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Article

Refugees: Negative health consequences without the anticipated savings

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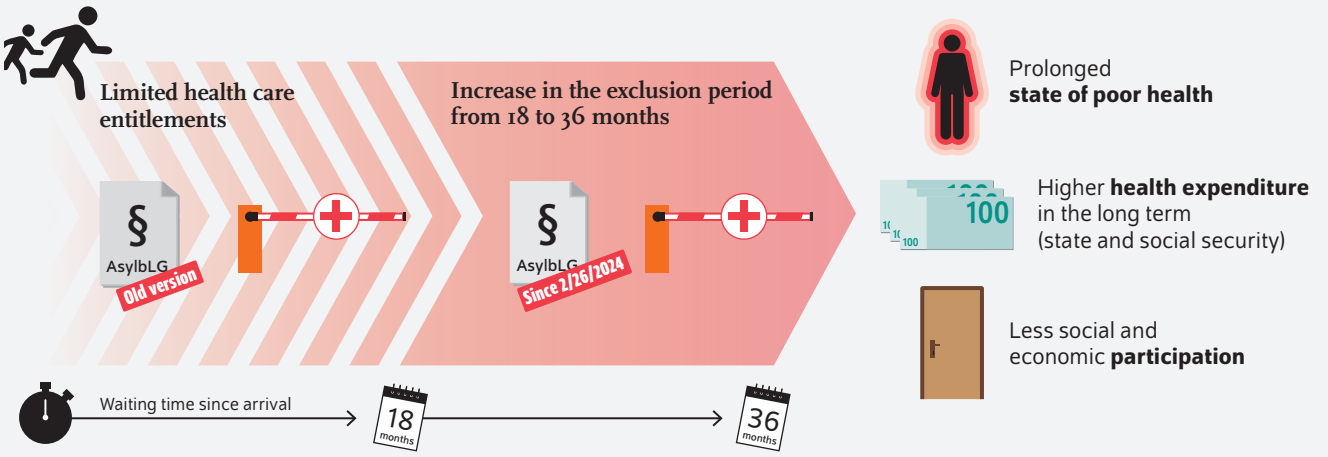
AT A GLANCE

Extended restrictions to health care entitlements for refugees: negative health consequences without the anticipated savings

By Louise Biddle

- As long as refugees are subject to the Asylum Seekers' Benefits Act (AsylbLG), they have limited health care entitlements
- Analysis using IAB-BAMF-SOEP survey data provides information on how the AsylbLG impacts different groups of refugees
- Scenario with an extended exclusion period shows: People with low level of education or little German knowledge are affected in particular
- Electronic health insurance card for refugees can cushion the negative effects of the changes to the AsylbLG by dismantling administrative barriers
- Access to health care should be simplified to save costs for the government in the long term

Restricted health care is a burden on refugees and society in the long term



Source: Author's depiction.

FROM THE AUTHORS

"The longer it takes for sick people to receive treatment, the more expensive that treatment becomes. Extending the restrictions to health care entitlements was counterproductive because refugees have to wait even longer to receive adequate care. Refugees with a low level of education and little knowledge of German are particularly affected."

— Louise Biddle —

Extended restrictions to health care entitlements for refugees: negative health consequences without the anticipated savings

By Louise Biddle

ABSTRACT

Refugees have limited health care entitlements during the asylum process. In February 2024, the maximum length of this exclusion period was increased from 18 to 36 months. This increase may double the actual waiting time, which is currently already more than one year, as data from the Socio-Economic Panel show. This particularly affects refugees with a low level of education and little knowledge of German. A longer waiting time not only negatively impacts the health of affected individuals but is also disadvantageous for the state; late treatment often requires more expensive treatment. Thus, shortening the period would have been more sensible than increasing it. The electronic health insurance card (EHIC) for refugees makes access to health services during this waiting period easier, as it reduces administrative barriers. However, just under 20 percent of all refugees have an EHIC, as the system has not been introduced in all federal states. The electronic health insurance card should be introduced nationwide in order to cushion the negative effects of extended restrictions on health care.

At the end of February 2024, the maximum period that a refugee is excluded from health care services under the *Asylbewerberleistungsgesetz* (Asylum Seekers' Benefits Act, AsylbLG) was increased from 18 to 36 months. The AsylbLG regulates the amount and type of social benefits asylum seekers receive before they are entitled to the citizen's benefit (*Bürgergeld*) and other social benefits. According to calculations on draft legislation by the CDU/CSU Parliamentary Group,[1] such an extension should result in savings "in the three-digit million range annually." This draft legislation was preceded by an agreement between the federal and state governments on a series of measures to reduce incentives for refugees to migrate to Germany as well as the costs incurred by state and local authorities, including increasing the exclusion period of the AsylbLG. However, the actual effects of such a change to the AsylbLG have not been discussed in detail. In this Weekly Report, health care will be used as an example to show how increasing the AsylbLG's exclusion period affects the health and integration of refugees as well as the financing of health care.[2] The effect of introducing the electronic health insurance card (EHIC) for refugees in this legal context is also explored.

Asylum seekers, refugees with exceptional leave to remain (*Geduldete*), and refugees required to leave the country (*Ausreisepflichtige*) have limited healthcare entitlements compared to social welfare recipients. By the end of February 2024, this exclusion period lasted 18 months; until September 2019, it was only 15 months. According to Section 4 of the AsylbLG, refugees are entitled to treatment for "acute illnesses and pain," vaccinations and medically required check-ups as well as pregnancy and birth. Further services can be provided on an individual basis according to Section 6 as long as

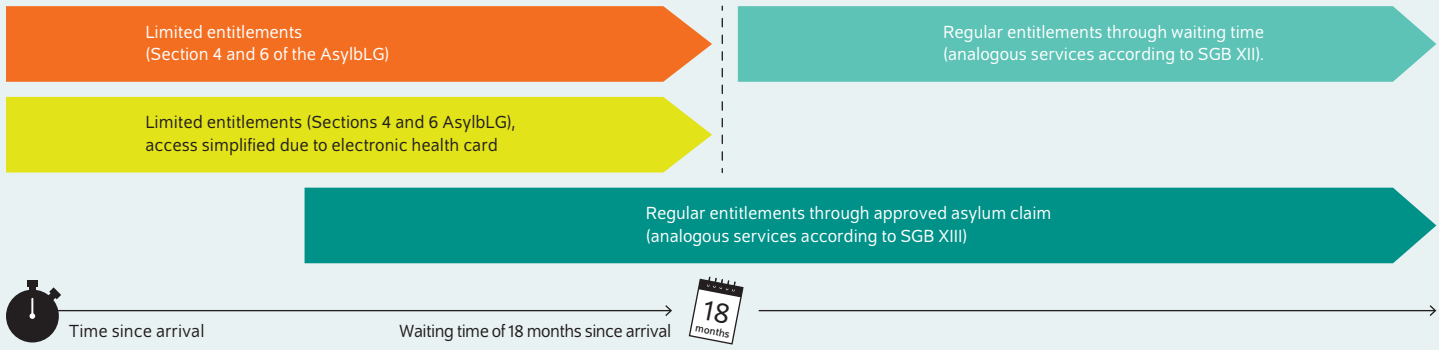
1 Deutscher Bundestag, "Gesetzentwurf der Fraktion CDU/CSU. Entwurf eines Gesetzes zur Weiterentwicklung des Asylbewerberleistungsgesetzes (Asylbewerberleistungsweiterentwicklungsgesetz – AsylbLWG)," *Bundestags-Drucksache* 20/9309 (2023) (in German; available online. Accessed on February 28, 2024. This applies to all other online sources in this report unless stated otherwise).

2 This Weekly Report uses the word refugees. This refers to all people who have submitted an asylum claim in Germany regardless of the result. Thus, this includes people in the middle of their asylum claim as well as people with a positive or negative (such as exceptional leave to remain or a requirement to leave the country) asylum decision. Ukrainian refugees are not affected by the *Asylbewerberleistungsgesetz* and are thus not included in the analysis.

DOI: https://doi.org/10.18723/diw_dwr:2024-12-1

Figure 1

Entitlement to health care under the Asylum Seekers' Benefits Act
Prior to February 26, 2024



Source: Author's depiction.

Until February 2024, refugees had limited entitlements to healthcare for a maximum of 18 months after arrival.

they are "vital to ensuring [...] health." With regard to health care, the AsylbLG offers considerable scope for discretion, as neither "acute pain conditions" according to Section 4 nor the "indispensability" of care according to Section 6 are precisely defined. It is therefore up to the responsible doctors to assess the situation and the social security offices to decide whether they will approve reimbursement.[3] This results in considerable inequality in refugees' realized access to health care.[4] It is clear, however, that refugees must initially expect considerable health care restrictions after their arrival in Germany. Refugees have the same entitlements to health care services as social welfare recipients only after the end of the AsylbLG exclusion period[5] or once their asylum claim has been approved (SGB XII, Figure 1).

The introduction of the AsylbLG in 1993 was accompanied by a change in health care financing from the health insurance companies to the municipalities and thus required a new billing structure. Health care vouchers were introduced for this purpose: Before a doctor's appointment, a refugee must apply for a health care voucher from the responsible social security office. The social security office reviews adherence to the AsylbLG as well as the medical necessity of the doctor's appointment. This process leads to unnecessary delays in treatment and is viewed as a barrier to care by patients and doctors.[6] In addition to the considerable amount of administrative work required, medical laypeople are acting as gatekeepers to the health care system.[7] An alternative system using an electronic health insurance card (EHIC) was introduced in Bremen for the first time in 2005 (Box 1). Currently, the EHIC has been introduced comprehensively in six states: Berlin, Brandenburg, Bremen, Hamburg, Thuringia, and Schleswig-Holstein. The EHIC has also been introduced in individual districts and municipalities in three other states (Figure 2).

The 2019 change to the AsylbLG's exclusion period and the gradual introduction of the EHIC since 2005 have resulted in differing health care entitlements for refugees depending on the place of residence and year. In addition, the entitlements depend on the processing time of the asylum claim, which has varied over the past years and by the applicant's country of origin. The number of refugees with exceptional leave to remain also plays a role, as they are subject to the AsylbLG regulations even after their asylum process has been completed.[8] Due to these circumstances, it is currently unclear how long refugees actually had to wait for full health care entitlements.

To assess the consequences of extending the exclusion period to 36 months, we must look at how many refugees are actually affected by such an extension. That is, how many individuals

3 Amand Führer, "Determinanten der Gesundheit und medizinischen Versorgung von Asylsuchenden in Deutschland," *Bundesgesundheitsblatt* no. 10 (2023): 1083–91 (available online).

4 Oliver Razum, Judith Wenner, and Kayvan Bozorgmehr, "Wenn Zufall über den Zugang zur Gesundheitsversorgung bestimmt: Geflüchtete in Deutschland," *Das Gesundheitswesen*, no. 11 (2016): 711–714 (in German; available online).

5 The exclusion period of the AsylbLG has also been the subject of reform discussions in the past and has been changed several times. Until September 2019, the period was 15 months. Between 2007 and 2015 it was 48 months, between 1997 and 2007 it was 36 months, and between 1993 and 1997 it was 12 months.

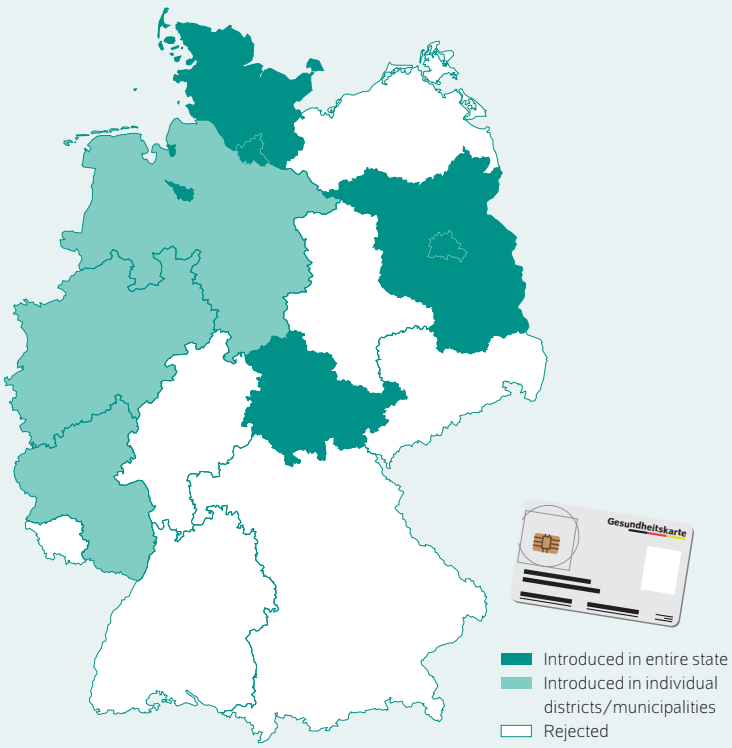
6 Anke Spura et al., "Wie erleben Asylsuchende den Zugang zu medizinischer Versorgung?" *Bundesgesundheitsblatt* 60 (2017): 462–470 (in German; available online).

7 Führer, "Determinanten der Gesundheit und medizinischen Versorgung von Asylsuchenden in Deutschland."

8 Many refugees whose asylum claim is rejected are granted an exceptional leave to remain, as returning to their home country is not possible for various reasons. In recent years, the share of people whose asylum claim has been rejected who have been given exceptional leave to remain has consistently been around 80 percent. Cf. information on the website of the Mediendienst Integration (in German).

Figure 2

Coverage of the electronic health insurance card (EHIC) for refugees in Germany



Source: Information portal of Medibüro/Medinetze (as of February 2024).

The electronic health insurance card has been introduced comprehensively in six federal states, while it has been partially introduced in three other states.

are expected to remain without a positive asylum decision during this period. Furthermore, it is unclear who is affected by long waiting times: The length of the asylum process varies depending on the applicant's country of origin, meaning that the actual waiting time for regular health care entitlements can vary greatly for certain groups of refugees. The burden of disease, especially for chronic illnesses, is higher among older refugees, women, or refugees with a low level of education and these groups thus have a higher need for health services.[9] If these groups experience very long waiting times, they experience a double hardship: Not only are they ill more often and more acutely, but they also experience additional barriers in accessing the health care system.

Some states have introduced the EHIC for refugees to simplify administrative access to health care during the AsylbLG exclusion period. However, it is currently unclear who the EHIC benefits. The waiting times for different groups of

9 Louise Biddle et al., "Health monitoring among asylum seekers and refugees: a state-wide, cross-sectional, population-based study in Germany," Emerging Themes in Epidemiology 16, no. 3 (2019) (available online); Jan Michael Bauer, Tilman Brand, and Hajo Zeeb, "Pre-migration socioeconomic status and post-migration health satisfaction among Syrian refugees in Germany: A cross-sectional analysis," PLoS Med 17 (2020) (available online).

Box 1

Electronic health insurance card for refugees

The electronic health insurance card for refugees makes it possible for refugees to use health care services legally without a health care voucher. Refugees receive a chip card that they can use to receive health care services directly in the same way as the statutorily insured via a framework agreement between state authorities and a health insurance provider. To this end, a range of services is defined in advance at state level that complies with the AsylbLG.[1] The costs of medical care are covered by the municipality, but the services are cheaper, as the municipalities now are subject to the health insurance providers' cost catalog.[2] The health care companies receive an administrative fee per chip card for their efforts; this is ten euros per month per person in Hamburg, for example.[3] The EHIC makes access to health care easier by removing bureaucratic obstacles for both patients and doctors, by creating clarity about the scope of health care services, and by minimizing waiting times associated with the health care voucher system.

In addition to the benefits for the municipalities, the introduction of the EHIC has significant benefits for the general health status and mental health of refugees.[4] These benefits are especially evident for refugees with language barriers.[5] In addition, the introduction of the EHIC results in higher utilization of primary care[6] while lowering utilization of emergency care.[7]

1 In practice, negotiating a benefits catalog with the health insurance providers often means that the restrictions of the AsylbLG are less severe in regions with the EHIC and, with a few exceptions, correspond to the benefits catalog of the statutory health insurance companies, see Marcel Wächter-Raquet, *Einführung der Gesundheitskarte für Asylsuchende und Flüchtlinge. Der Umsetzungsstand im Überblick der Bundesländer.* (Gütersloh: 2016, Bertelsmann-Stiftung) (in German; available online).

2 Without a framework agreement with a health insurance provider, the rates of private health insurance companies generally apply.

3 Wächter-Raquet, *Einführung der Gesundheitskarte für Asylsuchende und Flüchtlinge.*

4 Philipp Jaschke and Yuliya Kosyakova, "Does Facilitated and Early Access to the Healthcare System Improve Refugees' Health Outcomes? Evidence from a Natural Experiment in Germany," *International Migration Review* (2021): 812–842 (available online).

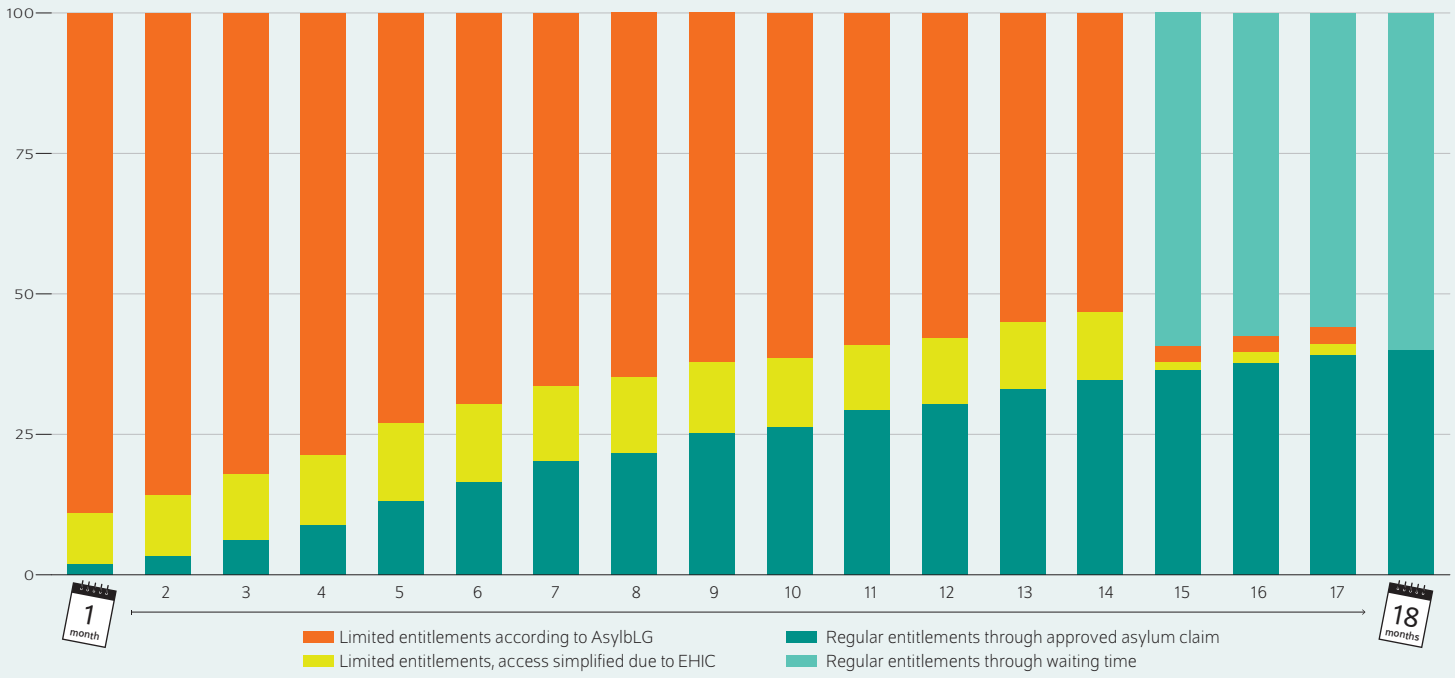
5 Jaschke and Kosyakova, "Does Facilitated and Early Access to the Healthcare System Improve Refugees' Health Outcomes?"

6 Kevin Claassen and Pia Jäger, "Impact of the Introduction of the Electronic Health Insurance Card on the Use of Medical Services by Asylum Seekers in Germany," *International Journal of Environmental Research and Public Health* (2018): 856 (available online).

7 Judith Wenner et al., "Differences in realized access to healthcare among newly arrived refugees in Germany: results from a natural quasi-experiment," *BMC Public Health* 20 (2020): 846 (available online).

Figure 3

Entitlements to health care system by months after arrival
In percent of all refugees



Note: Refugees who came to Germany between 2013 and 2020. Thus, for the majority of individuals, the maximum exclusion period was 15 months. Since 2019, the maximum exclusion period has been 18 months.

Source: Author's calculations using the Socio-Economic Panel (v. 38.1), wave 2021.

In only some cases is the maximum period of restricted entitlements to health care shortened by an approved asylum claim.

refugees and the extent to which the introduction of the EHIC simplifies access to health care during the waiting period can be examined in more detail in a cross-sectional analysis using data from the 2021 IAB-SOEP-BAMF Survey of Refugees (Box 2).

Refugees' have an average waiting time of over one year before receiving full health care entitlements

Overall, refugees who were living in Germany in 2021 waited over one year (376 days) until they received full health care entitlements. Sixty-four percent of the refugees had to wait for the end of the AsylbLG exclusion period,[10] whereas 36 percent were granted regular entitlements earlier due to their asylum claim being accepted. Thus, the majority of refugees experience a long exclusion period under the AsylbLG (Figure 3).

There are slight but statistically significant differences between men and women in the waiting period until full health care entitlements. On average, women had to wait 17 days longer than men (Figure 4). Refugees with a low level of education also had to wait longer: On average, they waited 24 days longer than refugees with a medium level of education.

36-month exclusion period likely to increase disadvantages for refugees with a low level of education and little knowledge of German

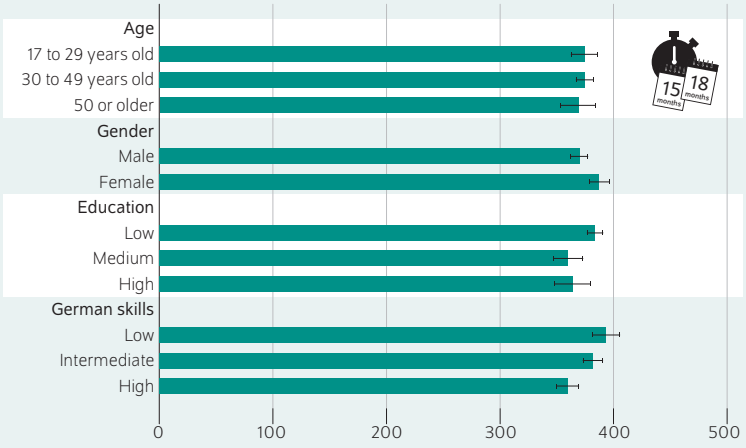
If refugees who were living in Germany in 2021 had had a waiting time of 36 months instead of 18 (or 15), they would have waited an additional 352 days on average before receiving regular health care entitlements. Fifty-two percent of the refugees would have had to wait for the end of the AsylbLG's exclusion period—so 36 months—whereas 48 percent would have received earlier access due to their asylum claim being accepted.

A hypothetical validity period of 36 months greatly exacerbates the differences in waiting times: Refugees with a low level of education would have to wait around three months longer than refugees with an intermediate or high level of education (Figure 5). Refugees with little or intermediate knowledge of German would have also had to wait around two months longer than refugees who understand German well.

10 At this time: 15 or 18 months.

Figure 4

Waiting time to regular health care entitlements by subgroup[1]
In days



1 Refugees who came to Germany between 2013 and 2020. Thus, for the majority of individuals, the maximum exclusion period was 15 months. Since 2019, the maximum exclusion period has been 18 months.

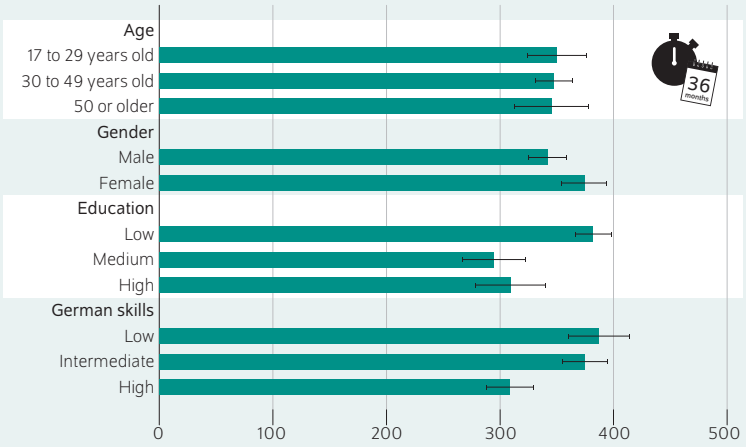
Note: The 95-percent confidence interval means that in 95 percent of cases, the unknown actual value is within this interval. The probability of error is therefore five percent. The narrower the interval, the more accurate the estimated effect.

Source: Author's calculations using Socio-Economic Panel data (v 38.1), wave 2021.

The waiting time for regular health care entitlements shows slight, but statistically significant, differences according to level of education and gender.

Figure 5

36-month scenario: Additional waiting time until regular health care entitlements by subgroup[1]
Average in days



1 The scenario examines the waiting time for refugees who arrived in Germany between 2013 and 2020 had they been subject to a maximum exclusion period of 36 months (compared to the actual exclusion period of 15 or 18 months).

Note: The 95-percent confidence interval means that in 95 percent of cases, the unknown actual value is within this interval. The probability of error is therefore five percent. The narrower the interval, the more accurate the estimated effect.

Source: Author's calculations using Socio-Economic Panel data (v 38.1), wave 2021.

Increasing the exclusion period exacerbates inequalities in waiting time according to education and German skills.

Majority of refugees do not benefit from the electronic health insurance card

In 2021, 24 percent of all refugees lived in a region that uses the electronic health insurance card. The gradual introduction of the EHIC since 2005 has resulted in easier access to health care services for a total of 17 percent of all refugees. Seven percent of refugees had full access to the health care system at the point of introduction and could thus not benefit from the EHIC although they lived in a region where it was in use (Figure 6). Thus, so far only very few refugees or municipalities have been able to benefit from the introduction of the EHIC (Box 1). The majority of refugees must face the uncertainty, extra effort, and treatment delays associated with the health care voucher system.

In addition, regional coverage of the EHIC is associated with inequality in regard to the refugees' level of education: Thirty-four percent of refugees with a high level of education live in a region with the EHIC. However, only 22 and 23 percent of refugees with an intermediate or low level of education, respectively (Figure 6), live in a region with the EHIC. Like the maximum exclusion period of the AsylbLG, the administrative regulations in the states result in a systematic health disadvantage for refugees with a low level of education, although this group generally has a higher burden of disease and already faces greater obstacles in accessing health care services.

Longer exclusion period from healthcare entitlements: Hope for cost savings is short sighted

The actual waiting time until regular health care entitlements is already significant and will more than double by expanding the AsylbLG exclusion period to 36 months. It is short-sighted to assume that limiting health care services will save money. In contrast, studies show that limiting refugees' health care is more cost-intensive in the long run.[11] This is because limiting health care access increased the chance that emergency or intensive treatment is required. Early intervention in primary care, on the other hand, can prevent expensive hospital stays, complex diagnostic procedures, and serious disease progression.[12]

The argument of cost savings is also short-sighted, as it ignores the consequences of poor health on refugees' social and economic participation. It is well documented that serious illness restricts a person's ability to participate in educational opportunities, find and keep a job, take care of their family, and participate in social activities.[13] Not addressing

11 Kayvan Bozorgmehr and Oliver Razum, "Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994–2013," *PLoS ONE* 10 (2015): (available online).

12 Aldo Rosano et al., "The relationship between avoidable hospitalization and accessibility to primary care: a systematic review," *European Journal of Public Health* (2013): 356–360 (available online).

13 Maria K. Christensen et al., "The cost of mental disorders: a systematic review," *Epidemiology and Psychiatric Sciences* 29 (2020) (available online).

Box 2

Data and methodology

This Weekly Report uses data from the Socio-Economic Panel's IAB-SOEP-BAMF Survey of Refugees (M3-M6) (SOEP, v.38.1).[1] This is a collaborative project between the SOEP, the Institute for Employment Research, and the Federal Office for Migration and Refugees that collects representative data on refugees who have been in Germany since 2013.[2] The newest available data from the 2021 survey is used in the analyses. The data analysis methodology is a means comparison of the waiting times 1) under current conditions, and 2) under a hypothetical expansion of the AsylbLG's exclusion period to 36 months within and between groups with 95-percent confidence intervals. The coverage of the electronic health insurance card is calculated as a proportion of all refugees.

To calculate the waiting time until regular health care entitlements under the current conditions (as of January 2024), two pieces of information are linked: the time since arrival in Germany and the date of approval of the asylum claim. If the approval occurred during the exclusion period of the AsylbLG (15 months or 18 months after September 21, 2019), time to approval was considered as the waiting time until regular entitlements. Otherwise, the exclusion period of the AsylbLG was used. If no information about the date of arrival in Germany was available, the date of the asylum claim is used. Individuals who have not yet received a decision on their asylum claim at the time of the survey and were still subject to the exclusion period of the AsylbLG, and for whom the final waiting time was thus unclear, are excluded from the analysis. Overall, 2,181 refugees who participated in the 2021 survey are included in the analysis.

Data on the date of arrival and the asylum claim are available for the respective month and year. For this analysis, however, days are used as the measure by using the midpoint of each month (the 15th day). It is assumed that the arrival of refugees is evenly distributed over the month, so a correct average number of days is calculated with a sufficiently large sample size. An advantage to using days instead of months is that distortions can be avoided if this information is linked with legislative changes, as these often happen at the beginning of a month.

In order to evaluate the waiting time under a hypothetical expansion of the exclusion period of the AsylbLG to 36 months, data on the date of arrival in Germany and the date the asylum claim was approved are similarly linked. However, in this case, a waiting time of 36 months is determined if the asylum claim was not approved within the first 36 months. Otherwise, the time until approval is considered as the waiting time. As with the evaluation of the waiting time under current conditions, people who had not yet received a decision about their asylum claim and had been in Germany for less than 36 months at the time of the survey are excluded from the analysis. For this hypothetical scenario, 2,152 refugees who participated in the 2021 survey are included in the analysis.

Regional data from SOEP is used to evaluate the coverage of the electronic health insurance card. These are linked with the date of introduction in the respective federal states, counties, or municipalities.[3] A survey respondent could benefit from the electronic health insurance card if they lived in a region with the EHIC and its introduction happened before they received regular access to the health care system (before the expiry of the AsylbLG exclusion period or the asylum claim).

To investigate inequalities in regard to people with a special need for health care, the calculated waiting time and EHIC coverage are considered separately according to four characteristics: gender (male/female), age group (17–29/30–49/50+), level of education in home country based on the ISCED-11 classification (low/medium/high), and German language skills, with speaking, writing and reading skills each recorded on a scale of 1-5, summed, and then tertiles of the total score formed (low/medium/high).

Cross-sectional weights are used for the analyses so that the results are representative for refugees living in Germany in 2021 (excluding Ukrainian refugees, as the AsylbLG does not apply to them).

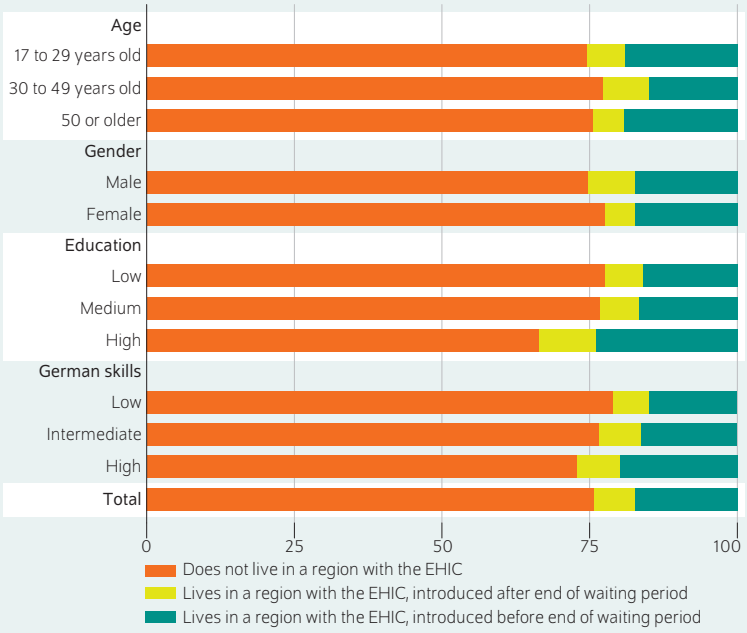
1 Socio-Economic Panel, *Daten der Jahre 1984-2021 (SOEP-Core, v38.1, Remote Edition – Update* , 2023, available online).

2 Herbert Brücker, Nina Rother, and Jürgen Schupp, "IAB-BAMF-SOEP-Befragung von Geflüchteten 2016. Studiendesign, Feldergebnisse sowie Analysen zu schulischer wie beruflicher Qualifikation, Sprachkenntnissen sowie kognitiven Potenzialen," *IAB-Forschungsbericht*, no. 13 (2017) (in German; available online).

3 For more on this process, cf. Philipp Jaschke and Yuliya Kosyakova, "Does Facilitated and Early Access to the Healthcare System Improve Refugees' Health Outcomes?" Evidence from a Natural Experiment in Germany," *International Migration Review* 55 (2021): 812–842 (available online).

Figure 6

Electronic health insurance card (EHIC) coverage by subgroup
In percent of refugees



Source: Author's calculations using Socio-Economic Panel data (v 38.1), wave 2021.

The electronic health insurance card has only benefitted a small number of refugees; refugees with a low or medium level of education are at a disadvantage.

health problems at an early stage with needs-based care can result in significant, long-term social and economic costs for the federal government and the social systems.

Thus, the savings cited in the CDU/CSU Parliamentary Group's draft legislation cannot be scientifically justified in regard to health care. Moreover, the presumption that increasing the exclusion period of the AsylbLG will make Germany a less attractive destination and that the number of asylum seekers will decline is not scientifically grounded.[14] In the context of forced migration, it is predominantly the conditions and events in the origin country that determine if asylum figures rise or fall, while more or less restrictive laws in destination countries play a less important role.[15]

Furthermore, increasing the exclusion period of the AsylbLG particularly affects refugees with a low level of education and little knowledge of German. However, these are the refugees that have the highest disease burden and thus require swift, appropriate care.[16]

Conclusion: Reduce health care access barriers for refugees

The existing legal and administrative provisions for refugees' access to health care are restrictive and will be further tightened by extending the AsylbLG to 36 months. This is a clear violation of the right to health, to which Germany has committed itself by ratifying the UN International Covenant on Economic, Social and Cultural Rights.[17] The restrictions are often justified by their temporary nature, but the long processing time of asylum claims in Germany, the high asylum claim acceptance rate, and the high share of refugees with exceptional leave to remain mean that the restrictions affect the people who remain in Germany for long periods of time.

Moreover, the health care restrictions result in negative health outcomes for refugees in the short-term, as well as incurring long-term costs for the state if delayed treatment results in high costs for emergency or intensive care. Instead of creating additional legal barriers for refugees, access to the health care system should be made easier, for example through low-threshold health care provision in refugee shelters,[18] the nationwide introduction of the EHIC to remove administrative barriers,[19] and appropriate interpretation and translation services.[20]

The introduction of the EHIC for refugees offers significant health and economic benefits, but is insufficiently implemented. By removing administrative barriers related to the health care voucher, health care services can be accessed earlier instead of delaying treatment. Arguments against the introduction of the EHIC are the relatively high administration fees charged by health insurance companies and the feared increase in health care costs. However, administrative costs of 1.6 million euros were saved annually in Hamburg using the EHIC compared to the health care voucher system.[21] Furthermore, easier access to health care via the EHIC did not lead to inappropriate use: In the Ruhr area, for example, the number of doctor's visits increased following the introduction of the EHIC, but was still lower than among non-refugees.[22] Thus, primary health care costs may rise in the short term depending on health needs.[23] However, this

14 Wissenschaftlicher Dienst des Deutschen Bundestags, *Push- und Pull-Faktoren in der Migrationsforschung* (2020) (in German; available online).

15 T.J. Hatton, "The Rise and Fall of Asylum: What Happened and Why?" *The Economic Journal* 119 (2009): 183–213 (available online).

16 Bauer, Brand, and Zeeb, "Pre-migration socioeconomic status and post-migration health satisfaction among Syrian refugees in Germany."

17 Kayvan Bozorgmehr, Judith Wenner, and Oliver Razum, "Restricted access to health care for asylum-seekers: applying a human rights lens to the argument of resource constraints," *European Journal of Public Health* 27 (2017): 592–593 (available online).

18 Katharina Wahedi et al., "Medizinische Versorgung von Asylsuchenden in Erstaufnahmeeinrichtungen," *Bundesgesundheitsblatt* 63 (2020): 1460–1469 (in German; available online).

19 Führer, "Determinanten der Gesundheit und medizinischen Versorgung von Asylsuchenden in Deutschland."

20 Amand Führer and Patrick Brzoska, "Die Relevanz des Dolmetschens im Gesundheitssystem," Gesundheitswesen (2022): 474–478 (in German; available online).

21 Frank Burmester, *Auswirkungen der Zusammenarbeit mit der AOK Bremen / Bremerhaven aus Sicht der Behörde für Arbeit, Soziales, Familie und Integration. Fachtag Gesundheitsversorgung Ausländer – Best Practice Beispiele aus Hamburg* (Berlin: 2014) (in German; available online).

22 Pia Jäger et al., "Does the Electronic Health Card for Asylum Seekers Lead to an Excessive Use of the Health System? Results of a Survey in Two Municipalities of the German Ruhr Area," *International Journal of Environmental Research and Public Health* 16, no. 7 (2019) (available online).

23 Alfons Hollederer, "Die Gewährleistung von Krankheitshilfen bei asylsuchenden Menschen: Zweiklassenmedizin in Deutschland?" *Bundesgesundheitsblatt* (2020): 1203–1218 (In German; available online).

expenditure is a long-term investment for the state that avoids expensive emergency and hospital treatments.[24]

Changes to the AsylbLG were made with the hope of saving money and reducing Germany's appeal as a destination for refugees. However, a look at the public health evidence shows that these assumptions cannot be substantiated in the health sector. In contrast: Considering the costs for the state and the affected refugees, it would make more sense to shorten the exclusion period of the AsylbLG rather than extend it. The nationwide introduction of the EHIC could minimize administrative barriers to accessing health care during the waiting period. The introduction of the EHIC should be actively pursued, especially now that the change to the AslybLG is further exacerbating the health situation of refugees.

24 Hollederer, "Die Gewährleistung von Krankheitshilfen bei asylsuchenden Menschen."

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