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International Centre for Migration Policy Development

State practices related to medical COI: Comparative report

Final report of state practices in 23 EU+ countries

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Authors and acknowledgements

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Disclaimer

This research was concluded in March 2026 and reflects the national and EU legal framework of that time.

Table of Contents

1. Introduction 5
2. Methodology 5
3. Medical claims in migration processes 7
   3.1. Legal basis 7
   3.2. Organisational Structure/ Responsibilities 10
   3.3. Procedures in medical migration cases 12
   3.4. Procedure of researching medical country of origin information 14
   3.5. Statistics 14
4. National Policies 19
   4.1. Medical severity of a person's health conditions 20
      4.1.1. Severity threshold to initiate research on medical COI 20
      4.1.2. Severity threshold for decision making 20
      4.1.3. Medical severity threshold 23
   4.2. Availability of medical treatment/medication in countries of origin 24
   4.3. Accessibility of medical treatment/ medication in countries of origin 27
   4.4. Residence and Return 34
      4.4.1. Residence granted 34
      4.4.2. Residence not granted 36

List of Tables

Table 1: Overview of national legal basis on medical migration claims 8
Table 2: Overview of national authorities 10
Table 3: Types of migration cases 13
Table 4: Data on migration cases with medical relevance 15
Table 5: Number of AVA (availability) and ACC (individual accessibility) requests submitted to the EUAA per country and year 18
Table 6: Overview of the severity threshold for decision making 21
Table 7: Overview of definitions and responsibilities for the "availability-assessment" 24
Table 8: Elements for the "availability-assessment" 25
Table 9: Overview of the definition and main features for the "accessibility-assessment" 27
Table 10: Overview of the main features constituting the "economic accessibility" 29
Table 11: Examples for the relevance of the "geographic accessibility" of medical treatment and/ or medication in the country of origin 30
Table 12: Overview of the main features for the "political accessibility" of medical treatment and/ or medication in the country of origin 33
Table 13: Overview of the types of residence permits granted 34
Table 14: Overview of medical support for returnees 36

1. Introduction

European asylum and migration authorities are increasingly confronted with applications that involve medical components, arising in asylum procedures, applications for residence permits, or in the context of return decisions. This is especially true in cases where the return of a denied international protection seeker or of a migrant in an irregular situation would breach the principle of non-refoulement due to a severe illness of the person concerned. These cases present particular challenges, as authorities are required to assess complex medical information and determine the severity of an applicant's health condition and the availability and accessibility of treatment in the country of origin. Central to such an assessment is whether the illness so severe that treatment or medication become indispensable, and whether responsibility for providing that treatment lies with the host country or can be assumed by the country of origin. Against this background, the research examines how selected EU+ Member States assess the availability and accessibility of medical treatment and medication in migration-related decision-making.

To support decision makers, medical country of origin information developed as a branch of general country of origin information. Since 2010, a number of European countries have joined to share and develop the research and use of country –of origin information related to medical cases further. The initiative was initially funded by the European Refugee Fund (ERF) and later by the Asylum, Migration and Integration Fund (AMIF), and moved to the European Union Agency for Asylum (EUAA) in 2018 (back then known as European Asylum Support Office – EASO). Since then, the EUAA has been conducting research, sharing, and harmonising medical country of origin information. The main clients of the services of the EUAA are immigration authorities in EU+ countries: EU Member States and associated countries (such as Switzerland, Norway and Iceland).

The practices of European countries on searching for and using medical country of origin information have been repeatedly assessed in the framework of the above-mentioned projects, last in 2018. In 2022 the EUAA commissioned ICMPD to – among other tasks – research and report on the state practices in all European states that use the services related to the provision of medical country of origin information by the EUAA MedCOI Sector. While states developed their policies on dealing with medical-related migration cases, European and national courts continued to set standards on when return is possible for ill third-country nationals (TCNs), and on the use of relevant country of origin information. This jurisprudence (collected in a separate study) strongly impacted the related policies in the states covered by this report.

This report compares the practices of 23 countries that currently use the services of the EUAA MedCOI Sector when dealing with asylum and migration cases with a medical component. The report is based on 23 individual country reports which examine how national migration procedures and legal frameworks address cases in which an applicant's health condition and MedCOI are decisive. They analyse decision-making practices, policies on assessing the availability and accessibility of medical treatment in the country of origin, and criteria for medical severity, including exceptional cases. In addition, the reports outline relevant organisational structures, professional roles, and available statistical data on medical-based migration cases.

2. Methodology

This report and the associated country reports build largely on a questionnaire that has been distributed and responded to by the countries in three waves: the first 12 country case studies

(Austria, Belgium, Czechia, Denmark, Finland, Germany, Luxembourg, the Netherlands, Norway, Poland, Sweden and Switzerland) were conducted in 2023, the next 6 case studies were conducted in 2024 (France, Greece, Hungary, Italy, Slovakia, Slovenia), and the remaining 5 country cases (Estonia, Iceland, Ireland, Latvia and Malta) were researched in 2025. To ensure the quality of the reports, the draft version of each country report was shared with the relevant national authorities for their review, and an additional exchange took place with country representatives to answer and clarify remaining questions from the survey. Finally, to ensure that all reports are consistent and up to date, the countries of waves 1 and 2 were asked to review the interim reports from 2023 and 2024 and flag any changes in their state practices. All national authorities opted to submit their initial responses in writing; with some countries, additional calls took place to clarify certain points.

The reports aim to explore how national migration procedures and legal frameworks address cases where an applicant's health condition and MedCOI play a significant role. They examine decision-making practices and written policies concerning the assessment of MedCOI, including the availability and accessibility of medical treatment in the applicant's country of origin, as well as criteria for determining medical severity and initiating MedCOI research. Additionally, the research identifies any existing policies for exceptionally severe cases, the use of assessments only focusing on medication, and the statistical data on medical-based migration applications and outcomes. Finally, the reports investigate the organisational structures and professional roles involved in handling medical procedures and MedCOI within national administrations.

For this report, the researchers contacted representatives of 25 countries; 23 countries responded to the questionnaire. The initial contact persons were the MedCOI national points. Due to the scope of the questions, the questionnaire was typically circulated to different relevant authorities.

3. Medical claims in asylum and migration processes

3.1. Legal basis

While medical conditions regularly come up in migration and asylum procedures, there is no dedicated legal status at EU level addressing such medical claims of third country nationals. Although medical claims may give rise to international protection needs under specific circumstances, they acquired particular relevance for asylum and migration processes in the context of the principle of non-refoulement under Article 3 ECHR which prohibits torture and inhuman and degrading treatment.

Since 1997 and the landmark decisions D v United Kingdom, the later N v United Kingdom, and more recently in Paposhvili v Belgium, the ECtHR developed the circumstances in which the removal of a seriously ill person may breach Article 3. In particular, removal may be prohibited where the absence or inaccessibility of appropriate treatment in the receiving country would expose the person to a serious, rapid and irreversible decline in health, resulting in intense suffering or a significant reduction in life expectancy. Thus, while EU asylum law does not establish a specific protection status based on medical conditions, international human rights law may nevertheless render removal legally impermissible where the relevant threshold is met. This gap between the absence of an EU-harmonised status and the obligation not to remove a person in breach of Article 3 ECHR has led Member States to develop national legal bases for granting residence or other forms of protection on medical grounds.

Across the countries examined for this report, migration frameworks rarely contain a dedicated procedure designed specifically for medical migration. Belgium incorporates an authorisation process for medical reasons in primary legislation, while the Netherlands refers to medical circumstances in general statutory provisions and further regulates them through by-laws. Other systems address medical elements within broader protection, return or humanitarian mechanisms rather than through specific procedures.

Medical considerations appear in different parts of national protection systems. Estonia applies the Act on Granting International Protection to Aliens, allowing medical factors to be considered during protection assessments and in relation to return. Ireland relies on the International Protection Act, where medical aspects are relevant both for protection and humanitarian evaluations. Iceland incorporates medical circumstances into its humanitarian residence permits. In Hungary, medical grounds may be examined before a return order is issued, while in Slovenia they may be assessed after return procedures have begun, consistent with the principle of non-refoulement. France extends its general protection and humanitarian frameworks with the "*Étranger malade*" procedure, which also applies to individuals in an irregular situation.

Entry or stay for medical purposes is available in several countries. Amongst others, Italy, France, and Slovakia have a legal basis to issue specific visas or residence permits for medical treatment, and Greece applies comparable arrangements under certain conditions.

Relevant legal references are dispersed across legislation governing international protection, return processes, humanitarian residence, and visa issuance. As a result, medical migration is often

addressed through a range of intersecting mechanisms rather than a uniform or autonomous procedural category, with each system incorporating medical considerations in line with its broader legal and administrative structure.

Table 1: Overview of national legal basis on medical migration claims

Country	Legal basis
Austria	Austrian Asylum Act 2005 (AsylG), paragraph 8 → with respect to non-refoulement in connection with Art. 3 ECHR
Belgium	Law from 15 December 1980 on access to the territory, residence, reception and removal of aliens: → Art. 9bis: requests for authorisation to stay for humanitarian reasons → Art. 9ter: requests for authorisation to stay for medical reasons
Czechia	→ Art. 14a (subsidiary protection) Asylum Law
Denmark	→ Article 9b (1) - (3) Danish Aliens Act humanitarian protection of an asylum seeker → In the context of family reunification
Estonia	→ Section 151(1) of the Estonian Act on Granting International Protection to Aliens
Finland	→ Sec. 51 Finnish Aliens Act on residence permit in case of obstacles to leaving the country → Sec. 52 Finnish Aliens Act residence permit on discretionary basis on humanitarian grounds
France	Code on the Entry and Residence of Foreigners and the Right of Asylum (CESEDA), Article L.425-9, the CESEDA law was introduced in 2004, though previous health permits have been issued since 1997
Germany	Sec 60 Law on Residence, Employment and Integration of Foreigners In the context of potential impediments to return
Greece	Asylum Code 4939/2022, Article 1, 14 → In the context of refugee status or subsidiary protection Greek Immigration Law 5038/2023 → Article 134: a residence permit for humanitarian and exceptional reasons → Article 163.4: a residence permit on medical grounds in the context of a national entry visa
Hungary	2007 Act LXXX, Article 25/B (1) → In the context of non-refoulement
Iceland	Art. 74 Foreigners Act No. 80/2016 and Art. 43a Regulation on Foreigners No. 540/2017 → Residence permits on humanitarian grounds
Ireland	International Protection Act, S. 28, S. 47 → Section 49(3)(b) refers to humanitarian considerations as a ground for granting Permission to remain

Italy	Legislative Decree 286/98, Article 19, at. 2, lett. D-bis → In the context of non-refoulement Legislative Decree 286/98, Article 36 → In the context of entry into Italy on medical grounds Legislative Decree 502/92 Art. 12, at. 2 lett. C, amended by Legislative Decree 517/93 → In the context of entry into Italy in the context of humanitarian programmes
Latvia	Latvian Immigration law, Section 11 → for a long-stay visa Latvian Immigration law, Section 23 → temporary residence permit
Luxembourg	Art. 130 Free Movement of Persons and Immigration Law of 29 August 2008 → mainly in context of return once IP has been denied
Malta	Article 17A(1) of the International Protection Act → for temporary humanitarian protection
Netherlands	→ Article 64 Aliens Act 2000 → Ministerial Decree 2000 → Aliens Act 2000 Implementation Guidelines
Norway	→ Section 38 Norwegian Immigration Act of 2008 → compelling health circumstances may constitute humanitarian reason for being granted a residence permit
Poland	→ Act on Granting Protection to Aliens within the Territory of the Republic of Poland of 2003 – Art. 15 on subsidiary protection → Act on Foreigners of 2013 – Art. 348 on residence permit on humanitarian grounds in the return procedure
Slovakia	Act 480/2002 Coll. on Asylum and the Amendment of Some Acts as amended, Section 9 → In the context of asylum for humanitarian reasons Act No. 404/2011 Coll. on Residence of Foreigners → in the context of a temporary residence permit to reunify with a family member in the Slovak Republic that has a temporary or permanent residence, as stipulated in section 27 of the Act on Residence of Foreigners, on the basis of medical conditions The Implementing regulation of the Minister of Interior to the Act on Asylum No. 34/2014, as amended → In the context of asylum for humanitarian reasons
Slovenia	Guidelines in the context of UPRS Judgment I U 2337/2018-11 Slovenian International Protection Act, Article 39 → In the context of asylum procedures Slovenian Foreigners Act, Article 73 → In the context of return procedures Foreigner's Act, Article 51(1) → In the context of residence on medical grounds Directive 2003/86/EC, Article 17 → In the context of family reunification

Sweden	→ Chapter 5 Section 6 of the Aliens Act "Residence permits on grounds of exceptionally distressing circumstances" → Chapter 12 Section 18 of the Aliens Act "Enforcement of refusal-of-entry and expulsion orders"
Switzerland	→ Article 83 of the Foreign Nationals and Integration Act

3.2. Organisational Structure/ Responsibilities

Across the researched countries, medical migration cases are primarily handled by immigration and asylum authorities, most commonly under ministries of interior, justice, or home affairs. These bodies are responsible for assessing medical claims within asylum procedures and other regular migrations applications, humanitarian residence applications, or return and removal processes, including the examination of impediments to return on medical grounds. In several systems, specialised units or medical advisory bodies support decision-making by providing expert opinions on health conditions and treatment needs, while distinct authorities may be involved at different procedural stages, such as admission, appeal, residence permit, or return enforcement. In some countries, responsibilities are further divided between asylum authorities, migration offices, police or border guard authorities, and appeal bodies.

Table 2: Overview of national authorities

Country	Relevant Authorities
Austria	Federal Office for Immigration and Asylum as asylum decision-making body that decides on impediment to return if International Protection is denied
Belgium	Migration Office - Directorate for Exceptional Stay
Czechia	Department for Asylum and Migration Policy within the Ministry of the Interior
Denmark	Ministry of Immigration and Integration - Humanitarian Residence unit within the Return Division Danish Immigration Service - Division for Family Reunification
Estonia	Police and Border Guard Board
Finland	Finish Immigration Service
France	Ministry of Interior – Office for Immigration and Integration (OFII)
Germany	Federal Office for Migration and Refugees reviews impediments to return Foreigners Office reviews impediment to return "now and here" (e.g. fit to fly)
Greece	Greek Ministry of Immigration and Asylum Greek Asylum Service in the context of asylum procedures Residence Permits Directorate in the context of regular migration procedures
Hungary	Ministry of Interior – National Directorate-General for Aliens Policing (NDGAP)
Iceland	Directorate of Immigration -Ministry of Justice Asylum Appeals Board
Ireland	International Protection Office - Department of Justice, Home Affairs and Migration

Country	Relevant Authorities
Italy	Ministry of Interior – Territorial Commissions for the Recognition of International Protection (TC) on assessing and deciding upon medical claims in the context of asylum Questura – on issuing residence permits in return procedures
Latvia	Minister of the Interior Office of Citizenship and Migration Affairs (OCMA) State Border Guard (SBG)
Luxembourg	General Department of Immigration - Ministry of Home Affairs
Malta	International Protection Agency Ministry for Home Affairs, Security and Employment (MHSE)
Netherlands	Immigration and Naturalisation Service (IND) on admission Medical Assessment Section (BMA) advises IND on medical cases Repatriation and Departure Service (DT&V) for return
Norway	Norwegian Directorate of Immigration - Ministry of Justice and Public Security Norwegian Immigration Appeals Board
Poland	Office for Foreigners in the asylum procedure State Border Guards in the return procedure Voivodship Offices on temporary stay
Slovakia	Migration Office of the Ministry of Interior
Slovenia	Ministry of Interior - Directorate for Migration Police authorities in the context of return procedures
Sweden	Swedish Migration Agency
Switzerland	State Secretariat for Migration

All countries indicated that the initial burden of proof lies with the applicant, who must demonstrate the existence of a health condition. This evidence is generally required in the form of a medical attestation issued by the treating physician. Norway requires the use of a standardised template to collect the applicant's medical information, established under a regulation to the Healthcare Professionals Act, while the Swedish Migration Agency has developed its own template for medical statements. The Netherlands and Belgium also apply specific mandatory templates for medical attestations. France uses a specific and standardised template (presented in 3 parts & pages: administrative/somatic/psychiatric) to facilitate the completion of information by the treating physicians, and welcomes all other medical reports related to the clinical case. Similarly, Ireland uses a template to ease and standardise the collection of medical information of the applicant. Several countries do not have a standardised medical attestation template.

All countries stated that they apply strict rules ensuring the confidentiality of the applicant's medical data. In the case of France, for example, the applicant must sign a written consent to allow OFII (Office for Immigration and Integration) health professionals to contact treating physicians, in order to complete medical files that are insufficiently documented.

In most cases, medical COI research is conducted by the caseworkers or COI researchers, using COI reports and the EUAA MedCOI website as reference. Sometimes medical COI research is conducted by relevant medical experts. All studied countries have reported having caseworkers (being) trained as EUAA MedCOI basic or advanced users.

Most countries did not explicitly highlight a division of responsibilities between those who conduct research on the availability and accessibility of treatment or medication. However, a certain division of responsibility is noted in countries where medical doctors are involved. Medical doctors in the Netherlands and in Belgium are rather involved in the research on the availability while questions on accessibility are addressed by the decision maker.

Medical expertise is incorporated into migration procedures through either in-house structures, external consultation, or collaboration with applicants' own health practitioners. Belgium and the Netherlands maintain dedicated medical advisory units within their immigration authorities, while Luxembourg relies on cooperation with medical professionals from the Ministry of Health. In France and Switzerland, medical doctors are directly employed within COI teams or advisory bodies, ensuring systematic access to clinical assessment. Some systems, such as those in Hungary, Italy, Slovakia and Denmark, draw on external medical experts in cases where specialised knowledge is required. Input may also be sought from applicants' treating physicians; this is explicitly noted in Slovenia, Greece, Czechia, Norway, and Sweden, where authorities may request clarifications or supplementary medical documentation to support case assessment.

Some countries also involve MedCOI research in the second instance decision-making process. For instance, in Austria, the Administrative Court can also receive medical COI from the BFA. Similarly, in France a law from 2022 stipulates that the administrative courts shall be able to request all medical COI gathered by the OFII. Additionally, officers from the first instance (medical and legal team) and from the second instance (only as basic users) have been trained (always organised via the first instance) as users of the EUAA MedCOI database. In Greece, the EUAA MedCOI sector has trained and given basic access (organised via the first instance) to legal rapporteurs of the Independent Appeals Committees.

3.3. Procedures in medical migration cases

The health situation of an applicant of in different migration processes may be relevant, including as a part of:

- legal migration for TCNs to seek medical treatment in another country because their own country does not provide a certain treatment.
- a national protection or humanitarian tool for TCNs that already reside in a host country and get seriously sick.
- an asylum procedure where health problems are brought forward in the course of an application for international protection.
- the return process where a returnee brings forward medical claims that potentially impede the return process.

In all countries, medical reasons may become decisive in the context of national humanitarian protection or impediments to return if medical reasons were brought up during the asylum and a regular migration procedure, but international protection was denied.

Countries most commonly reported that medical claims become relevant in the following procedures: international protection (8 out of 23 countries), national protection (12 out of 23 countries), regular migration (12 out of 23 countries), and return procedures (16 out of 23 countries). In addition, around half of the studied countries have some form of pathways for seriously ill individuals as part of the regular migration procedures, such special medical procedures or family reunification.

Table 3: Types of migration cases

	Int. Prot.		Nat. Prot.	Regular migration procedure		Return procedure
	Ref Prot	Subs Prot	Hum Prot.	Special med. procedure	Other	
Austria	X*	X				X
Belgium	X*			X		X
Czechia	X*	X				
Denmark	X*		X**		Family reunification	
Estonia	X*	X		X	Dublin procedure	X
Finland	X*		X			X
France	X*		X	X		X
Germany	X*					X
Greece	X*	X			Possibility for a temporary residence permit on medical grounds	
Hungary	X*	X	X			
Ireland	X*		X			X
Iceland	X*		X	X		X
Italy	X*		X	X	Human. programmes Family reunification Residence permit upon reaching the age of majority	
Latvia	X*		X	X		X
Luxembourg	X*					X
Malta	X*		X	X		X
Netherlands	X*			X		X
Norway	X*		X			
Poland	X*	X				X
Slovakia	X*	X	X		Possibility for a temporary residence permit on medical grounds Family reunification	X
Slovenia	X*	X			Possibility for a temporary residence permit on medical grounds Family reunification	
Sweden	X*		X			X
Switzerland	X*					X

*All countries acknowledged the possibility of medical claims being relevant under refugee protection, e.g. in cases where access to medical treatment is restricted for a specific group in a discriminatory way or similar cases.

	Int. Prot.		Nat. Prot.	Regular migration procedure		Return procedure
	Ref Prot	Subs Prot	Hum Prot.	Special med. procedure	Other	
** The asylum seeker has to separately apply for a humanitarian residence permit, and the case is handled outside the asylum procedure.						

3.4. Procedure of researching medical country of origin information

As a general rule, decisions are based on an assessment of the availability of both medication and treatment options in the applicant's country of origin. In some countries exceptions apply, allowing decisions to rely solely on research into the required medication. This may occur, for example, when medication is the only necessary form of treatment and can be administered without complexity, as reported in Czechia, Denmark, Hungary, Norway, the Slovak Republic, and Switzerland, or when MedCOI information about treatments is already available/known.

By contrast, Poland states that treatment options are always assessed alongside medication, as monitoring and follow-up care may still be required. Greece similarly reported that it consistently assesses both medication and treatment options in the applicant's country of origin.

3.5. Statistics

Only a few countries collect specific data on medical claims in migration processes, which makes the data difficult to compare. The lack of data can be explained by the fact that most countries do not foresee any special procedure for medical cases and therefore do not collect separate data. Instead, medical cases come up in asylum claims, humanitarian protection cases, or cases of impediment to return, which are not further broken down by specific reason. As such, medical cases are part of this broader data and cannot be retrieved separately.

Table 4: Data on migration cases with medical relevance

Medical Cases in Migration Procedures														
	Data	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
AT	# of med. queries to COI unit									260	274	211		
BE	Yearly application for med. Residence						1,450	1,237	1,166	1,156	1,147	1,294	1,399	
	Temp. stay based on med. grounds		213	134	140	240	240	178	182	119	160	248	313	
	Def. stay based on med. grounds		82	28	15	11	19	14	13	7	10	9	12	
CZE	# with MedCOI relevance: **Asylum**	13	8	8	12	14								
	# with MedCOI relevance: **Return**	1	1	1	0	0								
	# of total medical queries									11	9	10		
FI	# of requests to COI on 'health care' and/or 'MedCOI'								20*	28	20	15	12	26**
FR	# medical claims per year[1]							29,406	25,987	27,702	24,183	24,858	22,328	24,396
GR	#asylum requests with specific vulnerabilities											660	1,255	
	% requests with vulnerabilities of total number of asylum requests											1%	1.70%	
IT	# applicants granted complementary protection for medical treatment at the first instance												484	533***
LU	# of returns postponed on medical grounds	161	258	80	22	13	22	28	28	22	28	44	65	30***
NL	# of medical migration cases of the BMA							1,793	1,536	1,517	1,516	1,699	1,658	
SK	# of MedCOI queries received by MedCOI researchers from case workers											23		
SE	# of requests submitted to COI unit							93	96	77	60	106	91	71****
CH	# temp. admissions on med. grounds	185	274	201	204	209	191	145	176	161	114	127		

* June - December 2020; **January -September 2025; *** up to October 2025; **** up to 08.09.2025

Countries not listed in the table (DK, ES, DE, HU, IS, IRE, LT, MT, NO, PL, SL) do not collect separate statistics on medical migration cases

[1] From 1997 France enables all foreign citizens (including those entering/remaining in the country without a valid visa) to apply for a medical claim: that can explain why the numbers of medical claims on a yearly basis are important in the country.

In addition to the statistics shown in the table above, some countries were able to specify the main countries of origin involved in medical migration cases. Where available, this information provides contextual insight into the geographical profiles of applicants and beneficiaries, although the scope, level of detail, and reference periods of the data collected differ considerably between countries, making it difficult to compare the information between countries.

Belgium collects annual numbers on residence permits granted on medical grounds, disaggregated by country of origin. The data indicate that beneficiaries predominantly originate from a mix of countries, with recurring countries such as Morocco, the Democratic Republic of Congo, Albania, Guinea, and Armenia in both 2023 and 2024, alongside some year-to-year variation. Denmark reports aggregated statistics on persons granted residence permits on medical grounds by country of origin and year. The data show a concentration on a limited number of countries, mainly from the African continent and the Western Balkans region. The Netherlands distinguishes between different legal instruments and collects data accordingly. For residence permits for medical treatment, statistics identify the most frequent countries of origin of applicants, while for applications for suspension of departure (Article 64), longer-term data are available covering several years. Overall, the data highlight a small number of recurrent countries of origin, with Armenia featuring prominently across procedures. Switzerland provides data on persons granted temporary admission exclusively on medical grounds, disaggregated by country of origin and covering a multi-year period. The figures indicate that beneficiaries mainly originated from a limited group of countries, particularly Georgia, and several African states. France collects detailed statistical data on requests for residence permits on medical grounds, including the country of origin and the share of total requests. Greece compiles specific data on asylum requests involving recognised medical vulnerabilities, disaggregated by country of origin and including absolute numbers and percentages. The data reveal a strong concentration among applicants from Syria and Afghanistan, followed by a broader range of countries each representing smaller shares, reflecting the composition of the asylum-seeking population with medical needs.

In addition, three countries also collect data on the main illnesses underlying medical migration claims or decisions. Where available, this data provide insight into the types of health conditions most frequently invoked, although the level of medical detail and the way diagnoses are categorised vary significantly across countries. Denmark collects information on the types of illnesses most frequently invoked in applications for humanitarian residence on medical grounds. The data indicates that cases predominantly concern serious mental health disorders, such as schizophrenia, as well as life-threatening or chronic physical illnesses, including cancer, HIV/AIDS, insulin-dependent diabetes, and conditions requiring regular dialysis. The Netherlands collects statistical data on the most common medical diagnoses raised in medical migration claims. The data show a concentration on a limited number of recurring conditions, in particular PTSD, HIV, diabetes and hypertension, reflecting both mental health needs and chronic non-communicable diseases. France collects detailed statistical data linking main medical diagnoses to countries of origin in requests for residence permits on medical grounds.

Table 5: Number of AVA (availability) and ACC (individual accessibility) responses to requests submitted to the EUAA per country and per year.

	2021		2022		2023		2024	
	AVA	ACC	AVA	ACC	AVA	ACC	AVA	ACC
Austria	84	45	45	21	34	21	66	40
Belgium	189	8	164	2	246	2	251	8
Czechia	9	2	3	1	2	-	1	-
Denmark	59	33	71	44	68	36	42	28
Finland	10	1	13	-	16	1	9	-
France	2	0	23	2	37	2	12	1
Germany	131	49	131	40	173	48	163	46
Greece	-	-	-	-	3	2	13	7
Italy	-	-	-	-	2	-	8	2
Malta	9	-	7	2	17	-	5	-
Netherlands	328	-	352	-	436	-	350	-
Norway	15	4	12	5	20	4	17	6
Poland	2	-	4	-	4	-	4	1
Sweden	57	5	41	1	51	5	52	4
Switzerland	37	2	26	-	15	-	76	14

* Countries not listed have not requested AVA or ACC to the EUAA between 2021 and 2024

Source: Data provided by EUAA MedCOI Service.

Overall, the numbers of countries that send AVA and ACC requests to the EUAA have been rising since 2021. However, of the 23 researched countries, 8 have **not** submitted a request to the EUAA between 2021 and 2024. Nevertheless, there has been a strong overall growth in both the AVA and ACC requests, with big differences among the EU+.

Further, in all countries the yearly number of AVA requests submitted to the EUAA is considerably higher than the number of ACC requests. One common explanation for this difference is that since AVA requests are sent first, requesters in EU+ may not pursue ACC requests if AVA results are negative. Additionally, some countries conduct the ACC research themselves. For instance, the Netherlands, as one of the major clients of the EUAA MedCOI Sector, only submits availability requests and no accessibility requests. This, however, may be because, in Dutch practice, individual accessibility is only examined when the applicant puts forward plausible arguments that they may be unable to access the required treatment or medication. Moreover, in Czechia, it was further noted that an ACC assessment typically occurs only if there are specific doubts about the applicant's access to treatment and/or medication, even after availability has been confirmed. In Finland and Germany, information on the accessibility is usually sourced from EUAA MedCOI general reports or other references, which is why ACC requests are only submitted if the information has not already been found. Denmark may forgo individual ACC requests if prior accessibility assessments show low treatment costs. In France, the definition of accessibility refers mainly to the financial aspect of accessibility. To determine the

costs of treatment, the COI already available on the MedCOI portal is often detailed enough, making an ACC request no longer necessary.

4. National Policies

As previously mentioned, medical migration cases are handled through different national procedures, most commonly within asylum procedures. Some states provide specific medical permits or address medical cases under family reunification. Despite procedural diversity, national practices are guided by international human rights standards and jurisprudence developed by the ECtHR and the CJEU.

The ECtHR has recognised that the removal of seriously ill third-country nationals may breach Article 3 ECHR[2]. Initially, in *D v UK*[3] and later in N v UK,[4] the Court set a very high threshold, limiting protection to exceptional cases involving individuals close to death and lacking any care or support in the country of origin. This threshold was partially lowered in *Paposhvili v Belgium*,[5] where the Court clarified that applicants need not be at imminent risk of death and that required treatment must be not only available but also effectively accessible upon return.

The CJEU ruled in *M'Bodj v Belgium*[6] that where Art. 3 ECHR is successfully invoked in medical expulsion cases, such 'inhuman and degrading treatment' does not constitute 'serious harm' for the purposes of Art. 15 Qualification Directive.[7] Therefore, TCNs cannot be granted subsidiary protection as it "would be contrary to the general scheme and objectives of Directive 2004/83 to grant refugee status and subsidiary protection status to TCNs in situations which have no connection with the rationale of international protection (ibid, para 44)." This means that TCNs with medical conditions that impede return must rely on national protection statuses and are not, for the purposes of EU law, "persons with subsidiary protection status to whom social welfare and health care would apply (ibid, para 46)."

From this jurisprudence it follows that the severity of the disease as well as the availability and accessibility of medication and treatment are important when dealing with medical migration cases. Ultimately, the CJEU clarified that any status based on medical conditions must be a national one rather than subsidiary protection according to the Qualification Directive.[8] Below, the practice of the countries covered by this report when dealing with those elements is presented and briefly discussed.

[2] Art 3 ECHR prohibits torture or inhuman and degrading treatment.
[3] See ECtHR, D v UK, 1997. See also in more detail Desmond, A. (2022). From D v UK to Paposhvili v Belgium: The Evolving Meaning of 'very exceptional' in the Strasbourg Court's Article 3 Medical Expulsion Jurisprudence and its Reception in Council of Europe Member States. Journal of Immigration, Asylum & Nationality Law, 36(1), 5–15, p 5
[4] ECtHR, N v UK, 2008
[5] ECtHR, Paposhvili, 2016.
[6] CJEU M'Bodj, C-542/13, 2014.
[7] From June 2026, Art. 15 of the Qualification Regulation, see https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:L_202401347
[8] From June 2026, the Qualification Regulation, see https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:L_202401347

4.1. Medical severity of a person's health conditions

The severity of a person's health condition is a decisive element to decide whether a person can be returned due to their health condition. But the severity threshold may also be relevant at other stages of the procedure. Thus, the severity of a disease may be relevant in at least three instances:

- The severity to initiate research on medical COI
- The severity threshold for decision making
- The medical severity threshold

In the following, these three types of thresholds will be briefly explained and - where information has been provided by the researched EU+ countries - the relevant country practices will be presented.

4.1.1. Severity threshold to initiate research on medical COI

the severity threshold to initiate research on medical COI is intended to establish whether a disease is severe enough that the caseworker must investigate whether medication and/or treatment is available and accessible for the applicant in their country of origin or return. Conversely, it also considers whether certain diseases are of such low severity that caseworkers do not need to conduct medical COI research.

Most countries do not define a formal threshold for initiating medical COI research, leaving the decision to a case-by-case assessment by the competent authorities. Where thresholds are specified, they primarily relate to the severity of the illness and the risk associated with return.

The Netherlands applies a human-rights-based standard, requiring the illness to be so severe that return would violate the ECHR, irrespective of the availability of treatment in the country of origin. Denmark requires documented evidence of a severe, treatment-requiring illness. Switzerland applies a high severity threshold, conducting medical COI research only where the illness may lead to a life-threatening situation or to serious and irreversible consequences. However, in a majority of cases Switzerland uses the lower threshold of Article 83(4) FNIA[9] stating that the enforcement of a removal may be unreasonable for an individual if they are specifically endangered in the country of origin by a medical emergency. Moreover, even in less serious cases, the State Secretariat for Migration (SEM) may still conduct COI research if the specific case requires it.

Belgium follows a procedurally distinct approach, having introduced a "medical filter" in response to a high volume of medical migration cases. This mechanism excludes applications involving health conditions assessed as being of low severity from further examination.

4.1.2. Severity threshold for decision making

The second threshold refers to the commonly applied national standard set by the ECtHR and the CJEU. The threshold gives guidance on the level of medical severity that must be fulfilled when assessing the health situation of an applicant in view of whether the person can be returned or shall be granted a residence permit.

The close link to the jurisprudence of the ECtHR on Art. 3 ECHR is already evident from definitions used by the countries referring to the disease as "life-threatening", "irrecoverable deterioration of the

[9] "Enforcement may be unreasonable for foreign nationals if they are specifically endangered by situations such as war, civil war, general violence and medical emergency in their native country or country of origin." See: https://www.fedlex.admin.ch/eli/cc/2007/758/en#art_83

health" to "exceptionally distressing circumstances" or similar phrases defined by the ECtHR in *D v UK*, *N v. UK* and lately, also in the *Paposhvili v Belgium* rulings.

Table 6: Overview of the severity threshold for decision making.

Country	Disease		Consequences of lack of treatment
Austria	1) Life-threatening disease	and	1) Real risk of dying
	2) Seriously ill person		2) Real risk of serious, rapid and irrecoverable deterioration of state of health
Belgium	Disease is checked case by case by medical doctors		The affection poses a genuine risk 1) for his/her life or 2) of an inhuman or humiliating treatment, if there is no adequate treatment provided
Czechia			An imminent risk of dying caused by the return (Case law); endangering the person's life or causes a serious deterioration of the applicant's health situation
Denmark	Serious illness or serious disability certified by a medical doctor	and	The absence of treatment will lead to death, disability, or another form of irrecoverable deterioration of the person's state of health
Estonia	Seriously ill person	and	Risk of a serious, rapid, and irreversible decline in their state of health, or a significant reduction in life expectancy
Finland	Not necessarily life threatening		Reduction of life expectancy; significant physical or mental suffering
France			The disease becomes, within a not too long period of time and with a high probability 1) Life-threatening 2) Impairing on the major functional organs of the patient 3) Has a significant impact on the patient's physical integrity.
Germany	Life-threatening or serious illness	and	Would significantly worsen upon the return being carried out
Greece	A disease that is chronic and serious, decided on a case-by-case basis	and	A real risk to the applicant's life or a serious deterioration of the health condition if returned.
Hungary	1) Life-threatening disease or		1) The sickness worsens if return is executed.
	2) Likely to cause severe and permanent disability.		2) The sickness worsens if medication and treatment are not available or accessible.
Iceland	Very serious illnesses that are not necessarily life-threatening	and	Individual would suffer serious and irreversible harm
Ireland	Life-threatening conditions or circumstances	and	Would cause a serious, rapid, and irreversible deterioration in their health
Italy	1) Serious psychological conditions		Causes significant harm to their health upon return.
	2) Severe pathologies		
Latvia	Serious, rapid and irreversible decline in the state of health	and	1) Either intense suffering
			2) Significant reduction in life expectancy
Luxembourg			Consequence of exceptional severity, i.e. leading to:

Country	Disease		Consequences of lack of treatment
			1) death
			2) reduction of life expectancy
			3) severe handicap
Malta	1) Terminally ill or 2) Severe or life-threatening medical condition	and	The absence of treatment will lead to death, disability, or other forms of irrecoverable deterioration of the person's state of health.
Netherlands			The absence of treatment will lead to death, disability or another form of serious mental or physical damage
Norway	*'Life-threatening' (*refers to the patient's risk of dying if not treated)	and	'A*cute*' describes a relative short period of time in which a disease must be treated
Poland	No particular practice; case-by-case decision		
Slovakia	1) International Protection: case-by-case basis		1) N/A
	2) National Protection: Traumatised or serious ill applicants		2) National Protection: May lead to significant physical or psychological hardship or death.
Slovenia	Not specified – relevant are the consequences of the lack of treatment		Subject to serious harm in case of return
Sweden	Life threatening or severe disability	and	Risk of serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy
Switzerland			A health problem which may specifically endanger the applicant and cause a 'medical emergency' if not treated

Several countries explicitly include mental health conditions within their severity thresholds for medical migration decision-making, though the required level of seriousness varies. Finland refers to "significant physical or mental suffering", while the Netherlands applies a standard of "serious mental or physical damage". Norway similarly requires the presence of a "serious mental disorder", and Sweden recognises mental health conditions in "exceptionally severe circumstances". Furthermore, the ECtHR confirmed in Savran v Denmark[10] that the standard developed in Paposhvili is fully applicable to cases involving mental illness. The Grand Chamber clarified that Paposhvili provides a comprehensive framework, requiring an assessment of the severity of the condition and the real risk of serious deterioration in the event of removal, thereby confirming that mental health cases are not subject to a separate or higher threshold as such, but must be assessed under the same standard.

In cases involving children, several jurisdictions apply a lower threshold of severity than that used for adults. This approach is reflected in law or practice in Austria, Czechia, Finland, Germany, Norway, Sweden, and Switzerland, and is also mirrored in national jurisprudence. The reduced threshold is typically justified by the best interests of the child and the heightened importance of access to health care and continuity of treatment. This reasoning is illustrated by a 2021 decision of the Swedish

[10] ECtHR, Savran v Denmark, 2021

Migration Court of Appeal,[11] which held that the child's best interests and right to health outweighed the state's economic interests, resulting in the annulment of the expulsion order.

4.1.3. Medical severity threshold

Finally, some states recognise so-called medical severity threshold cases. These concern health situations of such extreme seriousness that the medical condition in itself is considered sufficient to preclude return and to justify the granting of a residence permit. In such cases, authorities may waive any assessment of the availability or accessibility of treatment or medication in the country of origin, as the illness is regarded as so severe that return is not considered an option. In the majority of countries (14) examined, this approach is either not expressly regulated, with decisions taken on a case-by-case basis and without further specification of the relevant criteria.

Some countries did state that they have the opportunity to grant a permit in very severe cases without conducting medical COI research; this usually concerns terminal or otherwise extremely severe conditions. And while there is some guidance on what constitutes a medical severity case, this is nevertheless usually decided on a case-by-case basis. For instance, Finland allows for the granting of a discretionary residence permit on humanitarian grounds without further medical COI research where the applicant's condition is extremely severe, for example, in cases of terminal-stage cancer. In Ireland, for instance, a person on dialysis who would not be able to travel without a lapse in care may be granted a status without COI research. The Netherlands applies a comparable approach: when a medical adviser determines that the applicant is in a terminal stage, receiving only palliative care, a simplified "Terminal Patient Memo" is issued instead of a full medical advisory report, on the understanding that the individual is expected to die within six months to one and a half years.

France also recognises exceptional medical threshold cases in which humanitarian status may be granted without prior medical COI research, particularly in cases where the applicant's condition is so severe that no ongoing treatment is being prescribed. Iceland follows a similar approach, allowing humanitarian protection in exceptional cases of clear, extreme severity, such as with terminal cancer patients, based primarily on medical documentation and an assessment of the risk of inhuman or undignified treatment or irreversible harm upon return. Italy bases such cases on constitutional and statutory protection of the right to health, with the Court of Cassation holding that return may be precluded where immediate enforcement would expose the individual to irreparable harm. Malta adopts a distinct approach, allowing temporary humanitarian protection without prior medical COI research where the illness qualifies as a disability that significantly impairs the applicant's ability to lead a normal life, pursuant to Article 17A(1)(c) of the International Protection Act.

Several countries frame the severity threshold in terms of whether it would be unreasonable to enforce return. In Switzerland, enforcement of an expulsion order may be considered unreasonable on humanitarian grounds without examining treatment availability when the illness is terminal and when other factors - such as age, family ties in Switzerland, and lack of a social network in the country of origin - clearly weigh against carrying out return. Belgium similarly accepts that an assessment of treatment availability may become obsolete if a medical doctor advises against return due to an extremely severe health condition, including complex medical situations, hospitalisation, or an inability to travel.

[11] Swedish Migration Court of Appeal, MIG 2021:18, 2021

By contrast, Poland does not apply a medical severity threshold that waivers medical COI research. Even in cases of extreme severity, such as a vegetative state, medical COI is conducted in order to determine the appropriate form of protection, either tolerated stay or humanitarian protection.

4.2. Availability of medical treatment/medication in countries of origin

The availability of medical treatment and/or medication in countries of origin is the first central element in deciding medical claims. The availability check is an important step to identify whether a certain disease could be treated in the country of origin or not. The availability check is conducted in all countries under research, albeit none of them has a legal definition. Instead, availability is established through administrative practice supported by COI and, in some cases, medical expertise.

In the majority of countries - such as Austria, Czechia, Denmark, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Norway, Poland, Slovakia, Sweden, and Switzerland - the case worker carries primary responsibility for the assessment, typically relying on COI units or comparable analytical services.

Some states integrate medical expertise more formally into the process. Belgium and the Netherlands involve medical advisors, with the latter drawing on guidance contained in implementing regulations under the Aliens Act. France assigns the assessment to a college of doctors, who rely on the MedCOI database and other verified sources, thereby embedding medical expertise more explicitly within the procedure. Luxembourg also incorporates advisors, though without a defined legal framework. In Malta, the protection officers, with the guidance of the International Protection Agency's management, carry primary responsibility for the assessment, typically relying on COI units or comparable analytical services.

While the "availability" of medical treatment and/ or medication seems rather straightforward at first glance, detailed interpretation of nuances may turn out to be complex when applied. A medication may be registered in a country of origin but may be temporarily (or indefinitely) out of stock. A country's economy may also be weak, and the black market may in part work more efficiently or even be more reliable than the official supply (of medication for example). A treatment or medication may be available but of lower quality than in the (current) host country of the applicant.

Table 7: Overview of definitions and responsibilities for the "availability-assessment"

Availability	Relevance	Legal definition	Availability is determined by
Austria	Yes	No	Case worker with support of COI
Belgium	Yes	No	Case worker with support of the medical advisor
Czechia	Yes	No	Case worker with support of COI
Denmark	Yes	No	Case worker with support of COI
Estonia	Yes	No	Case worker with support of COI experts
Finland	Yes	Preparatory work for the Aliens Act and agency guideline	Case worker with support of COI
France	Yes	No	College of doctors
Germany	Yes	No	Case worker with support of COI

Availability	Relevance	Legal definition	Availability is determined by
Greece	Yes	No (but basis in Greek Asylum Service's Directive)	Case worker with support of COI
Hungary	Yes	No	Case worker with support of COI,
Iceland	Yes	No	Case worker with support of COI
Ireland	Yes	No	Case worker with support of COI
Italy	Yes	No	Case worker with support of COI
Latvia	Yes	No	Case worker with support of COI
Luxembourg	Yes	No	Case worker with support of advisor
Malta	Yes	No	Case worker with support of internal consultations
Netherlands	Yes	Aliens Act implementing guidelines	Case worker with support of medical advisor
Norway	Yes	No	Case worker with support of COI
Poland	Yes	No	Case worker with support of COI
Slovakia	Yes	No	Case worker with support of COI
Slovenia	Yes	No	Case worker
Sweden	Yes	No	Case worker and decision maker with support of COI
Switzerland	Yes	No	Case worker with support of COI

Across European states, "availability" of medication in a country of origin is assessed through differing combinations of regulatory status, physical presence, continuity of supply, and the legitimacy of distribution channels.

Table 8: Elements for the "availability-assessment"

Country	Medication/ treatment must be…
Austria	→ Registered (not necessarily also on stock) → Legal channels
Belgium	→ Registered AND in stock
Czechia	→ Considered case by case, no specific guidance
Denmark	→ Determined supply → Legal channels
Estonia	→ Legal channels → Case-by-case considerations
Finland	→ Physically present in the country of origin → Legal channels
France	→ Registered → Regular resupply
Germany	→ Physically present in country of origin at the time of the decision → Treatment must be provided by professional (specialised) medical doctors
Greece	→ Registered AND regular resupply
Hungary	→ Registered OR "known" to be available through other channels

Country	Medication/ treatment must be…
Iceland	→ Present within a functioning healthcare system → Legal channel → Can be through public or private channel → Treatment must be sufficient; quality of medication must be sufficient → Stable and reliable supply → Registered
Ireland	→ Registered → Must be consistently in stock → Obtainable though formal channels → Sufficient quality and continuity of supply
Italy	→ Is (physically) present in the country of origin → legal channel
Latvia	→ Legal channels
Luxembourg	→ Determined supply → Treatment has to be provided in a medical facility
Malta	→ Obtainable through a public or private channel
Netherlands	→ Treatment/medication is present → Sufficient uninterrupted supply → Available at a certain time
Norway	→ Registered AND determined supply →Treatment has to be practiced in the country → Legal channels
Poland	→ Regular in stock AND available via legal channels → Treatment must be provided by specialised med doctors
Slovakia	→ Registered in the country of origin OR → Possibility to obtain an alternative through regular channels AND → Is (physically) present in the country of origin
Slovenia	→ Not specified
Sweden	→ "Must be there" → Legal channels
Switzerland	→ Registered AND regularly supplied AND in stock → Legal channels → At the time of decision-making

Several states prioritise both registration and proven stock of medication. Belgium requires a medication to be officially registered and actually in stock; Greece and Switzerland pair registration with regular resupply; Ireland also stresses consistent stock, formal supply routes, and assured quality.

Others focus on whether the medication is physically present and accessible within lawful channels. Germany looks for physical presence at the time of decision-making and requires treatment to be provided by professional (specialised) medical doctors. Finland and Italy similarly emphasise presence and legal distribution. Iceland adopts a broader system-based approach, examining whether medication is available within a functioning healthcare system, public or private, with stable and reliable supply. The Netherlands notes the need for uninterrupted supply. Hungary and Slovakia permit availability to be evidenced through registration or through other regular and reliable channels.

Some countries like Czechia and Estonia emphasised case-specific assessments, evaluating availability individually Netherlands notes the need for uninterrupted supply

4.3. Accessibility of medical treatment/ medication in countries of origin

Across European states, accessibility of medication and treatment is consistently regarded as relevant, yet formal definitions are not common. Most countries rely on individualised assessments, examining whether an applicant can, in practice, obtain the required care.

Table 9: Overview of the definition and key features for the "accessibility-assessment"

Accessibility	Relevance	Definition	Features
Austria	Yes, since Paposhvili	No	No specific rules: case owners enjoy a lot of discretion
Belgium	Yes	No	Scope depends on applicant's claim
Czechia	Yes	No	Case-by-case consideration
Denmark	Yes, since Paposhvili	No	Costs of the medication and treatment, the existence of a social and family network, and the distance to be travelled in order to have access to the required care
Estonia	Yes	No	Case-by-case consideration
Finland	Yes	No	Case-by-case consideration, individual overall assessment, only becomes relevant if several factors would accumulate and make the applicant's situation unreasonably harsh
France	Yes	No	Coverage of medication or treatment and/or care under the national health scheme, if an NGO programme covers the treatment or medication, or if the out-of-pocket money for care is considered low/affordable, considering socio-economic factors in the country or origin
Germany	Yes	No	There must be no obstacle to get hold of treatment/ medication
Greece	Yes	No (but basis in Greek Asylum Service's Directive)	No obstacles to receive the needed medical treatment or to acquire the necessary medication. It considers information on the health care system in the country of origin, the existence of health care providers providing specific treatments and medication, and geographical location and effective accessibility
Hungary	Yes	No	Economic, geographic, and political accessibility determine an individual's de-facto access to medical treatment
Iceland	Yes	No	Case-by-case consideration
Ireland	Yes	No	Case-by-case consideration
Italy	Yes	No	Real access to the adequate medication and/or treatment. Economic, geographic, and political accessibility are assessed
Latvia	Yes, in protection cases, not in medical visa cases	No	Case-by-case consideration
Luxembourg	Yes	No	Strongly depends on individual situation of applicant
Malta	Yes	No	Whether the applicant would be able to obtain the treatment or medication including an assessment of economic and geographic accessibility, as well as existence of a support network

Accessibility	Relevance	Definition	Features
Netherlands	Yes, since Paposhvili	Yes	"Actual accessibility" including "non-medical factors" such as "political, discriminatory, safety, geographical, economic, infrastructural and income aspects"
Norway	Yes	No	Actual access for the individual applicant
Poland	Yes	No	Case-by-case considerations
Slovakia	Yes	No	The applicants can afford the treatment and/or medication, based on their personal situation and available support in the country of origin.
Slovenia	Yes	No	De-facto actual accessibility is assessed on case-by-case basis by the case worker and their supervisor
Sweden	Yes	No	Accessibility is considered on an individual basis, taking into account the specific circumstances of the case and all relevant evidence and COI
Switzerland	Yes	No	Mainly the economic accessibility plays a role in practice

Austria, Czechia, Estonia, Iceland, Ireland, Latvia, Poland, Slovenia, Sweden, Luxembourg and Malta base accessibility decisions on case-by-case evaluations. These typically consider the applicant's personal circumstances and general information on healthcare provision in the country of origin, without detailed statutory rules. Here the discretion lies with the COI researchers and/or the case workers. In Sweden, for instance, the discretion lies with the case worker. The COI researcher merely provides the relevant country of origin information available; primarily through the EUAA MedCOI database.

Several states identify clearer factors influencing accessibility. Denmark focuses on treatment costs, available social or family support, and travel distance. Finland conducts an overall assessment, treating accessibility only when cumulative difficulties make the situation particularly harsh. Switzerland emphasises the affordability, Malta and Luxembourg refer to whether the applicant could realistically obtain care.

Other jurisdictions adopt broader assessments of structural barriers. France considers whether treatment is covered by national schemes or NGO programmes and whether out-of-pocket costs are affordable. Germany and Greece examine the absence of practical obstacles, considering healthcare infrastructure and geographical reach. Hungary, Norway, and Italy assess actual access for the individual applicant.

The Netherlands provides the most explicit definition, requiring an assessment of "actual accessibility", incorporating political, discriminatory, safety, geographic, economic, infrastructural, and income-related factors.

Across the region, accessibility is therefore consistently relevant but operationalised through different combinations of individual circumstances, socio-economic barriers, and systemic conditions.

Types of accessibility in the national context

While all countries need to establish whether a certain medical treatment or medication is available, the costs of the medication (hereby referred to as part of the "economic accessibility"), the distance between the residence of the returnee in their home country and the location where treatment is available (hereby referred to as "geographic accessibility"), and whether there are any discriminatory practices with regards to the actual access for a returnee (hereby referred to as "political accessibility") are of varying degrees of relevance in the selected countries for granting or denying permits based on medical reasons.

Economic accessibility

The economic accessibility implies that the returnee would have the financial means to obtain the "available" treatment/ medication necessary for treating the disease. To assess economic accessibility, different elements are considered, and can be clustered into the following aspects:

- *Costs* of medication and/or treatment
- *Human capital* of the persons concerned, including the person's age, fitness to work, expectations of finding work in the labour market of the country of origin.
- *Possible compensation* of costs through health care systems, family, or other sources.

Table 10: Overview of the key features constituting the "economic accessibility."

Country	Relevance of economic accessibility	Relevant (yes) or not relevant (no) elements to assess the accessibility						
		Costs	Wealth of applicant	Fit for work	Health care system	Family	Other support	Ability to generate income in CoO
Austria	Yes	Yes		Yes	Yes	Yes	Yes (IO)	
Belgium	Yes	Yes		Yes	Yes	Yes	Yes (IO)	
Czechia	Yes	May become relevant if different elements accumulate; costs are irrelevant (preliminary works for the Alien Act)						
Denmark	Yes	Yes				Yes		
Estonia	No							
Finland	Possible	Economic considerations may play a role in exceptional circumstances, where there is an accumulation of difference elements						

France	Yes	Yes	No*		Yes		Yes	
Germany	Yes	Yes		Yes	Yes	Yes		
Greece	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hungary	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Iceland	No	Economic consideration may be considered in a broader evaluation						
Ireland	Yes	Yes		Yes			Yes	Yes
Italy	Yes	Yes	Yes		Yes	Yes	Yes	
Latvia	Yes	No specific elements must be fulfilled, only all submitted evidence is considered in each specific case						
Luxembourg	Yes	Yes		Yes	Yes	Yes		
Malta	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Netherlands	Yes	Different elements are possible (family support, costs, income)						
Norway	Yes	Economic accessibility guaranteed even if the costs are high, unless the costs could 'only be covered by a small part of the population'						
Poland	Yes	Yes		Yes	Yes	Yes	Yes (IO)	Yes
Slovakia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Slovenia	Yes			Yes				
Sweden	Yes	Yes				Yes		
Switzerland	Yes	Yes	Yes	Yes	Yes	Yes	Yes (IO)	
* The financial situation may, nevertheless, be considered at a later stage of the process and still influence the final decision								

Economic accessibility concerns whether an applicant can afford the required medical care, and it is one of the most consistently applied elements in the accessibility assessments. Cost-based barriers play a prominent role in state practices of the researched countries. A clear majority of states treat economic obstacles as relevant, with twenty countries explicitly considering factors such as medication costs, treatment fees, and indirect expenses including travel and accommodation. Only two countries do not regard economic circumstances as pertinent. Overall, economic accessibility emerges as the most uniformly recognised dimension across the researched countries.

Geographic accessibility

The geographic accessibility may become relevant if the individual needs to return to a place which is not in direct proximity of the place where medical treatment and/or medication is available. It thus deals with potential practical obstacles to travel between those locations.

As such, the proximity of medical facilities and pharmacies in relation to the individual's place of residence may be relevant as well as the physical ability of the applicant to reach medical facilities, the influence of the security situation in the country of origin, the availability of transport, or the necessary frequency of travel to the medical facility. In accumulation with other accessibility elements, the costs of the transportation may also be of relevance.

Table 11: Examples for the relevance of the "geographic accessibility" of medical treatment and/ or medication in the country of origin

Country	Relevance	(Non)relevant elements
Austria	Possible	→ Applicant can be expected to relocate to a town/ region where medical care is available
Belgium	Possible	→ Geographic distance is irrelevant in most cases - the person may relocate if necessary (case-law) but depending on the country and/ or medical condition geographic accessibility might sometimes be taken into consideration
Czechia	Possible	→ Case by case considerations, no standard elements
Denmark	Yes	→ Distance to be travelled
Estonia	No	N/A
Finland	Possible	→ May be relevant if distance accumulates with other elements (e.g.: the security situation; or the costs for traveling; etc.)
		→ Distance/ long travel/ travel costs per se are considered irrelevant
France	No	→ N/A
Germany	Possible	→ May be relevant if distance accumulates with other elements (e.g., the security situation or the costs for traveling)
		→ Distance alone is considered irrelevant
Greece	Yes	→ The distance that the applicant would need to travel to access treatment
		→ The frequency with which the applicant would have to travel
		→ Whether the medical condition permits the applicant to travel or if rather they will experience restricted mobility
		→If the medical facilities offering a specific treatment are geographically restricted to a region within the country of origin, the case worker considers whether the applicant can be expected to move to that town or region where the treatment or medication is available
		→ Security concerns related to traveling to the treatment location, such as passing through conflict zones
Hungary	Yes	→ Proximity of medical facilities and pharmacies
		→ Physical ability of the applicant to reach those facilities
		→ Necessary frequency of travel to the medical facility
Iceland	Yes	→ Case by case considerations
		→ Physical ability of the applicant to reach the facilities
		→ Availability and cost of transportation
		→ Necessary frequency of travel to the medical facility
		→ Security situation in country of origin
Ireland	Yes	→ Geographic accessibility of treatment is not assessed as a separate factor when treatment is deemed to be available in the country of origin
		→ The security situation in a country of origin is considered when assessing the availability of treatment
Italy	Yes	→ Proximity of medical facilities and pharmacies
		→ Applicants' physical ability to reach the facilities
		→ Security in the country of origin
Latvia	Yes	→ Proximity of medical facilities and pharmacies
		→ Physical ability of the applicant to reach the facilities
		→ Security situation in country of origin

Country	Relevance	(Non)relevant elements
		→ Availability and cost of transportation
		→ Necessary frequency of travel to the medical facility
Luxembourg	Yes	→ Person must be reasonably able to reach the place where medical an
		→ Security of transportation
		→ Applicants' physical ability to reach the facilities
		→ Proximity of medical facilities and pharmacies
Malta	Yes	→ Physical ability of the applicant to reach the facilities
		→ Proximity of medical facilities and pharmacies and necessary frequency to travel
		→ Security situation in country of origin
		→ Availability of transport
Netherlands	Yes	→ different elements possible (e.g., infrastructure, distance)
		→ applicant has burden of proof
Norway	Possible	→ Geographic distance only relevant if extraordinary individual circumstances prevent the returnee to travel to the medication/ treatment
		→ Distance to obtain the treatment/ medication
		→ security problems on the way
Poland	Possible	→ Geographic distance may be relevant in exceptional cases (restricted mobility etc)
		→ Distance to the treatment/ medication
Slovakia	Yes	→ The ability and possibility to reach the required treatment
Slovenia	N/A	N/A
Sweden	Yes	→ Distance to obtain the treatment → May be relevant if a special allowance would be needed to reach medication/treatment
Switzerland	Yes	→ The case worker examines on a case-by-case basis, whether it is reasonable for an applicant to move close to the place of treatment

Geographic accessibility is widely acknowledged, though many states assess it only when it is specifically substantiated or clearly arises from the circumstances of the case.

Thirteen of the researched countries treat geographic obstacles as relevant, while seven examine geographic considerations only when they are specifically raised by the applicant or clearly apparent from COI. France on the other hand explicitly regards geographic factors as not relevant, noting that travel within the country is generally expected where required.

Political accessibility

Political accessibility may become relevant if healthcare is denied on discriminatory grounds. As such, it may become relevant if access to medical facilities or access to public insurance systems is denied due to the concerned person's race, religion, nationality, membership of a particular social group, or political opinion. Furthermore, political accessibility may become pertinent when an individual faces the risk of discrimination due to the stigmatisation of their medical condition, such as in cases involving HIV or psychiatric conditions.

Political accessibility is of minor importance in the context of the granting or denying of a residence permit in connection with the medical situation of a TCN. This is mainly because such assessment is

closely connected to the refugee status determination process in the context of the asylum procedure, which is – as stated above – the main migration process where medical claims come up.

Table 12: Overview of the key features for the "political accessibility" of medical treatment and/ or medication in the country of origin

Country	Relevance	Relevant elements
Austria	No	
Belgium	Possible	→ Only researched upon explicit claims that there may be difficulties
Czechia	Possible	→ Discrimination in accessing medical care
Denmark	No	
Estonia	Yes	→ Discrimination in accessing medical care
Finland	Possible	→ usually already determined during the refugee status determination process, however discrimination of a minority may influence accessibility, e.g. if a women required a male escort to travel to reach the treatment
France	Yes	→ Potential discrimination that may affect their access to medical facilities or access to the public health insurance system.
Germany	No	→ This element would already be assessed in the refugee protection determination process; thus, it only plays a minor role when assessing an impediment to removal
Greece	No	→ Discrimination of the applicant would be primarily considered part of the refugee protection determination process
Hungary	Yes	→ Discrimination in accessing medical facilities or the public insurance system due to their race, religion, nationality, membership to a particular social group, or political views.
Iceland	Yes	→ Discrimination in accessing medical care
Ireland	Yes	→ Discrimination in accessing medical care
Italy	Yes	→ Discrimination in accessing medical care
Latvia	Yes	→ Discrimination in accessing medical care
Luxembourg	Possible	→ Discrimination of the applicant would be primarily considered part of the refugee protection determination process, however, can become relevant if claims arise in the return proceedings
Malta	Possible	→ Discrimination of the applicant would be primarily considered part of the international protection determination process
Netherlands	Possible	→ Barriers are indirectly addressed through the requirement for guarantees and arrangements
Norway	Possible	→ Discriminatory practices concerning the actual access to health care
Poland	Possible	→ Relevant if discrimination below the level of individual persecution
Slovakia	Yes	→ Discrimination in accessing medical care
Slovenia	N/A	N/A
Sweden	No	→ Discrimination of the applicant would be primarily considered part of the refugee protection determination process
Switzerland	Possible	→ Relevant if claimed in the application

Nine of the researched countries state that it is possible that political barriers are being researched, assessing them when indications of discrimination are raised or apparent. Eight countries explicitly consider such obstacles relevant and incorporate them into their accessibility assessment. Five countries treat political factors as not relevant, as they would have already been assessed during the refugee status determination process.

4.4. Residence and Return

4.4.1. Residence granted

If a migrant's health situation has been qualified as severe and the necessary treatment/medication is not available and/or accessible in the country of origin, the person cannot be returned due to human rights concerns deriving from Art. 3 ECHR and the related case law. States consequently need to issue a permit which allows the person to remain in the country to further receive the necessary treatment.

The type of residence permit that is granted to people who cannot be returned due to medical reasons depends on the processes in which the medical situation has been claimed.

Table 13: Overview of the types of residence permits granted.

Permit	Type of permission to stay	Duration	Extendable	Issuance
Austria	1) Subsidiary status	1) 1 year	1) Yes	Federal Office for Immigration and Asylum
	2) Leave to remain	2) Synchronised with treatment	2) Yes	
Belgium	Residence permit (A-Card)	1 year or 2 years in severe cases	Yes, after 5+ years and not change in condition a permanent residence (B-Card) may be issued	Municipality
Czechia	1) Visa for tolerated stay	1) Depending on the individual situation, up to 1 year		Ministry of Interior
	2) Residence permit for tolerated stay	1) Depending on the individual situation, up to 1 year		
Denmark	1) Humanitarian Residence Permit	1) Normally 2 years for the first time	Yes	1) Ministry of Immigration and Integration
	2) Residence permit family reunification	2) 2 years		2) Immigration Service
Estonia	1) Refugee status	1) 3 years	Yes	Police and Border Guard Board
	2) Subsidiary protection	1) 1 year		
Finland	Residence permit on a discretionary basis on humanitarian grounds	1 year	Yes	Finnish Immigration Service

Permit	Type of permission to stay	Duration	Extendable	Issuance
France	Temporary residence permit on medical grounds	Up to 48 months	Yes, but by submitting a new claim	Decided by the Préfet, granted by the Ministry of Interior
Germany	Impediment to return	1-3 years	Yes	Foreigners' office in the Federal States
Greece	1) Subsidiary status	1) 1 year	1) Yes	1) Greek Asylum Service
	2) Temporary residence permit on humanitarian and exceptional grounds	2) 1 year	2) Yes, along with possibility to switch to another permit	2) Residence Permits Directorate
Hungary	Tolerated status	1 year	Yes	National Directorate-General for Aliens Policing (NDGAP)
Iceland	Residence Permit on humanitarian grounds	1 year	Yes	Directorate of Immigration
Ireland	1) Refugee status	1) Indefinite	N/A	Ministry of Justice, Home Affairs and Migration
	2) Subsidiary protection	2) Indefinite		
	3) Permission to remain	3) discretion of the decision maker	3) discretion of the decision maker	
Italy	Temporary permit on medical grounds	1) 1 year in the case of non-refoulement	Yes	Immigration Office of the Police (Questura)
		2) Equal to the duration of the treatment in the case of entry visa		
Latvia	Residence permit to receive treatment	For the expected duration of the treatment	Yes	Office of Citizenship and Migration Affairs (OCMA)
Luxembourg	Postponement of return	Depends on med certificate; up to 6 months	Yes, on demand	Directorate of Immigration
Malta	Temporary humanitarian protection	1 year	Yes	International Protection Agency
Netherlands	Postponement of departure (temp. humanitarian legal stay - no residence permit)	Synchronised with medical advice, up to 1 year	Yes	IND
Norway	Residence status based on humanitarian grounds	3 years (synchronised with treatment)	After 3 years, perm. res. permit possible	Norwegian Directorate of Immigration
Poland	1) Subsidiary status	1) 2 years	Yes	1) Office of Foreigners
	2) Humanitarian residence status	2) 2 years		2) Polish Border Guard

Permit	Type of permission to stay	Duration	Extendable	Issuance
Slovakia	1) Refugee status	1) Permanent residence permit	Yes	Migration Office of the Ministry of Interior
	2) Subsidiary status	2) Temporary residence permit		
	3) National Status	3) Permanent residence permit		
Slovenia	1) Refugee Status	1) 1-5 years, based on individual circumstances	Yes	Asylum directorate of the Ministry of Interior
	2) Subsidiary Status	2) 1 year		
Sweden	Residence permit on grounds of exceptionally distressing circumstances	13 months	Yes, for 2 years; after 3 years a permanent residence possible	Swedish Migration Agency
Switzerland	Temporary admission	1 year	Yes	SEM grants, Cantons issues the permit

4.4.2. Residence not granted

Should the severity threshold not be reached or should the applicant be able to receive treatment and/or medication in the country of origin, the TCN is to be returned. The countries foresee cash and/or in-kind support to returnees but also specific medical support of varying degree.

Table 14: Overview of medical support for returnees

Country	in cash	in-kind	types of support in connection with return
Austria	Possible	Possible (medication)	→ Possible short-term postponement for return (e.g., finishing education)
			→ Possible support by Assisted Voluntary Return (AVR) programmes
Belgium	No	No	→ Special needs programme providing tailored, financial support for essential medical and psychological follow-up care to vulnerable individuals
Czechia			
Denmark	No	Yes	→ Medical support can be provided for the first period (14 days - 1 month)
			→ Extensive Medical Care (EMC) may be granted
Estonia	No	No	→ Medical considerations can be made in the practical travel arrangements
Finland	No	No	→ Assisted Voluntary Return (AVR) programmes may contain medical support
France	Not specified		
Germany	Not specified		
Greece	Not specified		
Hungary	Yes	Yes	→ A medical check in detention and upon request to determine medical assistance during travel

Country	in cash	in-kind	types of support in connection with return
			→ Psychologist, medical specialist and health worker present in forced return for fit-to-fly assessment and to determine medical assistance during travel.
			→ Any necessary medication provided
			→ EU Reintegration Programme
Iceland	Yes	No	→ Financial support may be given; the need is assessed in a case-by-case basis
Ireland	Yes	No	→ The reintegration grant is adapted to the needs of the returnees. In conjunction with partners on the ground to generate a reintegration plan that's tailored to each returnee and their specific needs including medical assistance, that can be approved, up to the limit of their reintegration grant. Additionally, psycho-social supports and onward referrals in place.
Italy	Not specified		
Latvia	Not specified		
Luxembourg	No	No	→ Support via IOM
Malta	Yes	Yes	→ Support via IOM
Netherlands	/	Yes	→ DT&V, the Dutch Repatriation and Departure Service, may plan arrangements for the reception of the returnee patient in a hospital or with a doctor
Norway	No	No	→ Assisted Voluntary Return (AVR) programmes by IOM; specific support for medical reasons could be granted
Poland	Not specified		
Slovakia	Yes	Yes	→ EU Reintegration Programme
Slovenia	Yes	Yes	→ EU Reintegration Programme, doctor may prescribe therapy for a certain time period or a special reception in the country of origin
Sweden	No	No	→ Medication may be provided until doctors can be visited in CO
Switzerland	No	Yes	→ Returnee may apply for medical return assistance for up to 6 months