HHR Health and Human Rights

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Securing the Right to Health of Asylum Seekers: A Small-Scale Qualitative Case Study in Thessaloniki, Greece

FAYE VERVERIDOU AND TAMARA HERVEY

Abstract

Deploying legal analysis and a small-scale qualitative dataset, this paper considers the right to health of asylum seekers, as a subgroup of distress migrants, in Greece in the years preceding the COVID-19 pandemic and thereafter. The public health care system in Greece is operating under significant constraints stemming from austerity policies. We analyze the legal entitlements of asylum seekers as found in Greek and international law and confirm a significant gap between the right to health in theory and the right to health in practice. While some administrative matters have improved, in general, widespread human rights failures to provide the right to health for vulnerable asylum seekers arriving in Greece continue. In particular, shortcomings in the health care system's capacity and structure, as well as poor arrangements to secure the underlying conditions for good health, affect the practical realization of the right to health of asylum seekers, many of whom have complex health needs.

Faye Ververidou, LLB, LLM, is a former PhD candidate at the University of Sheffield and a part-time lecturer and research associate at South-East European Research Centre, City College, University of York Europe Campus, Thessaloniki, Greece.

Tamara Hervey, LLB, PhD, is Jean Monnet Professor of EU Law at City, University of London, United Kingdom.

Please address correspondence to Tamara Hervey. Email: tamara.hervey@city.ac.uk.

Competing interests: None declared.

Introduction

The right to health is among the most important international human rights, pertaining to human dignity and life itself. Within Europe, the right to health is largely secured through publicly financed health care systems, many of which were severely impacted by the global financial crisis of 2009.[1]

Worldwide, distress migration (stemming from "desperation, vulnerability, and needs, from living circumstances that are experienced as unbearable or deeply unsatisfactory and that precipitate serious obstacles to a reasonable or tolerable life") has been continuously on the rise.[2] One source of desperation, vulnerability, and unbearable living circumstances—the armed conflict in the Middle East, particularly Syria—has led to massive and continuing inflows into Europe of a specific sub-category of distress migrants: those seeking international protection. According to the European Union's (EU) Qualification Directive, asylum seekers are individuals who have made a formal claim for international protection but whose application has not yet been processed.[3]

Situated at the southeastern edge of the EU, Greece received an estimated over one million new migrants during 2015–2018, and almost 204,000 more between 2019 and August 2024, according to the United Nations High Commissioner for Refugees.[4] Figures from the Greek Ministry of Asylum Statistics suggest even higher numbers.[5]

While health and immigration law have each attracted significant academic interest, studying their intersection offers added value because both fields are traditionally regarded as domains of national sovereignty. States have long designed their health care systems principally around exclusion, prioritizing the needs of nationals over non-nationals.[6] Similarly, the enjoyment of human rights by migrants has often been perceived as conflicting with state sovereignty.[7] This paper challenges such assumptions by examining the legal entitlements of asylum seekers in Greece, particularly with respect to the right to health, flowing from both domestic and international human rights law.

Under the Greek Constitution, international conventions take precedence over conflicting domestic legislation.[8] This underscores Greece's formal commitment to its international legal obligations, whether from the United Nations (UN), the Council of Europe, or the EU.[9] While the issue of whether international law also supersedes *constitutional* provisions remains unresolved in Greece, legal scholarship has suggested that international *human rights* law may do so when it provides greater protection.[10] Thus, international law holds a prominent place within the Greek domestic legal framework, with supra-legislative authority and, for human rights protection, potentially a supra-constitutional status. Within the UN human rights framework, Greece has ratified all major international conventions that include the right to health and is therefore legally bound by their provisions according to its own constitutional provisions.

Deploying legal analysis and a small-scale qualitative dataset in Greece, supplemented by secondary data, this paper explores a twofold research question: (1) whether asylum seekers, as a specific subset of distress migrants, are entitled to a right to health under the international human rights conventions ratified by Greece, and (2) how these legal entitlements are realized in practice, particularly in the period leading up to and following the COVID-19 pandemic. We analyze the practical and administrative barriers faced by asylum seekers and the health professionals responsible for their care. We identify gaps between (legal) theory and practice and show that, despite these gaps, both asylum seekers and health professionals share a strong belief in human rights as an important vector for health protection and human flourishing. We conclude by arguing that the assumptions that sovereign states organize their health care systems to exclude non-residents seeking asylum are not wholly supported in the context of a state like Greece, which at least strives to respect its obligations under international human rights law when it comes to the right to health for asylum-seeking migrants.

Methodology

The paper's research questions require a combined methodology, utilizing both "doctrinal" and

"empirical socio-legal" approaches.[11] We employ a doctrinal method to analyze legal norms embedded in international human rights law and Greek legislation, relevant case law, and "soft law" documents.[12] Committees established by UN conventions offer authoritative interpretations of provisions through general comments, monitoring reports, and decisions on individual complaints.[13] These publications bridge the gap between international law on paper and national practice.[14] Thus, our doctrinal analysis focuses on the right to health in five international human rights instruments ratified by Greece, the pertinent national legislation, and an examination of 50 UN committee publications from 2011 to 2024, which are used to interpret state obligations (here, Greece's) under these international instruments. (The committees examined are the Committee on Economic, Social and Cultural Rights; the Committee on the Elimination of Racial Discrimination; the Committee on the Rights of the Child; the Committee on the Elimination of Discrimination Against Women; and the Committee on the Rights of Persons with Disabilities.)

We also employ empirical methods to investigate the practical application of the right to health of asylum seekers in Greece. Primary data were collected through 25 semi-structured interviews with Arab-speaking asylum seekers (n=15), aged 18–55, and health professionals (n=10), conducted between June and September 2019. Participants were selected using purposive and snowball sampling, respectively.[15] Thessaloniki's role as the second largest city in the country, the health care hub for Northern Greece, and its proximity to several reception centers for asylum seekers made it an ideal location for this study. The interview guide, tailored for each group of interviewees, was informed by the doctrinal legal analysis of the right to health, ensuring that the empirical research was grounded in the theoretical framework. Interviews with asylum seekers were facilitated by a native Arab-speaking interpreter through simultaneous interpretation, and all interviews were transcribed by Ververidou. Data saturation was reached despite the small sample size, respecting principles of data minimization.[16]

Thematic analysis, derived from the legal doctrine, was employed to systematically examine key themes across the interview data, allowing us to compare and contrast the theoretical legal obligations with practical challenges faced by asylum seekers.

Our primary data are complemented by secondary data on asylum seekers' access to health in Greece since 2020. This includes scholarship, gray literature, two European Court of Human Rights judgments, a UN monitoring report, news coverage, and nine reports from civil society organizations. These secondary data were also analyzed thematically, using key themes identified during the analysis of the primary data.

Legal context

The Greek legislative context for asylum seekers

Greece's legislative framework for asylum seekers, including their right to health, has been repeatedly reformed over the last decade, primarily to comply with EU law.[17] The current position is Law 4939/2022 (Asylum Code), which, despite successive legislative changes, has remained consistent on health care access, reception conditions, and medical screening for asylum seekers.[18] Here, Greek law aligns with and sometimes exceeds EU standards, which require emergency care and essential treatment.[19] Recognized by Greek law as a "socially vulnerable group," asylum seekers are entitled to free access to publicly provided primary and secondary health care, including pharmaceutical and hospital care, preventive care, sexual and reproductive health care, psychiatric care and mental health support, and chronic disease treatment.[20] This differs significantly from migrants who have not applied for asylum, whose access is limited to emergency care and psychosocial services.

Obtaining a social security number (AMKA) was a de facto requirement for asylum seekers to gain access to the public health care system. A July 2019 circular revoked asylum seekers' access to AMKA, effectively removing their right to receive medical treatment in public facilities. In November 2019, a new system for free health care access was

introduced solely for asylum seekers—the Foreigner's Temporary Insurance and Health Coverage Number (or PAAYPA).[21] Nevertheless, this new system was not put into operation until April 2020. Hence, from July 2019 until April 2020, a large number of asylum seekers in Greece had access only to emergency public health care and relied on private health care to cover non-emergency health needs.

Greek law also provides that asylum seekers should have an adequate standard of living, taking into account their resources, to safeguard their physical and mental health.[22] Irrespective of whether an asylum application has been lodged, newly arrived migrants are subject to medical screening on public health grounds, primarily to prevent the spread of communicable diseases.[23] Part of the legally defined process involves an assessment of the "vulnerability" of arrived persons. Greek law non-exhaustively enumerates categories of "vulnerable" individuals and affirms that they are considered to have particular reception needs and thus are entitled to specialized care and protection.[24]

The right to health in UN international human rights law

The human right to health is enshrined in numerous international conventions. This paper focuses on UN conventions, given their broad scope and universal applicability. The UN system lacks definitional uniformity across different conventions; has no hierarchical system among its committees, leading to overlapping or conflicting interpretations; and does not hold states to a singular standard of the right to health, instead taking into account each state's resources.[25]

Despite these complexities, there is some definitional agreement. According to Brigit Toebes's widely accepted definition, the right to health covers both access to health care (such as medical treatment) and underlying determinants of health (such as living conditions and environmental safety).[26] Our analysis builds on that definition and focuses on the right to health in five UN conventions ratified by Greece: the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5); the International Covenant on Economic, Social and Cultural Rights (art. 12); the Convention on the Rights of the Child (arts. 24 and 25, and its optional protocols); the Convention on the Elimination of All Forms of Discrimination Against Women (art. 12); and the Convention on the Rights of Persons with Disabilities (art. 25).

The AAAQ framework. The right to health is an expansive concept.[27] It is interdependent with other human rights, such as the rights to food, housing, work, and access to information.[28] In its authoritative interpretation of article 12 of the International Covenant on Economic, Social and Cultural Rights, the Committee on Economic, Social and Cultural Rights (CESCR) endorsed the AAAQ framework: availability, accessibility, acceptability, and quality. This framework is a practical tool to assess states' compliance with their convention-based, health-related obligations, and it has significantly influenced the activities of other international bodies.[29]

Availability refers to the presence of public health care programs, goods, facilities, and services, as well as access to safe and potable water, hygiene conditions, and essential medicines.[30] *Accessibility* encompasses nondiscriminatory, physical, and economic access to health care (affordability), based on equity and proportionality, and access to information. The inability to cover health expenses should not pose a barrier to enjoying health services, especially for impoverished or socially underprivileged populations.[31] *Acceptability* requires that health services be ethically and culturally appropriate, be gender and age sensitive, and respect privacy.[32] National health laws and strategies must promote the cultural training of health professionals.[33] *Quality* is associated with the availability of skilled health professionals, adequate medical infrastructure, scientifically approved medication appropriate for specific patient groups (such as children), and the provision of high-quality water and sanitation conditions.[34]

Progressive realization and the minimum core of the right to health. The International Covenant on Economic, Social and Cultural Rights recognizes the progressive nature of the right to health.[35]

Progressive realization means that states must work toward the full realization of rights based on available resources and their level of development. Immediate fulfillment may not be possible.[36] Scholars have attempted to strengthen the legal underpinnings of progressive realization by calling for accountability through examining state effort.[37] For others, however, progressive realization is impossible to define or effectively implement, rendering the right to health a mere aspirational goal.[38]

To address these concerns, the CESCR has articulated key limitations to the principle of progressive realization. States must continuously strive to realize rights as expeditiously as possible, through deliberate and targeted steps.[39] Any retrogressive measures must be justified.[40] Retrogression is measured by the country's current level of development, the severity of the alleged retrogression, and action by the state to find low-cost alternatives.[41] The nondiscrimination principle applies immediately.[42] Progressive realization does not affect the enjoyment of a minimum content of the right to health.[43]

The CESCR has developed an evolving list of such a "minimum core," beginning with access to primary health care and essential food and housing, and adding equitable and nondiscriminatory access to health facilities, goods, and services, especially for vulnerable individuals; essential medicines; safe and potable water; adequate and nutritional food; basic shelter and sanitation facilities; and a transparent and participatory national public health strategy.[44]

The CESCR's "minimum core" list is long and is not fixed.[45] The Committee on the Rights of the Child has compiled its own list of core right to health obligations, including universal coverage of primary preventive and curative health care services, and the preconditions of children's health.[46] We acknowledge the critiques of a "minimum core" approach.[47] However, for our purposes, recognition of a non-derogable core is valuable because it allows for an assessment of the human rights protection of vulnerable individuals—here, asylum seekers as a distinct category of distress migrants.

Results

Following Toebes's definition of the right to health, using the AAAQ categories of international law, we consider first access to health care, and second, the underlying determinants of health. We take into account the non-retrogression obligation and the obligation to provide a "minimum core" of protection.

Access to health care

Availability of services. Primary care, emergency care, and medical screening on arrival had been made available to at least some of the asylum seekers we interviewed.[48] However, not all asylum seekers had this experience: for example, AS5 reported a lack of vaccination for their baby, a finding that is reported more generally in the literature.[49] As noted by one health professional interviewee, asylum seekers prefer to go to hospital emergency services rather than book appointments with primary health care doctors.[50] Because referral from another doctor is not necessary, migrants accessing hospital outpatient health care have not necessarily accessed primary or secondary health care first.[51]

Some asylum seeker interviewees were able to access more than the "minimum core." For example, after initial difficulties arising from a lack of translation and information in their native language, AS1 reported access to secondary cancer care. But most of the interviewed asylum seekers were unable to access the treatment they felt necessary, reportedly primary care, or what they felt were essential medicines.[52]

On nondiscrimination in *accessibility*, views differed. Unsurprisingly, the health professionals we interviewed either felt that all patients are treated the same in the Greek health care system or, in one case, that asylum seekers should be treated differently because of their particular needs.[53] Among asylum seekers, AS1 felt that they were treated the same as Greek nationals, whereas AS2, AS5, and AS9 felt racism and a lack of professionalism from health professionals.

On practical accessibility, asylum seekers AS7 and AS8 had experienced easier access to health care provided by nongovernmental organizations

(NGOs) in the camps than state-provided health care once arriving on the mainland. Physical access to health care within the Greek system is also dependent on securing the necessary documentation. Interviewees with the relevant AMKA document found access easier. Health professionals are not involved in the documentation process, which is handled by hospital administrations.[54] D4, a health professional, explained that AMKA was used for registration in the hospital system and that health professionals asked for the patient's AMKA during a consultation. At the same time, some health professionals felt that no questions are asked about distress migrants' legal status, but rather that patients are all treated equally.[55]

However, some health professionals mentioned that they lacked information on how to proceed with prescriptions for migrants with and without AMKA; whether migrants have access to medication; and whether medical tests could be covered for those without insurance.[56] One health professional was clear that a lack of documentation would exclude an asylum seeker from access.[57]

Information accessibility is a prominent theme in our data. Lack of information about the right to health and unfamiliarity with the national health care system make practical access very difficult for asylum seekers.[58] Officially, there are no interpreters in the public health care system, which interviewees highlighted as a problem, especially for women and children.[59] NGOs were reported to be playing a critical and praiseworthy role, especially in information provision, in some hospitals.[60] Some asylum seekers were reliant on their own interpreters.[61] Lacking an available interpreter, AS8 resorted to the German language to communicate with a Greek doctor who also spoke German. D4 expressed the view that asylum seekers need to visit hospitals in an "organized manner," accompanied by someone who is aware of their medical and travel history and can facilitate communication.

Lack of interpretation significantly compromises the right to health. It can lead to delays in treatment.[62] Further, some interpreters were embarrassed to ask specific questions about medical issues related to cancer or fertility.[63] Some of the health professionals we interviewed felt that it was very challenging to get patients' full medical history, even when an interpreter was available.[64]

Many of the asylum seekers we interviewed had accessed health care through NGOs, especially Médecins de Monde, rather than the state.[65] Several reported that the state, by requiring documentation, had excluded them from even what they felt was very basic health care.[66]

Results concerning affordability were mixed. AS1 reported that costs were being met by the state. AS2 felt they had to pay for necessary (dental) treatment; AS9 reported being been told that they needed to pay for surgery. AS10 had used the private sector; AS5 was only using the private sector. D2 also linked the proximity to health care facilities with affordability, in the sense of migrants' capacity to afford the costs of traveling to hospitals.

Acceptability. Our interviews suggest some deficiencies in age-appropriate treatment.[67] Cultural and/or religious barriers to health care were also reported—for example, some health professionals noted resistance among patients to certain procedures (in fertility care, the husband was very reluctant to accept alternatives such as sperm donation) or when asked more personal questions.[68] Requesting a doctor of the same sex may also be driven by cultural or religious dimensions.[69] One health professional, D4, reported that a patient demanded that she remove the Christian Orthodox icons from her wall. Whether this is required by international human rights law is unclear.

In terms of health care, there is little about *quality* in our interviews. One asylum seeker, AS12, reported good prenatal and postnatal care for his wife and child. By contrast, AS2 felt that the treatment for kidney stones offered to them in Greece was not state-of-the art, citing what would be available in Lebanon as more advanced. Additionally, AS6 mentioned that the ophthalmologist provided the wrong prescription, which, combined with the general delays in finding medical appointments, left them without proper eyeglasses for several months.

Retrogression. Several asylum seeker interviewees described how the change in the Greek law in July 2019, which left a nine-month administrative gap in the ability to obtain a social security number, posed significant barriers to access to health care.[70]

Interviewees also expressed the view that the Greek state had done its best to respect the right to health within the resources available. As noted by one asylum seeker, "These camps need a country like America to take care of them."[71]

Underlying determinants of health

On the underlying determinants of health, we heard that no safe water was available in the island camps and that sanitation conditions were extremely poor.[72] While AS2 reported that essential food was available in the reception camps, AS12 had been housed four kilometers from the nearest market without access to any public transportation.

The effects of housing conditions on asylum seekers' health were prominent in our interviews. One interviewee had not been provided any housing and was living on the street.[73] Two had been housed in what they felt were unhealthy conditions and were now renting privately.[74] AS13 was also privately housed. Another, AS12, reported that a doctor had explained that the state-provided housing was the cause of their child's ill-health.

AS1 felt that their housing was unacceptable because it was unsanitary but also that the shared housing provided was detrimental to their mental health. AS4 reported that many migrants known to them were unhoused, living on the streets or squatting in unoccupied properties without water or electricity. AS13 described the island camps in a similar way, and one health professional, D1, stated that the living conditions there caused health problems. However, some interviewees felt that the conditions in the reception centers on the islands were better for their health than after moving on to Thessaloniki.[75]

Discussion

Our interview data confirm the findings of other studies in several respects, especially with regard to Greece's non-compliance with the human right to health. But in other respects—particularly in the case of asylum seekers falling into the category of vulnerable groups, who are protected not only in international law but also explicitly in Greek domestic law—our interviews paint a more positive picture of the state's compliance with and protection of the right to health.

Health care

Confirming our earlier data, overall, access to both primary and secondary health care was worse in the east Aegean Islands compared to the mainland in 2019–2020.[76] In practice, legal entitlements to medical screening on arrival, and necessary health care flowing from that, did not take place in the Moria refugee camp on Lesvos in 2019, and it is unclear whether it took place in any Greek reception centers in 2023.[77] In 2023–2024, the European Court of Human Rights granted interim measures after finding instances of insufficient access to medical treatment on Samos and Kos.[78] In one case, the court ordered the transfer to the mainland of a single mother and her infant, who was suffering from a serious heart condition, so that the child could receive proper treatment and accommodation.[79] In another, it found that two Afghan single-parent families were living in degrading conditions and should be granted "full access to reception conditions which respect human dignity."[80] In the Greek public health care system, the distinction between emergency, primary, secondary, and tertiary health care is unclear; in theory, hospitals constitute the tertiary level of health care, but in reality, hospitals offer emergency care and outpatient services as if they were primary health care units.

Delays in accessing emergency care (such as wait times for an ambulance) and secondary care (such as cervical cancer screening, mental health referrals, HIV care, contraception, and access to abortion) persist.[81] In 2024, the Committee on the Elimination of Discrimination Against Women confirmed limited access to sexual and reproductive health information, services, and contraceptives for migrant women.[82] Understaffing, particularly of pediatricians and psychologists, is regularly report-

ed as a key cause of lack of access, again chiming with our data.[83]

Practical accessibility is compromised by physical distance.[84] In some areas, access to specialist treatment involves travel to a hospital in Athens, which poses difficulties in terms of organization and transportation costs.[85] Organizational barriers—such as the lack of clear referral pathways and inefficient coordination between various state and nonstate services (e.g., mental health providers at accommodation sites and public health care facilities, schools, law enforcement, teams working at accommodation settings)—also compromise accessibility.[86] Further, a lack of access to essential medicines persists.[87] Language is another important barrier to access, still present as of 2024.[88]

The view that access to health care must be affordable irrespective of the patient's financial circumstances is reflected in our interviews. Health professionals believe that the right to health is universal and includes free access to public health care irrespective of one's financial, social, or cultural status.[89] But, as noted above, administrative delays in obtaining the PAAYPA hampered access, forcing asylum seekers to use costly private health care or placing the burden on NGOs.[90] Even for people with AMKA or PAAYPA, as for Greek citizens, copayments are required for some medicines, reducing affordability.[91] For a state such as Greece to deprive people of the most basic aspects of the right to health under the pretext of insufficient resources would constitute a breach of international human rights obligations.

The obligation to provide culturally sensitive treatment arises immediately upon migrants' arrival to the country, during their medical screening.[92] Health care professionals must have cultural expertise, which is reportedly lacking vis-à-vis some migrant populations.[93] During a formal visit to Greece in 2017, the UN Special Rapporteur on the human rights of migrants found that overlooking cultural sensitivities and the lack of interpretation services within the health care system are barriers to the right to health care.[94] Our data confirm this.

Insufficient medical equipment on the islands' reception centers was also reported in 2024.[95] Inexperience, together with insufficient training and capacity-building among health care professionals, has also been reported as contributing to a lack of quality health care.[96]

Underlying determinants of health

On the underlying determinants of health, poor sanitation conditions and the lack of safe water in the island camps persisted into 2023.[97] Here, the data are mixed. Some of our interviews confirm that the conditions in the island camps did not meet minimum core rights. Despite a temporary improvement deriving from the decrease in numbers of arrivals during 2019–2022, with numbers on the rise again, several camps are operating beyond their nominal capacity. Thus, more recent secondary data from 2024 show that the underlying determinants of health—such as food, water, housing, and hygiene—are insufficiently available to secure compliance with Greece's international obligations on the right to health.[98] But some of our interviewees praised the arrangements in the island camps, especially in comparison with what was provided in Thessaloniki.[99]

Vulnerable groups. Our interviews show that gender and age have routinely been treated as determinants of special treatment in the health sector, featuring in most international health-related agreements and embodied in Greek law.[100]

However, in practice, health care for minors, especially mental health care, is deficient: there is a lack of funding for enriching activities to build mental resilience, use of compulsory psychiatric admissions due to inexperienced staff, and unnecessarily prolonged hospitalization because of a lack of suitable accommodation.[101] Similarly, in practice, pregnant people experience difficulty accessing health services, including a lack of access to medicines and appropriate food, as well as inadequate information.[102]

Another important deficiency is the time it takes for migrants to obtain a formal designation as legally "vulnerable," with the protections that flow from that status: reportedly, in 2019–2020 and more recently where a public hospital examination

is required (all "non-obvious" cases and those needing a psychiatric examination), it has taken over six months, or even a year.[103] The quality of vulnerability assessments on the islands remains in doubt.[104] However, outside of minimum core obligations, nondiscrimination on nationality grounds, as opposed to grounds of race or ethnic origin, may be justified by legitimate and proportionate actions.[105] Potentially, the tightening of the AMKA rules represents such an action.

Human rights breaches—yet belief

Overall, in theory, international human rights law places significant obligations on states that are the destinations of asylum seekers. But, as we have shown, these legal rights are far from being realized in practice. Every interview in the dataset mentions at least one—and usually more—practical barriers to the right to health. A recurring theme in our interviews with health professionals is the lack of sufficient resources to provide health care or the underlying determinants of health. Our data thus confirm the findings of other studies, both in Greece and elsewhere, that show that fulfilling the right to health in international law may be a necessary, but not sufficient, step in protecting the right to health of asylum seekers.[106]

As noted above, Greek law introduced a new system—PAAYPA—in 2020. In practice, however, the process was slow, with fewer than 35% of asylum seekers provided with this number by the end of 2020, and similar deficiencies persisting into 2022, though significantly improved by 2023.[107] Between July 2019 and the activation of the PAAYPA, even the most vulnerable migrants pending an asylum decision were de facto excluded from access to the public health care system beyond emergency care.[108] Whether the AMKA and subsequent PAAYPA legal changes constitute "retrogression" has not been legally established: at least arguably, they are a breach of Greece's relevant international legal obligations, but at the same time they may be justified given the austerity measures imposed on Greece by the Eurozone fiscal rules, especially in the islands.[109]

The asylum seekers and health professionals we interviewed share a strong belief in human rights as an important vector for human health protection and flourishing.[110] Every health professional we interviewed was treating the patients who reached them, irrespective of the patients' formal legal status. This is also reflected in our interviews with distress migrants themselves. As one asylum seeker noted:

> *Here in Thessaloniki, she asked me for the AMKA. So I made myself very tired and I made myself very sad and she [attended to] me.*[111]

Conclusion

A relatively complex narrative emerges from our data: it is not as simple as Greece being in clear breach of its domestic and international law obligations to respect the right to health. Overall, our data do reinforce other reports of widespread failures to fulfill the right to health for vulnerable distress migrants (here, asylum seekers arriving in Greece). A comparison with more recent secondary data shows that these failures continue in the post-pandemic era. Our data confirm the practical difficulties flowing from the need for formal legal documentation, especially for health care that is not emergency or primary care and for care for pregnant people and children.

However, key aspects of Greece's fulfillment of the right to health have improved. Because the acquisition of PAAYPA has been integrated into the application and registration process since April 2020, the vast majority of asylum seekers no longer face restrictions flowing from a lack of access to documentation. Some interviewees reported that they were accessing the public health care system in Greece at no cost to themselves. Some were able to access secondary health care therein. Some were accessing health care to which they were legally not entitled. While many interviewees reported that their right to health had not been protected, some praised the reception from the Greek health care system, and indeed the Greek state.

That said, accessibility deficiencies flowing from the remote location of reception centers, on both the mainland and the islands, combined with a lack of transportation services, continue,

as do those deriving from a lack of interpretation services. Health care is often unavailable because of the understaffing of medically and psychosocially qualified professionals. Some restrictions arise from a lack of affordability; these seem to be worsening. Our interviewees recognized the limited nature of the right to health and the significant resource its protection requires.

Finally, this paper reveals that the intersecting domains of health and migration, where the needs and rights of nationals are expected to be prioritized over those of outsiders, are not necessarily characterized by traditional national sovereignty. Instead, a paradox in the Greek context emerges: while asylum seekers are ostensibly granted nearly the same primary and secondary health care rights as nationals, this formal equality does not consistently translate into fair and equitable access in practice. Asylum seekers experience the same systemic obstacles as nationals (such as delays and physical accessibility issues), while also facing additional barriers linked to substandard living conditions, linguistic differences, and financial constraints.

The legal concept of "vulnerability," embedded in both Greek and international law, currently provides enhanced human rights protection for specific groups of asylum seekers such as children and pregnant women. Recognizing and applying the right to health through the vulnerability lens for all asylum seekers could thus guide policy reforms aimed at true access equity. Future research is needed to examine which policy reforms could enable such a shift from equality to equity, as well as the potential inclusionary and exclusionary effects of a vulnerability-based policy approach to distress migrants.

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