OECD
BETTER POLICIES FOR BETTER LIVES

Migration Policy Debates

www.oecd.org/migration

N°17 November 2018

The past three years have witnessed one of the worst humanitarian refugee crisis with flows from conflict countries peaking in late 2015-early 2016 and millions of people seeking refuge in, mainly European, countries. Due to the hardships they face on their journey, refugees are at greater risk of health problems, such as exposure to communicable diseases and psychosocial and mental distress. To cope with the immediate health needs of refugees, OECD countries have organised medical screening programmes and emergency health care provision. In the medium term, providing better information about health care entitlements and about how health care systems are organised, facilitating outreach services and offering interpreting services are key helping immigrants' access care. In the long term, health care systems will need to be resilient and better prepared to respond to future refugee arrivals.

*This edition of **Migration Policy Debates** reviews current challenges and good practices for making OECD health systems more resilient in the face of a refugee crisis, drawing from a debate at a joint OECD, the World Bank and the Center for Mediterranean Integration conference on "Human Resources for Health (HRH): Integration of Refugees into Host Community Health Systems".*

How resilient were OECD health care systems during the "refugee crisis"?

Key findings

- Around 5.4 million migrants applied for asylum in OECD countries between January 2014 and December 2017, compared to 1.8 million between 2010 and 2013.
- Rates of depression, anxiety and poor well-being are at least 3 times higher among refugees than the general host-country population. OECD health systems need to do more to address refugee physical and psychological health needs.
- While health care systems have provided medical screening programmes and emergency health care to refugees in the short term, several barriers still impede refugees' access to care. Providing information about entitlements, available health care services or administrative procedures (as seen in Greece and Sweden), and offering interpretation services (as seen in Hungary, Australia, and Belgium) have the potential to ease access to care in the medium term. Developing outreach services is also important to better identify health needs of refugees and refer them towards the appropriate health care services, as shown by initiatives in Canada and Germany.
- More co-ordination of care is needed, in order to avoid repeated medical examination and make health service delivery more efficient. The Personal Health Record, a joint project of the European Commission and the International Organisation for Migration (IOM) to help reconstruct the medical history of migrants, is a positive step is this direction.
- Addressing more efficiently health needs of future refugees requires institutional changes to foster greater cooperation between institutions, humanitarian organisations, regional bodies and other non-governmental agencies. The "toolkit for assessing health system capacity to manage large influxes of refugees, asylum seekers and migrants", produced by the World Health Organization Europe, is a valuable initiative in this area.
- In the long run, there is scope to better train health care professionals to meet the need of migrants and refugees, but also to use the skills and competencies of the many people in need of protection who were previously working in the health sector. Fast-track procedures, as developed in Sweden and in Norway, are innovative policy responses to accelerate the entry of skilled immigrants into the health care sector and facilitate their integration in host communities.

Large refugee flows to OECD countries require resilient health care systems

Recent years have shown an unprecedented rise of refugee arrivals in OECD countries. Altogether OECD countries received 5.4 million asylum applications between January 2014 and December 2017, including almost 4 million to the EU (OECD, 2018).In addition Turkey has provided temporary protection to 3.4 million Syrians by end 2017.

Along the migration routes in Europe, countries have developed short-term solutions to address migrants' basic health needs. This generally entails the provision of medical screening in reception centres as well as emergency, primary and secondary health care to refugees and migrants. Once past the initial influx, some countries have been adapting their health systems to include better information provision about refugees' health care entitlements, easier access to outreach services and wider use of language interpretors. In the long term, countries' health systems will be needed to be better prepared for future refugee influxes or other demographic emergencies. This will require more training for health care professionals working with migrant and refugee populations, as well as linking health care services to early warning systems and adopting mitigation plans.

Box 1. The concept of "resilience"

As a concept, resilience was first used in the fields of engineering (infrastructure resilience) and biology (ecological systems resilience). Its application to social concepts and institutions is quite recent; in this context, "resilience" refers to systems' abilities to absorb, adapt to and anticipate shocks. In recent years, numerous crises – such as the global financial crisis, the epidemiological transition and rising burden of chronic conditions, and environmental change – have all put stress on health care systems and driven interest in applying the concept of resilience to them (OECD, 2013).

Three key features define a resilient health care system:

1. Immediate coping capacities in the face of external and unplanned shocks and an ability to absorb the shock during a short-term emergency.

2. Adaptive capacities in order to recover from the consequences of the shocks and to mitigate losses.

3. Transformative capacities in the long term in order to anticipate future similar crises and alleviate their consequences.

Short-term response: providing refugees with access to basic health services

Addressing refugees' multiple and complex physical and psychological health needs

Due to the hardships they face in their journey, most asylum seekers arrive in the host country in poor health. Many of them have experienced perilous travels and have stayed in transit centres during which they could have been exposed to communicable diseases, poor sanitation, lack of access to healthy food and a safe water supply, and other poor living conditions.

Most asylum seekers have also experienced mental stress or severe psychological problems. Those who lost a member of their family or a friend along the way, those who have been trafficked or abused as well as those who are disabled because of war injuries, often suffer severe mental health disorders and need strong psychosocial support (Priebe, Giacco, El-Nagib, 2016 and Box 2).

For all these reasons, as well as because recently arrived asylum seekers are concentrated in specific areas and are often highly mobile, the responses to health care services should be adapted to the specific needs of this population.

Box 2. Migrants and mental health problems

At least 50% of the refugees in Germany suffer from some form of definable mental illness (Bundes Psychoterapeuten Kammer, 2015).

On the Greek island of Lesbos nearly 66% of migrants settled there experience mental health disorders (MSF, 2017).

In Sweden, one in three Syrian refugees suffers from depression, anxiety and stress disorders (Swedish Red Cross, 2016).

Worldwide, rates of depression, anxiety and poor well-being are at least three times higher among refugees than the general population and this has been increasing over time (WHO, 2016a).

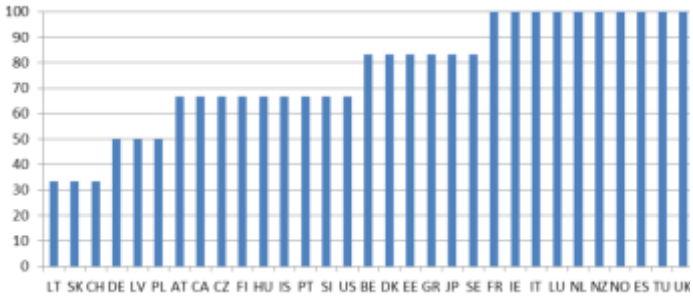
Migrants' rights to health is guaranteed by international laws

Migrants' right to health is generally guaranteed by countries' national laws and in several international human rights documents. Refugees are covered by the 1951 UNHCR convention and protocol relating to the status of refugees (Article 23)[1]. Asylum seekers in the EU are covered by the EU Reception Condition Directive (Article 19)[2]. More broadly, the Universal Declaration of Human Rights (Article 25[3]) specifies

that all people have the right to adequate medical care, while the the UN International Covenant on Economic, Social and Cultural Rights (Article 12[4]) mentions that people have the right to a good standard of physical and mental health. Finally, Article 35[5] of the EU Charter of Fundamental Rights also protects access to health care.

In practice, access is ensured for refugees in the OECD area but according to the Migration Policy Index, health care entitlements for asylum seekers vary widely across OECD countries (see Figure 1). Full access to health care is guaranteed to asylum seekers only in few countries, while in other countries they only have access to emergency health care. In many countries, asylum seekers must remain inside reception centres or designated areas in order to be eligible for care. The access to health for undocumented migrants is even more restricted. They usually have an access restricted to emergency health care, which is not always granted free of charge (see Box 3).

Figure 1. Health entitlements for asylum seekers, Migration Policy Index score, 2014



Note: "100" means unconditional access; "50" conditional access and "0" costs must be paid in full by the user or by a commercial insurance policy. *Source: Migrant Integration Policy Index 2014.*

Box 3. Access to health care by undocumented migrants and the role of local authorities

People who have been denied asylum or those who enter illegally or overstay their visa and are not looking for asylum are considered undocumented. Depending on the country, they may or may not have access to health services. In France, for example, such migrants have access to primary and secondary care if they apply to the State Medical Aid (Aide Médicale d'État) or through a free hospital department service – so-called the Permanence d'Accès aux Soins de Santé (PASS). To get the State Medical Aid, undocumented migrants have to prove that they have resided more than three months in France and that they have a monthly income of less than €720. A similar system exit in Belgium and full access is also possible for example in Spain, and Portugal.

In some countries, such as Greece, Hungary, Ireland, Poland and Sweden, undocumented migrants only have free access to emergency care (Spencer and Hughes, 2015). In others, such as Czech Republic, Germany, Ireland and the United Kingdom, undocumented migrants are required to pay the full cost of health care. This is also the case in New Zealand, Korea, Australia and Turkey. In the United States, undocumented immigrants are excluded from federally financed public benefits such as Medicare, Medicaid, the Children's Health Insurance Program and the Affordable Care Act.

In several OECD countries, local authorities have adopted more favourable health policies towards undocumented migrants (PICUM, 2017). For example, in Sweden, the city of Stockholm has encouraged health providers to give undocumented migrants access to healthcare in cases of emergency and immediate needs, such as life-threatening situations, pregnancy, cancer, or other systemic and serious mental conditions. In Belgium, the city of Ghent provides undocumented migrants with a medical card valid for 3 month. The cities of Amsterdam, Utrecht, Eindhoven and Nijmegen in the Netherlands provide financial support to local organisations that cover the cost of medicines for which reimbursement is not available under national law. In Canada, while the Health Act excludes undocumented immigrants from public health services, the province of Ontario provides funding to Community Health Centers. In the United States, local initiatives have offer low-cost primary care through public and nonprofit facilities. This is the case for example in San Francisco (Healthy San Francisco), Los Angeles (My Health LA), and New York City (ActionHealthNYC).

Most migrants have access to some sort of medical screening

All EU member states as well as most other OECD countries conduct health screenings when people apply for asylum. In some countries health screening is used to identify vulnerable persons, with a special attention to children and pregnant women. In other countries this is not part of the procedure to identify vulnerabilities and the purpose relates to public health safety with a view to identify people with communicable diseases. Resettled refugees also go through medical examination in order to identify their eligibility and needs upon arrivals.

In Europe, medical examinations are generally repeated: first on boats for those who are rescued at sea, once they arrive on the European soil at disembarkment (usually simply to verify general health condition), when their asylum application is registered in the hot spot and sometimes during the examination of their asylum claim in the final destination country. This clearly poses the question

of co-ordination between the different stakeholders.

Medical screenings which are carried out in reception centres, during the asylum application, tend to be more thorough and would generally include tuberculosis screening, hepatitis B & C, HIV, Rubella, sexually transmitted diseases, and vaccine preventable diseases.

In September 2015, the European Centre for Disease Control (ECDC) issued scientific advice on the public health needs of migrants across the EU. These include health screening for communicable diseases according to migrants' country of origin and transit (e.g. Hepatitis B & C, HIV, and Malaria), surveillance (e.g. respiratory diseases, diarrhoea and meningitis), vaccination (e.g. measles, polio and diphtheria) and a public health system to medically track migrants from their first point of entry to their final destination. In November 2015, Health Commissioner Andriukaitis launched the Personal Health Record (PHR), a template document that can help reconstruct the medical history of migrants who arrive with no documentation.

Medium-term responses: removing barriers to access to care

Resilience in the medium term means that health systems adapt to the presence of migrants, moving beyond the immediate emergency. They need to remove practical barriers impeding access to health care for asylum seekers and refugees, such as limited entitlements, inadequate information, administrative barriers, cost of treatment and/or medicine, limited availability of relevant health workers and cultural and language mismatches.

Providing information about health care entitlements and removing administrative barriers

Providing clear information about rules for access to care and about available services helps refugees, asylum seekers and other migrant groups access and use services in a more timely and appropriate way.

Asylum seekers and refugees need to learn how to navigate the health system: who to contact and where to go to depending on their needs. They also have to adapt to the cultural environment of their new host countries, for example the fact that health services can be delivered by a man or a women independently of the sex of the patient, or how responsibilities are shared between GPs, specialists, pharmacists and qualified nurses as well as between different levels of services.

Countries are exploring ways of providing such information. In Greece, for example, a specific website used to offer information on the geographical location of health care services and useful information on specific diseases or symptoms, on prevention and on legal issues, as well as a list of examination costs. The information was provided in several languages including English, French, Russian, Greek and Montenegrin.

In Sweden, information sessions are organised to encourage discussion among immigrants about common problems with navigating the health care system. A registered nurse provides participants with facts about the health care system (phone numbers, details about health facilities and NGOs offering support), specific information on their rights and entitlements to health care, and on frequent migrant health and illness (trauma, cognitive problems, etc.).

In a number of OECD countries, there are also administrative barriers to accessing care, such as long waiting periods or complex procedures for obtaining a registration number or exemption fees. This is the case in Greece where people need the issuance of a social security number (AMKA) to access health services. In Turkey, people need an International Protection Applicant Identification Card, which take a very long time to obtain. In Italy, asylum seekers need a residence address, which is not provided by all reception centres. Similar obstacles exist in many other countries, such as Austria and France. Cost is also a barrier for migrants, notably in Poland, Germany and Sweden.

Outreach services help to identify needs, notably mental health issues

Outreach services can offer asylum seekers and irregular migrants information, support and referrals, and advocate on their behalf. They are usually accessible (both financially and geographically) and can help identify the needs of newcomers and redirect them towards the appropriate providers. Social workers in outreach services are often familiar with the specific background of the population they support and are often trusted more than mainstream health services. Effective outreach services are those providing mental health services and those refering patients to such services (Priebe, Giacco and El-

Nagid, 2016). NGOs are generally well placed to fulfil this role.

In Canada, the Ottawa Community Immigrant Services Organisation offers clinical services for refugees with counsellors trained to assist war trauma and torture survivors. The support, available in several languages, is tailored to the cultural background of the beneficiaries. The German non-governmental organisation IPSO also offers online video-based psycho-social counselling for conflict victims. In 2016, the organisation trained refugees in Germany who would be willing to support other refugees.

Translators or interpreting services help overcoming language barriers

Language is a significant barrier. Refugees who cannot communicate with medical staff and who have complex health needs may not receive sufficient information about their health and thus may be less likely to participate in decision making. Language barriers can also reduce compliance with medical treatment or also lead to mistrust between physicians and refugees.

Language barriers can be overcome by using local interpreting agencies or employing staff with a range of linguistic abilities. In Hungary, for example, where cultural and language barriers have been reported as the strongest barriers to care, NGOs have provided translators or cultural mediators, often themselves refugees. The Menedék Association, for example, has provided cultural mediation to help overcome language and cultural barriers and facilitate access to health care for migrants.

Australia runs a specific telephone-based translating and interpreting service operating round-the-clock, seven days a week and in more than 100 languages. It covers all aspects of everyday life and medical practitioners can use it free of charge. They benefit from a priority line with an interpreter available within three minutes for the most common foreign languages.

In Belgium the Video-remote intercultural mediation (VRIM) was introduced in 1991. It aims at reducing the negative effects of the linguistic, socio-cultural and ethnic barriers on the accessibility and quality of health care. It makes it possible to provide intercultural mediation in over 20 languages in more than 100 health care institutions in the Brussels region in a cost-effective and flexible way.

More recently, the Refugee First Response Center (RFRC) provides live video translation services during medical visits in a repurposed shipping container. The mobile health clinic connects doctors and patients with 750 live interpreters that are fluent in more than 50 languages. Staffed by the University Hospital Hamburg-Eppendorf, RFRC completed over 5 000 medical exams within its first five months and is working with partners to launch shipping-container clinics in hotspots along migration routes.

Availability and training of medical staff

Access to health care can also be hindered by staff availability, notably when reception centres are located in rural or less densely populated areas where access to health care is already an issue for the general population. In such cases, availability of services may depend on the personal commitment and willingness of few dedicated health workers. This is even more an issue when asylum seekers and refuges have specific health care needs. The remoteness of some reception centres has been identified as a problem notably in Germany, France, Ireland and Poland.

In addition, specific training may be required to support skills development of health workers in welcoming and serving this new public. The lack of knowledge amongst frontline staff and managers about entitlements, as well as cultural differences and specific health needs, must be addressed, together with potentially negative perception of asylum seekers in the media and the local population.

Long-term response: anticipating future refugee influxes and other long-term needs

The key to providing resilient health services lies in the ability to transform today's service provision and organisation in anticipation of future shocks. Although forecasting movements of forcibly displaced people is a difficult exercise, natural disasters and environmental shocks are likely to result in an even bigger number of people fleeing their homes in the future. Health systems must re-evaluate their long-term ability to absorb and treat efficiently the health needs of future refugees. Countries need to facilitate integration of these vulnerable populations in the long run and to make the necessary institutional changes. This transformation could involve political and governance changes, changes in the training of

health professionals, and the recognition of refugee medical qualifications.

Co-ordinated actions

Co-ordination is needed for countries to better anticipate and prepare for future shocks. The WHO 2016 "Strategy and action plan for refugees and migrants", signed by member states, was a first step on this path (WHO, 2016b).

A whole-of-society approach allows co-operation between health institutions, humanitarian and regional bodies, but also between non-governmental institutions, private companies, international organisations and other countries. Fully integrated migrant and refugee health needs into existing health structures and legislations requires finding financing and in some cases changing legislation (Box 4).

Several countries already have initiated inter-ministerial strategies to address specifically migration issues. For example, in Greece the high-level Committee for the Co-ordination of Immigration Policy and Social Inclusion includes the General Secretaries of 10 Ministries.

Box 4. The World Health Organization Europe "Toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants"

This tookit focuses on health care at the moment of arrival in a country. It establishes a technical framework that countries can use to do a self-assessment of their health system capacities and outlines the technical steps in preparing and conducting such an assessment, including interview questions (WHO, 2016a). The toolkit takes a "whole-of-society" approach, describing the six "building blocks" that must work together in order for a health system to achieve its goals: leadership and governance; health workforce; medical products, vaccines and technologies; health information; health financing; and service delivery.

More generally there is a need to better integrate early warning migration systems with health care systems, as few countries have developed mitigation plans in the context of large inflows of people. At the EU level, the integration of a health component in the Integrated Political Crisis Response should be considered.

Education and training of health professionals needs better focus on migrant's health needs

By including specific training on migrant health in standard medical and nursing curricula and through continuous professional training, future generations of health care professionals can progressively adapt their practices to the needs of migrants and refugees. Several universities in OECD countries have introduced courses on the topic. Migrants' health rights and their specific vulnerabilities, as well as appropriate courses on cultural difference, could help physicians and other health care professionals better serve the needs of migrant populations.

Guidelines and training initiatives designed to improve health care professionals understanding of cultural differences exist in some OECD countries. For example:

- In Germany, Heidelberg University Hospital, in collaboration with the IOM, has recently organised a two-day training course aimed at improving the knowledge of health professionals on the public health implications of migration as well as strengthening the responsiveness of health services to migrants' specific needs. The training covered important topics such as mental health, occupational health, communicable and non-communicable diseases and health risk factors, as well as cultural diversities and conflict mediation.

- In Sweden, the transcultural Center in Stockholm, operating under the auspices of Stockholm County Council, organises training and consultation support for those providing mental health care and generalist care for refugees and asylum seekers. The trainings target employees from the social and employment services, primary care centres and psychiatric clinics in seven municipalities in the Stockholm area.

- In Spain, the Escuela Andaluza de Salud Pública in Granada developed an online training course to develop refugee/migrant-sensitive health services for health managers and health professionals. Interactive online activities and group exercises complement the information provided

Recognising health qualifications for refugees to allow them to contribute to their host society

Easing and accelerating the recognition of foreign credentials for refugee health care professionals would allow them to contribute to their community and host society (Box 5). Many refugees are highly trained with some qualified as doctors, nurses or pharmacists. With appropriate accreditation, training and other support, refugee health care professionals could contribute to addressing health care needs of both the host and refugee

populations. Already, the refugee population is well represented in the health care sector across OECD countries but not necessarily at their right level of qualification. In 2014, 15% of refugees aged 15-64 was employed in the health and social work area, against 10% of the native born population in the European Union.

In all OECD countries, health care is a regulated profession. A specific registration, certificate or licence awarded by a relevant professional licencing body is a prerequisite to be able to practice. These regulations are intended to protect the health and safety of populations by ensuring that professionals meet the required standards of practice and competency. However, recognition procedures across OECD countries tend to be long and expensive (OECD, 2017).

Innovative policy responses have been developed to speed-up recognition procedures and accelerate the entry of skilled immigrants into the health care sector. In Sweden, for example, a fast-track procedure for the assessment of foreign qualifications was implemented for the twenty-one regulated professions including in health and medical care. It includes early Swedish language training, early assessment and recognition of the experience and skills, vocational and study guidance, and employment matching.

In Norway, since 2015 NOKUT is developing a fast-track recognition procedure to be applicable to refugees settled in reception centres or camps. The overarching objective is to quickly assess refugees' educational background to provide relevant information to immigration authorities to find a suitable municipality for settlement.

The Building Bridges programme in Scotland and in the United Kingdom assists refugee doctors to re-qualify to UK standards and secure employment appropriate to their professional qualifications. It helps refugee doctors to refresh medical knowledge and skills before completing English and professionals skills test, look for a job through a professional mentoring and also to access post-graduate studies.

In Turkey, the university of Gaziantep with WHO and the Turkish Ministry of Health worked together to offer training courses to hundreds of Syrian doctors and nurses, aiming to familiarise them with the Turkish health system and focusing on family medicine and primary health services. Although it does not offer yet the right to work, Turkey plans to open migrant health centres in all Turkish cities with a Syrian refugee population over 20 000. The intention is that they will employ about 500 Syrian doctors and 300 Syrian nurses after their qualifications have been verified.

Box 5. The OECD-World Bank-CMI International Conference on Refugee Health Care Workforce Integration

The challenges concerning the integration of refugees health care professionals are a concern in numerous OECD countries and in the Middle Eastern and North Africa (MENA) region. On March 30-31, 2017, the OECD, jointly with the World Bank and the Centre for Mediterranean Integration, organised a workshop to discuss the difficulties and opportunities for strengthening the numbers and competencies of refugee health professionals in host countries to better address local needs. The event gathered health professionals, delegates from the OECD countries and the MENA region, officials from International Organisations, non-governmental organisations and scholars. The issues that were tackled included the mapping of the existing numbers of refugee health workforce in host countries, identification of the legal, regulatory and practical challenges to refugee integration, the options for recognising health workers credentials and different examples of training programmes to support the refugee health workforce.

Conclusion

Despite the high influx of refugees in recent years in Europe and their concentration in certain areas, health care systems have been quite resilient in the short term. Most refugees were able to see quickly a doctor and there were no serious public health issues. That said, many areas for improvement can be identified.

Firstly, for many people health support was not available along the way, except that improvised by NGOs. Co-ordination of care between different stakeholders at different moment of the asylum seeking process was also lacking and this led to some service delivery inefficiencies. Lastly, the practice of conducting health need triage only once migrants had reached their destinations left many people, notably those with mental health problems, falling between the cracks.

Secondly, asylum seekers faced a number of barriers to care, despite having in theory access in most countries. These barriers are linked to administrative issues, the cost of services or

difficulties in accessing qualified personal, and in many cases to communications difficulties.

The WHO "Toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants" offers a valuable framework for assessing the short- and medium-term resilience of health care systems. In the long run, however, a better integration of migration and health services as well as appropriate training of health professionals will be needed to ensure that the bottlenecks describe above are overcome in the future. In this context, there is scope also to better use the skills and competencies of the many people in need of protection who were previously working in the health sector themselves.

🕮 References

Bundes Psychoterapeuten Kammer (2015), "Standpunkt: Psychische Erkrankungen bei Flüchtlingen".

MSF (2017), Un an après l'accord UE-Turquie : lutter contre les contrevérités de l'UE, Athènes.

OECD (2013), Risk and Resilience: From Good Idea to Good Practice, OECD Publishing, Paris http://dx.doi.org/10.1787/5k3ttg4cxcbp-en.

OECD (2017), Making Integration Work: Assessment and Recognition of Foreign Qualifications, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264278271-en.

OECD (2018), International Migration Outlook 2018, OECD Publishing, Paris, https://doi.org/10.1787/migr_outlook-2018-en.

PICUM (2017), Cities of Rights: Ensuring health care for undocumented residents, April 2017.

Priebe, Giacco, El-Nagib (2016), "Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region", Health Evidence Network n°47.

Spencer and Hughes (2015), "Outside and In: Legal Entitlements to health care and Education for migrants with irregular status in Europe, COMPAS 2015".

Swedish Red Cross (2016), Refugees battle mental health problems in Sweden. Available at http://www.ifrc.org/.

WHO Europe (2016a), Toolkit for assessing health system capacity to manage large influxes of refugees, asylum-seekers and migrants, Copenhagen.

WHO Europe (2016b), Strategy and action plan for refugee and migrant health in the WHO European Region, Working document, Regional Committee for Europe 66th Session, Copenhagen, Denmark, 12–15 September 2016.

✉ Contacts

Caroline Berchet (Tel : +33 1 45 24 88 16) Email: caroline.berchet@oecd.org

Francesca Colombo (Tel : +33 1 45 24 93 60) Email: francesca.colombo@oecd.org

Jean-Christophe Dumont (Tel: +33 1 45 24 92 43) Email: jean-christophe.dumont@oecd.org

Marguerite Salles (Consultant to the OECD)

🖱 Useful links

www.oecd.org/migration
www.oecd.org/migration-insights
www.oecd.org/health

[1] Article 23 states that "Refugees lawfully staying should receive the same treatment with respect to public relief and assistance as is accorded to their nationals."

[2] Article 19 states that "states that *"Member States shall ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders"*

[3] "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care."

[4] "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12).

[5] Article 35 states that holds that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices."