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Briefing note

Briefing note on medical claims in migration processes across 23 EU+ countries

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Consider, for example, an asylum applicant who, during the examination of their application, informs the authorities that they are suffering from a serious medical condition. While the claim may initially appear to be simply a matter of providing information about the applicant's health, it may become relevant to several aspects of the migration process. The applicant may argue that the condition requires particular treatment, that adequate treatment is not available or accessible in their country of origin, or that their health condition is so severe that travelling or returning would expose them to serious harm. Similar medical claims can arise in a range of migration contexts. Beside the asylum procedure, they may be the main purpose for an application for a temporary or longer-term residence permit, or they may arise at different stages of a return procedure. The nature and relevance of the claim may vary: a person may simply report a health condition; argue that the condition prevents them from travelling or returning; contend that the necessary treatment is unavailable or insufficiently accessible in the country of origin; or claim that discriminatory practices or other barriers prevent them from accessing available medical services. Medical claims can therefore become relevant to different legal and procedural questions, requiring authorities to assess both the person's medical condition and the circumstances surrounding access to healthcare in the applicant's country of origin.

The impact of international case law on national policies

While medical conditions may initially raise humanitarian considerations in migration procedures, they can also raise legal questions of *non-refoulement.* A landmark decision was the European Court of Human Rights' (ECtHR) 1997 judgment in D. v. the United Kingdom, in which the Court examined whether the removal of a seriously ill person could engage Article 3 of the European Convention on Human Rights (ECHR), prohibiting torture and inhuman or degrading treatment. The Court found that, in the exceptional circumstances of the case, removal would expose the applicant to treatment contrary to Article 3. At the same time, the judgment set a very high threshold, involving a terminal illness, the absence of appropriate treatment and support in the receiving country, and a risk of intense suffering.

Since then, medical claims have become increasingly relevant to the assessment of asylum, migration, return, and related cases. The ECtHR's subsequent case law, in particular Paposhvili v. Belgium, recalibrated the threshold established in D. v. the United Kingdom, clarifying that applicants do not need to face imminent death and that the effective accessibility of treatment must also be assessed. The Court of Justice of the European Union (CJEU), meanwhile, has confirmed that protection based on medical grounds does not fall within the scope of subsidiary protection under EU asylum law, meaning that such cases must be addressed through national legal statuses.

Against this background, severity of illness, the availability of medication and medical treatment, and their individual accessibility in the country of return have become core elements of medical migration assessments across Europe. At the same time, practices vary among Member States with regard to the applicable legal basis, the organisational integration of medical expertise, the research of medical country of origin information, and the assessment of the severity of a disease and the availability and accessibility of treatment and medication in countries of origin.

Legal framework and procedures

Across the 23 EU+ countries examined, around half[1] reported a specific legal basis for residence permits on medical grounds. These constitute national, non-EU-harmonised protection permits. In some cases, they also provide a pathway for admission and may be applied for from abroad for the duration of the treatment. Many countries, however, do not have a dedicated medical pathway or permit. Instead, medical claims are addressed under broader national humanitarian permits, including where such claims are raised in procedures concerning international protection, appeals against return and removal, or the expiry of other legal statuses.

Medical considerations are therefore integrated at different stages of the migration procedures, depending on the national system. They may form part of legal migration pathways where third-country nationals seek entry to receive treatment unavailable in their country of origin. They may arise as part of humanitarian or national protection mechanisms for individuals who fall seriously ill while residing in a host state. Health considerations are frequently raised during asylum procedures, either as a subsidiary element of a protection claim or as an independent obstacle to return. Finally, medical claims may emerge during return procedures, where applicants argue that removal would expose them to inhuman or degrading treatment.

In all examined countries, medical reasons may become decisive where international protection has been denied but removal would raise concerns under Article 3 of the European Convention on Human Rights. National humanitarian statuses[2] or impediments to return therefore play a central role in accommodating medical claims.[3] Additionally, around half of the researched states also provide pathways within regular migration frameworks, such as medical residence permits[4] or family reunification.[5]

Organisational structure and responsibilities

Responsibility for medical migration cases generally lies with immigration and asylum authorities operating under ministries of interior, justice, or home affairs. These bodies assess medical claims within asylum procedures, humanitarian residence applications, and return processes, including the examination of medical impediments to removal.

Although institutional arrangements vary, the initial burden of proof in all examined countries rests with the applicant, who must substantiate the existence of a relevant health condition. This is usually done through a medical attestation issued by a treating physician. While some countries rely on ad hoc medical documentation, others have introduced mandatory templates to standardise medical evidence. Norway requires the use of a template established under healthcare regulations, and Sweden, Belgium, and the Netherlands have developed specific formats for medical statements. Across all systems, strict safeguards are reported to be in place to ensure the confidentiality of medical data throughout protection and return procedures.

In most countries, the same authority is responsible for assessing the severity threshold and researching availability and accessibility of certain treatments and/or medication in the country of origin. However, for example, Belgium applies a clear institutional separation with medical doctors assessing availability and legal decision-makers evaluating accessibility. In most other countries, these tasks are not formally divided, even if they may be conducted by different actors in practice.

Medical expertise is integrated into migration procedures through a variety of models. Belgium and the Netherlands maintain in-house medical advisory units, while France, Luxembourg, and Switzerland employ medical doctors directly within advisory or COI structures. Other countries rely on ad hoc external medical experts on a case-by-case basis.[6] Countries without in-house medical expertise can make use of the existing medical expertise of the EUAA. Authorities may also request supplementary information from applicants' treating physicians, particularly where clarification of diagnosis, prognosis or treatment needs is required.

Researching medical country of origin information

As a general rule, decision-making on medical claims is based on an assessment of both the availability of medication and treatment and the applicant's effective access to such care in the country of origin. This assessment requires specific country of origin information related to medical treatment and medication. Such medical country of origin information is researched by specialised COI units in national administrations and, since 2018, has received guidance and support from the EUAA's MedCOI sector, which provides specific medical country of origin information.

Medical COI is therefore commonly researched by caseworkers, drawing on research by national COI units, EUAA MedCOI resources and, where necessary, consultations with medical experts or advisors. All countries examined reported having staff trained as EUAA MedCOI basic or advanced users.

In several countries, appeals and second instance bodies are already involved in medical COI research. Courts in Austria and France may request access to medical COI gathered at first instance, and, in Greece, legal rapporteurs of the Independent Appeals Committees have been trained as EUAA MedCOI users. These practices reflect an increasing recognition of the evidentiary complexity of medical migration cases.

Statistics

Statistical data on medical migration remain limited. Most countries do not collect disaggregated data on medical claims, as these are embedded within broader asylum, humanitarian, or return statistics. Where data are available, they reveal considerable variation in volume and scope, reflecting differences in procedural frameworks and reporting practices.

Some countries collect information on countries of origin or underlying illnesses, providing insight into recurring patterns such as a high prevalence of chronic diseases, psychiatric disorders, and life-threatening illnesses.

Of the 23 researched countries, 15[7] have submitted requests to the EUAA MedCOI sector on individual availability or individual accessibility of medication and/or medical treatment. Data from the EUAA MedCOI sector indicate a steady increase in requests to the EUAA MedCOI sector related to the availability of treatment or medication since 2021, with availability requests consistently outnumbering accessibility requests. This disparity reflects procedural sequencing, institutional divisions of labour, and the fact that accessibility is often assessed using general COI sources or national expertise rather than through individualised MedCOI requests.

Medical severity thresholds

Severity plays a decisive role at multiple stages of the procedure. First, it may determine whether medical COI research is initiated at all. Most countries do not define a formal threshold, leaving this to case-by-case assessment, though some require documented evidence of a severe or treatment-requiring condition. Second, severity is central to the decision on return or residence, with national thresholds largely reflecting ECtHR jurisprudence and focusing on risks of death, serious deterioration, or irreversible harm. Mental health conditions are increasingly recognised within severity assessments, following confirmation by the ECtHR that the Paposhvili standard applies equally to mental health conditions.[8] Moreover, a number of jurisdictions may apply a lower severity threshold for children, justified by the best interests of the child[9] and the need for continuity of care.

Several states also recognise a distinct medical severity threshold, applicable in exceptionally grave cases where the health condition alone suffices to preclude return.[10] In such cases, authorities may dispense with any assessment of treatment availability or accessibility. This approach is typically reserved for terminal or comparably severe conditions and is applied on a discretionary basis. While some countries explicitly allow for such simplified assessments, Poland, for instance, still conducts medical COI research even in extreme cases to determine which status may be granted.

Availability and accessibility of treatment

Availability of treatment or medication is regarded as relevant throughout all countries, although formal legal definitions are rare. In practice, availability is assessed through medical COI, medical expertise, and administrative practice, with attention to factors such as registration of medication, physical presence of treatments and medication, continuity of supply, and lawful distribution channels. Interpretation may be complex, as formal registration of a medication does not necessarily guarantee reliable stock in practice.

Accessibility assessments focus on whether the applicant can, in reality, obtain the available care. Economic accessibility is the most consistently applied element, with most countries examining treatment costs, insurance coverage, family support, and the applicant's capacity to generate income.[11] Geographic accessibility is widely acknowledged but often assessed only where distance, mobility limitations, or security concerns create significant obstacles.[12] Political accessibility, discrimination in access to healthcare, plays a more limited role, as it is frequently addressed within the refugee status determination rather than in medical assessments as such. Out of the countries researched, eight assess political accessibility[13] and nine say that it is possible that political accessibility plays a role.[14]

Residence granted and return

Where a person cannot be returned due to medical reasons, states must issue a form of permission to stay allowing continued access to treatment. In the absence of an EU harmonised status, the nature, duration, and stability of such permits vary considerably, ranging from temporary humanitarian statuses to tolerated stays or postponements of removal. Where medical claims are rejected, return may be enforced, often accompanied by medical support, including short-term medication, assisted voluntary return schemes, or reintegration assistance.

Endnotes

1 BE, EE, FR, IS, GR, LV, MT, SI, SK, NL, IT
2 DK, FI, FR, HU, IRE, IS, IT, LV, MT, NO, SW
3 AT, BE, EE, FI, FR, DE, IE, IS, LV, LU, MT, PL, SK, SW, CH
4 BE, EE, FR, IS, IT, LV, MT, SK, SI, NL
5 DK, IT, SK, SI
6 DK, HU, IT, SK
7 AT, BE, CZ, DK, FI, FR, DE, GR, IT, MT, NL, PL, SW, CH
8 See ECtHR Savran v Denmark, 2021
9 See Art 3. UN Convention in the Rights of the Child; Art 24. Charter of Fundamental Rights of the EU
10 BE, FR, FI, IS, IT, MT, NL, CH,
11 AT, BE, CZ, DK, (FI), FR, DE, GR, HU, IE, IT, LV, LU, MT, NL, NO, PL, SK, SI, SW, CH
12 (AT), (BE), (CZ), DK, (FI), (DE), GR, HU, IS, IE, IT, LV, LU, MT, NL, (NO), (PL), SK, SW, (CH). Countries in brackets indicated that geographic accessibility possibly is assessed.
13 EE, FR, HU, IS, IE, IT, LV, SK
14 BE, CZ, FI, LU, MT, NO, PL, CH

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The International Centre for Migration Policy Development (ICMPD), established in 1993 by Austria and Switzerland, is an international organisation that works in migration-related fields. Although ICMPD has a European basis, it carries out its activities throughout the world, including in Europe, Africa, Central Asia, and the Middle East. ICMPD provides its Member States and numerous partners with in-depth knowledge and expertise in dealing with the phenomena of migration. It does so by using a holistic three-pillar approach: research, migration dialogues and capacity building. The present study has been commissioned by the European Union Agency for Asylum (EUAA) and is a product of the ICMPD Policy Unit.

Authors and acknowledgements

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Disclaimer

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