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Barriers to Healthcare: How Legal Status Shapes Migrants Healthcare Access in Germany

A qualitative content analysis of legal and administrative barriers

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Abstract

This thesis investigates how Germany's legal and administrative structures restrict migrants' access to healthcare and explores which policy changes could improve this access. The study uses a qualitative content analysis of legal documents, policy texts, and academic literature. It analyses healthcare entitlements of different legal status, particularly asylum applicants, individuals with tolerated stay, and irregular migrants. France, the Netherlands, and Sweden are used to draw comparative insights and identify alternative approaches. The baseline of this study is the perspective, that access to healthcare is a human right based on different international agreements. Germany has also committed to multiple international legal frameworks that obligate healthcare access for everyone, but national laws remain different.

The analysis reveals that healthcare access in Germany is highly stratified, with different administrative implementations of the law leading to unequal conditions for migrants. Irregular migrants face further barriers due to a reporting obligation. In contrast, the compared countries provide at some points a more inclusive systems of access for migrants. The policy elements that were identified in this thesis, such as electronic health cards, anonymous access mechanisms, and administrative harmonization, can be used to inform policy reforms in Germany.

In this work I made use of generative artificial intelligence. Please see the appendix for the disclosure statement.

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1. Introduction

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." – Constitution of the WHO

This is one of the principles laid down in the constitution of the World Health Organization in 1946, and yet, this is not the case in most countries of the world, including Germany (WHO, n.d.). Although Germany's healthcare system is considered to be one of the most comprehensive in the world (OECD, 2023), many migrants experience significant barriers to accessing adequate medical care (Hahn et al., 2020).

The German health care system is based on statutory health insurance (Gesetzliche Krankenversicherung) and private health insurance (Private Krankenversicherung). While most residents are insured via the statutory insurance, migrants are often excluded due to legal restrictions, lack of information on how to receive medical care, language barriers and complex administrative procedures (Hahn et al., 2020). Private insurance is often only available to civil servants, people with higher incomes and self-employed. Thus, migrants are often excluded, therefor this is not included in this thesis (Flegar et al., 2016).

This highlights a critical issue at the intersection of migration, public administration, and healthcare policy. The question of health care access for migrants and asylum seekers is not only a policy issue but also a human rights concern. Access to health care is a fundamental human right, yet migrants in Germany often face structural barriers that limit their ability to receive adequate medical services.

In addition to signing the WHO Constitution, Germany has also committed itself to the SDGs, including Goal 3.8 which aims to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (The Global Goals, n.d.). This commitment to the SDGs, as well as other international agreements and European Union directives which call for equitable healthcare access, national laws and regulations often fall short of these standards.

This research looks at what has happened in the recent years and whether the government is working to achieve better health care for migrants. While there is literature on healthcare access for migrants in Germany, many studies treat 'migrants' as a homogenous category. Other research does not look at the different legal categories in access for migrants and their specific administrative barriers. Furthermore, there is limited research on how specific changes could mitigate the challenges migrants face. This thesis looks at the current barriers which asylum seekers, tolerated individuals, irregular migrants and those with residence permits face in the German healthcare system. It addresses these specific healthcare gaps for the different categories by identifying the most pressing barriers, analysing other systems from European countries, and proposing solutions to improve migrants' access to healthcare in Germany.

The health care challenges faced by migrants in Germany are addressed because it is both a matter of human rights and a step towards a more inclusive society. Ensuring equitable access to health care not only ensures the well-being of vulnerable populations, such as migrants, but also promotes social cohesion through treating all people equally and giving them the same opportunities. Limited access for migrants increases social inequalities and hinders a successful integration into the society.

From a scientific perspective, this research contributes to the broader understanding of how legal and administrative structures influence access to healthcare. By proposing practical reforms, this thesis

seeks to inform and contribute to the academic discourse on the intersection of migration, public administration, and healthcare. It also emphasizes the interconnectedness of health policy and human rights, highlighting the importance of inclusive governance within different policy areas.

This thesis answers the following main research question:

In which ways do Germany's legal and administrative structures restrict migrants' health care, and how can policy changes improve migrants' access to health care?

To address this overarching question, the following sub-questions will guide the analysis:

1. How do Germany's health care criteria for migrants differ according to their legal status?

2. In what ways do administrative procedures create barriers to health care for migrants in Germany?

3. What policy lessons can Germany draw from other European countries to improve migrants' access to healthcare?

By looking at the current legal criteria, the current and most pressing barriers for migrants are identified. Rather than looking at migrants as a single category but seeing how there are differences in the legal status defined by the German government. As well as looking at the bureaucratic challenges that migrants face, as for example language barriers and lack of information and support. By also looking at other European countries, this research aims to learn from them and offer policy recommendations to improve access to health care for migrants of all legal statuses in Germany. The findings should help understand the complex interplay between healthcare policies, migration, and public administration, and then following to provide a basis for policy changes.

This thesis is structured as followed: Chapter 2 describes the theoretical framework on healthcare access, legal status definitions, and administrative barriers. Chapter 3 outlines the research methodology. Chapter 4 analyses current barriers to healthcare access by examining legal entitlements and administrative challenges for different migrant categories. Chapter 5 compares the German system with other systems from France, the Netherlands, and Sweden to identify potential solutions. Chapter 6 concludes with key findings, possible improvements, and areas for future research.

2. Theory

2.1 Healthcare and Access to Healthcare

2.1.1 Definition on Healthcare and Access to Healthcare

Healthcare refers to "services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health" (UHC, 2001). This includes not only physical well-being but also mental and psychosocial health. In Germany some migrants face difficulties accessing healthcare. Access to healthcare means the ability to receive appropriate healthcare including all necessary preventive, rehabilitative, and palliative services. Barriers to access may arise for various reasons, for example the lack of financial resources and information (UHC, 2001). Accessibility goes beyond the mere existence of availability of healthcare. Availability refers to whether

sufficient healthcare services, facilities and personnel exist to cover the needs of people (CESCR, 2000). Germany's healthcare system is characterized by a high level of availability to healthcare. Germany has above-average infrastructure, hospital capacity, and personnel compared to other EU countries (OECD, 2023).

While the quality of healthcare also plays an important role, it is mainly relevant after access has been secured. Quality refers to the extent to which healthcare services are effective (CESCR, 2000). Germany is widely regarded as having a high-quality healthcare system and once people have access to the system, they have access to effective medical treatment (OECD, 2023). Therefore, the central issue for many migrants is not the availability or quality of services, but rather the accessibility of care.

2.1.2 Access to Healthcare as a Human Right

The right to health has been written down as a fundamental human right in various international legal frameworks. As mentioned above by the WHO as well as by the International Covenant on Economic, Social and Culture Right (ICESCR), in Article 12. This Article obligates to recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (UN General Assembly, 1966). The UN Committee on Economic, Social and Cultural Rights outlines the core components of the right as availability, accessibility, acceptability and quality (CESCR, 2000). From this perspective, access to healthcare is not limited to the presence of services but also includes the ability of individuals to utilize the services. The right to health therefore requires that states not only stop discriminatory practices but also take positive steps to eliminate structural barriers to access, especially for marginalized groups such as migrants.

However, in practice, access to healthcare is influenced by national legislation and administrative structures. Although Germany has committed itself to those international human rights obligations, there are still significant disparities in the way different population groups experience the healthcare system. It highlights the gap between Germany’s international human rights commitments and its national policies. This research views healthcare access not as a privilege linked to citizenship or economic status, but as a legal and moral obligation of the state.

2.2 Legal Status

2.2.1 Migrant

In public discourses, the terms ‘migrant’ and ‘refugee’ are often used interchangeably as a blanket term. However, it covers different legal residence statuses and permits. This distinction is important from a legal perspective, as the different statuses implicate different rights and have implicit implications for access to healthcare.

While the term ‘Migrant’ is not a precise legal category in German law, ‘migrant’ serves as an umbrella term including various populations groups whose healthcare experiences are shaped by their specific legal classifications. There is also no universally recognised definition, which highlights the broad and often context dependent use of the term (IOM, 2021).

This research defines migrants as individuals which moved away from their original place of residence to a new place. More specific individuals who moved across borders. Thus, migrants are people that are not born in Germany or without a German citizenship but moved to Germany. This can be for example foreigners or already naturalised people (DESTATIS, n.d.). The term migrant is independent of the reasons and causes of the movement, also if it was voluntary or involuntary. It is regardless of the legal status or the length of the stay (UN, n.d.), as well as of the means whether regular or irregular (BAMF, 2018a). This thesis looks at the first generation of migrants, meaning those that moved personally from another country to Germany not the second generation which are their children, which are already born in Germany (bpb, n.d.).

2.2.2 Asylum seeker and applicant

2.2.2.1 Asylum seeker

Under German law the term asylum seeker (Asylsuchender) refers to a person who has declared their intention to seek asylum in Germany but has not yet formally submitted an application for asylum to the Federal Office for Migration and Refugees. According to § 63a of the Asylum Act (AsylG), an asylum seeker is a foreign national who expresses the wish to apply for asylum and has been through an identification procedure and is issued a certificate known as an 'Ankunftsnachweis' (arrival certificate). This document officially confirms the individual's status as an asylum seeker.

Asylum seekers are therefore in a preliminary legal position, they have initiated the asylum process by presenting themselves to the authorities, but they are not yet recognized as asylum applicants (Asylbewerber). The status of an asylum seeker is generally temporary and limited to a maximum of six months and can by exception be extended by a maximum of three months. It is subject to change depending on whether the person proceeds to submit an application and what the outcome of that process is (AsylG § 63a).

2.2.2.2 Asylum applicant

An asylum applicant can be defined as an individual who has already formally expressed their intention to seek protection in Germany. According to AsylG § 13 an asylum application exists when a foreign national expresses their intention to seek protection in Germany from political persecution, deportation, or return to a state where they may face persecution (AsylG § 3 (1)) or serious harm (AsylG § 4 (1)).

After applying for asylum, the foreigner receives a temporary residence permit called 'Aufenthaltsgesattung'. This is a permission to remain pending the asylum decision. The validity of this document is limited, if the applicant is required to live in a reception centre up to six months, in other cases up to twelve months (AsylG § 63).

2.2.3 Residence permit

2.2.3.1 Recognised refugee

After applying for asylum there are different categories in which the foreigner could fall, and different categories of residence permits. This decision is taken by the Federal Office for Migration and Refugees (§ 31 AsylG). The decision is issued in writing and includes a legal justification.

One central protection category is refugee status, as defined by § 3 AsylG in line with the 1951 Geneva Convention. Refugee status is granted when an individual demonstrates a well-founded fear of persecution in their country of origin based on race, religion, nationality, political opinion, or membership in a particular social group. This fear must force the individual to remain outside their country of origin. This might either be because they cannot or due to this fear do not wish to seek protection from their country of origin. It also can count for stateless persons, if the individuals were previously resided habitually in a specific country and they can prove this (AsylG 3). Persecution is legally understood as acts that seriously violate fundamental human rights, such as torture, unjust imprisonment, or discrimination that affects personal freedom or dignity (§ 3a AsylG). The perpetrators can be the state, non-state groups that control parts of a territory, or private actors when state protection is not available (AsylG § 3c).

Refugee status is excluded if the individual has committed serious crimes (AsylG § 3(2). It may also not be granted if the person already receives protection from another country or international organization (AsylG § 3(3)) or could reasonably relocate to a safe part of their home country (AsylG § 3e). Individuals with refugee status are granted a residence permit valid for three years (§ 25(2) AufenthG). They also have unrestricted access to the labour market and are entitled to privileged family reunification. (BAMF, 2019a).

2.2.3.2 Subsidiary protection holder

A subsidiary protection status is granted to individuals who do not qualify as refugees under the Geneva Convention but are nevertheless at serious risk if returned to their country of origin. This applies when there are substantial grounds to believe that the person would face serious harm in their country of origin (AsylG § 4). Serious harm includes the imposition or execution of the death penalty, as well as torture, punishment, inhuman or degrading treatment. Serious harm is also deemed to be when a serious threat to the life or integrity of a civilian exists, because of indiscriminate violence in situations of international or internal armed conflict (AsylG § 4 (1)).

However, subsidiary protection may not be granted if there are serious reasons to assume that the person has committed a crime against humanity under international law, as well as committed a serious non-political crime outside the country and before entering. Further, they will not be granted subsidiary protection if the person poses a threat to the public and national security (AsylG § 4 (2)). It also does not apply when the person could reasonably relocate to a safe part of their home country (AsylG § 4 (3)).

Subsidiary protection status therefore functions as a complementary legal safeguard for individuals who fall outside the refugee definition but still require international protection. They receive a residence permit typically valid for three years, similar to refugees (§ 25 (2) AufenthG). As well as they are entitled to unlimited access to the labour market but are not entitled to privileged family reunification (BAMF, 2024b).

2.2.3.3 Person entitled to asylum

Apart from the subsidiary protection and refugee status, the German law also acknowledges individuals who are entitled to asylum under Article 16a GG. A person is entitled to asylum (Asylberechtigter) if they have been subjected to political persecution. To be recognised as person entitled to asylum, direct entry from a non-safe third country must be proven (Art. 16a GG).

Individuals who are recognized as asylum beneficiaries are granted the same legal rights as refugees under the 1951 Geneva Convention. This means they enjoy the protections and advantages foreseen in the Convention, unless national law grants them more favourable conditions (§ 2 AsylG). Persons entitled to asylum are also issued a residence permit for three years (§ 25(1) AufenthG), and they are entitled to unrestricted access to the labour market as well as privileged family reunification (BAMF, 2023).

2.2.3.4 Deportation Protection

National Deportation protection represents a specific form of protection in the German asylum system when the three primary protection categories, which are asylum entitlement, refugee protection, and subsidiary protection, are not applicable. This protection is based on the prohibition of deportation (§ 60 AufenthG). A person is not allowed to be deported either based on human rights or based on concrete dangers in the country of deportation.

The prohibition based on human rights ensures that deportation decisions comply with international human rights standards (§ 60(5) AufenthG). The prohibition on concrete dangers, is based on dangers to life, limb or freedom in the destination country. Health related dangers are only recognized when the individual suffers from life threatening or serious illness that would significantly get worse due to deportation. It is not necessary for the medical care to be equivalent to the care in Germany, as well as adequate care already counts as guaranteed if it is provided in part of the destination country (§ 60(7) AufenthG).

When national deportation protection is granted, thus individuals will not be returned to the state for which the deportation prohibition applies, the foreign national authority (Ausländerbehörde) issues a residence permit valid for at least one year. The residence permit entitles the holder to pursue employment, but not a family reunification (BAMF, 2019b).

2.2.3.5 Permanent Residents

Permanent residence in Germany is granted through a Niederlassungserlaubnis (permanent settlement permit) or an EU long term residence permit. These are unlimited residence titles available to individuals under § 25 AufenthG, who have held a valid residence permit for several years and who meet specific requirements.

Conditions for a permanent residence in Germany include a secured livelihood, adequate housing, no significant criminal record, basic knowledge of the legal and social order as well as sufficient German language proficiency (§ 9 AufenthG). If the status is given it provides secure residency and unrestricted access to employment (BAMF, 2024a).

2.2.4 Tolerated stay

A tolerated stay (Duldung) is a legal status, which temporarily suspends deportation. It applies to individuals who are, in principle, obliged to leave Germany but whose deportation is currently not possible due to factual or legal reasons (§ 60a (2) AufenthG). Thus, the status of tolerated stay only suspends the criminal consequences of illegal residence, without constituting a lawful residence permit. Also, the tolerated stay expires when the person leaves the country and does not authorise them to return to Germany.

Factual obstacles may include the absence of travel documents, lack of transport connections to the country of origin, or medical conditions that prevent travel. Legal obstacles may include ongoing court processes related to the migrant. In addition, toleration can be granted if urgent humanitarian or personal reasons or significant public interests require the foreigner's temporary presence in Germany. Tolerated stay for urgent personal reasons can be given if the foreigner is taking a qualified vocational training. A tolerated stay is then granted for the duration of the vocational training (§ 60c AufenthG). Similarly, a 'Duldung' for employment purposes may be issued if specific criteria are fulfilled, such as identity clarification, long term employment subject to social security contributions, language skills, and a secured livelihood. This type of 'Duldung' can just be granted to foreigners who entered the country before December 31, 2022 (§ 60d AufenthG). If the individual continues to meet specific requirements over time, including a secured livelihood and sufficient integration, it is possible to transition from tolerated stay to a residence permit (§ 25(5) AufenthG).

Although tolerated persons may remain in Germany legally, they face significant restrictions compared to persons with formal residence permits. They remain legally obligated to leave Germany, and their freedom of movement is often restricted (bpb, 2016).

2.2.5 Irregular Migrant

Individuals without a valid residence permit or tolerated stay who reside within Germany without the knowledge of immigration authorities are referred to as irregular migrants. Irregular migrants are residing in Germany in violation of immigration law, either due to unauthorized entry, overstaying a visa, or remaining after their legal status has expired. An unauthorized entry would be one without a passport or a passport equivalent (§ 14 AufenthG).

Both unauthorized entry and stay are punishable offenses and may lead to fines or imprisonment up to three year (§ 95 AufenthG). However, if a person applies for asylum immediately after the unauthorized entry in the country, the criminal proceedings will be suspended until the asylum procedure has been completed. A positive asylum decision usually leads to the criminal proceedings being discontinued (§ 31 (1) AufenthG). German public authorities are generally obligated to inform the immigration authorities or police if they become aware of individuals residing in Germany without the required residence permit (§ 87(1) and (2) AufenthG) (BAMF, 2018b).

2.3 Administrative Barriers and Role of Bureaucracy

While legal status determines the formal entitlement to healthcare, administrative procedures heavily influence the practical accessibility of services. Administration is the organization of tasks and

responsibilities, as well as the delegation of authority and leadership. Political administration is a shorthand term for all institutions and entities of the executive branch. These are the executive bodies of the government which are the institutions and organs through which the government carries out tasks. The bodies plan, organize and monitor the migration process (Schubert et al., 2020). These include in this case for example the immigration offices (Ausländerbehörden), social welfare offices (Sozialämter) and health insurance providers (Krankenkassen). These institutions are involved in application processes and granting access to healthcare.

These processes are embedded within a bureaucratic framework characterized by high levels of formalization and strict procedures. Everything is precisely organized, and every task is clearly defined (Schneider et al., 2025). Thus, bureaucratic principles require that every service is tied to specific documents, deadlines, and legally regulated procedures. For migrants, these strict processes mean long waiting periods for decisions, along with the requirement to navigate through the complex bureaucratic system in Germany. This leads to the risk of losing entitlements due to missed deadlines and mistakes. This can happen through lack of information and support mechanisms, which leaves migrants unaware of their entitlements or steps to do. These challenges can be exaggerated through language barriers, for example when filling out papers in German.

2.4 Policy

In this thesis, policy refers to a set of decisions, actions, and guidelines formulated and implemented by public authorities. These policies should address specific societal problems or generally achieve certain goals. There are different processes during the building of policies. Decisions are made by governmental actors as strategic choices, actions represent the practical steps taken to implement these choices, and guidelines establish standards and procedures that shape decision-making and executive processes (Anderson, 2003).

Thus, Policies function as frameworks that shape the way public services are delivered and accessed. In the context of migrants' access to healthcare in Germany, policies directly impact whether and how foreigners can access healthcare services based on their legal status. But policies are not limited to laws alone, but also include rules, guidelines and implementation strategies for the executive. Therefore, if migrants are provided with supporting structures such as accessible information and language mediation services. It is not just about the existence of rights, but also about the realization of those rights through concrete administrative practices.

3. Methods

3.1 Research Design

This study employs a qualitative analysis research design. It uses a textual analysis to examine how legal and administrative structures in Germany restrict migrants' access to healthcare. Textual analysis is best suited to answer the research question because it allows for a comprehensive and interpretive understanding of how access to health care varies according to migrants' legal status and what policy implementations are best implemented for different migrant groups.

The primary method, textual analysis, is used to systematically examine how laws, policies, and administrative procedures shape access to health care. Textual analysis provides an in-depth examination of policy documents, legal texts, and academic literature. It highlights how laws and regulations affect migrants access to health care. This method allows for the identification of systemic patterns and policy gaps, particularly concerning legal status, administrative complexity, and human rights standards. It ensures a nuanced and detailed understanding, taking the complexity of the German healthcare system and the variations in access based on migrants' legal status into account (Given, 2008).

The study also uses a comparative case study approach, to answer sub-question three. In this case to look for policy reforms which could improve the access to healthcare. After finding out what the policy gaps are and where room for improvement is, the study looked at other countries to find potential changes in policies. The research compares Sweden, France and the Netherlands to Germany. These countries have been selected based on their EU membership, similar socio-political systems characterized by strong welfare states, and their comparatively inclusive approaches to migrant health care. The comparative approach allows the study to further assess how different legal and administrative choices affect access to healthcare, and to draw lessons from countries that have implemented progressive healthcare policies for migrants (George et al. 2005).

3.2 Method of Data Collection

The data for this research is collected through textual analysis of legal texts, government publications, NGO reports and academic literature. This method allows for a comprehensive investigation of how healthcare access for migrants is structured in both legal and administrative terms.

The primary dataset includes core German legislation such as the Asylbewerberleistungsgesetz (Asylum Seekers' Benefits Act), Sozialgestzbuch (Social Code Book) and other migration policies. These legal texts define the rights and limitations of the different migrant groups. Further European Union directives will be taken into account, to assess Germany's obligations.

Secondly, Government reports, NGO reports, publications from German federal institutions, particularly the Federal Office for Migration and Refugees (BAMF) are used. They are used to gain insights into the way in which policies are interpreted and implemented and how they should work. Official websites of various institutions were also used to find authorised definitions, and information on the rights of different migrant groups.

Lastly, academic literature is included to provide a scholarly analysis of migrant healthcare access in Germany and the selected comparative countries. This includes peer-reviewed academic articles published in journals that focus on healthcare policy, migration studies, public health, and human rights. To identify and access these articles, academic search engines and databases such as Google Scholar, SpringerLink and SAGE Journals, were used. The search strategy included a combination of keywords such as 'healthcare access', 'migrants', 'Germany', 'asylum seekers' and 'health policy'. The search focused mainly on publications from the last 5 years (2020–2025) to ensure relevance and to capture the most recent policy developments and research findings.

These sources helped to illuminate how healthcare policies are implemented in practice and how they affect migrants' lived experiences. Policy documents are treated as primary sources to understand the formal legal frameworks, while academic literature serves to critically assess these policies and the administrative implications.

For the comparative part, data on healthcare access in France, the Netherlands and Sweden is drawn primarily from peer-reviewed academic articles together with NGO reports. These were chosen not only to understand the formal policies in the specific countries, but also to gain insights in how these policies are implemented and how they work in practice.

3.3 Method of Data Analysis

The research used a content analysis as a method of data analysis. Content analysis is suitable for interpreting different types of texts, such as policy, legal, and academic texts. It enables the systematic identification of patterns, themes, and meanings in complex data, to get a better and deeper understanding of how access to healthcare for migrants is structured and regulated in both legal and administrative contexts (Given, 2008).

A deductive approach to content analysis was applied, meaning that the coding process was guided by predefined categories derived from the central research questions and theoretical framework of the thesis (Given, 2008). The main categories are legal barriers, administrative complexity, and comparative policy insights. The sub-categories for legal barriers and administrative complexity were based on legal status or entitlement regulations. Thus, it was looked at 'asylum seeker', 'asylum applicant', individuals with residence permit', 'tolerated stay' and 'irregular migrant'. When relevant further distinctions were made between different residents permits, so between 'recognised refugee', 'subsidiary protection holder', 'person entitled to asylum', 'deportation protected' and 'permanent residents'.

For each legal category access to healthcare was coded into one of three levels: no access/ not defined, limited access or full access. This gave an overview of which persons have which rights and enabled a systematic comparison across legal categories.

The coding was conducted in two rounds. In the first round, the main and sub-categories were applied to the different texts. In the second round, the codes were refined, and the levels of access were classified to increase specificity and consistency. To enhance reliability and transparency, all codes, as well as categories and definitions are documented.

The coding process was conducted using Atlas.ti a qualitative data analysis software. It was used to manage and organize, as well as unsure a consistent and transparent analytical process. The use of digital tools also facilitates the comparison of codes in different documents and helps to identify recurring themes and inconsistencies in access to healthcare for different migrant groups.

Lastly, comparative insights were gained from the cases of France, the Netherlands, and Sweden. These cases were analysed to identify best practices or alternative models. It was again looked at the different categories of 'asylum seeker', 'asylum applicant', individuals with residence permit', 'tolerated stay' and 'irregular migrant'. These categories are defined after the German legal definition. In some cases, this meant aligning other terminologies with corresponding German legal categories to ensure conceptual comparability. This meant, irregular migrants were often also named as undocumented migrants. With those corresponding categories, it was possible to compare with the German system and identify alternative approaches.

4. Barriers to Healthcare Access

4.1 Healthcare entitlement by Legal status

4.1.1 Healthcare Access for Asylum seekers and applicants

This section will address sub question one on how the healthcare criteria differ according to migrants' legal status in Germany. In Germany, migrants' access to healthcare is determined primarily by their legal status, which results in significant differences in the scope, quality, and accessibility to healthcare.

Asylum seekers and asylum applicants, defined under § 63 of the Asylum Act (AsylG), are persons who have at least declared their intention to seek asylum in Germany. During the time of the asylum procedure, they are only entitled to healthcare in cases of acute illness or pain, or in situations that require urgent treatment (§ 4 AsylbLG). This includes necessary medical and dental care, the provision of medicine and bandages, together with other services required to support recovery or relieve illness. Pregnant women and women who have recently given birth are above the entitled to more medical and nursing care. In addition, preventive health measures such as vaccinations and medically indicated check-ups, are also covered for asylum seekers and applicants.

Thus, preventive care, psychological support, or long-term therapies are usually not covered under this provision, unless they are deemed medically necessary. Additional healthcare benefits can be granted when they are essential for maintaining health or addressing special needs of children (§ 6 AsylbLG). This may include access to psychotherapy for trauma survivors, for example for victims of torture or sexual violence (Informationsverbund Asyl, 2023).

After 36 months without significant interruption of asylum seekers and applicants of being in Germany they are granted Analogleistungen. Analogue benefits enable access to healthcare services equivalent to those available to recipients of social welfare (§ 2 (1) AsylbLG). This does not only include treatment of scute and chronic illnesses, but also preventive care, dental care and medical rehabilitation.

This transition to analogues benefits assumes that they meet other eligibility requirements and have not deliberately prolonged their stay. This represents an improvement in their healthcare access from limited access before the 36 months to full access after 36 months. This transition was previously after 18 months but was raised to 36 months in February 2024 (Informationsverbund Asyl, 2024).

4.1.2 Healthcare Access for Foreigners with Residence permit

Recognised refugees, Subsidiary protection Holders, Persons entitled to Asylum and Individuals with deportation protection, all have a residence permit. They are also all entitled to the full range of healthcare benefits under the statutory health insurance system (§ 25 AufenthG). This includes comprehensive coverage for general and specialist medical services, mental healthcare, maternity care, rehabilitation, and preventive services, as well as prescription medication and medical aids.

The granting a residence permit, individuals transition from the AsylbLG to the standard security systems under the Social Security Code (§ 23 SGB XII). Thus, they are either automatically included in the statutory health insurance or registered through the Jobcentre if they receive social welfare benefits. The second means that costs are usually covered by social welfare offices or Jobcentres until they have employment and sufficient income (§ 5 SGB V). If they are employed it is mandatory to have

an insurance, this cost will be shared between employer and employee, as it is with every regular citizen (§ 3 SGB V).

Individuals with a residence permit hold the same rights and obligations as German citizens regarding healthcare. Recognised refugees, subsidiary protection holders and persons entitled to asylum have their residence permit for three years, therefore insurance is guaranteed for those three years if they do not do anything to that they lose the residence permit. For persons with deportation protection, this counts for least one year, if they do not leave the country. Lastly, if individuals received a permanent residence permit, they possess long term healthcare insurance and access to the full range of healthcare services (§ 25 AufenthG). From a legal standpoint, the healthcare access of residence permits is no longer restricted once the status is granted, thus they get full access to healthcare (Informationsverbund Asyl, 2023).

4.1.3 Healthcare Access for Individuals with tolerated stay

Individuals with a tolerated stay (Duldung) do not have a formal residence permit and are a unique legal category. Through this toleration, persons remain in a legally precarious position, which also affects their access to essential services such as healthcare. Healthcare access for individuals with a tolerated stay are the same as the ones for asylum seekers and asylum applicants (AsylbLG).

For the first 36 months of their stay in Germany they are entitled only to restricted healthcare services. These include treatment for acute illnesses and pain, emergency medical care, and maternity services. Mental health services are only covered in cases of severe psychological distress and typically require special justification. Other additional services can only be granted in exceptional cases, meaning they are granted limited access to healthcare (§ 4 AsylbLG).

After 36 months of uninterrupted stay in Germany, individuals with a tolerated stay become eligible for analogous benefits (SGB XII). It is needed that authorities do not classify them as having “self-inflicted” delays to their deportation. If this is not the case, they legally get full access to healthcare.

4.1.4 Healthcare Access for irregular migrants

Irregular migrants do not have a residence permit and also not a ‘Duldung’ (tolerated stay). Their legal status excludes them from regular social benefits and formal healthcare entitlements, placing them outside the scope of statutory health insurance and rendering them ineligible for regular social benefits under the Social Code Book. Thus, they are not regulated and are not meant to be supported financially for health care.

In addition to legal exclusion, a further barrier is created by the reporting obligations under § 87 AufenthG. According to this provision, public authorities, are obligated to report individuals who are residing unlawfully in Germany. The criminal nature of irregular migrants in combination with the legal obligation to report them creates substantial barriers for undocumented migrants.

However, it is important to note that emergency medical care cannot be denied, regardless of residence status. According to both medical ethics and German criminal law, hospitals are obligated to treat individuals in life-threatening situations. § 323c of the German Criminal Code (StGB) even states that

failure to render assistance in cases of accidents, common danger, or emergency is a punishable offense. In general irregular migrants are not specifically mentioned with regard to healthcare and thus not defined and granted access other than in life-threatening situations.

4.1.5 Discussion on the Differences in Legal Entitlements Based on Migrant Status

The analysis demonstrates that healthcare entitlements in Germany are multi layered and rising along legal status lines, ranging from exclusion in the statutory health insurance system to full inclusion. This legal fragmentation results in unequal treatment of migrants not based on their health needs, but on their legal categorization.

Germany's healthcare system for migrants operates on a clear hierarchical structure that directly correlates legal security with healthcare access. At the bottom of this hierarchy are irregular migrants, which are legally excluded from both statutory insurance and the Asylum Seekers' Benefits Act. Their healthcare access is undefined and relies on emergency care provisions. The system then progresses through asylum seekers and applicants, individuals with tolerated stay, and culminates with recognized refugees and those with residence permits who receive full statutory health insurance coverage.

Recognized refugees, subsidiary protection holders, persons entitled to asylum, individuals with deportation protection, and permanent residents are residence permits. They are legally integrated into the statutory health insurance system. Once this status is obtained and they receive a residence permit, they are entitled to comprehensive healthcare access in the same way as German citizens, including preventive, mental, and specialist care.

In between the extremes are asylum seekers, asylum applicants, and individuals with tolerated stay. These groups are legally restricted to care for acute illness and pain under § 4 and 6 AsylbLG during their first 36 months in Germany. Only after this period may they transition to 'analogous benefits', if conditions are met.

The stratification of entitlements outlined here demonstrates that Germany's healthcare system for migrants is based on a logic of conditionality. Access to adequate and comprehensive care is only granted to those with a residence permit, meaning secure legal status. For others, particularly those in asylum procedures or irregular migrants, have partial, temporary, or no entitlements. This system stands in conflict with the principle of universal healthcare access as formulated in human rights frameworks such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Germany signed.

4.2 Administrative Barriers

4.2.1 Healthcare Access for Asylum seekers and applicants

In addition to the legal restriction, asylum seekers and applicants in Germany face numerous administrative barriers that significantly complicate their practical access to healthcare. These barriers arise from a complex interplay of federal structures and significant discretion for local administrative bodies. The following part will look at sub-question two: In what ways do administrative procedures create barriers to health care for migrants in Germany?

When arriving asylum seekers are assigned to an Erstaufnahmeeinrichtung (initial reception centre), where the federal states are responsible for addressing their healthcare needs (§ 62 AsylG). In the decentralized system in Germany local social welfare offices manage healthcare access and funding. Some of the reception centres have inhouse clinics, which provide basic healthcare. However, these inhouse clinics do not exist in all reception centres, they vary considerably between the federal states and facilities, as well as the scope to access for different services (Gottlieb et al., 2020).

For other services that are not offered by the inhouse clinic or if there is no inhouse clinic, there are two administrative models for implementing the AsylbLG. These two models are either health care vouchers or the electronic health card. The health care vouchers are either issued for onetime use or for three months, depending on the local welfare offices which grant them (Gottlieb et al., 2020). Any health service requires a new voucher and therefore a new approval from administrative staff (Wenner et al., 2022).

Since the decision to approve services under § 6 AsylbLG is left to the staff of social welfare offices, outcomes depend heavily on local interpretation and available resources. There are no nationally binding guidelines for interpreting key terms such as " acute illness," and thus asylum seekers' access to healthcare varies widely by region. The administrative staff which decides about the health care vouchers do not have medical expertise. This administrative model has been criticized for creating unnecessary delays, confusion, and unequal access to care (Gottlieb et al., 2020). Through this need of approval for every heath service, there is also a further delay through bureaucratic processes (Gold et al., 2021b). Studies show that the use of health care vouchers is even associated with lower utilization of both general practitioners and specialist services, compared to the electronic health care model (Wenner et al., 2022).

The electronic health cards are issued by statuary health insurance on behalf of local authorities. Once it was issued, it allows asylum seekers to access healthcare services similarly to statutorily insured patients, reducing bureaucratic hurdles and stigma. While treatment entitlements remain limited to § 4 and 6 AsylbLG, the electronic health card model enables more consistent access. The electronic health card shows higher use for specialists (Wenner et al., 2022).

The decision of implementing electronic health cards lies in the first place with the federal states. Some states implemented the electronic health cards for all, some made it free to choose for the individual municipalities and other states have not implemented them at all. This shows the decentralization in Germany and big differences for migrant's access to the health system locally. It leads to geographic inequalities and makes healthcare access a matter of administrative choices (Gottlieb et al., 2020).

In general, the treatment for asylum seekers and applicants in their first 36 months in Germany remains limited to the treatment of acute symptoms, rather than addressing underlying or long-term health conditions. This symptom-oriented approach also hits particularly those suffering mental health disorders, which require systematic, targeted and sustained care (Janda, 2023).

Through healthcare vouchers and electronic health cards asylum seeks can access some of the healthcare system for free, but they could also always finance healthcare services themselves (Janda, 2023). Healthcare services are very expensive and a lot of migrants in general have financial problems because of medical care (Gold et al., 2021b).

After remaining 36 months in Germany, asylum seekers and applicants become eligible for 'analogous benefits' under § 2 AsylbLG. This marks a substantial administrative shift in healthcare access. They get the scope of benefits equivalent to those granted to German welfare recipients under the social code Books XII and V. Meaning they are now entitled to preventive care, mental health treatment, chronic disease management, and full specialist care (Gottlieb et al., 2020). They have free choice of doctor's

equivalent to the Statutory Health Insurance members (Janda, 2023). They are entitled to healthcare equivalent to the Statutory Health Insurance, but they are not formal members of the Sickness Funds and are not insured as other German citizens. Instead, the local welfare office continues to finance their healthcare, while the Sickness Fund simply administers the services and issues the electronic health card (Gottlieb et al., 2020).

A barrier that counts for all is the lack of information and language barriers. In many cases language mediation is only funded if it is seen as directly necessary for treatment, leading to under provision and more complications in medical appointments and before (Janda, 2023). The provision of language mediation also varies from municipality to municipality (Gerlinger et al., 2023). Through this language barrier in general, information on the access models is missing for around 10 percent (Wenner et al., 2022), there is often no information materials in the required languages (Henkel, 2023). These hurdles become more excessive if a health care voucher is needed compared to health cards in general (Gold et al., 2021b).

Although the 36-month rule under § 2 AsylbLG brings asylum applicants closer to full healthcare access, their administrative situation remains with barriers due to a lack of information or language translation services. They also remain dependent on highly fragmented, discretionary, and bureaucratic systems. Even after transitioning to statutory health insurance equivalent care, they are not fully insured in the formal sense, and access remains mediated by the welfare office, not based on independent membership rights (Wenner et al., 2022). Further, it takes long, 36 months, to even reach those analogue benefits, before that they are granted just limited access either through healthcare vouchers or the electronic health card.

4.2.2 Healthcare Access for Foreigners with Residence permit

Foreigners in Germany who have obtained a residence permit, such as recognised refugees, subsidiary protection holders, persons entitled to asylum, and individuals granted deportation protection, are entitled to comprehensive healthcare under the statutory health insurance system. Upon receiving their protection status, they become full members of a public insurance (Gottlieb et al., 2020). This transition marks a formal shift towards the full range of benefits. They get the same benefits as granted to the general population, but also have the same duties, like paying the insurance if they have a job. Despite legal equality through the insurance coverage, practical and administrative challenges remain that continue to affect the accessibility and quality of care (Gerlinger et al., 2023).

Insurance providers are governing themselves as public bodies but operating under state oversight and carry out tasks defined by legislation (Gerlinger et al., 2023). Public health insurance companies in Germany are legally required to accept any person, regardless of their health status (Flegar et al., 2016). Once migrants are accepted into the system, either as employed person through paying or by receiving social welfare benefits. They receive a regular health insurance card with which they have direct access to healthcare and can visit general practitioners, specialists, dentists, and hospitals just like any other insured person (§ 5 SGB V). They also have free choice of doctors within the statutory health insurance network

However, equal legal entitlements do not necessarily translate to equal access in practice. Migrants with residence permits can face the same structural problems that affect all patients, such as long waiting times or physician shortages in rural areas. But more importantly, they also encounter specific administrative and structural barriers related to their language skills and lack of information (Gerlinger et al., 2023).

A core issue is the lack of language mediation services. Communication between doctor and patient is foundational to effective healthcare, particularly in mental health and psychotherapy. Yet, under current legal interpretations, language mediation does not fall under the reimbursable services of public health insurance. Consequently, while health insurance covers medical treatment, it does not finance interpreters, even when they are necessary for understanding diagnoses or treatment plans. Migrants may legally have the right to care, but without adequate communication support, they are unable to access care effectively (Gerlinger et al., 2023).

Another challenge is the lack of accessible information. While healthcare providers and insurance companies are legally bound to inform patients about their rights and available services, such information is often provided exclusively in German. The lack of adequate multilingual resources creates an information gap for migrants with limited language proficiency. It undermines their ability to make informed decisions or navigate the system effectively (Gerlinger et al., 2023).

Furthermore, there are differences in the ability of patients to assert their right to healthcare. Administrative procedures, such as registering with a sickness fund or submitting claims, require a certain level of familiarity with the system. Migrants who are new to the country often lack this knowledge, and there is limited institutional support to help them understand the system. While residence permits are legally full members of the insurance system, they may struggle to realise their entitlements due to bureaucratic complexity and unfamiliarity with procedures (Gottlieb et al., 2020).

4.2.3 Healthcare Access for Individuals with tolerated stay

Individuals with a tolerated stay (Duldung) do not have a residence permit, they are just suspended from deportation. Which leaves them also without a statutory health insurance. They fall under the Asylum Seekers Benefits Act like asylum seekers and asylum applicants. During their first 36 months in Germany, they have only limited access to healthcare for acute illness and pain, which is also handled through health care vouchers or an electronic health card (Janda, 2023)

Each treatment usually requires prior bureaucratic approval, unless a federal state or municipality has introduced the electronic health card model. This leaves tolerated individuals with the same hurdles as asylum seekers and asylum applicants. Health care vouchers hinder the access through long administrative processes and again leads to geographical variations in access (Wenner et al., 2022). Additionally, they face language barriers and often limited knowledge of their entitlements (Janda, 2023).

After 36 months of uninterrupted and tolerated stay, they also may become eligible for ‘analogous benefits’ under § 2 AsylbLG. This transition entitles them to statutory health insurance equivalent care, administered by the statutory sickness funds. Hence formal entitlements exist, but de facto autonomy and some barriers in accessing healthcare remain, like language barriers and lack of information (Gottlieb et al., 2020)

Moreover, achieving this 36-month threshold is difficult for many tolerated individuals. Delays in deportation may be deemed “self-inflicted” by administrative staff, disqualifying them from the improved benefits even if their stay is above 36 months. This creates a situation of persistent legal uncertainty and administrative dependence, which contributes to missing out on healthcare (Janda, 2023).

4.2.4 Healthcare access for irregular migrants

Irregular migrants, those residing in Germany without a valid residence permit or tolerated status, face severe barriers to healthcare access. Legally excluded from both statutory health insurance and the entitlements defined by the AsylbLG. Their access to healthcare is neither systematically defined nor protected. While all individuals in Germany theoretically have a right to emergency medical care regardless of their residence status, the practical implementation of this right is complicated by the reporting obligations and the fear of detection.

The reporting obligation mandates that public authorities must notify the immigration office if they become aware of a person residing unlawfully in the Germany (§ 87(2) AufenthG). As a result, most irregular migrants get rejected for access or do not even access the healthcare system, because of the fear of being reported and deported. This fear is even higher when it comes to preventive healthcare, because the risk does not seem to outweigh the benefit. Most irregular migrants avoid seeking even urgent medical care (Flegar et al., 2016).

In response to this lack of healthcare, several German federal states have introduced regional initiatives to allow access to healthcare. Berlin for instance has implemented anonymized health care vouchers, allowing irregular especially undocumented migrants to receive medical treatment without revealing their identity to immigration authorities. However, such initiatives remain fragmented, and dependent on regional resources and political will (Flegar et al., 2016). These examples demonstrate that while healthcare access for undocumented migrants is not systematically provided at the national level, local policies can play a crucial role in facilitating inclusive care.

In other regions, NGOs such as Medinetz, Medibüro, or Medizinische Flüchtlingshilfe arrange medical care regardless of residence permit or health insurance status. These organizations act as informal mediators, connecting irregular migrants with healthcare providers who agree to offer care, often free of charge and anonymously. However, these services are often limited to emergency and immediate needs. These organizations or local policies are not represented everywhere in Germanies. In some parts of Germany, it is unclear for irregular migrants on how and if to get access to healthcare with the reporting obligation and financial costs (Flegar et al., 2016).

4.2.5 Discussion on Administrative Barriers

Even when formal legal entitlements exist, administrative procedures often restrict actual access. Bureaucratic complexity, decentralization, and inconsistent implementation create a second layer of inequality.

Asylum seekers and asylum applicants have limited access but if they can visit inhouse clinics, this is a low barrier to that access. Those clinics have low bureaucratic barriers, they can just go there and get checked. For other services that are not offered by the inhouse clinic or if there is no inhouse clinic it gets more complex. On the one hand are healthcare vouchers, which create a barrier for the access, through their long bureaucratic processes. On the other hand, is the electronic health card, which makes the access compared to vouchers better and quicker through lower bureaucratic hurdles.

Above that, there is no clear definition on acute illness and pain, thus it gets interpreted differently in every municipality and by every person in the administrative process. The decision is also taken by staff without medical expertise, which makes it not focused on the medical issue and open to discrimination. This different interpretation and different way of implementing healthcare for asylum applicants,

asylum seekers and tolerated persons shows inequalities in access even regionally. The access for them in the first 36 months is generally limited and there is room for improvement.

After 36 months migrants in the application process or with a tolerated stay (Duldung) can be granted analogue benefits, which allow for more than just healthcare in acute cases. But it takes three years to get there. This was shorter before, even at 18 months. Migrants in the application process or with a tolerated stay can get these analogue benefits when local authorities decide their stay is “uninterrupted” and whether any delay in their asylum or deportation process was “self-inflicted”. These vague criteria open the door to inconsistent application and uncertainty, which leaves room for discrimination.

Even migrants with full access through the statutory health insurance system, still face barriers in accessing healthcare. This can be through language and communication barriers. Official letters, application forms, and health-related documents are typically issued in German. Without translation support, it makes it extremely difficult to navigate through the system, request benefits, or advocate for their rights. Interpreter services are not systematically provided and are often not reimbursed by local authorities. This places the burden of communication on patients, which is especially problematic when mental health or complex conditions are involved.

It also hinders the access to information about how to access the healthcare system. Lack of information and guidance means that migrants are unaware of their rights, services that are available to them and the steps that are needed to obtain care. In many municipalities, staff is not trained to provide information in a culturally sensitive or linguistically accessible manner. This leads to a structural disempowerment, where individuals are dependent on NGOs or volunteers to access even basic healthcare services. Especially irregular migrants are bound to NGOs or volunteers, as public authorities must act under the reporting initiative and there are just a few exceptions. For irregular migrants it is almost impossible to access the healthcare system without help. They face always the risk of being reported and deported.

5. Comparison to other EU countries

5.1 France

Like Germany, France is a member of the European Union and a signatory of major international human rights frameworks. In practice, however access to healthcare for migrants in both countries, is conditional on their legal status and administrative eligibility. The French policies offer important insights for evaluating Germany’s healthcare approach for migrants and identifying possible reforms (Marsaudon et al., 2024).

Legal residents in France, including asylum applicants, are generally covered under Universal Health Coverage, the French universal health protection scheme. After residing in France for three continuous months, individuals can apply for Universal Health Coverage. Therefore, they need to provide documentation of their legal stay and proof of financial need. Once covered under the Universal Health Coverage, migrants are entitled to a wide range of healthcare services, equivalent to French citizens. This includes access to general and specialist care, mental healthcare, maternity services, and prescriptions (AIDA, 2024).

During the three-month waiting period migrants can just receive emergency care through hospital services or special health access points. France mandates public hospitals to offer specific health care services free and open for people to receive primary medical care without insurance. These clinics

ensure basic continuity of care and prevent avoidable emergencies, serving a similar function to the NGOs that provide anonymous care in Germany (Marsaudon et al., 2023). Apart from this, healthcare providers are legally encouraged to provide linguistically and culturally appropriate services. This does also apply for the following two cases.

Each group in France is granted access to healthcare through different legal frameworks, even irregular migrants. They can access healthcare through State Medical Aid, a public health insurance scheme specifically designed for them. It covers a wide range of services, including specialist consultations, hospital treatments and medications. The services provided are free of charge and the insurance is valid for one year, after which it must be renewed (Marsaudon et al., 2024).

Criteria for state medical aid is the proof of continuous residence in France for at least three months and also income below a defined threshold. The coverage of the state medical aid insurance is slightly less comprehensive than the access offered under standard public health insurance. Nonetheless, it represents a formal legal entitlement to healthcare for irregular individuals and has a measurable impact on healthcare utilization. Studies show that recipients are significantly more likely to access outpatient care and general practitioners than those without coverage (Marsaudon et al., 2024).

5.2 Netherlands

In the Netherlands national government has a regulatory role in healthcare, but the responsibility for the provision of services for migrants has been significantly decentralized to municipalities, similar to the German decentralized system (Flegar et al., 2016). The Dutch law distinguishes healthcare access of migrants primarily between asylum applicants, recognized refugees/ subsidiary protection holders and undocumented individuals.

Asylum seekers are not covered by the Dutch Health Insurance Act, but they receive care under the Regeling Medische Zorg Asielzoekers, a parallel arrangement. This scheme allows access to a broad package of basic care, including hospitalisation, general practitioner consultations, physiotherapy, limited dental care, and psychological care (Kuipers et al., 2022). They can access these healthcare services after two months of being in the Netherlands. During the first two months of their stay, they are entitled only to emergency and non-postponable healthcare (EMN, 2020).

Migrants who are granted refugee status or subsidiary protection are required to take basic Dutch health insurance under the Zorgverzekeringwet (Health Insurance Act). Thereby, they gain access to the mainstream health system. They are entitled to the same range of services as Dutch citizens, including primary and secondary care, hospital services, and maternity care (EMN, 2020).

Irregular migrants, those without a valid residence permit, are excluded from public health insurance (Kuipers et al., 2022). However, Dutch law guarantees access to “medically necessary care” for everyone. This care is defined by professional medical standards rather than legal eligibility (Hintjens et al., 2020). Healthcare for irregular migrants includes access to primary, secondary, and maternity care in necessary situations. It is offered through the mainstream healthcare system and providers are legally obligated to offer this care (AIDA, 2025a).

However, reimbursement is conditional because healthcare professionals must first attempt to collect payment from the patient. If the patient cannot pay, the provider may apply for compensation from the Centraal Administratie Kantoor, which reimburses up to 80 percent of general costs and 100 percent for maternity care (AIDA, 2025a). Hence, despite their entitlements, significant barriers persist. Studies

show that 29 percent of irregular migrants in the Netherlands did not receive the care they were legally entitled to, often due to fear of identification, or inability to pay. As well as they lack information, awareness and language barriers. Many irregular individuals do not trust healthcare providers, they fear that they would inform immigration authorities (Hintjens et al., 2020).

5.3 Sweden

Sweden's healthcare system also has decentralized structures. The county councils are responsible for administering primary health centres, hospitals, and dental care services, while the national government sets the regulatory standards (AIDA, 2025b).

During the asylum process, applicants are entitled to a limited but targeted package of healthcare services. They get access to “care that cannot be postponed”. What counts as “care that cannot be postponed” gets interpreted by medical staff. In general, it includes emergency and urgent medical or dental care that cannot be postponed, as well as gynaecological, and childbirth-related care. Healthcare access is managed through the issuance of a health card (LMA), which must be presented during medical visits (Raphaelswerk, 2019).

There are patient fees for asylum seekers, but those are subsidized and generally low (e.g., SEK 50 for doctor visits and SEK 25 for nurse consultations). If healthcare costs exceed SEK 400 within six months, asylum seekers may apply for reimbursement through the Swedish Migration Agency (AIDA, 2025b).

Persons who have been granted international protection or other forms of residence permits in Sweden, are entitled to full access to Sweden's public healthcare system. They have full access to the universal healthcare system, which is tax funded. This includes both preventive and curative services, with only nominal fees charged at the point of service. Individuals with residence permits are treated in the same way as Swedish citizens in the healthcare system and benefit from comprehensive coverage and accessibility (Ross, 2023).

Individuals without a residence permit and who are irregular in Sweden, are entitled to “care that cannot be deferred”. This is a legal concept that came into practice to cover nearly all urgent and non-deferrable healthcare needs. This was a major shift from the previous policies that allowed only unsubsidized emergency care. Despite these formal entitlements, significant other barriers to access still exist. Over half of irregular migrant’s report experiencing at least one barrier to accessing healthcare. These include a lack of awareness of rights, fear of deportation, language and administrative hurdles, and inability to pay even the subsidized fees (Mona et al., 2021).

5.4 Discussion

In the analysis of the cooperative cases, the focus lies mainly on legal entitlements to healthcare of migrants. This is due to the restricted scope of a bachelor thesis. Further, administrative barriers will just be mentioned broadly because of limited data of bureaucratic procedures or implementation practices.

The comparative analysis of France, the Netherlands, and Sweden revealed several differences in how healthcare access for migrants is structured, particularly irregular migrants or those in the application process. Even though they have the same commitments to human rights and EU values, each country has different institutional arrangements and policies.

One of the clearest differences lies in the treatment of irregular migrants. In contrast to Germany, which legally excludes illegal migrants from healthcare entitlements and discourages access through the reporting obligations (§ 87 AufenthG). France, the Netherlands and Sweden provide formal frameworks for irregular migrants to receive at least basic or emergency care. France's State Medical Aid as well as the other countries regulations of "medically necessary care" and "care that cannot be deferred", demonstrate that it is institutionally feasible to offer access without fully legalizing the status.

Fear of deportation is a common deterrent for irregular migrants across all countries. However, in France, the Netherlands, and Sweden, national or regional laws offer either confidentiality protections or anonymous access options to give the possibility to seek for treatment. In Germany, the lack of such protections in most places and the mandatory reporting law acts as a deterrent. Reforming § 87(2) to exempt public authorities from the reporting obligation, when it comes to healthcare access, would reduce fear and improve early treatment.

Another key finding is that the decentralized administration in Germany creates significant differences in how healthcare access is implemented, particularly for asylum applicants and individuals with tolerated stay. The fragmented use of healthcare vouchers and electronic health cards and the varying interpretations of terms like "acute illness", leads to regional inequalities. By contrast, Sweden's centrally issues LMA cards for all asylum seekers and applicants.

Germany could improve consistency of the implementation on healthcare access by mandating a national implementation of the electronic health card for all asylum applicants and tolerated persons. This would reduce bureaucratic hurdles and geographical inequality. Further, introducing national guidelines for interpreting eligibility criteria under AsylbLG § 4 and 6 would prevent arbitrary decisions at the local level. The criteria should also be interpreted by medical staff rather than administrative staff.

It should be noted that the category of tolerated stay (Duldung) is only a German legal construct and does not have a direct equivalent in France, the Netherlands, or Sweden. In comparative frameworks, individuals with tolerated status are typically classified as irregular migrants. In Sweden, irregular migrants are usually just granted care that cannot be deferred. In the Netherlands they have to pay for healthcare if they can. Thus, they are worse of then in Germany where they get limited access to healthcare for acute illness and pain in the first 36 months and after that full access.

In all three countries studied, access to healthcare begins earlier or is less strictly tied to long-term residence. For example, in France, asylum seekers can access services under the universal coverage scheme after three months. In contrast, Germany's 36-month waiting period before transitioning to more comprehensive "analogous" benefits represents a significant delay that can result in the worsening of untreated conditions. Reducing the 36-month waiting period for analogue benefits back to 18 months or even further would significantly improve access to necessary care.

All countries, including Germany, struggle with language barriers and a lack of accessible information. However, some countries offer better support mechanisms. In the Netherlands and Sweden, healthcare providers are legally encouraged to provide linguistically and culturally appropriate services. Germany, however, does not systematically fund interpretation services under the statutory health insurance, nor does it mandate multilingual information across all healthcare providers. Thus, they could introduce systematic language mediation services, funded either through statutory insurance or public

welfare offices. Further, national regulations could mandate the availability of multilingual healthcare information in all healthcare and administrative institutions.

6. Conclusion

This thesis set out to investigate the following question**:** In which ways do Germany's legal and administrative structures restrict migrants' health care, and how can policy changes improve migrants access to health care? Drawing on a qualitative content analysis of legal texts, policy documents, and academic literature, the research has generated important findings about the stratification of healthcare access in Germany, as well as how alternative systems in other European countries could contribute to more inclusive policies.

The analysis revealed that in Germany, access to healthcare for migrants is significantly stratified based on legal status. On the one hand, recognized refugees, subsidiary protection holders, persons entitled to asylum, individuals with deportation protection, and permanent residents can access the statutory health insurance system. On the other hand, asylum seekers, applicants, tolerated individuals, and especially irregular migrants face major administrative and legal barriers, including legal restrictions, different implementations through vouchers, and the reporting obligation of irregular migrants.

In sum, administrative procedures in Germany often function as gatekeeping mechanisms rather than as facilitators of access. While formal entitlements may exist on paper, actual access is hindered through bureaucratic processes, language barriers and lack of information. These processes particularly affect the most vulnerable groups, those without legal residence, with limited literacy, or in psychological distress, and further widen health inequalities. Furthermore, the German system produces unequal access to healthcare based on legal status rather than on medical need. This stratification is particularly harmful for individuals within the asylum process or tolerated stay. As they need to wait 36 months to get more than just access to acute healthcare. For irregular migrants, access to healthcare is from a legal perspective even more difficult. Irregular migrants are not granted any right to healthcare, they can only access for emergencies, as healthcare providers are not allowed to deny them. Moreover, irregular migrants face even then a significant risks because of the reporting obligation.

The comparative analysis shows that France, the Netherlands, and Sweden have developed more inclusive or more consistent healthcare systems for migrants. France offers State Medical Aid for irregular migrants and integrates asylum seekers already into the universal coverage scheme after three months. The Netherlands provides asylum seekers after two months with access to a broad package of basic care and allows irregular migrants to get "medically necessary care". Sweden uses a unified asylum card system and ensures at least "care that cannot be deferred" for irregular migrants. While none of these systems is without flaws, each offers elements that can inspire practical reforms in Germany.

The findings of this thesis have several implications for policy and practice in Germany. A first and central reform would be the revision of the reporting obligation under §87(2) of the Residence Act. Exempting healthcare providers like doctors but also administrative staff from the duty to report irregular migrants, would reduce fear and facilitate early medical intervention. Access for irregular migrants could further be improved through the establishment of a publicly funded scheme that enables anonymous or low-threshold treatment, drawing inspiration from France's State Medical Aid model or the Dutch state compensation approach.

Additionally, Germany could significantly improve equity by granting national access to electronic health cards for all asylum applicants and individuals with tolerated stay. This would reduce the currently existing regional differences with a standardized system. It would also reduce administrative burdens and enhance continuity of care.

Another important step would be the systematic funding and implementation of interpretation and translation services, either through public health authorities or within statutory health insurance. This would ensure that language is not a barrier to receiving appropriate care. Finally, federal guidelines should be introduced for the interpretation of benefit entitlements under the Asylbewerberleistungsgesetz. These would prevent arbitrary differences between municipalities. To implement these reforms, it would require coordinated action by the Federal Ministry of Health and the federal states, alongside cooperation with statutory health insurers, professional associations, and civil society organizations.

This thesis makes several contributions to the academic field. It provides a comparative legal and policy perspective on healthcare access for migrants, a subject that has a growing relevance because of both migration and public health studies. It focuses specifically on administrative and legal barriers and their interplay and sees what the different legal statuses mean for the access to healthcare. Finding out which category needs improvement and comparing to the approaches in France, the Netherlands, and Sweden. The thesis adds depth to our understanding of how welfare states manage access to basic rights for non-citizen populations and looks at how to improve the German system

At the same time, this study has several limitations. It relies just on qualitative document analysis and does not include empirical data, such as interviews with migrants, healthcare providers, or policymakers. Furthermore, the comparative analysis is limited to three Western European countries. In future research country models from Southern or Eastern Europe could be included. This could help to see other models and how they implement healthcare access for migrants. This could also help understand in detail how changes could specifically be implemented in Germany. Despite its limitations, this thesis provides a foundation for both scholarly inquiry and policy reform.

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8. Appendix

8.1 Use of AI

During the preparation of this work the author used ChatGPT and DeepL Write in order to brainstorm, find literature and check Grammer. After using this tool, the author reviewed and edited the content as needed and takes full responsibility for the content of the work.

8.2 Overview of Legal Access of Migrants in Germany

Category	**Subcategory**		**Code** (no access/ not defined, limited access, full access)	**Cite/ evidence**
Healthcare access through legal status	**Asylum seeker & applicant** (§ 63 & 63a AsylG)		Limited access (to full access)	§ 1 AsylbLG § 2 AsylbLG § 4 AsylbLG § 6 AsylbLG
	Individual with residence permit	**Recognised refugee** (§ 3 AsylG) **Subsidiary protection holder** (§ 4 AsylG) **Person entitled to asylum** (§ 2 AsylG) **Deportation protected** (§ 60 AufenthG) **Permanent residents** (§ 25 AufenthG)	Full access	§ 23 SGB XII § 26 SGB II § 5 SGB V § 25 AufenthG
	Tolerated stay (§60a-d)		Limited access (to full access)	§ 1 AsylbLG § 2 AsylbLG § 4 AsylbLG § 6 AsylbLG
	Irregular Migrant (§ 14 AufenthG).		No access/ not defined	§ 87 AufenthG § 323c StGB

8.3 Overview of Administrative Barriers of Migrants in Germany

<u>**Category**</u>	<u>**Subcategory**</u>		<u>**Code**</u>	<u>**Cite/ evidence**</u>
Administrative Barriers	**Asylum seeker & applicants** (§ 63 & 63a AsylG)		Before 36 months - inhouse clinic - healthcare voucher - electronic health card After 36 months -'analogue benefits'	- In-house clinics also offer basic health services . (Gottlieb et al., 2020) - two different administrative mechanisms to determine eligibility and regulate access to health care: the health care voucher (HV) and the health insurance card (HIC). (Gottlieb et al., 2020) - receive "analogous benefits", as defined by § 2 AsylbLG (Gottlieb et al., 2020)
	Individual with residence permit	**Recognised refugee** (§ 3 AsylG)	- public health insured	- Public insurance companies are obliged to accept any person (Flegar et al., 2016)
		Subsidiary protection holder (§ 4 AsylG)	- language barriers	
		Person entitled to asylum (§ 2 AsylG)	- lack of information	- burdens to access secondary care, and cultural, administrative, and language barriers (Mona et al., 2021)
		Deportation protected (§ 60 AufenthG)		
		Permanent residents (§ 25 AufenthG)		

	Tolerated stay (§60a-d)	Before 36 months - healthcare voucher - electronic health card After 36 months -'analogue benefits'	- two different administrative mechanisms to determine eligibility and regulate access to health care: the health care voucher (HV) and the health insurance card (HIC). (Gottlieb et al., 2020) - receive "analogous benefits", as defined by § 2 AsylbLG (Gottlieb et al., 2020)
	Irregular Migrant (§ 14 AufenthG).	- fear of being reported - some local initiatives - unclear access	- fear of being reported to or taken by the police or authorities (Mona et al., 2021) - Several Bundesländer have started initiatives to facilitate access to health care for undocumented migrants (Flegar et al., 2016)

8.4 Overview Coding of France, the Netherlands and Sweden

Country	Category	Cite
France	Asylum applicants	- First three months, they only have access to emergency health coverage (AIDA,2024) (- Open and free centres for Access to Health Care at their nearest public hospital (AIDA, 2024)) - Covered by the public health insurance (Marsaudon et al., 2024)
	Residence permit	- Covered by the public health insurance (Marsaudon et al., 2024)
	Tolerated stay	/
	Irregular migrants	- State Medical Aid (AME) enables them to receive free treatments in hospitals as well as in any doctors' offices (AIDA, 2024) (- Open and free centres for Access to Health Care at their nearest public hospital (AIDA, 2024))
Netherlands	Asylum applicants	- First two months of their stay entitled only to necessary non-postponable health care (EMN, 2020) - After […] they can access the same basic health package as citizens (EMN, 2020)
	Residence permit	- Can take out a health care insurance (EMN, 2020)
	Tolerated stay	/
	Irregular migrants	- "Medically necessary care" (Flegar et al., 2016) - Pay for health services unless they cannot afford the bill (Flegar et al., 2016)
Sweden	Asylum applicants	- "Care that cannot be postponed" (AIDA, 2025b) - LMA card must be presented when visiting a doctor (Raphaelswerk, 2019)
	Residence permit	- Full access to the host country's welfare and healthcare system (Ross, 2023)
	Tolerated stay	/
	Irregular migrants	- "Care that cannot be deferred" (Mona et al., 2021) - Laws of patient confidentiality (Mona et al., 2021)

8.5 Atlas.ti codes

name	groundedness	codegroups	comment
Asylum seeker & applicant	14	Asylum seeker & applicants	Limited access (to full access)
Deportation protection	11	Residence permit	Full access
Entitled to asylum	11	Residence permit	Full access
Irregular migrant	2	Irregular migrant	No access/ not defined
Recognised refugee	11	Residence permit	Full access
Subsidiary protection	11	Residence permit	Full access
Tolerated stay	14	Tolerated stay	Limited access (to full access)

document	document
AsylG.pdf	1) Dem Ausländer wird nach der Asylantragstellung in
AsylG.pdf	Einem Ausländer, der um Asyl nachgesucht hat und na
AsylG.pdf	§ 13 Asylantrag (1) Ein Asylantrag liegt vor, wenn sich
AsylG.pdf	§ 3 Zuerkennung der Flüchtlingseigenschaft (1) Ein Au
AsylG.pdf	(1) Ein Ausländer ist subsidiär Schutzberechtigter, we
AsylG.pdf	§ 2 Rechtsstellung Asylberechtigter (1) Asylberechtigt
AsylbLG.pdf	§ 4 Leistungen bei Krankheit, Schwangerschaft und Ge
AsylbLG.pdf	§ 6 Sonstige Leistungen (1) Sonstige Leistungen könne
AsylbLG.pdf	4. eine Duldung nach § 60a des Aufenthaltsgesetzes be
AsylbLG.pdf	(1) Abweichend von den §§ 3 und 4 sowie 6 bis 7 sind
AsylbLG.pdf	ein Asylgesuch geäußert haben und nicht die in den N
AsylbLG.pdf	§ 1 Leistungsberechtigte (1) Leistungsberechtigt nach
AufenthG.pdf	§ 60a Vorübergehende Aussetzung der Abschiebung (I
AufenthG.pdf	§ 60b Duldung für Personen mit ungeklärter Identität
AufenthG.pdf	§ 60d Beschäftigungsduldung (1) Einem ausreisepflich
AufenthG.pdf	§ 60 Verbot der Abschiebung (1) In Anwendung des Ab
AufenthG.pdf	(1) Öffentliche Stellen mit Ausnahme von Schulen sov
AufenthG.pdf	§ 25 Aufenthalt aus humanitären Gründen (1) Einem A
Informationsverbund Asyl 2023.pdf	Behandlung akuter Erkrankungen und Schmerzzustän
Informationsverbund Asyl 2023.pdf	im Einzelfall zusätzliche Leistungen gewährt werden, v
Informationsverbund Asyl 2023.pdf	nach 36 Monaten des Aufenthalts in Deutschland (du
Informationsverbund Asyl 2023.pdf	Daneben wird der Zugang auch durch einen Wechsel i
Informationsverbund Asyl 2023.pdf	mit gewöhnlichem Aufenthalt in Deutschland müsser
Informationsverband Asyl 2024.pdf	Nach 36-monatigem ununterbrochenem Aufenthalt i
Informationsverband Asyl 2024.pdf	Zuvor bestand der Anspruch auf Analogleistungen nac
StGB.pdf	§ 323c Unterlassene Hilfeleistung; Behinderung von h
SGB_5.pdf	§ 5 Versicherungspflicht (1) Versicherungspflichtig sir
SGB_5.pdf	§ 3 Solidarische Finanzierung Die Leistungen und sons
SGB_12.pdf	§ 1 Aufgabe der Sozialhilfe Aufgabe der Sozialhilfe ist e
SGB_12.pdf	3. Hilfen zur Gesundheit (§§ 47 bis 52)
SGB_12.pdf	§ 23 Sozialhilfe für Ausländerinnen und Ausländer (1)
SGB_2.pdf	§ 26 Zuschüsse zu Beiträgen zur Krankenversicherung

document	document
Asylum seeker & applicant	Limited access
Asylum seeker & applicant	Limited access
Asylum seeker & applicant	Limited access
Recognised refugee	Full access
Subsidiary protection	Full access
Entitled to asylum	Full access
Asylum seeker & applicant, Tolerated stay	Limited access
Asylum seeker & applicant, Tolerated stay	Limited access
Tolerated stay	Limited access
Asylum seeker & applicant, Tolerated stay	Full access
Asylum seeker & applicant	Limited access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Tolerated stay	Limited access
Tolerated stay	Limited access
Tolerated stay	Limited access
Deportation protection	Full access
Irregular migrant	No access/ not defined
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Tolerated stay, Asylum seeker & applicant	Limited access
Asylum seeker & applicant, Tolerated stay	Limited access
Asylum seeker & applicant, Tolerated stay	Full access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Tolerated stay, Asylum seeker & applicant	Full access
Tolerated stay, Asylum seeker & applicant	Limited access
Irregular migrant	No access/ not defined
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Recognised refugee, Entitled to asylum, Subsidiary protection, Dep	Full access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access
Recognised refugee, Subsidiary protection, Entitled to asylum, Dep	Full access

name	groundedness	codegroups
Asylum Seekers & Applicants	98	Administrative Barriers
Irregular Migrants	34	Administrative Barriers
Residence Permit	44	Administrative Barriers
Tolerated stay	92	Administrative Barriers

document	quotation
Gold et al., 2021.pdf	eGK für Asylsuchende erleichtert ac
Gold et al., 2021.pdf	eGK werden Hürden bei der Inanspr
Gold et al., 2021.pdf	eGK wirkt sich sowohl auf die psych
Gold et al., 2021.pdf	Abbau von Leistungseinschränkung
Gold et al., 2021.pdf	eine eGK mit Leistungseinschränku
Gold et al., 2021.pdf	Grundsätzlich empfehlenswert ist e
Gold et al., 2021.pdf	zusätzlichen Barrieren bei der Inans
Gold et al., 2021.pdf	Diskriminierung aufgrund dieses Sy
Gold et al., 2021.pdf	in den zuständigen Behörden i.d.R.
Gold et al., 2021.pdf	Die eGK baut im Vergleich zum Beh
Gold et al., 2021.pdf	Einführung der eGK ein erleichterte
Gold et al., 2021.pdf	nzureichenden Möglichkeiten zur q
Gold et al., 2021.pdf	psychische Gesundheit von Geflüch
Gold et al., 2021.pdf	Einführung einer eGK zeigt positive
Gold et al., 2021.pdf	eingeschätzte Gesundheitsstatus ist
Gold et al., 2021.pdf	Durch den Zugang zu einer eGK im V
Gold et al., 2021.pdf	einen geringeren Verwaltungsaufwa
Gold et al., 2021.pdf	Kosten eingespart werden, wenn As
Gold et al., 2021.pdf	höhere Gesundheitsausgaben pro K
Gold et al., 2021.pdf	Reduktion bürokratischer Komplex
Gold et al., 2021.pdf	Hierdurch können auch Wartezeite
Gold et al., 2021.pdf	eGK fällt zudem für Asylsuchende d
Gold et al., 2021.pdf	elektronischen Gesundheitskarte fü
Wenner et al., 2022.pdf	Access to healthcare is restricted fo
Wenner et al., 2022.pdf	ocal authorities implement differer
Wenner et al., 2022.pdf	ASR under the HV model showed lo
Wenner et al., 2022.pdf	HV are disadvantaged in their acces
Wenner et al., 2022.pdf	reduced by policy change from HV t
Wenner et al., 2022.pdf	many countries restrict the access c
Wenner et al., 2022.pdf	health entitlements are regulated b
Wenner et al., 2022.pdf	Given Germany's federal structure a
Wenner et al., 2022.pdf	Healthcare vouchers (HVs), which a
Wenner et al., 2022.pdf	Table 1 Overview of access policies f
Wenner et al., 2022.pdf	Regular access
Wenner et al., 2022.pdf	Electronic health cards (EHCs), whic
Wenner et al., 2022.pdf	after 18 months by granting SHI-eq
Wenner et al., 2022.pdf	Proponents of the EHC model claim
Wenner et al., 2022.pdf	HVs are difficult to handle for healt
Wenner et al., 2022.pdf	(12.5%), information on the access
Wenner et al., 2022.pdf	considerable difference between th
Wenner et al., 2022.pdf	7.9% reported at least one visit to t
Wenner et al., 2022.pdf	share of missing information was ra
Wenner et al., 2022.pdf	HV model were less likely to use spe
Wenner et al., 2022.pdf	EHC model were more likely to repo
Wenner et al., 2022.pdf	ASR under the HV model showed lo
Wenner et al., 2022.pdf	comparison of access between the t
Wenner et al., 2022.pdf	Odds of GP utilization (OR= 2.18 [0.

Wenner et al., 2022.pdf	Our results show significant differ- e
Wenner et al., 2022.pdf	access barriers that are inherent to
Wenner et al., 2022.pdf	significant association between reg
Wenner et al., 2022.pdf	lower utilization of outpatient serv
Wenner et al., 2022.pdf	ersons who are subject to the HV m
Wenner et al., 2022.pdf	advantages of the EHC model comp
Wenner et al., 2022.pdf	subject to the HV model are disadva
Wenner et al., 2022.pdf	could be reduced by policy change
Gold et al., 2021.pdf	Verbesserungsbedarfe insbeson- der
Gold et al., 2021.pdf	Prioritäre Verbesserungsansätze au
Gold et al., 2021.pdf	Abbau von Hürden bei der Inanspru
Gold et al., 2021.pdf	Schaffung adäquater Strukturen zur
Gold et al., 2021.pdf	Zusätzlich können sprachliche Barri
Gold et al., 2021.pdf	Sozialarbeiter*innen sind in den ve
Gold et al., 2021.pdf	ie Sicherstellung der Versorgung vo
Gold et al., 2021.pdf	psychologisch-psychiatrische und g
Gold et al., 2021.pdf	Sprachbarrieren und die administ- r
Gold et al., 2021.pdf	ooperationspartner die jeweiligen (
Gold et al., 2021.pdf	Fachärzt*innen scheint hingegen du
Gold et al., 2021.pdf	Für die befragten Sozialarbeiter*inn
Gold et al., 2021.pdf	2 Die Einführung von Videodolmets
Gold et al., 2021.pdf	ine Krankenschwester, zuständig sc
Gold et al., 2021.pdf	Mehr als die Hälfte der Befragten9 r
Gottlieb et al., 2020.pdf	federal structure and decentral- ize
Gottlieb et al., 2020.pdf	Some EAE have an in-house clinic, w
Gottlieb et al., 2020.pdf	local welfare offices play a central r
Gottlieb et al., 2020.pdf	For each occasion, a review determ
Gottlieb et al., 2020.pdf	no uniform guidelines for the interp
Gottlieb et al., 2020.pdf	room for interpretation. This has al
Gottlieb et al., 2020.pdf	asylum-seekers receive "analogous l
Gottlieb et al., 2020.pdf	receiving refugee status that a perso
Gottlieb et al., 2020.pdf	employment-based health insuranc
Gottlieb et al., 2020.pdf	local authorities enjoy autonomy ir
Gottlieb et al., 2020.pdf	Health care vouchers (HVs) are issue
Gottlieb et al., 2020.pdf	except for emergency care, which c
Gottlieb et al., 2020.pdf	can consult the local Health Office c
Gottlieb et al., 2020.pdf	health insurance card (HIC) enables
Gottlieb et al., 2020.pdf	con- tracted Sickness Funds issue th
Gottlieb et al., 2020.pdf	Fig. 1. Overview of asylum-seeker he
Gottlieb et al., 2020.pdf	n March 2015, the period during w
Gottlieb et al., 2020.pdf	Inequities within the group of asylu
Gottlieb et al., 2020.pdf	German health policies for asylum-s
Janda, Gerlinger et al., Henkel, 2023	Leistungen nach dem AsylbLG erhal
Janda, Gerlinger et al., Henkel, 2023	esgleichen Inhaber:innen einer Dul
Janda, Gerlinger et al., Henkel, 2023	der Ausreisepflichtige, denen aus hu
Janda, Gerlinger et al., Henkel, 2023	Personen, die noch keinen Asylantr
Janda, Gerlinger et al., Henkel, 2023	Durchführung des Gesetzes – Bestin
Janda, Gerlinger et al., Henkel, 2023	Behandlung kostenfrei erbracht un

Janda, Gerlinger et al., Henkel, 2023	Übernahme der Kosten einer Sprach
Janda, Gerlinger et al., Henkel, 2023	bernahme von Sprachmittlungskos
Janda, Gerlinger et al., Henkel, 2023	inerseits freie Arztwahl genießen
Janda, Gerlinger et al., Henkel, 2023	Übernahme der Kosten für eine Spra
Janda, Gerlinger et al., Henkel, 2023	ausreisepflichtige Personen, für die
Janda, Gerlinger et al., Henkel, 2023	Notversorgung nach § 4 AsylbLG erf
Janda, Gerlinger et al., Henkel, 2023	Ausreisepflichtige und andere Perso
Janda, Gerlinger et al., Henkel, 2023	So sieht zwar Art. 20 Abs. 3 RL 2013
Janda, Gerlinger et al., Henkel, 2023	zu feh- lenden Informations- und Au
Janda, Gerlinger et al., Henkel, 2023	mit einer eGK ein schnellerer und u
Janda, Gerlinger et al., Henkel, 2023	Mangel an Behandlungsplätzen, spe
Janda, Gerlinger et al., Henkel, 2023	esetzliche Krankenversicherun
Janda, Gerlinger et al., Henkel, 2023	Gesetzgeber überträgt ihr Aufgaben
Janda, Gerlinger et al., Henkel, 2023	Selbstverwaltung“ beschreibt zum
Janda, Gerlinger et al., Henkel, 2023	esetzlichen Bestimmungen zur Gest
Janda, Gerlinger et al., Henkel, 2023	Asylberechtigte oder Geflüchtete an
Janda, Gerlinger et al., Henkel, 2023	Leistungen, die nach dem Stand der
Janda, Gerlinger et al., Henkel, 2023	eistungsrecht gleichermaßen für all
Janda, Gerlinger et al., Henkel, 2023	Dies bedeutet allerdings nicht unbe
Janda, Gerlinger et al., Henkel, 2023	können sie mit den gleichen Einschr
Janda, Gerlinger et al., Henkel, 2023	Krankenkassen die Kosten für die Su
Janda, Gerlinger et al., Henkel, 2023	Etwas prononcierter ist die Position
Janda, Gerlinger et al., Henkel, 2023	nformation und Aufklärung, Diagno
Janda, Gerlinger et al., Henkel, 2023	ohne das Medium „Sprache“ schlec
Janda, Gerlinger et al., Henkel, 2023	gilt umso mehr für das in besondere
Janda, Gerlinger et al., Henkel, 2023	Migrant:innen bringen in vielen Fäl
Janda, Gerlinger et al., Henkel, 2023	Finanzierung von Sprachmittlung w
Janda, Gerlinger et al., Henkel, 2023	der gesetzlichen Krankenversicheru
Janda, Gerlinger et al., Henkel, 2023	Finanzierung durch die Sozialämter
Janda, Gerlinger et al., Henkel, 2023	arüber hinaus machen sie aber auch
Janda, Gerlinger et al., Henkel, 2023	Vollumfänglich zuständig für die Ve
Fleger et al., 2016.pdf	Public insurance companies are obl
Fleger et al., 2016.pdf	Undocumented migrants are not m
Fleger et al., 2016.pdf	rivate insurance companies are only
Fleger et al., 2016.pdf	government must inform and educa
Fleger et al., 2016.pdf	ederal states) have the discretion to
Fleger et al., 2016.pdf	reporting obligation for public auth
Fleger et al., 2016.pdf	The requirement of confidentiality
Fleger et al., 2016.pdf	Several Bundesländer have started i
Fleger et al., 2016.pdf	preventive health care to all childre
Fleger et al., 2016.pdf	Most notable are non-governmenta
Fleger et al., 2016.pdf	The Malteser, a large catholic medic
Fleger et al., 2016.pdf	Infection Protection Act, Fifth Socia
Fleger et al., 2016.pdf	vaccinations are offered in the inter
Fleger et al., 2016.pdf	there is no specific education or inf

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Asylum applicant	8	France
Asylum.Applicant	14	Sweden
Asylum applicants	9	Netherlands
Irregular migrant	20	Netherlands
Irregular.Migrant	13	Sweden
Irregular Migration	20	France
Residence permit	2	Netherlands
Residence permits	7	France
Residence.Permits	3	Sweden

document	quotation	codes
Sweden 1.pdf	ndividuals with a failed asylum claim ar	Irregular.Migrant
Sweden 1.pdf	persons who are planning to seek asylur	Irregular.Migrant
Sweden 1.pdf	weden a law was passed in 2013 that ga	Irregular.Migrant
Sweden 1.pdf	lack of knowledge about entitlement to	Irregular.Migrant
Sweden 1.pdf	In the study population, 51 (55.4 %) rep	Irregular.Migrant
Sweden 1.pdf	Fear" as having no belief in the staff kee	Irregular.Migrant
Sweden 1.pdf	some undocumented migrants did not	Irregular.Migrant
Sweden 1.pdf	Furthermore, the fear that health care s	Irregular.Migrant
Sweden 1.pdf	undocumented migrants are wrongly d	Irregular.Migrant
Sweden 1.pdf	Sweden, the cost of healthcare for undc	Irregular.Migrant
Sweden 2.pdf	During the asylum process and until the	Asylum.Applicant
Sweden 2.pdf	As far as possible the health care should	Asylum.Applicant
Sweden 2.pdf	County councils are the authorities resp	Asylum.Applicant
Sweden 2.pdf	Should there be a need for health care b	Asylum.Applicant
Sweden 2.pdf	If an asylum seeker pays more than SEK	Asylum.Applicant
Sweden 2.pdf	the health care an asylum seeker is entit	Asylum.Applicant
Sweden 2.pdf	Critics highlight that the concept of "he	Asylum.Applicant
Sweden 3.pdf	All asylum seekers are entitled to a free r	Asylum.Applicant
Sweden 3.pdf	Refugees who are illegal residents in Sw	Irregular.Migrant
Sweden 3.pdf	Due to insufficient information on servi	Irregular.Migrant, Asylum.Applicant
Sweden 3.pdf	. Moreover, the wording "treatments th	Asylum.Applicant
Sweden 3.pdf	The LMA card must be presented when	Asylum.Applicant
Sweden 3.pdf	Persons enjoying international protecti	Residence.Permits
Sweden 4.pdf	only those with a rightful claim to prote	Residence.Permits
Sweden 4.pdf	state/public healthcare system, with Sw	Residence.Permits
Sweden 4.pdf	both Germany and Sweden, the nationa	Asylum.Applicant
Sweden 4.pdf	estrictive measures notably for one grou	Asylum.Applicant
Sweden 4.pdf	asylum-seekers with temporary residen	Asylum.Applicant
Sweden 4.pdf	undocumented immigrants' access to n	Irregular.Migrant
Netherlands 1.pdf	llow undocumented people to access 'r	Irregular migrant
Netherlands 1.pdf	This is how it should be, since otherwise	Irregular migrant
Netherlands 1.pdf	Since 2009, under Article 122a of the D	Irregular migrant
Netherlands 1.pdf	Formal legal health rights of 'undocume	Irregular migrant
Netherlands 1.pdf	almost one third (29%) of un- documen	
Netherlands 1.pdf	earing identification, being unable to pa	Irregular migrant
Netherlands 1.pdf	did not trust the health authorities not	Irregular migrant
Netherlands 2.pdf	As any other person in the Netherlands,	Asylum applicants
Netherlands 2.pdf	The relevant legal provision on health ca	Asylum applicants
Netherlands 2.pdf	In medical emergency situations, there	Irregular migrant
Netherlands 2.pdf	Care providers who do help irregular mi	Irregular migrant
Netherlands 3.pdf	for undocumented migrants. While this	Irregular migrant
Netherlands 3.pdf	, undocumented migrants and asylum s	Irregular migrant
Netherlands 3.pdf	The access to healthcare for asylum seek	Asylum applicants
Netherlands 4.pdf	awaiting a decision on their asylum app	Asylum applicants
Netherlands 4.pdf	After these two months the adult asylur	Asylum applicants
Netherlands 4.pdf	granted refugee status or subsidiary pro	Residence permit
Netherlands 4.pdf	asylum seekers are in the first two mont	Asylum applicants

Netherlands 5.pdf	n the Netherlands, information is availa	Asylum applicants, Irregular migrant
Netherlands 5.pdf	range of private health insurers compet	Residence permit
Netherlands 5.pdf	Undocumented migrants have been exc	Irregular migrant
Netherlands 5.pdf	At the national level, the National Instit	Asylum applicants, Irregular migrant
Netherlands 5.pdf	The Netherlands has a National Immuni	Irregular migrant
Netherlands 5.pdf	However, based on Article 10(2) of the A	Irregular migrant
Netherlands 5.pdf	ndocumented migrants now pay for hea	Irregular migrant
Netherlands 5.pdf	Yet, in addition to regular care provider	Irregular migrant
Netherlands 5.pdf	While directly accessible services can be	Irregular migrant
Netherlands 5.pdf	As a result of the above-mentioned sche	Irregular migrant
Netherlands 5.pdf	lack of information about the entitleme	Irregular migrant, Asylum applicants
France 1.pdf	UM (individuals residing in a country wi	Irregular Migration
France 1.pdf	public health insurance program specifi	Irregular Migration
France 1.pdf	o be granted with MSA coverage, applic	Irregular Migration
France 1.pdf	egular migrants, refugees, and asylum se	Residence permits
France 1.pdf	positive impact on efficiency, equity, ar	Irregular Migration
France 1.pdf	roviding access to primary care services	Irregular Migration
France 1.pdf	By reducing the out-of-pocket payment	Irregular Migration
France 1.pdf	It shows that UM covered by MSA are m	Irregular Migration
France 1.pdf	The decreasing effect of MSA coverage o	Irregular Migration
France 2.pdf	State Medical Aid (Aide Médicale de l'Ét	Irregular Migration
France 2.pdf	The longer the length of the State Medic	Irregular Migration
France 2.pdf	niversal health insurance (Couverture M	Residence permits
France 2.pdf	mentary health insurance (Couverture M	Residence permits
France 2.pdf	State Medical Aid is a healthcare schem	Irregular Migration
France 2.pdf	To be eligible, a person must prove that	Irregular Migration
France 2.pdf	Refugees and asylum seekers are not elig	Asylum applicant
France 2.pdf	health insurance aimed at undoc- umen	Irregular Migration
France 2.pdf	ndocumented immigrant can access me	Irregular Migration
France 2.pdf	This proportion reached 89% amongst p	Irregular Migration
France 2.pdf	State Medical Aid coverage was asso- cia	Irregular Migration
France 3.pdf	like any other third-country nationals b	Residence permits
France 3.pdf	3-month residence requirement applies	Asylum applicant
France 3.pdf	equest to benefit from the PUMA is mac	Asylum applicant
France 3.pdf	during this 3-month period asylum seek	Asylum applicant
France 3.pdf	These 3 months without proper coverag	Asylum applicant
France 3.pdf	Persons who have no right to remain or	Irregular Migration
France 3.pdf	After this period, State Medical Aid (AM	Irregular Migration
France 3.pdf	ndividuals with low income and still aw	Residence permits
France 3.pdf	all public hospitals are required to offer	Irregular Migration, Asylum applicant
France 3.pdf	validity of PUMA is one year	Residence permits
France 3.pdf	However, in parallel they face many bar	Irregular Migration, Residence permit
France 3.pdf	National legislation does not provide ar	Asylum applicant