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Access of migrants and refugees to healthcare

Report[1]
Committee on Migration, International Protection and Economic Co-operation
Rapporteur: Ms Pelin YILIK, Türkiye, Members not belonging to a Political Group

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1. Reference to committee: Doc. 16112, Reference 4858 of 7 April 2025.

A. Draft resolution[2]

1. The Parliamentary Assembly affirms the imperative of ensuring that migrants and refugees have effective access to healthcare, including mental healthcare, in order to fully realise the fundamental right to health as enshrined in international human rights law for all persons, and underscores that such access is also essential from a public health perspective.

2. The importance of applicable international and regional legal instruments cannot be underestimated, in particular the European Convention on Human Rights (ETS No. 5) (notably Articles 3 and 8), as interpreted in the case law of the European Court of Human Rights, as well as relevant principles of international humanitarian law, in ensuring the protection of migrants, refugees and asylum seekers, including with regard to access to healthcare. It is furthermore important to achieving the United Nations Sustainable Development Goals, in particular those relating to universal health coverage and the effective management of health emergencies.

3. Recommendation CM/Rec(2011)13 of the Committee of Ministers to member States on mobility, migration and access to healthcare underscores the responsibilities of national and local authorities and the key role of organisations working to maintain and restore health.

4. The Assembly has repeatedly drawn attention to migrants' and refugees' precarious health and their difficulties in accessing health and social services, including in Resolution 2504 (2023) "Health and social protection of undocumented workers or those in an irregular situation" and Resolution 2627 (2025) "Promoting universal health coverage".

5. Migrants face extreme physical and mental precariousness when arriving on European soil. Their health situation is shaped by a combination of structural, institutional and individual factors that may significantly hinder effective access to healthcare and exacerbate existing conditions. These include, *inter alia*, legal and administrative barriers; insufficient availability, accessibility or continuity of healthcare services, including vaccination; inadequate reception conditions and precarious living or employment situations; as well as individual challenges such as limited knowledge of rights, fear of approaching authorities or services, language and health-literacy barriers, stigma, distrust and the cumulative impact of perilous and traumatic migration journeys.

6. Women and girls in migration are disproportionately exposed to trafficking, sexual and gender-based violence and exploitation, and face intersectional discrimination based on sex, migration status, poverty, disability and age. These factors, compounded by legal and administrative barriers, language obstacles, lack of information and inadequate screening and referral, limit timely access to essential services, including sexual and reproductive and maternal healthcare, mental health support and protection services. There are moreover insufficient training of professionals and gaps in culturally-appropriate care. Failure to ensure targeted access exacerbates maternal morbidity, untreated trauma and intergenerational harms to children, including developmental and psychiatric disorders. The Assembly therefore underscores the need for gender-responsive, trauma-informed and accessible healthcare pathways for women and girls.

7. With regard to migrant children, the Assembly underlines the necessity to harmonise age-assessment procedures for unaccompanied children, consistent with Recommendation CM/Rec(2022)22 of the Committee of Ministers to member States on human rights principles and guidelines on age assessment in the context of migration.

8. The Assembly thus invites Council of Europe member States as well as States whose parliament enjoys observer status with the Assembly to:

8.1. avoid relying on externalised migration and asylum policies, including return hubs, which systematically curtail healthcare access or shift protection burdens onto areas lacking the necessary infrastructure and safeguards;

8.2. strengthen their domestic legal framework through stable national migration legislation, with a view to including migrants and refugees in national health insurance schemes;

8.3. move towards a universal healthcare framework for migrants, in line with the central political commitment of the United Nations 2030 Agenda for Sustainable Development and the subject of target 3.8 of Sustainable Development Goal 3. This implies facilitating access to adequate healthcare

2. Draft resolution adopted by the committee on 13 May 2026.

cover for all foreign nationals lawfully residing in the country, including improved access to relevant medicines and in sufficient quantities, and ensuring the availability of adequate healthcare infrastructure, including purpose-built premises with fully equipped consultation rooms and spaces;

8.4. commit to protecting migrants' and refugees' health and, more broadly, public health in the short and long term. This implies equality and inclusion in healthcare through integrated migrant health policies and investment in preventive and primary care, including in reception and detention centres, in so-called "hotspots" culturally sensitive care and in hospitals;

8.5. ensure, with regard to mental health, access of migrants and refugees to psychological and psychiatric care and treatment to respond to symptoms of anxiety, depression or post-traumatic stress disorder. When appropriate, and as recommended by the European Commission against Racism and Intolerance (ECRI), the Assembly recommends developing strategic plans for the sustained support of persons fleeing war and other emergencies, with an emphasis on addressing mental health needs and delivering psychosocial support through community-based approaches, including in schools and reception settings;

8.6. ensure access of migrants and refugees to information about their rights. This implies providing effective communication on services and materials related to health, including through brochures and other written information available in an appropriate range of languages. The Assembly also strongly encourages the relevant authorities to provide interpretation services and cultural mediators in relevant languages, with appropriate culturally sensitive training.

9. The Assembly further encourages health authorities to:

9.1. ensure that migrants and refugees have free access to healthcare from the moment of first arrival, including emergency and other necessary healthcare, as well as access to vaccination and medicines. In this context, health authorities should prevent public and private healthcare providers from reporting migrants who are irregularly present in the country to the immigration authorities. The Assembly further encourages a systematic comprehensive medical examination by a healthcare professional to identify vulnerabilities and ensure appropriate placement, including for vulnerable populations such as women and unaccompanied children;

9.2. invite healthcare professionals to pay particular attention to the existence of any injuries. They should also screen for transmissible diseases – including systematic screening for signs of tuberculosis, and voluntary testing for HIV, hepatitis B/C –, chronic diseases and long-term conditions such as diabetes. Such policies help to prevent and tackle ill-treatment and to protect public health overall. However, the Assembly underlines that the decision to segregate a person for health reasons should be limited in duration and grounded in the principles of necessity, proportionality and respect for human dignity;

9.3. strengthen the capacities and qualifications of healthcare staff, including general practitioners, nurses and psychosocial support staff.

10. The Assembly furthermore encourages eligible Council of Europe member States to make full use of the opportunities provided by the Council of Europe Development Bank to strengthen healthcare infrastructure, equipment and staffing, in particular in reception and detention centres.

11. Finally, the Assembly calls on its own members, in their capacity both as national lawmakers and as members of the Assembly, to act at European and domestic levels to promote the relevant Council of Europe instruments, standards and expertise as well as to align national legislation and practice with the recommendations set out above.

B. Explanatory memorandum by Ms Pelin Yılık, rapporteur[3]

1. Introduction

1. People migrate for many reasons: to escape violence and war, as well as in response to demographic changes, human rights concerns, poverty and climate change. These factors drive forced global mobility, exposing individuals to new environments and, *inter alia*, to significant health challenges. Migration may therefore constitute an independent risk factor for ill health, often exacerbating pre-existing conditions or creating new ones.

2. The motion for a resolution I tabled on 3 February 2025 on "Migrants' and refugees' access to healthcare" (Doc. 16112) underlined the importance of ensuring effective access to healthcare, including mental health services, in order to give full effect to the right to health enshrined in international human rights law.

3. Migrants' and refugees' health problems may arise before, during and after their journey to Europe, reflecting the various dangers, injuries and trauma they encounter. They are frequently victims of violence, ill-treatment, beatings, loss or confiscation of belongings and pushbacks. Many travel by sea in small boats and face risks such as hypothermia in winter, dehydration and heatstroke in summer, as well as burns and inhalation of toxic fumes from engines. Even after arrival, significant physical and psychological health problems often persist. Such conditions may pose serious risks and can prove fatal if left untreated.

4. Forced migration and exposure to violence also produce lasting psychological harm. Although many arrive in Europe with hope, they frequently experience culture shock and disillusionment, leading to depression, post-traumatic stress disorder, anxiety and related conditions.

5. These risks are exacerbated upon arrival by inadequate nutrition, poor infrastructure, limited access to medical care, unhygienic living conditions, and adverse socio-economic circumstances. Additional barriers further undermine health and hinder access to treatment, including shortages of facilities and personnel, financial hardship, language and transport difficulties, lack of health insurance, restrictive migration laws, insufficient awareness of rights and available services, harmful traditional practices, overcrowded housing, unsafe water supplies, poor sanitation, and the absence of childcare services for working mothers.

6. Member States must take into account both formal and informal living situations when assessing migrants' and refugees' access to healthcare, including that of undocumented migrants.[4] Formal situations are more readily defined, as migrants are accommodated through official structures such as reception centres or hotspots. Informal settings – such as makeshift settlements, camps, squats, or street situations – pose additional challenges for public authorities. Nevertheless, for humanitarian reasons and in the interests of public health, such situations cannot be ignored. Access to healthcare is therefore essential not only for the individuals concerned but also for the well-being of host societies.

7. In formal contexts, addressing health needs begins at points of first arrival, particularly disembarkation areas, through medical screening, rapid diagnosis and initial treatment. Longer-term care is generally provided within national reception systems, often through dedicated health centres. However, not all member States – particularly those facing high numbers of first arrivals or congestion at borders areas – are able to meet such demands fully.

8. Migrants and refugees remain particularly vulnerable, whether within formal systems or outside them, and public authorities, together with non-governmental organisations, are not always able to guarantee effective access to healthcare, including mental healthcare, despite considerable efforts.[5] Those living entirely outside official structures face even greater risks, including acute shortages of basic necessities, constant threats to health and safety, and significant legal or administrative barriers.

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3. The explanatory memorandum is drawn up under the responsibility of the rapporteur.
4. On this latest point, see for instance "Access to State Medical Aid by Undocumented Immigrants in France: First Findings of the "Premiers Pas" Survey", www.irdes.fr/english/issues-in-health-economics/245-access-to-state-medical-aid-by-undocumented-immigrants-in-france-first-findings-of-the-premiers-pas-survey.pdf.
5. See in this respect the report entitled "The challenges and needs of public and private actors in migration management", debated by the Parliamentary Assembly on 26 June 2025. Rapporteur: Ms Sandra Zampa (Italy, SOC), Doc. 16192. Related Resolution 2613 (2025).

9. The above-mentioned motion recalls Resolution 2504 (2023) "Health and social protection of undocumented workers or those in an irregular situation", as well as Recommendation CM/Rec(2011)13 of the Committee of Ministers on mobility, migration and access to healthcare. Both underscore the responsibilities of national and local authorities and the key role of organisations working to maintain and restore health.

10. The Assembly and, in particular, its Committee on Migration, International Protection and Economic Co-operation (formerly the Committee on Migration, Refugees and Displaced Persons), has repeatedly drawn attention to migrants' and refugees' precarious access to health and social services. A recent example is Resolution 2613 (2025) "The challenges and needs of public and private actors involved in migration management", based on the report by Ms Sandra Zampa. That work, which included fact-finding visits to France (2023) and Italy (2024), provided valuable input for the present report.

11. Against this background, the present report adopts a broader perspective, affirming that effective social inclusion requires equal access to health and social services, including psychosocial support, for all, migrants and refugees alike. The right to health for everyone is both a human rights obligation and a public good that benefits host communities.

12. Following an overview of the international texts and sources at stake, and contributions from the Council of Europe's various relevant bodies, this report will examine the obstacles and difficulties faced by migrants and refugees in accessing healthcare, including the particular vulnerability of women, girls and unaccompanied children, as well as the issue of externalisation and return hubs. While approaches differ among member States, I have gone into more depth as an example the situation in Montenegro following the fact-finding visit conducted in that member State in March 2026. I finally propose a series of good practices and responses to ensure human-rights compliant healthcare for migrants and refugees.

2. International texts and sources, and the Council of Europe's bodies' contributions

13. Articles 3 and 8 of the European Convention on Human Rights[6] are pivotal in the European Court of Human Rights' case law on migrants' access to healthcare. This case law remains, however, underdeveloped.[7] Cases to date rarely address access to healthcare in respondent States, focusing instead on States' positive obligations regarding vulnerability. The Court has repeatedly noted that certain individuals or groups warrant special protection due to their vulnerability, which may arise from specific circumstances, including serious health conditions, notably mental health.[8]

14. In its Case-Law Guide on Immigration,[9] the Court states that conditions in transit zones may engage Article 3, applying principles from detention cases (Z.A. and Others v. Russia [GC], 2019, §§ 181-195). Violations arose in airport transit zones (Z.A. and Others v. Russia [GC], 2019; Riad and Idiab v. Belgium, 2008) and land-border zones (R.R. and Others v. Hungary, 2021, §§ 48-65), owing to inadequate food for an adult asylum seeker and poor conditions for his pregnant wife (with health issues) and minor children during four months in Röszke transit zone. No violation was found where severity thresholds were not met (Ilias and Ahmed v. Hungary [GC], 2019, §§ 186-194; Thiam v. Italy (French only), 2022, §§ 32-41). In H.M. and Others v. Hungary (2022, §§ 13, 21-27), Article 3 was breached when an asylum seeker was handcuffed and placed on a leash on his way to, and during, a hospital visit to interpret for his pregnant wife.

15. It is important to highlight, among key international instruments, the United Nations Global Compact on Refugees.[10] Adopted as a resolution of the UN General Assembly, the Compact aims to operationalise the principle of burden- and responsibility-sharing, mobilise the international community as a whole, and strengthen responses to refugee situations. In relation to health, the Compact calls on States to support protection-sensitive arrangements for timely security screening and health assessments of new arrivals; to expand and enhance the quality of national health systems in order to facilitate access for both refugees and host communities; and to build, equip, or strengthen health facilities and services, including through capacity development and training opportunities for refugees and members of host communities.

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6. Article 3, prohibition of torture, and Article 8 right to respect for private and family life.
7. See the key theme on immigration on the site of the Court, https://ks.echr.coe.int/web/echr-ks/immigration.
8. See Steering Committee for Human Rights (CDDH), "Analysis of the legal and practical aspects of effective alternatives to detention in the context of migration", CDDH(2017)R88add2, https://rm.coe.int/steering-committee-for-human-rights-cddh-analysis-of-the-legal-and-pra/1680780997.
9. https://ks.echr.coe.int/documents/d/echr-ks/guide_immigration_eng. See section "Applicants in poor mental health".
10. www.unhcr.org/about-unhcr/overview/global-compact-refugees.

16. The European Committee for Legal Co-operation published a Guide for Practitioners on the Administrative Detention of Migrants and Asylum Seekers (2023), covering healthcare standards. It includes checklists for healthcare professionals and lawyers addressing vulnerabilities.[11]

17. The Group of Experts on Action against Trafficking in Human Beings (GRETA) monitors trafficking victims' healthcare access, including among asylum seekers and migrants, examining gaps in protection in order to prevent vulnerabilities. Its 8th General Report devotes a chapter to victim assistance, with a section on medical aid.[12]

18. The European Commission against Racism and Intolerance's (ECRI) 7th monitoring cycle prioritises equality and inclusion in healthcare, with dedicated sections in all country reports, covering foreign nationals.[13] From 2025 onwards, initial reports (Albania, Austria, Monaco, Slovak Republic from June 2026; then Belgium, Czechia, Denmark, Norway) will elaborate further. Earlier reports addressed migrant healthcare under integration sections, including in respect of beneficiaries of protection. In 2024, ECRI issued factsheets on healthcare racism and migrant integration. Moreover, ECRI General Policy Recommendation No. 16 (2016) on irregularly-present migrants highlights the need for access to basic healthcare for this category of migrants and recommends that measures be put in place (so-called "firewalls") which would prevent state and private sector actors from *de facto* excluding these persons from access to healthcare through regulations or policies requiring the sharing of personal data or other information with the immigration authorities for the purposes of control and enforcement. (paragraphs 11-15, 21-24).

19. The Council of Europe Development Bank (CEB), also advances, through its social mandate, social cohesion and support for vulnerable groups, including migrants and refugees, by strengthening health-system resilience and equal access. In 2024-2025, it approved €1.1 billion for hospital upgrades and €2.2 billion for migrants, refugees and displaced persons. The 2015 Migrant and Refugee Fund (€39 million endowed; €37 million approved) funded, for instance, €1.15 million to Spain (2018) for equipment and training in Ceuta and Melilla. For Ukraine, €31 million in grants and loans included €100 million (2023, HEAL project) for mental health and rehabilitation, aiding in particular internally displaced persons. In Türkiye, SHIFA built or renovated facilities (65 new, 44 migrant centres), adding 110 rehabilitation units with equipment.

3. Health issues and obstacles faced by migrants and refugees in accessing healthcare

3.1. The overall situation

20. The obstacles and difficulties faced by migrants and refugees in accessing healthcare are multifactorial. In addition to the fact-finding visit to Montenegro, discussed in a separate chapter of this report, other fact-finding visits organised by the committee have provided opportunities to highlight these issues. The series of hearings held during committee meetings has also made it possible to hear from a range of actors working with migrants.

21. During a fact-finding visit to Calais, France, held on 25-26 October 2023, the *ad hoc* sub-committee established for that purpose visited, *inter alia*, the infirmary at the Coquelles administrative detention centre and, on the basis of information received from NGOs, was apprised of hunger strikes, limited access to medical services and serious health problems, with psychological disorders often downplayed by the authorities. The report issued following the visit also underlined that "[a]ccess to healthcare is deficient too, fortunately partly compensated by mobile infirmaries and clinics ensured by NGOs, either mandated or not, but not in a sufficient proportion. There are specialised departments in hospitals for access to healthcare dedicated to migrants, asylum seekers and refugees in Calais and Dunkirk hospitals, but they are most of the time not known by them. Due to the described policy of negligence and harassment, it is moreover difficult to reach the individuals in need and for them to reach hospitals considering the long distance from their living places. The delegation was told by NGOs that volunteers often use their own vehicles to transport patients to hospital."

22. During the fact-finding visit to Sicily, Italy, held on 16-18 September 2024, the *ad hoc* sub-committee established for that purpose was informed by the local authorities that the most common health issues included hypothermia in winter, dehydration and heatstroke in summer, diabetes, burns, and inhalation of toxic fumes from boats' engines. Within the reception system, the delegation observed the initial medical

11. https://rm.coe.int/administrative-detention-of-migrants-and-asylum-seekers-guide-for-prac/1680ad4c43, in particular pages 53 and following.
12. www.coe.int/en/web/anti-human-trafficking/-/greta-publishes-8th-general-report-on-its-activities, from p. 54.
13. See Information document, paragraphs 3, 5.

assistance provided to migrants after disembarkation at the port of Lampedusa. Once this first care is administered, migrants are transported by bus to the Lampedusa hotspot, where a dedicated health centre continues to provide medical support. Hotspots are governmental centres set up at places of disembarkation to provide information on how to apply for international protection.

23. During her fact-finding visit to the United Kingdom, held on 24-26 March 2025 in the context of the preparation of her report on "The challenges and needs of public and private actors involved in migration management", our current committee chairperson Ms Sandra Zampa (Italy, SOC) visited Manston Asylum Processing Centre, which follows first-arrival processing at Dover's Western Jet Foil processing centre. She explained that "[i]n this centre, the migrants go through a biometric room, which is managed by staff from the Home Office. The following phases with interviewers questioning the migrants about their crossing, intentions etc. are however sub-contracted to a private company. Similarly, the medication units are also sub-contracted to the private sector and are in charge of the assessment of health issues, diagnoses, and treatment."

24. In addition to these various fact-finding visits, I held several exchanges of views and hearings, which gave me the opportunity to complement the overview of migrants and refugees' health conditions and their access to healthcare services in Europe.

25. At a committee hearing held on 11 March 2026, Mr Yves-Laurent Jackson, doctor and professor at Geneva University Hospitals and the Faculty of Medicine of the University of Geneva, examined migrants' and refugees' access to healthcare, stressing that effective provision depends on both demand-side and supply-side dynamics. On the demand side, migrants' health-seeking behaviour is influenced by age, health status and priorities such as housing and security. Fear, mistrust, administrative obstacles and distance frequently discourage engagement with healthcare systems, while NGOs and community initiatives often fill these gaps. On the supply side, and drawing on the World Health Organization's health-systems framework, Mr Jackson emphasised the need for trained, culturally competent staff and comprehensive services extending beyond emergency care. Coherent policy frameworks, sustainable funding and reliable information systems are critical, especially for mobile populations requiring continuity of medical records.

26. He warned that fragmented services exacerbate chronic illness and mental health problems, leading migrants to rely on costly emergency departments. Inequalities in access harm both migrants and host communities, as seen during the COVID-19 pandemic. Addressing broader social determinants, including housing, employment and the environment, is essential to improve health outcomes, given migrants' disproportionate exposure to risk.

27. Mr Jackson cited evidence showing that inclusion in national health-insurance schemes, the use of interpreters and cultural mediators, and integration with social-support programmes all improve health outcomes. Health systems should bring care closer to affected communities through local partnerships with NGOs. He highlighted the positive impact of legal regularisation and the protection of personal data, and rejected the notion that healthcare availability acts as a migratory "pull factor".

28. In conclusion, Mr Jackson identified four priorities: integrated migrant health policies generate financial and public health benefits without creating migration incentives; social conditions must be addressed alongside medical care; sustainable funding frameworks underpin equity; and trust between healthcare providers and migrant communities is fundamental.

29. During an exchange of views held by the committee on 20 October 2025, Ms Sally Hargreaves, Professor of Clinical Public Health, City St George's, University of London, and Ms Inka Weissbecker, expert on Mental Health, Brain Health and Substance Use at the World Health Organization, underlined that migrants' and refugees' access to healthcare must be understood as a broad public-health and human-rights issue, with particular attention to infectious disease, chronic illness and mental health needs, as well as the barriers that prevent timely access to care. Both experts stressed that formal entitlement alone is insufficient unless accompanied by inclusive systems, effective outreach, culturally and linguistically appropriate services and stronger data collection.

30. Ms Hargreaves presented migrant health as dynamic rather than static. She noted that some datasets show a "healthy migrant effect" overall, but that this should not obscure the higher mortality and disease burden observed for certain conditions, particularly infectious diseases, nor the fact that migrants are overrepresented in some European infectious-disease datasets. She also pointed to delayed diagnosis, including for HIV, and argued that such delays undermine disease-control objectives and reveal the need for more proactive and inclusive healthcare delivery.

31. She further emphasised that migrants may be under-immunised, especially where health and vaccination systems have failed in countries of origin, and that exclusion from services on arrival can worsen these gaps. In addition, she warned that health often deteriorates over time after settlement, citing evidence of worsening outcomes in areas such as diabetes and cardiovascular disease.

32. Ms Hargreaves also highlighted the impact of employment conditions, noting that migrants, refugees and asylum seekers are often concentrated in "dirty, degrading and dangerous" work and face greater risks of occupational injury and exploitation, with consequences for both physical and mental health. She grouped the barriers to healthcare into legal and policy barriers, structural and economic barriers, and personal barriers, including lack of knowledge of rights, fear of approaching services, language and health-literacy obstacles, stigma and distrust.

33. Her recommendations were clear: Europe should move towards a universal healthcare framework for migrants, guarantee fuller access to mainstream services, maintain safety nets for undocumented persons, invest in preventive care, develop migrant-inclusive service models, work with community organisations, improve public health messaging, engage employers, strengthen workforce competencies and improve data collection across Europe.

34. Ms Weissbecker focused on mental health, stressing that refugees and migrants are exposed not only to traumatic events before and during displacement, but also to discrimination, exclusion and other stressors in the receiving country, which can be equally damaging. She distinguished normal distress from mental disorder, while noting that refugees and migrants nonetheless show higher prevalence of depression, anxiety and post-traumatic stress disorder than host populations.

35. She explained that access to mental healthcare is necessary not only because it is a human right, but also because untreated conditions impair everyday functioning, worsen physical health, hinder integration, affect families and communities, and generate avoidable social and economic costs. She also stressed the significant return on investment from treating common mental health conditions.

36. Among the main barriers she identified were poor understanding of mental illness, stigma, lack of information, cost, confidentiality concerns, language obstacles, underfunded interpretation, weak referral pathways, shortages of specialists, long waiting times, limited community-based services and insufficient cultural competence among providers. She therefore recommended moving beyond specialist-centred models by training non-specialists and community workers, integrating mental health support into community settings such as schools and asylum centres, ensuring financial coverage regardless of legal status, building referral networks, expanding outreach in relevant languages, collecting disaggregated data and improving continuity of care through better communication and portable health information.

37. During an exchange of views held by the committee on 8 December 2025, Ms Amira Yahiaoui, a clinical psychologist and doctoral graduate of Paris Cité University, presented the mental health challenges observed in France's administrative detention centres (CRAs), as well as the psychological vulnerability of exiled women and their children, drawing on ethnographic research conducted in eleven French detention centres between May 2021 and July 2022.

38. Ms Yahiaoui detailed systemic shortcomings in healthcare provision within CRAs. Although each centre includes a medical unit with general practitioners and limited nursing staff, psychiatric and addiction services remain gravely insufficient despite the prevalence of such disorders among detainees. Psychological support is often restricted to part-time interventions. Structural deficiencies, understaffing and lack of interpreters compound the distress of detainees, many of whom experience severe psychiatric symptoms, and exhibit violent behaviour and/or self-harm. Ms Yahiaoui emphasised that these reactions are not only expressions of individual suffering but manifestations of institutional neglect. The coercive environment, uncertainty of deportation and social isolation aggravate pre-existing trauma and impede communication, creating a space where violence and despair replace words.

39. She also underlined the economic and human inefficiency of detention, noting that it cost the French State €265 million in 2024 while more than half of detainees were released without deportation. The cyclical nature of detention and re-entry into France perpetuates psychological deterioration rather than public security.

40. In conclusion, Ms Yahiaoui called for a shift from treating these issues solely as psychiatric problems to addressing their political and structural roots, namely social precarity, segregation and the lack of legal and institutional protection, without which genuine mental health recovery cannot be achieved.

3.2. The economic perspective

41. From an economic perspective, Mr Jackson underlined that migrants often delay seeking medical care for a range of reasons until their condition is perceived as urgent or severely limiting. As a result, emergency departments frequently become the first point of entry into the healthcare system, with a significant proportion of consultation and hospitalisation costs potentially avoidable if earlier contact with health providers had been facilitated. Care delivered in emergency settings is both more costly, for healthcare systems and individuals, and less efficient than primary care in addressing health needs comprehensively. This includes the provision of preventive services that reduce the likelihood of future consultations. The limitations are even more pronounced in cases involving multiple health needs, as emergency-based systems are not designed to ensure continuity of care, thereby constraining the effective management of chronic conditions and increasing the risk of further avoidable consultations.

42. Mr Jackson referred to studies conducted in Germany and Switzerland demonstrating that inclusive policies can substantially reduce per capita healthcare costs by shifting care towards prevention and primary services. The Geneva regularisation pilot resulted in higher insurance coverage, improved mental health outcomes, and reduced reliance on emergency care. He also described an integrated, publicly funded health unit in Geneva that serves vulnerable groups through multidisciplinary teams and task-sharing, thereby ensuring comprehensive and equitable service provision. Overall, the most cost-effective healthcare systems are those that prioritise facilitated and universal access to primary care, complemented by emergency services reserved for severe and unavoidable situations.

43. From the same economic perspective, primary healthcare services in Türkiye are funded by the Ministry of Health through general budget allocations. Secondary and tertiary services, including those delivered by university and private hospitals following appropriate referral, as well as 112 Emergency Healthcare Services, are financed by the Presidency of Migration Management in accordance with the annually renewed “Global Budget Protocol”. The Presidency also covers the costs of outpatient medicines and medical supplies, such as orthoses and prostheses. In practice, the public sector bears the healthcare and medication costs for individuals under temporary protection and for victims of human trafficking, while health insurance for foreign nationals holding a work permit is covered by their employer.

3.3. Women, girls and unaccompanied children, a particularly vulnerable migrant population

44. Women and girls – who comprise roughly half of all migrants – are particularly at risk,[14] as are unaccompanied minors. Migrant women are disproportionately affected by trafficking and sexual violence, including rape. During migration, they frequently face complications in childbirth, unwanted pregnancies and anaemia. Both women and unaccompanied children encounter major barriers to accessing diagnosis, treatment, prevention, counselling and medication. Migrants with disabilities also constitute a particularly vulnerable group requiring targeted attention.

45. With regard to migrant and asylum-seeking women and girls, the findings of the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) highlight persistent barriers to healthcare access. These women and girls are often disproportionately affected by intersectional discrimination. Across its baseline evaluation reports, GREVIO has noted insufficient attention to the compounded risks faced by such women and girls, including inadequate awareness of rights and lack of accessible information in languages they understand. The mid-term Horizontal Review of 17 baseline evaluation reports identified recurring shortcomings. GREVIO has expressed concern over the absence of systematic vulnerability screening on arrival in countries such as Italy, Malta and Spain, which has led to inappropriate accommodation for women and girls with specific protection needs. It urged States to introduce systematic screening procedures to identify vulnerabilities and ensure appropriate placement.

46. The reports further emphasise the failure to guarantee access to, and information on, specialist support services, which are essential for victims of gender-based violence to disclose abuse and obtain psychological, medical and trauma-related assistance. Similarly, GREVIO has observed that in Finland, the Netherlands, Serbia and Sweden, support services remain insufficiently tailored to the needs of vulnerable groups, including migrant women and girls, who face cultural and linguistic barriers. GREVIO has also underlined a lack of standardised national protocols for identifying and responding to female genital mutilation and other forms of violence, noting significant disparities in healthcare responses across countries such as France, Finland, Malta, Serbia and Spain. The absence of uniform procedures has resulted in inconsistent quality of care. Finally, GREVIO has found widespread inadequacies in the training of healthcare professionals. It has

14. www.migrationdataportal.org/themes/women-girls-migration.

called on States, including Albania, Austria, Belgium, France, Italy and Malta, among others, to introduce compulsory training aligned with the Istanbul Convention to improve the identification, treatment and support of victims of female genital mutilation and sexual violence.

47. With regard to unaccompanied migrant children, and as emphasised by the Council of Europe's Steering Committee for Human Rights,[15] when considering family-based placements, it is important to recognise that unaccompanied and separated children have particular needs and circumstances.

48. The Council of Europe's Lanzarote Committee has also highlighted the Organisation's sustained efforts to strengthen international protection for migrant and refugee children through legal standards, monitoring and co-operative initiatives. Its urgent monitoring rounds on protecting children affected by the refugee crisis from sexual exploitation and abuse culminated in key reports, a declaration in 2018 and practical tools, including a handbook supporting practitioners across crisis contexts. Under the Strategy for the Rights of the Child (2022–2027), the Steering Committee for the Rights of the Child has advanced implementation of recommendations on guardianship and age assessment, stressing the need to strengthen national frameworks. The Committee has also developed co-operation projects in Ukraine, the Republic of Moldova and Armenia, which enhance child protection systems during and after crises.

49. During the above-mentioned exchange of views held by the committee on 8 December 2025, the psychologist Amira Yahiaoui described the extreme poverty, gender-based violence and social marginalisation faced by migrant mothers, which severely harms their own and their children's mental health. She additionally noted increased risks of developmental and psychiatric disorders among children living in deprivation.

3.4. Externalisation and return hubs

50. Since the mid-2010s, European Union and several member States have progressively outsourced border control and asylum responsibilities to states along African and Mediterranean routes (for example Niger, Libya, Tunisia and Morocco), combining funding, training and equipment for migration control with efforts to block departures and facilitate returns. Such policies are widely documented as worsening barriers to healthcare and creating avoidable public-health risks for migrants and refugees.[16]

51. In a report entitled "Externalised asylum and migration policies and human rights law", issued in September 2025, the Council of Europe's Human Rights Commissioner, Michael O'Flaherty, highlights that externalised asylum arrangements frequently jeopardise migrants' and refugees' access to healthcare and other core rights by shifting responsibility away from Council of Europe member States to countries where protection and reception systems are weaker. Legal standards such as the principle of *non-refoulement*, the right to life, freedom from torture and the right to an effective remedy under the European Convention and United Nations treaties require that States do not transfer people to places where they face real risks of serious harm, including through denial of medical care or deterioration in physical and mental health.

52. Practical barriers include the use of "safe third country" or external-processing schemes (for example the former United Kingdom-Rwanda and current Italy-Albania models), which may leave asylum seekers stranded in overcrowded, under-resourced facilities with limited or inadequate access to healthcare and prolonged uncertainty as to their status. The report stresses that assessments of such transfers must cover not only formal legal guarantees but also real-world conditions, such as whether healthcare services, livelihoods and protection for vulnerable groups are available and sustained over time.

53. Safeguards recommended in the report include rigorous, individualised risk assessments before any transfer; clear legal bases and enforceable rights to challenge transfer decisions with suspensive effect; and continuous monitoring of conditions in host countries, including healthcare and protection standards, to prevent refoulement and onward displacement. Member States are urged to ensure that externalised schemes do not rely heavily on detention, do not target children or other vulnerable persons, and are accompanied by robust transparency, independent monitoring and accountability mechanisms to protect migrants' and refugees' access to healthcare and other rights.

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15. Steering Committee for Human Rights (CDDH), Guide on family-based care for unaccompanied and separated children, CDDH(2021)R95 Addendum 1, https://rm.coe.int/steering-committee-for-human-rights-cddh-guide-on-family-based-care-fo/1680a4d5d9.

16. See for instance Médecins sans Frontières, "Fortress in the Sand – EU Externalisation Policies and Trans-Saharan Migration Routes", September 2025, www.msf.fr/sites/default/files/2025-10/Rapport Fortress in the sand-final_compressed.pdf.

54. The Assembly's General Rapporteur on European migration and asylum policies, Lord Michael German, has recently called for similar safeguards.[17] He stressed the need for appeals against expulsion orders to have suspensive effect, warning that expelling a person before their appeal has been decided could expose them to serious and irreversible harm and undermine the rule of law. He also recalled that the detention of migrant children is never in their best interest, and urged EU stakeholders to enshrine that principle in future legislation.

55. The only offshore "return hub" is currently the one operated by Italy in Gjader, Albania. The Lazio Detention Ombudsperson visited the centre last year and found potential risks for healthcare.[18] ASGI, a well-known legal studies NGO, found an extremely worrying picture of detainees' physical and mental conditions in the centre, with many cases of severe psychological distress, self-harm and several suicide attempts.[19] The report criticises migrants' and refugees' access to healthcare in Albania's Gjader pre-removal detention centre under the Italy-Albania Protocol, focusing on irregular migrants detained pre-removal. EU standards in Return Directive 2008/115/EC (Articles 15(2) and 16(3)) mandate timely and adequate essential medical care, contact rights and immediate release where detention is unlawful. Practical barriers include the absence of access to Italy's National Health System, which deprives detainees of specialist treatment, ongoing therapies, addiction services and mental healthcare. Albania's healthcare system has structural shortcomings and is unable to match EU and Italian standards; Gjader's remote location, with no nearby hospitals, further delays emergency care. Monitoring has revealed severe psychological distress, self-harm, suicide attempts and overuse of psychotropic drugs, worsening vulnerabilities without proper support. Safeguards are therefore insufficient, as these facilities, under Italian jurisdiction on Albanian territory, cannot meet complex health needs. Moreover, co-operation with Albanian stakeholders, particularly hospitals, is inadequate when hospitalisation is required, thereby compromising health rights and human dignity.

56. More broadly, concerning the Return Regulation, newly adopted by the European Parliament,[20] notable voices have raised alarms about its impact on healthcare. Beyond the health consequences of the expanded use of detention and forced deportations, the main new risks arise, first, from new measures to "detect" irregular migrants, which could oblige healthcare professionals to report them to the authorities (Article 6); and, secondly, from a new provision allowing the transfer of migrants' health data to third countries for the purpose of deportation (Article 41). The proposed changes have been heavily criticised by Commissioner O'Flaherty,[21] by a joint letter of sixteen United Nations Special Rapporteurs and by more than 250 non-governmental organisations.[22]

57. Some elements of the EU Pact on Migration and Asylum may have moreover questionable implications for migrants' access to healthcare. While the Pact includes certain health-related provisions, several risk limiting effective access to care in practice. Under the Screening Regulation, the mandatory health check is narrowly framed as part of identifying vulnerabilities and determining measures needed during the screening process. It does not establish a broader right to healthcare, nor does it guarantee follow-up treatment for conditions identified at that stage. Moreover, the requirement for individuals to remain at designated locations during screening may result in *de facto* detention-like conditions, where access to medical care is often limited, particularly with regard to mental health and specialised services.[23] The Reception Conditions Directive also leaves significant discretion to Member States, requiring only "necessary health care, including at least emergency care and essential treatment of illnesses".[24] This formulation may permit restrictive interpretations that exclude specialist, rehabilitative, or psychosocial care. Taken together, these provisions create a risk that healthcare remains formally guaranteed but substantively inaccessible, especially for applicants with chronic illnesses, trauma-related conditions, or mental health needs.

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17. https://pace.coe.int/en/news/10242/pace-general-rapporteur-urges-eu-to-abandon-proposal-to-detain-migrant-children-in-coming-returns-regulation.
18. Visit report (in Italian only): www.garantedetenutilazio.it/prima-visita-dei-garanti-anastasia-e-calderone-al-cpr-di-gjader.
19. www.asgi.it/wp-content/uploads/2025/07/2025_CPR-Albania-European-Commission_eng.pdf. See in particular Section 2.
20. www.europarl.europa.eu/news/en/press-room/20260324IPR38908/returns-regulation-meps-ready-to-start-negotiations.
21. www.coe.int/en/web/commissioner/-/council-of-europe-commissioner-alerts-to-human-rights-risks-in-upcoming-eu-returns-regulation.
22. www.statelessness.eu/updates/news/joint-letter-more-200-organisations-reject-eu-return-regulation.
23. Screening Regulation (EU) 2024/1356 Regulation – EU – 2024/1356 – EN – EUR-Lex.
24. Article 19 of the recast Reception Conditions Directive (EU) 2024/1346, Directive – 2013/33 – EN – Reception Conditions Directive – EUR-Lex.

58. In the above-mentioned 2025 report, Médecins Sans Frontières concludes that a decade of EU externalisation policies south of the Mediterranean has had "damaging effects", including deaths along trans-Saharan routes and at sea. The organisation calls for urgent review, suspension, or termination of co-operation agreements that fail to ensure due diligence and the protection of rights.

4. Case study, the fact-finding visit to Montenegro

59. In preparing this report, I undertook a fact-finding visit to Montenegro, a small yet strategically significant member State. Montenegro is currently the most advanced EU candidate country, having entered what the EU Council and Commission describe as the "final phase" of accession negotiations. All chapters are open, many provisionally closed, and the EU Council has signalled its readiness to proceed, subject to reform progress, towards drafting the Accession Treaty. Montenegro also represents a valuable case study as a key transit country on the Western Balkans migration route. Migrants regularly pass through its territory, primarily arriving from neighbouring Albania, Kosovo*[25], and Serbia.

60. The visit, conducted from 4 to 7 March 2026, formed part of broader efforts to assess migrants' and refugees' access to healthcare in Council of Europe member States. The programme combined meetings with national authorities, including the Ministries of Health and Interior, parliamentary committees and the Ombudsperson institution, with visits to reception and border facilities and consultations with key international and civil society actors such as the IOM, UNHCR, and the Red Cross. These engagements sought to obtain first-hand insight into Montenegro's institutional framework and practices concerning healthcare and protection for migrants and refugees, identify challenges and good practices, and inform the committee's wider work on equitable access to essential health services for all persons, regardless of status.

61. Interlocutors explained that most migrants originate from the Middle East, Afghanistan, Pakistan, Sudan, and other countries of these regions. This diversity reflects varying backgrounds, cultures, and religions, all of which must be taken into account in addressing migrant needs, even though the majority are merely transiting through Montenegro.

62. Representatives of the Ministry of Health and relevant public-health departments described the secondary legislation governing migrant and refugee healthcare. Migrants and asylum seekers benefit, under the national health insurance law, from basic healthcare protection, including medical examination and emergency treatment, in accordance with EU directives. Three levels of protection apply: emergency care and basic medical support, coverage for essential medicines, and basic treatments. Persons under international protection, including their family members, enjoy enhanced coverage, especially women and children. Rulebooks are in preparation to support implementation of this legislation, although the Red Cross noted that these instruments are not yet operational.

63. The Ministry of Interior oversees border monitoring and management. Migrants are registered upon arrival at crossing points and may indicate their intention to seek international protection, which entitles them to remain in a reception centre and travel within the country. However, many leave after registration, often continuing their onward journey to unknown destinations.

64. At the Božaj border crossing point, I met border officials responsible for three crossing points and a 90-kilometre stretch of "green and blue" border, including the land area and Shkodra Lake between Albania and Montenegro. The 167 border officers maintain security and control, addressing cross-border crime and managing heavy lorry traffic. Frontex supports their work through personnel and equipment. The Red Cross reported that most migrants enter Montenegro through this border, either via the crossing point or the green border.

65. Balancing security and humanitarian considerations, the Ministry of Interior conducts security checks on arriving migrants, supported by the Police Administration, the National Security Agency and Frontex. These checks include biometric data collection, fingerprints and photographs. Migrants intercepted along the green border are interviewed to determine whether smugglers were involved, and their belongings are inspected for weapons, while mobile phones are checked for travel routes. They may be held for up to six hours, during which they receive medical assistance at nearby facilities, as none exist directly at the border.

25. *All reference to Kosovo, whether to the territory, institutions or population shall be understood in full compliance with United Nations Security Council Resolution 1244 and without prejudice to the status of Kosovo.

66. In 2025, approximately 2.76 million vehicles crossed the Božaj point – up to 20,000 daily during the summer months. That same year, 338 migrants were intercepted at the crossing, although many more are believed to have entered undetected via the green border. The figures have remained stable in recent years. Most migrants cross through green areas in groups, assisted by smuggling networks operating from abroad, avoiding official checkpoints and only rarely hiding in lorries.

67. The Ministry of Interior also manages the two existing reception centres in Montenegro – Spuž and Božaj – which accommodate 104 and 60 persons respectively. At Spuž, a medical unit staffed by two nurses and a visiting doctor, who attends twice weekly, operates with the support of the Red Cross and provides part-time psychological assistance. A triage system has been adopted, and agreements with local clinics and hospitals allow for referrals, including psychiatric treatment at Kotor hospital.

68. Border officials noted that intercepted migrants frequently suffer from dehydration, exhaustion, and minor injuries. The Red Cross observed small wounds and chronic diseases and, on occasion, viral infections.

69. Co-ordination on healthcare access is facilitated by the Ministries of Health and Interior and by the Red Cross. Both reception centres have medical units, although staffing is limited. Costs are borne by the State budget. UNHCR and the Red Cross help to overcome linguistic barriers, including through online interpretation services in Arabic, French, Spanish, and Ukrainian.

70. Registration of migrant populations has recently begun, yet challenges persist in planning and financing because of inadequate data and limited public funding. Staffing shortages are critical: physicians are increasingly leaving public service for better-paid employment in the private sector, and nursing shortages were underlined by the Red Cross. Government measures to address these issues have not yet proved sufficient.

71. Consequently, systematic medical examinations are not available for all migrants entering reception centres. Interlocutors called for incentives to retain healthcare professionals in the public sector, exchange programmes to learn from effective practices abroad, and better equipment. Meanwhile, international organisations, notably the Red Cross, help fill gaps in services, although medical teams are not legally secured, as observed by UNHCR.

72. Where possible, doctors and nurses collect information on migrants' medical history. Residents of reception centres receive initial medical screening to identify disease and contagion risks. Representatives of IOM highlighted that this assistance applies only to those admitted to centres; migrants merely transiting through Montenegro, or unregistered at the border, do not benefit from medical services and are often unaware of their rights to access care.

73. Accessibility and timeliness of healthcare remain challenging, as they do for Montenegrin citizens. However, ad hoc solutions – such as hospital referrals through co-ordination with the Ombudsperson institution or the Red Cross – help mitigate problems, as confirmed by UNHCR. Special attention is required for vulnerable groups, notably women, girls and unaccompanied children. The Ombudsman reported cases of minors entering Montenegro without official registration.

74. The absence of systematic registration also undermines vaccination coverage, posing potential risks to public health and complicating vaccine procurement and immunisation planning. Interlocutors further identified the high cost and limited availability of medicines. The Red Cross partly covers these expenses, funding approximately 30 essential medicines, although donor restrictions prevent the purchase of many others required by migrants.

75. Access to mental healthcare and psychiatric support remains limited. The authorities have established contracts with private providers when public services are overstretched. These constraints also affect Montenegrin citizens. At the Spuž Centre, the psychologist – present part-time – interviews residents mainly upon request. She reported frequent stress, trauma and depression, and her assessments help to identify victims of trafficking and survivors of violence, especially women, girls and unaccompanied children. However, most migrants do not remain long enough to receive sustained psychological assistance.

76. The Parliamentary Committee on Security and Defence oversees border management and the prevention of migration-related crime, including human trafficking. The Ombudsperson institution also plays a key role in monitoring migrant and refugee conditions, reporting no major human rights violations. It co-operates closely with national and international bodies, especially UNHCR, conducting visits to reception centres and border areas. The Ombudsperson noted occasional tensions with local communities, mitigated by patrols in affected zones.

77. In conclusion, Montenegro has made commendable efforts to address migrants' transit and healthcare needs with humanity. Nevertheless, improvements are needed to enhance co-ordination among institutions and ensure reliable data collection on migrant flows and residence – essential for both domestic authorities and international partners. Strengthening legal certainty through stable national migration legislation would reinforce this progress, supported by the forthcoming national migration strategy mentioned by the Red Cross. As Montenegro approaches EU accession and may shift from transit to destination country, interlocutors emphasised the need for a stronger legal framework, inclusive health coverage, sustainable funding, equipment, human resources – especially in the context of demographic ageing – training, medical units, interpretation services and access to medicines. The exchange of good practices among member States will be invaluable in this regard. Harmonisation of age-assessment procedures for unaccompanied children remains crucial, consistent with Recommendation CM/Rec(2022)22 of the Committee of Ministers to member States on human rights principles and guidelines on age assessment in the context of migration.

5. Good practices and responses to ensure human-rights compliant healthcare for migrants and refugees

78. The committee's fact-finding visits, as well as the visit I conducted to Montenegro, demonstrated that simple and low-cost solutions exist to ease migrants' and refugees' access to healthcare. The hearings organised with the committee's support also promoted pragmatic solutions, and at times more ambitious ones, to facilitate such access to healthcare services for migrants and refugees.

79. In parallel, I gathered background information on international, European, and domestic laws and practices in selected member States, notably through a consultation launched via the European Centre for Parliamentary Research and Documentation (ECPRD).

80. Thirty-four member States responded to the consultation. The exercise revealed a variety of measures adopted to improve migrants', refugees', and asylum seekers' access to healthcare, particularly in relation to legal and policy guarantees, co-ordination and governance, service delivery in reception facilities, health screening and mental-health support, financing and insurance arrangements, as well as language, cultural support and information policies.

81. As regards legal and policy guarantees, most responding States have constitutional or legislative provisions ensuring the right to health and non-discriminatory access to healthcare regardless of nationality or migration status.[26] Several countries extend specific entitlements to beneficiaries of international protection, often aligning them with nationals regarding access to the public health system.[27] Other States provide universal-style coverage that includes foreigners in a regular situation, refugees, asylum seekers and stateless persons, as in Spain's "universal health system".[28] In addition, many countries guarantee at least emergency and essential healthcare for persons without legal residence, including hospital care and, in some cases, full coverage within public-tariff limits after a short period of residence, as under France's State Medical Aid scheme.

82. With regard to the rights of vulnerable groups, several States have adopted age-specific and gender-specific provisions. For example, Norway grants all children under the age of eighteen and women without legal residence access to essential healthcare and pregnancy-related services, including pre- and postnatal care and abortion. France likewise provides free prenatal and child-health follow-up through the maternal and child health protection system (PMI). In several responding countries, children and unaccompanied minors, regardless of their status, are explicitly entitled to basic healthcare services.[29]

83. In terms of governance and co-ordination, responsibility for migrants' and refugees' access to healthcare is organised in various ways, ranging from centralised models[30] to multi-level systems involving national, regional, and local authorities.[31] In some States, the national health ministry defines the overall framework, while migration-focused agencies co-ordinate medical assistance for asylum seekers and related contracting.[32] Other countries operate a multi-tiered structure, with municipalities delivering primary care,

26. Armenia, Canada, Czechia, Estonia, France, Georgia, Germany, Lithuania, Montenegro, Poland, Portugal, Slovakia, Slovenia, Spain, Türkiye, Ukraine, the United Kingdom.
27. Armenia, Bosnia and Herzegovina, Canada, Czechia, Estonia, Finland, France, Georgia, Germany (after a probation period of 36 months), Latvia, Lithuania, Luxembourg, North Macedonia, Republic of Moldova, Montenegro, Norway, Poland, Portugal, Romania, Slovenia, Spain, Ukraine, the United Kingdom.
28. Armenia, Czechia, Estonia, Finland, Hungary, Lithuania, the Netherlands, Norway, Poland, Slovakia, Türkiye, the United Kingdom.
29. Bulgaria, Finland, France, Lithuania, Portugal and Slovenia also provide healthcare for children and unaccompanied minors, regardless of their status.

regional authorities managing specialist services, and dedicated immigration bodies identifying new arrivals at reception centres and facilitating their access to healthcare. In Georgia, for example, the Ministry of Internally Displaced Persons, Labour, Health and Social Affairs sets policy, supported by an Integration Centre and local health departments.

84. With regard to services available in reception and accommodation facilities, most responding States reported that healthcare services can be provided within reception centres,[33] often through direct contracts or agreements with the public health system.[34] Where necessary, patients are referred to higher-level facilities, for instance, in Slovakia, public hospitals are used when care provided within centres is insufficient. Slovenia and Montenegro operate dedicated health centres or on-site medical services, with transport and referrals arranged through the accommodation infrastructure. In Montenegro, primary care is available directly within reception centres and at a border crossing, staffed by medical professionals from the Directorate for Reception of Foreigners, with referrals to the Clinical Centre of Montenegro when required.

85. Concerning health screening and mental-health support, several States conduct initial medical examinations and infectious-disease screenings for newly arrived asylum seekers, typically co-ordinated by dedicated health or refugee-health services.[35] However, while most States report the provision of at least basic healthcare, emergency services, and disease-control measures, coverage of mental-health services in reception facilities remains uneven, despite some States offering psychological support[36] or additional assistance for vulnerable groups.[37]

86. Concerning financing and insurance schemes, healthcare for migrants and refugees, including women and unaccompanied children, is predominantly financed through the State budget across the responding countries.[38] Many States integrate refugees and beneficiaries of subsidiary protection into the national public health-insurance system, sometimes after a probation period or following a short residence requirement.[39] Where they are not employed, individuals may pay reduced contributions while the State continues to cover costs for vulnerable groups. Children and unaccompanied minors are generally fully covered from the outset, regardless of status, and are frequently supplemented by humanitarian and civil society organisations that provide free or low-cost care and psychosocial support.

87. With regard to language, cultural support and information policies, several member States provide interpretation or translation assistance in healthcare facilities,[40] such as telephone interpretation in Spain and Switzerland, NGO-delivered services in Albania, Bosnia and Herzegovina and Slovenia, and in-person or remote interpretation in Montenegro. In some countries, however, no formal interpretation services exist, although multilingual information materials and counselling may be offered.[41] In other States, such as

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30. The Ministry of Interior, Service for Foreigners and Asylum is responsible in Croatia. Ministry of Social Policy, Demography and Youth of North Macedonia is responsible North Macedonia. In Armenia and Bulgaria, it is the Ministry of Health.

31. In Bosnia and Herzegovina, social rights including the right to health are spread at state level and local level between the entities of the Republika Srpska and the Federation of Bosnia and Herzegovina. In Lithuania, it is the mandate of the Ministry of Social Security and Labour. The municipalities co-ordinate the provision of social assistance, healthcare and education services to asylum seekers and foreigners who have been granted temporary protection. Belgium, Canada, Czechia, Estonia, Finland, Georgia, Germany, Hungary, Latvia, Norway, Poland, Romania, Slovenia, Spain, Switzerland, Türkiye and the United Kingdom have a multilevel system, involving a plurality of actors as well.

32. In Portugal, the National Health system guarantees access to all foreigners. The Agency for Integration, Migration and Asylum plays a role in supporting integration in general and the Health Regulatory Authority monitors the application and enforcement of the rules. Luxembourg, Montenegro, the Netherlands, Slovakia, Türkiye, and Ukraine have a similar system.

33. Belgium, Czechia, Finland, Georgia, Germany, Latvia, Lithuania, Montenegro, the Netherlands, Poland, Romania, Slovakia, Türkiye, Ukraine, the United Kingdom.

34. Armenia, Bosnia and Herzegovina, Bulgaria, Canada, Portugal, Luxembourg, North Macedonia, Republic of Moldova, Slovenia.

35. Czechia, Finland, Germany, Latvia, Luxembourg, Montenegro, the Netherlands, Norway, Slovakia, Ukraine.

36. Czechia, Belgium, Estonia, Montenegro, Spain, Türkiye. In France and Slovakia, it is provided by independent NGOs.

37. Armenia, Bulgaria, Czechia, Montenegro, Romania.

38. Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, Estonia, Finland, Georgia, Germany, Hungary, Latvia, Lithuania, North Macedonia, Republic of Moldova, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Spain, Sweden, Switzerland, Türkiye, the United Kingdom.

39. Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, France, Germany, Hungary, Luxembourg, Montenegro, Norway, Romania, Slovakia, the United Kingdom.

40. Belgium, Finland, Hungary, Luxembourg, Republic of Moldova, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, Switzerland, Türkiye.

41. Armenia, Estonia, Germany, Slovakia, North Macedonia, Latvia.

Lithuania, interpreters charge fees, which may create a barrier to access. Several countries train healthcare providers on services available to beneficiaries of temporary protection or on cultural competence and trauma-informed care, including through IRCC-funded initiatives in Canada. In Türkiye, Syrian doctors have been employed in Migrant Health Centres, which has supported the employment of Syrian doctors and enabled patients to receive care in their native language. In addition, under the EU-funded SIHHAT project,[42] sworn interpreters have been employed in hospitals located in regions where persons under protection are concentrated.

88. Information on healthcare rights is systematically disseminated to migrants and refugees on arrival,[43] through brochures, official websites, posters and information sheets in multiple languages. Countries such as Canada and Montenegro also provide practical guidance on accessing federal or local health and social programmes, including airport reception, temporary accommodation, needs assessment and onward referrals. In Türkiye, emergency and information services are available in five languages through the central 157 YIMER hotline (Communication Centre for Foreigners). Despite these measures, full implementation, particularly in cultural mediation and staffing, remains an ongoing challenge in several States.

89. Spain decided in March 2026[44] to introduce a measure to recognise the right of foreign nationals without legal residence in the country to receive medical care, presenting healthcare as an inherently universal human right. This followed the regularisation of 500,000 migrants in the preceding months. The regulation is designed to recognise a number of vulnerable groups who will henceforth be entitled to receive immediate care, regardless of their administrative status in Spain, including unaccompanied children, pregnant women, victims of gender-based violence, victims of exploitation and trafficking, and applicants for international protection or stateless status.

6. Conclusion

90. Migrants and refugees encounter persistent barriers to healthcare arising from administrative complexity, legal status, limited system capacity and language and cultural differences. Effective responses combine professional interpretation, culturally responsive care and stronger service integration. Evidence shows that restricted access stems less from migrants' behaviour than from systemic obstacles created by laws, administrative procedures and fees. This is especially true for undocumented migrants, whose lower use of services reflects administrative and legal impediments rather than lack of need.

91. Communication is central: interpreters, translated materials and cultural mediation are vital, yet insufficient if health systems remain understaffed or culturally insensitive. Clinicians often adapt by simplifying care or relying on informal support when strict compliance may harm patients. Primary care improves migrant health when staff capacity, communication and service integration are strengthened. Migrants' access to healthcare, including to mental healthcare, must be seen as a measure of health-system quality, not merely a minority-health issue. Persistent challenges include language barriers, cultural misunderstanding, and legal or financial exclusion; key remedies are the use of interpreters, professional training and integrated primary care.

92. Ensuring equal access to healthcare is both a human rights obligation and a public-health necessity, as denial or delay may endanger the wider population. Access to adequate nutrition, housing, and preventive and curative treatment remains essential to improving migrant and refugee health across Europe.

93. The Assembly must continue addressing these issues, recognising that health care in the context of migration is integral to achieving the United Nations' Sustainable Development Goals, including universal health coverage and effective management of health emergencies. Health, as a fundamental right under international law, requires a social, holistic, regionally grounded, and risk-group-oriented approach.

94. In line with Resolution 2627 (2025) "Promoting universal health coverage", the recommended strategy calls for a Europe-wide shift towards universal frameworks ensuring full access to mainstream services, maintaining safety nets for undocumented persons, investing in preventive care, and engaging communities through inclusive service models, public-health messaging, and data collection.

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42. For the Project website in three languages (Turkish, English and Arabic) see www.sihhatproject.org.
43. Albania, Armenia, Austria, Belgium, Bosnia and Herzegovina, Canada, Croatia, Cyprus, Czechia, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Latvia, Liechtenstein, Lithuania, Luxembourg, Republic of Moldova, Montenegro, North Macedonia, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Ukraine, the United Kingdom.
44. www.infomigrants.net/en/post/70323/spain-to-extend-free-healthcare-to-irregular-immigrants.

95. Experts further underline that inclusion in national health-insurance schemes, the use of interpreters and cultural mediators, and integration with social-support programmes enhance outcomes, while legal regularisation and data protection promote trust. Integrated migrant-health policies improve public health and financial sustainability; social determinants, including housing, employment and the environment, must be tackled alongside medical care; and the qualifications of migrant health professionals should be swiftly recognised.

96. Member States are furthermore encouraged to consider bringing more projects forward for loans from the Council of Europe Development Bank, to strengthen healthcare infrastructure, equipment, and staffing in reception and detention centres.

97. Finally, as regards age assessment for unaccompanied children, attention is drawn to Recommendation CM/Rec(2022)22 of the Committee of Ministers to member States on human rights principles and guidelines on age assessment in the context of migration, which member States should implement through appropriate legal and practical measures.