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REFUGEES' ACCESS TO HEALTH SERVICES IN THE EU FRAMEWORK: WHAT ROLE FOR PRIMARY HEALTHCARE?

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The contemporary conception of health is characterized by amplitude and complexity. These are features that need to be taken into account when analyzing the migratory phenomenon. With regards to its content, the definition given by the World Health Organization already in 1948, according to the WHO, health is "a state of complete physical, psychological and social well-being" and not simply the absence of an infirmity. However, such a broad definition of health prevents to make the content of a fundamental right, which could not be directly guaranteed in such broad terms only for citizens. A second profile of complexity of health, in fact, concerns the perimeter and the depth with which the legal order guarantees it. In this sense, we may speak of the right to health in positive terms, that is, individual and social right to receive a specific medical or health performance, which may be essential or ancillary, both in negative terms as an individual protection coordinated with the principle of personal freedom (by torture or inhuman and degrading treatment, by unwanted attention, by clinical trials).

European Constitutions acknowledge the right to health in different terms. For example, the Spanish Constitution of 1978 (Article 43)

recognizes the right to health protection, entrusting it with public powers (as a generic concept involving both local authorities and peripheral organs) exercising a sovereign State power. They must organize and protect public health through preventive measures and necessary services. However, in the Italian Constitution (article 32), health is protected as part of the ethical and social relations, which are placed in a fruitful link with the principle of solidarity; that is why health takes on a dual role, both a fundamental right and a collective interest. Solidarity is therefore declined in both directions: solidarity with people in need of care, but also solidarity with each other towards the needs of public health. Depending on the more or less extensive content of the right to health, the legal order recognizes protection in more or less intense terms. This intensity is conditioned by the costs and requires balancing the right to health with other relevant or constitutional interests, which can sometimes also be linked to the specific legal condition of a foreign person.

In terms of the right to freedom from degrading treatment or unwanted medical treatment, for example, the status of citizen or foreigner is not relevant, since such acts are prohibited to any person. At a time when a foreign person requires a particular treatment for the health service, even in order to promote what may be subjectively perceived as a state of health, the legal order intervenes in a selective way allowing treatments that are not considered essential; national law may also charge the state healthcare system for treatments that are considered specific and essential for migrants. Finally, the State may also prohibit treatments that are considered prejudicial to the subject's health (in 2006, for example, Italy approved a new Article 583 bis of the Criminal Code, punishing from 4 to 12 years of imprisonment for anyone who causes female genital mutilation in the absence of therapeutic needs).

Among the main rights recognized as fundamental to the sick person can be called: the right to life, the right to privacy, the right to non-discrimination, the right to be properly informed, the right to express their informed consent. Therefore, the protection of health must be considered as a social right of the citizen and the foreigner, with roots in the principle

of solidarity, which implies the refusal of separation between people and the recognition of the necessary interrelation between different life projects.

Here the specific condition of refugees and asylum seekers comes into play. It is a very simple legal concept to recall but very difficult to define. As many know, nowadays there is no single way to determine the legal protection regime. In a macro-group of migrants who are protected by the Geneva Convention, there are more precise legal situations in which the foreigner can enter and receive the same treatment.

The finding of inhuman and degrading treatment comes from international law and gives rise to the common forms of asylum and refuge. Additionally, the European framework has established subsidiary protection that binds the Member State to creating a reception system that does not violate the principle of discrimination, particularly in access to healthcare. However, a specific protection may also be provided by individual Member States through a domestic legislation, which gives rise to the so-called "constitutional asylum", as happens in the Italian legal system. In this tripartite judicial status, where some are more enduring than others, what kind of access should be granted to a foreigner in the protection of his or her health status?

Probably, we should change the terms of our question. Even before identifying "what" access to guarantee, we should determine "where" this access should be provided. Currently, holders of any form of international protection are not always in a healthy and dignified condition, especially because they stay in places where the prevention and maintenance of the external environment does not promote a proper prevention and monitoring of pathologies related to special travel conditions. Undoubtedly, the complexity of the migration routes influences the precarious state of mental and physical subjects. However, individual preconditions are a definite object of the national reception system.

European Union Member States have responded to this need in a discontinuous and schizophrenic way, elaborating multiple places (and non-places) where to ascertain, examine and ultimately provide

international protection. The migrant arrives today and is conducted in hot-spots, collection centers, self-managed camps, refugee camps, reception centers, detention centers. So many names to identify the same place and the same state of personal insecurity, which complicates access to medical care. Even for these reasons, it is not possible to develop a single European reception model. Yet, we will strive to outline the different stages between the arrival and the achievement of refugee status, to understand the intensity of access to health services.

In the first phase, which we will call "first-time hubs", medical staff are called to provide the first medical care, participate in photo reporting and request for international protection. In the second phase, which takes place in the transit centers, doctors must generally prepare a Census, a health screening and participate in the reception, waiting for the next transfer. In the third phase, the migrant is "temporarily" conducted to centers of greater capacity for the completion of the procedures relating to international protection.

At this point, the fate of the migrant can be distinguished, depending on how his request will be considered. We can identify three main and possible outcomes: insertion into a local protection system until the refugee title is obtained; relocation to other centers, including other Member States; transfer to other detention centers and repatriation, for all foreigners deemed irregular and not holders of international protection. According to the legal system, in each of these stages medical and health care must be guaranteed.

Regarding the first case, the European legislative framework has been sufficiently harmonized with the EU Qualification Directive (2011//995//EU), which lays down rules on the granting of uniform status for refugees or persons covered by subsidiary form as well as on the content of the protection granted. The new Qualification Directive seeks to achieve closer approximation of national recognition standards and essential elements of protection. On access to healthcare and to integration facilities, the subsidiary status is put on the same level as a refugee (art. 26, 30 and 34); similarly, it adds the obligation for Member

States to provide the necessary treatment of psychological and mental distress (art. 30).

These are very important changes, which bind both the powers of the receiving States and the healthcare providers involved in ensuring the protection of the right to health. The European directives, although not self-executing, must be transposed by each Member State. In this case, the Qualification Directive is no longer talking of “minimum standards”, but simply to "standards" (art. 1). Member States have always the right to introduce or maintain more favourable provisions (Art. 3) that are appropriate to the current European legislation.

Regarding the second and third cases, both the relocation and the repatriation reveal various critical profiles. This system has been replaced by a new resettlement scheme but it has been reinforced through the jurisprudential decisions in cases C-643/15 and C-647/15: it provides only the displacement of those people in obvious need of international protection, belonging to the nationalities whose security recognition rate is equal to or greater than 75%. At this point, we are entitled to ask whether the "state of health" can be a "clear need" for granting refugee status.

The ECJ judgment in the *case M'Bodj* (C-542/13) attempted to provide some answers, which are not too exhaustive. According to this Decision, Member States must grant health care as provided in Articles 28 and 29 of the Qualification Directive, only to beneficiaries of refugee status or subsidiary protection. They are not required to grant such benefits to foreigners who are allowed to remain on the basis of a domestic legislation, although for reasons of health. According to the Court, the actual deterioration risk of the health status of a migrant, who suffers from a serious disease - for which there is no adequate treatment in his country - is not equivalent to the recognition of refugee status or subsidiary protection, unless such neglect is not due to a deprivation of care inflicted intentionally.

Although in a separate context, the European Court of Human Rights seems to have an opinion in the opposite direction. With the *Paposhvili*

Decision (application no. 41738/10), the Strasbourg Court, in fact, confirms that the power to decide on the expulsion of persons, residing illegally in its territory, remains a prerogative of the States. However, this decree must be done in accordance with international conventions to which the States have joined, including the ECHR. As stated in previous judgments , there are cases where the health conditions of the person subject to expulsion measures prevent it from being enforced. In the present case, the severity of the disease must be established by a medical certificate, which must be produced after hearing the subject. In addition, within the threshold of gravity, the death of the patient must be predicted within three months. The Immigration Office must also assess the availability and accessibility of medical care in the country of return or origin, before disposing a departure, including respect for additional human rights related. Therefore, the expulsion cannot be completed, since many would violate the applicant's rights (health, privacy, family unit).

As can be deduced from these two judgments, the protection of the right to a migrant's health is a dichotomous and complex task: State is not the only regulator, the doctor and the patient are not the only subjects. So, on the basis of these brief considerations, let me outline three simple questions**:**

1) as regards the differentiation of status and places, on the one hand migration law has a strong "derogatory" component with respect to the common rules in force for citizens. In other terms migration rules differ from general rules, as for instance is the case for criminal law; this approach has allowed the legislator to entrust the authorities concerned with a more or less wide margin of discretion. However, healthcare can hardly be derogated in order to comply with constitutional and international obligations. Therefore, are we sure that compliance with these obligations is carried out correctly, in those places, centers and camps where the health and dignity are sacrificed every day?

2) Regarding the relationship between health and the migrant reception system, we should finally abandon the logic of emergency with which we face the phenomenon of migration. The differences and uncertainties

affecting the foreigner in seeking a legal status are still too obvious. This condition inevitably conflicts with refugees and their lack of awareness of their rights and the health system in the host country. There are still in the host societies linguistic and social barriers that, despite the commitment of health personnel, can lead to diagnostic errors, ineffective treatments, as well as cultural, religious and gender issues. Do we really believe that the refugees crisis is the real cause of other endemic difficulties in the national health care system?

3) So, I conclude, focusing on the relationship between the State, the right to health and the refugees deserve a more subtle and practical reflection. Public authorities are often perceived as the sole responsible for managing a social and political phenomenon. In this case, subsidiarity and interaction between the different institutional levels and actors involved is essential. There is a duty to defend public health, which corresponds to the right to care for each person. However, if the subject is a refugee or asylum seeker, is it fair to think that this inalienable human right is enriched with other decisive facets (the protection of human dignity, the prevention of torture, the elimination of inhuman and degrading treatment) also in the transit and reception territories?

Probably, it is necessary to understand that the vulnerability of these subjects, also as physical integrity, can and should be a reason for granting international protection. The certainty of the legal status, equal access to medical care and informed prevention are some of the goals that we must achieve to overcome the migration crisis. If we pursue other ways, we may be trapped in the so-called "paradigm of Polyphemus": our supposed superiority will prevent us from acknowledging the real nature the real nature of our limits.