Thoughts on the Importance of a Migrant Health Database in Connection with the Asylum Crisis of 2015 on the Occasion of the Consensus Conference

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The article examines public health issues related to the asylum crisis of 2015 in the European Union. It does so by first reviewing the Consensus Conference held in Pécs on the 8-9th October 2019. It examines legal aspects of creating a migrant health database on a European level consisting of health data of migrants and asylum-seekers in order to tackle public health risks brought by the mass influx of refugees. As a final point, the article suggests two possible ways to incorporate the migrant health database to the reform of the Common European Asylum System.

Keywords: European Union, asylum system, CEAS, public health, infectious diseases, Dublin System, reception conditions, European Parliament, European Commission

1. Introduction

There are many aspects of the asylum crisis of 2015 in the European Union. Most of the legal literature is engaged with the upcoming reform of the Common European Asylum System (CEAS) since the crisis showed that it has systemic flaws which must be corrected. However, another important aspect of the crisis is the public health system of member states in the context of migration and asylum. This article will specifically deal with the public health problems originating from the asylum crisis.

The so-called Consensus Conference organized by the Department of Operational Medicine WHO Collaborating Centre at the University of Pécs Medical School on the 8-9th of October 2019 aimed to discuss the importance of migrant health with specific regard to asylum-seekers. The purpose of the conference was to achieve consensus on conditions for establishing a European level migration health database, hoping that the common points determined could even guide lawmakers in creating such a database. On the first day presenters emphasized the importance of creating such a database which was followed by thematic workshops dealing with a diversity of questions which may arise in connection with the creation of a migrant and refugee health database. They discussed the potential data sources of which this database could feed, examined the legal aspects of creating a database which would clearly incorporate special categories of personal data,[2] exchanged best practices stemming from country experiences, studied the possibility of the integration of the data on refugee and migrant health in health information systems in the WHO European Region and last but not least discussed one of the most challenging aspects of creating such a database, namely how

[1] The study was supported by the ÚNKP-19-2 New National Excellence Program of the Ministry for Innovation and Technology.

[2] The special categories of personal data include personal data concerning the health of the data subject. See; *Handbook on European data protection law*. Publications Office of the European Union, Luxembourg 2018. p. 96.

states can provide enough human resource capacity to maintain this system.

In this article I will concentrate on the legal aspects of creating a migrant and refugee health database. I will briefly introduce the reasons for creating such a database which will be followed by the review of the workshop which examined data protection and legal aspects in connection with a database consisting of migrant health data. As a final point I will evaluate the CEAS from the point of view of how such a system can be translated into future reforms.

2. The Importance of Creating a Migrant and Refugee Health Database[3]

The conference started with a plenary session during which presenters mainly emphasized the need for a consolidated migrant and refugee health database (from here on: database) and the challenges lawmakers may encounter during the creation of this database.

Teymur Noori, colleague of the European Center of Disease Prevention and Control (ECDC) examined which infectious diseases are the most wide-spread among asylum-seekers coming to Europe. According to the data acquired by the ECDC these diseases include HIV, tuberculosis, hepatitis B and C partly because vaccination rates are much lower among refugees then the overall population of Europe. Multidrug resistant bacteria brought by asylum-seekers also pose a great threat. This situation gets worse with undocumented migration, since it results in migrants staying in Europe without the possibility to seek medical attention. However even asylum seekers are generally only provided with free screening which is not combined with access to treatment.

Iveta Nagyova, President of the Section of Chronic Diseases at the European Public Health (EUPHA) Association and member of the EUPHA Executive Board explained that the treatment of the above-mentioned infectious diseases burdens the economy of each state receiving asylum-seekers greatly. It incurs high costs to even identify them, not to mention treating them.

Jozef Bartovic, Technical Officer with the Migration and Health program at the WHO Regional Office for Europe, and Dominik Zenner, associate at the International Office of Migration both explained that many challenges must be overcome to create a migrant-sensitive healthcare starting with tackling linguistic barriers and finding a way to sufficiently gather and manage the specific data needed to prevent a public health crisis stemming from infectious diseases brought by asylum-seekers. Currently there is a great need to gather data on the overall health status of migrants and asylum-seekers then disaggregate this by sex, migration status, age and existing sub groups.[4]

2.1 Legal Aspects of Creating an EU-wide Database for Health Data of Asylum-seekers[5]

Several data protection and human rights specialists participated in the Workshop including Alexander Beck from the Office of the United Nations High Commissioner for Refugees, Tamás Molnár, legal expert at the European Union Agency for Fundamental Rights, Gergely László Szőke, senior lecturer at the University of Pécs Faculty of Law, Zsolt Pádár forensics expert from the University of Pécs Medical School and Ramóna Tömösi from the Hungarian National Authority for Data Protection and Freedom of Information. The workshop was chaired and moderated by Ágoston Mohay, associate professor at the University of Pécs, Faculty of Law.

[3] This part of the article was mostly created using facts, figures and statements provided by the presenters at the Consensus Conference.
[4] Teymur Noori suggested in his presentation that the gathered data should be disaggregated according to the country of origin which would help identify risks since asylum-seekers from the same country of origin tend to have the same infectious diseases.
[5] The review of the workshop is mainly based on the statement concluding the findings of the conference which is available on the website of the conference. See; https://www.mighealth-unipecs.hu/education-downloads/category/91-workshop-reports (17 November 2019)

First and foremost it must be laid down that there are two possible ways to establish a migrant health database. Either it may be established on a European level or based on data-sharing between national databases. A truly European database could be operated by the European Union Agency for the Operational Management of Large-Scale IT Systems in the Area of Freedom, Security and Justice (hereinafter: EU-Lisa).[6] However there are many examples for the other type of database as well which is based on the data-sharing between national databases such as the Europol Information System (EIS). According to the Europol Regulation which defines the sources of this information system, Europol may gather relevant data from Union, international and national information systems to maintain its own database.[7]

There are two other key issues which must be addressed in connection with creating a database for this purpose. Most importantly currently there is no legal basis provided either in the founding treaties of the EU or in any secondary legal act. As a result, a database of this kind can only exist in a fragmented manner on national level until the creation of an appropriate legal basis. With this solution Member states would have the possibility to share the data among each other, however a European system of any kind cannot be established in this manner. Nonetheless it must be noted that an EU-level database could be established by a legal act – providing legal basis for the establishment of such database – based on several articles of the Treaty on the Functioning of the European Union (TFEU), e.g. Arts. 77-78 TFEU on the common migration and asylum policy of the EU or Art. 74 TFEU which aims to enhance administrative cooperation of Member States. Furthermore Art. 168 TFEU provides legal basis for the adoption of legal acts regarding the public health system of Member States.

In addition it is also important to note that a database consisting of the health data of migrants and asylum-seekers must meet strict requirements regarding the processing of this data, since the General Data Protection Regulation (GDPR) of the EU generally prohibits the processing of special categories of data unless an exception determined in the regulation can be established in connection with the sensitive data. The processing of health data of migrants and asylum seekers could be based on purposes of preventive or occupational medicine or it could be processed for reasons of public interest in the area of public health.[8]

To sum up the findings of the workshop, a legal framework providing suitable and specific measures to safeguard the rights and freedoms of the data subject should be established in order to create a database. These safeguards shall cover both the collection and transfer of as well as the access to personal health data in the European Union. The Schengen Information System, also covering sensitive data, may provide good practice for regulating a European level database which could be managed by EU-Lisa. In addition it also needs to be clearly defined by law who the data subjects of such a database would be. Last but not least, if cooperation with international organizations is envisaged, it must be mentioned that these institutions also have their own data protection regimes which may differ from GDPR. As a result, first the different regimes must be harmonized before the cooperation can start.

[6] Currently the agency is responsible for the operational management of various European level databases, for example the Schengen Information System, the Visa Information System and the Eurodac. Its function is connected to the Area of Freedom, Security and Justice (AFSJ) so it would be the perfect choice for a migrant health database since the agency already has practice in managing databases established in the framework of AFSJ. See; OJ 2018 L 295/99 Art. 1. it. 3.

[7] OJ 2016 L 135/53 Art. 17. it. 3.The effectiveness of such databases can be illustrated by the cooperation of member states in the field of criminal justice. The competent authorities of member states discover in many cases that the same perpetrators are involved in crimes committed in different European countries with the help of EIS. Thus, it can be effectively used to counter transnational crime in the EU.

[8] OJ 2016 L 135/53 Art. 9. it. 2. points (h)-(i).

3. Evaluation of the CEAS Reform in the Abovementioned Context

As I have already mentioned in the introduction, the crisis showed that the CEAS has systemic flaws. These flaws result in the system not being able to process the amount of asylum applications which have been experienced in the last years. The problems arise in various areas of the European asylum system with the greatest issue being the faulty regulation of the Dublin System.[9] The system is not able to handle the mass influx of asylum seekers as it does not take into account the economic situation and geographical location of Member States.[10] Thus most asylum applications were received by border Member States. As a consequence, the asylum systems of these Member States were overburdened with asylum procedures.[11] Another issue is that Member States' asylum systems are not equipped to accommodate the mass influx of people while waiting for their application to be considered.[12]

These two factors can very well result in a situation – which was even experienced already – that bordering Member States do not register asylum-seekers in the EURODAC system since this act could make them responsible for having to process their asylum applications. Instead it happened that bordering Member States let through asylum-seekers allowing them to revive the practice of asylum-shopping, to move freely towards inner Member States and among many other problems bring with themselves whatever infectious diseases they may have unnoticed. The serious consequences of this phenomenon have already been discussed above however it must be stressed that these are diseases that are extinct in Europe, thus the European population is not accustomed to them. As a result there is a dire need to effectively fight them yet we seem to lose this fight.

One step towards the reform of the CEAS must be the correction of the Dublin System. The European Commission proposed a corrective allocation mechanism which would ease the burden on bordering Member States. To set up such a mechanism, the EU first needs an information system to keep track of all incoming applications. This would keep track of how many applications a Member State is responsible for. The allocation mechanism would determine how many applications a Member State is obliged to consider in a crisis-like situation in proportion (*inter alia*) to the population of the Member States and its Gross Domestic Product (GDP) ("reference rate"). The reference rate should be reviewed annually. This statutory method would determine the capacity of Member States. If the information system set up to monitor incoming applications shows that a Member State has currently received more than 150% of its quota, then Member States whose asylum systems are not overburdened should take over from that point on. If a Member State refuses to take over the asylum seekers in this system – which means it practically does not participate in the operation of the allocation mechanism – it would have to pay EUR 250.000 per asylum seeker to the Member State which accepts the transfer.[13]

On the other hand, the European Parliament intends to significantly change the allocation mechanism of the Commission's original proposal while retaining the reference key on which it is based. The proposal would lower the limit from 150% to 100%, so that the Member States' liability would already be suspended when the asylum system is full according to the reference key. In addition, it

[9] The Dublin System was put in place *inter alia* in order to prevent so called „asylum-shopping" which means that an asylum seeker applies for asylum in the state where he or she sees his or her future situation more favorable. This, on the one hand, multiplies the burden on MS and, on the other hand, raises the problem that the right to asylum does not include the right for the applicant to decide in which State of the common asylum system his or her application would be considered. See; Mohay Ágoston: *Nemzetközi jogi standardok az uniós menekültügyben*. Scriptura. Vol. 3, No. 1, June 2016 p. 106.; Nadine El-Enany: *The Safe Country Concept in European Union Asylum Law: In Safe Hands.* Cambridge Student Law Review. Vol. 2, No. 1, January 2006 p. 2.

[10] Lana Maani: *Refugees in the European Union: The Harsh Reality of Dublin Regulation*. Notre Dame Journal of International and Comparative Law. Vol. 8, No. 2, February 2018 pp. 98-99.

[11] The Dublin System does have its own mechanism in the event of a Member State's asylum system being overburdened. It is the Early Warning, Preparedness and Crisis Management Mechanism. However this mechanism does not, in fact, identify a tool to mitigate the migratory pressure on a Member State. See; Viola von Braun: *Europe's policy crisis: An analysis of the Dublin System*. SAOS Law Journal. Vol. 4, No. 2, December 2017 pp. 18-19.

[12] Hanne Beirens: *Cracked Foundation, Uncertain Future. Structural weaknesses in the Common European Asylum System*. Migration Policy Institute Europe, Brussels 2018. p. 8.

[13] COM(2016) 270 final pp. 18-19.

would create a permanent system for distributing asylum seekers. The Member State of first entry shall examine whether the asylum seeker has a genuine link with any Member State. If there is one, the Member State to which the asylum seeker is linked is responsible for examining the application for asylum. A close relationship is first and foremost a family relationship or other previous relationship, such as having previously studied in the Member State or having previously been lawfully a resident of the Member State. However, if such a link cannot be found, the automatic distribution of asylum seekers between Member States will take effect, and an electronic system would randomly determine which of the four least burdened Member States should be placed in the asylum seeker.[14]

The basic problem with the Dublin System is that whatever regulations are made on the reception of asylum applications, most asylum seekers will arrive first in the Schengen border Member States, almost without exception. The positions of the Member States in this regard are wide-ranging today. It is in the interest of border Member States that internal Member States take charge of asylum seekers, but many inward Member States reject it. This is why there is currently no solidarity between Member States. The details of the mechanism have not been agreed upon by Member States and even by EU legislature. The Commission envisaged a crisis management mechanism, while the European Parliament would set up a system for the distribution of asylum applications and severe sanctions in the event of a breach of the solidarity expected from Member States.

It is a striking difference between the two proposals that the Commission would trigger a crisis management mechanism 50% above the reference rate, while the Parliament proposal would immediately put in place a crisis management mechanism when the reference rate is reached to transfer asylum applications to one of the least burdened Member States. Moreover, the European Parliament's draft would create a permanent system that would reform the current system of criteria for the Dublin system. Above all, it would remove the current responsibility of Member States where the asylum seeker first entered the Union. In addition, it would apply criteria that effectively reflect the relationship between the asylum seeker and the Member State responsible for examining the application. In the absence of such a link, asylum seekers should be immediately distributed among the Member States. Indeed, such a system would be able to enforce the principle of solidarity between Member States and prevent the overloading of Member States' asylum systems by a permanent distribution. This could prove the right way to fix the Dublin System. However, it is not guaranteed that this can be realized in practice, as the cost of transporting asylum seekers would be extremely high.[15]

In addition, the reform of the Dublin System must find a solution for unregistered asylum seekers. This is a complex problem deriving from both state and individual practice. In recent years there had been many examples where Member States did not register asylum seekers in order to avoid taking responsibility to consider their applications. However, there is a tendency among asylum seekers as well to resist being registered since then they would be "stuck" in the first country of entry.[16] This could be corrected with creating a legal obligation for asylum seekers to be registered to the information system keeping track of the number of applications Member States receive.

In conclusion, the aim of the reform is to enforce solidarity between Member States and achieve the registration of every asylum-seeker in the EURODAC system. Once solidarity and the registration of every asylum-seeker is achieved there is a far better chance of fighting infectious diseases as well, since there would be a chance to register health data of asylum-seekers when their biometric data is collected.

[14] Wikström Report: http://www.europarl.europa.eu/doceo/document/LIBE-PR-599751_EN.pdf?redirect (8 September 2019) pp. 112-113.
[15] Steve Peers: *Unfinished Business: The European Parliament in the negotiations for reform of the Common European Asylum System.* (A too Ambitious Reform for a still Weak Legislator) EU Law Analysis: http://eulawanalysis.blogspot.com/2019/06/unfinished-business-european-parliament.html (8 September 2019)
[16] Maani: ibid. 99.

4. Suggestions for the Future

Returning to the problem of infectious diseases, the information system which is meant to be established with the reform of the Dublin System could store health data of asylum seekers if the regulation would provide a legal basis for it. However, it must be noted that the reform aims to establish this database in order to store biometric data of asylum-seekers and the fact that they applied for international protection. So its aims differ from the database containing health data of migrants and asylum-seekers. As a result, there is a more adequate alternative for this purpose than the integration of these databases, namely a database for storing health data of only asylum-seekers could be translated into the asylum system by the reform of the reception conditions directive.[17]

The EU framework of reception of asylum-seekers could effectively integrate such a database given the legal basis for it which could be established in the reform.[18] The reason for this is that the directive already has a few provisions related to public health issues and the mental and physical health of asylum-seekers accommodated for the time of their application being considered. First and foremost the directive provides the possibility for Member States to require medical screening of asylum-seekers on public health grounds.[19] Moreover the directive provides asylum-seekers admitted into the system with at least emergency health care and the essential treatment of illnesses and mental disorders.[20] This provision stands on the ground of material reception conditions providing asylum-seekers with an adequate standard of living, which guarantees their subsistence and protects their physical and mental health.[21]

Provisions relating to the mental and physical health of asylum-seekers are further elaborated in the reform of reception conditions. As a result, the adoption of the amended directive would provide greater protection for asylum-seekers in terms of their health. The proposal of the European Parliament highlights public health concerns. The new directive would provide preventive healthcare besides emergency care and essential treatment.[22] This provision would have great impact since most asylum-seekers are accommodated in so called accommodation centers which are places where the collective housing of applicants takes place.[23] Thus asylum-seekers are placed in accommodation centers where applicants of various third countries are housed. As I have already mentioned above according to their country of origin applicants may carry different diseases. In these centers they become vulnerable against diseases they have not yet encountered and they may bring infections others are vulnerable to. This is why preventive medicine, including vaccination is of great importance.

In conclusion the present reception conditions directive and the reform of reception conditions could ultimately achieve better healthcare of asylum-seekers. However, a database consisting of health data of asylum-seekers could further enhance the level of public health among them since it would make deciding on preventive measures easier and competent authorities may share these data with each other in order to provide a uniform standard of healthcare in every Member State for asylum-seekers. It could also allow for better follow-up treatments and the avoidance of unnecessarily repeated treatments. To this end the Consensus Conference achieved consensus regarding measures which could be applied in order to facilitate the establishment of a migrant and refugee health database. According to the final statement of the organizers measures to facilitate harmonization of definitions, variables, indicators and categories to ensure cross-border comparability of data and addressing the gaps in data collection are recommended in order to ensure compatibility

[17] The directive regulates a wide variety of needs related to the accommodation of asylum seekers for the time their application is considered by competent authorities.
[18] This could be based on Art. 78 TFEU as already stated in part 2.1.
[19] OJ 2013 L 180/96 Art. 13.
[20] OJ 2013 L 180/96 Art. 19.
[21] OJ 2013 L 180/96 Art. 17. para. (2).
[22] COM(2016) 465 final para. (31).
[23] OJ 2013 L 180/96 Art. 2. it. (i).

and completeness of data. Improving international cooperation and governance of data management is also advised in order to share and transfer data if there is a justifiable need for that. Last but not least inclusion of migration-related variables in routine data collection and data linkage is encouraged. Adopting these measures could greatly help create the health database which could effectively counter public health risks.[24]

[24] https://www.mighealth-unipecs.hu/education-downloads/send/89-final-document/206-outcome-document (17 November 2019).

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Pécs Journal of International and European Law

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