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## Access of migrants and refugees to healthcare

### Committee Opinion<sup>1</sup>

Committee on Social Affairs, Health and Sustainable Development

Rapporteur: Ms Yuliia OVCHYNNYKOVA, Ukraine, Alliance of Liberals and Democrats for Europe

### A. Conclusions of the committee

1. The Committee on Social Affairs, Health and Sustainable Development (hereafter “Social Affairs Committee”) welcomes the report on access of migrants and refugees to healthcare prepared by Ms Pelin Yılık of the Committee on Migration, International Protection and Economic Co-operation ([Doc. 16412](#)). The right to protection of health is enshrined in Article 11 of the European Social Charter (ETS No. 35) which complements Articles 2 and 3 of the European Convention on Human Rights (ETS No. 5). The two treaties are closely linked together on health-related aspects of human dignity. Moreover, Article 13 of the Charter spells out member States’ obligation to protect the right to social and medical assistance for anyone without adequate protection, while other articles of the Charter describe the needs and rights of vulnerable population groups that require enhanced attention of policy makers (such as children and young persons, pregnant women, migrant workers and their families, older persons and persons with disabilities).

2. The Social Affairs Committee underlines that guaranteeing access of migrants and refugees to healthcare is a critical public health imperative: by deterring migrants and refugees from seeking timely care, restrictive measures obstruct the early detection and management of transmissible diseases, thereby endangering both migrant and host communities. In order to adequately protect vulnerable populations, member States must adopt gender-responsive, trauma-informed healthcare pathways, ensuring universal access to health support. From an evidence-based policy perspective, timely provision of basic medical care for all would also alleviate the burden of costly emergency services for national health budgets.

3. The Social Affairs Committee concurs with the Committee on Migration, International Protection and Economic Co-operation in cautioning against the proliferation of externalised migration policies and offshore ‘return hubs’, which undermine migrants’ and refugees’ access to essential medical care, cut them off from national health systems and exacerbate trauma. Member States cannot divest themselves of their obligations under the European Social Charter by off-shoring migration policies. The Social Affairs Committee therefore wishes to highlight the importance of the European Social Charter for guaranteeing migrants’ and refugees’ access to healthcare in the Council of Europe member States, as well as the implications and obligations this treaty entails for the countries concerned. The committee therefore presents several amendments to this end.

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1. Reference to committee: [Doc. 16112](#), Reference 4858 of 7 April 2025. Reporting committee: Committee on Migration, International Protection and Economic Co-operation. See [Doc. 16412](#). Opinion approved by the committee on 23 June 2026.



## **B. Proposed amendments**

### *Amendment A (to the draft resolution)*

In paragraph 2, after the first sentence, insert the following sentence:

*“Moreover, member States that are Parties to the European Social Charter (ETS No. 35) and the European Social Charter (revised) (ETS No. 163) undertake to ensure “the effective exercise of the right to protection of health” (Article 11) and to uphold the right to social and medical assistance for anyone without adequate protection (Article 13).”*

### *Amendment B (to the draft resolution)*

At the end of paragraph 8.2., insert the following words:

*“, emphasising preventive primary care;”*

### *Amendment C (to the draft resolution)*

In paragraph 8.3., first sentence, after the words “in line with”, insert the following words:

*“the European Social Charter and”*

### *Amendment D (to the draft resolution)*

After paragraph 8.6., insert the following paragraph:

*“collaborate with international health organisations to develop secure, interoperable and portable digital patient summaries for refugees and asylum seekers in transit, ensuring that essential medical history, immunisation records and allergy data travel with the patient, thereby reducing redundant testing and preventing treatment interruptions.”*

### *Amendment E (to the draft resolution)*

In paragraph 9.1., first sentence, after the words “necessary healthcare”, insert the following words:

*“(such as maternal and neonatal care, essential treatment of chronic diseases and urgent mental health support)”*

### *Amendment F (to the draft resolution)*

After paragraph 9.3, insert the following paragraph:

*“facilitate the recognition of professional qualifications of refugees and migrants who are trained healthcare professionals, so that they can contribute to domestic health systems and to delivering culturally and linguistically appropriate care to migrant populations;”*

### *Amendment G (to the draft resolution)*

In paragraph 10, replace the words “eligible Council of Europe member States” with the following words:

*“Council of Europe member States concerned to fully implement the European Social Charter and”*

## **C. Explanatory memorandum by Ms Yuliia Ovchynnykova, rapporteur for opinion<sup>2</sup>**

1. According to the World Health Organisation (WHO), over 281 million individuals reside outside their native countries. The WHO European Region accounts for the largest proportion of this displaced population worldwide, hosting nearly 36% of all international migrants. The report by Ms Pelin Yılık takes a commendable and courageous stance against the outsourcing of border controls to third countries – such as Niger, Libya, or Tunisia – and the establishment of offshore 'return hubs', exemplified by the Italy-Albania model in Gjader. By shedding light on severe human rights violations, including documented cases of self-harm, suicide attempts, and a critical lack of essential medicines within these facilities, the text effectively exposes how shifting international protection burdens systematically compromises human dignity and public health safeguards.

2. Access to healthcare for migrants and refugees is not a matter of charity. It is a matter of fundamental social rights, human dignity and the rule of law. Under the European Social Charter (ETS No. 35 and ETS No. 163), Article 11 recognises the right to protection of health, while Article 13 guarantees the right to social and medical assistance. These are not abstract promises: they require effective access to healthcare systems for every person, including those who arrive in our countries in vulnerable circumstances. Indeed, several other articles of the Charter describe the needs and rights of vulnerable population groups that require special attention of policy makers (such as children and young persons, pregnant women, migrant workers and their families, older persons and persons with disabilities) (see amendments A, C and G).
3. Migrants and refugees often face language barriers, administrative obstacles, discrimination, deprivation and exclusion. Yet, health cannot depend on nationality, residence status or legal category. The right to health must be applied to all persons without any discrimination as a pillar of human dignity. When certain groups of the population are denied care, society as a whole does not become stronger; it becomes less fair, less healthy and less resilient.
4. The Parliamentary Assembly has on many occasions stressed that migrants and refugees should be guaranteed effective access to healthcare from the moment of their arrival on the European soil. That approach is fully consistent with the spirit of Articles 11 and 13 of the Charter: protection of health requires prevention, treatment and access to essential services, while social and medical assistance must be available to those who are in need, especially the most vulnerable.
5. Access to healthcare is also a question of equal opportunities. If we want integration to succeed, if we want children to learn, adults to work and families to live in safety, then we must ensure their timely access to healthcare. Early access is not only humane; it is also in the societal interest. It prevents emergencies, reduces public health risks and supports cohesion. The Council of Europe Development Bank as a bank with a social vocation can contribute to supporting member States in strengthening their health infrastructure and services so that all the population is adequately protected (see amendment G).
6. Rather than relying solely on moral obligations, the report presents a pragmatic economic perspective balanced with public health needs. Citing studies from Switzerland and Germany, it demonstrates that investing in early, accessible primary healthcare and medical check-ups at first arrival dramatically reduces long-term healthcare expenditure and avoids overloading emergency services (see amendment B).
7. While the explanatory memorandum rightly identifies the brain drain of medical professionals to the private sector and acute nursing shortages as critical institutional bottlenecks, the draft resolution fails to offer possible solutions to mitigate this crisis. Member States could establish institutional and financial incentive frameworks – such as hardship allowances, specialised training credits and targeted public service protections – to retain and motivate public sector healthcare workers deployed in reception facilities and transit border zones. Member States could also integrate into the mainstream health systems highly qualified refugees and migrants who are trained as healthcare professionals, so that they can contribute to domestic health systems and to delivering culturally and linguistically appropriate care to migrant populations (see amendment F).
8. The report demonstrates a structural friction between long-term health needs and the reality of rapid migration transits, noting that mobile populations rarely remain in one country long enough to receive sustained psychological or medical assistance. To address this, the Assembly should look beyond static national frameworks and recommend the development of secure, interoperable and portable digital health records across migration routes (see amendment D). This is essential to guarantee cross-border continuity of care and avoid the dangerous fragmentation of medical records.
9. The report rightly criticises European Union directives for their restrictive and vague definitions of essential medical treatment, which often leads to exclusionary national policies. However, the draft resolution falls into the same semantic trap by calling for 'emergency and other necessary healthcare' without further specification. To provide greater legal certainty, the text could clarify the substantive scope of 'necessary healthcare' (see amendment E).
10. The finding that some member States permit healthcare facilities to pass interpretation fees onto migrants and asylum seekers represents a high barrier to human-rights-compliant healthcare. The Assembly should condemn such a practice and urge member States to fully fund interpretation and mediation services, making them entirely free of charge for the patient.

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2. The explanatory memorandum is drawn up under the responsibility of the rapporteur.

11. Moreover, the operational reality in transit zones reveals insufficient access to pharmaceuticals, exemplified by the Red Cross being restricted to funding a mere 30 essential medicines, which leaves specific or severe chronic illnesses unaddressed. The problem could be tackled through the creation of centralised emergency medical funds or standardised 'migrant-essential medication lists' under the joint stewardship of the Council of Europe and WHO. This would help bypass restrictive donor clauses and better equip transit points with a full range of life-saving pharmaceuticals.

12. Member States should better handle the public health risks posed by restrictive clauses in the new EU Returns Regulation. These clauses deter undocumented migrants from seeking treatment for diseases like tuberculosis and HIV out of fear of deportation. Strict, statutory 'firewalls' in national legislation are needed. Domestic legal frameworks must explicitly prohibit healthcare providers and hospital administrations from reporting a patient's irregular status to immigration authorities, treat any such unauthorised disclosure as a punishable breach of medical confidentiality, and ensure that the delivery of healthcare remains decoupled from the administrative status of patients and is grounded solely in humanitarian and public health needs. Moreover, migrants in transit should not suffer from "medical history amnesia": digital health records are a public health necessity, not just an administrative convenience.

13. As rapporteur for opinion, I believe that we should affirm a simple principle: protecting the health of migrants and refugees protects the health of society as a whole. A rights-based approach grounded in human dignity, non-discrimination, equal opportunities and solidarity is not just legally correct. It is morally necessary and socially wise. I therefore propose to the Social Affairs Committee to approve these amendments as set out above in order to highlight the importance of the European Social Charter in defending fundamental rights which should be read together with those spelt out in the European Convention on Human Rights. The inclusion of these amendments will transform the draft resolution into a clear political and legal shield that protects the rights of migrant and refugee patients and strengthens public health systems, contributes to overcoming the shortage of medical professionals in Europe and underpins progressive reforms that advance social justice in member States and their neighbourhood.