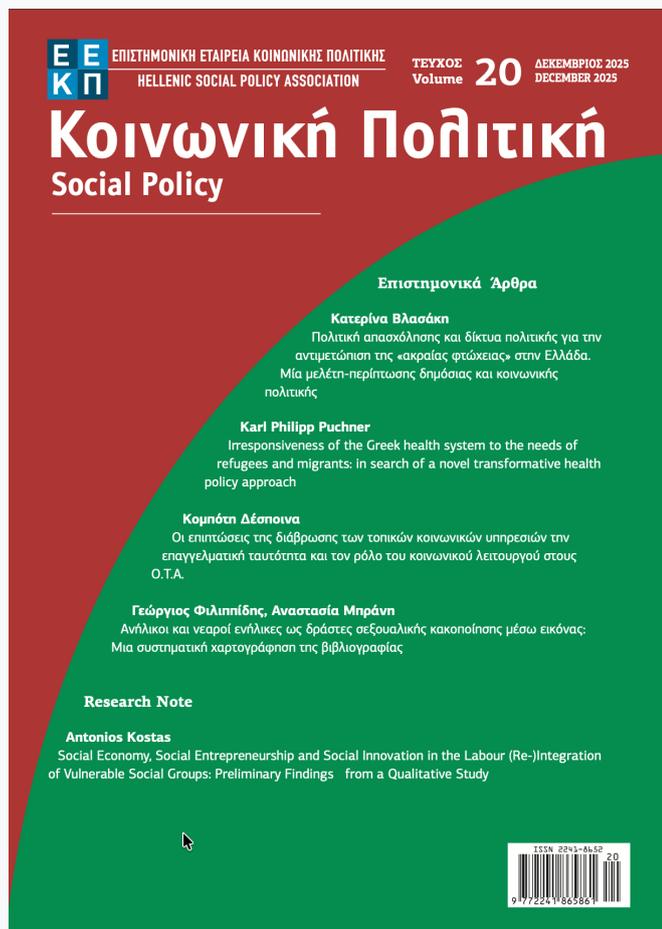


Κοινωνική Πολιτική

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Irresponsiveness of the Greek health system to the needs of refugees and migrants: in search of a novel transformative health policy approach

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Κοινωνική Πολιτική

Social Policy

Επιστημονικά Άρθρα

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Irresponsiveness of the Greek health system to the needs of refugees and migrants: in search of a novel transformative health policy approach

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Abstract

Refugee and Migrant Health constitutes a major challenge for host countries and their respective health systems due to the vulnerability and diversity of people in transit. The WHO outlines four models of health system response to address the health needs of Refugee and Migrants (RMs). Greece has hosted a significant number of RMs for over a decade, yet its public health system (ESY) has shown limited adaptation, lacking a clear care model or mixture of models for this population group. This reality is, among others, due to the convergence of structural weaknesses of the ESY, the absence of a national RM health strategy, and restrictive migration policies that hinder access to care and lead to negative social determination of health. A transformative health policy approach is urgently needed—focusing on RM - inclusive health system strengthening, the adoption of a national RM health strategy, and the reversal of restrictive migration policies.

Περίληψη

Η Υγεία Προσφύγων και Μεταναστών αποτελεί μείζονα πρόκληση για τις χώρες υποδοχής και τα συστήματα υγείας τους, λόγω της ευαλωτότητας και της ποικιλομορφίας των πληθυσμών σε μετακίνηση. Ο ΠΟΥ προτείνει τέσσερα μοντέλα φροντίδας για την κάλυψη των υγειονομικών αναγκών των ΠΜ. Παρότι η Ελλάδα φιλοξενεί σημαντικό αριθμό ΠΜ για πάνω από μία δεκαετία, το Εθνικό Σύστημα Υγείας (ΕΣΥ) παρουσιάζει περιορισμένη προσαρμογή, χωρίς να έχει υιοθετήσει ένα σαφές ή μικτό μοντέλο φροντίδας. Αυτό οφείλεται, μεταξύ άλλων, στη συνύπαρξη διαρθρωτικών αδυναμιών του ΕΣΥ, στην απουσία εθνικής στρατηγικής για την υγεία των ΠΜ και σε περιοριστικές μεταναστευτικές πολιτικές, που δυσχεραίνουν την πρόσβαση στην περίθαλψη και επηρεάζουν αρνητικά τους κοινωνικούς προσδιοριστές υγείας. Υπό αυτό το πρίσμα, απαιτείται επειγόντως μια μετασχηματιστική πολιτική υγείας με έμφαση: στην ενίσχυση του συστήματος υγείας με συμπερίληψη των ΠΜ, στην υιοθέτηση εθνικής στρατηγικής υγείας ΠΜ και στην ανατροπή των περιοριστικών μεταναστευτικών πολιτικών.

1. Refugee and Migrant Health in the era of mixed Migration

The 21st century has witnessed an unprecedented convergence of forced and voluntary migration dynamics (McAuliffe and Khadria, 2020). At the individual level, economic motivations for movement are more and more often intertwined with the urge to flee human rights violations, violence and persecution, climate change, extreme poverty and food insecurity (Van der Klaauw, 2010). Consequently, there is an increasing consensus that what was once classified as voluntary migration is far less voluntary, driven by a multifaceted set of structural and situational push factors (Kent J, 2021). At the same time, legal pathways for migration have become increasingly limited, and heightened border securitization have pushed both refugees and migrants (RMs) toward hazardous irregular migration routes (Waerp, 2024). In order to capture this novel and complex reality, the term “Mixed Migration” has been introduced (Mesnard et al., 2024).

Within the context of Mixed Migration, Refugee and Migrant Health constitutes a particularly complex field, characterized by significant intrinsic challenges, as it focuses on the provision of adequate and equitable health care to people in transit, exhibiting high-impact vulnerabilities and rapidly changing health needs and epidemiological patterns, subject to the phase of the migratory process (International Organization of Migration, 2019). Further challenges of Refugee and Migrant Health stem from the prolonged exposure to insufficient (legal) protection, social exclusion and volatile and precarious socioeconomic conditions of the target population (Puchner et al., 2018).

In addition to the pre-migration health burden imposed by conflict, food insecurity, extreme poverty and other adverse conditions RMs are fleeing from, individuals in transit frequently encounter a wide variety of farther health risks (Puchner et al., 2018; Nisbet et al., 2022). It should not be forgotten that movement along migration routes and trespassing of borders under irregular conditions - often the only option due to the severe limitations of legal migration pathways for those seeking international protection- are per se extremely precarious undertakings and expose individuals to a series of health hazards. These may reach from (lethal) traffic accidents, severe illness as consequence of exposure to extreme weather, food insecurity and living conditions, to (sexual) violence and exploitation by state and non-state actors, culminating even in murder, imprisonment, trafficking or rape (Canova et al., 2024; Bronsino et al., 2020; Arsenijević et al., 2018).

Typically, epidemiological profiles of RMs populations and perceived health needs are substantially influenced by the different phases of the migratory process. While acute and pressing health problems such as accidents and acute infections typically dominate the epidemiology of the movement phase of the migratory process, with provisional or permanent settlement often the full burden of chronic diseases and mental health illness unfolds (Zimmermann et al., 2011). The changing patterns in the epidemiology depend on the phase of the migratory process, however they do not pose the only factor complicating apt public health planning and tailored health care provision. The often-significant discrepancies in cultural and epidemiological backgrounds of RMs to that of the general population of host countries constitute a further context-specific public health challenge (Baauw et al., 2019). These differences arise not only from distinct disease patterns among refugees and migrants (RMs) compared to the general population, but also from varying health literacy, health-seeking behaviors, beliefs, and language barriers, often leading to

a mismatch between their needs and available health services—and consequently poorer health outcomes (Lebano et al., 2020; Ahmadinia et al., 2022; Robinson et al., 2025; Shahin et al., 2021).

Furthermore, it should be noted that persistent fear, chronic anxiety, heightened stress, and a pervasive sense of uncertainty and loss of control are common emotional states among RMs. Evidence shows that prolonged exposure to these states can have a detrimental effect on mental and overall health, which are often already undermined during the premigration stage (Levecque et al., 2007). However, increased vulnerability is not solely the result of psychological distress; it is also driven by deeper structural factors that influence the fundamental Social Determinants of Health (SoDH) (International Organization for Migration, 2009). SDoH encompass all non-biomedical factors that influence the health of individuals and populations—such as working conditions, education, income and social protection, and access to healthcare and are recognized by the WHO as key priority in global health policy (Commission on Social Determinants of Health, 2008). These determinants appear to have a particularly disproportionate impact on the health of RMs, with migration itself increasingly being recognized as an independent SDoH (Castañeda, 2015).

Finally, it is important to acknowledge that this population group often presents with context-specific health needs and priorities requiring health services not prevalent in, or distinct from, those routinely offered in the host country's health system. Unaccompanied minors, victims of torture, malnourished children, pregnant women and people living with chronic (infectious) diseases on the move, represent some subgroups of the RM population with complex and distinct health needs as well as heightened vulnerabilities in comparison to the general population. As such, they often warrant in addition to general health access, tailored interventions and specialized services (Savas et al., 2024; Fair et al., 2021; Board et al., 2020).

All the above highlights that the complex Mixed Migration – health nexus requires special attention by health policy makers and providers, with responsiveness of host country health systems being of paramount importance in meeting adequately the health needs of RM populations, especially when these populations are demographically heterogeneous and of significant size.

2. Models of health system responsiveness to RM health needs

Responsiveness constitutes a main objective of national health systems and is understood as the ability of the system to foresee and adjust to changing health needs and priorities, seize opportunities to promote health and improve quality of health services (Mirzoev and Kane, 2017). According to the WHO, health system responsiveness is a key element for ensuring the provision of adequate, comprehensive, accessible, affordable and equitable health services for RMs (World Health Organization, 2021). National health systems may adapt in different ways to accommodate the needs of RMs populations, usually by applying one (or more often a mixture) of the following models of care:

- i. Mainstream model: this model foresees full health registration of RMs in primary health care and mainstreaming of their health needs and access pathways in the public health system used by the general population. The health workers for the health service deliv-

ery in this model belong to the host country's usual health system workforce. This model of care has been adopted by several countries hosting large numbers of refugees and migrants (RMs), such as Sweden and the Islamic Republic of Iran. While it is considered highly effective in ensuring equitable access for RMs and promoting their integration, it relies on the availability of adequately trained personnel to deliver culturally responsive care, which is often more time- and resource-intensive. Challenges in implementation may also arise during periods of mass RM influx or public health crises, as the model's capacity for rapid expansion and adaptation is limited.

- ii. Specialized – focus services model: in this model, within the framework of the public health system, a separate stream of services tailored to the specific needs of the respective RM population residing in the country is being developed and delivered by personnel hired and/or trained for these types of services. Countries such as Turkey, which host large numbers of refugees and migrants (RMs), often implement this model alongside the mainstream or gateway models. In this approach, migrant health clinics are integrated into the national health system and staffed by medical professionals, including members of the Syrian RM community living in the country. This structure ensures that healthcare services are tailored to the needs of RMs and delivered in a culturally sensitive manner.
- iii. Gateway services: through the establishment of a health system external points of very basic primary health care and health care checks, dedicated to RMs, entry to and referral within the public health system is being facilitated. Typically, the workforce involved operates outside the formal health system, and while service delivery may be long-term, the model is inherently transitional in nature. Gateway models – adopted mainly by countries hosting large numbers of RMs such as Germany and Turkey - if appropriately networked with all levels of care (primary, secondary and tertiary level) of the public health system constitute a safe and resilient mechanism of addressing RM health needs in volatile migratory influxes.
- iv. Limited services: services covering specific or basic health needs of RMs are provided by public health system external actors such as NGOs, charity, UN agencies etc. in agreement and alignment with the government and the responsible authorities of the host country. The services are often delivered by volunteer health workers, private sector health workers, international staff of NGOs and UN agencies, exhibiting frequently high staff turnover and limited sustainability. This model – though having a limited scope of services and lacking integration of RMs in the national health system – constitutes a pragmatic solution for mainly resource-poor countries, such as Sudan or Pakistan. However, due to its easy scalability, it is also occasionally adopted by more affluent countries—such as Italy—as a complementary approach to the mainstream model during sudden influxes of RMs.

3. Mixed Migration in the Greek context

The Eastern Mediterranean and Balkan Migration Route (EMBMR) is one of the world's main Mixed Migration corridors (Mixed Migration Centre, 2020). Being the geographical extension of the Middle East and part of a fragile geopolitical zone, the region of the Eastern Mediterranean

and the Balkans has long seen large population movements (King, 1996; Bonifazi, 2004). Aggravating instability across the Middle East in the recent past has driven unprecedented numbers of RMs along the EMBMR since 2015 (Doignon, 2023).

Situated at an important junction knot in the EMBMR, Greece has been hosting, varying but consistently significant numbers of RMs for over a decade. In 2024 alone, new RM arrivals, through land or sea, surpassed 60,000, with most of the RMs originating from Syria, Egypt, Afghanistan and Palestine and to a lesser extent from countries of the Sub-Saharan Africa and the Indian Subcontinent (International Organization for Migration, 2024). Apart from the heterogeneity with respect to the country of origin, the RM population moving along the EMBMR and thus transiting, or settling (provisionally) down in Greece reveals extreme demographic diversity; there are significant numbers of unaccompanied minors alongside with families, single male and female adults, pregnant women, people living with disabilities, and elders (European Council on Refugees and Exiles, 2024). By the end of 2024, Greece counted 83,895 active international protection residence permits, and 32,572 temporary protection residence permits (Refugee Support Aegean, 2025) in addition to a large and demographically diverse stock of already settled economic migrants, which exceeds a million (Gemi, 2024).

4. (Ir)responsiveness of the Greek health system to the needs of RMs

Although Greece has long been a crucial junction along a major Mixed Migration route, the Greek National Health System (ESY) has shown limited capacity to adapt to and address the health needs of RMs (Gunst, 2019). For more than two decades, the ESY has grappled with enduring structural challenges including a fragile and inadequately developed primary health care sector, understaffing in key professions/specializations across all levels of care and austerity-driven budget cuts and shrinkage that have significantly weakened its ability to deliver Universal Health Coverage (UHC) to the general population (Economou, 2017; Kentikelenis, 2014). Unsurprisingly, this inadequate coverage extends to RMs, who face numerous barriers when attempting to access healthcare services of the ESY. As a result, they experience disproportionately high levels of unmet health needs, further hindering progress toward achieving UHC in Greece (Kotsiou, 2018). While the ESY's inability to adequately accommodate health needs of RMs is largely rooted in its broader systemic dysfunction, specific institutional shortcomings, restrictive migration policy and a lack of strategic direction – exemplified best by the absence of a national Refugee and Migrant Strategy - also play a considerable role in the continuous failure to respond effectively in the field of Refugee and Migrant Health (Joseph et al., 2020; Gunst et al., 2019).

To date, no clear responsiveness model- or mixture of models – seems to have been adopted by the Greek state, to ensure Universal Health Coverage of RMs within the ESY. At first glance, features of a mainstream -based model of response seem to be in place, as recognized refugees and migrants with a valid residence permit are, in theory, entitled to an AMKA — the national health insurance number — which grants access to free public health services. Yet, in practice, as will be analyzed in detail below, existence of multiple administrative obstacles

hinders access to free of charge and equitable services of the ESY, undermining therefore the feasibility of the mainstream approach. Indicatively, a newly passed joint ministerial decision (Αριθμ. Φ80320/109864) foresees that activation of the AMKA number – which is a prerequisite for accessing the ESY free of charge - requires residence registration and proof of employment or enrollment in a Greek educational institution (Ministry of Labour and Social Security, 2024). These preconditions are often unmet by many RMs during the early stages of social integration, especially by those with poor health (Refugee Support Aegean, 2025). This joint ministerial decision, which in practice hinders access to health care, together with the adoption of a series of deterrence measures—such as the tightening of eligibility criteria for asylum seekers, increased border securitization, and systematic pushbacks by Greek state actors—illustrates a decisive shift toward more restrictive migration policies by the central government (AIDA-GR_2023-Update.pdf). Furthermore, within this unfavorable political context, RMs applying for asylum are issued a provisional AMKA (PAAYPA), which allows access to ESY services but excludes them from several key social benefits, such as access to the labor market, free public transportation, and the ability to obtain an unemployment card (European Council on Refugees and Exiles, 2024). In addition to the well-documented poor living conditions in reception facilities and limited housing options, this exacerbates further the already negative social determination of health of this highly vulnerable population group (European Council on Refugees and Exiles, 2024). Moreover, mainstreaming of health needs of RMs remains extremely challenging even at the operational level, as the ESY still lacks officially deployed interpreters, and the limited interpretation services available in some ESY facilities are entirely reliant on NGO initiatives (Fouskas, 2019). Finally, as exemplified by the COVID-19 vaccination campaign, even when RMs are identified as a highly vulnerable group, practical integration of their needs in public health interventions, remains insufficient. Evidence suggests that vaccine distribution to RMs was significantly delayed and vaccine uptake in this population was low, leading to inadequate protection against COVID-19. of this at-risk group (Puchner, 2024).

While it is evident that under the current conditions described above, the mainstream model cannot sufficiently cover the health needs of RMs, alternative response models also appear to be underdeveloped and inapplicable within the Greek context. The limited services model, which during the peak years of the RMs influx (i.e. 2015-2017) in Greece, constituted the dominant model of care for RMs, seems to lose drastically its relevance as many external actors (NGOs, UN-agencies, charity) reduce or withdraw their involvement in the field of Refugee and Migrant Health and Greece in general (CARE International, 2017; Refugee Support Aegean, 2019). Moreover, it should be noted that the extremely rapid and unilateral expansion and subsequent dismantling of the limited services model, in conjunction with the absence of strategic direction by the responsible Ministries of Health and Migration, had a detrimental impact on ESY, impairing its initial engagement in Refugee and Migrant Health and limiting its ability to gradually and sustainably develop its institutional capacities in this very field (Kotsiou et al., 2018; Gunst et al., 2019).

Gateway services previously provided under programs like PHILOS by the National Public Health Organization (EODY) are now being phased out. Launched in 2016, PHILOS aimed at on site provision of basic primary health care and psychosocial support in RMs residing in

camps, reception and identification centres (RICs) throughout the country, functioning at the same time as a facilitated entry and referral point for primary, secondary and tertiary care in nearby facilities of the ESY (World Health Organization, and Ministry of Health of Greece, 2019). Despite notable design limitations and operational shortcomings – reaching e.g. from insufficient personnel deployment to rather suboptimal vaccination coverage in target pediatric populations in camps- PHILOS's integration within EODY guaranteed closer alignment with the public health sector and provided the opportunity to the ESY to participate more actively in the planning and delivery of services (Mellou et al., 2019, Joseph et al., 2020). Currently, PHILOS is being replaced by a public-private partnership (i.e. the Hippokratris project), a fact that distances Refugee and Migrant Health, both operationally as well as administratively, from the ESY framework (Chouzouraki, 2024). Within this context, gateway services and provision of health care are outsourced to the international agencies (i.e. IOM) and the private health sector, entailing the risk thus creating a siloed, unsustainable health system and leading to further welfare retrenchment for RMs (Centre for Gender Rights and Equality DIOTIMA, 2024; Gottlieb et al., 2020).

Finally, the failure to respond to the urgent and unique needs of RMs, is perhaps most tellingly underscored by the complete absence of specialized, context-specific services within the ESY. Despite the broad consensus among scholars as well as the multiple testimonies and reports of NGOs, UN-agencies and other field actors on the necessity of tailored health services for certain subcategories of the RM- population residing in Greece, the ESY to date exhibits extreme structural inflexibility, compromising the health and, in some cases, even the lives of RMs (Liapi, 2019; Ververidou, 2024; European Council on Refugees and Exiles, 2024). The absence of HIV services, on the islands of the Eastern Aegean, like Chios, Lesbos or Samos – all of them equipped with ESY secondary level health care facilities – constitutes a striking example of the institutional rigidity of the public health system. These islands, host a significant proportion of the total RM population residing in Greece and among these also people originating from high-endemic HIV countries (European Council on Refugees and Exiles, 2024). Consequently, they might as well host non-negligible numbers of diagnosed or undiagnosed HIV-positive RMs. Recently, the Greek Government has been condemned by the European court of Human Rights for depriving a HIV-positive asylum seeker, having her asylum case being examined on the island of Lesbos, from access to antiretroviral treatment (European Court of Human Rights, 2023). It should be noted that even short interruptions in antiretroviral treatment endanger the lives of people living with HIV and strain the ESY's already overstretched tertiary care system, which must handle severely deteriorated cases transferred from the islands (Tsiakalakis, 2021). In addition, the complete lack of responsiveness of the ESY becomes evident when considering the health care needs of Victims of Torture, Trafficking or Sexual and Gender Based Violence. Despite the high prevalence of such experiences among the RM population and in contrast to many other European countries, no secondary or tertiary public health facilities currently offer specialized rehabilitation or outpatient services in these areas (European Council on Refugees and Exiles, 2024; Support for Torture Victims, n.d.; Liapi, 2019; Hospital Clínic de Barcelona, 2024). Though guidelines developed by EODY might exist in some of these areas (National Public Health Organization (EODY), 2023), operational implementation of these highly spe-

cialized and context-specific healthcare services remains extremely neglected within the ESY framework. This neglect is evident in the fact that, although Greek law designates public health facilities as responsible for certifying victims of torture—a key step in both the health of RMs and the asylum process—no such institutions currently possess the required expertise, training, or translation capacity to carry out this specialized task (European Council on Refugees and Exiles, 2023) . Lastly, child and maternal health provision fails to address the specific health needs of this distinct population. Although health and vulnerability assessments are routinely conducted in Reception and Identification Centres and RM camps across the country, they do not include systematic screening for malnutrition, immunization coverage, or growth delays among RM children (Chouzouraki, 2024; Grammatikou et al., 2019). Similarly, reproductive healthcare services—including contraceptive, antenatal, and abortion-related care—are largely inaccessible or unsuitable for RM women, often failing to consider their preferences and specific needs, such as access to long-acting injectable contraceptives, medical abortion options (e.g., the “abortion pill”), or mobile antenatal care services within camps (vom Dahl et al., 2024).

5. Conclusions

As demonstrated above Greece, hosts and receives relative to its population size, significant numbers of RMs, serving as an important junction point on the EMBMR, one of the world’s major Mixed Migration corridors. With increasing regional instability and despite the efforts of the Greek government to intensify boarder securitization, it is highly unlikely, that the number of RMs residing and arriving to Greece will drop significantly in the near future (International Centre for Migration Policy Development (ICMPD), 2025). Consequently, Refugee and Migrant health— with all its complexity and inherent challenges – remains and will continue to be a critical of concern for health policy of the country. Yet, as analyzed above, the healthcare needs of RMs residing in Greece, are in practice, largely neglected by the public health system, ESY. To date, none of the WHO suggested health system response models seems to be implemented in the Greek context – a fact suggestive of a persistent irresponsiveness of the ESY to accommodate Refugee and Migrant Health in its scope.

However, it should be stressed that this phenomenon does not occur in isolation but is representative of the systems’ failure to achieve genuine Universal Health Coverage not only for the RMs, but also for the general population (Kentikelenis et al., 2014, Economou et al., 2017). This failure is the product of more than two decades unfolding erosion of ESY’s coverage and performance due to austerity driven rationalization policies and central government decisions aimed at gradually dismantling the public health system in favor of the full privatization of health-care, insurance, and related welfare (Myloneros and Sakellariou, 2021; Kondylis et al., 2024; Kondylis and Benos, 2023). The reduced institutional capacity of ESY to respond to the health needs of RMs coincides with the adoption and gradual intensification of restrictive migration policies by the Greek government (Human Rights Watch, 2022; Reuters, 2025; Refugee Support Aegean, 2025; Kanellis, 2025) alongside the growing prevalence of xenophobic rhetoric in the public sphere (Vlachopoulous and Christou, 2023; Vouliwatch, 2023). Furthermore, there

is an evident lack of institutional coordination, leadership and ownership of the Refugee and Migrant Health portfolio by the Ministries responsible (i.e. Ministry of Migration and Ministry of Health) (Tramoundanis, 2022). This has resulted in a lack of strategic direction, significantly hindering efforts to develop and implement, within the ESY framework, a feasible and comprehensive Refugee and Migrant Health strategy (World Health Organization, and Ministry of Health of Greece, 2019). This convergence of weak system performance, policy inertia and predominance of restrictive migration policies, has fostered a denialist stance towards Refugee and Migrant Health within the ESY and has exacerbated further negative social determination of health (Hodes et al, 2018). As a result, RMs in Greece face substantially impaired health access to free of charge, tailored and equitable healthcare services - whether as consequence of deliberate policies or through systemic neglect (Desipris et al., 2022; Joseph et al., 2020).

Evidence shows that systemic negligence of RM health needs leads to direct negative consequences such as higher health expenditures, overstretched health system capacities, epidemic outbreaks and increased (infant) mortality, morbidity and overall disease burden (Bozorgmehr and Razum, 2015; Chiarenza et al, 2019; Abbas et al., 2019; Puchner et al., 2018). Beyond these direct health impacts, such neglect undermines integration prospects of RMs and thus prosperity and long-term economic and demographic growth of host societies (Lebano et al., 2020; Tramoundanis, 2022).

In this light, it becomes evident that improving responsiveness of the ESY to RM health needs requires following intersectoral policy reforms:

a) RM-inclusive health system strengthening,

b) Introduction of genuine Universal Health Coverage of the whole population residing in Greece

c) Reversal of restrictive migration policies affecting negatively SoDH of RMs.

For these policy reforms to materialize despite evident institutional inertia and opposing mainstream political trends, mobilization, coordination and joint political efforts by health worker unions, academia, (critical) media, political actors, civil society and large segments of the Greek constituency are required. At the same time initiatives at a more technical/bureaucratic level could enhance responsiveness of the health system to RM needs. ESY health workers and administration, along with other public health institutions such as EODY and in collaboration with international health agencies and NGOs with mandate and experience in Refugee and Migrant Health, should jointly advocate for inclusion of this population in all health policies of the central government and lead the development of the first National Refugee and Migrant Health Strategy. The strategy should also carefully define and promote implementation of the most suitable responsiveness model for addressing RM health needs within the ESY. However, sustainable implementation of any model or mixture of models—whether mainstream, specialized, or gateway—will ultimately depend on the broader intersectoral policy reforms outlined above.

It is essential to recognize that the shortsightedness of institutional negligence of Refugee and Migrant Health not only can have detrimental effects on public health and population health outcomes but may also put the overall social cohesion of the Greek society at risk.

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