January 2020
Volume: 17, **No**: 1, pp. 155 – 163
ISSN: 1741-8984
e-ISSN: 1741-8992
www.migrationletters.com

First Submitted: 14 January 2019 Accepted: 7 August 2019
DOI: https://doi.org/10.33182/ml.v17i1.680

Inequalities in Healthcare Provision to Third Country Nationals in Cyprus and the Prospect of a Promising Health Reform

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Abstract

The rise of migratory inflows in post-crisis Cyprus raised crucial policy challenges, one of which was about the urgent and pressing problem of their access to healthcare services. The old system was characterised by health inequalities that resulted in high unmet needs, especially among migrants from third countries. Drawing on a document analysis of legislative acts, official reports and research papers regarding national health policy, as well as pilot findings from the field, the main aim of this paper is to shed light on this situation and explore under what conditions the ongoing healthcare reform could address the problem of coverage and access to healthcare services for this vulnerable group.

Keywords: *Access to healthcare; inequalities; third country nationals; Cyprus.*

Introduction

Cyprus, as a member state of the EU since 2004, has been considered an attractive migration destination due to its strong economy and rewarding labour market. The high migratory inflows of the last fifteen years came to a halt only in 2012-2015, due to the unprecedented financial crisis that hit the country. However, since 2016, migration flows have risen again, particularly in the last half of 2018, for various reasons including the rapid recovery of the economy. A large proportion of the newcomers come from non-European countries, mainly from the Philippines, Sri Lanka and India (Republic of Cyprus, 2017), covering labour shortages especially in the low-skilled sectors of the economy. Additionally to the increased labour migration, there is also the exacerbation of the refugee crisis; 70% increase in asylum seekers[4] and 285% in granting refugee status since 2014 (Republic of Cyprus, 2017a). Further to the above, Cyprus in 2016 was the third country in the EU, behind Luxembourg and Malta, with the highest proportion of migrants (20.4 per 1000 inhabitants vs EU average of 4.6 per 1000 inhabitants) and among the top EU countries with the highest shares of non-EU citizens (Eurostat, 2018).

In spite of the relatively high share of third country nationals, which in 2017 accounted for 7% of the total population[5] and the importance of this workforce for the economy in terms of boosting competitiveness (Christofides et al., 2007), there are distinct voids in social protection and in integration policies adversely affecting migrants' welfare. According to the Migrant Integration

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[4] As the Asylum Service Statistics show, the number of asylum applications rose to 7761 in 2018, compared to 4582 in 2017, 2936 in 2016, 2253 in 2015 and 1728 in 2014.
[5] Eurostat Online Database: Code: [migr_pop3ctb], assessed August 2019.

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Policy Index, a set of indicators that evaluate and compare what governments are doing to promote the integration of migrants, Cyprus ranks 36th out of the 38 countries of the sample (Migrant Integration Policy Index, 2015). Alongside with other serious shortcomings of the Cyprus welfare system, one of the weakest areas of social protection for third country nationals is the provision of healthcare services (Theodorou et al., 2018) resulting to large inequalities between native and third country migrants in terms of health status and access to services. Migrants may experience greater vulnerability to communicable diseases, such as HIV/AIDS or hepatitis and face higher risks of non-communicable diseases and mental health problems. These vulnerabilities are the result of poor socio-economic and living conditions, limited access to services and difficulties in adapting to a completely new challenging work environment in the host country (Rosano et al., 2017; WHO, 2015; Omariba, 2015; Sandvik et al., 2012).

The operation of the new national health system, which launched in June 2019 with the provision of outpatient care and will be fully completed by June 2020 with the provision of hospital care, is expected to fundamentally change the healthcare environment, ensuring universal coverage, improving access and, hopefully, tackling inequalities. The aim of this paper is to analyse how this promising reform is going to affect inequalities in healthcare provision to third country nationals and, furthermore, to provide policy recommendations of how the new system can better achieve health equity, drawing on the analysis of the relevant legislation, official documents and research papers on the topic. Amartya Sen's capability approach is adopted as an interpretive tool to identify the potential pitfalls which might compromise the potential of the new health reform to eliminate health disparities.

Furthermore, it should be noted that the case of Cyprus is interesting for a variety of reasons. Firstly, until 2019, Cyprus belonged among the few EU countries lacking a health system of universal population coverage. Secondly, Cyprus exhibits the highest share of out-of-pocket payments in Europe. The combination of the above, altogether with the statutory exclusion of third country nationals from the old public scheme, created a particularly problematic situation for this group of migrants worth being examined and discussed, especially in the context of a structural reform which promises to fundamentally change the healthcare environment.

The system until May 2019

The system of Cyprus, until the end of May 2019, consisted of a highly centralised publicly funded sector and a poorly regulated private sector. It was characterised by a low level of public spending (2.9% of GDP), high level of private expenditure (3.9% of GDP) and a very high share of out-of-pocket payments (49% of total health expenditure, on a fee-for-service basis). This allocation of resources greatly differentiated Cyprus from the rest of Europe. According to Baeten et al. (2018), on average, nearly 80% of health spending in EU countries is funded through general taxation or compulsory health insurance schemes, 15% by households through out-of-pocket payments and only 5% through voluntary health insurance. The heavy reliance on private expenditure was the root of considerable inequalities.

The public sector provided services through a network of hospitals and health centres that were directly controlled by the Ministry of Health. The private sector, on the other hand, consisted of independent providers, mainly located in urban areas, working in solo or in groups providing services to those who could afford to pay for the treatment, either from their own resources (i.e. uninsured persons as well as public system beneficiaries who were forced to visit private providers

due to the long-waiting times in public hospitals[6]) or through private insurance providers (Theodorou et al., 2018).

Free access to the public healthcare sector was restricted to those who fulfilled a series of criteria. Specifically, the eligible recipients had to satisfy several conditions such as having Cypriot or European citizenship and residing permanently in Cyprus, having contributed to the social protection system[7] and having income below certain thresholds[8]. There were certain exemptions to the above conditions applying to certain categories (civil servants, persons with chronic illnesses, guaranteed minimum income recipients, asylum seekers and recognized refugees). Overall, the beneficiaries of the public system were about 76% of the total population, while third country nationals were explicitly excluded from the provision of free healthcare services. The repercussions of the latter are elaborated in the next section.

Third country nationals' access to healthcare services within the old system

Figure 1 depicts the healthcare options which were available to third country nationals before 2019. An obvious possibility was to stay uninsured and remain exposed to the risk of a serious illness the treatment of which could lead to catastrophic health costs. Yet, according to Cypriot legislation third country nationals who legally resided in Cyprus, most of whom are temporary workers, had to be covered by a private insurance company with the cost of the contract being equally shared between the employer and the employee (Ministry of Interior, 2014). In order to respond to the demand of this type of health coverage, several insurance companies in Cyprus prepared and launched into the market very basic health insurance packages for migrants, which were considered to be more affordable for both employers and employees. These insurance schemes enabled migrants to use the public and private health sectors and be reimbursed for up to 90 percent of the cost incurred. These specific schemes encompassed direct payments which had to be made at the point of access with the healthcare cost being shared between the insurer and the insured on a 90-10 percent basis. An upper threshold existed above of which the insurer was not obliged to reimburse the insured. Furthermore, several services were excluded from reimbursement such as dental and preventive care. According to Kantaris et al. (2014), in the overwhelming majority of cases, migrants were covered by low budget contracts with limited coverage, significant restrictions and problematic utilization of services.

There is no information about the proportion of uninsured third country nationals nor any quantitative evidence on the share of out-of-pocket payments in their, generally low, disposable income or on the incidence of catastrophic health expenditures among migrants living in Cyprus. However, a recent study by Kontemeniotis and Theodorou (2019) shows that out-of-pocket payments in Cyprus are heavily skewed towards the lowest income group. Given that the risk of poverty is very high among third country nationals, (almost reaching 40%)[9], there can be reasonably deduced that young age is the only factor limiting incidences of catastrophic health expenditures among uninsured migrants. Yet, in cases of serious health problems, it was almost certain that either

[6] During the 2012-2015 recession, an increasing number of people turned to the public sector and the problem of waiting lists worsened. For example, knee and hip replacements are being delayed by 30 months and cataract surgeries by 15 months (Theodorou et al, 2018).For example, in many public health care systems, the well-known problem of long waiting lists has usually negative implications for vulnerable groups that mostly bear the burden of the limited supply of services (Abásolo et al, 2014; Laudicella et al, 2012).

[7] In particular, they ought to have paid insurance contributions for a minimum period of three years.

[8] Government Medical Institutions and Services Law of 2013.

[9] According to Eurostat, the poverty rate of adult persons with non-EU28 citizenship in Cyprus reached 39.6% in 2017 (Eurostat Online Database, code: [ilc_li31]).

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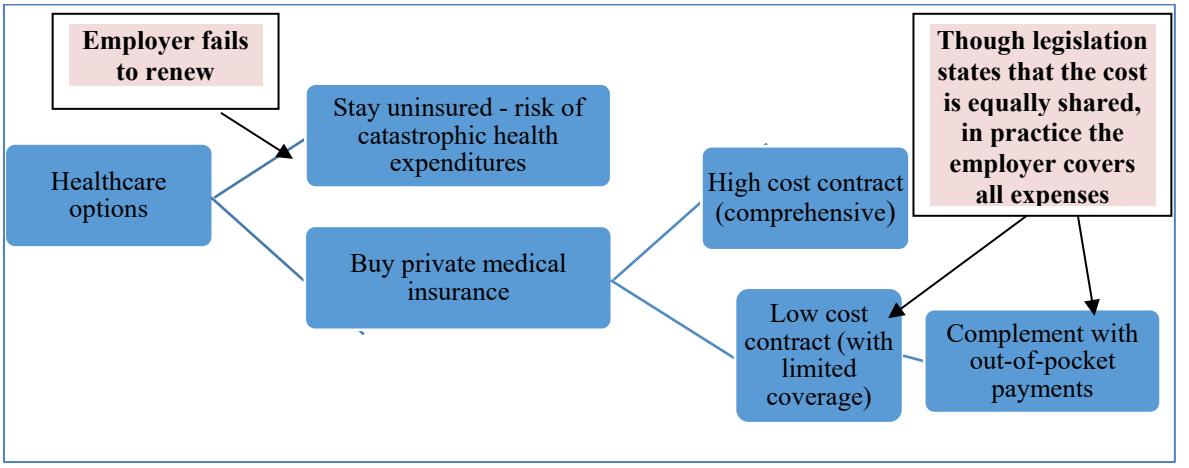
financial difficulties were created for the employer or devastating costs were caused for the migrant himself.

Figure 1: Healthcare options of third country nationals in Cyprus in the old system



Source: Kantaris et al., 2019

A study investigating the role of the Cypriot employer in a sample of migrant domestic workers from third countries, gave a strong indication that some employers failed to renew the basic and low-budget private health insurance contract, leaving the migrant worker exposed to substantial financial and health-related risks (Kantaris et al., 2019). The same study demonstrated the pivotal role of the employers in migrant workers' health matters. In particular, the high degree of dependency between the migrant workers and their employers often acts as a barrier to access healthcare (Kantaris et al., 2019; Kantaris et al., 2014).

Additionally, due to the lack of effective state control, quite a lot of third country nationals remain on the island long after their residence permits expire. These immigrants eventually remain without any health insurance coverage and are either fully dependent on the goodwill of their employer, if there is any employer at all, or rely solely on their own financial means, when they need to visit a doctor. In general, however, the problem of access to health services exists even for those migrants who have private health insurance. Typical example is the case of females from Philippines and Sri-Lanka (almost half of the non-EU population in Cyprus) who work as domestic workers in Cypriot households. Although they are obliged by law to have private health insurance contracts, their access to adequate and quality healthcare services is far from being satisfactory. According to a study, 18.2% of those workers reported unmet health needs of which 10% for pharmaceuticals (Kantaris and Theodorou, 2013). This percentage is extremely high compared to both national and international averages[10]. The study also revealed the complete lack of autonomy in making own healthcare decisions. Sixty-two percent reported that their first action in case of a health problem is to seek advice from their employer, 8 out of 10 that they were accompanied by their employer during their visit to a doctor or hospital and half of them that they use medicines directly provided to them by their employer. In conclusion, the access of third country migrants to

[10] The percentage of self-reported unmet needs for medical care in the total population was 1.6% in EU28 and 1.5% in Cyprus in 2017, (Eurostat Online Database, code: [tespm110].

health services within the previous system was very problematic if they were covered by private health insurance and non-existent if they were not.

The new system

After more than 20 years of discussions and planning on health, eventually in June 2017, the Parliament approved two bills, which opened the road for the establishment of a new National Health System (NHS). This long-anticipated[11] modern scheme is a comprehensive health system of universal coverage, financed by contributions levied on the beneficiaries' annual earnings, along with contributions from employers and the state. The new system is in the process of implementation. It began its operation in June 1st 2019, with the provision of outpatient care services (family doctors and specialist, laboratory tests and medicines) and will be fully operational a year later, in June 1st 2020, by providing inpatient care.

The ongoing health reform will bring together the public and private sectors, under a single-payer system, into a competitive environment, in which public and private providers will compete each other for patients, based on quality and not price. The reform leads to changes in financing, coverage, provider payments, administration, auditing and data collection, which are anticipated to improve quality of care, equity of access, efficiency and financial protection of beneficiaries, elements that were not safeguarded by the old system.

Beneficiaries of the new system will be all Cypriot and European citizens, third country nationals with permanent residence status (or having acquired the right of equal treatment as defined by the national legislation), their dependent family members as well as refugees and persons under subsidiary protection. The income criteria of the previous system as well as other prerequisites granting access to the public system have been abolished. Each beneficiary is now entitled to choose his or her family doctor, who will have a gatekeeping role. The new system will provide full coverage to all beneficiaries, including the treatment of chronic and severe illnesses. Thus, for the first time in Cyprus, migrants will have the same healthcare coverage as all Cypriot and European citizens, reducing or even eliminating the disadvantages of the previous state of dependency on private insurance.

In principle, the successful implementation and efficient operation of the new system is expected to reduce overall out-of-pocket payments at a large extent, bringing them closer to the EU average. This is particularly important for low-income households and especially third country nationals as it can significantly reduce unmet health needs which were caused due to cost considerations under the old regime and limit the risk of catastrophic health-related expenditures.

Should we be optimistic?

Although there are good reasons to be optimistic, since the new system will ensure universal coverage and free access to both the public and the private sector for all beneficiaries, including third country nationals, the risks are always there in such major reforms. For example, despite that the law, in principle, aims at creating an equitable system to adequately protect the poor and the most vulnerable groups, there is the risk of turning into a system, which fosters inequalities through the creation of two-tier patients. This could happen to some extent if a significant number of "well-

[11] The legal foundation for a new national health system was agreed by Parliament in 2001 [General Healthcare System Law of 2001 (N. 89(I)/2001)], but the implementation of this founding law had been continuously postponed for nearly two decades.

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known" private doctors and hospitals refuse to join the new system[12], resulting to high-income patients having the additional choice of receiving high quality services from the private sector, unlike to low-income patients.

Moreover, according to Ruger (2006), who has applied Amartya Sen's capabilities approach[13] to healthcare provision, providing the same service to all is not adequate to address health inequalities if individuals' actual opportunities for a healthy life are not taken into account. In this conceptual framework, factors such as the availability of quality services, attitudes towards health and health agency (defined as the individual's ability and freedom to make right choices concerning his/her health) are fundamental to understanding and interpreting differences in health outcomes (Ruger 2006, 2010). Specifically, health agency seems to be very relevant in regard to the effective utilisation of healthcare services among migrants (Abel and Frohlich, 2012). Indeed, in many countries, even though migrants have access to public healthcare systems or are covered by insurance packages, a confluence of individual and institutional factors are responsible for the existence of considerable health disparities between them and natives (Allin et al., 2007; Baeten et al., 2018; Klein and von dem Knesebeck, 2018), while there is also evidence that targeted integration policies might reduce these inequalities (Giannoni, 2016).

In the context of Cyprus, Pithara et al. (2012) found that third country migrants with temporary residence permits, even if they have access to healthcare services, still face considerable difficulties in effectively utilising the health resources which are available to them. Language is an often-mentioned barrier as newcomers from third countries do not speak Greek, while the functionality of their English is limited. Effective communication between the patient and the health professional is crucial, and its lack might result to frustration, lack of trust and misdiagnosis. In the case of domestic workers, as already discussed, the employers often act as an 'informal' mediator between the worker and the health professional. However, this practice clearly limits the autonomy of the patient, while there is also evidence that may lead to misunderstandings with serious health consequences (Flores, 2005). Studies also suggest that health professionals might be predisposed with stereotypes stemming from patients' ethnicity (WHO, 2010). Despite that perceived stereotypes do not necessarily result to a low quality of service; yet, they might discourage migrants from utilising services by causing them sentiments of frustration (Pithara et al., 2012).

Ignorance or incomplete knowledge of rights has also been highlighted as a factor seriously limiting individual's capabilities. In the case of Cyprus, it is evident from recent studies that information to migrants about the healthcare system is very poor. The majority of migrants from third countries have poor or moderate knowledge on health insurance issues and the healthcare system in Cyprus, including issues pertaining to access to services (Kantaris et al., 2014; Kouta et al., 2013; Pithara et al., 2012). Long bureaucratic procedures and administrative complexities might act as deterrents, especially among migrant groups which are accustomed to completely different health systems and practices and, additionally, might be alienated due to their limited linguistic capacity and their continuous struggle to adapt in a new challenging environment.

[12] Two months after the implementation of the first phase the new system, many specialists and the majority of private hospitals refuse to join the new system, demanding higher fees and the right to practice private medicine within the new system for additional income.

[13] Amartya Sen deployed the well-celebrated capability approach in his text-book "Commodities and Capabilities", Sen (1985).

More importantly, health illiteracy is likely to exacerbate by the introduction of a completely new and relatively complex institutional environment regulating healthcare choices. This was evident from a new pilot study where key informants[14] who were invited to participate, reported ignorance about the new system underway and the recent inception of primary care as a first phase leading to its full implementation in June 2020. Findings also show that migrants had very little knowledge about how to register in the new system so as to become beneficiaries and about the new structure of family doctors. In those few cases that they were aware of the new coverage conditions, this information was mainly originating from their employers, who were responsible for the payment of the contributions in accordance to the legislation. Those migrants-key informants who had already accessed the new primary care system, were better informed about the new system and more satisfied particularly with respect to the free of charge provision of services. The findings of this pilot study show that employers continue to remain the primary source of information on health-related issues for immigrants. The dependence on the employer may have to some extent different content compared to the old system such as the online registration in the new system and the choice of a family doctor, which is usually the same for both the employer and the migrant.

It is sensible to hypothesize that these obstacles and inequities will be transmitted to the new system unless policymakers adopt specific policies and take action to eradicate them. Yet, as the public and policymakers are predominantly preoccupied with several macro-level issues concerning the economic sustainability of the system as well as overcoming the resistance of interest groups in implementing the scheme[15], not much emphasis has been given on integration policies. Furthermore, particular sub-groups of migrants might continue to have problematic access to the new system. Undocumented migrants might be deterred from accessing public hospitals due to fear of deportation (as it is the case today), while it is not entirely clear how the new system will address the particular needs of an increasing population of asylum seekers (Theodorou et al., 2018).

Concluding remarks

Among other aspirations, the new healthcare reform promises to remedy long-standing health inequalities, which are especially intense for migrants from third countries. The main message of this paper is optimistic. Undoubtedly, the provision of universal coverage is a big step forward in accordance to the wider EU health and social policy goals. Indeed, according to the 16th principle of European Pillar of Social Rights "*Everyone has the right to timely access to affordable, preventive and curative health care of good quality"* (European Commission, 2017); a recommendation clearly violated by the old system. However, critical challenges and obstacles lay ahead. Most importantly, policymakers should be aware that the provision of universal coverage does not guarantee health equity, especially when the focus is on very vulnerable groups, which face multidimensional disadvantages in terms of health literacy, perceived stereotypes, limited awareness and/or enforcement of their social rights, marginalisation and social exclusion.

In such cases, the most important message is that whenever policymakers reform a health care system, social integration policies should be adopted and measures should be taken targeting both patients and health providers, in order to reduce those factors leading to health inequalities. Both the international literature and practice have shown that measures such as increasing the number of migrant health professionals, improving the intercultural competencies among professionals, using

[14] These were representatives of migrant workers and international student organised groups.

[15] For an elaborate discussion on these issues, see "Inequalities in access to healthcare: Cyprus", by Theodorou et al. (2018) and "Is the healthcare reform process in uncharted waters?" by Theodorou (2019).

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cultural mediators, informing beneficiaries about their rights and adopting measures to promote health literacy can significantly reduce health inequalities. Finally, it is important to develop migrant-related health indicators in order to promote accountability among health administrators.

Lastly, the effective operation of the new system is crucial. From the two first months of its operation, the results are encouraging. The problems during these first 60 days were not very serious and, most importantly, were manageable. Most problems had to do with the difficulties of providers in using the NHS information system, but also with the lack of adequate information about the new access procedures to various health services. In some cases these problems have created crowding in waiting rooms and delays in patient care. These difficulties seem to be gradually addressed and the new system appears to embark progressively on a steady path. Furthermore, more and more specialists of the private sector are contracting with the system, while the referral system is working satisfactorily. Time seems to work in favour of the new system.

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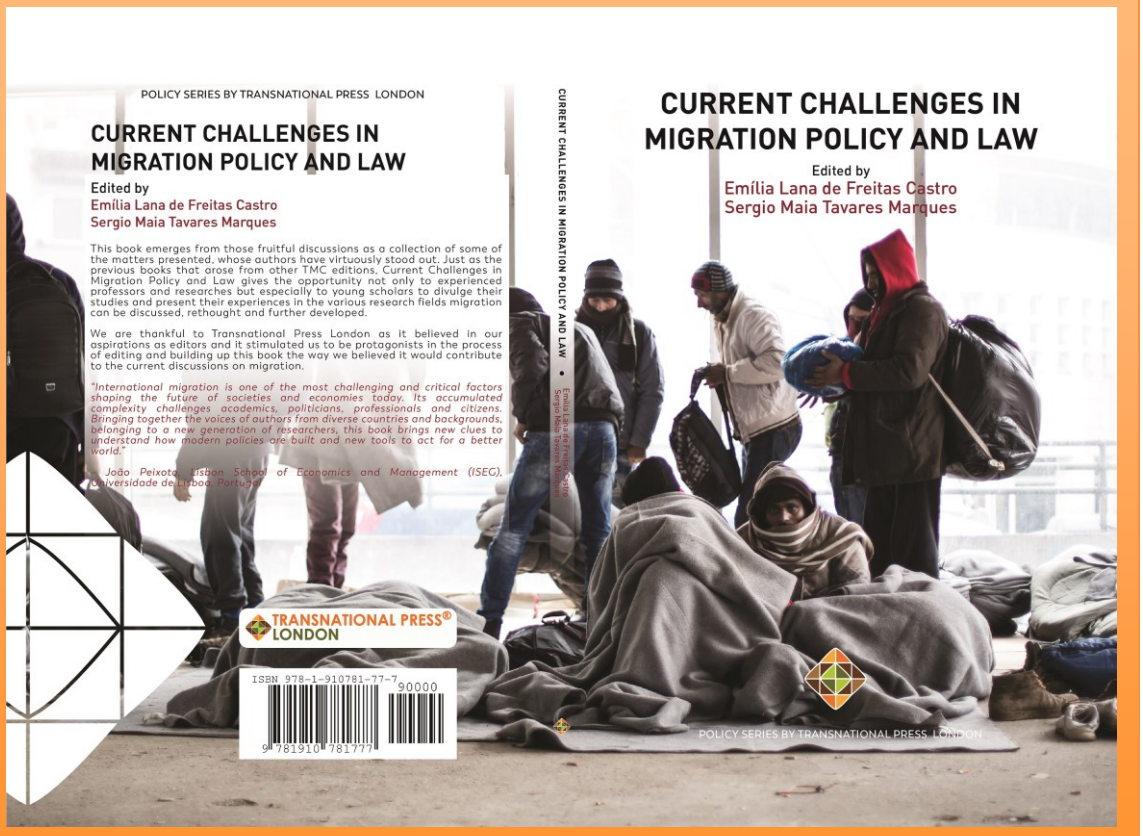

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