The European Journal of Public Health Advance Access published October 17, 2005

European Journal of Public Health

doi:10.1093/eurpub/cki191

Access to health care for asylum seekers in the European Union—a comparative study of country policies

Marie Norredam, Anna Mygind, Allan Krasnik

Background: The aim of our article is to characterise and compare current standards of health care provision for asylum seekers in the 25 European Union (EU) countries in order to identify the needs and potential for improving access to health care for asylum seekers. **Methods**: The study is based on an e-mail survey performed between April and June 2004. The questionnaire was concerned with asylum seekers' access to medical screening upon arrival, and their general access to health care services on April 1, 2004. The questionnaire was sent to ministries and NGOs responsible for asylum seekers' health care in the 25 EU countries. A total of 60% of the ministries and 20% of the NGOs responded. We received answers from 24 out of the 25 countries. **Results:** Medical screening was provided to asylum seekers upon arrival in all EU countries but Greece. The content of screening programs, however, varied as well as whether they were voluntary or not. We found legal restrictions in access to health care in 10 countries. Asylum seekers were only entitled to emergency care in these countries. A number of practical barriers were also identified. Legal access to health care changed during the asylum procedure in some countries. Access to specialised treatment for traumatised asylum seekers existed in most countries. **Conclusion:** Health policies towards asylum seekers differ significantly between the EU countries and may result in the fact that the health needs of asylum seekers are not always adequately met.

Keywords: access, asylum seekers, Europe, medical screening, refugee health

Introduction

By the end of 2004 the United Nations High Commission for Refugees (UNHCR) had 9.7 million refugees under their mandate, most of whom stayed in Asia or Africa, near their home countries.[1] Some refugees, however, manage to travel legally or illegally to the European Union (EU) countries to seek asylum there. The right to seek asylum is embodied in the Universal Declaration of Human Rights, which states 'everyone has the right to seek and to enjoy in other countries asylum from persecution'.[2] An asylum seeker can obtain asylum if he/she meets the United Nations (UN) Refugee Convention's definition of a refugee, as someone who has a 'well founded fear of persecution on the grounds of race, religion, nationality, membership of a particular social group, or political opinion'.[3]

Figure 1 shows the number of asylum applications from 2000 to 2004, distributed on 'old' and 'new' EU countries and a total. The EU countries received a total of 282 480 new asylum applications in 2004. This represents a 19% drop in applications to EU countries compared with 2003. The trend is entirely due to a drop in asylum seekers in the 15 'old' countries, whereas the 'new' countries have experienced a slight increase.[4] Asylum trends are determined by a host of suddenly changing factors, both in the region of origin and of destination. Therefore, the drop in applications to 'old' EU member states may partly be due to a total fall in the world's refugee population in 2004 and partly to more restrictive asylum polices in all the EU countries.[1] The majority of new asylum seekers in the EU in 2004 came from Russia (the majority of whom are Chechens), Serbia and Montenegro and Turkey. Meanwhile, the number of claimants from Afghanistan and Iraq dropped by more than 80%. France was the main destination country for asylum seekers in the world in 2004. Compared with the national population size, however, Cyprus received the largest number of asylum seekers during 2000–2004, followed by Austria and Sweden.[4] In addition to new applicants, hundreds of thousands of asylum seekers in the EU are waiting for a decision in their asylum case. At the end of 2003, the highest number of undecided cases among the EU countries was found in Germany (154 000), the Netherlands (45 000), and Sweden (35 000).[4] Consequently, the total number of new applicants and undecided cases in the EU countries involves a significant number of people.

Knowledge about asylum seekers' health and access to health care services is still limited. We searched the PubMed database on March 21, 2005, using the keyword 'asylum seekers', and found only 310 references since 1986. Asylum seekers, however, constitute a vulnerable population due to a host of pre- and post-migration risk factors. Pre-migration factors include torture and refugee trauma, which may result in mental and physical illness.[5,6] Moreover, asylum seekers often come from conflict areas, without access to adequate health services. Post-migration factors also play a role for health. They include: detention, length of asylum procedure, language barriers, and lack of knowledge about the new health care system.[7–9] So far, literature on asylum seekers' health particularly concerns mental health problems and infectious diseases. Burnett & Peel[10] reviewed the literature and found that one in six asylum seekers had severe physical problems and two-thirds had experienced mental problems. Prevalent physical problems included tuberculosis, HIV/AIDS, hepatitis A and B, parasitic diseases, and non-specific body pains. Mental health problems include depression and Post Traumatic Stress Disorder, which are due to traumatic experiences, including torture.[11,12] In conclusion, asylum seekers are at the risk of having many and severe health problems of a varied nature.

Literature on asylum seekers' use of health care services and the barriers they face when seeking care is even scarcer. Asylum seekers, however, find themselves in a difficult situation as they

Department of Health Services Research, Institute of Public Health, University of Copenhagen, Denmark

Correspondence: Allan Krasnik, Department of Health Services Research, Institute of Public Health, University of Copenhagen, Øster Farimagsgade 5, 1014 Copenhagen K, Denmark.
e-mail: Krasnik@pubhealth.ku.dk

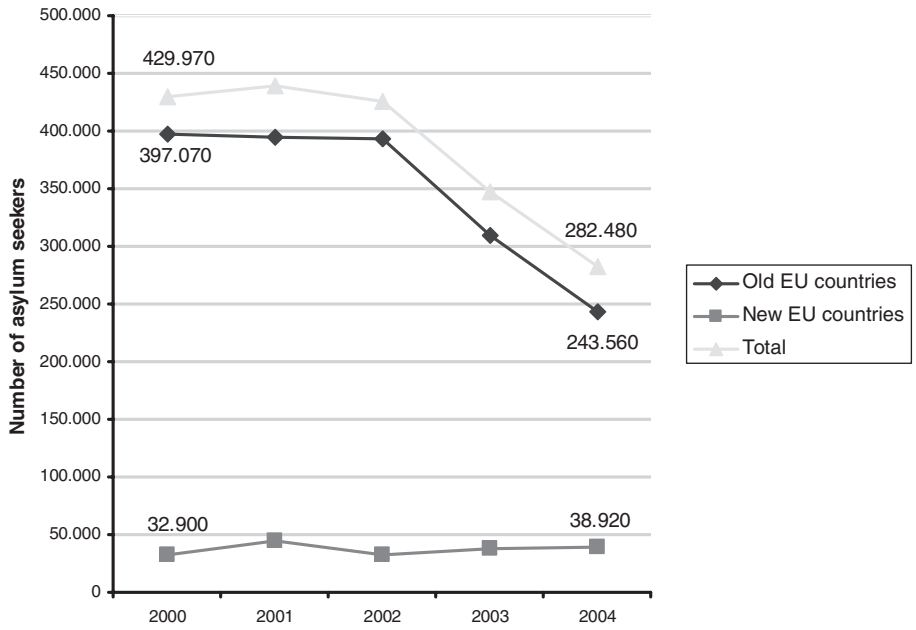

Figure 1 The number of asylum applications submitted in 'old' and 'new' EU countries, 2000–2004. Source: UNHCR. Asylum levels and trends in industrialised countries. Geneva: UNHCR, 2004 (Available at: www.unhcr.ch)

are residing in a country—sometimes for years while waiting for a decision in their case—without necessarily having the same legal rights as citizens. In the meantime, they may face limitations on access to health care compared with the citizens. One might therefore fear that asylum seekers' already vulnerable health situation combined with possible restrictions on access to care may severely worsen their health. Consequently, we found it important to characterise and compare current standards of access to health care for asylum seekers in the 25 EU countries in order to identify the needs and potential for improving health care services in relation to asylum seekers. Our aim was to answer the following questions: (i) To what extent do medical screening programmes for newly arrived asylum seekers exist and how comprehensive are they? (ii) To what extent do asylum seekers have access to national health services upon arrival compared with the citizens?

Methods

The study is based on a questionnaire, which was sent to relevant ministries and NGOs in the 25 EU countries. We identified the ministry responsible for asylum seekers' health care for each country. Depending on the country, the ministry was related to interior affairs, health, social affairs, immigration, or foreign affairs. The ministries were contacted by phone to obtain e-mail addresses of relevant contact persons if possible. To ensure that relevant NGOs were contacted we used a list of NGOs under the network of the European Council for Refugees in Exile (ECRE). ECRE is an umbrella organization of refugee-assisting agencies in Europe working towards fair and humane policies for the treatment of asylum seekers and refugees.[13] ECRE's list only provided personal mail addresses for 65 NGOs. In total 25 ministries and 104 NGOs received the questionnaire by e-mail. Respondents answered by e-mail or regular post. The questionnaire was sent on April 19, 2004, allowing a response time of 4 weeks. A reminder was sent out on June 3, 2004. Likewise, allowing a response time of 4 weeks. We received 36 responses, divided on 15 ministry and 21 NGO responses. Eight e-mails were returned because of errors in the address or by people who did not possess the adequate knowledge to answer the questionnaire. This amounted to a response rate of 30% (36/121) distributed as follows: ministries 60% (15/25) and NGOs 20% (21/104). In total, we received either an answer from a ministry and/or one or more NGOs for 24 out of the 25 countries. Portugal is the only country from which we did not get any responses.

The questionnaire referred to how conditions were on April 1, 2004. It was divided into two parts. The first part was concerned with the access to medical screening programmes for asylum seekers and the second part was concerned with access to general health care for asylum seekers. In case of conflicting answers from two or more respondents from the same country, we decided to exclude those responses from our analysis (as shown in the tables).

Results

Medical screening

Medical screening of newly arrived asylum seekers existed in all the responding EU countries but Greece. But, differences were found in the way medical screening was carried out. In some countries, like the Nordic, medical screening was systematically offered to all new asylum seekers, whereas in other countries, such as Austria, France, Spain, and Britain, it was only carried out in the so-called induction or reception centres. Newly arrived asylum seekers who do not enter these centres access medical screening randomly. In Greece, medical screening was only offered to asylum seekers, who applied for a work permit. According to the respondents, regional variations in the provision of medical screening also existed within countries. This was the case of Italy and Germany. For Italy it was not explained in detail, but for Germany it was related to the federal states, which individually decided if they wished to provide screening or not.

Table 1 shows our results regarding access to specific medical screening programmes, including HIV and tuberculosis (TB) screening as well as physical and mental examinations and other screenings. Table 1, moreover, shows whether these screening programmes were carried out on a compulsory or voluntary basis. Greece was excluded from the table because no screening programmes existed for asylum seekers upon

Table 1 Access to specific medical screening programmes in the 25 EU countries—on compulsory and voluntary basis. ($n = 23$ in the table as Greece was excluded)

	Screening				No screening	
	Compulsory	Voluntary	Total	%	Total	%
HIV	5	14	19 (23)	83	4 (23)	17
TB	12	10	22 (23)	96	1 (23)	4
Physical[a]	6	11	17 (22)	77	5 (22)	23
Mental[b]	3	8	11 (18)	61	8 (18)	39
Others[c]	4	8	12 (19)	63	7 (19)	37

a: Germany excluded due to ambiguous responses regarding physical health screening
b: Denmark, Estonia, Germany, Hungary, and Luxembourg excluded due to ambiguous responses or no responses regarding mental health screening
c: Estonia, Germany, Hungary, and Slovenia excluded due to ambiguous responses or no responses regarding 'other' screenings

arrival. Table 1 is therefore based on 23 countries. Countries with ambiguous or no responses were excluded, which explains the different number of total countries in the table. HIV screening was carried out in a total of 19/23 (83%) countries. HIV screening was compulsory in 5/19 (26%) countries, and voluntary in 14/19 (74%) countries. It is important to add, however, that in Germany HIV screening was only compulsory in certain states, and in the Czech Republic it was only compulsory for pregnant women and in Spain only in reception centres. As for TB screening, this was carried out in 22/23 (96%) countries. TB screening was carried out on a compulsory basis in 12/22 (55%) countries. Again, in countries such as Austria, Britain, and Spain, TB screening was only compulsory for asylum seekers accommodated in induction or reception centres. In the Netherlands, TB screening was carried out on arrival and again after 6, 12, 18, and 24 months. Only the first of these five screenings was compulsory.

In 17/22 (77%) countries physical examination was part of the screening programme. Mental health was the least frequent screening component, and was only carried out in 11/18 (61%) countries. Screening programmes other than the above mentioned were carried out in 12/19 (63%) countries. According to the respondents, 'other' screening programmes include children's vaccination programmes, stool test for bacteria and parasites, hepatitis B, syphilis, and malaria. In all countries screening was financed by the government. Screening was carried out by the authorities in all countries, but Denmark where Danish Red Cross carried out all screening of asylum seekers.

Access to health care

The second part of the survey was concerned with legal restrictions in access to health care for asylum seekers at the time of their arrival compared with the citizens in the host country. The results are shown in Table 2. The table is based on all 24 responding countries. Again, countries with ambiguous or inadequate responses were excluded, which explains the different number of totals in the table. Access might differ for children and pregnant women compared with adults, because they are considered more vulnerable and thus have more rights. We, therefore, asked the respondents about access for all the three groups. In total there were legal restrictions in access to health care for pregnant asylum seekers compared with citizens in 5/21 (24%) countries. Legal restrictions for children and adults were found in, respectively, 7/23 (30%) and 10/23 (43%) countries. In total, we found legal restrictions in access to health care for one or more of the three groups in 10/23 (43%) countries. These countries were Austria, Denmark, Estonia, Finland, Germany, Hungary, Luxembourg, Malta, Spain, and Sweden. In all countries, except

Table 2 Legal restrictions in access to health care for asylum seekers at the time of their arrival compared with citizens in the host country

	Number of countries				
	Restrictions		No restrictions		Total *N*
	N	%	*N*	%	
Pregnant[a]	5	24	16	76	21
Children[b]	7	33	16	67	23
Adults[c]	10	43	13	57	23
Total[d]	10	43	13	57	23

a: Denmark, Germany, and Slovakia excluded due ambiguous responses regarding access to health care for pregnant women
b: Slovakia excluded due to ambiguous response regarding access to health care for children
c: Slovakia excluded due to ambiguous response regarding access to health care for adults
d: The total shows number of legal restrictions in access to health care for one or more of the three groups. Slovakia excluded due to ambiguous responses for all three groups

Austria, legal restrictions were due to the fact that asylum seekers were only entitled to emergency care. In Austria the legal restriction laid in the fact that asylum seekers were entitled to emergency care only, if they left the reception centre before they were assigned residence in a federal state. Later, if they travelled or moved to other federal states, they could also only receive emergency care.

The absence of legal restrictions to access does not necessarily imply equity in access as practical barriers may hinder this. We identified a number of practical restrictions in access to care. According to our responses, practical restrictions could overall be divided into (i) lack of awareness of available health care services, (ii) language barriers, (iii) cultural barriers, and (iv) structural barriers. Lack of awareness of availability of services was due to insufficient or no information to asylum seekers about the health care system in the host country. Language barriers were especially related to inadequate provision and education of interpreters. Cultural barriers were related to different ways of viewing illness and the role of health care providers versus patients. Two structural barriers were mentioned more than once. Firstly, services dealing with the specific needs of asylum seekers were considered inadequate. This especially was concerned with the access to treatment for traumatised

asylum seekers. Secondly, in Austria and Greece, asylum seekers needed respectively a medical card and an identity card before they had access to health care services. In both countries, however, it could take several months before they received the card, due to bureaucratic delays.

Respondents were also asked whether the legal access to health care for asylum seekers changed over time. This was only the case for Germany, Luxembourg, Spain, and Malta. In Germany asylum seekers got full access to care in the same way as the citizens after 36 months of arrival. In Luxembourg asylum seekers got access to care in the same way as the citizens after 3 months and in Spain as soon as they registered at the Town council, where they lived and applied for a social security card. Malta did not describe the nature of the change in status.

Respondents were further asked whether access to specialised treatment for traumatised asylum seekers existed in their country. In Cyprus, Latvia, and Luxembourg, specialised treatment for traumatised asylum seekers did not exist at all. In the remaining 21 countries some kind of access to specialised treatment for traumatised asylum seekers existed.

Discussion

Our results should be interpreted with caution as they are based on simple comparisons of different, complex health systems. Asylum law, moreover, is multifaceted and continually changing within the EU countries. Consequently, the study only serves to provide a rough picture.

To get a nuanced and more valid representation, we approached both ministries and NGOs as they might have expressed different opinions. But, we found a high degree of agreement between the ministry and NGO responses. Therefore, we instead decided to exclude the few exceptions from our analysis. We received answers from 15 ministries and 21 NGOs, representing 24 out of 25 countries. Our total response rate was 30%, distributed as follows: ministries 60% (15/25) and NGOs 20% (21/104). The low response rate was probably due to several factors. Firstly, the questionnaire may have been sent to a person in a ministry or NGO, who could not answer it, but did not pass it on. We tried to avoid this by identifying relevant persons and organizations on before hand. We had, however, more difficulties identifying key persons in NGOs compared with ministries. This also relates to the validity of the study. One must expect that even for the respondents, who indeed answered the questionnaire, knowledge on the specific topics have most probably been varying, some have had deep knowledge and others more peripheral. This may have resulted in the fact that answers were conflicting for some countries. In that case, we excluded the country from the analysis in question. We finally tried to ascertain the validity of our answers by sending our preliminary results to all the respondents. As a result minor corrections were made in the case of four countries.

Firstly, our findings showed that medical screening was provided upon arrival to asylum seekers in all the 24 included EU countries but Greece. In some countries it was systematically offered to all new asylum seekers, whereas in others it was only provided to asylum seekers living in reception centres. Medical screening may be available for asylum seekers living outside the centres, but using it depends on individual initiative and there might be a number of barriers. Consequently, it is far from all asylum seekers who are medically screened upon arrival in the EU, although the majority of countries offered some kind of medical screening. The extent of medical screening also varied within countries. In Italy and Germany, various regions and federal states had autonomous policies regarding medical screening of asylum seekers.

Secondly, we found that medical screening programmes differed in their content from one EU country to another. For example, TB screening was included in the screening programmes of all countries but one, whereas screening for mental health problems was carried out in less than half the countries. Overall, medical screening programmes appear to have two aims. One is to secure the well being of asylum seekers, and the other to guarantee the safety of the population in the host country. The content of the screening programmes is likely to depend on how the country priorities these aims. For example, screening for infectious diseases seems more related to the safety of the host population and mental health screening more to the well being of asylum seekers.

Regarding access to health care, we firstly found that access was restricted to only emergency care at the time of arrival in 10 countries. The results, however, do not show, if some countries offered alternative measures in case of chronic illness. We know this was the case in Denmark, where immediately necessary or life saving treatment of chronic illnesses may be covered by the Danish Immigration Service.

Restricting access to emergency care is, however, not unproblematic. It may lead to an accumulation of health problems, which—apart form the human costs—may prove expensive for societies if inpatient treatment is required at a later date. Moreover, excluding patients with communicable diseases such as HIV from treatment is against the public health policy of most countries. In Britain an alternative way of restricting access for some asylum seekers was recently introduced by charging services. Charging, however, seems unethical and unrealistic as asylum seekers in many EU countries are prohibited from working. Paradoxically, the health care systems of several of the most restrictive EU countries are built on policies based on equity in access. An important aspect of equity in access is, however, to ensure the medical rights of vulnerable and marginalised groups in our societies.

Secondly, we found that asylum seekers faced a number of practical barriers when seeking health care. Most of the barriers were concerned with immigrant populations in general, and are related to language, culture, and lack of information about the health care system in the host country. But, practical barriers specific for asylum seekers were also identified. The most severe of which include waiting for months or years on paperwork that will ensure access to health care, while only having access to emergency care in the meantime. Additionally, the literature shows that asylum seekers' access to health care may be compounded by other barriers, such as confinement in detention centres,[9] and dispersal policies leading to disruptive and compromised care.[14] Unfortunately, problems due to legal and practical barriers to access are compounded when the process of acquiring refugee status takes many months, or, in some cases, years.

Thirdly, we found that legal access to health care services changed over time for asylum seekers in three countries. We specifically referred to changes during the asylum seeking procedure itself. But, several respondents spontaneously added that asylum seekers' rights to health care were immediately restricted to emergency care if their application was refused. Failed asylum seekers may likewise be stripped of the other rights in an attempt to force them out of the host country. Ironically, failed asylum seekers include persons who cannot return because their countries are deemed unsafe by UNHCR. Britian is one of the countries using increasingly restrictive measures towards failed asylum seekers. Failed asylum seekers used to have free access to NHS, but since 2004 they cannot obtain free secondary health care, and primary health care may also soon be withdrawn.[15]

Finally, we showed that access to specialised treatment for tortured and traumatised asylum seekers exists in all countries but Latvia, Luxembourg, and Cyprus. The study, however, does

not document the quantity and quality of the programmes in each country. What we know is that in some countries, asylum seekers' treatment in rehabilitation centres is not covered by the state, but rather must be paid for through grants and donations. As a result, treatment centres are scarce and have huge waiting lists.[16] In other countries, rehabilitation centres only treat refugees with residence permits for financial and therapeutic reasons, leaving asylum seekers without specialised help.[17]

To heighten the standards and minimise the heterogeneity of services across Europe, one might wish for a coordinated effort regarding asylum seekers' access to health care services. In 2003, an EU directive was launched as part of an effort to harmonise the reception of asylum seekers within the EU.[18] All EU countries should have incorporated the articles of the directive into the national law before February 2005. The articles of the directive provide minimum conditions for different aspects of asylum seekers' access to health care. Concerning medical screening it states that 'member states may require medical screening for applicants on public health grounds'. This does not oblige member states to provide medical screening for asylum seekers, neither does it lay out important minimum contents of medical screening. The paragraph therefore seems to be without consequence, and if anything it is more focused on protecting nationals than asylum seekers.

Regarding access to health care, the EU directive states that 'member states shall ensure that applicants receive the necessary health care, which shall include at least emergency care and essential treatment of illness'. It is unclear what is meant by 'essential treatment'. This paragraph may serve to heighten the standard of some countries. On the other hand it allows other countries to lower their provisions of health care to emergency care only. The last paragraph states 'member states shall provide necessary medical or other assistance to applicants who have special needs'. Applicants with special needs include minors, pregnant women, and single parents with minor children, elderly, victims of torture, and other vulnerable people. This will clearly require some countries to enhance their level of health service provision for asylum seekers. The paragraph, however, could have been more explicit in its requirements of what constitutes 'necessary medical or other assistance'.

The directive constitutes an attempt towards the development of a common European asylum system. It does provide asylum seekers with certain minimum reception standards regarding access to health care, which the member states are obliged to fulfil. On the other hand the flexible and general character of the articles allow member states to maintain very different national policies that in some cases may fall short of an adequate standard of health care. The directive, moreover, does not embrace all people in the asylum seeking process, such as failed asylum seekers. Especially, in the light of the falling number of asylum seekers, most governments should be able to devote more attention to improving their asylum systems from the point of view of protecting the refugees.

In conclusion, the provision of health care for asylum seekers in the EU countries appears heterogeneous and often based on minimum standards. The existing EU guideline uses broad terms that essentially are without consequences for most member states. Therefore, it is still mainly up to individual member states to protect asylum seekers and ensure that they are given the same medical rights as we take for granted as citizens.

Key points

- The study investigates standards of health care provision for asylum seekers compared with citizens in the 25 EU countries.
- Medical screening of asylum seekers exists in nearly all EU countries, but the content and comprehensiveness show large variations.
- In almost half of the countries, access to health care for asylum seekers is legally restricted to emergency care only.
- European health policy makers should ensure access to health care for asylum seekers comparable with the medical rights of citizens.

References

1 UNHCR. *2003 Global Refugee Trends*. Geneva: UNHCR. Available at: www.unhcr.ch (accessed on 15 June 2004).

2 United Nations Declaration of Human Rights. Adopted by the United Nations General Assembly on 10 December 1948. Article 14. Available at: www.unhcr.ch

3 United Nations Convention relating to the Status of Refugees. Adopted by the United Nations General Assembly on 28 July 1951. Available at: www.unhcr.ch

4 UNHCR. Asylum levels and trends in industrialized countries, 2004. Geneva: UNHCR. Available at: www.unhcr.ch (accessed on 1 March 2005).

5 Sundquist J, Johansson SE. The influence of exile and repatriation on mental and physical health. A population-based study. *Soc Psychiatr Epidemiol* 1996;31:21–28.

6 Goldfeld AE, Mollica RF, Pesavento BH, Farone SV. The physiological and psychological sequlae of torture: symptomatology and diagnosis. *JAMA* 1988;259:2725–9.

7 Laban CJ, Gernaat HB, Komproe IH, et al. Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *J Nerv Ment Dis* 2004;192:843–51.

8 Bischoff A, Bovier PA, Rrustemi I, et al. Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral. *Soc Sci Med* 2003;57:503–12.

9 Keller AS, Rosenfeld B, Trinh-Shevrin C, et al. Mental health of detained asylum seekers. *Lancet* 2003;362:1721–3.

10 Burnett A, Peel M. Health needs of asylum seekers and refugees. *BMJ* 2001; 322:544–7.

11 Basoglu M, Parker M, Parker O, et al. The physical and psychological effects of torture: a comparison of tortured with nontortured political activist in Turkey. *Am J Psychiatry* 1994;151:76–81.

12 Burnett A, Peel M. The health of survivors of torture and organised violence. *BMJ* 2001;322:606–9.

13 Available at: www.ecre.org.

14 Creighton S, Sethi G, Edwards SG, Miller R. Dispersal of HIV positive asylum seekers: national survey of Britian healthcare providers. *BMJ* 2004;329:322–3.

15 Hargreaves S, Holmes A, Friedland JS. Charging failed asylum seekers for health care in the UK. *Lancet* 2005;365:732–3.

16 Pross C. Third class medicine: health care for refugees in Germany. *Health Hum Rights* 1998;3:41–53.

17 www.rct.dk/rehabilitation (Accessed on 5 May 2005).

18 European Council. European Council Directive—laying down minimum standards for the reception of asylum seekers. Adopted by the European Council on January 27th, 2003. Available at: www.ue.eu.int

Received 9 June 2005, accepted 29 June 2005