

## B6 | ACCESS TO HEALTHCARE OF MIGRANTS IN THE EU

### Introduction

Over the last decades, issues related to migration have emerged as a fundamental and defining factor in European societies. As a consequence, migrants' access to healthcare has also become a pressing social and political issue with multiple implications – ranging from human rights, individual and collective well-being, to public budgets. Moreover, migrants' health is a crucial determinant of social cohesion, as illness and marginalization are part of a vicious circle that hinders integration (Ingleby et al., 2005).

The response in Europe has been far from uniform. The direct remit of the European Union (EU) on matters related to health is limited. Apart from a role in matters of public security, the EU only has an 'advisory' role on health issues (limited to raising concern and encouraging countries to take action). It does not have the authority to prescribe actions which are binding on all EU members or harmonize policies and measures on health.<sup>1</sup> EU member states are free to design the way their health systems are funded and the coverage they provide. Thus, identifying common patterns regarding migrants' access to healthcare is not an easy task. However, the following general trends are worth noting:

1. *Migrants are among the most disadvantaged population groups in Europe.* According to a report by the Organisation for Economic Cooperation and Development (OECD) and the European Commission, "Immigrants are twice as likely [as the] native-born to live in households which fall within the poorest income decile and below the national poverty threshold" (OECD/EU, 2015, p. 161). This is linked to multiple factors: their economic background and pre-migration conditions, restrictive access to the labour market, exploitation, lack of efficient integration policies and lack of representation in political and social structures.
2. *Several studies have shown that seeking healthcare is not a major motivation for most migrants to come to Europe* (Médecins du Monde, 2014, p. 19; 2015, p. 25; 2016a, p. 17). In fact, the use of healthcare facilities by migrants is significantly lower than by local populations (Sarria-Santamera et al., 2016).
3. *The European Commission encourages member states to articulate inclusive healthcare systems.* In its advisory capacity, the European Commission has issued several communications raising concerns over the special vulnerability of migrants regarding health inequalities (Commission of the European

- Communities 2009, p. 8) and called for EU countries to ensure universal access to healthcare (European Commission 2016, p. 12).
4. *National legislations group migrants into various categories, providing different sets of access rights.* Students, workers from third-party countries, asylum seekers and undocumented migrants are categories typically identified in many European countries, with different and varying levels of access associated with each of them. Most countries grant full access rights to migrants who have acquired permanent residence. At the other end of the spectrum, access for undocumented migrants is usually restrictive.
  5. *The recent increase in the arrival of refugees has added a new challenge: an unprecedented flow of people in transit with health needs significantly different from those of settled migrants* (Médecins du Monde 2016a, p. 45). Europe's response to this situation has been far from ideal; it has turned a blind eye on widespread human suffering, a case in point being the EU-Turkey Agreement (Box B6.1).
  6. *Legal implementation tends to be deficient, exacerbating migrants' exclusion from healthcare.* Migrants themselves are more often than not unaware of their entitlements, even as desk personnel and health professionals in the healthcare system ignore the applicable law. As a consequence, even if they are eligible, fewer migrants attempt to access the healthcare system and many are wrongfully denied their rights. This circumstance tends to be exacerbated by migrants moving from one country to another.
  7. *Despite the different national regulations, European countries remain bound by international human rights commitments.* One of the most notable is the International Covenant on Economic, Social and Cultural Rights (ESCR), which recognizes in its Article 12 "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". This has been interpreted by the ESCR Committee to entail the obligation to "respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health service" (UN Economic, Social and Cultural Rights Committee 2000, para. 34).



**Image B6.1** Refugees from Syria  
(Cem Terzi)

**Bux B6.1: It is not a 'refugee crisis'***The situation of refugees in Turkey*

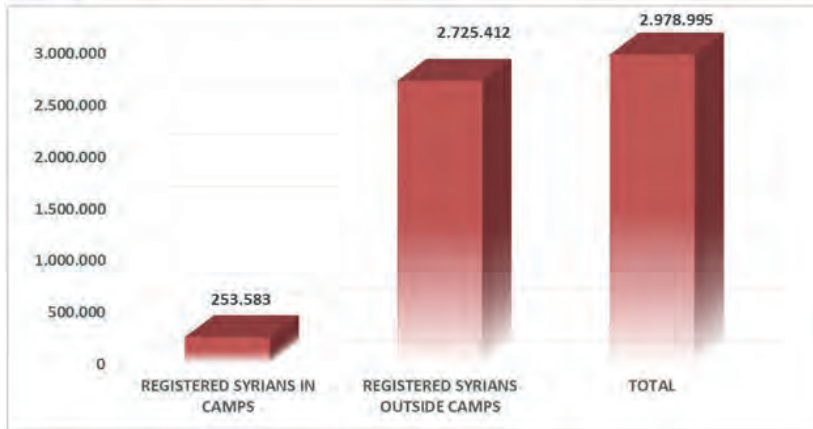
Since April 2011 approximately 7 million Syrians were forced to migrate because of the civil war, which intensified after the intervention of several countries. Of this number almost 4 million fled to Turkey. This is not a 'refugee crisis', but a humanitarian, political, historical and economic crisis.

The recently published UN report *Global Trends – Forced Displacement in 2015* (UNHCR 2015) finds that the number of forcibly displaced people has reached its highest number ever: 65.3 million (1 out of 122 people in the world). Unfortunately, the EU has not kept its promise to relocate 22,000 people from the UN camps to Europe, and until the end of 2015 only 600 of these were relocated. In 2015, developed countries admitted a total of only 107,100 refugees for resettlement. In contrast, developing regions (mostly Turkey, Pakistan, Lebanon, Iran, Ethiopia and Jordan) hosted 86 per cent of the world's refugees (ibid.). Closing the borders to the refugees and signing an agreement for returning them back to Turkey means ignoring the problem and bearing no responsibility.

The EU-Turkey Readmission Agreement is akin to an act of official human trafficking. Since its implementation, 1,487 people have been transferred to Turkey from Greece in one year and, as of March 2017, 3,565 refugees have been resettled from Turkey into the EU. These numbers fall far below the stipulated relocation limit of 72,000 refugees from Turkey to Europe. Moreover, in comparison to the more than 3 million Syrians in Turkey, setting the limit of uptake into Europe to such a low number is clearly inadequate.

So-called illegal (economic) migrants are being sent back, under the assumption that we do not have any special obligations towards migrants as we do towards refugees. However, today concepts like refugee, migrants, economic migrants, irregular/undocumented workers, exiled or asylum seekers, and the differentiation between forced migration and economic migration, have lost their relevance. For instance, those who are stateless; those who have lost their houses and jobs and do not have a future in their homelands; those who are marginalized under the economic, political and cultural pressures enforced by neoliberal policies and have to leave their homes are not considered refugees by the UN.

Turkey has nearly 4 million refugees, of which 3.5 million are Syrians (official numbers are less than this as the official figures include only registered people). Only 10 per cent of the Syrian refugees live in 25 refugee camps close to the border with Syria, while the rest are scattered in other parts of Turkey (Figure B6.1). They struggle to live by begging,

**SYRIANS UNDER TEMPORARY PROTECTION STAYING IN AND OUTSIDE OF ACCOMMODATION CENTERS**

**Figure B6.1**

Source: Directorate General for Migration Management (2017).

Note: Numbers as at 13 April 2017; these are the official numbers and are generally less than the actual numbers as they include only registered people.

through temporary jobs of a precarious nature and employment in the informal sector, or by getting social aid, which for ‘non-camp residents’ is very limited.

### *Conditions of living*

Turkey refuses to grant legal refugee status to refugees from outside Europe, thereby depriving them of the rights and benefits they are entitled to. Syrians living in Turkey are considered to be ‘guests’ with temporary protection status. Of the Syrian refugee population, 75 per cent are women and children (87 per cent of refugee women have no employment); 55 per cent are less than 18 years of age; 42 per cent are between 18 and 59; 3 per cent are over 60 (Directorate General for Migration Management 2017). There are nearly 1 million school-aged children, but only 14 per cent of primary school-aged children outside the refugee camps are enrolled in school in Turkey. Moreover, 150,000 Syrians have given birth in Turkey and their children have no citizenship – either Syrian or Turkish.

Without a work permit Syrian migrant workers in Turkey (uninsured and undocumented) survive by doing dangerous and heavy physical work. They earn far below the minimum wage, and have no recourse to justice in the case of wage disputes or accidents at work.

As on July 2016, only 5,500 Syrian refugees have been granted an official work permit. This means that a million people are either jobless or work illegally. This has led to the rise of a new ethnic underclass in

Turkey. Since parents have difficulty in finding jobs and are underpaid, children tend to work to support the household. Among Syrian refugees child labour is a prominent problem, while a 'lost generation' takes shape.

#### *Access to health*

The health conditions of Syrian refugees in Turkey are adversely affected due to lack of adequate housing and food. There are also problems in accessing health services, as most Syrian refugees have temporary identity documents (IDs) that cover only emergency medical problems. Preventive healthcare, especially for children and women, is not available for most people. Except for a few public health centres, routine follow-up for infants and pregnant women is not offered. Thousands of children have not been vaccinated or have received incomplete vaccination.

Since most refugees are forced to keep changing locations to find a job, they cannot register with a family physician and access primary healthcare. They also find it very difficult to reach secondary and tertiary care facilities due to lack of documentation, the complex organization of the Turkish healthcare system, lack of information about the health system, and language barriers.

#### *A need for a change*

As a middle-income country Turkey cannot cope with 4 million refugees. European countries and others, especially those that are militarily active in the region, should take responsibility for the refugees. The ploy of keeping refugees away from Europe by providing political benefits and financial aid to countries such as Turkey should be ended. Legal and safe passage should be ensured to those who want to go to Europe. Anti-immigrant border policies that cause deaths and human rights exploitation should be stopped.

(Substantial material for this box has been sourced from The 'Association of Bridging Peoples'. See: <http://www.halklarinkoprusu.org/en/>)

### **Migrants' health in times of crisis**

The vulnerability of migrants has been aggravated by the economic crisis affecting Europe since 2008. Higher unemployment rates and precarious conditions of employment have pushed many migrants even further to the margins of the system. Poor living conditions are worsening migrants' health, counteracting the initial 'healthy immigrant effect' -- the better health status of newly arrived migrants, as compared to that of the national population due to the fact that sick persons are less likely to migrate/flee (Ingleby 2009,



**Image B6.2** Volunteer physicians examine children at a refugee camp (Cem Terzi)

p. 11). Xenophobia has also been on the rise: recession and absence of opportunities have made national populations more prone to hate discourses that use migrants as a scapegoat for the country's problems (Médecins du Monde, 2013, pp. 28–29).

In such contexts, the states' responsibility to protect and promote the right to health for all is of paramount importance. However, as austerity has become the new dogma in response to the economic crisis, constraints on public budgets have translated into reduced investments in healthcare. For example, the obligation contained in the Stability and Growth Pact (SGP)<sup>2</sup> to reduce public deficit has been used by the Spanish government to defend its policy of social sector cutbacks, particularly in the field of healthcare.<sup>3</sup> Highly indebted countries, such as Greece, Ireland, Portugal, etc. have received EU loans conditional to strict structural adjustment policies. In certain cases, as in Portugal, such requirements include concrete demands to reform the healthcare system (Eurofound, 2014, p. 7).

Regressive social measures, when unavoidable, should always refrain from targeting the most disadvantaged sectors of the population. Unfortunately, this has not been the case in several European countries with regards to migrants' access to healthcare. While some countries, such as Luxembourg, have been traditionally closed to undocumented migrants (undocumented migrants are not entitled to free healthcare), in recent years we have seen an increase in the number of countries following this approach (Médecins du Monde, 2016b, pp. 85–86).

Spain (Médecins du Monde, 2014, pp. 31–32) and the UK (Médecins du Monde, 2015, pp. 8–9), once home to the most inclusive national healthcare systems in Europe, have now adopted national legislations excluding

### Box B6.2 Migrants' access to healthcare in Spain

A major turning point for the Spanish healthcare system was 20 April 2012. Until that date, the National healthcare system (NHS) in Spain was seen as a model in Europe due its inclusive nature which granted access to the care to all citizens and residents, whether authorized or not. While this system was far from perfect, since administrative barriers prevented some migrants from receiving assistance, it did provide some level of secure access to care for migrants. In 2012 the government imposed, without any parliamentary or popular debate, the Royal Decree Law (RDL) 16/2012. The RDL altered the principle of universality by linking the right to access to contribution to the social security system. The requirement of residence (to access care) was replaced by an insurance/benefit scheme which removed around 900,000 undocumented migrants from the system. With the enforcement of the RDL, assistance for undocumented migrants was available only for emergencies; pregnancy, childbirth and post-partum; minors; applicants for international protection; and victims of human trafficking (REDER, 2015, pp. 11–15).

Due to the high level of decentralization of the Spanish NHS, and in the absence of adequate and sufficient information, the RDL was applied in an arbitrary manner by hospitals and healthcare centres. As a consequence, denial of assistance even in cases allowed by the RDL (pregnant women and minors, for example) and the invoicing of emergency services that should have been free of charge became common. (REDER, 2015, pp. 18–20).

This outrageous exclusion from healthcare was contested by civil society. Médecins du Monde, Amnesty International, the Spanish Society of Family and Community Medicine, social movements such as Yo Sí Sanidad Universal and other platforms for the defence of public health, as well as healthcare professionals (who refused to implement the RDL and continued assisting all patients) denounced the grave breach of human rights that was being perpetrated, and demanded that the RDL be repealed. This mobilization in turn triggered the creation of a national network – REDER (Network for Denouncing and Resisting the Royal Decree-Law 16/2012) – of more than 300 social organizations and professional associations, which has been actively advocating for the adoption of a new legislation to ensure a universal system for every person living in Spain, regardless of her/his administrative status.

As a result of the mobilization, some regional governments did not implement the RDL while most political parties signed a declaration committing to repeal the RDL should they be in government (Medicos Del Mundo, 2015). Following the regional elections of May 2015, several new

regional governments adopted measures to provide some sort of access to healthcare to undocumented migrants (REDER, 2016). Nonetheless, as regional governments lack the competence to undo national legislation, these measures are inadequate. Meanwhile the source of the problem remains: a structural reform of the system where the human right to health has been stripped of its very nature to make its enjoyment dependent on economic criteria rather than ethics (REDER, 2017).

undocumented migrants from healthcare (Box B6.2). Both governments have argued in favour of this policy, alleging that their respective healthcare systems are on the verge of collapse as a result of migrants' 'abuse' of social services. In Spain, this justification uses the term 'healthcare tourism' in a misleading way, by intentionally mixing two very different phenomena. On one hand, wealthy Europeans travel to Spain to receive medical treatment; and, on the other, undocumented workers from non-EU countries using healthcare resources to a significantly lower degree than the native population. The UK has passed the Immigration Act 2014, according to which even children of undocumented migrants and pregnant women are to be charged for healthcare and maternity care, in what constitutes a clear breach of minimum obligations under human rights law (Justfair, 2015, pp. 118–19). There is no evidence that these policies result in any significant financial savings for public budgets. Clearly undocumented migrants are being blamed to divert attention of the public from unpopular social sector cutbacks.

While regulations openly discriminating against migrants are easy to identify, less obvious provisions often produce similar effects. In the Netherlands, for example, the government has elevated drastically the minimum amount a patient has to pay for healthcare in order to be entitled to a reimbursement (Médecins du Monde, 2015, p. 8). This decision disproportionately affects the poorest sectors of the population, including most migrants.

Fortunately, not all countries affected by the economic crisis have resorted to restricting migrants' right to health. Italy (Médecins du Monde, 2016b, pp. 170–73) and Portugal (Eurofound, 2014, p. 23) have maintained, at least on paper, an inclusive healthcare system that allows access to undocumented migrants (Box B6.3). France has been promoting access to health services by increasing the income ceiling for the *Aide Complémentaire de Santé*, which supports healthcare for the poor, and for the *Aide Médicale d'Etat*, which supports undocumented migrants (Médecins du Monde, 2016b, pp. 38–44). Even Greece, undergoing the consequence of both the economic crisis and the high inflow of refugees, has introduced a reform to open its public healthcare system to the most disadvantaged groups, although this does not cover all undocumented migrants (ibid., pp. 64–66). However, even in countries



### **Box B6.3: Migrants' access to healthcare in Italy**

Health policy for migrants in Italy has, from its very origin, been shaped by an engaged civil society. This has given the country one of the most progressive and inclusive legislations on access to healthcare for foreigners, compared to other European countries (Marceca, 2017). Article 32 of the Italian Constitutional Charter, 1848, grants the right to health to all 'individuals', de-linking it from citizenship. However, in spite of this, migrants face difficulties in accessing care.

Civil society has played a role in drafting the two health articles in the 1998 Immigration Law, which are still in force today and grant full rights to immigrants who can enrol in the NHS. This includes immigrants and their families who have a work permit as well as asylum seekers and refugees. Undocumented migrants can access emergency care for free, but are also entitled to second- and third-level care for health needs that are 'urgent or essential'. This includes all interventions that, if not done or postponed, may cause harm to their health. Migrants from other countries of the EU, who hold the European Health Insurance Card, have access to some level of care, while those who regularly work in Italy can enrol in the NHS. However, those who have lost their job, or their legal residency, have to cover the full cost of care through the NHS.

The interpretation of the immigration law has been highly uneven in the country, creating situations of unjustifiable inequalities between regions and between urban and rural areas. An interregional effort has attempted to promote a harmonized document, aimed at offering binding guidelines for shaping health policies at the local level. Despite being signed by all the regional governors in December 2012, the interregional agreement is not being implemented in large measure.

While the right to access exists on paper, enforcement is weak. Since in the Italian NHS, family doctors are the entry point in the system, and undocumented migrants do not have access to family doctors, alternate primary healthcare facilities need to be in place. Often voluntary doctors' organizations and NGOs fill this gap between health needs and health services. Another requirement involves ensuring that access is economically sustainable. Despite the national law providing for user-fee exemption for the most deprived, in many regions this is not applied to migrants who are not registered with the NHS. Finally, there are other requirements: training health professionals in 'soft technologies', such as relational, intercultural and linguistic skills, and the overall organization of the health service, which is too often informed by rationality and efficiency and not centred around effectively responding to health needs, particularly of the most disadvantaged.

Given this situation, there are inequalities in access to healthcare and in health outcomes between native and migrant populations (Barsanti and Nuti, 2013; Tognetti, 2015). Several studies have shown that migrants underuse primary care and hospital services and overuse emergency services. This has much to do with immigrants' awareness of their rights and the means of exercising them; health workers' knowledge of these rights and procedure related to them; and resources within the health system for granting these rights. Studies have also shown that immigrants' access to services is conditioned by various factors: organizational, cognitive and bureaucratic. Clearly it is not enough to offer health services and make them claimable, one needs to promote and actively inform people (and workers) if such resources are to become truly accessible.

where the law allows access to healthcare for undocumented migrants, actual implementation is flawed and migrants continue to face exclusion from the healthcare system.

### **Barriers and challenges for migrants seeking healthcare**

Regardless of the differences in national legislations, migrants face some common barriers and challenges, preventing them from accessing the healthcare system.



**Image B6.3** Children at a Syrian refugee camp in Turkey (Cem Terzi)

*Lack of information and fear of being reported* Absence of adequate information regarding the functioning of the healthcare system and available entitlements constitutes the first obstacle. Confronted with a different reality than the one in their country of origin and often lacking a social network in the country of destination to ease them into the system, migrants usually ignore the most basic processes in seeking healthcare (Médecins du Monde, 2014, p. 27; 2015, p. 34; 2016a, p. 27).

Moreover, legal ambiguities and insufficient state action to ensure that health workers know and apply correctly the law leads to arbitrary interpretations, resulting in denial of access (International Organization for Migration, 2016, p. 18; Médecins du Monde, 2014, p. 28; 2015, p. 35; 2016a, p. 30). This has the effect of reinforcing migrants' perception of lack of right of access, and as a consequence they desist from demanding assistance even if needed (Médecins du Monde, 2016a, p. 29).

Undocumented migrants may also refrain from seeking health services out of fear of being reported to the police (Médecins du Monde, 2015, p. 36; 2016a, p. 30). This fear is justified as legislation in a majority of European countries explicitly requires health workers to notify the authorities whenever they assist an irregular immigrant. (International Organization for Migration, 2016, p. 19).

*Administrative barriers* Lack of information is made worse by complex administrative processes, tedious and difficult to understand. Moreover, the fact that identity documents are usually required is often an impediment in accessing care (Médecins du Monde, 2014, p. 27; 2015, p. 34; 2016a, p. 27). The issue is particularly complicated for undocumented migrants, especially in countries (for example, Belgium, France and Spain) where they are eligible for certain entitlements. Proof, in the form of an identity card, cannot always be presented by people who have recently migrated from distant places and might have lost all or most of their material possessions in the course of an extremely traumatizing process. Another obstacle is posed by the necessity to provide a proof of residence, as undocumented migrants often lack a rent contract or are simply homeless (Médecins du Monde, 2016b, pp. 17, 41–43).

*Financial barriers* Most European countries have some sort of a co-payment scheme where the cost of medical attention is partly borne by the patients. As is obvious, paying for social services has a greater impact on the most disadvantaged and impoverished sectors of the population, including most migrants. While some countries such as France and Belgium have exceptions for the poorest, not everyone can qualify to benefit from these mechanisms (Médecins du Monde, 2016b, pp. 14–18, 37–43). Undocumented migrants are the worst affected when co-payments become necessary. This is particularly so in Germany (Box B6.4) where, in order to get refunded for non-emergency

#### **Box B6.4: Migrants' access to healthcare in Germany**

In Germany, healthcare is organized through an insurance-based health-care system. As in most European countries, access to healthcare for immigrants depends on their legal status. International migrants with work or study permits are usually insured and can access healthcare free of cost like most Germans.

However, migrants from some countries of the EU face major barriers to healthcare as health insurance in these countries is often insufficient or invalid despite the theoretical existence of a European Health Insurance Card. Migrants from the southern and eastern European countries make up a major proportion of migrants seeking help from the many support organizations that assist in accessing healthcare in Germany (Medibuero, 2016).

Asylum seekers are entitled to access healthcare for acute or painful medical conditions and everything that is indispensable to maintaining health, leaving the comprehensiveness of care to the interpretation of the local government or doctor (Fluechtlingsrat Berlin e. V, 2016; Medizinische Flüchtlingshilfe Göttingen e. V, 2016). In practice, access to healthcare varies substantially in scope and quality between German federal states, ranging from electronic health insurance cards for asylum seekers with nearly equal access to care as for Germans to paper-based referral cards that are hard to get and entitle one to care only for acute or painful diseases (ibid.). Changes in asylum legislation in 2014 and 2015 have failed to address the lack of clarity in defining access to care for asylum seekers and missed the opportunity to establish a uniform regulation for comprehensive access to care (Medizinische Flüchtlingshilfe Göttingen e. V, 2016). The restrictive interpretation of laws by healthcare personnel has resulted in asylum seekers being denied care because of the refusal to provide or accept paper-based referral cards. Many asylum seekers have suffered severe medical consequences, including death (Fluechtlingsrat Berlin e. V, 2016). As healthcare services remain insufficient, many people have volunteered to support asylum seekers in their struggle to access healthcare. While voluntary help is necessary to address the immediate need of asylum seekers, it remains impossible to guarantee rights, including access to healthcare, on the basis of volunteer work. (Medibuero, 2016).

Undocumented migrants are entitled to emergency care; however, accessing such care may result in deportation as state institutions are, with some exceptions, obliged to report undocumented migrants to migration authorities. These exceptions are however largely unknown to healthcare institutions, and undocumented migrants continue to risk deportation when they officially access healthcare in case of emergency. Although many NGOs, anti-racist initiatives and individuals are volunteering to improve healthcare and organize medical appointments within the networks of volunteer doctors and hospitals, healthcare remains inadequate.

care costs, migrants need to apply to the social welfare office, which is obliged to report the matter to the authorities (ibid., p. 56).

*Language barriers* Communication is a basic requirement while seeking healthcare. Yet, as Médecins du Monde (2016a, p. 27) has shown, a significant number of migrants all across Europe require translation services, which are not always available.

*Xenophobia and discrimination* Racism in healthcare services is a barrier that migrants have to face, intermittently or all the time, across Europe (Médecins du Monde, 2014, p. 28; 2015, p. 36; 2016a, p. 30). While at the moment, the number of cases remains relatively low, there is serious concern that they may escalate in the near future as xenophobic extreme right-wing parties are gaining more support within several EU countries.

### Conclusion

In 2017, the EU celebrates 60 years since its establishment by the Treaties of Rome. We should not forget, however, that the EU is primarily ‘a common market’, and that economic, not social, priorities have been guiding the shaping of the EU from its inception until today. Also, in 60 years the EU has not been able to inform, design and implement progressive health and social policies, or to protect the most vulnerable sectors of society and promote their rights.



**Image B6.4** Living conditions at a refugee camp (Cem Terzi)

In 1907, the pathologist and founder of social medicine Rudolf Virchow wrote “How sad it is that thousands have to die in misery, so a few hundred may live well”. Over a century later, the situation seems similar, with inequalities still on the rise as reflected also in health indicators. If what should be ‘our’ institutions are not acting in the interests of people and in the direction of equality, we should join forces and advocate more to radically change them, challenging with the power of the many the interests of a few.

## Notes

<sup>1</sup> While this is the theory, we shall later discuss how this legal framework has been bent in the context of the economic crisis, enabling the troika (the EU Commission, the European Central Bank and the International Monetary Fund) to impose health budget constraints on certain EU member states.

<sup>2</sup> The SGP is the mechanism established by the EU to control member states’ budget deficits and limit public debt. According to the SGP, budget deficit cannot exceed 3 per cent GDP while public debt should be maintained under 60 per cent GDP. States which incur deficits in a breach of these terms could be subjected to sanctions. See European Commission (n.d.).

<sup>3</sup> The Stability And Growth Pact is an agreement involving the countries of the European Union (EU) and use the Euro as currency. The SGP, enacted in 1997, was created to establish rules to ensure that all involved countries help maintain the value of the euro by enforcing fiscal responsibility.

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