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Europe's Refugee Crisis and the Human Right of Access to Health Care: A Public Health Challenge from an Ethical Perspective

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If access to health care is considered a human right, who is considered human enough to have that right?" (Farmer, 2005)

Abstract

Over a million people fled to Europe in 2015, initiating a refugee crisis. European countries differ concerning access to health care for refugees. Most refugees are in poor health and require medical assistance. The refugees' human right of access to health care gets violated by the European Union. This article analyzes the issue from the perspective of public health ethics.

The decision-making framework for public health of Tannahill and a report on public health ethics of the Nuffield Council on Bioethics were used as a base for this article.

The ethical principles *do good*, *respect*, and *equity* are often violated by the health care systems in Europe. The *stewardship* framework emphasizes the role of governments with responsibility for their citizens, including refugees' health. Even though the European Union legally recognizes everyone's right to access to health care, this right is often violated due to economic reasons and political disputes.

Introduction

The corpse of three-year-old Syrian Aylan Kurdi found on a Turkish beach in September 2015 became the symbol of Europe's refugee crisis (Al Jazeera And Agencies, 2015). According to the United Nations High Commissioner for Refugees [UNHCR], 1,015,078 refugees arrived in Europe by crossing the Mediterranean Sea during the peak year 2015. Despite a decreasing trend since then, 100.016 sea arrivals to Italy, Greece, Spain, and Cyprus were reported in 2018 by mid-November. Since the beginning of 2015, 14,042 refugees attempting to cross the Mediterranean Sea were stated dead or missing (UNHCR, 2018). This refugee crisis is considered as unprecedented within Europe since World War II (Morabia and Benjamin, 2015).

Referring to the UNHCR definition, a refugee is a person who *"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country"* (UNHCR, 1951). The Universal Declaration of Human Rights by the United Nations [UN] includes the topic of health in article 25: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care (...)"* (UN, 1948). The International Covenant on Economic, Social and Cultural Rights [ICESCR] defined the right to health more specifically in article 12: *"The right of everyone to the enjoyment of the highest attainable standard of physical and mental health"* (ICESCR, 1966). According to the World Health Organization [WHO], the right to health includes *"access to timely, acceptable, and affordable health care of appropriate quality."* This accessibility of health facilities, goods, and services include the dimensions of information and physical accessibility, economic accessibility which corresponds to affordability, and non-discrimination (WHO, 2015).

The European Union [EU] allocated over 10 billion Euros in 2015/2016 to address the refugee crisis (European Commission, 2018). The European countries which are still feeling the economic crisis from 2008 and which are entry points for refugees crossing the Mediterranean Sea are experiencing an additional economic strain due to arriving refugees. Moreover, many of those countries are prepared for disasters like floods or earthquakes, but not for providing health care to a large number of refugees, let alone coordinating or financing it (Soares and Tzafalias, 2015).

Within Europe, the legal access to official health care — excluding institutions run by voluntary health care workers — can be divided into three categories (*Table 1*). In the countries labeled "no access," refugees are legally entitled to receive only access to emergency care, which in some countries (marked with *) has to be paid by refugees themselves. The countries which allow "partial access" aim to make access to services like primary care or maternity care possible or facilitate access for certain subgroups e.g. children or pregnant women. In the countries with "full access," refugees are legally entitled to receive treatments like nationals and to get the same range of health care services under certain preconditions, e.g. the ability to prove their own identity (Nowhereland, 2010). This was the legal situation in 2010, but little improvement was achieved since. The legal status is still one of the main formal barriers for refugees' access to health care. In most European countries, access to health care is still reduced to emergency care, which is not always free of charge (Scholz, 2016). Germany is the European country allowing the largest number of refugees to enter, but according to local physicians, thousands still do not get adequate access to health care (Hyde, 2016; The Lancet, 2016).

Medical support is organized by non-governmental organizations [NGOs] and depend on the help of voluntary health care workers without appropriate training for working under these conditions (Morgan, 2015). According to professional health care workers in Europe, the accessibility to health care is hindered by several issues: language

barriers, difficulties to arrange care for refugees without health care coverage, social retraction and traumatic experiences in the past, lack of familiarity with the European health care systems, different cultural backgrounds, diverse understandings of illness and treatment, negative attitudes towards each other among professional health care workers and patients, and lack of access to the medical history of the refugees (Priebe et al., 2011).

One-third of refugees state that their self-perceived health status is poor or very poor (Doctors of the World, 2012). In general, refugees are suffering primarily from diseases like respiratory tract infections and hypothermia (Morgan, 2015) due to their exhausting journey to Europe, and post-traumatic-stress-syndrome and scabies as a result of insufficient hygienic conditions in refugee camps (Topping, 2015). All of these ailments require immediate medical care. Additionally, refugees are dependent on continuous treatment for common chronic diseases like diabetes, hypertension, and heart conditions (Morgan, 2015).

Refugees have an overall worse health status compared to non-refugees: Male and female refugees have a statistically significant higher risk of poor mental health compared to non-refugees. Hospitalization due to depressive disorders is very common among unemployed female refugees. Additionally, male refugees have a higher mortality risk due to cardiovascular diseases compared to male non-refugees (Hollander, 2013). Furthermore, refugees are at higher risk of maternal and child health issues compared to non-refugees. The risk of maternal mortality is four times higher for refugees compared to non-refugees (Rechel et al., 2011). Mental health and perinatal care needs are frequently unfulfilled. Unaccompanied refugee children or those who experienced violence are at special risk concerning their mental health. Pregnant refugees are confronted with serious unmet needs, which lead to increased perinatal mortality (Bradby et al., 2015).

Consequently, needs-assessments of refugees are urgently required to tackle these inequities between refugees and non-refugees, especially in the fields of mental and maternal health. There is a clear lack of statistics about refugees' legal status of access to health care in Europe; their health status; and the medical care they receive (Bozorgmehr et al., 2016). Scientific data about the long-term health outcomes of refugees is scarce (Führer et al., 2016).

This article analyzes refugees' situation in Europe concerning their human right of access to health care from the perspective of public health ethics.

Methods

This article is based on the ethical principles *do good*, *respect,* and *equity*, described by Tannahill (2008) and the framework *stewardship* of the Nuffield Council on Bioethics (2007). *Do good*, *respect,* and *equity* are considered the main principles of Tannahill (2008) in the discussion of refugees' human right of access to health care. These principles are part of a triangle in combination with evidence and theory to achieve improved decision-making in health policy (Tannahill, 2008). In this article, these principles are used to discuss the refugees' human right of access to health care from an ethical perspective and to elaborate suggestions based on ethical consideration to improve the health of refugees and to address thereby Europe's health policies.

The scientific literature was primarily gathered on the PubMed Database. During the search on the PubMed Database, the following keywords were included to find publications in scientific journals: Refugee crisis, Europe, human right of access to health care, ethics, public health. In terms of objectivity, literature reviews and statistics were preferably included compared to letters, editorials, and comments. Considering the previously mentioned keywords, data from internationally acknowledged organizations with expertise on the subject e.g. the UNHCR were included. Since this article describes a recent topic, the most up-to-date data was prioritized, followed by information about previous comparable refugee waves in Europe.

Primarily in the public media, but in scientific literature as well, refugees, irregular migrants, and asylum seekers are mentioned as a homogenous group, which is politically not correct, and which makes a differentiation between those groups challenging. This article focuses on people arriving in Europe who have gained refugee status or are awaiting it. Therefore, for better understanding and for consistency, only the term "refugee" is used.

Results

The body of this article consists of the application of ethical principles (Tannahill, 2008) and the framework of *stewardship* (Nuffield Council on Bioethics, 2007).

Ethical principles

As described in the definition of access to health care by WHO, the following aspects are included: dimensions of information and physical accessibility, economic accessibility which corresponds to affordability, and non-discrimination (WHO, 2015).

Regarding the information accessibility to health care, the main issue across the whole of Europe is the lack of awareness amongst refugees about their human right of access to health care (Global Health Watch, 2016). This makes it challenging for voluntary and professional health care workers to reach refugees in need and thereby fulfill their duty to *do good*, which leads to critical shortages when refugees do not get the required information about how and where to get medical assistance. It is the responsibility of European health policies to inform refugees about such information.

The life in refugee camps in Europe makes physical access to health care challenging, since health institutions are often too far away to reach or the transport and treatment are not affordable for Refugees (UNHCR, 2011); this deters economic accessibility. *Respect* and *equity* are thereby violated, since — compared to the underlying population — refugees experience hindered access to health care. Many national health care systems disadvantage refugees despite international commitments and treaties intended to protect their human rights (Global Health Watch, 2016).

Non-discrimination concerning accessibility to health care covers a broad range of aspects. Access to health care for refugees varies within Europe when it comes to legal entitlements and formal regulations (Bradby et al., 2015). Thereby linguistic or cultural barriers occur between refugees, voluntary and professional health care workers. This leads to discrimination and violates *equity* of refugees in moments of communication without a translation service or when a

voluntary or professional health care worker is not aware of the cultural sensitivity of refugees' different ethnic background (UNHCR, 2011). Discrimination against refugees and poor cultural competencies of voluntary and professional health care workers (Asgary and Segar, 2011) are clearly violating the core idea of *respect* and *equity*.

The regulations in the countries with "no access" or "partial access" are discriminating and lead to boundaries for professional health care workers to *do good*. Mental health issues, such as psychological instability due to the loss of a family member during the journey, demand professional psychological assistance (Morgan, 2015), which is denied by restricted health care access; this is discriminating and ignores thereby *respect* for refugees.

Refugees have the right to experience *respect* as human beings and as a disadvantaged subgroup, which requires an additional amount of *doing good* by the voluntary and professional health care workers to achieve *equity* in all health outcomes.

Stewardship Framework

Access to health care is a key point of the *stewardship* framework (Nuffield Council on Bioethics, 2007). This access is hindered by the lack of coordination due to capacity issues. NGOs are responsible for health care for refugees until national health care systems can take over these patients (Morgan, 2015).

Moreover, the framework of *stewardship* explains the role of the state. This role of the European governments can be described as an approach which consists of two different ideas. On the one hand, the European governments are not in a position to force people or restrict the individuals' freedom in any way if it is not inevitable, meaning they cannot force refugees to receive medical treatment or refuse access to health care. On the other hand, the European governments have the responsibility to provide living conditions for every person such that individuals are able to lead a healthy life if they wish to do so. This includes unrestricted access to health care for all refugees in all European countries. One exemplary aspect of this governmental responsibility is the protection and special attention to the health of vulnerable subgroups like refugees. The overall objective of the *stewardship* framework is closing the health gap between the least and most healthy individuals in the whole European population to reduce health inequities, aiming at *equity* (Nuffield Council on Bioethics, 2007). However, the coordination between the EU and the individual countries seems problematic, since the national governments tend to prioritize the responsibility for their own population.

Certainly, there are critical voices against the *stewardship* framework. Since caring for vulnerable subgroups and *equity* are central, it might be seen as a "nanny state interference" (Krebs, 2008). Furthermore, the *stewardship* framework is difficult to implement in the real world of policies, even in the health care systems of Northern Europe, which are strongly focusing on *equity* (Saltman and Ferroussier-Davis, 2000).

Discussion

This article aims to analyze refugees' situation in Europe concerning their human right of access to health care from the perspective of public health ethics.

Despite the lack of scientific literature concerning the improvement of health conditions of refugees, suggestions have been published.

Obligatory medical examination of every refugee needs to be undertaken including pain, psychological health issues, and vaccination status (Führer et al., 2016). On the one hand, the EU takes thereby the responsibility — as described in the *stewardship* framework — of protecting refugees as a vulnerable subgroup by obtaining a needs-assessment, which fulfills *do good*. On the other hand, an obligatory medical examination means that refugees would not have the right to refuse, which goes against *respect* and which is contradictory to the response of the WHO's Regional Office for Europe in which obligatory disease screenings for refugees are not recommended. Instead, a triage at the point of entry into Europe is recommended; firstly, checking for communicable and non-communicable diseases as an identification process of health issues among refugees; secondly, proper diagnosing; and thirdly, appropriate treatment with a focus on children, pregnant women, and the elderly (Scholz, 2016). Those three steps would ensure assistance for refugees in need and address *do good* and *equity*.

Medical treatment needs to be adjusted to linguistic and cultural diversities among refugees, and voluntary and professional health care workers (Führer et al., 2016). This suggestion seems essential for the improvement of health care access for refugees. Actions to improve the linguistic and cultural challenges lead to non-discrimination, *do good*, *respect*, and *equity*.

For refugees with chronic diseases, continuous support needs to be achieved to avoid interruptions of treatment (Morgan, 2015). To achieve this continuous support and protect the human right of access to health care, physical and economic accessibility need to be given, otherwise, refugees do not get the same access to treatment as locals with the same chronic disease, which goes against *equity*. This violation of *equity* has been described by German physicians, who are strongly voting for a nationwide health insurance card for refugees, as some German states are using for their citizens (Hyde, 2016). This suggestion would be a necessary step to enable *do good* for professional health care workers, towards non-discrimination of refugees and towards the improvement of access to health care for refugees in need.

Regarding perinatal health, every reported maternal death should be analyzed by the UNHCR Maternal Death Review Report (UNHCR, 2011). Through such monitoring, important data could be gathered to improve the health of pregnant refugees and their unborn children. *Do good* would be fulfilled and it would give *respect* towards refugee families who lost a pregnant family member.

To support children suffering from mental health issues, participation in school, local friendships, and language proficiency are key factors (Montgomery, 2011). Many NGOs organize child-friendly spaces for psychosocial support of unaccompanied refugee children (Ventevogel et al., 2015). Furthermore, the United Nations International Children's Emergency Fund [UNICEF] provides safe places to learn and play, and psychological first aid for thousands of children (UNICEF, 2015).

Even though the *stewardship* framework might be seen as a "nanny state interference" (Krebs, 2008), refugee children have to be a focus of EU health policies. The above-mentioned interventions to provide safe and positive surroundings for children to find friends, get psychological help, and to learn and play need to get high attention. Those interventions clearly improve the overall health of children and create *equity* and non-discrimination.

Radio and television programs, leaflets, and information sessions in different languages are concepts to reach refugees concerning information accessibility (European Council on Refugees and Exiles, 1999). To achieve *equity* and to give voluntary and professional health care workers the opportunity to *do good*, these concepts have to be applied by EU health policies to reach all refugees in need.

In terms of physical and economic accessibility, transportation to health care facilities needs to be possible and affordable for Refugees (UNHCR, 2011). Depending on where refugees are located, this suggestion might be difficult to put into practice, since most refugees are staying in camps or other facilities located in rural areas where health care facilities are difficult to reach. Therefore, it seems more reasonable to send voluntary and professional health care workers to those facilities for refugees with primary health care issues. In case more specialized health care is required, patients should be transported to a health care facility free of charge for refugees.

Recommendations to all European countries such as provision of free vaccinations and development of mechanisms to protect sick refugees from being deported to their home countries, which lack the ability to deliver appropriate treatments (Villanueva Gutierrez Arruda Marques, 2012), are actions against discrimination of refugees, and ensure *do good*, *respect,* and *equity*.

Refugees have to be integrated into what is for them an unfamiliar health care system. To improve the overall health status of refugees, not only do the health services need to be adapted, but also the determinants of health need to be taken into account. The improvement of the determinants of health includes stable income, food security and nutrition, suitable housing, education for children and adults, and access to hygienic water and sanitation services (UNHCR, 2011). Improving the determinants of health in the lives of refugees promises *equity* in the long run and follows the idea of the European governments' responsibility to provide living conditions in which individuals are able to lead a healthy life, as the *stewardship* framework proposes.

WHO's Regional Office for Europe demands full access to hospitals, prevention actions, and a high quality of health care for all refugees. Through providing interpretations and translations, training of professional health care workers in psychological support, health promotion actions, and health literacy interventions, access to health care for refugees should improve (Scholz, 2016). Furthermore, the EU recognizes everyone's right to access to health care in the Charter of Fundamental Rights (EU, 2010). However, this right and the ethical principles *do good*, *respect,* and *equity* are frequently violated in Europe's refugee crisis. This is likely due to economic reasons which force the EU member states to prioritize their own needs instead of those of refugees. Those economic difficulties lead most likely to

political and cultural concerns, pushing the countries toward nationalism and actions such as closing the borders or refusal of refugees.

The economic burden for the EU and especially its member states Italy, Greece, Spain, and Cyprus, which are the main entry points for refugees, can be seen as the foremost counterargument when considering ethical aspects of the human right of access to health care for refugees. Nevertheless, 86% of the worldwide forced displaced population are hosted by developing countries (WHO, 2018) and therefore outside of the EU. Moreover, with a total EU budget of 157.9 billion Euros in 2017 (EU, 2018), the 10 billion Euros allocated in 2015/2016 to address the refugee crisis — of which only parts are going into the provision of health care — seem too little to have a major impact on the EU economy.

Despite this economic burden for Europe, many street demonstrations from locals against the acceptance of refugees, and political debates, legal full access to health services and acknowledgment and respect of this human right needs to be guaranteed by all European countries. The EU has to tackle the refugee crisis as a collective to improve the health of refugees.

Conclusions

The hindered and partially restricted access for refugees to a stable health care system in Europe indicates inequities between refugees and the underlying population and violates their human right of access to health care.

The improvement of access to health care needs to be achieved during the journey of refugees within Europe, during their stay in refugee camps, and after their arrival at their final destination.

Up to the present, the above mentioned ethical principles are still unfulfilled: the principles of *do good* and *respect*, which refugees deserve, and *equity* for every refugee, can only be achieved if the EU is collaborating on a legal base.

As described in the framework of *stewardship*, the EU has to act with good governance with responsibility for all inhabitants including refugees, to make equal access to health care possible despite economic challenges for the EU.

Further research is warranted to protect the human right of access to health care of every single refugee in order to assure his or her health in the long run.

Table

Table 1
Three categories of access to health care in Europe

No access *	No access	Partial access	Full access
Finland	Estonia	Norway	The Netherlands
Sweden	Denmark	United Kingdom	Switzerland
Latvia	Lithuania	Belgium	France
Ireland	Poland	Italy	Portugal
Czech Republic	Germany		Spain
Luxembourg	Slovakia		
Romania	Austria		
Bulgaria	Hungary		
Malta	Slovenia		
	Greece		
	Cyprus		

* Emergency care has to be paid by refugees themselves.

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