Identifying Factors Limiting Refugee Access to Healthcare and Potential Measures Which Combat Them

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Refugees and asylum seekers (ASRs) face many hardships and hindrances throughout their displacement and integration into their host country. These circumstances have led to the under-utilisation of healthcare within this population. This paper aims to identify factors which limit the utilisation of healthcare amongst ASRs using the current literature and intends to propose measures which reduce the impact of said factors. 10 studies were included in this review after a thorough search across three literature databases and 10 common themes were acknowledged as barriers to ASR access to healthcare. This included communication, lack of information and intersectionality, to highlight a few. Various potential measures including adequate training of staff, increasing the availability of translated information and community outreach programmes were proposed to tackle the recognised barriers. The implementation of these measures aims to increase the accessibility of healthcare and reduce health inequalities faced by the ASR population.

As of midway through 2024, there were over 122 million people worldwide who have been forcibly displaced from their homes.[1] This is a number which has doubled within the last ten years.[1] Reasons for its dramatic increase include ongoing and new wars, gender-based violence, climate change, political instability and natural disasters.[2] These circumstances create unsafe and uninhabitable conditions which force people to undertake journeys to seek safety and stability in a new place.[2] However, it is not always so straightforward, sometimes the journeys themselves are a risk to life or as they reach their new destination, there can be uncertainty about whether they will be allowed to stay in these locations.[1] This is why there are different terms to describe people within these populations. The term "refugee" describes the forcibly displaced population who have been granted (usually temporary) citizenship within the country they have

travelled to for safety.[1] Whilst “asylum seeker” (AS) refers to the forcibly displaced who have submitted an application to be granted citizenship whilst their country is unsafe to live in.[4]

In the UK, the forcibly displaced population can enter as either resettled refugees or AS.[3] Resettled refugees are those who enter the UK after already having been accepted to a resettlement scheme by the home office they were referred to by the United Nations High Commissioner for Refugees (UNHCR).[3] AS arrive to the UK where they are initially interviewed before they can apply to become refugees.[3] During the time AS wait for their application to be reviewed, they are not able to work or access benefits and although they may receive help from charities and organisations, most AS live in poverty.[3] This process can prolong AS registration to primary healthcare.[3] Both AS and refugees (ASRs) are entitled to free healthcare during the application process and if they have been granted asylum in the UK.[1] If refused asylum, ASRs are no longer entitled to free healthcare in England, however it does not affect their entitlement in the rest of the UK.[1] Many ASRs may not have been able to see a doctor since their transit to the UK as Doctors of the World UK found that over 80% of ASRs asked for help trying to register with a GP.[7] Knowing their entitlement and how to access the NHS is crucial as this population are likely to have been exposed to conditions which predispose them to requiring healthcare.[3,8]

ASRs are vulnerable to mental and physical health conditions due to what they have experienced before, during and after fleeing their country.[8] Such experiences may include witnessing violence, injury, unsanitary living conditions, malnutrition, no access to clean water, and abuse.[3,8] The displaced population are at an elevated risk of infection of communicable diseases due to the circumstances of their journey to a host country and the impoverished living conditions they are subject to throughout and following their transit.[8,9] Tuberculosis and Hepatitis B are infectious diseases which are prevalent in this population and therefore should be screened for.[9] ASR women commonly first present to healthcare when they become pregnant.[8] It is crucial that pregnant ASRs obtain maternal healthcare as both mother and child face worse outcomes than that of the host

population.[8] Pregnant ASRs may also need a mental health screen as ASR women and girls are more vulnerable to sexual violence during travel and upon arrival to their new host country, especially if they were unaccompanied.[10] Khouani et al.[11] (2023) found that 75.7% of female AS in their study had experienced sexual violence before arriving in France and 26.8% had experienced it after arriving in France. Sexual abuse is only one of the experiences that puts those who seek asylum at larger risk of developing mental health issues, which is why it is important for them to have access to mental health services.[12] Other experiences which contribute to a decline in mental health in this population include physical violence, torture, exploitation, and gender-based violence like female genital mutilation.[12] The uncertainty of their right to remain in a country can also add to their mental stress as well as affect their physical health.[13] Another risk factor for poorer physical outcomes (such as myocardial infarction, cerebrovascular accidents and malignancy) are changes in lifestyle between their home and host country as ASRs tend to partake in less healthy practices like exercising less and eating unhealthily in their host country.[14] All of these factors and more prove that ASRs require accessible healthcare in their host country.

However, the under-utilisation of healthcare continues to be a challenge within the forcibly displaced population.[15] This is due to circumstances affecting their ability to gain access to it which are recognised as “barriers to healthcare”.[16] Barriers to healthcare can occur at an individual, community, population or systematic level.[16] Examples include financial concerns at an individual level, lack of public transport at a community level, cultural differences at a population level, and long waiting times at a systematic level.[17] Additionally, many ASRs are more vulnerable to health inequalities in the National Health Service (NHS) due to the stigmatisation of their population and their placement in impoverished conditions in the UK.[18] These experiences contribute to difficulty accessing and receiving adequate and appropriate care therefore generating further barriers to healthcare for this population.[18]

Healthcare organisations worldwide strive to optimise health services for everyone by investigating into barriers to healthcare and trying to

combat them.[15] Despite this, there is very little research into the barriers affecting ASRs in the UK specifically. Therefore, the objective of this review was to analyse the current literature on ASR access to UK healthcare and identify overarching themes that may limit its utilisation. Furthermore, another intention of this study was to highlight potential measures for application in future research which could reduce barriers to UK healthcare for the forced migrant population.

Methods

The studies used in this literature review were found using three separate research databases - PubMed, SocINDEX and ScienceDirect – as well as searching through the citations of studies. The last search was conducted on: 30th November 2024.

The search terms used to narrow down the number of studies included “refugees” or “asylum seekers”, “access”, “healthcare”, and variations of “UK”. These were accompanied by search limitations such as studies had to be published within the last five years and in the English language.

The results accumulated from these searches were then whittled down by their title and abstract to identify if these studies were relevant to this review. And finally, the remaining journal articles were then reviewed using the inclusion and exclusion criteria seen in Table 1.

The themes derived from the selected publications were chosen due to their reoccurrence throughout the reading process.

Results

From the literature search ten studies[19-28] were deemed to be relevant to this review and in-keeping with all the inclusion and exclusion criteria, as shown in Figure 1. All ten studies[19-28] were carried out within the last 5 years (2019-2024) in the UK.

Seven[19-21,24-26,28] of the studies used interviews alone in their study design, whilst one[23] study used a questionnaire to collect data.

Two[23,27] of the studies used focus group discussions to gather information, one[27] of which used these discussions alongside interviews in their study design.

Eight[21-28] of the studies collected information from the ASR population. Five[19-22,26] of the studies gathered data from those who work closely with ASR populations.

The over-arching themes identified which hinder access to healthcare for these populations include lack of information, communication, service access, affordability, health beliefs/literacy, cultural differences, prioritisation, transience, intersectionality, and psychological factors.[19-28] Communication[19-22,24-26] and service access[19-23,25,27] were recognised as a hindrance to healthcare access in seven studies. Affordability was highlighted in six of the studies as a barrier to healthcare.[19-21,23,25,26] Lack of information[19-21,25,26] and intersectionality[20-22,26,27] were each identified in five studies as a barrier to healthcare. Health beliefs/literacy[20-22,24] and transience[20,22,23,25] were themes identified in four studies as a barrier to healthcare. Psychological factors[20,24,25] were recognised in three studies as a barrier to healthcare. Cultural differences[20,22] and prioritisation[20,28] were themes identified in two studies as a barrier to healthcare.

Table 2 shows a breakdown of each study, the year it was published, the journal it was published in, its study design, the population it collected data from, and the themes identified which restrict access to healthcare.

Quality of the literature included was examined using the following criteria of credibility, dependability, confirmability, transferability and reflexivity.[29] It was concluded that all studies were of a good standard as the findings were clearly represented and described, their methods were sound and replicable, and their findings aligned with one another as well as other existing research.

Discussion

The themes highlighted from the ten papers analysed are discussed below in the subsequent sections.

Lack of information

ASRs struggled with utilising healthcare services as they had not been given clear information or assistance with how to do so.[19-21,25,26] Some ASRs were even unaware of their entitlement to free healthcare in the UK.[19] This unfamiliarity with the processes of registering with a GP, booking an appointment, and the referral system were shown to challenge ASRs as they were different from those of their home country.[21] One study included a quote which captured the uncertainty of ASRs when it came to registering with a GP:

"When I arrived to the UK, I was pregnant in my seventh month so I have to go and register … it was very difficult for me because I didn't know anything about the system".[25]

However, a lack of information was not only the problem for ASRs, but those who work with them as well.[20,21] Healthcare professionals and organisations which work with ASRs also struggled to advise them on their entitlements to healthcare in the UK and how to access it.[20,21]

"I don't think the NHS does a particularly good job of communicating out through local authorities and with organisations that support vulnerable groups. So, often organisations themselves don't know how to access dental services or how to signpost individuals to advise on oral health".[20]

Healthcare professionals also had a gap in their knowledge when it came to ASR health.[21] So, although ASRs had been able to utilise the NHS, it may not have been the most conducive consultation as the healthcare professional was unfamiliar with ASR health problems, therefore hindering their ability to treat them effectively.[21]

"These barriers arose not only in relation to healthcare professionals' limited awareness of… but also in relation to the professional understanding of the particular healthcare backgrounds of refugees and asylum seekers, many of whom have considerable mental and physical health needs arising from histories of trauma and/or torture". [21]

Previous studies[30-33] largely agreed that a lack of information obstructed ASR access to healthcare. Adding that, due to their forced displacement, ASRs would have been unable to research the healthcare system beforehand.[32] And that the insufficient knowledge surrounding ASR health held by healthcare professionals leads to scepticism of the care provided.[33]

Communication

Many ASRs speak a limited amount of English which made booking health appointments difficult due to the nature of needing to make a phone call to arrange one, and the possibility of being dismissed due to the services' inability to accommodate their needs.[19-25] Language is commonly acknowledged as a barrier to healthcare for ASRs within existing literature.[30-35]

"… or you have limited English, then it's very difficult to even make that call".[20]

"Like for example, when I want to book an appointment, they say that you have to wait for the Arabic GP, because they've got an Arabic GP there." [25]

ASRs also may feel as though they are not able to authentically convey their symptoms and feelings to their doctor in English which makes them hesitate to try to do so.[20,21,25] Khanom et al.[34] (2021) found that feeling ill or anxious may intensify their inability to explain further. Additionally, the assumption that they will be misunderstood due to the language barrier can lead to their refusal to contact their GP.[35]

"For the translation I think it's not very helpful, sadly… I mean every expression or word I give out has a certain feeling to it, and for a translation it might not give out the proper meaning or it won't come out the intended way, I believe". [24]

Language also interferes with the ASRs' ability to understand what doctors explain to them surrounding probable diagnoses, investigations and treatment.[20-22,24,25] A lack of understanding of the information being told to them also introduces difficulty for the healthcare professional when trying to consent ASR patients.[21,24,25] Due to misunderstanding, explaining medical terminology or procedures may be time-consuming and ASRs find that some healthcare professionals are impatient in these cases.[30]

"I think that's the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones […] the language...".[24]

"Their accent is very difficult for me. I cannot understand anything. I remembered that I was calling my husband and crying because I didn't understand anything, anything at all, yeah".[25]

A lack of understanding of diagnoses and procedures was only further exacerbated by the insufficient amount of written information provided to ASRs in different languages.[20,21,26] A different study[34] found that ASRs preferred to receive this translated information digitally rather than a physical printed medium.

"We've had one learner who's sent me pictures of a letter from a consultant at a hospital to his GP, which he's been copied into, and it's all in English, he doesn't speak any English, so he hasn't received any kind of translated version of it… but it's really important the stuff that it's talking about…".[21]

Certain aspects of using interpreting services also limited ASRs' access to healthcare due to a lack of adequate services or the use of interpreters creating an uncomfortable environment for ASRs. Restricted access for ASRs was often the result of interpreters being

unavailable.[19-22,25,26] Also due to the various dialects in languages such as Arabic, occasionally the presence of an interpreter did nothing to resolve the language barrier.[26]

"… people have been rejected because there was no available interpreter at that time".[20]

Uncomfortable environments created in consultations were a result of multiple factors. Interpreters sometimes noted that the doctors ended up ignoring the patient as they addressed their questions to them instead of the ASR.[22] Some ASRs did not feel comfortable with a stranger who was not a healthcare professional being present during the consultation.[24,26] And in a few cases, it was noted that interpreters had imparted their own opinions on the situation to the ASR without the knowledge of the doctor.[26] One existing study[32] found that these factors regarding interpreters were caused by a shortage of funding, a lack of standards set for interpreters and healthcare professionals receiving no training to work with interpreters.

"I told them also that the presence of a translator will not make me feel comfortable… sometimes you want to say personal things, or things straight from your heart, so to have a third person as a translator, it will be a bit difficult". [24]

Accessibility

Registering for primary care can be a near-impossible process for ASRs due to the requirement of identification and proof of address.[19,21,24,26] Existing literature[32,33,36] corroborated that providing documentation was a barrier experienced by ASRs across Europe. This was due to the governments' ability to access ASR medical records which deters them from registering in the first place in fear of deportation.[19,23,25]

The physical location of health services or where the ASR was placed also tends to impact their healthcare, especially if they are placed within a detention centre.[20,27] Residing in a detention centre is thought to be associated with limited medical care due to lack of staff, mistrust

and inadequate training.[37] Palattiyil et al.[27] (2021) described the experiences of asylum seekers being detained and their struggle to follow their HIV medication regimen throughout that period of time.

Being unable to afford or not having access to a phone or internet also had a negative impact on the ability of an ASR to access healthcare.[20,22,25]

Accessing healthcare is also delayed by misconceptions surrounding the affordability of it and the travel to and from appointments being too expensive.[19,21,23,25,26] Tomkow et al.[38] (2020) identified that 45% of ASRs they interviewed were not aware of their entitlement to free primary care.

"Oh well we walked for two hours to get here, if we'd paid for the bus we wouldn't have enough food for the day".[21]

Dental health is a sector which is not guaranteed to be covered by the NHS for ASRs, the inability to pay for appointments and treatment results in poorer oral health within this population.[20,25,39]

Health and Cultural Differences

ASRs may delay or refuse to utilise healthcare services in certain circumstances due to their health beliefs which differ from those typical of the UK, for example, this is common in mental health presentations.[19,21,23] This is a result of problems such as mental health not being recognised within their cultures and therefore having no reference for how it presents.[40]

"A lot of people come from cultures where mental health wouldn't be something that was even recognised as an issue, so being able to describe that in the first place [is a barrier]…".[21]

Also, not knowing what to expect when accessing healthcare impacts their experience as they do not utilise it in fear of the unknown.[20,22] This can be due to the unfamiliarity of investigations or treatments required to diagnose or manage conditions.[40]

Cultural differences between ASRs and the host country potentiated difficulties when discussing health with professionals as they either did not have any insight to the ASRs culture or ASRs and/or translators were uncomfortable with the topics being discussed.[20,22] Certain cultures may require specific topics of conversation to be discussed with the appropriate conditions e.g. discussing women's health may require only female doctors and interpreters be present.[41] Existing literature[40] revealed that healthcare professionals' lack of understanding towards an individuals' culture produced interactions that ASRs perceived as disapproving and insensitive, which in turn breaks down any rapport they have established.

The Asylum Process

ASRs were more likely to put their health on hold as concerns regarding their asylum status, living conditions and financial concerns took precedence.[20,28,35]

"Once in the host country, other 'pressing priorities', such as, 'what is happening with my case?', 'where am I going to live? How am I going to get money for food?', take precedence over oral health". [20]

Transience of the ASR community results in difficulty registering for and receiving continuous healthcare which results in poorer health outcomes.[20,22,23,25] It also creates difficulty to build rapport with ASRs as each move means they must begin all over again.[42]

"…they are highly likely to be moved regularly and without warning to other accommodation, providing further challenges in accessing the healthcare system as constant re-registration is required".[25]

ASRs face multiple levels of discrimination due to their asylum status, race, sex and their past medical history which make them more hesitant to access healthcare services due to how they are treated.[20-22,26,27] In the UK, seeking asylum has been vilified in the media which has resulted in a rise in discrimination towards ASRs.[32] This can have detrimental effects to refugee health services as it can lead to the defunding of them.[32]

"It is just because I am black? Is it just because I am a woman? Is it just because I am HIV? Is it just because I am an asylum seeker?".[27]

ASRs were reluctant to speak to doctors due to the doctors' lack of similar lived experience, believing they would not care about what ASRs have been through, or due to the healthcare environment reminding them of past traumatic experiences.[20,24,25] Paudyal et al.[24] (2021) described his interviewees' disinclination to talk through their experiences with British-born doctors due to their inability to understand or relate to what they have been through.

Structural Barriers to Healthcare

It is important to highlight that only four papers included in this study outrightly mention governmental and institutional policies which affect ASR interactions with healthcare.[19-21,23] However, nine of the studies identify barriers to healthcare which are a result of structural processes.[19-27] For example, although four studies[20,22,23,25] comment on transience as a barrier to healthcare, only one[23] of these studies acknowledges the government's role in creating this systemic barrier.

Potential Measures to Combat Limitations

Potential measures to combat the barriers identified above are required to increase the utilisation of healthcare by ASRs and in turn improve their health outcomes as well.

One such measure thought to increase the likelihood of ASR attendance to healthcare is the appropriate training of staff.[19-22] This training would include learning about other cultures and their practices so that all staff within a practice or health service can competently work with ASRs and create a safe space for them.[43] The implementation of this training may reduce the limitations to ASR healthcare involving lack of information, communication, health and cultural differences, intersectionality and psychological factors.[43] Additionally, introducing ASR health into medical students' curriculum may expand future doctors' abilities to care for ASRs and allow for better ASR experiences within healthcare.[44]

Another means to promote the use of healthcare services by ASRs are community outreach programmes targeting this population.[20,21,23,24] ASR community health programmes were shown to provide health education in a way which is easily understood and accounts for cultural differences.[45] They promote the awareness of health risks and allow for a voice for the ASR population.[45] These programmes decrease the effect of barriers to healthcare involving lack of information and communication, accessibility, health and cultural differences, and psychological factors.[45] One programme introduced ASRs to locations where they could access healthcare, this was found to help their understanding of the healthcare system despite a language barrier.[21]

"Actually the most useful part was when a visitor came to my home and he actually took me and my husband to the places and he was speaking English but he tried to show how the places looked like, I didn't understand everything he said but it gave me the idea how to get used to the system, so he actually took us to the places and, yeah, tried really hard to explain . . . ".[21]

Increasing the availability of the appropriate translators and translated information is another measure which is believed to improve the use of health services by ASRs.[20,21,25] By providing these services more availably, they lower the number of challenges faced by ASRs involving lack of information and communication.[45]

Another initiative proposed to improve ASR utilisation of healthcare includes services specialised towards the health of ASRs.[21,24,27] The establishment of these services may improve the health of ASRs via the introduction of specifically trained staff and ASR healthcare models.[46] This reduces the barriers to health involving lack of information, communication, and intersectionality.[46]

Limitations

Limitations of this review include the singular author, the screening process excluding non-UK studies, and the lack of formal quality assessment. Having one author means that there was no strict oversight on the screening of papers which can mean that potential titles were missed. The exclusion of non-UK studies may mean that

this study is non-transferable to ASR populations situated in other countries due to a difference in experiences and healthcare and asylum systems. Furthermore, the lack of formal quality assessment introduces a risk of bias within this study, however this risk was mitigated as much as possible through regular contact with a supervisor well-versed in ASR literature who could identify areas of bias.

Conclusion

The purpose of this review was to analyse current literature on ASR access to healthcare, recognise difficulties that may limit its use and produce potential measures which may improve its utilisation in the ASR population. The literature search identified ten papers where themes relating to lack of information, communication, accessibility, health and cultural differences, and the asylum process were consistently recognised as barriers to ASR healthcare. Potential measures identified to tackle these barriers include adequate ASR training for healthcare staff (including translators), the availability of translated information, community outreach programmes, and specialist ASR services. To improve ASR healthcare, future research should conduct studies surrounding the implementation of such measures and follow the ASR population's response and outcomes as a result of them.

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Appendix

Inclusion Criteria	Exclusion Criteria
Conducted within the last 5 years (2019-2024)	Conducted out-with the last 5 years
Conducted in the UK	Conducted out-with the UK
Focused on the refugee and asylum-seeking population	Includes economic migrant or non-migrant populations
Has a focus on the accessibility of healthcare	No focus on the accessibility of healthcare
Methodology includes interviews/ questionnaire to acquire results	Methodology does not include an approach to collect qualitative data
Obtains qualitative data	Does not obtain qualitative data
	Systematic or Scoping Reviews

Table 1: Inclusion and Exclusion Criteria for Literature found in the Database Search.

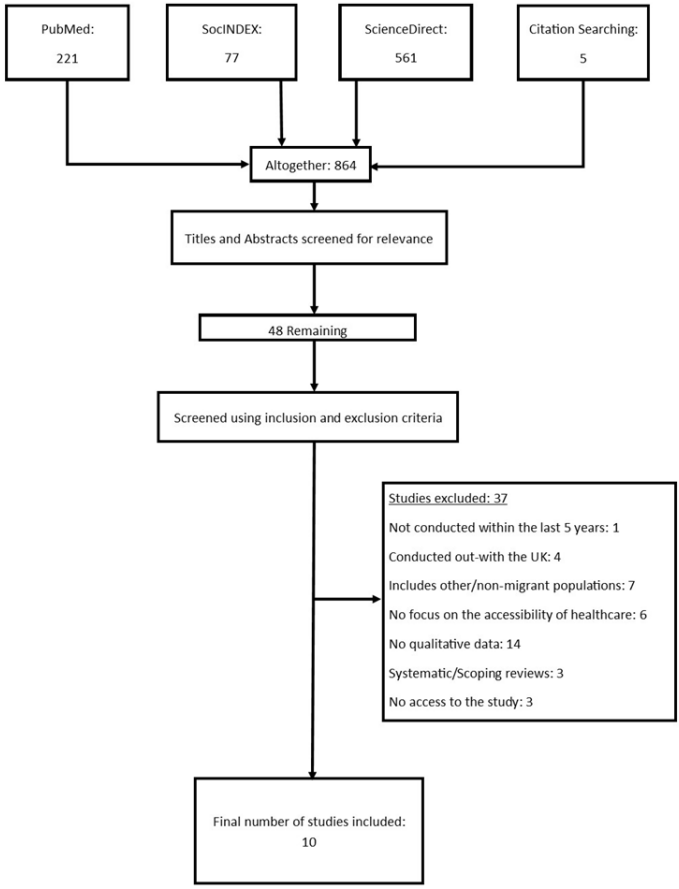

Figure 1: PRISMA diagram of literature search.

Author(s)	Year	Journal	Study Design	Population(s) Interviewed?	Themes Identified
Asif and Kienzler.[19]	2022	SSM – Mental Health	Interviews	Caseworkers who volunteer with ASRs	Lack of Information, Communication, Service Access, Affordability
Paisi et al.[20]	2022	British Dental Journal	Interviews	Those who work with ASRs	Lack of Information, Communication, Service Access, Affordability, Health Beliefs/Literacy, Cultural Differences, Prioritisation, Transience, Intersectionality, Psychological Factors
Moffat et al.[21]	2023	International Journal of Environmental Research and Public Health	Interviews	ASRs and those who work with them	Lack of Information, Communication, Service Access, Affordability, Health Beliefs/Literacy, Intersectionality
Scott, Forde and Wedderburn.[22]	2021	Journal of Immigrant and Minority Health	Questionnaires	ASRs and those who work with them	Communication, Service Access, Health Beliefs/Literacy, Cultural Differences, Transience, Intersectionality
Mudyarabikwa et al.[23]	2021	Journal of Immigrant and Minority Health	Focus Group Discussions	Refugee and immigrant community health champions	Service Access, Affordability, Transience
Paudyal, Tattan, Cooper.[24]	2021	British Medical Journal	Interviews	Refugees	Communication, Health Beliefs/Literacy, Psychological Factors
Talks et al.[25]	2024	International Journal of Migration, Health and Social Care	Interviews	ASRs	Lack of Information, Communication, Service Access, Affordability, Transience, Psychological Factors
Trueba, Axelrod and Ayeb-Karlsson.[26]	2023	Journal of Ethnic and Migration Studies	Interviews	ASRs and their support workers	Lack of Information, Communication, Affordability, Intersectionality
Palattiyil and Sidhva.[27]	2021	Journal of Human Rights and Social Work	Interviews and focus group discussions	AS with HIV	Service Access, Intersectionality
Isaacs et al.[28]	2022	Critical Public Health	Interviews	ASRs	Prioritisation

Table 2: Information extracted from each study included in this review.