drugs in the reimbursement system are free for children under 18[229].

The medicine fee system is different for asylum seekers and undocumented migrants. According to the Regulation on care fees for foreign nationals staying in Sweden without the necessary permits, asylum seekers and undocumented migrants only have to pay a fee of a maximum of SEK 50 (€4.70) per prescribed drug[230]. This applies to medicines subsidised by the State.

Dental care can be accessed free of charge by people under 20[231]. The rest of the population receives a fixed annual grant of SEK 300 or 600 (€28-56) depending on age, for check-ups and preventive dental care[232]. For other dental services, within a 12-month period, if the services cost more than SEK 3,000 (€282), the patient will be refunded for 50% of the costs and if dental care cost more than SEK 15,000 (€1,410), s/he will be refunded for 85% of the costs[233].

For children under 18, healthcare is mostly free of charge, depending on the county council. All children in Sweden also have access to free vaccination, according to a national vaccination programme[234].

Sexual and reproductive health rights

Maternity care

All care and treatment provided to women during their pregnancy within the framework of maternal healthcare is free of charge, regardless where the care is performed[235].

Termination of pregnancy

Under the Abortion Act, termination of pregnancy is allowed before the end of the 18th week of pregnancy[236]. If the pregnancy poses a serious danger to the life or health of the woman, the National Board of Health and Welfare (*Socialstyrelsen*) may grant approval to terminate the pregnancy until the 22nd week[237].

The procedure of a termination of pregnancy is covered by national health insurance but the appointment is charged between SEK 150 and 330 (€14-30), except for young people under 18 years old. Since 2008, women from other countries also have the right to get an abortion in Sweden[238].

Family planning services

Prescribed contraception is free for young people under 21 years old, and in some regions or county councils, people under 25 years old only have to pay a small cost[239].

Sexually transmitted infections

Some STIs are covered by the Diseases Act[240], which states that certain testing and treatment are free of charge for residents in Sweden and for those who are covered by the

[228] *Ibid*.

[229] *Ibid*.

[230] *Regulation on care fees for foreign nationals staying in Sweden without the necessary permits*, 2013:412, 30 May 2013, Article 7, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Forordning-2013412-om-varda_sfs-2013-412/.

[231] A. H. Glenngård, "The Swedish Health Care System", *op. cit.* note 213, p. 148.

[232] Tandvårds- och Läkemedelsförmånsverket, "Dental Care Benefits Scheme", 12 June 2018, https://www.tlv.se/in-english/dental-care/dental-care-benefits-scheme.html.

[233] *Idem*.

[234] The vaccination programme includes eleven vaccines against the following diseases: Diphtheria, Whooping cough, Tetanus, Polio, Haemophilus influenza type B (Hib), Pneumococci, Measles, Mumps, Rubella, Rotavirus, Hepatitis B, Human papillomavirus (HPV) (for girls only). 1177 Vårdguiden, "Vaccinationer – Vaccinationsprogrammet för barn", 1 September 2019, https://www.1177.se/Ostergotland/behandling--hjalpmedel/vaccinationer/vaccinationsprogrammet-for-barn/.

[235] Vårdgivarguiden, "Mödravård, MVC", 18 December 2018, https://www.vardgivarguiden.se/Patientadministration/Patientavgifter/avgiftshandboken/Oppenvard/Modravard-MVC/.

[236] *Abortion Act (Abortlag)*, 1974:595, 12 June 1974, Article 1, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/abortlag-1974595_sfs-1974-595.

[237] 1177 Vårdguiden, "Abortion", https://www.1177.se/en/Stockholm/other-languages/other-languages/graviditet---andra-sprak/abort--andra-sprak/.

[238] *Law on Health and Medical Services for Asylum Seekers and Others (Lag om hälso- och sjukvård åt asylsökande m.fl.)*, 2008:344, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-2008344-om-halso--och-s_sfs-2008-344/.

[239] Migrationsverket, "Health care for asylum seekers", 17 April 2019, https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care.html.

[240] *Diseases Act (Smittskyddslagen), 2004:168*, 7 April 2004, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/smittskyddslag-2004168_sfs-2004-168.

EU regulation 883/2004 on the coordination of social security systems[241].

The law covers STIs such as HIV and hepatitis. People may have to pay testing and treatment for STIs that are not included in the Diseases Act[242].

Since the 2013:407 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act[243], undocumented migrants also have access to testing and treatment free of charge. Destitute EU citizens are also entitled to free testing under the Diseases Act.

Female genital mutilation

FGM is prohibited and punishable under the Act Prohibiting the Circumcision of Women, regardless of whether or not consent has been given and no matter where the act has been carried out[244].

Medical and psychological assistance is provided for victims of FGM in Stockholm and another healthcare facility exists in Angered (a suburb in Gothenburg), providing medical care.

Violence against women

In 1998, the Parliament introduced the offence of "gross violation of integrity" of women in the Criminal Code. A man who committed crimes constituting part of a repeated violation of the integrity of a woman with whom he has or has had a close relationship is liable to imprisonment between 9 months and 6 years[245].

Female victims of violence can have access to assistance and healthcare services within the Swedish national healthcare system. Also, pregnant women are screened for intimate partner violence when beginning maternity care.

Access to healthcare for EU/EEA migrants

Access to healthcare in Sweden is granted for legal residents. But the EU Directive 2004/38/EC[246] transposed into the Foreigners Act[247] states that after three months, EU/EEA migrants can lose their right to reside in Sweden if they do not have health coverage and sufficient resources.

The 2013 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act is not clear on whether destitute EU citizens who have lost their right to reside are currently able to access subsidised healthcare on the same basis as undocumented migrants from a third-country.

The Government Bill of 2012 merely stipulates that it "*[…] is not ruled out that [the law] in individual cases may also be applicable to citizens of the Union*", without further precision[248]. In 2018, the National Coordinator noted that there is uncertainty on the interpretation of the 2013 legislation and on whether it could also apply to EU citizens[249].

Moreover, county councils provide different solutions for EU/EEA citizens who have lost their right to reside. Some

[241] EU, *Regulation (EC) No. 883/2004*, European Parliament and Council, 29 April 2004, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:en:PDF.

[242] 1177 Vårdguiden, "Könssjukdomar - sexuellt överförda infektioner", 5 June 2019, https://www.1177.se/sjukdomar--besvar/konsorgan/konssjukdomar/konssjukdomar---sexuellt-overforda-infektioner/.

[243] *Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act (Lag om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd)*, 2013:407, 30 May 2013, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2013407-om-halso--och-sjukvard-till-vissa_sfs-2013-407.

[244] *Act Prohibiting the Circumcision of Women (Lag med förbud mot könsstympning av kvinnor)*, 1982:316, 27 May 1982, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-1982316-med-forbud-mot-konsstympning-av_sfs-1982-316.

[245] *Criminal Code (Brottsbalk)*, 1962:700, 21 December 1962, Chapter 4, Article 4a, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/brottsbalk-1962700_sfs-1962-700.

[246] EU, *Directive 2004/38/EC*, 29 April 2004, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32004L0038.

[247] *Foreigners Act (Utlänningslag)*, 2005:716, 29 September 2005, Chapter 3a, http://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/utlanningslag-2005716_sfs-2005-716.

[248] Government Bill on healthcare for people staying in Sweden without permission, 2012/13: 109, p. 41, https://data.riksdagen.se/fil/F74913A6-4504-46F0-9B17-FD9413B212A6.

[249] C. Ling-Vannerus, National Coordinator for vulnerable EU citizens, "Assignment regarding national coordination on vulnerable EU/EEA citizens lacking right of residence in Sweden – interim report", *County Administrative Board of Stockholm (Länsstyrelsen i Stockholm)*, 2018, p. 41,

of them offer subsidised healthcare, pursuant to the 2013 Act, but according to MDM Sweden, it is very rare and most of them remain in the former system and have to pay the fee for receiving healthcare in hospitals and health centres.

They also have to pay full price for healthcare both before and after the period of three months if they are uninsured in their country of origin.

The Swedish government has not taken initiative to clarify this situation and as a consequence, access to subsidised healthcare for EU/EEA patients can be denied if they lack EHIC[250]. Thus, they have weaker healthcare protection than other people in Sweden, including undocumented migrants (see below: Undocumented migrants).

Focus on pregnant women and children of EU/EEA migrants

Under the 2013 Health and Medical Care Act for foreigners without documents, women can access to care during pregnancy and childbirth, as well as post-natal care. Also, children have access to all healthcare and medical services free of charge[251].

However, as discussed above, there is no certainty that the 2013 Act applies to EU/EEA citizens without health insurance. Thus, if the Act is not applied to them by the healthcare providers, they will have to pay the cost of the healthcare services.

Access to healthcare for third-country nationals

Asylum seekers and refugees

Pursuant to the 2008 Law on Health and Medical Services for Asylum Seekers and Others[252], asylum seekers are entitled to[253]:

- Healthcare "that cannot wait";
- Childbirth care;
- Maternity care;
- Contraceptive advice;
- Abortion care;
- Healthcare under the Swedish Communicable Diseases Act.

The Swedish Migration Agency (*Migrationsverket*) provides asylum seekers with a personal card (*Lagen om mottagande av asylsökande* - LMA card) which proves that the person is an asylum seeker and is entitled to stay in Sweden while s/he waits for a decision on asylum application. This LMA card must be produced to the healthcare provider or when collecting a medicine from a pharmacy. It allows asylum seekers to pay lower patient fees and lower costs for prescribed medicines in some cases[254].

Upon their arrival in Sweden, asylum seekers are offered a health assessment to get advice about health matters[255].

For any visit to a healthcare centre or hospital, adult asylum seekers pay SEK 50 (€4.70) and for most of the prescribed medicines, around SEK 50 (€4.70)[256]. For medical transport, they pay a maximum of SEK 40 (€3.71)[257]. According to the Reception of Asylum Seekers Act (LMA)[258], asylum seekers who are registered are entitled to assistance, including a daily allowance.

If they have paid more than SEK 400 (€37) for doctor's appointments, medical transport and prescription drugs within six months, asylum seekers can apply for a special

http://eumedborgareisverige.se/sites/default/files/utsatta-eu-ees-medborgare-utan-uppehallsratt-sod1-eu-6.pdf.

[250] Amnesty International, "Sweden: A cold welcome. Human Rights of Roma and other 'vulnerable EU citizens' at risk", 2018, p. 44, https://www.amnesty.org/download/Documents/EUR4294032018ENGLISH.PDF.

[251] *Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act*, *op. cit.* note 246, Articles 7 and 6.

[252] *Law on Health and Medical Services for Asylum Seekers and Others*, *op. cit.* note 241.

[253] Migrationsverket, "Health care for asylum seekers", *op. cit.* note 242.

[254] Migrationsverket, "LMA card for asylum seekers", 3 June 2016, https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/LMA-card.html.

[255] Migrationsverket, "Health care for asylum seekers", *op. cit.* note 242.

[256] Migrationsverket, "Fees for health care", 16 April 2019, https://www.migrationsverket.se/English/Private-individuals/Protection-and-asylum-in-Sweden/While-you-are-waiting-for-a-decision/Health-care/Fees-for-health-care.html.

[257] *Ibid*.

[258] *Reception of Asylum Seekers Act (Lag om mottagande av asylsökande m.fl.)*, 1994:137, 30 March 1994, http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Lag-1994137-om-mottagande-a_sfs-1994-137/.

allowance so the Swedish Migration Agency will compensate the costs over SEK 400 (€37)[259], paying the county administrative board for medical examinations and care received by asylum seekers.

Asylum seekers and refugees also have access to emergency care but this is not free of charge. According to the 2013 Regulation on foreign nationals and care fees[260], the caregiver should decide the cost for such care that is not mentioned in the regulation, and emergency care is not mentioned. Therefore, each county decides what the cost for emergency care should be. In Stockholm, and in many other counties, the cost is around SEK 300 (€28).

If an asylum seeker's claim for asylum is rejected , they must return their LMA card but they are still entitled to care but as undocumented migrants (see below: Undocumented migrants).

It must be noticed that county councils can offer care to a greater extent than what is provided by law. For example, since 2016, six county councils offer complete healthcare to asylum seekers but also to undocumented migrants[261]. But it remains that asylum seekers can face obstacles to access healthcare services and do not always receive care they are entitled to[262] due to a number of challenges such as the lack of information or of translators[263].

Focus on pregnant women and children of asylum seekers and refugees

Pregnant women seeking asylum have the right to receive healthcare under the conditions detailed above. They are entitled free of charge to childbirth care, maternal care and obstetric care, including care in connection with abortion. They can also have free advice on contraception[264].

Children of asylum seekers have the same access to medical and dental care as children of nationals and authorised residents[265] (see above: Accessing the Swedish healthcare system), even after their application for asylum has been rejected.

Undocumented migrants

Undocumented migrants have the same access to healthcare as asylum seekers and refugees since the implementation of the 2013:407 Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act in July 2013. Prior to the implementation of the 2013:407 Act, undocumented migrants had to pay full fees for receiving healthcare, even in cases of emergency.

Consequently, undocumented migrants are entitled to[266]:

- Health and dental care "that cannot be deferred" (*vård som inte kan anstå*);
- Maternal healthcare;
- Care for abortion;
- Contraceptive counselling;
- Medicines covered by the Law on Pharmaceutical Benefits[267];
- Medical examination (unless obviously unnecessary).

In addition, the county councils may offer undocumented migrants wider health coverage up to the level available to residents, as they may do for asylum seekers.

The 2013:407 Act was nonetheless criticised for its imprecision. In February 2014, the National Board of Health and Welfare came to the conclusion that the terms "that cannot be deferred" are "*not compatible with ethical principles of the medical profession, not medically applicable in health and medical care and risk jeopardising patient safety*"[268].

[259] Migrationsverket, "Fees for health care", *op. cit.* note 259.

[260] *Regulation on care fees for foreign nationals staying in Sweden without the necessary permits*, *op. cit.* note 233, Article 1.

[261] Socialstyrelsen, *"Healthcare and dental care for asylum seekers and newly arrived" (Hälso- och sjukvård och tandvård till asylsökande och nyanlända)*, Final Report, October 2016, p. 27, https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2016-10-13.pdf.

[262] *Idem*, p. 7.

[263] See *Idem*, pp. 86-87.

[264] Migrationsverket, "Health care for asylum seekers", *op. cit.* note 242.

[265] *Law on Health and Medical Services for Asylum Seekers and Others*, *op. cit.* note 241, Article 5.

[266] *Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act*, *op. cit.* note 246, Articles 7-11.

[267] *Law on Pharmaceutical Benefits*, *op. cit.* note 226.

[268] Socialstyrelsen, "Vård för papperslösa - Vård som inte kan anstå, dokumentation och identifiering vid vård till personer som vistas i landet utan tillstånd", 28 February 2014, p. 28,

Focus on pregnant women and children of undocumented migrants

Under the 2013:407 Act, undocumented pregnant women are entitled to free maternal healthcare[269]. However, in practice, women are often denied maternity care. According to MDM Sweden, they are regularly rejected at the stage of signing in for care because they lack an official personal identity number.

Regarding termination of pregnancy, the care related to the procedure is free of charge[270]. However, women have to pay around €5 for the termination itself, which is the same amount as a regular medical consultation.

Under the 2013:407 Act, children of undocumented migrants have the same rights to medical and dental care as the children of Swedish nationals[271] (see above: Accessing the Swedish healthcare system).

Unaccompanied minors

Since the 2013:407 Act came into force, asylum seekers, refugees and undocumented migrants have the same access to healthcare. Thus, unaccompanied minors, regardless of their status, should have access to healthcare, in particular to vaccination.

The county councils are in charge of providing the same quality of health services, including healthcare, for children under the age of 18 seeking asylum as for other children who are citizens or residents in Sweden. The National Board of Health and Welfare supervises the municipalities' reception of unaccompanied children. Unaccompanied minors have full access to primary healthcare and to any essential or specialised medical care and counselling, including emergency treatment. They also have equal access to school nurse, counsellor and psychologist[272].

New rules for age assessment were implemented in March 2017. Asylum seekers can undergo a voluntary medical age assessment (consisting of X-ray and MRI), which estimated outcome will be included in the decision process for the refugee status. However, this age assessment methodology is known to be imprecise and can only produce an estimation of the minority of the applicant. The uncertainty of the results has been the subject of much debate in Sweden. In March 2018, the National Board of Forensic Medicine (*Rättsmedicinalverket*) which performs the age assessment, adjusted its probability scale for the age assessment of girls in order to adapt it to new scientific knowledge[273].

Protection of seriously ill foreign nationals

Under the 2005 Foreigners Act, a residence permit can be granted to a foreign national on grounds of exceptionally distressing circumstances[274]. The evaluation of eligibility for such a residence permit includes the health state.

However, in 2016, temporary restrictions have been put in place regarding the possibility of obtaining subsidiary protection. Since the 20 July 2016, the residence permit is limited in time and only valid for 13 months[275] whereas before this Act, foreign nationals could be granted a permanent residence permit. This law was intended to apply until 19 July 2019 but it has been extended until 19 July 2021 by a 2019 amendment[276].

Access to healthcare for homeless people

https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2014-2-28.pdf.

[269] *Health and Medical Care for Certain Foreigners Residing in Sweden without Proper Documentation Act*, *op. cit.* note 246, Article 7.

[270] *Ibid*.

[271] *Idem*, Article 6.

[272] Migrationsverket (Ed.), "National Approaches to Unaccompanied Minors Following Status Determination - Country Report Sweden", *European Migration Network*, Report 2017:4, p. 33, https://ec.europa.eu/home-affairs/sites/homeaffairs/files/27a_sweden_uam_2017_en_0.pdf.

[273] Rättsmedicinalverket, "Medicinsk åldersbedömning: Förändrad bedömning för flickor", 9 March 2018, https://www.rmv.se/aktuellt/medicinsk-aldersbedomning-flickor/.

[274] *Foreigners Act*, *op. cit.* note 250, Chapter 5, Article 6.

[275] *Temporary restrictions on the possibility of obtaining a residence permit in Sweden Act (Lag om tillfälliga begränsningar av möjligheten att få uppehållstillstånd i Sverige)*, 2016:752, 22 June 2016, Article 12, https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2016752-om-tillfalliga-begransningar-av_sfs-2016-752.

[276] *Amendments to the Foreigners Act Law (Lag om ändring i utlänningslagen)*, 2005:716, 19 June 2019, https://www.lagboken.se/views/pages/getfile.ashx?portalId=56&docId=3661756&propId=5.

The National Board of Health and Welfare provides support to the municipalities in their work to combat homelessness.

Also, many counties provide healthcare to homeless people in special health centres. However, most of these initiatives are only applicable for nationals and therefore do not concern EU citizens or undocumented migrants. There are a few initiatives that provide healthcare to homeless EU citizens locally. For example, in the city of Gothenburg, a public healthcare centre for homeless nationals also offers care for EU citizens, regardless if they are homeless, although it is mostly MDM Sweden that provides health services to homeless EU citizens.

Political perspective

The Convention on the Rights of the Child (CRC)[277] is about to be incorporated into Swedish law, meaning that its provisions are applicable as law in Sweden. Under Article 24 of the Convention, the States recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment. They shall ensure that children are provided with medical assistance and healthcare, especially primary care, as well as mothers with pre-natal and post-natal healthcare. They shall also take appropriate measures to develop preventive healthcare (e.g. family planning education and services). According to the Government, there was no sufficient impact of the rights of the child on decision-making processes concerning children. It considers that incorporating the CRC into Swedish law will entail a clearer obligation on courts and legal practitioners to take into account the rights provided in the Convention in the decision-making[278]. On 13 June 2018, the Riksdag (the Swedish Parliament) adopted a bill on making the Convention Swedish law. The act should enter into force on 1 January 2020[279].

[277] *Convention on the Rights of the Child*, 1989-1990, 196 State parties, https://www.ohchr.org/en/professionalinterest/pages/crc.aspx.

[278] Government Offices of Sweden, "Questions and answers about incorporating UN Convention on the Rights of the Child into Swedish Law", 17 April 2018, https://www.government.se/articles/2018/04/questions-and-answers-about-incorporating-un-convention-on-the-rights-of-the-child-into-swedish-law/.

[279] Government Offices of Sweden, "Convention on the Rights of the Child will become Swedish law", 14 June 2018, https://www.government.se/articles/2018/03/new-legislative-proposal-on-the-convention-on-the-rights-of-the-child/.

UNITED KINGDOM

National Health System

Legal basis

The 1946 National Health Service Act established a comprehensive public health service for England and Wales. It states that "*[i]t shall be the duty of the Minister of Health […] to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness […]*"[280]. This Act came into effect on 5 July 1948. The NHS Scotland and the Health and Social Care in Northern Ireland were also established in 1948 but separately.

The NHS Act has been replaced several times and currently, two different Acts are in force, the National Health Service Act 2006 and the Health and Social Care Act 2012.

The Health Act 2009 established the NHS Constitution for England[281], which formally "articulates the shared values of the NHS, and the responsibilities towards the NHS that patients, families, carers, the public and staff have as they experience or work in NHS services"[282]. Scotland, Northern Ireland and Wales have also agreed to a high-level statement regarding the NHS principles but they may provide their services differently depending on their health needs and situations[283].

Organisation and funding of the British healthcare system

The NHS, known as a Beveridgean system, provides universal health coverage for all, with access based on clinical need and not on ability to pay. With the exception of charges for some prescriptions and services, the NHS remains free at the point of use. This principle applies throughout the UK but decisions about specific charges may differ in the different countries of the UK.

The NHS is funded by the central government through general taxation, and for a small part by national insurance contributions (a payroll tax) and co-payments from people using NHS services as private patients[284].

The NHS is managed separately in England, Northern Ireland, Scotland and Wales. Some differences have emerged between these systems in recent years but they remain similar in most respects and continue to be described as a unified system.

On 1 April 2013, the Health and Social Care Act[285] established Clinical Commissioning Groups (CCGs) which are groups of GP practices coming together in order to commission the best services for the population in their area[286]. The CCGs commission different types of health services including planned hospital care, rehabilitative care, urgent and emergency care, most community health services, mental health services and learning disability and/or autism services[287]. This system of local decision-making does however contribute to spatial inequalities in access to some treatments as the decisions of the CCGs can differ from one area to another depending on their local priorities[288].

Although the NHS is the dominant provider of healthcare in England, there is also a private health sector. In 2015,

[280] *National Health Service Act 1946*, Section 1(1), http://www.legislation.gov.uk/ukpga/1946/81/pdfs/ukpga_19460081_en.pdf.

[281] Department of Health, *The NHS Constitution for England*, 27 July 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

[282] Department of Health, "Guide to the Healthcare System in England Including the Statement of NHS Accountability for England", May 2013, p. 2, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF.

[283] K. Grosios et al., "Overview of healthcare in the UK", *EPMA Journal*, 2010, p. 530, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405352/pdf/13167_2010_Article_50.pdf.

[284] R. Thorlby and S. Arora, "The English Health Care System", In E. Mossialos and al. (Ed), "International Profiles of Health Care Systems", *The Commonwealth Fund*, May 2017, p. 49, https://www.commonwealthfund.org/sites/default/files/documents/__media_files_publications_fund_report_2017_may_mossialos_intl_profiles_v5.pdf.

[285] *Health and Social Care Act 2012*, http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted.

[286] NHS England, "Clinical commissioning groups (CCGs)", https://www.england.nhs.uk/commissioning/who-commissions-nhs-services/ccgs/.

[287] *Ibid*.

[288] J. Bradshaw, K. Bloor and T. Doran, "ESPN Thematic Report on Inequalities in accession to health care: UK", European Commission, *European Social Policy Network*, 2018, p. 6.

around 10% of the population had private voluntary health insurance offering more rapid and convenient access to healthcare[289].

Accessing the British healthcare system

Primary care

Primary care is the first point of contact for people in need of healthcare and is provided by professionals (e.g. GPs, dentists, pharmacists and opticians) [290].

Under the Health and Social Care Act 2012, NHS England has the obligation to secure the provision of primary medical services for patients throughout England.

All patients in England are entitled to free primary care, even if they are not "ordinarily resident"[291] and regardless the length of time that the patients are in the UK. Thus, anyone can register and consult with a GP without charge whether registering as an NHS patient or as a temporary patient if the person is in the area for more than 24 hours and less than three months[292]. Patients can register with a GP practice regardless their nationality or immigration status. Therefore, asylum seekers, refugees, students, people on work visas, overseas visitors[293] and homeless people, whether they have permission to reside in the UK or not, are eligible to register with a GP practice[294].

GPs cannot refuse to register a patient for discriminatory reasons on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition[295]. A GP practice can only refuse to register a patient if their list is closed to new patients, the patient lives outside the catchment area, or they have other reasonable grounds[296]. Inability to provide proof of address or proof of identity are not reasonable grounds to refuse a registration[297].

In England, Section 3 of the NHS Act 2006[298], as amended by Section 13 of the Health and Social Care Act 2012[299] states that CCGs have responsibility for "*persons who usually reside in the group's area*". Usual residence is not formally defined but Regulation 3 of the National Health Service (CCGs – Disapplication of Responsibility) Regulations 2013[300] specifies that people are to be treated as "usually resident" at the address given by them (or by someone on their behalf). If they give no address, they are to be treated as usually resident wherever they are present, thereby formally unlinking immigration status from eligibility for primary care.

Regulation 2 of the NHS (General Medical Services Contracts) Regulations 2004[301] (GMS Regs), which governs the delivery of many NHS primary medical services[302], defines "patient" as including temporary residents. Paragraph 16 of Schedule 6 GMS Regs goes further in specifying that "*[t]he contractor may [...] accept a person as a temporary resident provided it is satisfied that the person is temporarily resident away from his normal place of residence and is not being provided with essential services (or their equivalent) under any other arrangement in the locality where he is temporarily residing; or is moving from place to place and not for the time being resident in any place*"[303].

[289] R. Thorlby and S. Arora, "The English Health Care System", *op. cit.* note 287, p. 49.

[290] Healthtalk.org, Youth health talk, "What is secondary care?", http://www.healthtalk.org/young-peoples-experiences/seeing-gp-advice-and-tips-young-people/what-secondary-care.

[291] NHS England, "Primary Medical Care - Policy and Guidance Manual (PGM) version 2", April 2019, p. 143, https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/.

[292] Public Health England, "Guidance NHS entitlements: migrant health guide", 12 June 2019, https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide.

[293] The term "overseas visitors" refers to any person who is not "ordinarily resident" in the UK.

[294] NHS England, "Primary Medical Care - Policy and Guidance Manual (PGM) version 2", *op. cit.* note 294, p. 144.

[295] *Idem*, pp. 146-147.

[296] *Idem*, p. 147.

[297] *Ibid*.

[298] *National Health Service Act 2006*, Section 3, http://www.legislation.gov.uk/ukpga/2006/41/section/3.

[299] *Health and Social Care Act 2012*, Section 13, http://www.legislation.gov.uk/ukpga/2012/7/section/13.

[300] *The National Health Service (Clinical Commissioning Groups—Disapplication of Responsibility) Regulations of 2013*, 2013/350, Regulation 3, http://www.legislation.gov.uk/uksi/2013/350/regulation/3/made.

[301] *The National Health Service (General Medical Services Contracts) Regulations of 2004*, 2004/291, Regulation 2, http://www.legislation.gov.uk/uksi/2004/291/regulation/2/made.

[302] Many primary medical services are provided under the NHS (Personal Medical Services Agreements) Regulations 2004 (PMS Regs) instead, but the relevant provisions are identical in both sets of Regulations.

[303] *The NHS (General Medical Services Contracts) Regulations of 2004*, 2004/291, Schedule 6, http://www.legislation.gov.uk/uksi/2004/291/schedule/6/made.

Regarding medicines, as of April 2019, the prescription charge in England is £9 (€9.87[304]) for each medicine, but some patients who need four or more prescriptions in three months, or 14 or more prescriptions per year can buy a Prescription Prepayment Certificate (PPC) in order to freeze prescription related expenses[305]. A 3-month PPC costs £29.10 (€31.91) and an annual PPC costs £104 (€114.07)[306]. In Wales[307], Scotland[308] and Northern Ireland[309], prescription charges have been abolished.

Some categories of patients are entitled to free NHS prescriptions, including patients over 60 years old, under 16 (under 25 in Wales) and under 18 for full-time students, pregnant women and mothers who have had their child in the last year, patients with specified medical condition or continuing physical disability, patients holding a valid war pension exemption certification and NHS inpatients, as well as cancer and renal dialysis patients[310].

Patients on a low income can claim for help with health costs through the NHS Low Income Scheme, which covers prescription, dental, eye care, healthcare travel costs, and wigs and fabric supports[311]. Help with health costs depends on the patient's financial resources and not on immigration status. The capital limit in England is £23,250 (€25,021) for people living permanently in a care home and £16,000 (€17,239) for the others[312]. The patient need to complete an HC1 form and then the NHS decides whether s/he should receive full help (HC2 certificate) or partial help (HC3 certificate). The certificate is valid from six months to five years, depending on the circumstances of the applicant[313].

Secondary care

Secondary care refers to healthcare that need particular expertise and is often provided by a hospital[314]. The NHS is a residence-based system, meaning that the entitlement to receive healthcare services without charges is based on the concept of ordinary residence.

Ordinary residence

The power to charge people in the UK who are not "ordinarily resident" for health services (created in the NHS (Amendment) Act 1949 and now contained in Section 175 of the 2006 NHS Act[315]) was first used in 1989[316] to make Regulations in relation to NHS hospital treatment, now consolidated as the NHS (Charges to Overseas Visitors) Regulations 2015[317] and the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017[318].

Since 1989, only those "ordinarily residents" in the UK are entitled to free NHS secondary care services, whilst those not "ordinarily resident" have to pay for these services, unless they fall under an exemption category (see below: Exempt categories of person). Since 23 October 2017, non-NHS providers of NHS funded secondary care, such as private or voluntary sector providers, are required to make and recover charges from those not "ordinarily resident"[319]. As of 21 August 2017, NHS community

[304] Exchange rate as of July 2019.

[305] Department of Health and Social Care, "NHS prescription charges from April 2019", February 2019, https://www.gov.uk/government/speeches/nhs-prescription-charges-from-april-2019.

[306] "Get a prescription prepayment certificate", https://www.gov.uk/get-a-ppc.

[307] NHS Wales, "Budget & Charges", http://www.wales.nhs.uk/nhswalesaboutus/budgetcharges.

[308] NHS Inform, "Prescription charges and exemptions", 9 July 2019, https://www.nhsinform.scot/care-support-and-rights/nhs-services/pharmacy/prescription-charges-and-exemptions.

[309] NI direct government services, "Prescriptions", https://www.nhsinform.scot/care-support-and-rights/nhs-services/pharmacy/prescription-charges-and-exemptions.

[310] NHS, "Am I entitled to free prescriptions?", 1 April 2017, https://www.nhs.uk/using-the-nhs/help-with-health-costs/get-help-with-prescription-costs/.

[311] NHS, "NHS Low Income Scheme (LIS)", 1 April 2017, https://www.nhs.uk/using-the-nhs/help-with-health-costs/nhs-low-income-scheme-lis/.

[312] *Ibid*.

[313] *Ibid*.

[314] Healthtalk.org, "What is secondary care?", *op. cit.* note 293.

[315] *NHS Act 2006*, Section 175, https://www.legislation.gov.uk/ukpga/2006/41/section/175.

[316] *National Health Service (Charges to Overseas Visitors) Regulations 1989*, 1989/306, Regulation 4, http://www.legislation.gov.uk/uksi/1989/306/regulation/4/made.

[317] *National Health Service (Charges to Overseas Visitors) Regulations 2015*, 2015/238, http://www.legislation.gov.uk/uksi/2015/238/contents/made.

[318] *National Health Service Charges to Overseas Visitors (Amendment) Regulations 2017*, 2017/756, http://www.legislation.gov.uk/uksi/2017/756/pdfs/uksi_20170756_en.pdf.

[319] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", January 2019, p. 25, https://www.gov.uk/government/publications/overseas-nhs-visitors-implementing-the-charging-regulations.

services (i.e. secondary care services delivered outside a hospital), became chargeable[320].

The concept of ordinary residence takes its meaning from case law and means, broadly, living in the UK on a lawful and properly settled basis for the time being[321]. This means that, to be considered "ordinarily resident", a person must have both a legal right to reside in the UK and be living in the UK on a properly settled basis according to the definition of case law[322].

On 6 April 2015, the Immigration Act 2014[323] introduced the additional requirement that non-EEA nationals who are subject to immigration control must have indefinite leave to remain (ILR) in the UK in order to be "ordinarily resident" in the UK. According to the Government, the Act was intended to "*prevent "illegal immigrants" accessing and abusing public services or the labour market*"[324]. The Act applies to those who require leave to enter or remain but also those currently living and working in the UK with an ILR for a limited period[325], therefore excluding many non-EEA nationals from free secondary care to which they previously had access.

Those not considered "ordinarily resident" will be charged at 150% of the NHS national tariff for any secondary care they receive unless the service is exempt from charges (see below: Exempt services)[326] or the person falls within an exempt group (see below: Exempt categories of person).

However, the Immigration Act 2014 also introduced an immigration health surcharge ("health surcharge") for non-EEA nationals without ILR applying for a visa to enter or remain in the UK for longer than six months [327]. In January 2019, the health surcharge was increased from £200 to £400 (€431) per year (£150 to £300 (€323) for students)[328], payable upfront and for the total period of time for which persons are given permission to stay in the UK. It entitles the payer to NHS services free at the point of use on the same basis as "ordinarily residents", except for assisted conception services (e.g. in vitro fertilisation)[329]. If the person fails to pay the surcharge, his/her leave to remain will be cancelled or immigration application refused or considered invalid[330] and the person will be charged for NHS services.

Visitor visas and those who applied for a short-term visa (six months or less) do not need to pay the health surcharge and will be charged at 150% of the NHS national tariff for any secondary care they receive, except for exempt services[331].

Under Regulation 14 NHS (Charges to Overseas Visitors) Regulations 2015, "*[n]o charge may be made or recovered in respect of any relevant services provided to an overseas visitor where those services are provided in circumstances covered by a reciprocal agreement with a country or territory specified in Schedule 2*"[332] of the Regulations. Thus, non-EEA nationals from countries with healthcare agreement with the UK are exempt from charges for the relevant treatments.

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[320] *Idem*, p. 26.

[321] *Shah v. Barnet London Borough Council and others*, [1983] 1 All ER 226. In this case, which concerned entitlement to grants for higher education but applies to the NHS Act 2006 and the Charging Regulations, the House of Lords defined ordinary residence as "*a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or of long duration*".

[322] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 30.

[323] *Immigration Act 2014*, http://www.legislation.gov.uk/ukpga/2014/22/contents/enacted.

[324] Home Office, "Collection: Immigration Act 2014", 15 May 2014, https://www.gov.uk/government/collections/immigration-bill.

[325] *Immigration Act 2014*, Section 39, http://www.legislation.gov.uk/ukpga/2014/22/section/39/enacted.

[326] Department of Health and Social Care, "Guidance: How the NHS charges overseas visitors for NHS hospital care", 1 August 2018, https://www.gov.uk/government/publications/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care.

[327] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 38.

[328] "Pay for UK healthcare as part of your immigration application", https://www.gov.uk/healthcare-immigration-application/who-needs-pay.

[329] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 38.

[330] *Idem*, p. 39.

[331] "Pay for UK healthcare as part of your immigration application", *op. cit.* note 331.

[332] *NHS (Charges to Overseas Visitors) Regulations 2015*, 2015/238, Regulation 14, http://www.legislation.gov.uk/uksi/2015/238/regulation/14/made.

Short-term visiting EEA nationals insured for healthcare in another EEA member state have a right to receive "medically necessary treatment" free of charge, including NHS secondary care (see below: EU/EEA migrants).

Immediately necessary or urgent treatments

The NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017 introduced an obligation on NHS trusts to secure payment for the estimated amount of charges from those not "ordinarily resident" before providing a service "*unless doing so would prevent or delay the provision of (a) an immediately necessary service; or (b) an urgent service*"[333]. Immediately necessary or urgent services, as decided by a clinician but including all maternity care, must be provided without waiting for payment or deposit[334]. The patient may still be billed wherever possible, unless this would prevent or delay the treatment.

Hospitals are required to inform the Home Office of patients who owe the NHS a debt of £500 (€539) or more that have been outstanding for two months or more[335]. If the unpaid debt is of £1,000 (€1,077) or more, the person may be refused visa renewals or extension of stay[336].

Exemptions

Persons not "ordinarily residents" may have to pay for secondary care but some NHS services are free of charges and some individuals are exempt from payment. These exemptions apply for NHS England.

Exempt services

Some services are free at the point of use for all patients, regardless their status, except if the overseas visitor has travelled to the UK for the purpose of seeking that treatment[337]:

- Accident and emergency services, including those provided at an NHS hospital, for example, those provided at an accident and emergency department, walk-in centre, minor injuries unit or urgent care centre. This does not include those emergency services provided after being admitted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitors are exempt from charge in their own right;
- Services provided for the diagnosis and treatment of a number of communicable diseases, including HIV, tuberculosis and Middle East Respiratory Syndrome (MERS)[338];
- Services provided for the diagnosis and treatment of sexually transmitted infections;
- Family planning services (does not include the termination of pregnancy or infertility treatment);
- Services for the treatment of a physical or mental condition caused by torture, female genital mutilation, domestic violence, or sexual violence;
- Palliative care services provided by a registered palliative care charity or a community interest company;
- Services that are provided as part of the NHS111 telephone advice line.

[333] *NHS Charges to Overseas Visitors (Amendment) Regulations 2017*, *op. cit.* note 321, Regulation 3(1A).

[334] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 67.

[335] Department of Health and Social Care, "Overseas chargeable patients, NHS debt and immigration rules: Guidance on administration and data sharing", 26 March 2019, p. 2, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793132/overseas-chargeable-patients-nhs-debt-and-immigration-rules.pdf.

[336] *Ibid*.

[337] Public Health England, "Guidance NHS entitlements: migrant health guide", *op. cit.* note 295.

[338] The exact list of diseases for which no charge is to be made is specified in Schedule 1 of the Regulations 2015: Acute encephalitis, Acute poliomyelitis, Anthrax, Botulism, Brucellosis, Cholera, Diphtheria, Enteric fever (typhoid and paratyphoid fever), Food poisoning, Haemolytic uraemic syndrome (HUS), Human immunodeficiency virus (HIV), Infectious bloody diarrhoea, Invasive group A streptococcal disease and scarlet fever, Invasive meningococcal disease (meningococcal meningitis, meningococcal septicaemia and other forms of invasive disease), Legionnaires' disease, Leprosy, Leptospirosis, Malaria, Measles, Mumps, Pandemic influenza (defined as the "Pandemic Phase") or influenza that might become pandemic (defined as the "Alert Phase") as defined by WHO, Plague, Rabies, Rubella, Severe Acute Respiratory Syndrome (SARS), Smallpox, Tetanus, Tuberculosis, Typhus, Viral haemorrhagic fever, Viral hepatitis, Whooping cough and Yellow fever. *NHS (Charges to Overseas Visitors) Regulations 2015/238*, Schedule 1, http://www.legislation.gov.uk/uksi/2015/238/schedule/1/made.
The Middle East Respiratory Syndrome (MERS) has been included in the list by Amendment. *National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015/2025*, Amendment to Schedule 1 to the Principal Regulations, http://www.legislation.gov.uk/uksi/2015/2025/regulation/7/made.

Exempt categories of persons

Some categories of persons are exempt from charges[339]:

- Refugees (those granted asylum, humanitarian protection or temporary protection under the immigration rules) and their dependents;
- Asylum seekers (those applying for asylum, humanitarian protection or temporary protection whose claims, including appeals, have not yet been determined) and their dependents;
- Individuals receiving support under Section 95 of the Immigration and Asylum Act 1999[340] from the Home Office, and their dependants;
- Those whose application for asylum was rejected and who receive support under Section 4(2) of the Asylum Act 1999[341] from the Home Office or those receiving support from a local authority under the Care Act 2014[342] or the Social Services and Well-being (Wales) Act 2014[343], by the provision of accommodation, and their dependents;
- Children looked after by a local authority;
- Victims, and suspected victims, of modern slavery or human trafficking plus their spouse or civil partner, and any children under 18 provided they are lawfully present in the UK;
- Those receiving compulsory treatment under a court order, or who are liable to be detained in an NHS hospital or deprived of their liberty (for example, under the Mental Health Act 1983 or the Mental Capacity Act 2005) are exempt from charge for all treatment provided, in accordance with the court order, or for the duration of their detention;
- Prisoners and immigration detainees.

There may also be exceptional humanitarian reasons where the secretary of state can determine that exemption from charges for relevant services is justified. This exemption also applies to their child and/or companion who is authorised to travel with them, for whom the exemption is limited to treatment that cannot await their return home[344].

Individuals who are covered by reciprocal healthcare agreements, such as the European Health Insurance Card or who have paid the immigration health surcharge may also be exempt from payment[345].

Sexual and Reproductive Health Rights

Maternity care

The majority of maternity services are secondary care services, delivered by NHS hospital trusts either in hospitals or in the community. The Government Guidance states that maternity services, including antenatal care, must be treated as being "*immediately necessary*"[346]. Thus, maternity services cannot be denied or delayed if the person is not ordinarily resident and cannot afford to pay.

Termination of pregnancy

Termination of pregnancy is possible during the first 24 weeks of pregnancy (and later in the pregnancy in certain circumstances) and must be carried out in an NHS hospital or a licensed clinic (e.g. in some local family planning clinics or genitourinary medicine clinics that are also accessible to undocumented women)[347].

However, the Abortion Act of 1967 allowing abortion during the first 24 weeks of pregnancy does not extend to Northern Ireland where women face life sentence for abortion. Until June 2017, women could still travel to England to terminate their pregnancy, but would not be covered by the NHS and would have to pay the full cost. In June 2017, the Parliament passed an amendment allowing Northern Ireland women to be covered by the

[339] Public Health England, "Guidance NHS entitlements: migrant health guide", *op. cit.* note 295.

[340] *Immigration and Asylum Act 1999*, Section 95, http://www.legislation.gov.uk/ukpga/1999/33/section/95.

[341] *Idem*, Section 4(2), http://www.legislation.gov.uk/ukpga/1999/33/section/4.

[342] *Care Act 2014*, Part 1, http://www.legislation.gov.uk/ukpga/2014/23/part/1/enacted.

[343] *Social Services and Well-being (Wales) Act 2014*, Section 35 or 36, http://www.legislation.gov.uk/anaw/2014/4/part/4/crossheading/meeting-care-and-support-needs-of-adults.

[344] Public Health England, "Guidance NHS entitlements: migrant health guide", *op. cit.* note 295.

[345] *Ibid*.

[346] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 67.

[347] NHS, "Overview: Abortion", 17 August 2016, https://www.nhs.uk/conditions/abortion/.

NHS for abortion in England[348]. But in June 2018, the UK's Supreme Court held that the abortion law in Northern Ireland was incompatible with the rights protected by the ECHR although the Lords said that they had no jurisdiction to consider the case as there was no victim of an unlawful act involved in it so did not issue a declaration of incompatibility[349]. Then, in July 2019, the UK's House of Commons passed an amendment to extend abortion rights to Northern Ireland (see below political perspective).

Two registered medical practitioners must agree that a termination would cause less damage to a woman's physical or mental health than continuing with the pregnancy[350].

Termination of pregnancy is considered secondary care, so it is chargeable for persons not "ordinarily resident", unless the patient is in a category of persons exempt from charging. Most abortions services are delivered in the community, often by voluntary sector organisations (funded by the NHS). Since 23 October 2017, the NHS Charges to Overseas Visitors (Amendment) Regulations 2017 extended charges, meaning that women who are not ordinarily resident in the UK may have to pay for such treatment. Government guidance states that if a person, who presents seeking a termination of pregnancy and satisfies a ground under the Abortion Act 1967, cannot reasonably be expected to leave the UK before the date at which an abortion may no longer be a viable option for her, treatment should be regarded as being urgent and should not be delayed or withheld in order to establish chargeable status or to seek payment. At the time of writing, voluntary sector providers of the NHS funded abortion do not appear to be applying charges to women not "ordinarily resident" provided they are referred by a GP.

EEA nationals travelling to the UK to seek termination of pregnancy will be charged unless they have obtained a S2 form[351].

Family planning services

Family planning services are part of exemption services. Those services include contraceptive products and devices to prevent pregnancy but do not include abortion services.

Sexually transmitted infections

Services provided for the diagnosis and treatment of STIs are covered by the exemption and are free of charge for all patients.

Female genital mutilation

FGM is an offence under the Female Genital Mutilation Act 2003[352]. Services provided to a girl, woman or transgender men for the treatment of any condition, including mental health condition, caused by the FGM, are covered by the exemption and are free of charge, and any maternity services when the need for which is caused by the mutilation is also included[353]. The exemption applies regardless where and when the FGM was performed, unless the overseas visitor has travelled to the UK for the specific purpose of seeking that treatment[354].

Violence against women

Services provided for the treatment of any condition, including mental health services and maternity services, caused by domestic violence or sexual violence are exempt from NHS charges[355]. The exemption applies unless the overseas visitor has travelled to the UK for the specific purpose of seeking that treatment.

Access to healthcare for EU/EEA migrants

[348] BBC News, "Northern Ireland women to get free abortions in England", 29 June 2017, http://www.bbc.com/news/uk-politics-40438390.

[349] UK Supreme Court, 7 June 2018, [2018] UKSC 27, § 2 and 3, https://www.supremecourt.uk/cases/docs/uksc-2017-0131-judgment.pdf.

[350] *Abortion Act 1967*, Section 1(1), http://www.legislation.gov.uk/ukpga/1967/87/section/1.

[351] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 81.

[352] *Female Genital Mutilation Act 2003*, 2003/31 http://www.legislation.gov.uk/ukpga/2003/31.

[353] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, pp. 58-60.

[354] *Idem*, p. 57.

[355] *Idem*, pp. 58-60.

Note: EU rules continue to apply, at least until the UK leaves the EU.

EU/EEA nationals may be considered "ordinarily resident" in the UK and therefore are entitled to free NHS secondary care if they are there lawfully and on a properly settled basis. Under the Immigration (EEA) Regulations 2006[356] and EU Directive 2004/38[357], those economically active in the UK (i.e. employed, self-employed, involuntarily unemployed for less than six months or temporarily incapacitated) are likely to have a right to reside in the UK.

Those not considered "ordinarily resident" will be charged at 150% of the NHS national tariff for any secondary care they receive, unless the service is exempt from charges (see above: Exempt services)[358] or the person falls within an exempt group (see above: Exempt categories of person).

Short term visiting EU/EEA nationals insured for healthcare in another EU/EEA member State have a right to receive free of charge "*all treatment that is medically necessary before their planned date of return*", i.e. treatment medically necessary to have during the temporary stay of the patient in the UK, including NHS secondary care. They will need to present either an EHIC from that member State or a Provisional Replacement Certificate (PRC)[359].

In England, the covered treatments are[360]:

- Diagnosis of symptoms or signs occurring for the first time after the visitor's arrival in the UK;
- Any other treatment which, in the opinion of a registered medical or dental practitioner, is required promptly for a condition which:
  - Arose after the visitor's arrival; or
  - Became acutely exacerbated after their arrival; or
  - Would be likely to become acutely exacerbated without treatment;
- The treatment of chronic or pre-existing conditions, including routine monitoring.

Planned treatments are not covered by the EHIC, patients from EU/EEA must request an S2 form from their home country so they will not be required to pay anything themselves, or via the EU Directive route[361], they can purchase state or private healthcare in England and seek reimbursement from the home country[362]. Due to an arrangement between the UK and the Republic of Ireland, visitors from Ireland are not required to present an EHIC[363].

Focus on pregnant women and children of EU/EEA migrants

EU/EEA nationals considered "ordinarily resident" in the UK will not be charged for NHS maternity services. Those who are not "ordinarily resident" but with insurance in another EU/EEA country (evidenced by an EHIC) will receive free maternity care, including antenatal and postnatal care, providing the reason for the visit is not specifically to give birth or receive maternity treatment. If it is the case, the patient need to provide an S2 form so that no payment will be required[364].

Children of people insured in another EU/EEA country are also exempt from charges when lawfully visiting the UK with them, but only if they do not have a right to an EHIC or PRC on their own[365].

Access to healthcare for third-country nationals

Asylum seekers and refugees

[356] *Immigration (EEA) Regulations 2006*, http://www.legislation.gov.uk/uksi/2006/1003/contents/made.

[357] EU, *Directive 2004/38/EC*, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32004L0038.

[358] Department of Health and Social Care, "Guidance: How the NHS charges overseas visitors for NHS hospital care", *op. cit.* note 329.

[359] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 74.

[360] *Idem*, p. 75.

[361] EU, *Directive 2011/24/EU*, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32011L0024.

[362] NHS, "Visitors from the European Economic Area (EEA) or Switzerland", 10 September 2018, https://www.nhs.uk/using-the-nhs/nhs-services/visiting-or-moving-to-england/visitors-from-the-european-economic-area-eea-or-switzerland/.

[363] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 74.

[364] *Idem*, p. 75.

[365] *Idem*, p. 15.

Regulation 15(a) of the NHS (Charges to Overseas Visitors) Regulations 2015[366] , which applies to England, states that anyone who has been granted temporary protection, asylum or humanitarian protection under the immigration rules made under Section 3(2) of the Immigration Act 1971 is exempt from charges for any relevant services. Moreover, Regulation 15(b)[367] states that anyone who has made a formal application with the Home Office to be granted temporary protection, asylum or humanitarian protection is also fully exempt from charges whilst his/her application is being processed. This includes certain applications for leave to remain made on the basis that return to the country of origin would breach Article 3 ECHR[368]. Thus, the persons concerned are entitled to access NHS services free of charge on the same basis as an "ordinarily resident". The NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017 extended this exemption to dependants.

Asylum seekers and rejected asylum seekers who are not entitled to free prescriptions under these categories can make a Low Income Scheme (LIS) HC1 claim (see above: Primary care).

In Scotland and Wales, asylum seekers and refused asylum seekers, and their dependants, are entitled to free secondary healthcare on the same terms as any other ordinary resident[369]. In England, only refused asylum seekers who receive accommodation and support from the Home Office under Section 4(2) of the Immigration and Asylum Act 1999, or from a local authority under Section 21 or Part 1 of the Care Act 2014 are entitled to free secondary healthcare[370].

Focus on pregnant women and children of asylum seekers and refugees

Pregnant asylum seekers and refugees have free access to antenatal, delivery and postnatal care.

Asylum seekers, refugees and refused asylum seekers who receive accommodation and support from the Home Office under Section 4(2) of the Immigration and Asylum Act 1999, or from a local authority under Section 21 or Part 1 of the Care Act 2014 are entitled to free NHS maternity care.

The children of asylum seekers and refugees, like adults, have free access to the NHS and this includes vaccination.

Undocumented migrants

Undocumented migrants have free access to primary care, and there is no requirement to provide documentation proving immigration status when registering a GP. In the same way as UK citizens, undocumented migrants can benefit from NHS Low Income Scheme and be exempt from some charges (e.g. prescription charges, eye and dental care charges).

Adults over 60 have automatic free prescriptions and eye tests. They can obtain free dental treatment with an HC2 certificate. However, obtaining an exemption certificate does not ensure that an undocumented patient can access NHS care, it only helps with the cost of prescriptions.

Regarding access to secondary care, undocumented migrants not considered "ordinarily resident" are only entitled to limited free secondary care (see above: Exempt services), unless they fall within one of the categories of people who are exempt from charges. Thus, they have to pay to access secondary care, although immediately necessary or urgent treatment should not be withheld pending payment.

Hospitals are required to inform the Home Office of patients who owe the NHS a debt of £500 (€539) or more that have been outstanding for two months or more[371]. If the unpaid debt is of £1,000 (€1,077) or more, the person may be refused visa renewals or extension of stay[372].

Focus on undocumented pregnant women and children of undocumented migrants

[366] *NHS (Charges to Overseas Visitors) Regulations 2015*, *2015/238*, Regulation 15, http://www.legislation.gov.uk/uksi/2015/238/regulation/15/made.

[367] *Ibid*.

[368] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 61.

[369] Public Health England, "Guidance NHS entitlements: migrant health guide", *op. cit.* note 295, https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide#special-groups.

[370] *Ibid*.

[371] Department of Health and Social Care, "Overseas chargeable patients, NHS debt and immigration rules: Guidance on administration and data sharing", *op. cit.* note 338, p. 2.

[372] *Ibid*.

The majority of maternity services are secondary care services, delivered by NHS hospital trusts either in hospitals or in the community. Undocumented migrant women will not be entitled to free maternity care unless they fall into one category of exemption.

The Government Guidance states that maternity services, including antenatal care, must be treated as being "*immediately necessary*"[373]. Thus, maternity services cannot be denied or delayed if the undocumented migrant is not "ordinarily resident" and cannot afford to pay.

Vaccination is available for all children and adults through their GP and baby clinics. All children are exempt from prescription charges, dental care and optometry charges. Charges for secondary care apply to undocumented children in the same way as adults, but services provided by health visitors and school nurses are exempt from charge.

Unaccompanied minors

Unaccompanied minors who are seeking asylum or have refugee status are exempt from charges in the same way as any other asylum seeker or refugee. Once an unaccompanied minor makes an asylum application to the Home Office, they are entitled to relevant services free of charge on the same basis as those "ordinarily resident"[374].

Unaccompanied minors without an asylum application and those whose asylum applications have been refused will usually be exempt from NHS charges. In the absence of a person with parental responsibility able to look after the child, the Children Act 1989 places an obligation on the local authority to care for the child. The NHS (Charges to Overseas Visitors) Regulations 2015 exempts a child who is looked after by a local authority from NHS charges[375]. Once a child turns 18 and leaves local authority care, s/he can no longer be exempt from charging.

Protection of seriously ill foreign nationals

The discretionary leave to remain is granted to persons (seeking asylum or not) who require medical, social or another form of assistance which can be provided in the UK.

The improvement or stabilisation of an applicant's medical condition resulting from treatment in the UK and the prospect of serious or fatal relapse in case of expulsion do not in themselves render expulsion an inhuman treatment contrary to Article 3 of the ECHR.

As interpreted by the ECtHR in the Paposhvili case[376], the threshold of Article 3 can be met in "very exceptional cases" which refers to "*situations involving the removal of a seriously ill person in which substantial grounds have been shown for believing that he or she [...] would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy*"[377].

The duration of Discretionary Leave granted is determined by a consideration of the individual facts of the case but leave is not normally granted for more than 30 months at a time. Subsequent periods of leave can be granted providing the applicant continue to meet the relevant criteria[378].

Access to healthcare for homeless people

Registration with a GP is free for homeless people and GP practice cannot refuse registration because the person is homeless, does not have proof of address, identification or because of his/her immigration status[379]. If the person has an HC2 certificate, s/he will not be charged for the medicine[380].

Political perspective

[373] Department of Health and Social Care, "Guidance on implementing the overseas visitor charging regulations", *op. cit.* note 322, p. 67.

[374] *Idem*, p. 63.

[375] *Idem*, p. 62.

[376] *Paposhvili v. Belgium*, *op. cit.* note 25.

[377] *Idem*, §183.

[378] Visa and migration, "Discretionary Leave to Remain", https://www.visaandmigration.com/service/discretionary-leave-to-remain/55.html.

[379] NHS England, "People who are homeless: How to register with a doctor (GP)", https://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Documents/how-to-register-with-a-gp-homeless.pdf.

[380] *Ibid*.

After the vote on Brexit, the UK government has proposed to the EU member States and the European Free Trade Association (EFTA) States that the healthcare arrangements remain even in case of a no-deal scenario until December 2020. The government said that EU and EFTA nationals and students lawfully living in the UK will be able to "*use the NHS as they do now*" after the UK leaves the EU[381].

In July 2019, the UK's House of Commons passed an amendment decriminalising abortion in Northern Ireland and requiring the government of Northern Ireland to regulate access to abortion[382]. However, there has been no government since January 2017 so the new law is expected to come into force on 22 October, unless the government is restored before then[383].

[381] Department of Health and Social Care, "Guidance: Healthcare for EU and EFTA nationals living in the UK", 19 March 2019, https://www.gov.uk/guidance/healthcare-for-eu-and-efta-nationals-living-in-the-uk.

[382] BBC News, "Abortion: 'No criminal case in Northern Ireland' after October", 5 September 2019, https://www.bbc.com/news/uk-northern-ireland-49595590.

[383] BBC News, "Abortion law in Northern Ireland set to change", 25 September 2019, https://www.bbc.com/news/uk-northern-ireland-49824575.

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