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Understanding the legal barriers and political (un)willingness determining healthcare access among asylum seekers and undocumented migrants: A comparative case study analysis of two German federal states

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Positionality statement

This research discusses legislation that affects highly vulnerable and stigmatized groups of people that are discriminated against in Germany. As a white German woman, I have not personally experienced any form of systematic racism or discrimination based on my nationality or race. Growing up, I was less aware of asylum seekers and undocumented migrants' struggles within German society until I started researching about it for this thesis. By conducting interviews with NGO staff who are confronted with migrants' experiences on a daily basis, I aimed to more accurately reflect the lived realities of migrants in Germany. However, I want to acknowledge that I am merely scratching the surface of what asylum seekers, undocumented migrants and refugees go through everyday and want to encourage others to engage with this topic within their local context, as I did and will continue to do in mine.

Abstract

Across Europe, asylum seekers and undocumented migrants are subjected to numerous barriers to healthcare access. In Germany, asylum seekers' and undocumented migrants' healthcare access is most significantly shaped by the Asylum Seekers' Benefits Act (1993), the Residence Act (2005) and the Asylum Procedure Acceleration Act (2015) which have been vehemently criticized by scholars and non-governmental actors. Across the country, healthcare access strongly differs between and among both groups of migrants. This study explores how legal barriers and their practical implications affect asylum seekers' and undocumented migrants' healthcare access in Germany. Moreover, it aims to understand the patterns in healthcare access by determining whether and how policy-outcomes are shaped by political willingness among key decision-makers. In order to do so, two comparative case studies were conducted that examined how federal legislation was individually implemented and adapted to in the contexts of the federal states Saxony and Bremen. The case study analysis builds on a content analysis of national law, local policy documents and exhaustive stakeholder interviews with NGO staff. The results indicate that the analyzed legal framework foresees an insufficient scope of healthcare entitlements and preserves discriminatory and impractical practices. A common thread across all policies is the strong diffusion of responsibility among stakeholders, thereby impeding political action. The case studies showed that the pursuit of permissive health policies in local contexts seems to depend on political willingness, which tends to be more present among progressive forces. Saxony's case however illustrates a neglect of migrants' health needs across the political spectrum. This study highlights that migrants' right to health is under increasing scrutiny and thus, achieving Universal Health Coverage for all residents in Germany requires confronting the underlying political motives within the legislation as well as rethinking healthcare as a right, not a privilege.

Keywords: healthcare access, asylum seekers, undocumented migrants, legal barriers, political willingness, Germany, federalism, UHC, right to health.

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List of Abbreviations

APAA - Asylum Procedure Acceleration Act
AfD - Alternative für Deutschland (Alternative for Germany)
AS - Asylum Seekers
ASBA - Asylum Seekers' Benefits Act
CCS - Comparative Case Study
CDU/CSU - Christlich-Demokratische Union/Christlich-Soziale Union (Christian Democrats)
CEAS - Common European Asylum System
EU - European Union
FDP - Freie Demokratische Partei (Liberals)
PHI - Private Health Insurance
MIPEX - Migrant Integration Policy Index
NGO - Non-Governmental Organization
RQ - Research Question
SHI - Statutory Health Insurance
SDG - Sustainable Development Goal
SPD - Sozialdemokratische Partei Deutschland (Social Democrats)
UHC - Universal Health Coverage
UM - Undocumented Migrants
UN - United Nations
WHO - World Health Organization

1. Introduction

Germany is a key immigrant destination country worldwide (Bozorgmehr & Razum, 2020; Krämer & Fischer, 2018, p. 6). Among industrialized countries it was the number one recipient of asylum applications between 2013 and 2016 (Bozorgmehr & Razum, 2020). Nonetheless, Germany retains one of the most discriminatory migrant health policies among European Union (EU) countries, particularly towards undocumented migrants (UM) (Van Ginneken, 2014). Evidently in Figure 1, Germany's legislation is unique: by law, UM receive the same healthcare entitlements as asylum seekers (AS) but for all non-emergency care, they are required to seek out social service departments who are obligated to report them to immigration authorities (European Union Agency for Fundamental Rights, 2011, p. 75). Drawing on German legislation and stakeholder interviews, this study explores AS' and UM' legal barriers to healthcare access in Germany, focusing on the Asylum Seekers' Benefits Act (ASBA), §87 of the Residence Act and the Asylum Procedure Acceleration Act (APAA). Research shows that there is a patchwork of healthcare access across Germany (Bozorgmehr & Razum, 2020; Gottlieb & Schülle, 2020). This study aims to answer how access is shaped as a result of federalist legislation and varying degrees of political willingness in federal states, as some studies suggest that German asylum policy-making depends highly on political attitudes (Günther et al., 2019; Meyer et al., 2021).

After a comprehensive literature review covering theoretical considerations of healthcare access and barriers, an analysis of the legislative framework and two case studies is conducted. The case study analysis explores the different processes of implementing national law, focusing on the introduction of the e-health card in two federal states, as well as the reasons for and against it, taking into account the local political debates, key actors and structural differences. The states chosen as case studies are Bremen and Saxony: Bremen is a Western German city-state with a majority of progressive voters which was the first state to introduce the e-health card for AS in 2005 (Baeck, 2014), whereas Saxony is a more conservative, Eastern German territorial state. The Saxon state government rejected the e-health card in 2016, highlighting the stark contrast in migrants' healthcare access between both states (Wächter-Raquet, 2016-a). Therefore, the research questions (RQ) of this paper are: *What are the legal barriers for asylum seekers and undocumented migrants to access healthcare across Germany? How has access*

been shaped differently by political willingness (or a lack thereof) in the German federal states Saxony and Bremen?

While research on migrants' healthcare access and barriers in Europe is expanding (Lebano et al., 2020; Savas et al., 2024; Stevenson et al., 2024; Van Ginneken, 2024), there is only limited research available comparing access among singular groups such as AS and UM (Asgary & Segar, 2011), much less through the lens of legal barriers. There are some studies dedicated to understanding which factors shape migration policies in Germany (Günther et al., 2019; Meyer et al., 2021), but no research has focused on how political willingness as such affects healthcare access across federal states. Consequently, this study aims to close gaps in understanding how legal status, regional policy-making and political willingness converge and produce unequal healthcare access for AS and UM in Germany. It contributes to broader debates on health equity, human rights and the responsibilities of democracies toward non-citizens. Furthermore, in a time of right-wing politics regaining wide-spread momentum (Habersack & Werner, 2023), it is unclear how migrants' healthcare access will change in the future.

In the following some key terminologies are defined that will be referred to throughout this paper. The World Health Organization (WHO) defines a *migrant* as someone who changed their country of usual residence, which includes any person, regardless of legal status, length of stay or cause of migration that crossed international borders (WHO, 2022). Among the most vulnerable groups of migrants are AS and UM, as they face particularly high barriers to healthcare access[1] (International Organization for Migration, 2016). The term *asylum seeker* refers to such individuals who apply for protection before their application for asylum has been accepted by the government of their host country (Asgary & Segar, 2011). AS are "seeking international protection abroad but are not yet recognized as refugees" (Krämer & Fischer, 2018, p. 5). To clarify, *refugees* constitute a specific group of forced migrants that face conflict-induced displacement, according to the Geneva Convention (Krämer & Fischer, 2018, p. 5). In Germany, around several hundred thousand migrants apply for asylum each year (Statista, 2025). According to Van Ginneken (2014), *undocumented migrants* "include individuals who have entered a country without documentation, people whose residence status [...] has expired or become invalidated[2], those who have been unsuccessful in obtaining asylum, and those born to

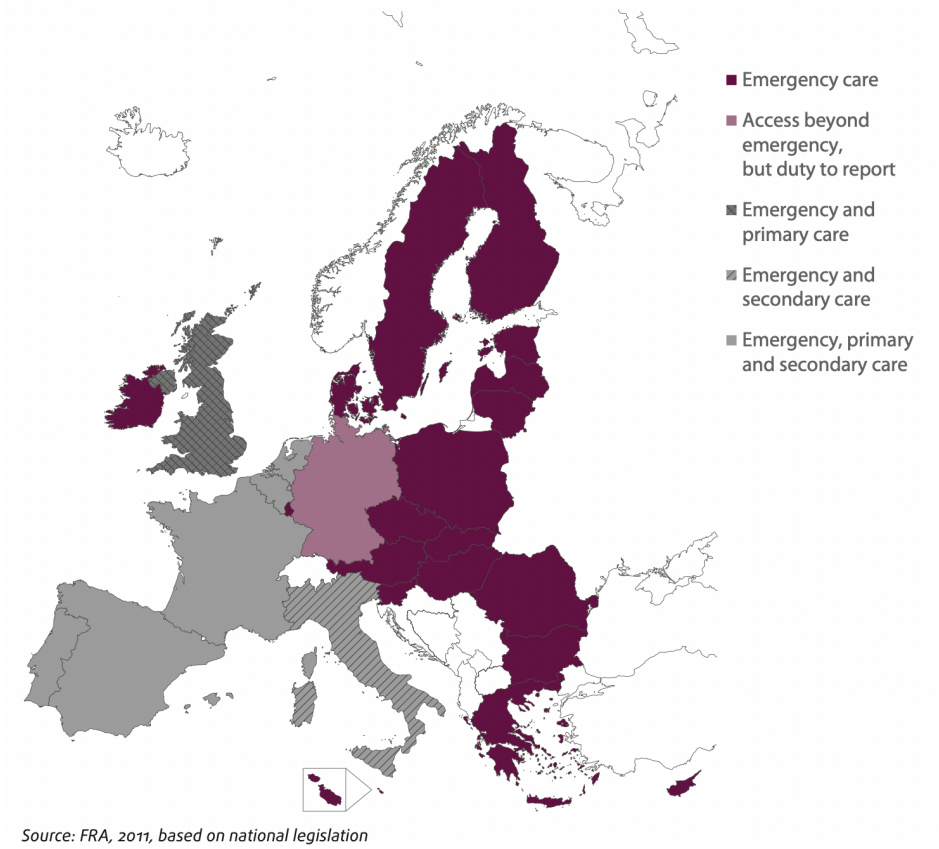
[1] Throughout the paper, the term *migrant* is sometimes used as an umbrella term referring to both AS and UM.

[2] This could include a visa, residence or work permit (Van Ginneken, 2024).

undocumented parents". UM are sometimes referred to as "illegal" or "irregular", however these terms have been widely criticized, among others by the United Nations (UN) and European Union (EU), as they can imply the person as criminal and deny their humanity (Stevenson et al., 2024). In 2014, it was estimated that there are between 180.000 and 520.000 UM living in Germany ("Krank und ohne Papiere", 2018). Political willingness or political will is defined by Post et al. (2010) as "the extent of committed support among key decision makers for a particular policy solution to a particular problem". More specifically, they argue that political will requires a sufficient set of decision makers; with a common understanding of a particular problem on the formal agenda; who are committed and incentivized to support a commonly perceived, potentially effective policy solution (Post et al., 2010). Political will is considered central to policy outcomes (Post et al., 2010).

Figure 1

Undocumented migrants' healthcare entitlements, EU27.



Note: from European Union Agency for Fundamental Rights, 2011, p. 75.

2. Literature review

The following literature touches upon 1) Universal Health Coverage (UHC) and the right to health, 2) theoretical understandings of healthcare access and barriers, 3) barriers faced particularly by AS and UM and 4) the German healthcare system.

2.1 Universal Health Coverage and Health as a Human Right

UHC is an important concept inside migrant health research. It is "based on the principle that all individuals and communities should have access to quality essential health services without suffering financial hardship, regardless of an individual's immigration status" (Stevenson et al., 2024). Including migrants in a health system is a "key to the moral imperative stipulated by the UN in the Sustainable Development Goals (SDGs) [...] and the drive towards UHC by 2030"[3] (Stevenson et al., 2024). The right to health is enshrined in Article 25 of the 1948 Universal Declaration of Human Rights, which states that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family" (United Nations). All EU Member states have signed various human rights agreements preserving health as a human right which should be universally available within a state's jurisdiction (Van Ginneken, 2024). Human rights, however, do not simply materialize, they require time, energy and empathy (Savas et al., 2024). Moreover, human rights imply all human beings, including AS and UM, as "right holders" and are thus not conditioned to any merit (Savas et al., 2024). The responsibility to enforce human rights lies with the state as a "duty bearer" and "guarantor of rights" (Savas et al., 2024). Yet, many states are unwilling to offer political recognition to e.g. stateless people, leaving individuals with no legal nationality or residence status little to no venue in which to make claims to their right to health (Savas et al., 2024).

2.2 Universal Barriers to Healthcare Access

In the last decades, literature on healthcare access has expanded. Healthcare access is an intrinsic principle to achieve UHC and can mean "enabling a patient in need to receive the right care, from the right provider, at the right time, in the right place, dependent on context" (Saurman, 2015). Healthcare access is a key factor for advancing population health outcomes

[3] UM' level of access to healthcare can be considered the "ultimate barometer for UHC" as they are often in the most precarious situations in society (Stevenson et al., 2024).

(Nguyen, 2023). Penchansky and Thomas introduced a theory of access in 1981, in which they explore several dimensions of access: availability, accessibility, acceptability, affordability and adequacy, which, together, measure the level of access (Saurman, 2015). Their model conceptualizes access based on the barriers to healthcare utilization (Nguyen, 2023). Availability depicts the relationship between the volume and type of existing services and the patients' volume and type of needs, thereby referring to the adequacy of the supply of health systems (Penchansky & Thomas, 1981). Accessibility describes the relationship between the location of supply and clients, considering transportation resources, distance, travel time and cost (Penchansky & Thomas, 1981). Acceptability expresses the relationship of patients' attitudes about personal and practice attributes of providers to the actual attributes of existing providers, and vice versa. Affordability illustrates the relationship of service prices to the clients' income, ability to pay and health insurance. Finally, accommodation or adequacy as referred to by Saurman, depicts the organization of a service that makes clients able to use it, such as by adequate opening hours, and appointment systems (Penchansky & Thomas, 1981; Saurman, 2015). Their model is, to this day, an important reference for public health researchers (Nguyen, 2023). Additionally to their theory, awareness and health literacy seem to be relevant factors in realizing UHC, as patients can be unaware of available services or policymakers of local contexts and needs (Saurman, 2015).

2.3 Barriers Most Pertinent to Undocumented Migrants and Asylum Seekers

Existing literature suggests that despite European aspirations to UHC, plenty of barriers to comprehensive healthcare access continue to persist among migrants[4] (Lebano et al., 2020; Savas et al., 2024; Stevenson et al., 2024; Van Ginneken, 2024). In 18 out of 29 countries UM are only entitled to emergency care services, while in 11 they are expected to pay for these services in spite of lower incomes[5] (Van Ginneken, 2024). It is argued that little progress has been made in the last 20 years, if anything, the current socio-political climate in Europe based on deterrent migration policies and meager support for migrant-sensitive care puts increased strains

[4] Some common health conditions among AS and UM include psychological issues, especially post-traumatic stress disorders, anxiety and depression but also physical health problems, such as infectious diseases, hypertension and diabetes (Asgary & Segar, 2011; Bozorgmehr & Razum, 2020; Stevenson et al., 2024).

[5] These countries include the 27 EU member states plus Norway and Switzerland (Van Ginneken, 2024).

on healthcare provision, undermining UHC (Savas et al., 2024; Stevenson et al., 2024). The Migrant Integration Policy Index (MIPEX) is a measure which monitors policies affecting migrant integration across countries (International Organization for Migration, 2016). Results of a report published in 2016 on the MIPEX show that migrants in Europe generally face poor legal entitlements and higher administrative barriers in comparison to nationals: while migrant workers score 71 on a scale to 100 (100 would mean absolute parity with nationals), AS score 60 and UM only 35 (International Organization for Migration, 2016). Lebano et al. (2020) describe UM' access to healthcare as "especially problematic".

There are several challenges that UM face when accessing healthcare. The first barrier relates to a lack of legal entitlements tied to a migrant's residence status: law and policy decide whether migrants are entitled to insurance coverage or subsidized services (Lebano et al., 2020; Van Ginneken, 2024). As a second set of challenges, research highlights implementation and practical access to services (Lebano et al., 2020; Van Ginneken, 2024). Oftentimes, both healthcare providers and UM are uninformed about their respective duties and rights, leading to an underutilization (Lebano et al., 2020) or unjustified refusals of care (Van Ginneken, 2024). This might be connected to complicated and fragmented rules and stigmatization, as migrants are often viewed as invalid members of society (Stevenson et al., 2024). Another key practical concern is the risk or fear of being identified by authorities and consequently being deported, which hinders people from utilizing healthcare (Stevenson et al., 2024; Van Ginneken, 2024). Further challenges to accessing healthcare that AS also experience include language, cultural and economic barriers (Lebano et al., 2020; Stevenson et al., 2024; Van Ginneken, 2024). Language barriers may cause miscommunication and difficulties in proper treatment, while cultural differences can affect the use of services (such as women's reluctance to see a male doctor) (Van Ginneken, 2024). Generally, policies can differ from reality (Van Ginneken, 2024) and tend to not be implemented as intended, because of inadequate funding, monitoring and training of health professionals (International Organization for Migration, 2016; Lebano et al., 2020; Stevenson et al., 2024). This is sometimes cited as the "implementation gap" (Stevenson et al., 2024).

2.4 German Healthcare System

Health insurance is compulsory in Germany and characterized by a dual insurance system (Blümel et al., 2024; WHO, 2022), thus all citizens and long-term residents are required to enroll either in statutory health insurance (SHI) or private health insurance (PHI) (Blümel et al., 2024). The SHI is financed via loan-based contributions that enter sickness funds where money is pooled and reallocated (Blümel et al., 2024), while unemployed people's contributions are covered by social welfare services (Kratzsch et al., 2022). SHI covers a broad range of benefits beside essential services (Blümel et al., 2024). Healthcare coverage in Germany is said to be universal (Kratzsch et al., 2022) with high service availability and density across the country, though with lower accessibility in rural areas (Blümel et al., 2024). Overall, Germany's per capita health expenditure is comparatively high (Blümel et al., 2024). About 89% of the population are covered by SHI, excluding the number of people without healthcare coverage which is estimated to include 61,000 individuals (Blümel et al., 2024). This estimation however omits irregular migrants and homeless people (Kratzsch et al., 2022). The health system is governed in a decentralized manner: while the Federal Ministry of Health sets the national legal framework, the 16 state governments are responsible for tasks such as public health services (Blümel et al., 2024). Moreover, part of the governmental power is delegated to corporatist entities, these being associations of providers and sickness funds, which play essential roles in decision-making processes (Blümel et al., 2024).

3. Methodology

This study employs mixed methods. A comparative case study (CCS) approach was chosen, in order to explore AS' and UM' healthcare access in Bremen and Saxony. It relies on a content analysis of national law, local policy documents and in-depth stakeholder interviews.

3.1 Literature Review and Policy Analysis

Firstly, a comprehensive literature review was conducted, for which relevant articles and reports were found by using the search engines Google Scholar and SmartCat provided through the University of Groningen. Some key search words included: *barriers to healthcare access, legal barriers, UHC, asylum seekers, undocumented migrants, Germany, right to health*.

Additional data sources were obtained through snowballing and experts' recommendations[6]. Articles were considered relevant if they contained data on the legislation shaping healthcare access for migrants in Germany and thereby answer RQ1. The literature review served as an important foundation for the conduct of the stakeholder interviews and the choice of policies for the legislative analysis. Hence, as policies of interest the ASBA (*Asylbewerberleistungsgesetz* - AsylbLG, 1993), the Residence Act (*Aufenthaltsgesetz* - AufenthG, 2004) and the APAA (*Asylverfahrensbeschleunigungsgesetz* - AsylVfBeschlG, 2015) were chosen, since these are the most frequently mentioned policies in studies on legal barriers to migrants' healthcare access (Gottlieb & Schülle, 2020; Noret, 2017; Schammann, 2015). The Residence Act is considered in the analysis but not examined in-depth, since this would exceed its scope. The analysis thus draws on primary data sources, these being national legislation, stakeholder interviews and local policy documents which were referred to during the interviews. The local policy documents consist of three written responses from key political actors in Saxony to motions submitted by parliamentary parties and an official policy document from the Bremen health authority.

The policies and case studies were analyzed and structured in line with the *policy triangle* (see Figure 2) developed by Walt & Gilson (1994). The policy triangle dissects policies into their context, content, process and actors. While it is highly simplified, it portrays the inter-relationships that need to be considered in a policy analysis: actors are embedded in a context (influenced e.g. by political stability and culture), the process of policy making (How do policies perform?) is shaped by actors' power positions and interests and the content usually reflects all factors (Buse et al., 2012, p. 9).

3.2 Stakeholder Interviews

Next, stakeholder interviews were conducted and formed an integral source of data collection for the analysis. The aim behind conducting interviews was to elicit specific information about the perspective and impact of non-governmental organizations (NGOs) on the migrant healthcare policy landscape. As local NGOs are highly involved in the provision of healthcare for migrant groups (Kratzsch et al., 2022), it seemed essential to research their viewpoint in order to comprehensively encapsulate the practical implications of the legal barriers faced by migrants. Talking to stakeholders can serve as a rich source of contextual data or data

[6] E.g., one interview participant sent a newspaper article prior to the interview.

on political interests (Buse et al., 2012, p. 204), which is highly relevant considering RQ2 that inquires how healthcare access is shaped by political willingness (or a lack thereof). Semi-structured interviews were chosen because they enable an interactive and comfortable setting for the participant: the non-rigid structure offers various conversation pathways and can facilitate unforeseen topics to emerge (Buse et al., 2012, p. 204). Per state, one staff member of a locally active NGO was interviewed online per Google Meet Video Call for 45-60 minutes. Only two interviews were conducted, as the goal was to ensure sufficient detail in the conversations, moreover response rates and time were limited.

The selection of NGOs was based on their type of involvement in supporting AS' and UM' health. Only NGOs that provided health services or legal advice to AS or UM and which were engaged in political lobbying were contacted. This was to ensure their expertise in at least two of the health, legal and political spheres. The first participant (P1) is an active volunteer and member of the Saxon Refugee Council (*Sächsischer Flüchtlingsrat*), which is a human rights organization founded in 1991 (Sächsischer Flüchtlingsrat, n.d.). The Council offers legal advice and advocates for migrants' rights in Saxony (Sächsischer Flüchtlingsrat, n.d.). During the search for suitable interview partners, a 2022 open letter to the Saxon state government demanding the state-wide introduction of an e-health card for AS came up which was co-signed by the Refugee Council ("Landesweite Gesundheitskarte…", 2022). This positions them as an active civil society actor and therefore a suitable participant. Furthemore, P1 engages in a local human rights initiative (*Medibüro/Medinetz*) that arranges free and anonymized access to healthcare for migrants with insufficient or no health insurance by connecting them with doctors working pro bono (Medibüro Chemnitz, n.d.). The second participant (P2) from Bremen is an executive staff member at Refugio Bremen, an organization from 1989 which supplies psychological and psychosocial support for migrants who have become victims of torture or PTSD by offering therapies and consultations (Refugio Bremen, n.d.). Due to psychological issues being unusually prevalent among migrants (Bozorgmehr & Razum, 2020; Stevenson et al., 2024) but psychological care not being one of the entitlements listed in the ASBA (AsylbLG, 1993), Refugio's experiences in filling crucial healthcare gaps was considered particularly insightful.

Both participants were asked around 20 questions about their NGOs' work, their perceptions of the direct and indirect effects of policies on AS‘ and UM‘ healthcare access and their observations of the largest barriers to healthcare access among AS and UM. Moreover, they

were asked to describe the political climate and policy changes in their respective state in recent years, and to share their perceptions of the state's process of implementing/rejecting the e-health card. Finally, they were asked to share demands and recommendations for people in decision-making positions[7]. The interviews were manually transcribed and conducted in German, thus needing to be translated to English. The Microsoft Word translation tool was used, after which the translation was manually checked for errors. Finally, the data was collected in an Excel spreadsheet. The interview results inspired further reviewing of literature, which is presented in connection with the findings in the discussion section. The interviews permitted a detailed understanding of both case studies, which constitute the latter part of the analysis.

3.3 Case Studies

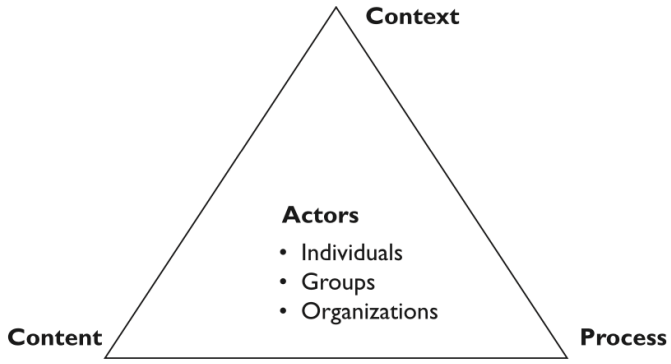
Case studies are a widely used research strategy. According to Yin (2009, p. 18), a case study is "an empirical inquiry that investigates a contemporary phenomenon in-depth and within its real-word context". This research takes the approach of a descriptive case study, i.e. it depicts what migrants' healthcare access looks like in Saxony and Bremen and considers the various factors shaping it. The case study approach was chosen as migrants' healthcare access in Germany varies strongly across the country (Bozorgmehr & Razum, 2020) and opting for a case study restricts the scope accordingly, thereby offering an accurate understanding of migrants' healthcare access. The CCS approach, according to Bartlett & Vavrus (2017), is a model comparing several contexts across multiple axes, e.g. through the horizontal look which contrasts one case with another but "also traces social actors, documents or other influences across these cases". This study's application of the CCS approach offers a nuanced understanding of the impact of contextual factors and visualizes the space for political (in)action within the legislation, therefore pairing well with the policy triangle. In the following section, the contextual information for the analysis is presented prior to the findings as this was retrieved from secondary data[8].

[7] See Appendix for Interview Guide.

[8] Each policies' content is presented under policy content (5.1.1 and 5.2.1) and each implementation process is presented under practical implications (5.1.2 and 5.2.2). For each case study, the relevant actors were identified and presented (5.3 and 5.4, see Table 2).

Figure 2

Policy analysis triangle



Note: by Walt & Gilson (1994)

4. Contextual background

4.1 Legal Framework

Once carrying one of the world's most liberal asylum systems, Germany has drastically revised migration policies since increased migration flows in the 1980s and 1990s in order to curb the intake of AS (Pross, 1998). Following international conflicts such as the Yugoslavian war, the number of people seeking asylum in Germany rose to 440,000 asylum applications in 1992, compared to 107,800 in 1980 (Bozorgmehr & Razum, 2020; Pross, 1998). Xenophobia in the German population grew, with racist pogroms targeting AS (Pross, 1998). In 1992, the government drafted an asylum compromise (*Asylkompromiss*) and enforced the ASBA in 1993, decided upon by the government coalition of the conservative Christian Democrats (CDU/CSU) and the Liberals (FDP) with the help of the Social Democrats (SPD) in opposition[9] (Classen, 2022, p. 20; Pross, 1998).

The obligation of social service departments to report UM is enshrined in §87 of the Residence Act which was formulated in 2004 and passed as part of the broader Immigration Act (*Zuwanderungsgesetz,* 2005)[10]. Yet, what constitutes §87 today was already formulated in §76 of

[9] The SPD's votes were necessary to achieve a two-thirds majority in order to remove the basic right to asylum from Article 16 of the Basic Law and introduce the ASBA (Classen, 2022, p. 20).

[10] The Immigration Act for the first time provided a legal framework that facilitated the control and effective limitation of immigration as a whole, as well as measures to integrate migrants into German society ("Zuwanderungs- und Aufenthaltsgesetz", 2007).

the Foreigners Act (*Ausländergesetz*, 1990), enacted by the same CDU and FDP government coalition in 1990 (Gesellschaft für Freiheitsrechte & Ärzte der Welt e.V., 2021). Their justification was that the residence without the necessary residence permit was a circumstance of such crucial relevance that in any case the immigration authorities must be made aware of this (Gesellschaft für Freiheitsrechte & Ärzte der Welt e.V., 2021).

In 2015 more than one million migrants entered Germany in the search for asylum (Wächter-Raquet, 2016-a). Especially after the eruption of the Syrian civil war in 2011, millions of Syrians were forced to flee their country and have since then formed the majority of AS in Germany ("Syrische Flüchtlinge…", 2025; Wächter-Raquet, 2016-a). This so-called "refugee crisis" perpetuated the need for better healthcare services for migrants (Bozorgmehr et al., 2016) and improved institutional performance (Günther et al., 2019). While the Green Party (*Bündnis 90/Die Grünen*) and Left Party called for a fundamental reform of the ASBA, the then federal government of CDU and SPD under Angela Merkel decided to enact the Asylum Package I (*Asylpaket I)* and as part of it, the APAA (Bozorgmehr & Razum, 2020; Classen, 2022, p. 26).

4.2 Saxony and Bremen

Saxony is located in former East-Germany and has around 4 million inhabitants[11] (Ismayr & Fleck, n.d.). Its state capital is Dresden and it has 421 municipalities (Ismayr & Fleck, n.d.). Since reunification in 1990, all Saxon state administrations have been led by the CDU, and since 2004 in collaboration with coalition partners, those being the Liberals, Social Democrats and the Green Party (Ismayr & Fleck, n.d.). More recently however, the far-right party Alternative for Germany (AfD) has gained momentum and popularity in all of Germany, but particularly in East Germany (Weisskircher, 2020). Already in the German Democratic Republic and during post-reunification times, the far-right youth scenes and other far-right parties have built a strong foundation for the AfD's successes, with Dresden being an epicentre of far-right protests (Weisskircher, 2020). In the 2024 Saxon state elections, the AfD almost surpassed the CDU as the strongest party in parliament and throughout Saxony, it won up to 30-40% of votes in most districts ("Wahlergebnisse", n.d.). Various research has pointed out that the East German population is more prone to holding anti-immigration attitudes than in the West (Meyer et al., 2021; Weisskircher, 2020) and that dissatisfaction with the political system is stronger in the

[11] In 2018, there were 23.759 AS in Saxony (Ismayr & Fleck, n.d.).

East, which may link to a lack of political representation, lower numbers of migrants in proportion to the population and an economic divergence between the West and East (Weisskircher, 2020).

Bremen is a city-state and the smallest federal state in the North-West of Germany with a population of 680.000 inhabitants, a third of which has a migratory background (Ketelhut, n.d.). A constant element of the political landscape in Bremen is the SPD that has formed every Senate since 1947 until today and has defended its position as the strongest party (Ketelhut, n.d.). Recently, the AfD has also gained power in Bremen, winning 15% of Bremen's votes in the 2025 nationwide elections[12] ("Bundestag election 2025", 2025). Nevertheless, a 2017 survey shows: when asked about their attitude towards migrants, respondents from Bremen and three other progressive states showed comparatively positive attitudes (Meyer et al., 2021). Another report by the Bertelsmann foundation confirms that in a countrywide comparison, social cohesion and acceptance of diversity is among the highest in Bremen (Arant et al., 2017).

5. Findings

The findings are structured in two parts: the first section explores the legal framework shaping healthcare access for AS and US across Germany and highlights the e-health card as a policy change in 2015. The second section analyzes how these policies were implemented in Saxony and Bremen and examines how this connects to varying political willingness. Table 1 summarizes the main findings.

Table 1:

Summarized findings.

1. The ASBA and Residence Act **restrict AS' and UM' healthcare access** in discriminatory ways, because they provide a slim legal basis for the provision of benefits, impose access barriers and require social service departments to report UM (P1; P2).
2. **Responsibilities** in implementing the ASBA and APAA, as well as the question of who bears the costs, **are fragmented and diffused,** leading to drastically different access patterns across the country (P1).
3. The **political composition and willingness** of the state government, councils and

[12] In the Bremen Senate however, the AfD currently holds no seats as it was not authorized to participate in the civic elections of 2023 ("Wahl in Bremen ist gültig…", 2024).

individual key actors strongly **shape the outcomes** of initiatives aimed at improving healthcare access for AS and UM (P1; P2). Even progressive political figures may lack political willingness (P1).

5.1 The Asylum Seekers' Benefits Act and Residence Act

5.1.1 Policy content

From the participants' perspectives, the most prominent legal barrier to healthcare access for AS is accredited to the ASBA (P1; P2). Its legal basis for entitlements is incomprehensive and insufficient, as only the most acute health issues are treated and other needs, such as psychological care are not covered (P1; P2). Briefly summarized, the ASBA covers who is entitled to benefits in §1, what the benefits entail in §3, the range of benefits for sickness, pregnancy and birth in §4, the provision of other services in §6 and who is responsible for implementing the regulations accordingly in §10 (AsylbLG, 1993). According to §4 of the ASBA, AS are entitled to basic healthcare services including:

- treatment for acute illness and painful conditions, and everything necessary for curing, improving or relieving the illnesses and their consequences, including dental care;
- antenatal and postnatal care;
- vaccinations;
- preventive medical tests and anonymous counselling and screening for infectious and sexually transmitted diseases (AsylbLG, 1993).

The granting of *other* services can be decided upon a case-by-case basis, depending on their necessity in ensuring survival and health (§6 AsylbLG, 1993). Benefits are preferably granted in the form of material rather than financial benefits (§§3, 6 AsylbLG, 1993). In case of non-emergency care, AS are dependent on receiving a healthcare voucher, which they receive from the municipal social services department (P1). The benefits listed in §4 and §6 are valid during the first 36 months of the asylum process, with this period having been increased continuously from 15, to 18 and recently to 36 months (P1; P2). The execution of the law, i.e. the provision of benefits and integration of AS, is delegated to the federal state governments who in turn decide which local authorities are responsible to enforce the law and pay for the emerging costs (§10 AsylbLG, 1993). Generally, the municipality that an AS is assigned to is responsible

to provide services (§10 AsylbLG, 1993).

UM are also implied under §1 of the ASBA, as those "obliged to leave the country, even if a deportation is not yet or no longer enforceable" and are thereby entitled to the same healthcare benefits as AS during this restricted period (AsylbLG, 1993). However, in practice UM face the risk of getting deported by social service departments when claiming their right to healthcare services due to §87 of the Residence Act (P1). §87 requires public bodies to "inform the competent foreigners authority without delay if, in connection with the fulfilment of their duties, they become aware of the residence of a foreigner who does not hold a required residence permit and whose deportation has not been suspended" (AufenthG, 2004).

5.1.2 Practical implications

The ASBA has been widely criticized, both domestically and internationally (P1). Firstly, its scope of entitlements is too slim and produces gaps in provision, making it incompatible with human rights standards (P1; P2). In practice, it legally excludes AS from full healthcare coverage and offers are less than the number of people who require them (P2). In Chemnitz for example, international practices did not treat children but regular pediatricians referred these children back to international practices, saying that they are not responsible, thus leaving AS' children in this context unattended (P1). UM need to make use of parallel services provided by non-government actors such as collectives of volunteer doctors which operate outside of the regular healthcare system, but increasingly AS, too, seek them out as the ASBA's legal basis is insufficiently equipping them with healthcare benefits (P1). Covering only basic medical services can trigger complications, for example in the psychotherapeutic field, where a lack of treatment can produce unnecessary costs and health consequences (P2). This positions NGOs as critical actors in the provision of healthcare services who take over governmental tasks (P1).

Secondly, the ASBA causes a national patchwork of health provision (P1). With §10 delegating tasks to the concerned municipalities, administrative practices may even differ within the same state (P1). The law requires civil servants working in local authorities to determine what services are deemed urgent, without any medical expertise (P1). The political orientation of the clerk could affect their willingness to grant the coverage of services, with AS sometimes required to go into "blatant dispute in order to receive the benefits they are entitled to" (P1).

Unclear regulations can cause uncertainties among practitioners and for migrants, it is a "gamble" what conditions they find depending on which municipality they are allocated to (P1). Thirdly, the ASBA foresees poor administrative or bureaucratic practices (P1; P2). This includes that opening hours of health authorities are often limited, e.g. on weekends and unless counteracted by a "flat-rate voucher", AS need to continuously request follow up vouchers for treatments which produces high bureaucratic effort and administrative costs (P1; P2). P1 contests that especially for someone requiring additional medical help due to injury or a disability these practices are unreasonable. Hence, the ASBA's legal regulations not only restrict healthcare access by separating AS from the regular health system - they also create high thresholds and time-consuming procedures when accessing services (P1; P2).

For UM, a paradoxical situation prevails: whenever they would want to request a healthcare voucher for the financial coverage of treatments, §87 of the Residence Act requires social service departments to report them to immigration authorities which strongly inhibits UM' use of services (P1). NGOs stand up for UM to receive at least the basic medical services enlisted in §4 of the ASBA, while simultaneously arguing that this legal basis is not sufficient in the first place (P1). According to P1 and P2, it is difficult to improve the structural situation of UM, because once they have gone into "hiding", it is almost impossible to regain a legal status of residence and UM inevitably enter a cycle of "no papers, poverty and the deterioration of health care".

5.2 Introduction of the Electronic Health Card

5.2.1 Policy content

The APAA foresaw several policy changes, including some amendments to the ASBA and the Residence Act, such as the abolishment of the announcement of deportations (§3 AsylVfBeschlG, 2015). Yet, most importantly for this study, a novel paragraph was added to §264 of the Social Code Book V (*Sozialgesetzbuch Fünftes Buch,* 1988) which offers an e-health card for the provision of healthcare services towards AS in line with §4 and §6 of the ASBA (§11 AsylVfBeschlG, 2015). For AS to receive the card, the state government or a state authority commissioned by it can oblige a SHI to come to an agreement, either at state-level with SHI state associations or at least at municipal level (§11 AsylVfBeschlG, 2015). This agreement is to be reached with the support of framework recommendations clearing up issues of cost settlement

and reimbursement for SHIs, which were developed at the federal level by umbrella organizations of SHIs and of the authorities providing healthcare services to AS (§11 AsylVfBeschlG, 2015).

5.2.2 Practical implications

E-health cards are handed out to AS upon registration and have been shown to reduce administrative effort, costs and access barriers, as AS no longer need to request a health voucher before each appointment and healthcare providers directly invoice health insurances who in turn settle the costs with municipalities (P1; P2). The e-health card clarifies the utilization of benefits because of a uniform scope of entitlements, which means that staff in the social service departments do not decide over AS' entitlements, thereby inhibiting discrimination and arbitrariness (P2). Finally, AS' can choose a doctor and are not restricted to specific international practices and additionally, they can exercise quick doctor visits, which increases accessibility, especially in rural areas (P1; P2).

Nevertheless, both interview participants acknowledged failures and problems that persisted. Firstly, the APAA did not enshrine the e-health card as a nationwide care concept but essentially left it up to states and municipalities whether to implement the e-health card or not (P2). Consequently, it was only introduced in a few municipalities and states in Germany but did not expand as expected (P1; P2). P1 found the lack of communication between federal states on their experiences of introducing the e-health card inexplicable, arguing that it would be helpful to exchange about how to best implement it. The second critique entails that the e-health card is only available to a limited target group, i.e. everyone who applies for asylum or who is temporarily "tolerated", therefore excluding UM (P1; P2). Thirdly, NGOs contend that the e-health card does not change the insufficient scope of the ASBA, thereby maintaining healthcare provision gaps (P1; P2). Nevertheless, it offers a significant procedural improvement for both AS and authorities, saving time and costs while reducing barriers to healthcare access (P1; P2).

5.3 Case study: Saxony

The Saxon political landscape has been strongly shaped by the steady CDU governments, with most council members and district administrators being CDU-adherent (P1). The Saxon

CDU is considered more conservative or right-wing than other regional CDU factions (P1). Still, the AfD seems to greatly shape public debates and political narratives in Saxony, particularly surrounding migration (P1). Based on P1's perception, the majority of Saxons holds a rather negative attitude towards migrants, only wanting skilled or "useful" migrants to immigrate. This is also observable in the Saxon coalition agreement of the new CDU/SPD administration, which foresees increased border police and expensive, new deportation centres, as well as budget cuts for essential integrative measures (P1). These budget cuts would mean an 80% reduction in funding in 2026 and no funding at all by 2027 (P1). This unchecked influence of the AfD and other right-wing nationalist parties on political decision-making has been underestimated for a long time and P1 partly blamed this on other parties and the media (P1). With the SPD being the smaller coalition partner, there might have prevailed a sentiment of hopelessness against conservative forces, next to a need for political survival which could have driven the progressive coalition partners to become more opportunistic (P1). To P1 it seemed as if their attachment to human rights values might have decreased and that they became "as variable as the wind", trying to ensure voter loyalty and popularity. Despite the SPD remaining the more favourable contact partner and ally for NGOs in comparison to the CDU, P1 asserted that they, too, lack political motivation. Overall, P1 highlighted that the party constellation of the district and city councils highly influences political outcomes, as in larger left-leaning cities, such as Leipzig, progressive initiatives working towards improved healthcare access for migrants receive more political support (P1).

In Saxony, the relevant political actors consist of the Ministry of Social Affairs with Petra Köpping as the current SPD Minister, the SHI state associations, the Saxon County Council and Saxon Cities & Municipalities Assembly as superordinate organizational levels of municipalities, next to NGOs and volunteering organizations representing migrants' interests (P1). Overall, P1 stated that there is a strong political orientation towards municipalities with them holding great power, whereas other political actors such as Petra Köpping, despite her authoritative function, take on passive roles. Actors tend to point at each other in terms of who is responsible to advance the issue and to bear additional costs which leads to inaction and a diffusion of responsibility (P1). P1 recounted lobbying talks their NGO held with Petra Köpping or with a representative for health and migration at the Saxon City Council, during which P1's perception was that both were superficially informed about the issues that NGOs witness. Various NGOs work towards

improving healthcare access for migrant groups and continuously urge political decision-makers via lobby talks and open letters, together with oppositional parties, to implement the e-health card in Saxony too (P1). However, a structural issue they encounter is that their work is project-financed, meaning that governmental funding is provided only for specific tasks during limited financing periods which puts them under financial pressure (P1). P1 stated that "the work with refugees [...] is always considered a project, so you are just supported for certain things from 01.01. to 31.12 as if [the need] were over then". According to Saxony's funding structure, integrative measures are generally considered voluntary tasks: while other budgets are non-negotiable, integrative expenditures can be cut regularly (P1). During the interview, P1 also shared their doubts on whether their NGO could significantly affect policy-making, as only few lobbying efforts are successful, such as the clearing and anonymous healthcare vouchers centre CABL e.V. in Leipzig[13]. However, these initiatives remain highly precarious with little budget and thus, are highly dependent on political budget decisions (P1). Moreover, P1 stated that they cannot change the structural problems of the ASBA but serve more as imminent fixes (P1).

In Saxony, every leeway that the ASBA provides, the administrative authorities generally interpret in the most restrictive ways, meaning that benefits are reduced to a minimum and AS have to fight for the recognition and treatment of their health issues (P1). The APAA of 2015 did little to improve healthcare access for AS and UM in Saxony, as all efforts to introduce the e-health card for AS were shut down (P1). Only in Dresden was the e-health card introduced in 2020 but other municipalities did not follow suit (P1). P1 mentioned that the back-then CDU Minister of Social Affairs Barbara Klepsch and today's Minister Köpping both received several requests from the Green and Left Party that have called for the state-wide introduction of the e-health card (Klepsch, 2015-a; Klepsch, 2015-b; Köpping, 2020). In the following, their responses to these requests will be expounded.

In their responses, both politicians listed several arguments against the implementation of the e-health card, one being that improved access to healthcare would increase per capita healthcare expenditures (P1). Klepsch contended that integrating AS into the SHI financing pool would cause a burden on the general population paying into that fund (Klepsch, 2015-a). Furthermore, Köpping argued that the patchwork situation in other states would show that

[13] CABL e.V. integrate UM into the regular health system by issuing similar healthcare vouchers for UM as the social service department does for AS, but which are anonymous and thus, UM can go to the doctor without fear (P1).

framework agreements are predestined to fail (Köpping, 2020). Köpping also voiced that the state is only responsible for the initial reception of refugees for which it has created reception centres where medical care is ensured, whereas the municipality is the bearer of responsibility for integrating AS and thus the decision remains up to them (Köpping, 2020). P1 countered that the conditions in these often isolated centres or camps are detrimental with only preliminary medical teams on site that generously prescribe painkillers and sleep medication and no possibility for AS to access proper treatment or specialists. Moreover, P1 asserted that since the legal changes of the APAA, the final decision to implement the e-health card did not necessarily lie with municipalities but with a state authority such as Köpping's Ministry that can make agreements at the state level with health insurances and offer to cover costs. Another widely used argument was that the e-health card would create incentives and pull-factors among migrants, thus leading to an overutilization of benefits (P1). Additionally, Köpping expressed that AS receive the e-health card anyway after the period of entitlement restrictions is over (Köpping, 2020), even though this waiting period has been regularly increased in recent years (P1). Klepsch and Köpping both stated that current medical practices, such as the international practices in the three largest cities, provide sufficient, high-quality healthcare (Klepsch, 2015-a; Köpping, 2020). Overall, P1's perception was that the state authorities have no interest in providing a comfortable environment to migrants and show strong political motivation to pursue "isolationist policies". Due to the gradual political shift to the right, P1 reported that the potential improvements (e.g. e-health card) discussed in 2020 now feel far away from possible, with the debate steered towards restrictive rather than permissive policies.

5.4 Case study: Bremen

Based on P2's perception, the continuous electoral successes of progressive parties in the Bremen Senate reflect the voting-patterns of a politicized majority in the population that is supportive of pro-migrant policies and human rights. While there are naturally districts that vote differently, overall, there seems to be high acceptance of pro-migrant projects (P2). P2 also referred to the cost effectiveness of most projects, which might resonate within the broader population as Bremen is also known to experience financial precarity. Bremen's progressive Senate constellations, that involved the Left party in government, have provided opportunities to

push forward solutions such as the e-health card or a humanitarian consultation hour for UM[14] which were not possible in other states (P1; P2). Simply put, a political majority was in favor of these initiatives and was met with little criticism, as it was clear that they would ultimately pay off (P2).

Still, throughout the initial period of introducing the e-health card, there were skeptical voices from the CDU that warned against a loss of control (P2). They, too, referred to the creation of pull-factors for migrants as they argued implementing the e-health card would lead to the exploitation of opportunities (P2). Nevertheless, Bremen was able to become a pioneer within Germany with a permissive approach to migration health policies in what has been named the Bremen model (P1, P2). Recognizing the implications of the legal limitations of the ASBA, the 1983-2008 Head of the Main Health Authority in Bremen, Heinz-Jochen Zenker, co-developed the Bremen model (P2). Following discussions between politicians, doctors and the health authority, the Bremen model was implemented in 1993 with the aim to provide more comprehensive and equal healthcare access to AS and UM (Gesundheitsamt Bremen, 2011, p. 20). Carried out by the Bremen health authority, a key strategy included fostering connection and collaboration between the Senate and important stakeholders, such as organizations providing healthcare services, which enabled co-led projects (Gesundheitsamt Bremen, 2011, pp. 20-21; P2). Moreover, the Bremen model prioritized the provision of low-barrier, basic healthcare , sufficient living conditions in the AS reception centres and referred patients with chronic or complex diseases into the general health system, paving the way for an integrated approach (Gesundheitsamt Bremen, 2011, pp. 20-21). All medical data collected throughout the programme was scientifically processed in order to form a basis for future policies, which was unique in Germany at that time (Gesundheitsamt Bremen, 2011, p. 20). Bremen also became the first state in Germany to introduce the e-health card in 2005 (P2). This happened in collaboration with the local SHI, which is reimbursed for the emerging costs by the State of Bremen (Gesundheitsamt Bremen, 2011, p. 41). The high utilization of medical services in reception facilities indicated a wide acceptance of medical care among AS (Gesundheitsamt Bremen, 2011, p. 41).

[14] The MVP Bremen (Association for the Promotion of Medical and Health Care for Uninsured and Paperless People in Bremen) is a partly state-financed initiative that offers a humanitarian consultation hour similar to anonymized treatment certificates where health services for people without papers are compensated financially (P2).

But how was this success possible in Bremen? P2 pointed to Zenker as a key figure in the health department, stating that policy successes depend on the willingness and convincingness of individual politicians. Other relevant actors during the implementation period of the e-health card consist of the local health insurance AOK and civil society organizations (P2). NGOs and healthcare providers such as the Bremen Refugee Council, Medinetz Bremen and Refugio Bremen have collaborated and organized public events or lobby talks with politicians to raise awareness on the issue and continue taking on substantive roles in healthcare provision (P2). Next to this, P2 also emphasized the argument of lower costs as an important advantage of the e-health card due to Bremen's financial struggles. Still, P2 shared that beside the cost efficiency aspect, there was also a human rights debate on equality, participation and the right to health. Finally, one needs to consider structural factors such as Saxony being a territorial state while Bremen is a small city-state which, according to P2, make a large difference in healthcare provision. Overall, to P2 it seems to have been a mixture of politically willed individual actors combined with beneficial circumstances of a progressive Senate which opened up unique possibilities in Bremen.

Disappointingly, the Bremen model stayed a flagship project and was not widely imitated on a national scale (P2). This was accredited to the political stance in other states: while health insurances showed interest in replicating the e-health card in other states, the health needs of migrants were simply deprioritized in political agendas (P2). There are political voices in Bremen expressing that the only reasonable solution is to reform or abolish the ASBA, but Bremen does not have a political majority to push this agenda forward at the federal level (P2). The initiatives filling healthcare gaps in Bremen encounter similar financing issues as those in Saxony: they, too, struggle to collect sufficient subsidies and rely on funding from various sources (P2). Financing commitments are usually limited to a few years, which puts a burden on staff members (P2). When asked if there was a possibility of undoing the progress made in Bremen, P2 responded that unless the political climate in Bremen or Germany changes drastically, there is no acute risk of reversing achievements including the e-health card which exist on an institutional level, because this would produce only more costs. Still, P2 could not rule out the risk of migrants' healthcare access deteriorating in Bremen and emphasized that currently, there is little to no chance of a nationwide uniform care concept due to a general political attitude of demarcation and inequality. Here, P2 referred to the new German coalition

agreement of 2025 that foresees an intensification of restrictive migration policies. In summary, Table 2 compares the findings from both case studies.

Table 2:

Comparative table depicting the case studies' findings.

	State of Saxony	**State of Bremen**
Context	Territorial and conservative state, strong influence of CDU and AfD on decision-making and narratives, optional/limited funding for integrative work due to budget cuts and no steady funding	City-state, majority of progressive voters, partly state-financed care work for migrants but NGOs also struggle financially, good collaboration between actors
Actors: Who was primarily involved in the implementation/ rejection of the health card?	Ministry of Social Affairs and Ministers Barbara Klepsch and Petra Köpping, state associations of health insurance, municipalities (represented through the Saxon County Council and Saxon Cities & Municipalities Assembly), NGOs, volunteering organizations and healthcare providers	Bremen Senate, Former Head of the Health Department Heinz-Jochen Zenker, Local Health Insurance (AOK), NGOs, volunteering organizations and healthcare providers
Process: How is healthcare access today?	Restrictive interpretation of benefits listed in the ASBA, still no state-wide e-health card, only Dresden implemented e-health card in 2020, insufficient conditions in reception facilities, NGOs try to fill provision gaps	Since 2005 AS receive e-health card, benefits provided according to ASBA but initiatives offer more comprehensive healthcare, health card only for limited target group (not including UM)
Process: What arguments were listed for/against the implementation of the health card?	**For:** E-health card would inhibit patchwork of healthcare access, reduce administrative and healthcare costs, etc. **Against:** Healthcare expenditure would increase and put a financial burden on SHI, municipalities would not want to join state-wide agreement and final decision is up to them, card creates pull-factors and overutilization of services, current infrastructure is	**For:** E-health card would decrease administrative costs, humanitarian motivations **Against:** Loss of control, creates pull-factors

	deemed sufficient	
Process: What factors contributed to the implementation/ rejection?	Diffusion of responsibility, opportunism and little political willingness of progressive parties, conservative party constellation in councils, NGOs lobbying efforts have produced small successes but overall limited influence	Key figures in health sector and decision-making positions were politically willed to introduce the health card, progressive state government, NGOs engaged in lobbying

6. Discussion

This study explored the legal barriers to healthcare access for AS and UM in Germany with the aim to understand how they shape access in theory and practice. The analysis of two case studies permitted deeper insights into how national laws were implemented and adapted to in accordance with local political structures, therefore contributing to a better understanding of AS' and UM' healthcare access patterns in Germany. In this discussion section, three core arguments will be put forward that are based on this study's results and supported by existing literature: firstly, the decentralized structures inside the ASBA and APAA produce a diffusion of responsibility among stakeholders, causing a patchwork of healthcare access for migrants in Germany. Secondly, the political constellation and willingness of decision-makers significantly affect migrant health policy, with conservative forces aiming to deter migrants by restricting access. Yet, within progressive parties one can also observe a lack of political motivation. Finally, it is argued that the presented legal framework is fundamentally based on the strong political motivation to impose discriminatory restrictions on migrants' healthcare access. This motivation can be led back to narratives of exclusionist nativism which do not align with UHC aspirations and the basic, universal right to health.

6.1 Federalism in Legal Frameworks

As is the case for other policy domains (e.g. education) in Germany, federalism leads to political and administrative responsibilities being delegated to federal states which in the case of migrants' health has led to a patchwork of healthcare access among and within states (P1; Bozorgmehr & Razum, 2020; Reiter & Töller, 2019). As shown in the analysis, §10 of the ASBA

delegates the provision of healthcare services for migrants from national to federal and finally the municipal level (AsylbLG, 1993). This generates relative autonomy in the implementation of the law, with individual workers issuing health vouchers differently under the same conditions due to more or less restrictive interpretations (Gottlieb & Schülle, 2020; Noret, 2017). And because AS are assigned their host communities randomly[15], "chance decides over access to care" (Bozorgmehr & Razum, 2020; Gottlieb & Schülle, 2020). This study suggests that a grave diffusion of responsibility among the multiple actors involved in the accommodation of migrants prevails, as tasks and costs are split up in a complex web between the state, federal states and municipalities (Bozorgmehr & Razum, 2020; P1). The APAA was a first attempt to standardize healthcare access, however leaving the decision of implementing the e-health card (and to which extent) as well as who takes over these costs up to each state only perpetuated the patchwork of access for AS, thus confirming experts' worries in 2015 (Wächter-Raquet, 2016-a).

Specifically, the APAA foresees that municipalities are responsible for financing unless the state offers to reimburse costs, which makes municipalities technically free to decide whether they join the federal contract (Wächter-Raquet, 2016-a). It seems that municipalities do not want to bear all costs and hesitate to agree to the e-health card (P1), e.g. in North-Rhine Westphalia only 25 of the 396 municipalities joined a state-wide agreement with SHIs, mainly due to cost disputes (Gesundheit für Geflüchtete, n.d.). Günther et al. (2019) found that if emerging healthcare costs are reimbursed to the municipality by the federal state, this seems to increase the likelihood of municipalities joining such an agreement (Günther et al., 2019). Thus, we can observe an under-utilization of the e-health card if state governments do not arrange state-wide agreements with local SHIs.

In a 2016 published report, the Bertelsmann foundation collected evidence on the states that decided to implement the e-health card (Wächter-Raquet, 2016-a). In only six German states have state governments made state-wide agreements with SHIs on the issuing of an e-health card (Noret, 2017). In three states individual municipalities implemented the e-health card, while the remaining seven states negotiated or immediately rejected the e-health card as a viable option, thereby perpetuating the patchwork of healthcare access (Gesundheit für Geflüchtete, n.d.). Consequently, in 2021, only 24% of AS lived in a region where the e-health card had been

[15] Specifically, after accommodation in asylum reception centres, AS are re-assigned to one of Germany's 16 states in line with the 'Königsstein Quota System' which aims to provide a fair distribution of AS among states according to socio-demographic and economic measurements (Gottlieb & Schülle, 2020).

introduced (Biddle, 2024). Figure 2 provides an overview showing the progress of implementing the e-health card in Germany.

Figure 2

Degrees of implementation of the e-health card in Germany, 2024.

Note: Made by author based on http://gesundheit-gefluechtete.info/gesundheitskarte/.

This policy change, albeit a procedural and financial improvement compared to the health vouchers (P1; P2), showcases how a "fragmented and decentralized governance system (for both health and immigration) translate[s] into a heterogeneous and ambiguous policy landscape" (Bozorgmehr & Razum, 2020). Federal legislators at the time of implementing the APAA possibly overestimated the regional policy-makers' willingness to take initiative in introducing the e-health card and underestimated the political inaction that would unfold. Besides, these policy-making processes also link to power: the case of Saxony highlights how decision-making power is carefully distributed in a sensitive ecosystem of stakeholders, with a Minister not willing to impose executive orders on municipalities. This points to a "strong local level

government authority" which can only be countered by assertive central health governance (Gottlieb & Schülle, 2020).

6.2 Political Willingness and Policy-Making

The vast differences in healthcare access produced by the federal design of the ASBA and APAA are further perpetuated by disparities in political willingness (Bozorgmehr & Razum, 2020; P1; P2; Schammann, 2015). In Bremen, where progressive parties have been in power for decades, healthcare access for both AS and UM is decisively better than in Saxony (P1; P2). Naturally, there are other factors at play, such as Saxony being much larger in size and population or a possibly more complex variety of stakeholders due to the sheer number of municipalities in Saxony. Nonetheless, the political debates in both states reflect different approaches towards accommodating AS and UM which probably did not diverge by chance. Research confirms this: A few studies have tried to explain this variance in policy-making by exploring the relationship between migrant health policies and party-political orientation in the German context (Günther et al., 2019; Meyer et al., 2021). In a quantitative study conducted by Günther et al. (2019), the correlation between the introduction of an e-health card for AS and factors including the party-political orientation, the percentage of foreigners and the socio-economic situation in a federal state was examined. Their findings show that a left-oriented state government is a requirement for the implementation of the e-health card[16], while other factors such as unemployment or the West-East differentiation did not significantly affect the decision. Contrary to the researchers' hypothesis, higher debt in a state led to more willingness to implement the card (Günther et al., 2019), which might connect to the financial savings associated with the e-health card (Bozorgmehr & Razum, 2020).

This analysis shows that some political parties, certainly the AfD but to some extent also the CDU, display the intention to deter migrants and inhibit the implementation of policies working towards improving their healthcare access (P1; P2). The advantages of the e-health card were nationally not widely recognized or ignored (P1), as granting migrants additional health benefits in a time of increasingly influential right-wing narratives might have been perceived as

[16] A similar study conducted by Meyer et al. (2021) consolidates these findings: socio-demographic and economic circumstances or the attitude of populations towards migrants do not seem to significantly influence policy-making, whereas a progressive and non-authoritarian governing party in the state government seems to be a prerequisite for permissive migration policies.

too permissive of an approach. Some literature suggests that center-right and even left-wing parties increasingly imitate far-right policy profiles (Habersack & Werner, 2022). With right-wing parties entering mainstream electoral territory, other parties aim to reconquer voters' support by engaging with nativist ideologies and adopting similar positions on immigration (Habersack & Werner, 2022). Similar patterns could be observed in Saxony where progressive parties seem to opportunistically surrender their political convictions and support restrictive policies (P1). Thus, in some contexts progressive parties which are otherwise considered allies in the fight for migrants' rights, may resort to more passive stances and not exhibit the political willingness that is expected or required from them (P1), especially in a decentralized policy landscape. In Saxony, key political figures downplayed the clear healthcare provision gaps and authoritative capabilities of the Ministry to order a state-wide introduction of the e-health card (Klepsch, 2015-a; Köpping, 2020). Moreover, it was argued that the introduction of the e-health card would increase costs and create pull factors, whereas research does not support these claims. An internal evaluation from Hamburg, which introduced the e-health card in 2012, shows that costs of over €1 million a year were saved[17] (Bozorgmehr & Razum, 2020). If anything, data analyses demonstrate that *restricting* AS' entitlements to healthcare results in higher healthcare expenditures compared to when granted full access to services[18] (Bozorgmehr & Razum, 2020; Wächter-Raquet, 2016-b). Furthermore, there is no evidence suggesting that the provision of an e-health card creates pull factors (Wächter-Raquet, 2016-b). Lastly, providing healthcare access to migrants was portrayed as a financial burden on the publicly insured which prompts a critical question relating back to the right to health: are state and society not responsible to ensure medical care for the entire population, particularly its most vulnerable?

6. 3 Exclusionist Legislation and Future Outlook

The results indicate that migrants' right to health is clearly violated in Germany, due to restrictive national legal legislation, consisting of the ASBA (AsylbLG, 1993) and the Residence Act (AufenthG, 2004). While other barriers that are picked up in theoretical frameworks of healthcare access, such as language, information and economic barriers, definitely persist, the

[17] Moreover, in Bremen, expenditure on AS is on average lower than for German citizens enrolled in a SHI (Wächter-Raquet, 2016-a).

[18] This is because delayed and emergency care is usually more expensive than primary care (Bozorgmehr & Razum, 2020; Krämer & Fischer, 2018, p. 29).

legal framework was mentioned as the largest hindrance to more equitable healthcare access in Germany (P1; P2). Relating this back to the theory of access by Penchansky & Thomas (1981), AS and UM experience higher barriers than German citizens likely do across all dimensions of healthcare access. This is visible in an inadequate supply of services, a low accessibility anywhere where no particular international practices exist, stigmatization towards migrants, lack of affordability due to UM' limited capacities to receive financial reimbursement and impractical or complex procedures enshrined in the ASBA, which require AS to request healthcare vouchers (P1; P2; PICUM, 2024). Several civil society organizations and academics have sharply criticized the ASBA and the Residence Act for their insufficient entitlements and administrative barriers, because they disadvantage AS and force UM to avoid official encounters with healthcare providers, risking the exacerbation of health issues[19] (Bozorgmehr & Razum, 2020; Gesellschaft für Freiheitsrechte & Ärzte der Welt e.V., 2021; Schammann, 2015). Even the United Nations High Commissioner for Refugees voiced that the ASBA infringes upon constitutional rights and the SDGs' aim of UHC by 2030 (Schammann, 2015; Stevenson et al., 2024). In fact, in 2012 the German Federal Constitutional Court ruled that the financial benefits under the ASBA are incompatible with the fundamental right to a minimum subsistence level (Schammann, 2015), arguing that the basic right to a minimum existence level is equally applicable for everyone residing in Germany, no matter their citizenship[20] (Classen, 2022, p. 23).

Up until 1993, AS were included in the general SHI system, but the ASBA de-facto excluded AS into a parallel healthcare system not financed by the general citizens' healthcare financing pool (Bozorgmehr & Razum, 2020; Gottlieb & Schülle, 2020; Schammann, 2015). When placing the ASBA, Residence Act and APAA within their respective contexts, it becomes clear that all policies were formulated as a reaction to sharp increases in the number of immigrants entering Germany. This emphasizes the tendency of policy-makers to formulate policies in line with securitized narratives instead of considering potential long-term benefits of integrating migrants into the society as well as an underlying political motive to impose

[19] The campaign "Gleichbehandeln" (equal treatment) demands that the health sector be exempted from the obligation to report undocumented migrants to immigration authorities enshrined in §87 of the Residence Act (AufenthG, 2004; Gleichbehandeln, n.d.).

[20] The Federal Constitutional Court emphasized that the legislator must provide empirical evidence of the alleged group-specific lower needs of AS if it stipulates a lower benefit level in the ASBA. In the meantime, the Federal Government has been obliged to provide the same standard rates under the ASBA as under the Social Code Book II/XII for Germans welfare recipients (Classen, 2022, p. 13).

structural barriers in healthcare access in order to deter migrants (P1). Schammann (2015) contends that the ASBA's creation was strategically formulated in order to curb migration: it bore high symbolic relevance, however with an unclear practical purpose. There is no evidence suggesting that the ASBA has successfully steered away AS (Classen, 2022, p. 21).

The very inception of the ASBA was based on citizenship being the key condition for accessing comprehensive healthcare, which P1 described as a racist system that opens up classifications of people with attributed sets of rights. These classifications into in- and out-groups or "useful" and "exploitative" migrants are commonly seen in right-wing narratives (Blum, 2024). More specifically, this connects to welfare selectivity or chauvinism, a term describing "(un)deservingness constructions along the lines of native vs. non-native populations" (Blum, 2024). Migrants' bodies are thus sites of contestation, politics and of administrative categories (Madbouly, 2025) which can manifest e.g. in the material exclusion from access to state benefits. Boswell identified this preferential treatment towards national citizens as a governmental strategy of "[mobilizing] popular support through demonstrating their willingness and ability to exclude outsiders from access to finite socioeconomic resources" (Boswell 2007, p. 90).

By situating the German migrant health policy-framework within this discussion, this study aims to shift the discursive focus towards the underlying political motives undermining equity in healthcare access and inhibiting UHC, which all EU member states agreed to when signing the SDGs (Stevenson et al., 2024). Looking into the future, it seems that political support for permissive migrant policies is shrinking, both in Germany and Europe (PRO ASYL, 2023). The Common European Asylum System (CEAS) reform passed in 2024 has been highly criticized by scholars and human rights activists for promoting violent practices at European borders and thus, is classified as a huge setback for European asylum law[21] (Niebauer & Urbitsch, 2024; PROASYL, 2023). Therefore, research should continue monitoring the legislative reforms shaping migrants' health as well as critically explore how the developing political landscapes in Germany shape policy-making. Rather than volunteers and NGO employees working tirelessly to fill migrants' serious gaps in healthcare access, the federal and

[21] The pact is likely to increase the number of AS and children in detention camps and substandard border asylum procedures (Amnesty International, 2023). Moreover, in times of increased arrivals (termed as *crisis)*, states would be allowed to opt out of asylum regulations, generating worry amongst critics that this would lead to breaches in refugee and international human rights law (Amnesty International, 2023).

state governments should be held accountable to take on these tasks. Some key recommendations based on the stakeholder interviews can be found in Table 3.

Table 3:

Key recommendations based on stakeholder interviews.

1. **Reform** or **abolish the Asylum Seekers Benefits Act** by increasing the scope of healthcare entitlements, in order to alleviate current non-state healthcare providers.
2. **Abolish the obligation** of social service departments **to report UM** (§87 AufenthG, 2004).
3. **Introduce the e-health card** for AS (and ideally UM) uniformly **in all federal states**, from day one. A prerequisite for this would be to reform the Social Code Book V as the APAA did, but to further assign clear financial relationships between state, SHIs and municipalities, in order to alleviate and encourage municipalities to adopt the e-health card.
4. **Establish adequate medical infrastructure and access to information** for AS and UM, especially in rural areas.
5. **Provide stable financing commitments for NGOs** and other healthcare providers critical for AS and UM's healthcare provision.
6. **Abolish or drastically improve reception camps**, as the currently described conditions are inhumane.
7. **Offer solutions for UM to escape illegality** under the Residence Act.
8. Support the intercultural opening up of the health system, i.e. higher prevalence of language mediation in order to **avoid language barriers**.

6.4 Limitations

This study shows several limitations: firstly, the case studies' results are not generalizable to other regional or national contexts, as there might be case-specific circumstances leading to different policy outcomes. Further research could e.g. study the federal states who partially introduced the e-health card in order to understand the nuanced barriers in implementation and inform future policy decisions. The findings could possibly be more applicable if the scope were limited to individual municipalities, however this was not considered because of limited data. Due to time and resource constraints, only two interviews were conducted and consequently, particularly the case study results are closely tied to the participants' perspectives and could be expanded on in the future. Moreover, this study is based on publicly available documents, secondary data and stakeholder interviews, which does not include direct voices of affected AS and UM.

7. Conclusion

This study has shown that although healthcare access is a universal human right, for AS and UM in Germany it remains highly restricted. The ASBA allocates insufficient healthcare benefits to AS, produces uneven patterns of healthcare access and imposes avoidable bureaucratic barriers and administrative costs. §87 of the Residence Act de-facto denies UM the right to health. The APAA displayed an attempt to improve and standardize healthcare access for AS through the possible state-wide introduction of an e-health card. However, as German health policy is decentralized with most decisions delegated to federal states and municipalities, so too was the decision to implement the e-health card which only added to the already apparent diffusion of responsibility and the patchwork of access. The results also suggest that whether progressive health policies are implemented in a local context seems to correlate strongly with political willingness and orientation, next to structural factors. The case studies showed that Bremen, a progressive state, has made vast progress in improving migrants' healthcare access, whereas Saxony, a conservative state, has shown little interest to better accommodate migrants' health needs. In Saxony, strong conservative forces and unwilling progressive political actors have impeded the introduction of the e-health card, which despite its faults including the continuous exclusion of UM, still offers an improvement to the practices enlisted in the ASBA. In both contexts, NGOs pick up governmental tasks and cover essential provision gaps, although this study emphasizes that the right to health should be enforced by state actors. The analyzed policies seem to underlie a political motivation to disincentivize migrants from entering Germany by instrumentalizing barriers to healthcare access. As stated by the interview participants, the health needs of migrants are a highly stigmatized and deprioritized topic, yet seeking asylum or being paperless usually has justifiable reasons and integration measures are an integral task that the state and politicians should accept as such, as migration is and will always remain a self-evident part of society. We are still far from sufficiently responding to the "diverse cultural reality of contemporary European societies" (Savas et al., 2024). But as the German Federal Constitutional Court stated in its 2012 ruling on the ASBA, "human dignity cannot be relativised in terms of migration policy" (Classen, 2022, p. 13).

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9. Appendix

9.1 Interview Guide

Introductory Section

Thank you for taking the time to participate in this interview. This interview is part of my bachelor thesis, in which I compare the healthcare policies for asylum seekers and undocumented migrants in Bremen and Saxony. If at any point you feel uncomfortable or do not wish to answer a question, please let me know.

1. Do you consent to this interview being audio-recorded and anonymized in my research?

Background & Role of the Organization

2. Can you briefly introduce yourself and your role in your organization?
3. What kind of healthcare services or support does your organization provide to asylum seekers and undocumented migrants?
4. What are the main challenges in terms of *health and healthcare* that you see in asylum seekers and undocumented migrants?
    a. What are the barriers to healthcare access for asylum seekers and for undocumented migrants? How do they differ?

Political Climate and Developments

5. Bremen and Saxony have different political contexts. Can you briefly describe how you perceive your respective federal state's political landscape and climate in regards to migration?
6. How has the political debate on healthcare access for asylum seekers and undocumented migrants been shaped by the political parties in your federal state?
7. Would you say that there have been significant political changes in recent years that have caused shifts in health policies for the specified groups, if so, what are they?
8. How far do you think the government's political willingness (or lack thereof) reflects the general population's public opinion?

9. Do your organization or other NGOs & activists influence policy making, if so, to what extent?

The E-Health Card for Asylum Seekers

10. In Bremen, an electronic health card was introduced for asylum seekers, whereas Saxony has not implemented such a system. How has this decision affected asylum seekers' access to healthcare in your federal state?
11. What were the main arguments for and against the implementation of the health card?
12. Can you describe the process of implementing (or rejecting) the health card in your state?
    - Who were the key decision-makers? Did your organization play any role in this process?
    - What were the biggest obstacles?
    - Were there any political conflicts?
13. In your opinion, what have been the biggest successes and failures of the health card system (or lack thereof)?

Undocumented Migrants & Access to Healthcare

14. What are the informal solutions that NGOs and healthcare providers use to help undocumented migrants and possibly bypass legal barriers?
15. Has there been any political or legal discussion in your state about improving healthcare access for undocumented people and can you tell me something about it?
16. Can you give me one or two examples of social and political reasons why undocumented migrants remain largely excluded from formal healthcare systems?

Future Perspectives & Recommendations

17. Based on your experience, what recommendations would you give to policymakers in your federal state regarding improved healthcare for asylum seekers and undocumented migrants (policy changes, funding, structural changes, etc.)?
18. Do you think a nationwide standardized healthcare approach for these groups is realistic? Why or why not?

19. Can you think of any practices from other regions or countries that you believe should be adopted in Germany?

Closing Section

20. Is there anything else you would like to add that we haven't discussed?
21. Would you be open to a follow-up conversation if I need further clarification on some points?
22. Do you have any questions for me? If so, feel free to ask them now.