How-to: Provide high-quality primary care for people seeking asylum, migrants and refugees

Health Equity Evidence Centre

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HOW-TO GUIDE

Authors: Emily Clark, Heidi Lynch and John Ford

Aims

- To support practices and the primary care workforce in caring for refugees and displaced persons.
- To provide evidence-based recommendations that outline how to provide culturally competent care, improve access, and undertake initial health assessments.

Summary

Primary care is the most frequent point of access to healthcare in the country of resettlement for people seeking asylum, refugees and displaced persons. Despite having poorer health than the rest of the population, displaced persons face multiple challenges accessing health and social care. The NHS policy of free primary health care for all regardless of immigration status has proven insufficient to remove barriers for unwell migrants. Mounting evidence suggests that strong primary care systems can improve health outcomes and lower rates of hospital admission and mortality. Addressing health needs of refugees and displaced persons early via preventive and good quality primary care reduces health inequalities and reduces long-term costs for the healthcare systems.

What is the challenge?

The number of forced migrants in the UK due to war, persecution and political instability has reached unprecedented levels. In 2022, there were 74,751 asylum applications made to the UK Home Office, the highest number since 2002 (5).

People seek refuge in the UK for diverse reasons, making forced migrants a heterogeneous group. They are often described as facing the "triple burden" of infectious diseases, non-communicable diseases, and mental health issues (6). displaced persons have poorer health than the general population, but have worse access to health and social care (3). They may have faced

DEFINITIONS

A **refugee** is defined by the United Nations High Commissioner for Refugees (UNHCR) as a person 'who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion'.

A **person seeking asylum** is an individual who is seeking international protection but whose request for sanctuary has yet to be processed. The preferred term of person seeking asylum or person seeking sanctuary is less de-humanizing (1, 2).

Forced migrants include refugees, internally displaced persons and those who have been displaced by environmental, chemical or nuclear disasters, famine or development projects (3).

A **displaced person** is someone who has been forced to leave their home, especially because of war or a natural disaster (4).

There are many other groups of individuals who do not fall into these categories but may be vulnerable, including those who have had their request for asylum refused, have been trafficked or who have remained in the UK after a visa has expired (2). The UK government perceives they have no right to remain or recourse to public funds.

significant trauma and adversity in their country of origin, or during their journey, leading to higher mental health needs than the general population (7).

On arrival in the country of destination refugees and displaced persons face challenges to access primary care (8). Commonly cited barriers include insufficient awareness of, difficulty navigating and poor understanding of the NHS, fear of incurring healthcare costs, cultural and language barriers, discrimination, geographical isolation and travel costs (9, 10).

Health professionals face time constraints in both managing patients and keeping their knowledge and skills up to date. Managing the high burden of disease commonly associated with migration within a 15-minute consultation is challenging if not unachievable (9).

Practice and policy landscape

The NHS policy for migrant access to primary care is clear: anyone in England can register and consult with a GP without charge (6) and practices are not required to ask for proof of identity, address, immigration status or an NHS number (6, 11). Regardless, vulnerable migrants face multiple hurdles accessing appropriate care. An investigation conducted by the Bureau of Investigative Journalism of GP clinics across England, Scotland and Wales revealed that policy is not translated into practice (12). Only 24% of practices stated they were willing to register patients without proof of address, identification, or legal immigration status. Of the remaining practices, 62% said they would not register the patient and 14% stated they were unsure.

Hostile Environment policies (13) continue to foster fear and create barriers to access (14). Previously, data-sharing between NHS Digital, the Department of Health and the Home Office was used as a lever for identifying and deporting undocumented migrants (14). The volatility of immigration status, which can change quickly and many times, is a source of confusion for both practices and patients (13). Disruption in continuity of care is often attributed to instability of accommodation. This is particularly an issue for people seeking asylum living in housing provided by the Home Office, who can be relocated at any time on a no-choice basis (13).

Steps needed to support refugees and displaced persons

1. Ensuring culturally competent multidisciplinary team

- Cultural competence - Individual practitioner cultural competence, responsiveness and awareness of health beliefs underpin quality care for this diverse group (15-17). Culturally and linguistically appropriate educational materials about cancer screening are known to improve screening uptake (18).
- Patient navigation - Contact with navigators (lay person or nurse) matched by culture and language background are demonstrated to remove patients' individual psychological and logistical barriers to screening (18-21).
- Social prescribing - Social prescribing programmes must be adapted and tailored as much as possible to migrants' preferences for language, culture, gender and service delivery format (17).

2. Improving access

Access to primary care

- Registration - Ensure that reception and administrative staff understand what is contractually required and do not incorrectly refuse to register vulnerable patients (7, 11). Individuals may need support to register with a GP and navigate the NHS (11).
- Entitlements – People seeking asylum and refugees can access free prescriptions, dental treatment and sight tests by applying online for a HC2 certificate (22).

Access to secondary care

- Manage expectations - Secondary care is free for those with an active asylum application or refugee status (7) but expectations around waiting times for secondary care may need to be managed (22).
- Fees – People who have been refused asylum may be charged for secondary care (7). However, if a course of treatment was already underway before their application was refused, all people seeking asylum may continue with this free of charge (7). For new courses of treatment, any treatment that clinicians consider urgent (needed before the patient can leave the UK) will be provided even if payment is not made in advance of treatment (7). Accident and emergency care, family planning and treatment of infectious disease are free (6). Maternity care will always be provided, even when charges apply (6). Victims of certain types of violence (such as sexual violence) are also treated free of charge (6).

3. Undertaking initial health assessments

Information gathering

- Use professionals - Professional interpreters are better than family members or friends because they are more likely to communicate accurate information (11). Consider patient preference regarding interpreter dialect, gender, and cultural background, as these may have an impact on trust and disclosure of information (22). Record keeping of interpreters allows rebooking and continuity.
- Appointment length - Provide longer appointment times for those with complex needs to establish a therapeutic relationship and allow for interpreters to be used (9).
- Information gathering - Inquire about circumstances before migration, the journey, and current circumstances (including discrimination) within a person-centred assessment of any presenting migrant patient (11, 22, 23).

Communicable diseases

- Screening - Screen for communicable diseases dependent on the country of origin (22). Latent tuberculosis should be screened for using interferon-gamma release assay via a single blood test in new entrants under 65 years old from high incidence countries (24). If symptomatic, refer new entrants from high incidence countries who have not had pre-entry screening for a chest X-ray and to the local multidisciplinary TB team (24). Screen for hepatitis B in migrants from countries with intermediate (HBsAg prevalence ≥2%) and high (HBsAg prevalence ≥5%) prevalence (25). Consider sexual health screening, and screening for human immunodeficiency virus (HIV) and parasitic infections (22).
- Immunisations - Assume that patients are unimmunised if they are unable to provide reliable written or verbal vaccination history (8). Offer vaccination according to the host country's vaccination schedule, including COVID-19 vaccinations (8).

Non-communicable diseases

- Medications - NCDs may be undiagnosed or poorly controlled due to interruption or lack of medical care, loss of medication, and limited access to, or knowledge about, health systems in the host country (9). Explain where and how to collect medication, how to order repeat prescriptions, and advise about any prescription charges and exemptions (22).
- Systematic approach - Consider nutritional and metabolic condition, oral health, pregnancy, contraception and a history of female genital mutilation (11, 22). In children, perform childhood growth and development assessments (22).

Looking after mental health

- Consider trauma - Be alert to symptoms of depression and anxiety, and in the context of trauma, specifically inquire about symptoms of post-traumatic stress disorder (15, 22). If the person has a history of significant trauma they may not wish to disclose it, and a disclosure may not be essential to assess mental health (15). Recognize the impact of trauma on psychological and social wellbeing, avoiding over medicalising understandable distress, understanding the risks of re-traumatisation and second-hand trauma, and approaching treatment with a focus on safety, sensitivity and collaboration (26).
- Therapy - Culturally adapted cognitive behavioural therapy and other psychotherapies may be acceptable and hold considerable promise in reducing depressive symptoms (27, 28).

Other issues to consider

- Somatisation - There may be high levels of somatisation in this group, understand the somatic element of psychological trauma as it may be a key factor for the increase in utilisation of general primary healthcare as compared to mental healthcare (29).
- Gender of staff - Some migrants may wish to discuss more sensitive matters with health professionals of the same gender (22).
- Lifestyle advice - Lifestyle advice needs careful contextualisation and awareness of the social, financial, and practical constraints of the patient e.g. hotel accommodation where all meals are provided without choice (22).
- Wider determinants of health - gain awareness of the social and economic support available for displaced persons including immigration advice, language classes, community and voluntary services and meaningful activities (19, 30).

Useful links

- The UK Office for Health Improvement and Disparities: Migrant Health Guide
- Doctors of the World UK's Safe Surgeries' Toolkit
- The UK Health Security Agency (UKHSA): Infectious diseases in asylum seekers: actions for health professionals
- British Medical Association: Asylum seeker and refugee health
- ECDC: Public Health Guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA
- WHO: Promoting the health of refugees and migrants global action plan, 2019-2023

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contact@heec.co.uk