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Health care coverage and access for displaced persons from Ukraine: Assessing the implementation of the Temporary Protection Directive across EU Member States

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ABSTRACT

Background: Since the beginning of the conflict in Ukraine, close to 4.3 million non-EU citizens have been granted temporary protection in the European Union (EU). Beneficiaries gain access to health care in their host countries. All EU countries must ensure coverage for and access to a minimum set of health care services, but they can arrange delivery and extend the services covered as they deem feasible, necessary, and appropriate.
Objective: The aim is to assess the implementation of temporary protection across 27 EU countries, including legislative provisions and health care coverage foreseen. This study offers a comparative overview of health care entitlements and financial coverage, access to services and barriers encountered in host health systems.
Methods: This study is based on three qualitative survey rounds conducted with members from the EU Health Security Committee and the Health Systems Policy Monitor network (European Observatory on Health Systems and Policies).
Results: All Member States have made the necessary legal provisions. However, large variations in health care benefits and financial coverage exist. The main reported access barriers relate to language, pre-existing capacity limitations, and lacking awareness of provisions on both beneficiary and health care provider sides.
Conclusion: As displaced persons from Ukraine transition into stable living conditions in host countries, data should be collected systematically to ensure health services can be tailored to meet their needs. Better aligning health care provision with other services, such as social care, may help unburden health systems and maximise the use of available resources.

1. Background

In 2001, the European Union (EU) adopted the Temporary Protection Directive 2001/55/EC (hereafter the Directive or TPD), a legal framework designed to ease the management of displaced persons and unburden Member States' asylum systems in the event of a mass influx from outside the Union[1,2]. The Directive was conceived against the backdrop of the conflicts in former Yugoslavia when a large inflow of people from affected areas had been anticipated across the EU. Yet, the Directive was not activated at the time of its inception and remained unutilised for >20 years. Following the Russian invasion of Ukraine on 24 February 2022, the Council of the EU approved a Decision on 4 March 2022 to trigger the Directive for the first time since its adoption[3].

The Directive sets out the minimum legal obligations of Member States towards incoming beneficiaries, including their right to free movement within the EU's borders, as well as access to adequate housing, social services, employment, and health care in the hosting country. While Member States had already transposed the Directive into national law in the years following its entry into Community law, they were forced to rapidly adapt existing legislation in the days following

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the Council's Implementing Decision.

Article 13 of the TPD defines the legal requirements underlying the provision of health care, stating that "at least emergency care and essential treatment of illness" must be ensured by any hosting EU country[2]. While article 13 sets minimum standards of care for the medical treatment of displaced persons from Ukraine, it leaves room for the Member States, which are in charge of health care planning and organisation under EU law[4], to tailor the delivery and expand the scope of available and covered health services as they deem appropriate.

Over 6 million people displaced from Ukraine are estimated to be on European soil and close to 4.3 million non-EU citizens fleeing Ukraine (including primarily Ukrainian citizens but also small numbers of persons with other citizenships such as Russian, Nigerian and Azerbaijani) have been provided temporary protection (or equivalent protection) in an EU Member State as of April 2025[5,6]. Among EU countries, Germany, Poland, and Czechia are currently hosting the highest numbers of beneficiaries[6]. The highest ratios relative to the resident population are observed in Czechia (33.5 per 1000 inhabitants), Poland (27.2 per 1000 inhabitants) and Latvia (26.4 per 1000 inhabitants) (see Table S3 for further details)[6].

The aim of this study is to shed light on how the TPD has been implemented across EU Member States, to provide an overview of the key legislative provisions undertaken at national levels and to elucidate which level of health care coverage countries foresee for beneficiaries of temporary protection. Beyond offering a comparative perspective of their entitlement to health care benefits and financial coverage, this study presents findings on health care access and the barriers encountered by beneficiaries of temporary protection, as they have started navigating host countries' health systems across the EU.

2. Methods

Information presented in this paper stems from three consecutive survey rounds. The first two rounds were conducted between March and May 2022 and the third was conducted in the first quarter of 2023. All three rounds involved representatives from governmental, non-governmental and academic institutions located in the 27 EU Member States. The first survey round consisted of a short multiple-choice questionnaire which was designed and carried out by the European Commission in March 2022 with members of the Health Security Committee (HSC), the EU's coordination and guidance group on health security[7]; 24 of 27 Member States responded. The second round was commissioned by the European Commission and aimed to fill remaining information gaps and expand on specific aspects of health care coverage (survey questions are provided in the online Annex). The survey, which used open-ended questions, was designed in agreement with the European Commission and conducted by the European Observatory on Health Systems and Policies (hereafter Observatory) with experts from the Health Systems and Policy Monitor (HSPM) network[8] and an expert from the Greek Council for Refugees; responses from 27 Member States were collected, and explored among others implementation of the Directive, benefit and cost coverage as well as cross-border health care coverage (i.e., coverage of health care services delivered in an EU Member State other than the host country). The third survey round was again requested by the European Commission and conducted by the Observatory; it aimed to confirm and update the information on health care coverage provided by the country experts one year on, as well as to collect additional insights on the practical implementation of the Directive and possible health care access problems encountered by beneficiaries in the respective health care systems. The third survey was designed by the Observatory and consisted of open-ended questions which built on questions included in the first two survey rounds, as well as drawing from previous Observatory work on health care coverage and a conceptual framework to explore specific access gaps (summarised in box 1)[9,10]. Replies were collected from experts in the Observatory's HSPM network, some of whom had already responded to the first two rounds, as well as other representatives from governmental, non-governmental and academic institutions; replies were collected from experts in 25 Member States and complemented with information obtained from representatives in the European Commission's Solidarity Platform network. Survey responses in both second and third rounds were reviewed, revised, and approved by the Member States through the European Commission's HSC. A final consistency check and update was conducted with the HSPM and country experts in March 2024; any new information added by the country experts after the survey rounds in 2022 and 2023 is clearly signposted in the Results (in italics) and has not been reviewed or approved by the HSC. A list of the contributing HSPM and country experts is provided.

The survey outcomes were collated, reviewed, and complemented with additional information obtained from a review of relevant literature encompassing official websites and documents from governmental and intergovernmental organisations (including official Member State sources, the United Nations High Commissioner for Refugees, the European Commission, the EU Agency for Asylum), as well as news items and documents published in academic journals and by non-governmental organisations (NGOs)[11]. This paper summarises the findings from all three survey rounds and the literature review (with data updated to March 2024 following a final consistency check and update with the HSPM and experts' network). Summary tables of the survey responses provided by the experts can be found in the online Annex.

3. Results

3.1. Legislative frameworks

Overall, 26 Member States transposed the Directive into national legislation and one Member State made equivalent provisions at national level. Among these, 18 countries reported having previously adopted national legislation in the aftermath of the Directive's adoption in 2001. In addition, after its first activation in March 2022, 16 countries introduced new legislative motions or modified existing legislation on temporary protection. Legislative acts and/or amendments specific to health care, social security and health insurance were reported by five country experts participating in the survey. All legislative acts reported in the 2022 survey rounds (and updated in the 2023 round) are summarised in the Annex (note: Denmark, not being legally bound by the Directive in accordance with the Protocol on the position of Denmark annexed to the treaty on European Union and to the Treaty establishing the European Community, has made analogous provisions at national level).

As highlighted in the introduction, the Directive foresees that "assistance necessary for medical care shall include at least emergency care and essential treatment of illness"[2]. This leaves a margin of freedom for Member States to arrange health care delivery and extend the range of services covered as they deem feasible, necessary, and appropriate. From the survey results collected, four main types of coverage provisions could be identified from the legislative acts implemented at national level, each translating into different benefits and cost coverage levels for beneficiaries of temporary protection (TP) (see Table 1 for an overview). More details are provided in the following sections.

Depending on how their health systems are organised, most EU countries have either opted to adapt their health insurance systems to include beneficiaries of temporary protection or, if their systems are mixed or not insurance-based, have made provisions to register beneficiaries and issue permits granting coverage to public services including their national health systems. In some cases, beneficiaries are required to sign up with an insurance fund themselves, while in others inclusion is mandatory and their status might be equivalent to other residents or nationals with limited financial means.

Box 1
Main types of health care access gaps explored in the third survey round (based on the conceptual framework by Palm et al. 2021)[9]

- Physical (un)availability of services (e.g., due to physical distance or limited network of contracted providers)
- Attitude of the health care provider (e.g., due to discrimination based on patient nationality or religion)
- Beneficiaries' (in)ability to obtain necessary care (e.g., due to linguistic or cultural barriers)
- Organisational and systemic barriers (e.g., due to administrative requirements or differences between the Ukrainian and host health system)

Table 1
Health care coverage provisions for beneficiaries of temporary protection adopted in EU Member States (information in blue was updated in March 2024).

Mode of health care coverage	Countries
Coverage mostly limited to emergency, acute and necessary care	Hungary, Lithuania, Malta, Slovakia, Slovenia, Sweden
Coverage granted by inclusion in or equivalence to individuals insured in national health insurance systems	Austria, Belgium, Bulgaria, *Croatia*,* Czechia, Estonia, France, Germany, Luxembourg, Romania
Coverage granted through issuance of permits and national identification numbers (with direct access to services through national health systems)	Cyprus, Denmark, Greece, Ireland, Italy, Latvia, *Poland**,* Portugal, Spain
Coverage granted through regulations covering asylum seekers, refugees or nationals/ordinary residents receiving social security benefits	Finland, Netherlands

Source: Authors' compilation; Notes: *In Croatia, foreigners under temporary protection exercise the same rights to health care as insured persons under compulsory health insurance but are not part of the formal insurance system; **In Poland, coverage is organised on a fee-for-service basis (instead of capitation), limiting access to preventive care and coordinated care programmes.

In the first survey round, one in four Member States reported providing limited coverage including emergency, acute and necessary health care for beneficiaries of temporary protection, although exceptions and broader coverage may apply to vulnerable population subgroups in specific cases, including children, pregnant women, disabled and elderly persons. In some of these countries, permanent residency and/or employment may subsequently grant eligibility for broader coverage and integration into national health (insurance) systems. Lastly, in a small group of countries, health care coverage runs via existing legislation that covers other recognised asylum seekers and refugees or through social security systems, which also apply to uninsured nationals and residents below a certain income threshold.

Several legislative and organisational changes were reported during the follow up survey held in 2023. These generally related to simplifying and improving the efficiency of existing procedures, as well as adapting the benefits and financial arrangements governing health care access for beneficiaries of temporary protection. While in some countries this has led to the expansion of services covered by the health system (e.g., for dental care), in others, changes have tightened the rules in place, notably with regards to regulating the conditions for financial coverage.

3.2. *Benefits coverage*

Health care provision and benefits coverage for beneficiaries of temporary protection varies across EU countries. In line with the minimum requirements set in the Directive, countries including Lithuania, Malta, Slovakia, and Slovenia, reported limited coverage of elective and specialist care. In these countries, coverage is generally restricted to acute care, emergency medical and dental care, paediatric, pregnancy and obstetric care, as well as treatment for chronic conditions (including medicines) and vaccinations foreseen in national vaccination calendars. In some cases, full benefits coverage becomes available with employment and the payment of contributions *(e.g., Malta*). Upon activation of the Directive, Bulgaria and Germany were among the countries with limited entitlement to benefits, but soon introduced legislation to extend coverage to the full benefits basket (Bulgaria) and integrate beneficiaries

into the national social security system equating them to recognised asylum seekers at first, and subsequently ensuring full coverage under Social Code II and XII (Germany). Yet another group of countries, comprising Hungary and Sweden, restrict coverage with exceptions for specific subgroups, including (unaccompanied) minors and (pregnant) women, who are entitled to receiving the full national benefits baskets (*Sweden: this applies only to minors*) or a select range of additional services (*Sweden: women have access to maternal health care, abortion care and contraceptive advice*). Most EU countries (20 out of 27), including Austria, Belgium, Cyprus, Croatia (*equivalent to individuals with compulsory health insurance*), Czechia, Denmark, Estonia, Finland, France, *Germany*, Greece, Ireland, Italy, Latvia, Luxembourg, the Netherlands, Poland, Portugal, Romania, and Spain offer full coverage equal or equivalent to nationals and legal residents once temporary protection, or a temporary residence status, has been provided although access to specific services such as cross-border health care might be limited (see Box 2). The provision of services may be organised separately in specific designated health care facilities or within reception centres, where refugees are registered upon arrival. A detailed overview of benefits coverage in different EU countries is provided in Table 2.

3.3. Cost coverage

Cost coverage is equivalent to nationals and legal residents in most EU countries (see Table 2); in some, beneficiaries are exempt from cost-sharing requirements or subject to discounts due to financial and social vulnerability. For example, in the Netherlands acute dental care up to 250 euros is covered for beneficiaries (but not included in the Dutch benefits package). Selected services, including pharmaceutical prescriptions, may foresee co-payments for beneficiaries in some Member States. For instance, beneficiaries pay 40 % contributions for pharmaceutical prescriptions in Spain (*same as nationals earning less than EUR 18 000 per year*). In countries where user fees apply also with temporary protection, specific groups, including children, pregnant women, dependent spouses, students, pensioners, disabled persons, may be exempt. User fees, including health insurance contributions, generally start to apply when beneficiaries transition into stable employment and/or permanent residency. A handful of countries reported that changes in employment status would not affect cost-sharing requirements for beneficiaries, including Finland, France, Italy, Poland, and Spain, although employment may require beneficiaries to start paying tax contributions and thereby indirectly contribute to financing the host country health system in some of these countries.

3.4. Tailored health programmes

Access to COVID-19 testing, therapeutics and vaccines is granted in most Member States. Similarly, vaccinations foreseen in national vaccination calendars, including childhood and booster shots, are generally covered and in some cases necessary for children to enter the host country schooling system. Some countries foresee general health screenings which may be required upon arrival and to obtain documentation such as work permits. In addition, tailored support for victims of conflict is offered in selected countries. Infectious disease screening, prophylaxis and therapy is offered for selected conditions, including diseases of high prevalence in Ukraine such as HIV/AIDS and Tuberculosis[14]. Services are offered by State actors, but also by non-governmental and volunteer organisations.

See Table 3 for a comprehensive overview of reported services.

3.5. Access and barriers to accessing health care

The Directive defines minimum standards of care providing a baseline to inform the coverage and provision of health care for beneficiaries in EU Member States. However, given that health systems are primarily a national competence, as defined in the Treaties, EU Member States organise them in different ways. Examples include differences in levels of coverage and health service delivery, which have led to variations in access for beneficiaries of TP. One important difference relates to gatekeeping, which is a key competence of general practitioners (GPs) in some EU countries (e.g., Lithuania), while in others, referrals to access specialist health care are not needed (e.g., Austria). Similarly, some countries reported setting up special coordination structures, including crisis management teams (Ireland), stationary and mobile care (Belgium) offices to facilitate care delivery for displaced persons from Ukraine, while others had no such services.

Information relating to access problems or barriers encountered by beneficiaries trying to access host country health systems is provided below (also see Fig. 1, Table 4 and Table S2). To date, information on access barriers is sparse and primarily stems from grey literature sources and anecdotal expert reports. We provide specific country examples which illustrate the different types of access barriers reported by our experts (in the text and in Table 5). However, comprehensive information is lacking, and we cannot exclude similar issues in other countries (that currently remain unreported). In addition, some of the issues reported below may apply to all users of the respective health system, while others may be specific to displaced persons from Ukraine.

3.6. Access problems relating to limitations in coverage

The main coverage-related access problem stemmed from health services (with a focus on dental care) and pharmaceuticals which are not covered by the benefits package offered in the host country's health system (e.g., Bulgaria, Croatia, Denmark, Poland). In some cases, this may concern services or pharmaceuticals previously obtained in the Ukrainian health system, requiring beneficiaries to switch to alternative therapeutic options in their EU host country (e.g., Finland). Similarly, some pharmaceuticals may be subject to prescriptions or high co-payments in the host country, which beneficiaries had not previously experienced in Ukraine. While it is likely that the high cost of pharmaceuticals hampers access among wider sections of the population, including nationals and residents, there have been reports of displaced persons from Ukraine crossing the EU border to purchase medicines in Ukraine or using pharmaceuticals incorrectly to delay having to purchase them in the host country (e.g., from Poland).

Conversely, in some countries, dental care was reported to be at least partially covered by the health system and exemptions from contributions were reported for some user groups, including chronic disease patients, who may be dependent on obtaining continuous pharmaceutical care. In addition, NGOs were reported to offer financial aid for the purchasing of pharmaceuticals (e.g., Bulgaria), while also contributing to health service provision in several countries.

Another problem relates to the way patients are integrated into national health systems. *For instance, although they have the right to free public health care under similar conditions as the general population, lack of beneficiaries' inclusion in patients lists in Poland, which means the services they obtain are covered on a fee-for-service basis instead of capitation, restricts access to certain services such as preventive care and coordinated care programmes. Similarly, in Croatia, coverage is equivalent to nationals with compulsory health insurance, but they are not part of the formal insurance system and do not have access to monetary benefits or supplementary health insurance policies.*

3.7. Access problems due to a lack of physical availability of services

Accessing health care may be contingent on the accommodation arrangements and geographical distribution of beneficiaries. According to collected survey replies, frequent changes in accommodation or concentration in rural areas within host countries, have left some beneficiaries struggling to access health care due to physical distance and the reduced availability of services in rural regions (e.g., Bulgaria,

Table 2
Benefits and cost coverage for beneficiaries of temporary protection in EU Member States (information in blue has been updated by HSPM and country experts in March 2024).

	Benefits coverage	Cost coverage
Austria	Covered as nationals	Exemptions from cost-sharing˘
Belgium	Covered as nationals	Covered as nationals
Bulgaria	Covered as nationals	Covered as nationals
Croatia	Coverage limited compared to nationals***	Exemptions from cost-sharing˘
Cyprus	Covered as nationals	Exemptions from cost-sharing˘
Czechia	Covered as nationals	Exemptions from cost-sharing˘
Denmark	Covered as nationals**	Covered as nationals
Estonia	Covered as nationals**	Covered as nationals
Finland	Covered as nationals	Exemptions from cost-sharing
France	Covered as nationals**	Exemptions from cost-sharing˘
Germany	Covered as nationals	Exemptions from cost-sharing˘
Greece	Covered as nationals	Exemptions from cost-sharing˘
Hungary	Coverage limited compared to nationals*	Exemptions from cost-sharing˘
Ireland	Covered as nationals	Exemptions from cost-sharing˘
Italy	Covered as nationals**	Covered as nationals
Latvia	Covered as nationals	Exemptions from cost-sharing˘
Lithuania	Coverage limited compared to nationals**	Exemptions from cost-sharing˘
Luxembourg	Covered as nationals**	Covered as nationals
Malta	Coverage limited compared to nationals	Exemptions from cost-sharing
Netherlands	Covered as nationals	Exemptions from cost-sharing
Poland	Covered as nationals****	Covered as nationals
Portugal	Covered as nationals	Covered as nationals
Romania	Covered as nationals	Exemptions from cost-sharing˘
Slovakia	Coverage limited compared to nationals	Exemptions from cost-sharing
Slovenia	Coverage limited compared to nationals	Exemptions from cost-sharing˘
Spain	Covered as nationals	Exemptions from cost-sharing˘
Sweden	Coverage limited compared to nationals*	Exemptions from cost-sharing

* Specific population groups have access to full benefits or a wider range of services

** Service coverage same as nationals after residence permit/temporary stay is granted

***Service coverage same as nationals with compulsory health insurance, excluding monetary benefits and the possibility of concluding a supplementary health insurance policy.

****Service coverage same as nationals, except for specific services including rehabilitation, sanatorium treatment and cross-border health care. Due to coverage on a fee-for-service basis (instead of capitation), access to preventive care and coordinated care programmes is limited.

Normal user fees apply except for specific exempt groups (e.g., children, (pregnant) women, persons under certain poverty threshold)

˘Subject to the same exemptions/discounted rates as nationals under a certain income threshold/covered by some form of social welfare

Exempt until employment conditions change and same conditions/financial contributions as nationals start to apply

Box 2
Entitlement to cross-border health care

With integration into national health (insurance) systems, beneficiaries of temporary protection gain access to cross-border health care in several EU countries. Some experts reported the possibility to issue European Health Insurance Cards (EHIC), granting access to planned health care as foreseen by EU Regulation 883/2004[12] and Directive 2011/24/EU[13]. Other countries regulate access to health care provided abroad, limiting entitlement to those services unavailable at national level (Cyprus) or granting approvals on a case-by-case basis (Malta, *Netherlands – except emergency care that cannot be postponed until return to the Netherlands and is covered without prior approval up to the Dutch market price or maximum tariff in line with provisions for nationals*, and Slovenia). Coverage is limited to care offered on the national territory in Finland, Latvia, Poland, and Sweden.

Ireland). In addition, continuity of care may be hampered as a result of the frequent relocation and internal displacement of beneficiaries.

Another challenge relates to the choice of service provider. In some countries, health care for beneficiaries is provided through a designated network, restricting the choice of providers from whom beneficiaries are entitled to seek care (e.g., Cyprus, Estonia, Finland). Relatedly, experts reported capacity issues and long waiting times, an issue which in some countries affects both the displaced and resident populations. Specific examples impacting health care provision among beneficiaries are related to mental health services, which are sometimes provided in group settings due to capacity limitations, and issues registering with GPs, hampering access to further specialist care and prescription pharmaceuticals subject to gatekeeping.

3.8. Provider-related access problems

A range of provider-based problems have been reported, suggesting that language barriers, reimbursement and capacity issues may impact beneficiaries' access to care. While EU host countries have introduced the legal and administrative changes needed to ensure health care coverage, reports from some countries suggest health care providers may not be fully informed of the eligibility requirements for the provision and reimbursement of health services, including the inclusion of beneficiaries in national vaccination programmes. This has resulted in reluctance to provide services to beneficiaries or upfront payment requests in a few reported cases (e.g., Bulgaria, Czechia, France, Romania, Poland).

3.9. Organisational and systemic barriers

Differences in how host countries' health systems are organised (compared to the Ukrainian health system) may complicate the process of accessing health care for beneficiaries. As highlighted above, some beneficiaries have reportedly struggled to obtain the pharmaceuticals and services they were using in Ukraine and failed to go through their GPs to access them due to a lack of awareness of GPs' gatekeeping function. Relatedly, anecdotal reports of patients attending their GPs without an appointment or for multiple family members at once were presented in the survey (e.g., Estonia).

Although most countries have scaled up translation and interpretation services and produce tailored information material in different languages (including Ukrainian), health service provision has been reported to be impacted by language barriers. Beyond capacity and cost considerations linked to the provision of interpretation services, lack of proficiency in medical terminology among available interpreters and possible issues with doctor-patient confidentiality, particularly in mental health services, stood out among cited barriers (e.g., Denmark, Poland).

3.10. Access problems related to beneficiaries' lacking ability to obtain necessary care

Language issues can constitute an important barrier to accessing health care, as mentioned above. They also exacerbate existing information gaps, which can impact beneficiaries' ability to access care. Country experts reported a lack of understanding and knowledge of host country health systems among the beneficiary population, including poor awareness of how to access the system and who to contact (e.g., to schedule a visit), as well as the payment conditions for services (e.g., Estonia, Lithuania). Experiences of the Ukrainian health system have also shaped expectations from the host country systems concerning organisational factors such as gatekeeping, but also the use of informal payments when seeking needed care.

4. Discussion

Following the activation of the TPD, all EU Member States rapidly responded by implementing legislative and organisational provisions at national levels. The results from our surveys have demonstrated that health care coverage in line with the Directive's legal requirements is currently provided to beneficiaries by all Member States. In several countries, the health system offers a broader benefits basket and financial coverage for health care than the Directive foresees. However, our investigations also suggest that translating health care coverage into real-world access on the ground may not be entirely seamless. Through consecutive rounds of surveys conducted with country experts, we also collected valuable information on health care access barriers encountered by displaced persons from Ukraine across the EU countries currently hosting them. Among the most frequently reported problems, language barriers, pre-existing capacity and resource limitations, as well as lack of awareness concerning existing provisions on both beneficiary and provider sides appear to be hampering access to health care to some extent in the surveyed countries. Some of these identified access problems, including long waiting lists and an uneven urban-rural distribution of providers, are not exclusive to the beneficiaries of TP. These issues may also apply to other vulnerable groups (e.g. irregular migrants or asylum seekers) or even residents fully covered by the health system, pointing to wider system challenges[9,18,19], such as health workforce shortages, which were reported by most EU countries in 2022 and 2023 [20]. Our survey results also suggest that access to GPs, routine and preventive specialist care may be more challenging to obtain than acute care, disproportionally affecting patients with chronic conditions and potentially hampering continuity of care. As described in the introduction, some countries host high numbers of displaced individuals in absolute and/or relative terms. Particularly smaller Member States and those in close geographical proximity to Ukraine are likely to experience pressure on their social and health care systems.

Due to the ongoing conflict and martial law, a large proportion of the

Table 3
Tailored health services offered by EU Member States (information in blue was updated in March 2024).

Services offered	Countries
Targeted actions to improve childhood immunisation rates	Bulgaria (individual immunisation plans to cover missing vaccinations), Czechia (vaccination and awareness campaign with UNICEF), *Finland,* Ireland (nationwide catch-up vaccination programme), *Italy (assessment of vaccination coverage and extension of childhood immunisation), Netherlands (catch up vaccination programme), Spain (catch up vaccination programme)*
Mental health services and/or psychosocial support	Austria, Belgium, Bulgaria, Croatia, *Czechia,* Germany, *Finland,* France, Italy, Latvia, Lithuania, Malta, Netherlands, Poland, Romania, Slovakia, Slovenia, Sweden
General health assessments to identify immediate health needs	Croatia, Czechia, Estonia, Finland, France, Hungary, Ireland, *Italy,* Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, *Spain,* Sweden
Tuberculosis screening and/or treatment	Austria, *Cyprus,* Estonia, Finland, Hungary, Italy, Latvia, Malta, Slovenia, Spain, Sweden
HIV screening and/or treatment	*Cyprus,* Estonia, Finland, Hungary, Slovenia, Spain, Sweden
Hepatitis B and C screening and/or treatment	*Cyprus,* Finland, Slovenia, Sweden
National hotlines, online platforms and Digital health services	Bulgaria (telemedicine consultations), *Czechia (information on the national health care system and initial psychological consultations),* Estonia (national hotline, online chat function, video counselling), Poland (LikarPL mobile application for medical advice and patient-doctor communication)
Support for addiction/narcotic drug users	Estonia, Slovenia
Specialist health care provided through volunteer doctors/dentists	Bulgaria (specialist care), Lithuania (dental care)

Source: Authors' compilation

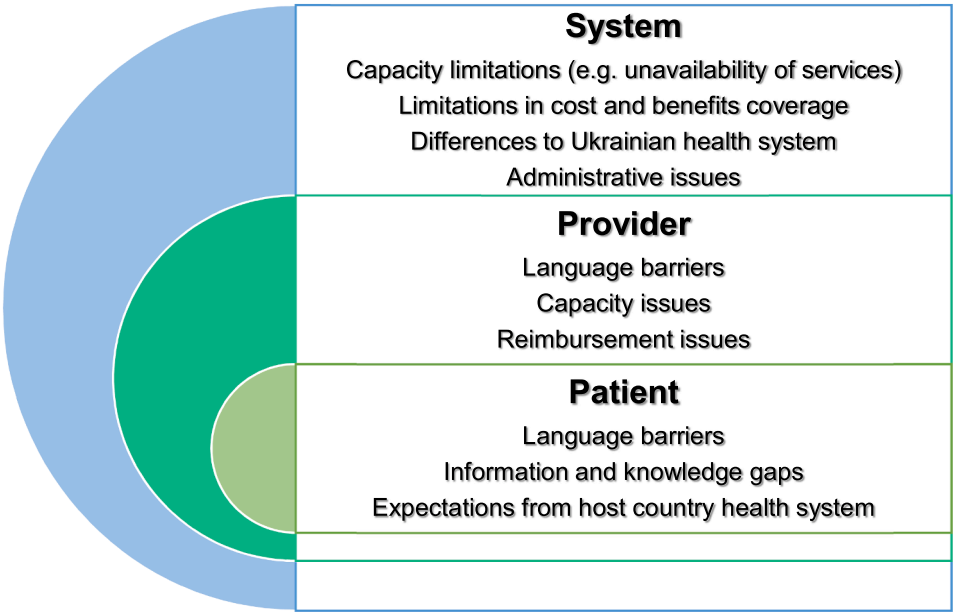

Fig. 1. Dimensions of health care access barriers.
Source: Authors' compilation.

Table 4
Main types of access problems.

Type of access problem	Countries reported
Limitations in coverage	Bulgaria, Croatia, Denmark, Finland, Latvia, Poland
Physical (un)availability of services	Bulgaria, Cyprus, Czechia, Estonia, Finland, Germany[1], Hungary, Ireland, Lithuania, Netherlands, Poland, Romania, Slovenia
Attitude of the provider	Bulgaria, Czechia, France, Poland, Portugal, Romania
Beneficiaries' (in)ability to obtain care	Croatia, Czechia, Denmark, Estonia, Germany[1], Greece, Hungary, Ireland, Lithuania, Malta, Poland, Portugal, Romania, Slovenia, Sweden
Organisational and systemic barriers	Austria, Estonia, Denmark, France, Hungary, Lithuania, Poland, Romania, Slovakia[1], Slovenia, Sweden

Source: Authors' compilation; Notes: [1]Information identified from desk research; Further information is provided in Table S2.

refugee population from Ukraine is made up of women, children, and older individuals[14]. This is reflected in a higher prevalence of pre-existing chronic conditions, such as cardiovascular conditions and diabetes, requiring continuous medical attention, a higher susceptibility to vaccine-preventable diseases, and increased demand for sexual and reproductive health care[14]. Our results demonstrate that some dedicated health programmes are being set up in the Member States to provide beneficiaries with support tailored to their needs. In addition to state-organised services, NGOs across many countries are working towards filling service delivery gaps and addressing already identified access problems, such as subsidising pharmaceutical costs and offering psychological support services.

Given the dynamic and rapidly evolving nature of the situation and the lack of systematic data collection systems to document health system access barriers, the primary limitation of this paper relates to data availability. The data included can only provide first insights into the types of barriers beneficiaries of temporary protection are experiencing, being primarily based on expert accounts, grey literature sources such as newspapers, and early designs of surveys and interviews conducted on the ground with small samples of displaced persons from Ukraine. Although experts from all Member States were consulted throughout the data collection stage, there is some cross-country variation in the amount and depth of information we were able to include in the paper. Another limitation relates to the lack of data on user experiences, which we were only able to source in a few countries already operating surveys with refugees on the ground. Similarly, data on the utilisation of health services by displaced persons from Ukraine is mostly unavailable to date. While the numbers of people registered for temporary protection are already being systematically collected, data on utilisation and access to tailored services specifically remain scarce and fragmented and are hence not reported in this paper.

5. Conclusion

While we have been able to paint a fairly comprehensive overview of the legislative provisions taken by EU Member States to implement the Directive, the extent of health care access problems and registrations within host health systems, as well as health service utilisation data remain difficult to ascertain. Our paper provides one of the first comparative cross-country reports of access gaps experienced by beneficiaries of temporary protection across EU countries. As displaced persons from Ukraine transition into more stable living arrangements and become integrated in hosting Member States' societies, it will be crucial to collect data more systematically, including by scaling up existing surveys and interviews on the ground, to collect lived experiences and ensure health services can be further tailored towards beneficiaries' specific needs. Any coverage or access gaps that may emerge from displaced persons starting employment and becoming subject to cost-sharing requirements or health insurance contributions will also need to be monitored and managed in a timely manner to reduce unmet health needs and catastrophic spending. There are important capacity and resource limitations across EU health systems, which were exacerbated during the COVID-19 pandemic and which many countries continue to grapple with. Better aligning health care provision with other services offered to beneficiaries, such as social care, education, employment and accommodation, may contribute towards unburdening these systems and maximise the efficient use of available resources.

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Table 5
Country examples of health care access barriers(References ([15–17] is cited in table body part).

System	Capacity limitations	**France** Following a legislative change which has tightened the administrative process to access health care, lack of personal identification and temporary residence documentation hinders issuance of permanent social security numbers required to obtain health insurance cards (*carte vitale*) and open online patient files (*Ameli*).
	Limitations in cost and benefits coverage	
	Differences to Ukrainian health system	
	Administrative issues	
Patient	Language barriers	**Malta** A survey conducted by *Citizens Lab*[1] found that a large share of respondents felt totally uninformed or only slightly informed with regards to their rights to access health care and which services are available to them in Malta (16).
	Information and knowledge gaps	
	Expectations from host country health system	
Provider	Language barriers	**Czechia** Primary-care physicians may refuse to register new patients beyond a tolerable workload level. However, there is no legally agreed threshold of what 'tolerable workload' constitutes, for instance in terms of number of registered patients. According to the third wave of the *Voice of Ukrainians*[2] survey, 18% of respondents were refused admission by a health care provider, although the reasons for this were not defined (17, 18).
	Capacity issues	
	Reimbursement issues	

Source: Authors' compilation. Notes: 1. Citizen lab is a civil society platform developed by SOS Malta. No information on sampling size or methodology was available for this survey. More information on the results is available here: https://citizenslab.org.mt/wp-content/uploads/2022/09/UA-Survey-statistics.pdf.
2. Voice of Ukrainians' is a multi-wave online survey of Ukrainian refugees conducted by PAQ Research in cooperation with the Institute of Sociology at the Czech Academy of Sciences. More information on the methodology used and the survey results can be found here: https://www.paqresearch.cz/post/voice-of-ukrainians-education-housing-employment-poverty-mental-health/ (in English); https://www.paqresearch.cz/post/hlas-ukrajincu-zdravi-sluzby (in Czech).

Contributors

NM and EvG conceptualised the survey methodology and the manuscript. The network of HSPM and country experts collected and reported data from their national contexts. NM, CHQ, AE and GS collected, collated, analysed and curated the data obtained from the expert network. NM and EvG wrote the first draft, and all authors reviewed and provided inputs to the final version of the manuscript.

Data sharing statement

The data presented in this paper stems from three rounds of qualitative surveys. Survey replies have been collected, summarised and published in two European Commission reports which are freely accessible on the European Commission website[11]. Key findings from the surveys are also summarised in the supplementary materials published with this article.

CRediT authorship contribution statement

Nicole Mauer: Writing – review & editing, Methodology, Validation, Data curation, Writing – original draft, Formal analysis, Conceptualization. **Cristina Hernandez-Quevedo:** Validation, Writing – review & editing, Data curation, Formal analysis. **Astrid Eriksen:** Formal analysis, Validation, Writing – review & editing, Data curation. **Giada Scarpetti:** Writing – review & editing, Data curation, Formal analysis, Validation. **Ewout van Ginneken:** Validation, Writing – original draft, Conceptualization, Writing – review & editing, Methodology.

Declaration of competing interest

The authors have no conflicts of interest to declare.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.healthpol.2025.105434.

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