Refugee Health Inclusion: Legal, Geopolitical, and Economic Barriers

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Abstract

This commentary examines how structural constraints shape health access in refugee camps. It stems from a recent workshop on refugee health and reflects an interdisciplinary, policy-focused dialogue. We argue that humanitarian aid alone is insufficient. Instead, long-term, rights-based approaches are needed. Donor dependency, legal exclusion, and geopolitical dynamics undermine access to care. These challenges create artificial divides between camp and non-camp settings. Our analysis complements a companion piece on health system design (See Tarnas et. al, this issue). Together, the two pieces call for ethical, inclusive models that recognize refugee health as a global responsibility not a temporary emergency.

Commentary

As scholars and practitioners working at the intersection of migration and public health, we are deeply concerned with the long-term health equity of displaced populations. This commentary reflects our ongoing reflections on these challenges, initially brought together through a multi-stakeholder workshop in Cairo focused on reimagining health in refugee camps. With growing political tensions globally and more nations facing instability and war, the number of refugees is rising drastically, leading to the establishment of more camps to accommodate them (United Nations & High Commissioner for Refugees, 2024). However, the conditions in refugee camps are concerning. Some camps are inhumane, while others provide only the bare minimum for survival. Some have become permanent settlements with only essential basic services (Agier, 2011). The conditions of refugee health within camps are a reflection of broader systemic and structural barriers—legal, geopolitical, and economic—that affect refugees' access to care across all settings. Health is a major concern in camp settings: upon arrival, refugees not only carry the burden of pre-existing health conditions, but also suffer from new infections, psychological distress, and injuries. Additionally, those who remain in poorly equipped camps for extended periods face a heightened risk of contracting various infectious diseases (Adams et al., 2004; Kiapi et al., 2021). As per

the Human Rights-Based Approach to Health, every refugee has the right to health. Nevertheless, the health of refugees is determined by various sociopolitical and economic factors. These factors are not only linked to the availability and quality of health services but also to global and local legal, economic, and policy barriers. Addressing these challenges requires a comprehensive approach that goes beyond immediate humanitarian aid to tackle the underlying socioeconomic and geopolitical constraints shaping refugee health.

THE POLITICAL ECONOMY OF REFUGEE HEALTH AND THE POLICY DILEMMA

The political economy of refugees' access to health services is shaped by various factors, including the hosting countries' policies, aid availability, and the migration governance system. Host countries' policies on refugee integration are influenced by their economic situation, political considerations (security concerns and public perception), and strategic efforts to secure international aid (Tschunkert, 2024). These policies vary across nations, with some offering free primary and secondary care, while others restrict access to emergency services (El-Gamal & Hanefeld, 2020). Regardless of the approach, refugee integration places economic pressure on host countries and tests the resilience of their public services. As most refugees are hosted in low-income countries, these resources are already strained and providing health services to refugees often increases the burden on the health system (Guner, 2021). International aid plays a crucial role in alleviating this burden. Donor countries provide financial assistance to help host nations manage refugees. Host countries tend to be more accepting of refugees when they receive aid (Bermeo & Leblang, 2015). Beyond financial aid, international organizations such as UNHCR (United Nations High Commissioner for Refugees), IOM (International Organization for Migration), UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East), and nongovernmental organizations play a crucial role in supporting host countries in health provision for refugees. They operate complementarily, often acting as policy advisors or implementing partners to enhance these healthcare services (Elnakib et al., 2024).

Despite this, however, refugees face numerous challenges and barriers in accessing healthcare because of policy restrictions and systemic limitations. Host country policies often restrict access to services because of economic constraints, security concerns, and political reluctance. Many governments limit healthcare to emergency care or exclude refugees from national health systems. Host governments often justify these restrictions under security concerns or fears of encouraging further migration. Moreover, the services available to individuals change based on their legal status (e.g., refugee, internally displaced individual, or stateless individual), and nonspecific language or movement between categories can complicate peoples' ability to seek or receive care. This care is also, in many instances, separate and of lower quality than that provided in the host country, reinforcing long-term exclusion from national systems. This segregated healthcare model risks becoming institutionalized, preventing refugees from fully integrating into health services.

Another key concern is the instability of donor-driven health systems. Funding fluctuates based on political priorities, making long-term healthcare unsustainable. For example, Syrians in Türkiye have access to free public healthcare under the Temporary Protection Regulation. In contrast, non-Syrian refugees typically lose access after one year, unless under exceptional protection, which significantly limits continuity of care and increases financial hardship. Likewise**,** international organizations play a crucial role in refugees' healthcare. However, their efforts often lack coordination, leading to fragmented and inconsistent services: Palestinian refugees, as an example, strongly rely on UNRWA, which has highly politicized funding, and millions are left vulnerable when resources are reduced or withdrawn. This

closure, dismantling, or relocation causes refugees to lose essential healthcare access. Camps require a sustainable and coordinated healthcare approach that is resilient to political and funding shifts and that promotes long-term integration.

LEGAL AND SOCIOECONOMIC BARRIERS TO EQUITABLE CARE

Refugees face many barriers to accessing healthcare, including legal and socioeconomic barriers. Being refugees, asylum seekers, or persons without legal status impacts access to healthcare. The access to healthcare in Türkiye, differentiated by legal status is one such example (Gokalp Aras et al., 2021). Other barriers such as unemployment, financial constraints, language difficulties, cultural differences, and poor health literacy exist and vary contextually (Chuah et al., 2018; Murray & Skull, 2005).

While these barriers are common for most refugees, several socio-demographic groups face compounded challenges that intensify their vulnerability. Women struggle with limited access to reproductive healthcare while disabled refugees face barriers including mobility restrictions and inadequate disability-inclusive care. In addition to these physical health challenges, mental health and trauma are also widely neglected. Many refugees experience high levels of psychological distress, increasing their need for mental health support and services.

Another key area where legal and socioeconomic barriers intersect is restrictions on refugees who are trained health professionals. Many refugees are qualified medical professionals but are unable to practice due to licensing and employment restrictions, preventing them from contributing to healthcare services in and around camps. Instead, empowering these individuals can be part of broader reframing that enables refugees to support themselves and the community they join. According to the Capability Approach, empowering individuals with skills and opportunities will lead to enhancing their well-being (Sen, 1990). Equipping refugees with skills and opportunities to manage their own health, rather than relying solely on host countries' providers and humanitarian aid, can create more sustainable and ethical systems.

MOVING BEYOND THE HUMANITARIAN MODEL: REFUGEE HEALTH AS A HUMAN RIGHT

Healthcare provision to refugees is increasingly recognized as a fundamental human right rather than a humanitarian act (Clark, 1997). Some refugee camps have existed for decades, making displacement a protracted situation that often feels more permanent than temporary. As a result, temporary aid-driven healthcare systems are no longer sufficient to meet the long-term needs of displaced populations. Healthcare provision must adapt to different settings by balancing immediate emergency responses with sustainable long-term care models. This includes addressing both acute and chronic health needs (Matsumoto et al., 2019), as well as recommitting to a broad definition of health that moves beyond just biophysical health. Shifting from a humanitarian model to a more sustainable one is essential. This includes moving beyond short-term donor aid toward more stable and inclusive financing mechanisms—such as integrating refugees into national health insurance schemes or using pay-for-performance models—to ensure continuity of care and long-term health system integration (Spiegel et al., 2018).

Refugee healthcare must be reframed as a human rights issue rather than merely humanitarian aid. A rights-based approach ensures that healthcare for refugees is treated as a long-term obligation rather than temporary relief, though the question of whom is obligated also must be answered. Health clusters and integrated service models can improve long-term sustainability by enhancing coordination among

healthcare providers and reducing service fragmentation. To achieve this, legal reforms are essential. Without proper legal recognition, refugee healthcare systems will remain unstable and dependent on inconsistent humanitarian aid. Strengthening legal frameworks can provide refugees with more stable access to national healthcare systems, reducing their reliance on external assistance.

CONCLUSION

This commentary complements a companion piece from the same collaborative initiative, which focuses on ethical design and sustainability of health systems in refugee camps. While that piece explores community-centered infrastructure and service delivery models across phases of displacement, our commentary emphasizes the broader structural constraints—such as funding instability, legal exclusions, and geopolitical dynamics—that shape refugee health access and governance.

Refugee health extends beyond the healthcare system. It is a political, socioeconomic, and governance issue, where temporary aid is insufficient to address the multifaceted and compounding needs. Currently, refugee health provision relies on unstable aid, and shifting donor priorities disrupt access. Questions remain about who will fund such sustainable approaches, especially amid heightened uncertainty following changes in U.S. funding priorities, including withdrawals from programs such as USAID. A long-term, sustainable approach is essential. Central to this is refugees' integration into host communities, even if just during their camp tenure. Many refugees are excluded from national services and resources, largely othering and isolating them. Legal and policy reforms can help remove these barriers. Without this, healthcare remains fragmented and inconsistent. We also argue that refugees can play a role in their own healthcare. Many are trained health professionals but cannot work legally. Developing refugee-run healthcare systems can reduce dependency and improve care, ultimately strengthening services.

Lastly, a global framework for refugee health governance is needed. A model similar to UNRWA can help coordinate funding and policies. An UNRWA-like model would include a comprehensive, institutionalized service provision system designed to meet the long-term needs of displaced populations. Similar to UNRWA, which has provided education, healthcare, social services, and emergency relief to Palestinian refugees since 1949, such a model would integrate holistic needs provision while ensuring community-led service delivery, enabling culturally sensitive and self-sustaining service provision. It would function independently of broader refugee response frameworks and would ideally be institutionalized, long-term, and insulated from shifting donor priorities, ensuring more stable and rights-based service provision. Central to this would be the cemented use of common language, including a shared understanding of what health provision entails. We argue that this must move beyond biophysical health to be equitable, ethical, and sustainable. Effective and just policies and structures are essential to ensuring that refugees can access the care they need. Systemic changes that recognize refugee health as a human right, not just an act of aid, are necessary.

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