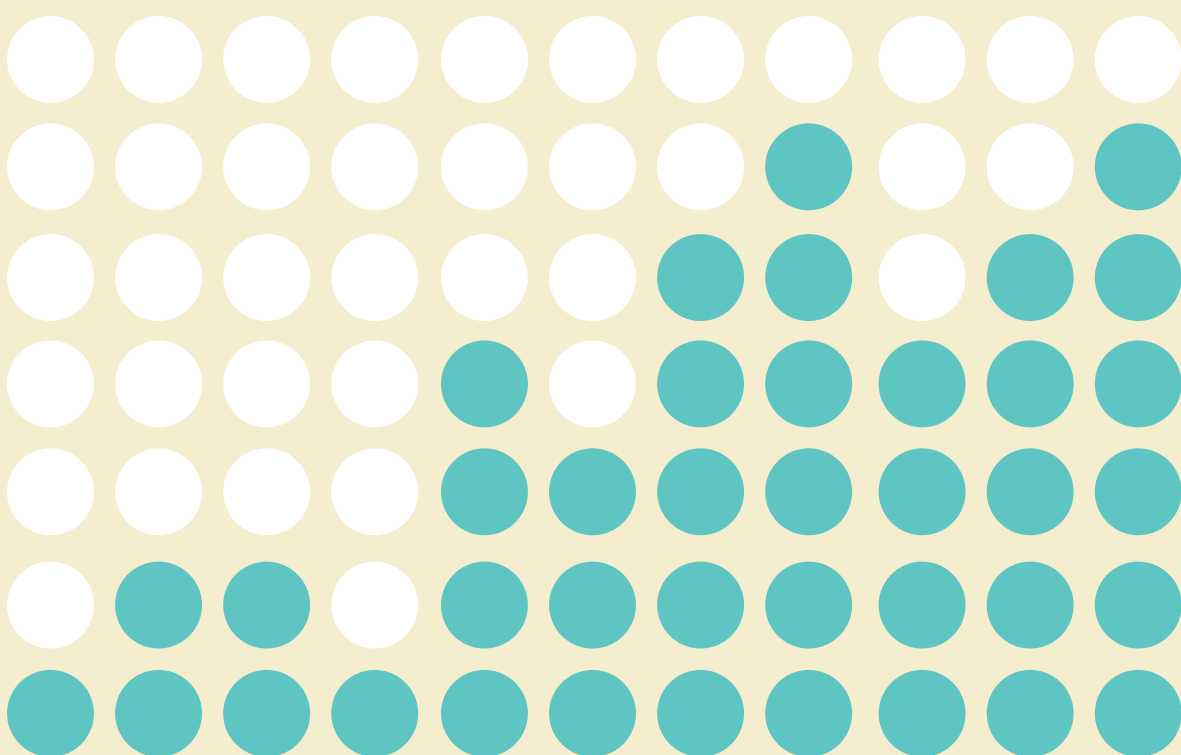


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Implementation of the right to health care under the UN Convention on the Rights of the Child

Status report for the European Union



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Key messages

Article 24 of the UN Convention on the Rights of the Child (UNCRC) establishes a fundamental right for children to access health care services and facilities for the treatment of illness and rehabilitation of health. This entails the obligation for States Parties to ensure that no child is deprived of his or her right of access to health care services.

Depending on the type of health system, children are normally covered either directly on the basis of citizenship or residence status, or indirectly as dependants of statutorily insured persons. The special status that children have in statutory health coverage generally applies until the legal age of 18 years. However, in many cases, this status is extended for as long as they remain financially dependent on their parents or guardians. For specific groups of children who are excluded from the main statutory system, access to health services may be organized through alternative forms or according to specific schemes. Even if Art. 24 UNCRC does not define the exact range of services that each child should be entitled to, it seems clear that if access was limited to only emergency care this should be considered too restrictive.

Although all EU Member States have ratified the UNCRC, only four (Cyprus, Croatia, Italy and Spain) have introduced a legal disposition that guarantees this right to all children living in their territory, irrespective of their legal status (nationality, social insurance or residence). Two of them (Cyprus and Italy) explicitly refer to the UNCRC. Seven other countries (France, Greece, Malta, Poland, Portugal, Romania, Sweden) ensure health care to all groups of children residing in their territory through regular health care legislation by setting out the eligibility criteria or by organizing special additional schemes for specific groups that fall outside the main statutory coverage.

In countries with statutory health insurance systems, which are based on the professional status of the parent and/or on the payment of contributions or insurance premiums, certain children may fall between the cracks and be left without coverage, especially if parents or guardians are not in compliance with administrative or financial conditions for statutory health insurance.

In countries where statutory coverage is based on residence status, the definition of *residence* varies in level of restrictiveness across countries. For resident children who were previously not covered by any social security system in an EU Member State (e.g. privately insured, children of international civil servants, non-EU residents who were previously insured outside the EU), eligibility to health care coverage may not be guaranteed.

Most Member States award asylum-seeking children the same protection and coverage as children within the statutory system. In some cases, this protection is extended to the period before starting the asylum process or maintained even after their application for asylum has been rejected. However, a few countries restrict care for asylum seekers, including children, to emergency care only (Hungary, Latvia).

Children living in a country with no regular residence status are generally the most vulnerable when it comes to eligibility to statutory health services. Access is often conditional and restricted to emergency care or so-called “urgent medical aid”, which usually extends beyond the mere scope of emergency care.

It should be noted that even if health care for children is legally guaranteed, many administrative, practical and external barriers can impede access. Financial hurdles, determined by the extent of statutory coverage (benefit basket and user charges), can also limit access. Several countries provide more comprehensive coverage for children compared with adults, and apply child-specific user charge policies (reductions, caps or exemptions) to ensure affordable care for children. Special attention is given to ensure children’s access to preventive services.

Finally, the UNCRC includes an obligation for countries to ensure appropriate prenatal and postnatal health care for mothers (Article 24.2 (d) UNCRC). Across a wide range of countries, legal provisions ensure a right to prenatal and postnatal health care for all mothers. However, in some countries, vulnerable groups of pregnant women (e.g. nonresidents, irregular resident pregnant women) have only limited access to prenatal and postnatal health care or, occasionally, to only emergency care.

Table 1. Basic assessment of EU Member States' legal compliance

The “traffic light” table below provides a basic assessment of EU Member States' minimal legal compliance with the obligations contained in Art. 24.2 (b) UNCRC for four different categories of children:

- children with the nationality of the country where they reside (nationals) – this also includes children who benefit from international protection either as refugee under the Geneva Convention or as stateless person, or who are granted subsidiary protection;
- children with either EU/EEA nationality or non-EU/EEA nationality (third-country nationals) who have regular residence status in the country where they reside;
- children who are registered as asylum seekers;
- children living in the country with irregular residence status.

Children who are temporarily staying in the territory of a Member State (e.g. visitors, students, tourists) are not taken into consideration.

children - legal situation population coverage	Belgium	Bulgaria	Czech Rep.	Denmark	Germany	Estonia	Ireland	Greece	Spain	France	Croatia	Italy	Cyprus	Latvia	Lithuania	GD Luxembourg	Hungary	Malta	Netherlands	Austria	Poland	Portugal	Romania	Slovenia	Slovakia	Finland	Sweden	United Kingdom
nationals	green	green	green	green	yellow	green	green	green	green	green	green	green	green	green	green	green	green	green	yellow	green	green	green	green	green	green	green	green	green
EU and third-country residents	green	green	yellow	green	yellow	green	green	green	green	green	green	green	green	yellow	green	green	green	green	yellow	green	green	green	green	green	green	green	green	green
asylum seekers	green	green	green	green	green	green	green	green	green	green	green	green	green	yellow	green	green	green	green	green	green	green	green	green	yellow	green	green	green	green
irregular residents	yellow	red	yellow	yellow	yellow	yellow	red	green	green	green	green	green	green	red	red	red	red	green	yellow	green	green	green	red	yellow	red	green	green	yellow
Source: Authors' own compilation																												
Legend:	red	red = non-compliance with the obligations contained in Art. 24.2 (b) for each category of children.																										
	yellow	yellow = intermediary compliance with the obligations contained in Art. 24.2 (b) for each category of children;																										
	green	green = full compliance with the obligations contained in Art. 24.2 (b) for each category of children;																										

Introduction and objectives

The aim of this study is to assess the legal right to health care for children in the 28 EU Member States. More specifically, the study explores whether EU Member States comply with the obligation contained in Article 24 of the UN Convention on the Rights of the Child (UNCRC) to ensure that no child¹ is deprived of his or her right to access to health care services.

Therefore, the main question is whether all children in a particular country are legally guaranteed access to health services, as is stated in the UNCRC. First, the study explores the general eligibility for statutory cover. Depending on the type of health system, children are generally covered (1) directly on the basis of citizenship, (2) by residence status or (3) indirectly as dependants of statutorily insured persons. For specific groups of children who are excluded from the main statutory system, access to health services might be organized through alternative forms or according to specific schemes.

Access is not only a matter of eligibility for health care coverage (personal scope of application), but it is also determined by the scope of coverage (i.e. which services or benefits are covered) and the depth of coverage (i.e. what proportion of the benefit costs are covered), both of which are legally defined. Although not the main focus of this study, these two dimensions of coverage are addressed to explore any variations in the extent of coverage between different groups of children within each country.

This study narrowly focuses on the legal situation of children's access to health care. However, these legal rights are not always guaranteed to be implemented in practice. As evident from various reports, many administrative, practical or external barriers can impede actual access to health services (e.g. lack of implementation, availability of services, financial constraints, fear of deportation, information, language and other cultural factors). A detailed assessment of these factors was beyond the scope of this study.

Furthermore, the report examines the legal situation of mothers. The Convention also obliges States Parties to ensure appropriate prenatal and postnatal health care for mothers (Article 24.2 (d) UNCRC). However, given the fact that mothers² are often not a legally defined category and that their eligibility to health services, in principle, follows general eligibility rules, this study mainly focuses on the accessibility to prenatal and postnatal care. Nevertheless, such care poses problems because it is not clearly defined: it can include preventive and curative services, which can relate to both mother and child, and it can be closely or loosely related to pregnancy and birth. Some systems cover prenatal and postnatal care as part of their statutory cover, whereas others organize it separately, especially the preventive aspect. In the relevant sections, only prenatal and postnatal care given to women will be considered.

This report first explores how the right to health care is defined under the UNCRC. Second, it describes the methods used to gather and analyse the information and puts forward a conceptual model for assessing minimal legal compliance with the UNCRC. Third, by drawing on the country information obtained, the report describes the main trends found and highlights examples of good practices. The country information obtained is summarized in comparative tables at the end of the report.

The Convention and the universal right to health care

The UN Convention on the Rights of the Child (UNCRC) was signed in New York on 20 November 1989 and opened for signature, ratification and accession by General Assembly resolution 44/25. In accordance with its article 49, it entered into force on 2 September 1990.

¹ According to Article 1 Convention on the Rights of the Child, a child is defined as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier".

² Although Article 24.2 (d) of the Convention does not define the term of "mother", it should be understood in this context: *any female person who is pregnant or has delivered a child until the immediate postnatal period*.

Two optional protocols followed, respectively (1) on the involvement of children in armed conflict and (2) on the sale of children, child prostitution and child pornography.³ A third protocol was approved in 2011 on a communications procedure that allows individual children to submit complaints regarding specific violations of their rights under the Convention and its first two optional protocols. This protocol entered into force in April 2014.

The implementation of the Convention and related protocols by its States Parties is monitored by the Committee on the Rights of the Child (CRC), which is an internationally elected body of 18 independent experts. It reviews the reports that are to be submitted by the governments on the status of children's rights in their countries. Following the third optional protocol on a communications procedure, the CRC may also initiate confidential inquiries upon receipt of reliable information on serious, grave or systematic violations by a State party of rights set forth in the Convention.

The UNCRC has been ratified by all EU Member States. However, not all EU Member States have yet signed or ratified the third optional protocol containing the individual communications procedure and the inquiry procedure (see table below).

EU Member States' ratification status

Convention on the Rights of the Child					
Country	Date of signature	Date of ratification / accession	Date of signature of the third optional protocol	Date of ratification / accession third optional protocol	
Austria	26/08/1990	6/08/1992	28/02/2012		
Belgium	26/01/1990	16/12/1991	28/02/2012	30/05/2014	
Bulgaria	31/05/1990	3/06/1991			
Cyprus	5/10/1990	7/02/1991	27/07/2012		
Croatia		12/10/1992	27/12/2013		
Czech Republic		22/02/1993	30/04/2015	2/12/2015	
Denmark	26/01/1990	19/07/1991		7/10/2015	
Estonia		21/10/1991			
Finland	26/01/1990	20/06/1991	28/02/2012	12/11/2015	
France	26/01/1990	7/08/1990	20/11/2014	7/01/2016	
Germany	26/01/1990	6/03/1992	28/02/2012	28/02/2013	
Greece	26/01/1990	11/05/1993			
Hungary	14/03/1990	7/10/1991			
Ireland	30/09/1990	28/09/1992	24/09/2014	24/09/2014	
Italy	26/01/1990	5/09/1991	28/02/2012	4/02/2016	
Latvia		14/04/1992			
Lithuania		31/01/1992	30/09/2015		
Luxembourg	21/03/1990	7/03/1994	28/02/2012	12/02/2016	

³ These two optional protocols have been ratified by all EU Member States, except Ireland for the optional protocol on the sale of children, child prostitution and child pornography.

Malta	26/01/1990	30/09/1990	18/04/2012	
Netherlands	26/01/1990	6/02/1995		
Poland	26/01/1990	7/06/1991	30/09/2013	
Portugal	26/01/1990	21/09/1990	28/02/2012	24/09/2013
Romania	26/01/1990	28/09/1990	13/06/2012	
Slovakia		28/05/1993	28/02/2012	3/12/2013
Slovenia		6/07/1992	28/02/2012	
Spain	26/01/1990	6/12/1990	28/02/2012	3/06/2013
Sweden	26/01/1990	29/06/1990		
United Kingdom of Great Britain and Northern Ireland	19/04/1990	16/12/1991		

Source: Database of the United Nations Office of Legal Affairs (OLA) <http://indicators.ohchr.org/>

Although the EU has not signed the UNCRC as a separate party, children's rights are an integral part of the body of human rights that are protected and respected within the Union. This is explicitly mentioned in the Treaty of the European Union, which includes the protection of the rights of the child as an explicit objective (Art. 3.3 TEU), not only within the EU but also in its relations with the wider world (Art. 3.5 TEU). It is also reflected by the inclusion of the rights of the child in the Charter of Fundamental Rights of the EU, which specifies that children shall have the right to such protection and care as is necessary for their well-being (Art. 24). Therefore, the protection of children's rights is to be guaranteed by EU institutions, as well as by EU countries when they implement EU law.

As with all human rights, children's rights are universal, indivisible, interdependent and interrelated.⁴ In addition, child rights are governed by four overarching principles:⁵

- nondiscrimination (Art. 2)
- devotion to the best interests of the child (Art. 3)
- the right to survival and development (Art. 6)
- respect for the views of the child (Art. 12)

The right to health care under the UN Convention on the Rights of the Child (UNCRC)

Article 24 UNCRC establishes a fundamental right of the child to access services and facilities for the treatment of illness and rehabilitation of health. This entails the obligation for State Parties to ensure that no child is deprived of his or her right of access to health care services, including:

- the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care (Art. 24.2 (b)); and
- the appropriate prenatal and postnatal health care for mothers (Art. 24.2 (d)).

In its General comment No. 15 (2013)⁶ on the right of the child to the enjoyment of the highest attainable standard of health (Art. 24), the Committee on the Rights of the Child (CRC) has further specified the various provisions contained in Article 24. It interprets the right to health as an inclusive right in line with the definition of health in the WHO Constitution and within the broader framework of human rights obligations. To fully realize the right to health for all children, States' parties have an

⁴ Vienna Declaration and Programme of Action, Adopted by the World Conference on Human Rights in Vienna on 25 June 1993, paragraph 5;

⁵ https://www.unicef.org/crc/files/Guiding_Principles.pdf

⁶ Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)

obligation to ensure that children's health is not undermined as a result of discrimination, which is a significant factor contributing to vulnerability.

With respect to the universal access to health care for children the Committee emphasizes the importance of primary care. While the CRC does not specify the exact range of services to be covered – this varies from country to country – it considers that certain packages of treatment, such as the [WHO Model Lists of Essential Medicines](#) (including [the list for children](#)) should be made available, accessible and affordable. Furthermore, the CRC highlights the importance of children's mental health, health promotion and health service provision within schools. It urges states to give special attention and protection to children at risk because of their family or social environments and to children affected by humanitarian emergencies.

The right to prenatal and postnatal health care for mothers is derived from the need to protect children from the profound impact that (preventable) maternal mortality and morbidity may have on their own health and development. This requires universal access to a comprehensive package of sexual and reproductive health interventions based on the concept of a continuum of timely and high-quality care from pre-pregnancy, through pregnancy to childbirth, and throughout the postpartum period. According to the CRC, this continuum should include – but not be limited to – essential health prevention and promotion, and curative care, such as:

- the prevention of neonatal tetanus, malaria in pregnancy and congenital syphilis;
- nutritional care;
- access to sexual and reproductive health education, information and services;
- health behaviour education (e.g. relating to smoking and substance use);
- birth preparedness;
- early recognition and management of complications;
- safe abortion services and post-abortion care;
- essential care at childbirth;
- prevention of mother-to-child HIV transmission, and care and treatment of HIV-infected women and infants.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- a) To diminish infant and child mortality;*
- b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
- c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;*
- d) To ensure appropriate prenatal and postnatal health care for mothers;*
- e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
- f) To develop preventive health care, guidance for parents and family planning education and services.*

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to

achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Methodology

This study and status report was prepared by the European Observatory on Health Systems and Policies at the request of the European Commission's Directorate General for Health and Food Safety. The report was conceived as a rapid assessment and does not claim to be exhaustive in terms of the literature on this topic nor cover all aspects or details with respect to the issue of access to health care for children and prenatal and postnatal health care for mothers.

The aim of this study is to assess the state of implementation of the obligation contained in the UN Convention on the Rights of the Child to ensure access to health care services. Specifically, the study has the following objectives:

- establish if statutory access to health services is guaranteed to all children in a particular EU Member State;
- explain how eligibility criteria for children are defined;
- provide the reference to the legal acts that define the eligibility of children;
- check if any reference is made in the relevant law to the UN Convention on the Rights of the Child in this respect;
- identify the groups of children falling outside the scope of normal statutory cover and explore if any particular legal arrangements or schemes exist to guarantee their right to health services;
- assess whether children are treated equally as to their access to health care and whether any child-specific exemption or reductions for user charges apply;
- explore what arrangements are in place to organize universal prenatal and postnatal care and establish if all mothers are granted access, considering the same above objectives for children's coverage.

The remainder of this section outlines the data collection methods, the main methodological challenges encountered, and finally, our methodological approach to assess countries' legal compliance while addressing some of the methodological complexities.

Data collection

The data collection was carried out mainly in June–July 2016 through the following consecutive steps:

- First, we carried out an initial and systematic screening of the relevant sections of the HiT health system reviews⁷ of the different EU Member States by the HiT editors, completed with any other relevant sources at hand, to provide a preliminary assessment of compliance. The survey template is detailed in the box below;
- Second, the initial assessment was sent to a group of country correspondents in the various EU Member States (see Acknowledgements), mostly from the Observatory's Health Systems and Policies Monitor network, to validate the initial findings and fill remaining gaps.
- Finally, we undertook an additional search and scanning of additional relevant sources, reports and literature. References to all consulted sources can be found underneath every country report as well as at the end of the report for the more comparative sources.

In the second stage, the extensive information received for all 28 Member States was further analysed and summarized in a set of comparative tables, which provide a systematic overview of statutory coverage for children and of access to prenatal and postnatal care for mothers (see

⁷ These HiT reports provide a detailed account of the health system in a particular country as well as the ongoing reforms and developments. Based on a common template they systematically describe the functioning of health systems in the countries of the WHO European Region as well as some additional OECD countries.

Appendix 1). The legal situation of children's eligibility to health services for different categories was then summarized and assessed in a "traffic light" table to identify (1) the groups that face legal problems when it comes to access to care and (2) compliance with the obligations set forth in the UNCRC.

Box: Survey template

A. Universal right to health care for children?

1. Is there any legal provision in your country that ensures a right to health care for all children?
 - a) Is there a defined set of services that is guaranteed to all children?
 - b) Is any explicit reference made to the UN Convention on the Rights of the Child (i.e. resp. article 24.2 (b)) in regulating and determining the rights and entitlements to health services for children?
2. If not, how are eligibility criteria for statutory coverage of children defined?
 - a) What is the legal basis for their entitlement to publicly funded health services?
 - b) How are children defined by these schemes (age and other conditions)?
 - c) Do they have the same coverage (benefit package, user charges)?
 - d) Are there any arrangements in place to protect children from user charges?
3. Which groups of children are excluded from statutory coverage?
 - a) Are any specific schemes or arrangements in place to ensure their access to health care?
 - b) How are their entitlements defined under these schemes?
4. Are there any groups of children who despite their legal entitlements face practical or specific problems in accessing health services?

B. Universal right to prenatal and postnatal health care for mothers?

5. Is there any legal provision in your country that ensures a right to prenatal and postnatal health care for all mothers?
 - a) Is there a defined set of services that is guaranteed to all pregnant mothers?
 - b) Is any explicit reference made to the UN Convention on the Rights of the Child (i.e. resp. article 24.2 (d)) in regulating and determining the rights and entitlements to prenatal and postnatal health care?
6. If not, are prenatal and postnatal health care services covered under statutory coverage?
 - a) Do all mothers with statutory cover have the same coverage (benefit package, user charges)?
 - b) Are there any arrangements in place to protect mothers from user charges?
7. How do mothers without statutory coverage access prenatal and postnatal health care services?
 - a) How are their entitlements defined?
 - b) Are they more restricted than for statutorily insured mothers?
 - c) How are services organized?

Methodological issues and discussion

With this report, we try to provide an answer to a fundamental question: do EU Member States comply with the obligation contained in Art. 24 UNCRC to ensure that no child is deprived of his or her right of access to health care services? Despite sounding straightforward, the question is not easily, unequivocally answered.

First, as noted above, access to health care for children is determined by many factors, some of which fall outside the scope of statutory entitlements. Second, in addition to personal eligibility, access also depends on the material scope and level of coverage (i.e. benefit basket and cost sharing). Third, factors inherent to the organization of the health system (e.g. availability, choice, timeliness), as well as social and economic conditions relative to the child's personal environment, can determine actual access to health services.

Even by exclusively focusing on the legal status and eligibility of children to health services, it is complex to assess whether all groups of children are covered and whether all children within these groups are covered in all cases. Only some Member States have enshrined in their legislation an unconditional and universal right to health services for children. In most cases, describing the rights and entitlements of children is not easily dissociated from general eligibility to statutory cover. Often the rights of children are derived from the rights or status of their parents or legal guardians.

Finally, the obligations in Article 24 UNCRC with respect to access to health care are not clearly defined. Not only does it not specify the exact range of services that should be guaranteed to children – let alone what needs to be understood by prenatal and postnatal care for mothers – the fundamental question of to whom exactly this obligation extends still remains, as well as whether this obligation entails equal (or even free-of-charge) access to necessary medical assistance and health care among all children. If we consider that “all children living in a country” should be entitled to health care, does this only include children (and mothers) permanently and legally residing in that country? Or should it also extend to nonresidents (i.e. people staying only temporarily in a country such as tourists, students, temporary workers), people residing with a special status (i.e. asylum seekers) or irregular migrants? It is important to distinguish between these different situations and capacities, especially as residence status is a crucial criterion in defining entitlements to statutory health care. In many countries, these latter categories may have reduced entitlements to care, including children.

Definition of terms, concepts and criteria for compliance assessment

In order to establish a solid foundation for assessing whether or not Member States comply with the obligation of the UNCRC, we define here the different terms, concepts and criteria employed in a consistent manner while addressing some of the methodological complexities outlined above.

If we consider all children who can be found on the territory of an EU Member State, we can synthesize them into the following categories:

- children with the nationality of the country where they reside;
- children with EU/EEA nationality and regular residence status in the country where they reside;
- children with non-EU/EEA nationality (third-country nationals) and regular residence status in the country where they reside;
- children who benefit from international protection either as refugee under the Geneva Convention or as stateless person, or who are granted subsidiary protection;
- children who are registered as asylum seekers;
- children living in the country with irregular residence status;
- children who are temporarily staying in the territory of a Member State (e.g. visitors, students, tourists).

Since this study focuses on children (and mothers) who reside in a country on a more or less permanent basis, the latter category of children temporarily staying in a Member State will not be considered. Also, the group of children with international protection will not be dealt with separately since they are legally granted the same protection and treatment as nationals.⁸ For the purpose of simplifying the minimal assessment of compliance, we can group the children into four broader categories. In the rest of the report, children will be termed in the following abbreviated way:

- A. own nationals (children);
- B. EU/EEA citizens and third-country nationals (children);
- C. asylum seekers (children);
- D. irregular residents (children).

⁸ Article 31 Directive 2011/95/EU on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted

The assessment itself mainly focuses on formal eligibility to some form of public coverage or provision of health care services. Additionally, it provides a rough estimation as to whether the guarantee in terms of type of services is sufficiently broad to meet the standard as set out in the Convention.

While Article 24 UNCRC does not define the exact range of services that each child should be entitled to it seems clear that some standard should be upheld. For example, if access would be limited to only emergency care, this would have to be considered too restrictive. As further detailed by the Committee on the Rights of the Child in its General comment No. 15 (2013), the right to health is to be understood as an inclusive right that needs to ensure that children grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health.⁹ It also explicitly mentions primary health care as well as preventive services. Many countries refer to the concept of “urgent medical aid” when it comes to describing the range of services guaranteed mainly to children and mothers not covered by the regular system. In many cases, this is broader than just emergency care and would typically include regular primary care, prenatal and postnatal services to newborn babies and their mothers, as well as preventive care (including vaccinations), but would exclude elective forms of care.

To account for these complexities, we apply the following “traffic light” scoring system with two clear categories (full compliance and noncompliance) and a third intermediate one between both.

- **Red (noncompliance):** the country clearly does not meet the UNCRC requirements for coverage because the whole group of children is not covered or not sufficiently covered by law (i.e. only emergency care provided).
- **Yellow (partial compliance):** the country only partially meets the UNCRC requirements for coverage since some children in the group may not be covered by law and/or legal coverage is limited to a reduced set of services (i.e. urgent medical aid is guaranteed, which may entail greater coverage than emergency care).
- **Green (full compliance):** the country meets the UNCRC requirements as all children in the group are sufficiently covered by law.

⁹ Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Art. 24), p2;;

Summary of Results

Defining children's general eligibility to health care

The main form of statutory coverage for children depends on the type of health system. We identify three broad categories:

- In more traditional social health insurance (SHI) systems (Austria, Belgium, France, Germany, Greece, Luxembourg, the Netherlands, Poland, Romania), children are generally indirectly covered as dependants of a parent or guardian (e.g. foster parent, grandparent) who is directly insured. However, some categories of children may be covered in their own right: orphans, disabled children, unaccompanied foreign minors.
- In tax-funded health systems, children are typically covered directly on the basis of their residence status (Denmark, Cyprus, Finland, Ireland, Italy, Malta, Spain, Portugal, Sweden, the United Kingdom).
- In hybrid and mixed forms of social health insurance systems that were developed in some EU13 Member States after the 1990s political transition, children are insured by the state on the basis of their residence status. This means that they have a direct legal right to statutory coverage for which either the state pays the contribution (Bulgaria, Croatia, Czech Republic, Hungary, Latvia, Lithuania, Slovakia) or they are affiliated as noncontributing insured persons (Estonia, Slovenia).

While most countries aim to guarantee universal coverage for health care to their population, not all have actually fully achieved it. Even when only considering the aspect of population coverage (personal scope of application), the eligibility criteria may often leave certain groups without statutory cover. However, this is less the case for children, who are generally considered a vulnerable group that deserves special protection; and therefore, they often have a special status when it comes to entitlements to obtain medical attention. This special status can relate to their general eligibility for health services, but it can also generate specific privileges when it comes to financial protection (e.g. user charge exemptions) or priority treatment. The same can apply to pregnant women and young mothers.

The special status that children have in statutory health coverage generally applies until the legal age of 18 years. However, in many cases, this status is extended for as long as they remain financially dependent on their parents or guardians. This is most often linked to continued training or education¹⁰ (e.g. Austria, Cyprus, Ireland, Poland) and to military service (e.g. Cyprus). In most cases, there is a maximum age limit for this special status. In Luxembourg, dependency status can be extended until the age of 30 if the person's income is below the guaranteed minimum income. For disabled children, dependency status can often continue indefinitely into adulthood (e.g. Germany) or they are covered in their own right (e.g. Belgium, Greece). In certain Member States, also students (including PhD students) generate their own rights. For example, in Poland, both undergraduate and postgraduate students under 26 years old are insured without needing to pay contributions. Similarly, in Ireland, children may be regarded as dependants up to age 18 (or 23 years if in full-time education). In Cyprus, the definition of a "dependent" child is extended to include children up to 21 years or older provided that they are maintained by their parents, such as soldiers or students.

Minimal assessment of EU Member States' legal compliance

This section provides a minimal assessment of EU Member States' compliance with the obligations contained in Art. 24.2 (b) UNCRC based on the findings obtained in the mapping exercise for the four groupings of children (nationals, EU and third-country residents, asylum seekers and irregular residents). Based on the criteria for compliance, assessment occurred in three groupings (full compliance – green; intermediary compliance – yellow; noncompliance – red) as described in the methodological section above. The results are summarized in Table 1.

¹⁰ In countries where students in higher education obtain study grants and loans, they can obtain an independent status.

Only four Member States have enshrined in their legislation an unconditional and universal right to health services for all children living on their territory: Cyprus, Croatia, Italy and Spain. In Spain, the Royal Decree Law 16/2012 implementing the reform on urgent measures to improve the sustainability of the health system, established that all minors have access to health care services, under the same conditions as Spanish minors, regardless of their nationality or residence status. In Croatia, Article 9 of the Law on compulsory health insurance states: "*Children under the age of 18 with residence or permanent residence permit in the Republic of Croatia are covered by the compulsory health insurance and acquire the status of the insured person*". While the Law is not explicit about irregular migrant children, in practice they are covered. Cyprus, which has not yet achieved universal health coverage, established provisions to ensure that every child, including children of irregular migrants living in Cyprus, has access to a high standard of health care services in the public sector (Circular MoH.11.11.09(4), 2/12/2011). This circular of the Cypriot Ministry of Health introducing the universal right to free health care for children under the public system (also extended to pregnant women) explicitly refers to the UNCRC. Similarly, Italy issued a Code on the Rights of Minors to Health and Health Care Services that explicitly sets out the rights of children under the age of 18 to health and health services in relation to the requirements under the UN Convention on the Rights of the Child. The Code has no formal legal status, but it is aimed at making health care providers aware of their legal obligations to children and to ensure homogeneous implementation nationwide. Also, some other countries make reference to the UNCRC in child protection laws and policy documents but without any direct or clear implications for the definition of entitlements to care for children. For instance, in Estonia the Child Protection Act makes explicit reference to the Convention to guarantee necessary assistance and care in a timely manner for children whose health and well-being are in danger. However, the rights and entitlements to health services are determined by both the Health Insurance Act and the list of services by the Government level act.

In addition to the previously stated four Member States, seven other countries, in practice, ensure health care to all groups of children residing on their territory (France, Greece, Malta, Poland, Portugal, Romania, Sweden). They have done so through regular health care legislation setting out the eligibility criteria or by organizing additional special schemes for specific groups falling outside the main statutory cover. For instance, the Portuguese NHS provides health services to anyone in its territory, irrespective of nationality, residence or financial status. In order to close gaps in statutory coverage for various groups including children, some countries have extended eligibility, stabilized entitlements and ensured continuity of coverage. In Greece, the recently passed Law 4368/2016 grants entitlements to public health care and medicines without having to contribute to their cost for various groups of legal and permanent residents who do not fulfil conditions for health coverage (for example, uninsured Greeks, expatriates) and their children, as well as specific categories of people and their children without residency papers (such as pregnant women, refugees and minors). More examples are given in the next section.

The results of this basic assessment of EU Member States' legal compliance with the obligations contained in the UNCRC that are summarized in the table will now be further detailed for each of the four categories in the following subsections. Detailed country assessment of compliance is provided in the country overview sections.

Table 1. Basic assessment of EU Member States' legal compliance

The “traffic light” table below provides a basic assessment of EU Member States' minimal legal compliance with the obligations contained in Art. 24.2 (b) UNCRC for four different categories of children:

- children with the nationality of the country where they reside (nationals) – this also includes children who benefit from international protection either as refugee under the Geneva Convention or as stateless person, or who are granted subsidiary protection;
- children with either EU/EEA nationality or non-EU/EEA nationality (third-country nationals) who have regular residence status in the country where they reside;
- children who are registered as asylum seekers;
- children living in the country with irregular residence status.

Children who are temporarily staying in the territory of a Member State (e.g. visitors, students, tourists) are not taken into consideration.

	Belgium	Bulgaria	Czech Rep.	Denmark	Germany	Estonia	Ireland	Greece	Spain	France	Croatia	Italy	Cyprus	Latvia	Lithuania	GD Luxembourg	Hungary	Malta	Netherlands	Austria	Poland	Portugal	Romania	Slovenia	Slovakia	Finland	Sweden	United Kingdom
children - legal situation																												
population coverage																												
nationals																												
EU and third-country residents																												
asylum seekers																												
irregular residents																												
Source: Authors' own compilation																												
Legend:		red = non-compliance with the obligations contained in Art. 24.2 (b) for each category of children.																										
		yellow = intermediary compliance with the obligations contained in Art. 24.2 (b) for each category of children;																										
		green = full compliance with the obligations contained in Art. 24.2 (b) for each category of children;																										

Own nationals (children)

Under this heading, we look at children who reside in the country of their nationality, which is by its very nature the largest group of children.

As already mentioned above, children in this group are typically covered for health services – directly or indirectly (as dependants) – through the statutory health system. Although in most countries all children in this category are covered (especially in those where eligibility is based on residence), in some cases certain children may fall between the cracks and be left without coverage. This risk tends to be higher in statutory health insurance systems, which are based on the professional status of the parent and/or on the payment of contributions or insurance premiums. In Austria, eligibility to child allowances is a requirement for statutory health insurance as a dependent child. Children living in a joint household with parents who are not compulsorily insured for health (e.g. employees with remuneration below the low-income limit and students eligible for voluntary self-insurance) could be left without coverage. In Belgium children are generally co-insured for health services (only orphans receiving an orphan allowance and children of 15 and older who are declared disabled are directly insured). If parents or guardians are not in compliance with administrative or financial conditions for statutory health insurance (approximately 1% of total population), the dependent children might also become uninsured. However, in those cases, alternative arrangements are in place to guarantee access to care. Regular resident children without employment or income (or with income below a certain threshold) who cannot rely on co-insurance with a directly insured parent or legal tutor, can be directly insured without paying any personal contribution.

Again, in order to avoid that children become uninsured, several Member States have introduced measures to stabilize entitlements and ensure continuity of coverage. This is sometimes done by dissociating the entitlements from the obligation to pay insurance contributions or even by instituting an individual and direct right to statutory health care services. For example, in Luxembourg, where children are usually covered as dependants, the coverage gaps are subsidized with social contributions paid by the State for all other children who legally reside on its territory. In France, the recent reform of universal health protection that entered into force on 1 January 2016, established a stable and personalized entitlement to health care for all persons who work or reside in France. This consolidates the logic that was initiated in 1999 with the CMU (universal health coverage), which broadened health insurance coverage to people who did not meet any of the eligibility criteria of the professional-based health insurance system but did reside in France in a stable and regular manner (for more than 3 months). Until the age of 18, children derive their right as dependants of their parents or guardian. Once they turn 18, they have entitlements in their own right, even if they do not pursue a professional activity. In the Netherlands, mandatory health insurance was replaced in 2007 by an individual mandate for citizens to purchase health insurance. Children are in principle included in one of the parents' health insurance plans (or their legal guardian's), but no separate premium has to be paid as they are covered through a government contribution to the national health insurance fund. Children whose parents do not purchase insurance for themselves or do not register their children may end up uninsured. If the parents refuse to purchase health insurance on religious grounds then they need to be explicitly enrolled in a specific scheme that was set up for conscientious objectors, which is funded on the payment of a general income tax (instead of a personal health insurance premium). In Germany, children's coverage depends on the insurance of their parents. Because part of the population is not statutorily insured or can opt out (i.e. civil servants, self-employed or workers with higher salaries), an obligation to purchase private health insurance was introduced in 2009. However, contrary to the Netherlands, a specific premium is to be paid for the children.

EU/EEA citizens and third-country nationals (children)

Under this subheading, we analyse the situation of both children with EU/EEA nationality and children with non-EU/EEA nationality (third country nationals) who legally reside in another Member State.

For children, residence rights are usually based on the residence right of an adult family member who they are accompanying or joining in the host Member State.¹¹ Once legal residence is achieved, eligibility to health care coverage would, in principle, apply in the same way as for own nationals. This is definitely the case for EU/EEA citizens as they cannot be discriminated against on the basis of nationality.

As such, nationality or citizenship is not a decisive factor for assessing eligibility to health coverage. It is more its relation with the right of residence – and hence insurance status – that makes it relevant. While own nationals have a natural right to reside in the country of their nationality, for other nationals there may be conditions to obtain a right to permanent residence. According to Directive 2004/38/EC of 29 April 2004 on the right of citizens of the EU and their family members to move and reside freely within the territory of the Member States, the right for EU citizens and their family members to reside in another Member State is guaranteed without any conditions or formalities up to 3 months. Beyond this period, EU citizens who are not working in the host Member State (as employed or self-employed) are required to have sufficient resources for themselves and their family members as well as comprehensive sickness coverage in the host Member State. Only after 5 years of uninterrupted legal residence in the host Member State are they no longer subject to any conditions and can rely on social assistance in the same way as nationals. For third-country nationals who wish to obtain long-term residence status (after 5 years of continuous legal residence) in an EU Member State, the same conditions apply: sufficient, stable and regular resources for themselves and their family members, as well as, sickness insurance in respect of all risks normally covered for own nationals in the Member State concerned (Art. 5 Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents).

While residence is often a condition for obtaining statutory health coverage, health insurance coverage may in some cases be a condition for getting residence status. However, the requirement to have sickness insurance only seems to relate to the person who is moving, not to the family members (including children) who are accompanying him or her. Moreover, in practice, this requirement is often met through the implementation of Regulation 883/2004 on the coordination of social security systems, which guarantees health care coverage to social security beneficiaries when they move to another Member State or when they reside in a Member State other than the one competent for social security.¹² This means that for the fulfilment of the applicable eligibility criteria (such as periods of insurance, employment, self-employment, residence) in the host Member State, similar periods previously completed in another Member State will be taken into account (Art. 6). These rules apply to both EU and non-EU nationals and their family members who are covered by social security legislation in one EU Member State (Regulation 1231/2010 extends application to third-country nationals who are legally resident in the EU and in a cross-border situation).

In case eligibility to health care is residence-based, Member States may apply different concepts of residence in their national legislation. While some countries seem to apply a loose notion of residence, in several Member States residence only concerns permanent legal residents (e.g. Czech Republic, Finland, Slovakia, Sweden). In the United Kingdom, if a child is subject to immigration control then they will also need to have Indefinite Leave to Remain at the time of receiving hospital treatment to be considered an ordinary resident. Under Regulation 883/2004 “residence” is defined as the place where a person habitually resides (Art. 1 (j)), which means where the habitual centre of his or her interests can be found.¹³

For resident children who cannot benefit from the guarantees provided by the social security coordination Regulations, such as children who were previously not covered by any social security system in an EU Member State (e.g. privately insured, children of international civil servants, non-EU residents who were previously insured outside the EU), eligibility for health care coverage may not

¹¹ However, this may be inverted in exceptional cases when the child has EU citizenship while the parents are third-country nationals.

¹² See also Coucheir M et al. The relationship and interaction between the coordination Regulations and Directive 2004/38/EC, tress Think Tank Report 2008.

¹³ Article 11 of the Implementing Regulation 987/2009 lists a number of criteria to assess which country is to be considered as the place of residence.

be guaranteed. This was demonstrated by a case of a chronically ill child temporarily residing in Malta with no social security coverage under the European regulations.¹⁴ In the Czech Republic, the residence requirement is even further linked to Czech (and by extension EU) citizenship, which means that non-EU-resident children are not automatically covered by statutory health insurance.

Asylum seekers (children)

Under this subheading we consider children who are officially registered as asylum seekers (i.e. people applying for international protection). In principle, this subsection does not include refugee children who are not (yet) registered as asylum seekers. They are covered under the next subsection (irregular residents). Also, it does not consider children who have been legally granted refugee status. They are covered under the first subsection (own nationals). Indeed, under Directive 2011/95/EU on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted, Member States who grant a person international protection are obliged to ensure that they have access to health care under the same eligibility conditions as nationals (Article 31).

Asylum seekers (children) are formally granted protection, including access to health services, from the first country where they apply for asylum. Directive 2013/33/EU laying down standards for the reception of applicants for international protection obliges Member States to ensure that they receive the necessary health care, which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders (Article 19.1). Applicants who have special reception needs should receive necessary medical or other assistance, including appropriate mental health care where needed (Art. 19.2). In practice, access rights may be routinely denied particularly at the asylum determination stage.¹⁵ Also, applicants can be required to cover or contribute to the cost of these services and Member States can make their provision subject to a means test (Article 17).

Most Member States award asylum-seeking children the same protection and coverage as children within the statutory system and often include them into the regular statutory health system with contributions paid directly from federal funds or by the responsible regional authority (e.g. Austria, Cyprus, Czech Republic, Denmark, France, Germany, Greece, Italy, Luxembourg, the Netherlands, Poland, Slovakia, Spain, Sweden, the United Kingdom). In some cases, this protection is maintained even after their application for asylum has been rejected (e.g. Sweden) or before starting the asylum process (e.g. France). In Sweden, the full statutory coverage for asylum seekers under 18 is based on the UNCRC.

Some countries organize access to care for this group outside the regular statutory health system with funding coming directly from the competent state service for asylum seekers (e.g. Belgium, Estonia). In these cases, the extent of coverage may be different. In other cases, they have more extensive protection through entitlement to a broader range of services compared with the general statutory benefit package (also provided completely free-of-charge). In Belgium, asylum seekers are entitled to all medical assistance needed to lead a life in dignity. For instance, they may get over-the-counter medicines for free, which are not usually covered, but may not get elective services that are statutorily covered. Also, care may be provided directly by the reception centre, which would limit choice of provider (e.g. Slovenia). A few countries restrict care to asylum seekers, including children, to only emergency care (e.g. Hungary, Latvia).

¹⁴ Mercieca C, Aquilina K, Pullicino R, Borg AA, Freedom of movement across the EU: legal and ethical issues for children with chronic disease, *J Med Ethics* 2012;38(11):694–6.

¹⁵ Bradby H, Humphris R, Newall D, Phillimore J. Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network synthesis report 44, p1).

Irregular residents (children)

Under this final category, we consider children living in a country with no regular residence status, often commonly classed as undocumented migrants.

Children under this category are generally the most vulnerable when it comes to eligibility to statutory health services. Irregular migrant children are often not entitled to statutory health services, or at least not to the full range of services. Irregular migrant children on arrival in France, are entitled to coverage under a specific state insurance scheme, called AME (*“Aide Médicale d’Etat”*), whereas adults with irregular residence status can only benefit from it after an uninterrupted residence of 3 months. However, often access to care is restricted and conditional (e.g. Denmark, Austria, Germany, Slovenia, the Netherlands). Several Member States restrict care to irregular migrants, including children, to *“urgent medical aid”* (e.g. Austria, Belgium, Czech Republic, Estonia, Germany, Slovakia). In several cases, this seems to go beyond the mere scope of emergency care. In Belgium, it comprises both preventive and curative care, and it can be provided in both outpatient and inpatient settings at the expense of the local social welfare centre. In Denmark, all nonresidents, including children, are entitled to emergency hospital care free of charge *“in the event of an accident, childbirth, acute illness or sudden aggravation of a chronic disease”* (Danish Health Act). In Finland, access for irregular foreigners is restricted to urgent medical care, including urgent oral health care, mental health care, substance abuse care and psychosocial support. Although the law specifies that this relates to cases where immediate medical intervention is required and where treatment cannot be postponed without risking the worsening of the condition or further injury, it remains unclear what services are actually covered. In any case, irregular migrants are requested to primarily cover all costs of care, even in emergencies. However, the municipal council of Helsinki has decided to grant children under 18 with irregular residence status free health services on the same grounds as resident children and mothers. Other cities are slowly following this example. Additionally, in several countries, irregular migrants can still get statutory health cover for themselves and their dependants if they work under an official labour contract and the employer pays social contributions for them (e.g. Austria, Belgium, Estonia).

Often administrative requirements are likely to constitute barriers to access for irregular resident children. In Spain, despite the fact that universal access is guaranteed to all children, they are usually included as beneficiaries of the mother, thus accessing health care services through their mothers’ card, which could be more difficult for irregular children due to administrative barriers or misinformation. In cases where children are orphans or a legal tutor is not available (i.e. unaccompanied minors), the state is designated as legal tutor and a health care card or similar document could be issued for the child under such circumstances. In Denmark, according to the Aliens Act (section 42 a, paragraph 2) the Danish Immigration Service is covering expenses of any necessary health care services for aliens who are not entitled to stay in Denmark, but only if their place of residence is known. This may often make the right *“theoretical”* for irregular migrants as they fear being expelled in that case. In Belgium, the discretion of the local social welfare centres to check on medical urgency, actual residence of the claimant, and his or her financial state of indigence before awarding the urgent medical aid certificate can all be sources of insecurity, delay and discrimination for applicants. In Luxembourg, the social party payer system only applies to legal residents. In the United Kingdom, children with irregular residence status are only accepted by general practitioners (GP) if at least one of their parents is already registered. While they have free access to dental care, charges for secondary care are applied to irregular resident children in the same ways as to adults. In Poland, even if care is accessible it is not always free of charge and depends on the financial status of the patient.

In various countries, a variety of social organizations and nongovernmental organizations offer free medical assistance to irregular migrants and asylum seekers if they cannot find it elsewhere. The Danish Medical Association, the Danish Red Cross and the Danish Refugee Council recently established a new private clinic for irregular migrants that will not require them to register with the authorities. In Finland, Global Clinic, a voluntary organization, currently provides medical assistance for irregular migrants in four main cities (Helsinki, Turku, Oulu and Joensuu). In countries like Belgium, Greece, France and the United Kingdom, organizations such as Doctors of the World are

providing basic health care to people excluded from access to health care and report about their situation, including on the specific problems related to children and pregnant women,¹⁶ raising political awareness around this issue.

Scope and depth of coverage

As mentioned before, access to health care is not only a matter of eligibility, but it is also determined by the scope of coverage (the extent of services included in the benefit package) and the depth of coverage (the share of the health care cost).

Under the statutory health system, all children are generally covered in the same way. In those countries where they are insured as dependants, differences may occur if cover varies according to schemes. In decentralized health systems, differences in coverage may occur between different regions. For example, in Spain and Italy, regions may choose to offer additional immunization beyond the package agreed at national level.

All regular health services for children are generally included and are equivalent to the statutory benefit package provided to adults (e.g. Poland, Germany, the Netherlands, Austria). In some countries, access to paediatric services, as with all specialist care, is subject to referral by a GP. However, in a number of countries a specific exemption applies for paediatricians and gynaecologists.

Several countries provide additional and better coverage for children compared with that for adults. In Bulgaria, the 2005 Law on Health extended the right to health care for children up to age 16 beyond the scope of the compulsory health insurance package. A special fund provides financial assistance to children who need treatment abroad. In Germany, children under 18, in addition to being exempt from user charges, benefit from a more generous benefit catalogue. Additionally, nonprescription drugs are free for those under the age of 12.

Dental care cover is generally much better for children, with preventive and restorative services often free of charge or at reduced costs (e.g. Denmark, Malta, Poland, Hungary, Estonia). For example, in Malta, children up to 16 years of age are eligible for comprehensive dental treatment, including orthodontic care. In Hungary, the age limit is expanded to include children under 18 years of age. In Poland, children under 18 years are entitled to additional dental services and materials.

Next to the general reductions, exemptions and caps on user charges that apply to protect vulnerable groups (e.g. socially deprived households, chronic patients), many countries apply child-specific user charge policies to ensure affordable care for children. In some countries, children are completely exempt from user charges or for specific services (e.g. Croatia, Finland, Poland, Portugal, Sweden, the United Kingdom). In others, they benefit from preferential reimbursement or lower co-payments (e.g. Belgium, Denmark). Sometimes child-specific thresholds are applicable (e.g. Belgium, Ireland). Sometimes extra billing is not allowed for children in hospital (e.g. Belgium). In some cases these privileges are limited to young children (e.g. exemption in France and Italy for children under age 6) or specific groups of children (e.g. orphans, disabled, children in low-income households).

Access to preventive services for children is given special attention. Countries generally have free immunization programmes for infants and children up to 16 (e.g. Malta, Ireland, Denmark), which are provided to all residents, irrespective of status, as a public health precautionary measure to protect population health. Several preventive services are organized as part of the prenatal and postnatal monitoring of mothers and children or school health programmes.

¹⁶ Doctors of the World, Access to health care for the most vulnerable in a Europe in social crisis. Focus on pregnant women and children, May 2014, 40p <http://doctorsoftheworld.org/wp-content/uploads/2014/05/MdM-2014-EU-report-access-to-care.pdf>

Prenatal and postnatal care services for mothers

While we have mainly focused on the situation of children, the Convention also includes an obligation for countries to ensure appropriate prenatal and postnatal health care to mothers (Article 24.2 (d) UNCRC).

Across a large range of countries, legal provisions ensure a right to prenatal and postnatal health care for all mothers (e.g. Croatia, France, Greece, Ireland, Italy, Lithuania, Poland, Romania, Spain, Sweden, the United Kingdom). In Cyprus, for instance, the special and universal protection granted to children is also extended to pregnant mothers (Circular MoH.11.11.09(4), 2/12/2011). In Estonia, all pregnant women whose pregnancy has been identified by a doctor or a midwife are automatically health insured and therefore eligible for all prenatal and postnatal health care services. The state pays social tax (including health insurance contribution) for all mothers who are not employed. In Poland, all pregnant women have a temporary right to the full range of health care services during pregnancy, delivery and puerperium. In other countries, mothers who are on parental leave are state insured (e.g. Czech Republic).

Special and universal schemes for maternal and child health care are often organized outside statutory health insurance, often by decentralized bodies or levels (e.g. *départements* in France, federated entities in Belgium). In Austria, the Preventive Mother and Child Pass, monitors and promotes the health of pregnant women and children up to the age of 5, irrespective of their residence or insurance status. They are entitled to have medical examinations by panel doctors free of charge: five screening cycles during pregnancy and nine screening sessions for participating children. Pregnant mothers also have free counselling by a midwife for one hour between the 18th and the 22nd weeks of pregnancy.

Where this is organized within statutory coverage, mothers may be left without proper monitoring (e.g. Luxembourg). In several Member States, vulnerable groups of pregnant women (i.e. nonresidents, irregular resident pregnant women) have only limited access to prenatal and postnatal health care (e.g. Croatia, Denmark, Finland) or they are provided all necessary care and billed afterwards (e.g. Malta). For example, in Finland, irregular migrant mothers have no right to free prenatal and postnatal health care, with care for delivery provided as emergency care according to legislation. In Croatia, uninsured nonmigrants are entitled to emergency medical care only. In Malta, expectant mothers who are third-country nationals and do not fulfil any criteria for access to health services (e.g. persons who come as tourists and overstay, or who come with a work permit and end up out of work) are usually provided all the necessary care and billed afterwards. Since adult asylum seekers (as opposed to children) do not always get full statutory coverage, mothers in this group are vulnerable, even if maternal care is considered to fall within the range of urgent medical aid (or care that cannot be deferred cf. Sweden).

Concluding remarks

This report aims to answer the question of whether EU Member States comply with the obligations of Art. 24 UNCRC that no child should be deprived of his or her right to access health care services. The answer to that question is not as straightforward as it may seem. Although all EU Member States have ratified the Convention, only a few have introduced a legal disposition that guarantees this right to all children living in their territory, irrespective of nationality or residence status. While most health systems have a vocation to ensure universal coverage – especially to children who are generally considered as a vulnerable group that deserves special protection – in practice, not all children are covered in the same way. The same applies more so to pregnant mothers in need of prenatal and postnatal care.

Clearly, children with irregular residence are the group that faces the most problems when it comes to legal eligibility to statutory health services. Often, their access to medical treatment is restricted and conditional. Sometimes, administrative requirements or procedures are barriers to care. However, even among groups of children who legally reside in a country, access is not always guaranteed. Some children fall between the cracks of the eligibility criteria or are left uninsured due

to administrative barriers (e.g. payment of contributions). To prevent this, some countries have extended eligibility, stabilized entitlements, or ensured continuity of coverage (e.g. by dissociating entitlements from contribution payment or instituting a direct individual right to care). Children of migrant workers (EU citizens and third-country nationals) who move to an EU Member State and cannot benefit from the social security coordination rules (or similar rules found in bilateral social security agreements) to obtain seamless access to health services in the new country of residence, may also be left without statutory coverage in certain Member States. In some cases, they can even lose their residence status if they cannot prove to have comprehensive sickness cover in the host Member State.

Besides the legal criteria of eligibility, the material scope of application is also an important factor in assessing a Member State's compliance with the UNCRC provision regarding access to care. Even if the exact range of services that each child should be entitled to is not defined by international law, some standard should be upheld. Clearly, access to only emergency care is too restrictive and does not fit with the idea of an inclusive right that allows children to grow to their full potential. This risk occurs in certain Member States for the noninsured, asylum-seeking or irregular resident children. Pregnant women in certain countries also face limitations and restrictions in obtaining prenatal and postnatal care based on their legal status.

Introducing a general legal provision based on the UNCRC that would ensure statutory coverage for all children (and pregnant women) living in a country irrespective of their nationality, residence or administrative status would be an effective way to avoid existing legal gaps in coverage.

Country overview 1: Austria – Belgium – Bulgaria – Croatia

	Austria	Belgium	Bulgaria	Croatia
Reference to UNCRC	No	No	No	No
Universal right for children	No	No	Yes	No
Children mostly covered as	SHI dependent	SHI dependent	State insured / Resident	State insured / Resident
Additional ways of statutory cover	Direct insurance for children with remunerated employment, orphans, unaccompanied minor foreigners	Direct insurance for orphans, disabled, unaccompanied minor foreigners and regular resident nondependent children (subject to health insurance contribution payment depending on employment or income status)	n/a	n/a
Definition of children (in statutory health protection)	Up to age 18, extended by 24 months (continued insurance), continued education (up to 27) or for impaired/care-dependent children	Up to age 25	All children and students (including foreign citizens) up to age 26 (continued education) are health insured by the State	• State-insured up to age 18 with residence or permanent residence permit • Students and unemployed persons between 18 and 26 years old are insured through their parents' insurance
Legal reference	ASVG §123 Abs2 (General social insurance Act)	Art. 32 Act compulsory insurance for medical care and allowances coordinated on 14 July 1994 + Art. 123–128 Royal Decree of 3 July 1996 concerning the compulsory insurance for medical	• 1998 Health Insurance Act • Article 82 (3) 2005 Law on Health (special chapter dedicated to the children's health	• Article 17 Law on Health Care (2008) • Art. 9 Law on Compulsory Health Insurance (2013)

	Austria	Belgium	Bulgaria	Croatia
		care and benefits	protection) Asylum and Refugees Act (2002)	
Financial protection (user charges)	- General prescription fee exemption for specific vulnerable groups + prescription fee cap - Cost-sharing exemptions for children covered under a parent's policy - Child-specific exemption for €10 service fee for the ambulatory physician care e-card (Article 31c ASVG) - Child-specific exemptions (up to age 15) for therapeutic aids and injections	- Preferential reimbursement for children belonging to low-income households, orphans, disabled, unaccompanied minor foreigners, which also give right to third-party payer for general practice - Child-specific co-payment ceiling of €650, irrespective of household's income - Child-specific preferential reimbursement for chronically ill children under age 19 (coverage of all related additional costs above €650) - Child-specific free dental (regular preventive and restorative services) + third-party payer for all dental services (at request) - Prohibition of fee supplements in hospital (except for admission of child with accompanying parent in private room at own request)	- Children up to 16 years of age have a right to health care beyond the compulsory health insurance package - Fund for treatment of children established by a Council of Ministers' Decree provides financial assistance to children who need treatment abroad - Unlimited access to paediatric care (National Framework Contract) – no GP referral needed - Children exempt from "consumer fee", reduced user charges for dental care	- Complete (preventive, curative and rehabilitative) health care for children and youth under the age of 18 - Children are exempt from co-payments

	Austria	Belgium	Bulgaria	Croatia
Cover for excluded groups of children (refugees/asylum seekers, irregular migrants, uninsured, others)	- Children who have been granted asylum status are covered by SHI - Irregular and uninsured children covered by the need for protection (<i>Schutzbedürftigkeit</i>) and receive urgent medical aid at point of care (any emergency care) - Voluntary health care provider programmes are available especially in bigger cities like Vienna or Graz	- Asylum seekers: free medical assistance needed to lead a life in human dignity (Art. 23 Act of 12 January 2007 concerning the reception of asylum seekers and certain other categories of foreigners) - Irregular / uninsured: urgent medical aid (art. 57§2 Act of 8 July 1976 + Royal Decree of 12 December 1996 concerning urgent medical aid) subject to medically certified urgency and financial state of indigence (through a mandatory social inquiry). - Serious illness as a ground for granting temporary residence and statutory health insurance entitlement	Asylum seekers: if in SAR services then have access to primary medical care services, interpretation services for the registration and asylum process, heating, separate facilities for men and women, and a monthly assistance; asylum seekers outside SAR are covered through national health care system	- Equal entitlements for migrant children: Protocol – measures to protect against infectious disease and content of the medical examination of persons seeking asylum and asylum seekers, foreigners under temporary protection and foreigners under subsidiary protection - Other nonresidents (i.e. uninsured nonmigrants) are entitled to emergency medical care only
Specific schemes for (pregnant) mothers and children	Preventive Mother and Child Pass for all pregnant women and their children up to age 5: medical examinations by panel doctors free of cost even without coverage of health insurance	Preventive care centres of the Regional Offices for birth and child care organize free consultations for mothers and children (age >3), incl. monitoring of pregnancy	- Pregnant women are entitled to more services than the general insured population - No GP referral needed to consult a gynaecologist	- Comprehensive health care for women, especially with regard to family planning, pregnancy, childbirth and motherhood - Pregnant women are exempt from co-

	Austria	Belgium	Bulgaria	Croatia
				payments for diseases associated with pregnancy
Cover for mothers excluded from statutory cover	• Voluntary health insurance (part-time employees or inactive) subject to contribution payment • Beneficiaries of needs-based minimum income are covered by SHI	• Same as for asylum seekers and irregular/uninsured • Pregnancy as a ground for continued health insurance and extending legal residence	• Uninsured mothers have right to only one free of charge examination during the pregnancy and free of charge delivery • Also obstetric assistance beyond the scope of the compulsory health insurance (based on Minister of Health Ordinance)	• Migrant women (asylum seekers, foreigners under temporary protection and foreigners under subsidiary protection): same entitlements • Other nonresidents (i.e. uninsured nonmigrants): entitled to emergency medical care only

Country overview 2: Cyprus – Czech Republic – Denmark – Estonia

	Cyprus	Czech Republic	Denmark	Estonia
Reference to UNCRC	Yes (Circular MoH.11.11.09(4))	No	No	Yes (Child Protection Act)
Universal right for children	Yes (Access to free or affordable health care)	No	No	No
Children mostly covered as	Permanent resident / Cypriot / EU citizens	State insured / permanent resident / Czech/EU citizens	Legal resident	Noncontributing insured / resident
Additional ways of statutory cover		Non-EU foreigners without permanent residence are required to have health insurance either employer-based or private (Act No. 326/1999 Coll. E)		
Definition of children (in statutory health protection)	Under age 18	- Children: under 18 - Students: up to 26 (PhD students: up to 28)	Under age 18	Up to age 19
Legal reference	(Circular MoH.11.11.09(4)) - The Government Medical Institutions and Services Law of 1978	- Law on care of human's health 20/1996 Sb - Law on public health insurance 48/1997 Sb - Law on the protection of human's health 258/2000 Sb - Constitution	Danish Health Act	- Health Insurance Act - Social Tax Act
Financial protection (user charges)	Circular MoH.11.11.09(4)), 2/12/2011 ensures that all children (aged 0–18) have access to health	User charge for emergency room visits equally applies to children, except for: Children up to age 3 living	- Outpatient prescription drugs: children under 18 are always reimbursed for at least 60% - Dental care is free for	- Hospital fee exemption and free dental care (contracted providers) for all children - Pharmaceuticals: free

	Cyprus	Czech Republic	Denmark	Estonia
	care under the public system	in children's home or foster family Children on poverty allowance	children under 18 under the municipal dental health service Special waiting time guarantee for child and adolescent psychiatry	under age 4 and higher (90%) reimbursement for children 4-16 Under age 2: Co-payment exemption for GP home visits and outpatient specialists
Cover for excluded groups of children (refugees/asylum seekers, irregular, uninsured, others)	- All documented children, including asylum seekers, are entitled to the same health care as children who are residents of Cyprus - Equal treatment for children of irregular migrants living in Cyprus (Circular MoH. 11.11.09(4))	- Asylum seekers are also state-insured - Foreign children without permanent residence and parents not employed by Czech-based employer: private insurance - irregular children: urgent medical aid at point of service	- All documented children, including asylum seekers, are entitled to the same health care as children who are residents of Denmark - All nonresidents (incl. irregular migrant children) are entitled to emergency hospital care free of charge <i>"in the event of an accident, childbirth, acute illness or sudden aggravation of a chronic disease"</i> (Danish Health Act) - The Danish Immigration Service covers expenses to necessary health care services for aliens who are not entitled to stay in Denmark (Aliens Act, section 42 a, paragraph 2). However, this right may often be "theoretical" for irregular migrants, since they are	- Asylum seekers: care organized by accommodation centre - irregular children: only urgent medical aid provided at point of service

	Cyprus	Czech Republic	Denmark	Estonia
			required to inform the authorities about their place of residence	
Specific schemes for (pregnant) mothers and children	• Circular MoH. 11.11.09(4) ensures appropriate prenatal and postnatal health care for mothers irrespective of their residence status • Every child has free of charge access to Maternal and Child Welfare Centres / Vaccination Centres	• Mothers on maternal leave are state insured • Compulsory vaccination and preventive examinations for children of specific age groups • Every child has to be registered with a paediatrician; every woman with a gynaecologist • All pregnant women are eligible for a set of services, e.g. second-trimester screening, blood tests, regular check-ups	• Pregnant women have free maternity care (incl. prenatal screening) • Services for children: free-of-charge regional prevention programme (incl. vaccination); municipal oral dental care; primary and secondary schools offer all children at least two health checks	• All pregnant women whose pregnancy has been identified by a doctor or a midwife are insured (even if social tax is not paid) and therefore eligible for all prenatal and postnatal health care services • The state pays social tax (including health insurance contribution) for all mothers who are not employed until child is 3 (or 8 in case of 3 or more children) • Pregnant women exempt from hospital fee and co-payment for GP home visits and outpatient specialists + higher dental reimbursement (incl. for mothers of children up to age 1)
Cover for mothers excluded from statutory cover	• Asylum seekers are entitled to health care services • Circular MoH. 11.11.09(4) ensures appropriate prenatal and postnatal health care for mothers	• Asylum seekers are also state-insured • Foreigners without permanent residence and not employed by a Czech-based employer: private insurance	• Asylum seekers (adults) are only entitled to certain services. Special services exist for pregnant women • Nonresident mothers: same as above (children)	• Asylum seekers: care organized by accommodation centre • irregular mothers: only urgent medical aid provided at point of

	Cyprus	Czech Republic	Denmark	Estonia
	irrespective of their residence status	irregular mothers: urgent medical aid at point of service	The Danish Medical Association, Red Cross Denmark and Danish Refugee Council established a private clinic for irregular migrants in Copenhagen and Aarhus	service

Country overview 3: Finland – France – Germany – Greece

	Finland	France	Germany	Greece
Reference to UNCRC	No	No	No	No
Universal right for children	No	Yes	No	Yes
Children mostly covered as	Permanent residents	Legal residents (after 3 months)	SHI/PHI dependent	SHI dependent
Additional ways of statutory cover			Direct insurance for remunerated employment, orphans, unaccompanied minor foreigners with a legal guardian	Direct insurance for remunerated employment, orphans, disabled, unaccompanied minor foreigners via “social welfare booklet”
Definition of children (in statutory health protection)	Under 18	- Under age 18: still SHI dependent - as of age 18 (or 16 if child is not at school): personal right (even without professional activity)	Up to age 18, extended to 23 if unemployed, extended to 25 if in training or education, indefinitely if disabled	N/A
Legal reference	Health Care Act No. 1326/2010	Universal Health Protection (PUMa): instated by Act no. 2015-1702 of 21 December 2015 on the financing of social security for 2016 (article 59)	- SHI (§§ 5, 6, 8, 9, 10 SGB V) - SGB V (Social Code V) regulates SHI	- Joint Ministerial Decision No. 139491 of 30 November 2006 - Law 4368/2016 - Joint Ministerial Decision No. A3(g)/GP/oik. 25132/2016
Financial protection (user charges)	There are no user charges for children in public health care	Children under 6 are exempt from any co-payments, as well as beneficiaries of complementary CMU programme (free	Children up to 18 years of age exempt from user charges and have a more	Free public health care for children residing in social care units or other institutions (public or private law bodies) and

	Finland	France	Germany	Greece
	Many children from wealthier families have voluntary private health insurance policies, as it buys easier access to services and lower co-payments at the private sector at the point of use	complementary health insurance for people with low income)	generous benefit catalogue¹⁷ - Over-the-counter pharmaceuticals are free for children up to the age of 12 years - Benefits within SHI catalogue same and differ only slightly between sickness funds (i.e. reimbursement of additional check-ups) - Dental care included in SHI benefits for children up to 20 years old	children placed in foster families
Cover for excluded groups of children (refugees/asylum irregular, uninsured, others)	- Asylum seekers: entitled to same health services as residents but organized by refugee reception centres (Act on Adaptation of Immigrants and Reception of Asylum Seekers) - Everyone (regardless of citizenship or residence status) is entitled to emergency treatment due to sudden illness or accident; although uninsured/irregular	- Refugees and registered asylum seekers are covered under PUMa - Irregular migrants with uninterrupted residence of more than 3 months can benefit from a state insurance AME ("Aide Médicale d'Etat") on the basis of ongoing stay of minimum 3 months)	- Children who have been granted asylum status are covered by SHI - Irregular and uninsured children can receive urgent medical aid at point of care (any emergency care)	- Free public health care¹⁸ and medicines for: legal residents (i.e. uninsured Greeks, expatriates, citizens of EU Member States and of third countries plus dependants - Pregnant women, refugees and minors without residency papers receive free public care

¹⁷ Except for dentures, orthodontics, transportation.

¹⁸ Free cover includes: clinical and diagnostic tests, hospital treatment, prenatal care, rehabilitation, transfer abroad for specialist treatment and the handing out of medicines and other consumables.

	Finland	France	Germany	Greece
	migrants are expected to cover their own costs - The municipal council of Helsinki decided to grant irregular children under 18 and pregnant mothers free health services on the same grounds as resident children. Others cities are about to follow this example - Global Clinic, a voluntary organization, provides medical assistance for irregular migrants (currently) in four cities; Helsinki, Turku, Oulu and Joensuu			
Specific schemes for (pregnant) mothers and children	1. Maternal and child health care services provided by a comprehensive network of municipal clinics and school nurses are free of charge under statutory coverage	- Mother and Child Protection facilities (PMI): birth-related care and follow-up care are free of charge for all resident pregnant women and children under 6 (incl. irregular migrants) - Pregnancy care has ALD status (long-term illness) for which 100% cover applies - Women more than 6	2. SHI covers a set of services for pregnant women and mothers¹⁹ 3. Pregnant women and antenatal care are exempt from user charges under the SHI 4. Convalescent care for mothers or fathers with child	- Free access to public health care for the uninsured single pregnant women and uninsured single mothers and their children - All individuals earning less than €2400 per year (higher for more dependants) will not have to pay anything for medicines or health care

¹⁹ Mothers do not have specific legal status within general eligibility criteria for entitlement to publicly funded health services.

	Finland	France	Germany	Greece
		months pregnant are exempt from any co-payments (until 12th day after birth), as well as beneficiaries of complementary CMU programme		
Cover for mothers excluded from statutory cover	Same as above (children)	Same as above (children)	• The same set of prenatal and postnatal services is guaranteed for all mothers, regardless of their status or health insurance • All pregnant mothers are entitled to medical care, midwifery, provision of pharmaceuticals and medical aids, delivery, home help and maternity allowance (§24c SGB V)	Same as for asylum seekers and irregular/ uninsured

Country overview 4: Hungary – Ireland – Italy – Latvia

	Hungary	Ireland	Italy	Latvia
Reference to UNCRC	No	No	Yes ²⁰	No
Universal right for children	Yes ²¹	No	Yes	Yes
Children mostly covered as	Resident / state insured	Resident/ SHI dependent	NHS dependent/Resident	Resident/state insured
Additional ways of statutory cover	Direct insurance for remunerated Hungarian-based company employment, orphans, additional voluntary health insurance	n/a	All regular foreigners can access NHS under same conditions as Italian citizens	n/a
Definition of children (in statutory health protection)	Minors are under the age of 18 years who are not married	For health services, 16 years of age is the usual cut-off (however children may be regarded as dependants up to 18 or 23 if in full-time education)	Under the age of 18	All children, including orphans and unaccompanied minor foreigners under the age of 18, provided they are resident in the country, are covered by the State
Legal reference	• Hungarian Constitution²² • Act LXXX of 1997 (Eligibility for Social Security Benefits and Private Pensions) • Act CLIV of 1997 on Health care	Health (General Practitioner Service) Act 2014	• SSN (Law 833/1978) • Decree Law 286/1998 • DPR no. 394/1999 • Article 34 of Law 286 • DPR 334/2004 • Article 35 of Law 286 • Law n. 176 in 1991	• The Medical Treatment Law, Section 3 part two, Section 16, 17, 18 • Article 110 and 111 of Satversme [the Constitution] of the Republic of Latvia

²⁰ Italy issued a Code on the Rights of Minors to Health and Health Care Services (*Codice del diritto del minore alla salute e ai servizi sanitari*) in 2013. Available from: http://garanteinfanzia.s3-eu-west-1.amazonaws.com/s3fs-ublic/documenti/Codice_diritto_alla_salute_dic15.pdf.

²¹ All patients have the right to emergency, life-saving care.

²² Article XX, Article XXI, Article XXII, Article XV (5), Article XVI.

	Hungary	Ireland	Italy	Latvia
	- Act LXXXIII of 1997 (Services of the Compulsory Health Insurance System) - Civil Code Act V. of 2013			
Financial protection (user charges)	- Universal coverage, comprehensive benefits package with few exclusions²³ - Preventive care and health education provided to pregnant women and children under 6 years²⁴ - Abandoned children, regular social cash or disability beneficiaries exempt from user fees - Dental treatment is free up to the age of 18 - Children with disabilities and chronic illness and orphans receive nursing or orphan allowance	- Children under 6 years old receive free GP visits - Children have capitation caps of 125 EUR²⁵ - Immunizations free of charge - Free school health screenings - Range of services provided free of charge for children even if parents do not have medical card - Infant entitled to free GP services only if it has GP or medical card	- Children under 6 except from co-payments - Primary and inpatient care are free of charge for all	- Children are exempt from charges and a number of services are paid from the State budget only in the cases where services are provided to children - For children up to the age of 18, all medicine and medical devices included in the reimbursable medicines list will be compensated to the children to the amount of 100% - Children up to the age of 24 months are compensated to the amount of 50% for prescription medicines (except medicines that are included in the reimbursable medicines list)
Cover for	All children have the right	A person living in Ireland	By law, no children are excluded	Irregular migrants have the right

²³ Co-payments for pharmaceuticals, medical aids and prostheses, and some additional medical services

²⁴ Provided through municipalities

²⁵ 50 EUR year diagnosis, 45 EUR subsequent annual check

	Hungary	Ireland	Italy	Latvia
excluded groups of children (refugees/asylum seekers, irregular, uninsured, others)	to emergency treatment Foreign children without residential status or refugee status, or protected children status are reported to authorities and placed under authority of child protection organization	for at least 1 year is considered by the HSE to be “ordinarily resident” and is entitled to either full eligibility (Category 1) or limited eligibility (Category 2) for health services. This includes asylum seekers and their children - Asylum seekers under 6 qualify for GP visit cards (just like other Irish people) - irregular migrants only have access to emergency care	from coverage by the SSN (SHI)	to emergency care and other health care if willing to pay out-of-pocket payments (not for detained persons, including children)
Specific schemes for (pregnant) mother and children	- State covers costs for child development screening examinations, consultancy about pregnancy and child care for mothers²⁶ - Mothers who have not paid or are unable to pay social-health contributions can register with the social care system to receive	- Maternity and Infant Care Scheme²⁷ for ordinary residents of Ireland - Mothers are entitled to free inpatient, outpatient and accident and emergency/casualty services as well as hospital charges related to birth with or without medical GP visit care	In 2016, the Renewal of the basic basket of services, included a compulsory package of services for maternal care, either during pregnancy (including services for the father, in case) and children up to the 6th month after birth The new basket indeed foresees the introduction of compulsory	n/a

²⁶ From 1 month before the data of the birth till the 3rd year of the child the state pays for the insurance of the mother and child.

²⁷ Guaranteed two postnatal GP visits; first pregnancy: initial GP examinations, five examinations before delivery (six examinations for subsequent pregnancies); significant illnesses warrant an additional five GP visits (i.e. diabetes, hypertension); postnatal: two developmental examinations free of charge and public health nurse visits within first 6 weeks.

	Hungary	Ireland	Italy	Latvia
	coverage		screening even for hereditary genetic diseases, in case of need – the SNE, Neonatal enlarged Screening	
Cover for mothers excluded from statutory cover	• Foreigners without legal residence can make payments to the HIF to receive public hospital treatment at a very low charge • Urgent medical first aid and emergency treatment are provided at point of service free of charge to all	• Maternity and Infant Care Scheme	• Foreigners not qualifying for NHS (short stay, irregular, refugees/asylum seekers) have access to health care²⁸ and maternity care, prenatal and postnatal care and child care²⁹ • Vaccinations are provided free of charge • Nonprofit organizations from social care services provide additional services for maternity care³⁰ • Beyond the NHS, the family planning services, included as part of the health and social care services, play a vital role in providing services for children and mothers in Italy, even for protecting young women from cultural traditions to	• For asylum seekers, child delivery aid is covered by the state • Voluntary health insurance with regional health insurance fund subject to contribution payment • Irregular migrants have access to maternity care and tuberculosis screening/treatment

²⁸ Outpatient and inpatient care, due to emergency and/or essential for survival, because of illness or injury; Preventive medicine and public health interventions, due to emergency and/or necessary for the individuals or the collective safety. Non-documented migrants can access care via a FAMMI funding programme.

²⁹ As foreseen by the UN Convention of 1989, which entered into force in Italy with Law n. 176 in 1991.

³⁰ Article 35 of Law 286.

	Hungary	Ireland	Italy	Latvia
			support awareness and safe reproductive health	

Country overview 5: Lithuania – Luxembourg – Malta – the Netherlands

	Lithuania	Luxembourg	Malta	The Netherlands
Reference to UNCRC	No	No	No	No
Universal right for children	Yes	Yes	Yes	No
Children mostly covered as	Compulsory Health Insurance Scheme insured	SHI dependent	Social Security system dependent	SHI dependent
Additional ways of statutory cover	n/a	State insured under 18 (all residents) or if disabled; after 18 voluntary continuation or directly insured on the basis of studies, professional training	n/a	n/a
Definition of children (in statutory health protection)	All children under the age of 18	Up to age 18, can be extended up to age 30	All children, including children of irregular migrants and nonaccompanied minors (no age limit provided)	All children under the age of 18, whose insurance needs to be arranged for by their parent or legal guardian (e.g. in case of orphaned children)
Legal reference	Health Insurance Law (1996), Article 6.4.6	Articles 1, 2 and 7 of the Code of Social Security's First Book on health and maternity insurance (CSS)	Article 25, Health Act, 2013	General legal provisions regulating care access: Health Insurance Act of 2015 (Zvw), Long-term care act (Wlz), Social Support Act (Wmo), Youth Act (Jeudgwet), Preventive care act
Financial protection (user charges)	There are no official user charges for clinical care and inpatient pharmaceuticals for those insured by CHI; however, patients,	The by-laws of the National Health Fund foresee in certain cases exemptions for user charges or renewal periods as	Children are exempt from co-payments	Children do not pay premiums, they are covered through a government contribution

	Lithuania	Luxembourg	Malta	The Netherlands
	including children, have to pay for outpatient pharmaceuticals, even those with prescription. State compensates from 0% to 100% of the base price (depending on pharmaceutical); however, even in case of 100% compensation by the state patients have to pay the difference between the base price and the retail price	well as specific reimbursements for children and youngsters		to the national health insurance fund Cost sharing is the same as for adults. However, children are exempt from the €385 deductible
Cover for excluded groups of children (refugees/asylum seekers, irregular, uninsured, others)	- Asylum seekers and refugee children are entitled to care just as insured individuals, as both refugees and asylum seekers are groups covered by the state, irrespective of their age. - Children of irregular residents (those without legal permanent or temporary residency) are potentially not covered - Unaccompanied foreign minors are also covered by the state	- Legal residents in difficulty: social third party payer system gives free access to health care (Act of 18 December 2009 organizing social aid) - Asylum seekers and other foreigners under international protection: entitlement to all appropriate health care under the same conditions as Luxembourg residents (Art. 62, Act 18 December 2015 concerning international and temporary protection) - Temporary extension of legal residency in case of a health issue of exceptional gravity	Children of persons who do not have access to health services, e.g. irregular migrants, overstayers are still provided all the necessary health care services	- Refugees are entitled to health care in the Netherlands as soon as they are registered at the Central Agency for the Reception of Asylum Seekers and living in a refugee housing location - Asylum seekers <i>do not</i> have to pay for insurance or a mandatory deductible - Irregular migrants are entitled to medically necessary care but they cannot purchase health insurance under the Health Insurance Act. They have to pay for the care they receive out-of-pocket

	Lithuania	Luxembourg	Malta	The Netherlands
Specific schemes for (pregnant) mother and children	Women on maternity leave (i.e. employed), and women not in work from 28th week of pregnancy to 56 days after childbirth are insured by the state as a separate group (Law on Health Insurance, 6.4.4.), provided they are legal residents	Children under 18 have free access to the basic vaccinations under statutory health insurance		n/a
Cover for mothers excluded from statutory cover	n/a	Irregular pregnant women are not systematically monitored Same as above for children • Social third-party payer system for legal residents • Asylum seekers and other foreigners under international protection	Expectant mothers who are third-country nationals and do not fulfil any criteria for access to health services (for example, persons who come as tourists and overstay, or who come with a work permit and end up out of work – these are called irregular migrants) are usually given all the necessary care and billed thereafter	Irregular mothers have access to medically necessary care but financial barriers may be substantial

Country overview 6: Poland – Portugal – Romania – Slovakia

	Poland	Portugal	Romania	Slovakia
Reference to UNCRC	No	No	No	No
Universal right for children	Yes	Yes	Yes	No
Children mostly covered as	Declared dependants of parents (citizens) who are insured	Resident	Insured by law	State-insured/permanent residents
Additional ways of statutory cover	n/a	n/a	n/a	Children without permanent residence are required to have private health insurance
Definition of children (in statutory health protection)	- Under 18 years old - Students and postgraduate students under 26 years old are insured without the need to pay contributions	All children resident in Portugal, including irregular residents	- Children under 18 years old, even if they are unable to prove their identity - Young people up to 26 years old if they are enrolled in any form of education or coming out of child protection institutions, with no income	Dependency: until completion of compulsory education (age 16) and can be extended for studies up to age 30 (if they do not extend the standard length of their study)
Legal reference	Article 2 of the 2004 Law on Health Care Services Financed from Public Sources and the Constitution (for example, for orphans)	- Article 64 Constitution of the Portuguese Republic (1976) - Law No. 29/2012, of 9 August 2012	Law 95/2006 on the Health Reform, republished in 2015, Title VIII, Chapter II, Section 1; Art. 224 (1) a) and b)	- Act No. 577/2004 Coll. on the scope of health care defrayed on the basis of public health insurance - Act No. 580/2004 Coll. on the health insurance

	Poland	Portugal	Romania	Slovakia
Financial protection (user charges)	Health care services provided to children under 18 years old (or students under 26 years old) are free of charge	Children aged 18 or under are exempt from user charges since 2015	Children are exempt from co-payments	• Hospital user charge exemption (under 16) • Child-specific reduced quarterly co-payment for drugs • Free basic dental care subject to annual oral examination for children • A series of preventive check-ups (incl. compulsory vaccinations) are granted to infants and children under the age of 16 (Law 577/2004)
Cover for excluded groups of children (refugees/asylum seekers, irregular, uninsured, others)	• Persons with a refugee status or protection obtained in Poland; persons with an approval for a stay for humanitarian reasons or a tolerated stay are covered and hence, are not excluded from statutory cover • Uninsured nonresidents or noncitizens must reimburse service providers at a later date for any received care. Care is accessible, but it is not necessarily free or reimbursable for all	Since 2001, Portugal's NHS services cannot refuse treatment based on nationality, legal or financial status of the migrant There are several agreements that allow citizens from Portuguese-speaking African countries and also Andorra and Brazil to use the National Health Service	• Foreigners (incl. children or pregnant women) in the accommodation centres waiting to be expelled or returned, as well the victims of human trafficking during the procedures of identity setting, hosted in special centres are insured with the contributions paid from the state budget (Law 95/2006 on the Health Reform, republished in 2015, Title VIII, Chapter II, Section 1; Art. 224 (2) e)	• Asylum seekers are covered by SHI • Irregular and uninsured are only entitled to urgent medical aid (patient must cover costs)

	Poland	Portugal	Romania	Slovakia
Specific schemes for (pregnant) mother and children	All pregnant women (Polish citizens residing in Poland or women who are recognized as refugees or were granted right to temporary stay in Poland) have a temporary right to the full range of health care services during pregnancy, delivery and puerperium	Some bilateral agreements make specific reference to “protection for illness and maternity”	- Pregnant and afterbirth women, if they have no income or with income under the national minimum gross wage are insured with no obligation for the contribution payment (Law 95/2006 on the Health Reform, republished in 2015, Title VIII, Chapter II, Section 1; Art. 224 (1) f)) - Persons on maternity leave for up to 2 years (3 years for children with disabilities), or on medical leave for mothers of children with disabilities between 3 and 7 years of age are insured with contributions paid from the state budget (Law 95/2006 on the Health Reform, republished in 2015, Title VIII, Chapter II, Section 1; Art. 224 (2) b))	- All persons taking care of children (full-time) aged up to 3 are state-insured (can be extended to age 6) - Monthly preventive check-up during and after pregnancy (also dental) Hospital user charge exemption for breastfeeding mothers
Cover for mothers excluded from statutory cover	Uninsured nonresidents or noncitizens must reimburse service providers at a later date for any received care. Care is accessible, but it is not	Mothers have the right to access ALL health care services in Portugal, according to their health needs	All mothers are covered for all prenatal and postnatal services	Same as above (children)

	Poland	Portugal	Romania	Slovakia
	necessarily free or reimbursable for all			

Country overview 7: Slovenia – Spain – Sweden – United Kingdom

	Slovenia	Spain	Sweden	United Kingdom
Reference to UNCRC	No	No	No	No
Universal right for children	Yes	Yes	Yes	No
Children mostly covered as	SHI/Legal residence	SHI	Permanent legal residence	Resident
Additional ways of statutory cover	Direct insurance for remunerated employment, orphans, disabled, unaccompanied minor foreigners	Art 1.3 below income limit		n/a
Definition of children (in statutory health protection)	All persons under the age of 18 are dependants (up to 26 years of age if students or pupils) ³¹	All persons under 18 years old regardless of their nationality or residence status	Children and young people (under age 20)	- For the purposes of the NHS Charging Regulations, a child is someone under the age of 18 - If a child is subject to immigration control then they will also need to have Indefinite Leave to Remain (ILR) at the time of receiving treatment to be considered ordinarily resident
Legal reference	Health Care and Health Insurance Act of 1992	Royal Decree Law 16/2012, of 20 April	1982 Health and Medical Services Act	National Health Service Act (1946)

1. ³¹ Minimum age for employment is 15 years. If dependants have means to pay contributions, they begin payments at 18 years if not in school (if a person is without any income or personal property, the municipality of residence pays contributions if a person applies for this)

	Slovenia	Spain	Sweden	United Kingdom
	(Article 23, point 1 of Act) • Patient Rights Act of 2008 (Article 8)		• 2015 Patient Act	
Financial protection (user charges)	Children are exempt from most co-payments	• Children have the same co-payments as adults • Co-payments only exist in pharmaceuticals, ortoprotheses and dietetic products • Art 4.13; according to income level, in the same way that the insured person • There is no exception for children for pharmaceuticals	• Exemption from patient fees (most county councils) • Free dental care (incl. regular check-ups) • Free vaccinations, examinations, consultations and certain treatments during school age in primary care clinics and schools • Prescription drugs are free for under 18	There are no user charges for health care in general (primary care, hospital care, inpatient pharmaceuticals, etc.) and children are exempt from the fixed charges for optical care, NHS dental care and outpatient prescriptions
Cover for excluded groups of children (refugees/asylum seekers, irregular, uninsured, others)	• Care delivered to foreigners without insurance or without a known payer, is paid by state budget • A person who is legally working in Slovenia and contributions are paid by an employer, also has legal residence • Entitlement to health care is related to employment and residence, not to citizenship	• As all other children, children of undocumented migrants need to have a Health Card in order to receive health care under the same conditions as Spanish citizens	• Asylum-seeking and undocumented children under 18: right to the same subsidized health and medical services as permanently resident children. (2008 Health and Medical Care for Asylum Seekers and Others Act and 2004 Communicable Diseases Act)	• Undocumented migrants have to pay at the point of use • Some provision of services in the “third” sector, but these are limited and usually for a specific area • Historically most doctors have not questioned a child’s eligibility so they have received treatment irrespective of their formal eligibility, but more recently there have been moves to effectively make health care workers

	Slovenia	Spain	Sweden	United Kingdom
				implementers of immigration policies and check that the people they treat are entitled to access services free of charge
Specific schemes for (pregnant) mothers and children	• National prevention programme related to reproductive health • Services are delivered in primary, secondary and tertiary care, as well as in community nursing • Mothers exempt from most co-payments • Childbirth paid for by compulsory health insurance	• National prevention programme related to reproductive health, pregnancy and antenatal primary care • Regular check-ups, screening (i.e. diabetes, pre-eclampsia, infectious diseases) and pregnancy follow up and care in primary, secondary and tertiary care, as well as in community midwives (nursing) units within primary care • Childbirth and neonatal care are paid for by health insurance in all cases • Newborn screening for phenylketonuria • Newborn follow up includes mandatory vaccinations and periodical check-ups standardized within a specific "Healthy Child	• All maternal health care is free of charge • Regular check-ups, screening, psychological support and education during the entire pregnancy in antenatal primary care clinics • All newborn babies are tested for phenylketonuria • Alternative practitioners are not allowed to examine or treat children under 8 years old	n/a

	Slovenia	Spain	Sweden	United Kingdom
		Programme")		
Cover for mothers excluded from statutory cover	• Legally no groups of mothers are uninsured or without coverage • All mothers have special rights to care within statutory insurance • Asylum seekers, foreigners without legal residence, and non-nationals are covered • Care is provided to all regardless of insurance status, but once stabilized physicians or hospitals might require a fee • Compulsory health insurance fully covers reproductive (preventive and curative) health services including family planning and contraception, pregnancy, delivery / birth and postpartum period	All women, regardless of their nationality or residence status, are entitled to prenatal and postnatal health care	• Adult asylum seekers have the right to receive care that cannot be deferred (i.e. maternity care, abortion and advice on contraception) • Undocumented adults: right to receive nonsubsidized immediate care. However, since irregular adults may be refused care if they cannot pay, services for this group are in practice restricted	• If the woman is not "ordinarily resident", they should still be able to access GP services where some antenatal and postnatal care is provided Since August 2011, they would be expected to pay for antenatal care (such as scans) and delivery costs if they are not eligible for free care under the NHS

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Article 24 of the UN Convention on the rights of the child (UNCRC), which was adopted in 1989, establishes a fundamental right for every child to access services and facilities for the treatment of illness and rehabilitation of health. This entails an obligation on countries to ensure that no child is deprived of his or her right of access to health care services, irrespective of nationality, residence or legal status. This study assesses the legal right to health care for children living in one of the 28 EU Member States, all of which have ratified the UNCRC.