***"Unmet Needs for healthcare Among Migrants and Refugees: The Role of Destination Context in the EU"***

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**Background and motivation**

Health inequalities between migrants and native populations have long been a key concern in public health and migration research. A well-established finding is that migrants often arrive in destination countries in relatively good health, a phenomenon known as the "healthy migrant effect" (e.g Razum et al., 2000). This advantage is usually attributed to positive self-selection processes and pre-migration screening. However, the mechanism does not typically apply to refugees, who represent a distinct and more vulnerable population group. Forced migration due to conflict, persecution, or disaster exposes refugees to prolonged physical and psychological hardship, resulting in poorer health upon arrival and specific healthcare needs (Hollander et al. 2012; Nørredam et al. 2012; Crepet et al., 2017; Simonnot et al., 2016). Over time, migrants' initial health advantage tends to deteriorate—a process known as the "exhausted migrant effect" (e.g Bollini & Siem, 1995). This deterioration results from a combination of factors: exposure to unhealthy behaviors, poor living and working conditions, loss of social networks and social status and experiences of discrimination (Giannoni et al., 2016; Barbiano di Belgiojoso, et al. 2024, Antecol & Bedard, 2006; Wallace & Wilson, 2019). Finally, migrants face several formal and informal obstacles and barriers in accessing health services (Devillanova and Frattini, 2016), due to their legal status, linguistic and cultural barriers and discrimination (Borrell et al., 2015). The health outcomes of migrants and refugees are therefore deeply conditioned by the institutional and policy environment of the host country, particularly regarding integration and healthcare access. Across Europe, healthcare entitlements and integration policies vary considerably. Inclusive systems tend to promote migrants' well-being by improving access and reducing discrimination, whereas restrictive ones reinforce marginalization (Tip et al., 2019; Walther et al., 2020; Jaschke & Kosyakova, 2021; Neureiter & Waldmann, 2025). Healthcare access is a particularly important determinant of health for migrants and refugees. Several factors influence the degree to which migrants can access healthcare, including the legal right to services, awareness of this right, and the ability to navigate the healthcare system effectively commonly referred to as "health literacy." Formal barriers include legal restrictions and administrative complexities, such as requiring documentation for access to care (Alawa, Zarei, & Khoshnood, 2019). In the European Union, many countries limit healthcare access for irregular migrants and asylum seekers, offering only emergency care (Norredam, Mygind, & Krasnik, 2006; Cattacin & Björngren-Cuadra, 2010). Informal barriers further complicate access, including language difficulties, socio-cultural differences, and communication breakdowns with healthcare providers (Fagundo-Rivera et al. 2025).

While previous research has documented unmet healthcare needs among migrants, only a few cross-country studies have examined the individual-level factors that explain differences within and between European regions (Kullamaa & Reile, 2023; Fares et al., 2023; Neureiter & Waldmann, 2025). Among these, only Fares et al. (2023) include country-specific factors to account for the relatively high prevalence of UHN and its regional variation in selected national contexts. To our knowledge, no study has yet considered the heterogeneity of the migrant population in terms of legal status and origin background, providing a more detailed understanding of UHN patterns among migrants in Europe.

To address these gaps, the present study draws on the Second European Union Minorities and Discrimination Survey (EU-MIDIS II), a valuable dataset which remains largely underutilized in migration research (see Van Tubergen & Kros, 2024; Neureiter & Waldmann, 2025). EU-MIDIS II offers a unique opportunity to explore a large and diverse sample across European countries, providing detailed and comparable information on migrants' and refugees' socio-demographic and health-related characteristics.

This study adopts a cross-national European perspective to examine how legal, socioeconomic, and contextual factors influence self-reported unmet healthcare need. In doing so, it contributes to a deeper understanding of health inequalities within migrant populations and the role of destination-country conditions in shaping access to healthcare in Europe.

## Data and methods

### Data and sample

This study draws on data from the Second European Union Minorities and Discrimination Survey (EU-MIDIS II), collected during 2015–2016 (FRA, 2018). The survey covers 28 EU countries and targets specific population groups, including immigrants and their descendants from Turkey, North Africa, Sub-Saharan Africa, South Asia, and Asia, as well as two ethnic minorities (Roma and individuals of Russian background). The survey aimed to collect nationally representative data for each targeted group through face-to-face interviews using translated questionnaires (FRA, 2018). The full dataset includes a total net sample size of (Ni =) 77,656 interviews across the (Nj =) 28 EU member states.

Our analysis focuses on the UHN among adult migrants and refugees. We excluded respondents under the age of 18 (25,492 individuals) and those belonging to non-migrant ethnic minorities (23,271). A further 1,304 cases with missing information on target group membership were removed. To capture unmet need conditional on perceived necessity, we restricted the sample to individuals who reported having needed medical treatment during the previous 12 months (7,456 cases).

The final analytical sample comprises observations from 19 EU countries: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom. The remaining nine EU countries were excluded because they only sampled non-migrant minorities or lacked information on ethnic origin. These exclusions result in a clean analytical sample on which all models were estimated (N= 4,810 observations). In the weighted sample, approximately 8% of respondents were classified as refugees and 92% as other migrants. Among them, 72% are first-generation migrants and 28% are second-generation individuals.

### Measures and Methods

The dependent variable, unmet healthcare need, is coded as 1 if respondents reported not receiving medical care each time it was needed in the past 12 months, and 0 otherwise.

The main independent variable distinguishes refugees (1) from other migrants (0), based on the reason for migration: respondents who selected "seeking asylum or protection" were coded as refugees, even if other reasons were also mentioned.

Control variables include sociodemographic factors (gender, age, citizenship/residence permit), socioeconomic characteristics (education, employment, language proficiency), family composition (marital status, household size), contextual variables (ethnic origin, country cluster by UN geoscheme, length of residence), and access to national healthcare systems and perceived discrimination. To capture potential non-linear effects, we included the squared terms of age and length of residence in the models. Access to national healthcare systems was measured using the question *"Does the national basic health insurance scheme currently cover your healthcare expenses?"* (1 = yes, 0 = no). Experiences of ethnic harassment were coded as 1 if respondents reported being personally harassed because of their ethnic or immigrant background in the past year, following Van Tubergen & Kros (2024).

We estimate binary logistic regression models predicting the probability of UHN. Model 1 examines the baseline association between migration status and UHN; Model 2 introduces gender-stratified estimates; Model 3 adds the interaction between migration status and regional context.

## Preliminary Findings

### Descriptive results

Weighted descriptive results show that UHN affect around 7% of both refugees and other migrants, indicating no substantial difference between the two groups at the descriptive level. By origin, respondents from North Africa (10%), South Asia (9%), and Sub-Saharan Africa (9%) report the highest levels of unmet need, whereas those from Asia (6%) and especially Turkey (2%) exhibit considerably lower levels. Women show slightly UHN (8%) than men (7%), while younger migrants (18–24) report the highest levels (13%), suggesting informational or administrative barriers for youngers. Similarly, migrants with shorter residence in the host country (<10 years) show higher levels of UHN (11%) than long-term residents (7%), suggesting that administrative and informational obstacles may gradually decline with time spent in the destination country.

Legal and social inclusion strongly reduce UHN: migrants with national health coverage report much lower unmet need (7%) than those without (22%). Likewise, those who experienced ethnic discrimination report three times higher unmet need (15% vs. 5%). UHN is slightly more common among the unemployed (8%) than the employed (7%). These patterns confirm that institutional inclusion and social exclusion are powerful determinants of access to care.

**Multivariate results**

The logistic regression models presented in Tables 1 estimate the probability of UHN among migrants and refugees in the EU. In the pooled model, refugee status does not significantly predict unmet healthcare need once sociodemographic, socioeconomic, and contextual characteristics are controlled for. This indicates that, on average across Europe, refugees and other migrants report similar probabilities of not receiving medical care when they needed it.

When models are stratified by gender, however, a relevant difference emerges. Among women, refugee status is not associated with UHN, confirming the pooled result. Among men, in contrast, refugee status shows a significant negative association with unmet need, indicating that refugees are less likely than migrants to experience UHN. This pattern may reflect specific support mechanisms embedded in reception and asylum procedures, which could make health services more accessible to men with refugee status than to labour migrants.

When the effect of refugee status is allowed to vary by destination context through an interaction between migration status and country group (North, South, and West Europe), a clear context-dependent pattern appears. Both refugees and other migrants living in Southern Europe display overall lower levels of UHN than those residing in Northern Europe, suggesting that Southern European contexts are, on average, less exclusionary in terms of reported unmet need. Yet the positive and significant interaction term for *refugee status × Southern Europe* ($\beta = 1.88$, $p < 0.05$) indicates that within Southern Europe refugees are more likely than other migrants in the same countries to report UHN and more likely than refugees in Northern Europe. In other words, the Southern context seems to reduce unmet need overall, but it also widens the internal gap between refugees and other migrants. In Northern and Western Europe, by contrast, no significant difference between refugees and other migrants is detected, suggesting more equal access across migrant categories.

Across all models, lack of health insurance coverage and experience of discrimination emerge as the strongest predictors of unmet need. Education and marital status are protective, while longer residence reduces UHN at a decreasing rate. These results underscore that healthcare inequalities are structured by both individual vulnerabilities and national institutional frameworks.

**Table 1.** Logistic regression estimates of *unmet healthcare need* (reference: no unmet healthcare need) for the whole sample, gender-specific models (women, men), and the *refugee status × country* interaction specification.

| *Dependent variable: unmet healthcare need* | **Whole sample** | **Woman** | **Man** | **Interaction** |
|---|---|---|---|---|
| Refugee status (ref. Other migrant) | -0.19 | 0.27 | -0.52* | -0.70 |
| Country (ref. Norther Europe) | | | | |
| Southern Europe | -0.61*** | -1.20 | -0.17 | -0.73 |
| Western Europe | 0.0004 | -1.87 | 0.04 | -0.10 |
| Migratory status#Country (ref. refugee#Norther Europe) | | | | |
| refugee#Southern Europe | | | | 1.88* |
| refugee#Western Europe | | | | 0.60 |
| Citizenship/ residence status (ref. No) | 0.02 | -0.01 | 0.07 | 0.02 |
| Origin (ref. Sub Saharian Africa) | | | | |
| Asian origin | -0.65 | -0.33 | -0.49 | -0.79 |
| Turkish origin | -0.71*** | -0.81** | -0.76*** | -0.69 |

| | | | | |
|---|---|---|---|---|
| North African origin | 0.35 | 0.79* | -0.20 | 0.37 |
| South Asian origin | 0.57 | 0.56 | 0.30 | 0.53 |
| Gender: Woman (ref. man) | 0.01 | | | 0.0003 |
| Age (in years) | 0.02 | 0.12** | -0.13** | 0.02 |
| Age squared term | -0.0002 | -0.001** | 0.001* | -0.0003 |
| Length of stay (in years) | -0.05** | -0.05*** | -0.04 | -0.05** |
| Length of stay squared term | 0.0006*** | 0.0009*** | 0.0002 | 0.0006*** |
| Education (ref. No formal/primary) | | | | |
| Secondary | -0.42* | -0.69 | -0.18 | -0.43 |
| Upper secondary, vocational | -0.67* | -0.99 | -0.35 | -0.67* |
| Post- secondary or tertiary | -0.77** | -1.19** | -0.30** | -0.77** |
| Language proficiency (ref. No) | -0.05 | 0.40 | -0.54 | -0.05 |
| Employment (ref. No) | -0.07 | -0.53 | 0.38*** | -0.07 |
| Married (ref. No) | -0.65*** | -0.89*** | 0.22 | -0.65*** |
| N. of household components | -0.04 | -0.007 | -0.11 | -0.04 |
| Access to national health services (ref. No) | -1.28*** | -1.01*** | -1.35*** | -1.29*** |
| Experienced discrimination (ref. No) | 0.84* | 0.79** | 0.91* | 0.84* |
| Constant | -0.42 | -2.75 | 2.73 | -0.32 |

**Source:** authors' elaborations on EUMIDIS II data. **Note:** * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

## Conclusion and Further Development

This study provides one of the first cross-national analyses comparing unmet healthcare needs among refugees and other migrants in Europe. Using EU-MIDIS II data, it identifies both gendered and contextual disparities that shape healthcare access.

The next step of the analysis will focus on understanding how destination country characteristics shape UHN among migrants and refugees. To examine this variation, we plan to estimate multilevel models, with individuals nested within destination countries. This approach will allow us to disentangle individual-level effects from country-level influences and to assess whether structural and institutional features of host countries help explain the observed disparities in healthcare access.

Since the EU-MIDIS II dataset identifies the country of residence but not subnational regions, the analysis will be limited to country-level variables. This represents a constraint, as within-country heterogeneity, such as regional differences in health service provision, cannot be captured. Nevertheless, cross-country variation remains substantial, offering an opportunity to test whether national economic conditions, welfare structures, and integration policies contribute to explaining the patterns observed at the individual level. Country-level indicators will include socioeconomic factors (GDP per capita, Gini index, unemployment rate, and migrant share), the share of the population with a migrant or refugee background**,** health-system characteristics (number of physicians or hospital beds per capita, health expenditure, WHO Universal Health Coverage index, and Eurostat self-reported unmet need in the general population), and integration policies from the Migrant Integration Policy Index (MIPEX). The multilevel framework will make it possible to test whether national welfare and healthcare systems moderate individual-level inequalities, and whether more universalistic and inclusive contexts reduce the gap between refugees and other migrants.

Ultimately, this research aims to provide an analytical understanding of how institutional inclusion and social exclusion jointly shape healthcare access in Europe's diverse societies. By linking individual experiences to macro-level structures, it contributes to ongoing debates on equity, universality, and the right to health in European countries.

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