What works: Fostering equitable access to primary health care for asylum seekers, migrants and refugees

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EVIDENCE BRIEF

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Summary

Primary care is the most frequent point of access to healthcare for people seeking asylum, refugees and displaced persons. Refugees experience a higher burden of disease than the rest of the population. The NHS policy for free primary healthcare has proven insufficient to remove barriers for unwell migrants. Factors relating to the individual, workforce, and service level continue to inhibit timely access to high-quality care.

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 long-term healthcare costs and inequalities. This brief presents current available evidence focusing on three broad categories: health service design, patient navigation services and culturally and linguistically tailored care.

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-humanising (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.

Current challenges

The number of refugees and displaced persons in the UK due to conflict, climate change or lack of opportunities has reached unprecedented levels.

74,751

Asylum applications made to the UK Home Office in 2022, the highest number since 2002 (5).

1-3 years

The average waiting time for an initial decision on an asylum case in 2022 (6).

24%

The percentage of applications refused in 2022, its lowest point since 1990 (5).

Health of refugees and displaced persons

Refugees and displaced persons are a heterogeneous group. They are often described as facing the "triple burden" of infectious diseases, non-communicable diseases, and mental health issues (7). Displaced persons have poorer health than the general population, but are less likely to access health and social care (8). They often originate from settings with higher rates of infectious disease(s) (9). Non-communicable diseases may also be undermanaged on arrival in the country of destination because of unstable access to care during the transition from their countries (8). They may have faced significant trauma and adversity in their country of origin or on their journey, leading to stress, depression, anxiety and post-traumatic stress disorder (10, 11). Fear and stigma around mental health within communities of origin and diaspora communities may prevent displaced persons from expressing distress and accessing timely care (12-14).

Barriers accessing health care

Primary care in the UK is free regardless of immigration status, yet vulnerable migrants face multiple barriers accessing care due to personal factors, the design of the healthcare system or health professionals' behaviour and attitudes (15, 16). Commonly cited barriers include insufficient awareness of UK health care structures, difficulty navigating the NHS, fear of incurring healthcare costs, cultural and language barriers, discrimination, geographical isolation and travel costs (17, 18). Digital initiatives to improve access, such as digital registration and online and telephone appointment triage systems may instead create additional barriers for those who lack access to devices and the internet or have poor digital or language competency (7, 8, 19).

Health system factors

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 10-15 minute consultation is challenging if not unachievable (20). The complex medical needs of the refugees and displaced persons are frequently compounded by distress around situational factors (7). Post-migration stressors refer to contributory social, environmental and political factors which can impact on the level of distress. They include discriminatory policies, racism, the protracted nature of the asylum-seeking process and exclusion, living conditions, poverty, language barriers, the hostile political environment, lack of community cohesion and lack of meaningful work or other activities (21).

Summary of the evidence

We identified 18 articles relating to what works to address inequalities for people seeking asylum, migrants and refugees accessing primary care: eight systematic reviews, four scoping reviews and six primary studies. We identified three broad categories of interventions to improve primary care:

- Health service design
- Patient navigation services
- Culturally and linguistically tailored care

Health service design

A systematic review identified 17 studies that assessed interventions designed to improve access and delivery of healthcare for refugees and people seeking asylum (20). Enhanced care models were examined in seven studies and identified improvement in uptake of services and communication as well as measurable health outcomes such as blood glucose, blood pressure and medication adherence. These models integrated multiple strategies: algorithms to link patients to appropriate care within three weeks of arrival; provision of care in multiple languages; and delivering culturally-orientated family-focused collaborative care. One study demonstrated a reduction in patient mental illness following the implementation of a 'whole community model' which linked mental health, physical health, youth development, communication and delivery of emotional empowerment interventions across a refugee community (22). The same study also reported improvements in baseline levels in all 50 participating diabetic patients; 62% in blood pressure, blood glucose and behavioural risk factors for disease, 30% in medication compliance and 11% in communication (22).

Two randomised controlled trials, assessing colorectal cancer (CRC) screening rates found implementation of multilevel interventions increased uptake by immigrants in the United States (23, 24). Lima et al. found that the 409 intervention group patients were more than twice as likely to undergo CRC screening than the 814 control patients following the 9-month intervention period (27% versus 12%) (24). Intervention components included language matched video education, brochures, paper-based reminders, procedure scheduling and provision of transportation. A multifaceted education program in Canada aimed to improve breast and cervical cancer screening uptake in immigrant and marginalised women (25). Just under 2000 women participated in the study, at the end of

which 26% and 36% of women who were age eligible underwent pap smear and mammography respectively, compared with 9% and 14% in the control group (25).

Proximity of healthcare services to migrant residences was found to improve engagement and hasten initial access in six studies within a systematic review (20). Access interventions such as outreach services to patients' homes, free transport to appointments and extended consultation hours also demonstrated benefit (26). Knowledge and promotion of migrants' rights and entitlement to services by both clinical and non-clinical staff within primary care was identified as an important area for development (27). Educating all staff in financial, legal and cultural matters impacting migrants' access to healthcare is also a key lever (20).

Patient navigation services

Multiple studies demonstrated evidence to support patient navigation services for reducing inequalities in access among migrant populations (25, 28-32). In all studies, engagement with breast and cervical cancer screening improved substantially in migrant women who were matched by culture and language background to navigators. One study involved patient contact by phone or in person to remove individual psychological and logistical barriers to screening (28). Navigators provided culturally and linguistically appropriate educational materials about cancer screening in addition to support with scheduling and attending appointments. These interventions resulted in an increase in screening uptake in the study group of 188 refugee women from 64.1% to 81.2% over the 4-year study period. An appraisal of this study 5 years after the programme's end demonstrated persistence in levels of mammography uptake (33). A patient navigation program for 95 Bosnian refugee women improved uptake of mammography from 44% to 67% after 1 year (30). A key component to the success of this programme was identified as the navigator having the same first language and being from the same country of origin as the patients, as well as also having been displaced due to the Bosnian war.

Culturally and linguistically tailored care

One review compared routinely available data from the UK, Ireland, Austria, Germany and the Netherlands to determine facilitators to migrant health in primary care (27). This review and another primary study identified translation services and bilingual staff as levers to the effective delivery of care (34). Qualitative findings demonstrated that a multidisciplinary workforce with inter-cultural communication skills is effective in enabling access to primary care in migrants (27). In another study, collaboration with Hispanic community health workers in the creation and promotion of screening resulted in increased uptake of cervical cancer screening (35). However, there were a few studies that found no impact of culturally adapted services in certain circumstances. For example, one systematic review investigated depression interventions in first generation immigrants and found no discernible relationship between treatment adherence and cultural adaptation of therapy (13).

Two systematic reviews examined measures to promote physical activity, improve nutrition and reduce obesity in migrant populations (36, 37). Chapman et al. included four studies with a total of 395 South Asian immigrants, three of which found that trained bilingual community link workers led to higher engagement of South Asian immigrants in physical activity and dietary interventions (36). One randomised controlled trial within this review, in which 112 patients in the study group received education from community link workers, reported improvement in knowledge in all parameters (38). Knowledge of diabetic complications increased from 18% to 78%, correctly identifying different food nutritional value from 57% and 71% and regular glucose testing from 68% to 92% (38). Similarly, a systematic review by Tovar et al. reported that interventions with a cultural focus showed positive effects among both adult and children Latino immigrants (37). Home-engagement and a community-based approach were associated with success in child and adult interventions respectively (37).

Limitations

The complexities and challenges of conducting longitudinal studies with displaced persons are well documented in current literature (20). The breadth of available research regarding mental health is limited and under-representative of the full ethnic diversity of migrant groups. There is very little disaggregation by migrant sub-group in the literature to allow for population-specific understanding of health needs and appropriate interventions and service delivery (20).

What works: key recommendations

The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) framework has been adopted to grade the quality of the evidence and support recommendations.

Recommendation	Target audience	GRADE certainty
Delivering culturally and linguistically appropriate care is needed to improve initial and ongoing engagement with primary care	Practices/ PCNs/ ICBs	⨁⨁⨁⨁ High
• Availability of translation services or bilingual staff within primary care	Practices/ PCNs/ ICBs	⨁⨁⨁⨁ High
• Provision of linguistically and culturally tailored multi-media education material (videos, brochures, handouts)	Practices/PCNs/ ICBs	⨁⨁⨁◯ Moderate
Provision of culturally and linguistically matched community link workers/ patient navigation workers	Practices/PCNs/ ICBs	⨁⨁⨁◯ Moderate
Practices should consider additional interventions to remove barriers for migrant patients	Practices	⨁⨁◯◯ Low
• Access interventions: transportation services, outreach services, extended consultation hours	Practices/PCNs/ ICBs	⨁⨁◯◯ Low
• Recall and reminder systems to promote ongoing engagement particularly for chronic disease and cancer screeningww	Practices/PCNs/ ICBs	⨁⨁◯◯ Low
• Application of multifaceted enhanced care models	Practices	⨁⨁◯◯ Low
• Educating all staff and ensuring promotion of migrants' rights and entitlement to services	Practices/PCNs/ ICBs	⨁⨁◯◯ Low
• Community-based approaches to provision of care	Practices/PCNs/ ICBs	⨁⨁◯◯ Low
Further data disaggregated by country of origin and ethnicity is needed to understand and track inequalities	Practices/PCNs/ ICBs	⨁◯◯◯ Very low

Lived experience case study

This case study is adapted from a case described in the Equality and Human Rights Commission Research report 122 (39).

Amna has been seeking asylum in Britain for two years and has had one previous application for asylum refused and is awaiting a decision on a second application. She has recently relocated to London and is currently residing in temporary accommodation provided by a voluntary organisation. She has no reliable source of income and no supports within the community. Amna is 37 weeks pregnant and visits a primary care provider for antenatal care. Prior to now she has faced significant barriers accessing appropriate antenatal care, largely because she was not aware of the available services she was entitled to.

Amna requests an interpreter during her consultation and Language Line is used but it is challenging and leads to numerous misunderstandings. She has not previously been offered an interpreter and as a result has misinterpreted many aspects of the healthcare she would need during her delivery. Amna was subjected to female genital mutilation as a child and was under the impression that a delivery would pose a significant risk to her and her child's life. She has been offered a caesarean and defibulation in the past but with inadequate explanation of the relatively low risks of these procedures.

Useful resources

- Doctors of the World UK Safe Surgeries Toolkit
- NHS Entitlements: migrant health guide
- Assessing new patients from overseas: migrant health guide
- WHO: Promoting the health of refugees and migrants: A framework of priorities and guiding principles to promote the health of refugees and migrants
- Infectious diseases in asylum seekers: actions for health professionals

References

1. City of Sanctuary United Kingdom. Guide to Use of Language 2021 [Available from: https://cdn.cityofsanctuary.org/uploads/2020/11/Guide-to-Use-of-Language-and-Terminology-1.pdf.
2. The United Nations Refugee Agency. A Great British Welcome 2023 [Available from: https://www.unhcr.org/uk/.
3. European Commission. Forced Migrant. 2023. [Available from: https://home-affairs.ec.europa.eu/networks/european-migration-network-emn/emn-asylum-and-migration-glossary/glossary/forced-migrant_en#:~:text=A%20person%20subject%20to%20a,environmental%20disasters%2C%20chemical%20or%20nuclear.
4. Cambridge Dictionary. Cambridge: Cambridge University Press and Assessment; 2023. Cambridge Advanced Learner's Dictionary and Thesaursus.
5. House of Commons Library. Asylum Statistics 2023 [Available from: https://commonslibrary.parliament.uk/research-briefings/sn01403/ (Accessed: 22 October 2023).
6. Refugee Council. Thousands seeking asylum face cruel wait of years for asylum decision – fresh research shows 2021 [Available from: https://www.refugeecouncil.org.uk/latest/news/thousands-seeking-asylum-face-cruel-wait-of-years-for-asylum-decision-fresh-research-shows/ (Accessed: 12 October 2023).
7. Knights F, Munir S, Ahmed H, Hargreaves S. Initial health assessments for newly arrived migrants, refugees, and asylum seekers. bmj. 2022;377.
8. Organisation WH. Refugee and migrant health 2022 [Available from: https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health
9. United King Health Security Agency . Infectious diseases in asylum seekers: actions for health professionals 2022 [Available from: https://www.gov.uk/guidance/infectious-diseases-in-asylum-seekers-actions-for-health-professionals.
10. Royal College of Psychiatrists. Asylum seeker and refugee mental health 2023 [Available from: https://www.rcpsych.ac.uk/international/humanitarian-resources/asylum-seeker-and-refugee-mental-health
11. Blackmore R, Boyle JA, Fazel M, Ranasinha S, Gray KM, Fitzgerald G, et al.. The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. PLoS medicine. 2020;17(9):e1003337.
12. Pollard T, Howard N. Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. International Journal of Mental Health Systems. 2021;15(1):1-15.
13. Antoniades J, Mazza D, Brijnath B. Efficacy of depression treatments for immigrant patients: results from a systematic review. BMC psychiatry. 2014;14:1-12.
14. Due C, Green E, Ziersch A. Psychological trauma and access to primary healthcare for people from refugee and asylum-seeker backgrounds: a mixed methods systematic review. International journal of mental health systems. 2020;14(1):1-18.
15. Public Health England. NHS entitlements: migrant health guide. 2014.
16. Zeidan AJ, Khatri UG, Munyikwa M, Barden A, Samuels-Kalow M. Barriers to accessing acute care for newly arrived refugees. Western Journal of Emergency Medicine. 2019;20(6):842.

17. Kang C, Tomkow L, Farrington R. Access to primary health care for asylum seekers and refugees: a qualitative study of service user experiences in the UK. British Journal of General Practice. 2019;69(685):e537-e45.

18. Brandenberger J, Tylleskär T, Sontag K, Peterhans B, Ritz N. A systematic literature review of reported challenges in health care delivery to migrants and refugees in high-income countries - the 3C model. BMC public health. 2019;19(1):1-11.

19. World Health Organization. Promoting the health of refugees and migrants. 2023.

20. P. Iqbal M, Walpola R, Harris-Roxas B, Li J, Mears S, Hall J, et al.. Improving primary health care quality for refugees and asylum seekers: A systematic review of interventional approaches. Health Expectations. 2022;25(5):2065-94.

21. Kings College London. Ten Years of the 'Hostile Environment': Resistance, refuge and the role of cities in the asylum journey. 2022 [Available from: https://www.kcl.ac.uk/ten-years-of-the-hostile-environment-resistance-refuge-and-the-role-of-cities-in-the-asylum-journey

22. Grigg-Saito D, Toof R, Silka L, Liang S, Sou L, Najarian L, et al.. Long-term development of a "whole community" best practice model to address health disparities in the Cambodian refugee and immigrant community of Lowell, Massachusetts. American journal of public health. 2010;100(11):2026-9.

23. Aragones A, Schwartz MD, Shah NR, Gany FM. A randomized controlled trial of a multilevel intervention to increase colorectal cancer screening among Latino immigrants in a primary care facility. Journal of general internal medicine. 2010;25:564-7.

24. Percac-Lima S, Grant RW, Green AR, Ashburner JM, Gamba G, Oo S, et al.. A culturally tailored navigator program for colorectal cancer screening in a community health center: a randomized, controlled trial. Journal of general internal medicine. 2009;24:211-7.

25. Dunn SF, Lofters AK, Ginsburg OM, Meaney CA, Ahmad F, Moravac MC, et al.. Cervical and breast cancer screening after CARES: a community program for immigrant and marginalized women. American Journal of Preventive Medicine. 2017;52(5):589-97.

26. Joshi C, Russell G, Cheng I-H, Kay M, Pottie K, Alston M, et al.. A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. International journal for equity in health. 2013;12(1):1-14.

27. O'Donnell CA, Burns N, Mair FS, Dowrick C, Clissmann C, van den Muijsenbergh M, et al.. Reducing the health care burden for marginalised migrants: the potential role for primary care in Europe. Health Policy. 2016;120(5):495-508.

28. Percac-Lima S, Ashburner JM, Bond B, Oo SA, Atlas SJ. Decreasing disparities in breast cancer screening in refugee women using culturally tailored patient navigation. Journal of general internal medicine. 2013;28:1463-8.

29. Gondek M, Shogan M, Saad-Harfouche FG, Rodriguez EM, Erwin DO, Griswold K, et al.. Engaging immigrant and refugee women in breast health education. Journal of cancer education. 2015;30:593-8.

30. Percac-Lima S, Milosavljevic B, Oo SA, Marable D, Bond B. Patient navigation to improve breast cancer screening in Bosnian refugees and immigrants. Journal of immigrant and minority health. 2012;14:727-30.

31. Carter N, Valaitis RK, Lam A, Feather J, Nicholl J, Cleghorn L. Navigation delivery models and roles of navigators in primary care: a scoping literature review. BMC Health Serv Res. 2018;18:1-13.

32. Percac-Lima S, Ashburner JM, McCarthy AM, Piawah S, Atlas SJ. Patient navigation to improve follow-up of abnormal mammograms among disadvantaged women. Journal of women's health. 2015;24(2):138-43.

33. Rodriguez-Torres SA, McCarthy AM, He W, Ashburner JM, Percac-Lima S. Long-term impact of a culturally tailored patient navigation program on disparities in breast cancer screening in refugee women after the program's end. Health equity. 2019;3(1):205-10.

34. Michelen W, Martinez J, Lee A, Wheeler DP. Reducing frequent flyer emergency department visits. Journal of health care for the poor and underserved. 2006;17(1):59-69.

35. Watson-Johnson LC, Bhagatwala J, Reyes-Garcia C, Hinojosa A, Mason M, Meade CD, et al.. Refinement of an educational toolkit to promote cervical cancer screening among Hispanic immigrant women in rural southern Georgia. Journal of health care for the poor and underserved. 2012;23(4):1704.

36. 36. Chapman J, Qureshi N, Kai J. Effectiveness of physical activity and dietary interventions in South Asian populations: a systematic review. British Journal of General Practice. 2013;63(607):e104-e14.

37. Tovar A, Renzaho AM, Guerrero AD, Mena N, Ayala GX. A systematic review of obesity prevention intervention studies among immigrant populations in the US. Current obesity reports. 2014;3:206-22.

38. Hawthorne K, Tomlinson S. One-to-one teaching with pictures--flashcard health education for British Asians with diabetes. British journal of general practice. 1997;47(418):301-4.

39. Nellums LB, Rustage K, Hargreaves S, Friedland J, Miller A, Hiam L, et al.. The lived experiences of access to healthcare for people seeking and refused asylum. 2018.

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