Meeting the healthcare needs of refugees and asylum seekers – a survey of general practitioners
Meeting the healthcare needs of refugees and asylum seekers – a survey of general practitioners

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Summary

Aim
This report offers an overview of some key issues facing general practitioners (GPs) attempting to meet the healthcare needs of refugee and asylum seeker patients. It is aimed at those who make policy decisions that impact on the health of refugees and asylum seekers, and for healthcare professionals who work with refugees and asylum seekers.

A survey of GPs was undertaken to examine the incidence of refugees and asylum seekers using GP surgeries, and the impact this is having. The aim of the study was to identify and better understand the challenges facing GPs who treat this group of patients and what can be done to best meet the needs of all concerned.

Findings
• The majority of GPs report a range of problems associated with carrying out consultations with refugees and asylum seekers. These include the lack of a common language, lack of information about previous medical history, length of consultations, lack of information about other services for asylum seekers and information about the eligibility of asylum seekers for local services.
• The majority of GPs state that they are able to carry out successful consultations with refugees and asylum seekers most of the time or at least sometimes, with only a few never able to do so. There are a number of difficulties associated with consultations.
• Access to good quality, professional translators and interpreters is reported by respondents as being the most important factor in the effective treatment of refugees and asylum seekers. Most GPs use family members to translate at least some of the time and some respondents find professional interpreters to be less effective than family members, who are often more culturally aware and sensitive.
• Three-quarters of GPs report that having asylum seekers registered on their list affects their ability to meet targets, and a quarter state that this has a big impact on their ability to meet targets. The main reason given for this is non-attendance at some sessions, particularly for procedures such as immunisations.
• The majority of GPs state that having refugee and asylum seeker patients in their practice does affect the service offered to other patients, and nearly a quarter feel that the service is greatly affected. The main reason for this is the lengthy, often complex consultations that refugees and asylum seekers need.
• Language and the lack of resources including staff, time, funding, cultural support and knowledge of local services were identified as key issues which need to be addressed if the health needs of refugees and asylum seekers are to be adequately met.

Recommendations
• Trained interpreters and advocates should be used where possible to provide a sensitive service for refugees and asylum seekers. Whilst sometimes inevitable, the practice of using family members and friends as interpreters, can in some cases, be a barrier to effective care, particularly where sensitive issues are involved.
• Introducing interpreters into regular use requires changes in administration procedures, training to make effective use of them and adjustments to the practice. For example, practices should ensure that the ability of a patient to converse in English is recorded, so that support can be arranged as soon as an appointment is made.
• Refugees and asylum seekers must be provided with information in appropriate languages, about how the NHS works. This will help to ensure continuity of care and assist access to health promotion and preventative services.
• Support for GPs and healthcare staff should take the form of information about the entitlement to and availability of NHS and other services to refugees and asylum seekers and some background about the key issues affecting the health of this group and their access to healthcare. This will help to increase awareness of the specific needs of refugees and asylum seekers.
• In the absence of any national guidelines, guidance and advice must be available at a local level to GPs. This should include a general information package, information about social services, education and interpreting services and a directory of key local sources of information and assistance.
• The effectiveness of any information pack developed will be enhanced by widespread promotion to all GP practices and related healthcare providers.
• GPs need training and support to develop a greater understanding of cultural, social and other issues relating to refugees and asylum seekers.
• Appropriate assessment, treatment and support should be provided at the point of arrival to ensure that the health needs of asylum seekers and refugees are addressed adequately. All new arrivals to the United Kingdom should be given health checks at the point of entry, to establish the health status of individuals, including the presence of diseases such as tuberculosis.
• GPs should offer permanent registration to refugees and asylum seekers, rather than temporary registration, wherever possible. In offering permanent registration, they are more likely to be able to offer ongoing care and to obtain previous medical records, where they exist.
• It is important that sufficient funding is available for GPs providing healthcare for refugees and asylum seekers. Given the income streams available under the new GMS contract from 2004/05, and the uneven distribution of this group of patients, it seems most appropriate to deliver this funding via local enhanced services (LES) arrangements.
Introduction

In October 2002 the British Medical Association (BMA) launched the report, *Asylum seekers: meeting their healthcare needs*. This report reviews the healthcare requirements of asylum seekers and examines the implications of the immigration process on health. It is aimed at those who make policy decisions that impact on the health of refugees and asylum seekers, and for healthcare professionals who work with refugees and asylum seekers.

The magnitude of this issue is of central importance and in an attempt to inform and progress the debate further, a survey of GPs was undertaken to examine the incidence of refugees and asylum seekers using GP surgeries, and the impact this is having. The aim of the study was to identify and better understand the challenges facing GPs who treat this patient group and what can be done to best meet the needs of all concerned. This report presents the findings of this study.

Background

Whilst all refugees, asylum seekers and those with exceptional leave to remain have the right to free primary and secondary National Health Service (NHS) care, government policy towards refugees and asylum seekers lacks coherence and can often overwhelm the capacity of local services to provide for this vulnerable group. It has been suggested that the effect of the most recent legislation, the 1999 Asylum and Immigration Act, on key refugees and asylum seekers’ health and determinants of health has not been wholly conducive. Whilst the lack of resources and poor quality accommodation are serious concerns, compulsory dispersal into regions outside London and the South East has resulted in the influx of refugees and asylum seekers to parts of the United Kingdom, where appropriate services have not been developed and where there are no local communities of people of the same ethnic background. In many cases, service providers in these areas have had little experience in working with refugees and asylum seekers. Whilst refugees and asylum seekers are entitled to be registered with a GP and receive prescriptions free of charge, entitlement is not always synonymous with use and many find it difficult, if not impossible, to access health services when needed.

General practitioners are often, because of their accessibility, the first port of call for most refugees and asylum seekers presenting complex physical, psychological and social needs. Many of the health problems facing this group are not necessarily specific to refugee or asylum seeker status, but reflect the wider problems of poverty and social deprivation. Whilst many asylum seekers and refugees arrive in the United Kingdom in apparent good health, an important minority arrive in considerable distress, and may suffer physical effects of war, torture and displacement, communicable diseases and mental health problems following trauma. Asylum seekers are not a homogenous group and come from a wide range of backgrounds and situations. Some may have come from backgrounds where access to healthcare is limited due to conflict or lack of resources. Furthermore, it is unlikely that health will be the initial priority of recently arrived refugees and asylum seekers, as issues of housing, asylum, security, food and warmth are likely to take precedence.

Whilst the detrimental impact of the asylum process on the health of asylum seekers and refugees is recognised, there is concern that despite their entitlement to free NHS treatment, many refugees and asylum seekers receive poor healthcare in the United Kingdom. In reality, there are a number of barriers to refugees and asylum seekers adequately accessing primary healthcare. The current delivery of healthcare to refugees and asylum seekers is patchy and anecdotal evidence suggests that this group is often discriminated against within the NHS. Furthermore, refugees and asylum seekers sometimes have problems registering with a GP because of closed lists or a lack of awareness about rights and entitlements among primary care staff. Even when access is gained, many refugees and asylum seekers find it difficult to make use of the health service without interpreters.
Method

This study aims to provide information for policy makers to enable them to effectively respond to the needs of GPs working with refugees and asylum seekers. A postal survey of GPs was used to explore the perceived challenges in providing primary care services to refugees and asylum seekers. Following successful piloting, the survey was sent to a random sample of 4,000 GPs across the United Kingdom and received a response rate of 27 per cent (1,089/4,000). Of the total respondents, one third (365) indicated that they treated refugees and asylum seekers and these GPs were asked a series of questions about the experience of carrying out consultations and treating refugees and asylum seekers and the impact this is thought to have on the delivery of service generally.

Survey results

Characteristics of respondents

Of the total respondents (1,089/4,000) to the survey, one third (365) indicated that they do treat refugees and asylum seekers. Nevertheless, the characteristics of practices who do and do not treat refugees and asylum seekers are very similar. Both groups have similar average numbers of patients on their lists, the same mean number of whole time equivalent doctors in the practice, and similar numbers of support staff (table 1).

Table 1: Characteristics of respondent practices

<table>
<thead>
<tr>
<th>Practice does treat refugees and asylum seekers</th>
<th>Practice does not treat refugees and asylum seekers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients on practice list</td>
<td>7,775</td>
</tr>
<tr>
<td>Number of whole time equivalent doctors in the practice (mean)</td>
<td>4</td>
</tr>
<tr>
<td>Number of whole time equivalent practice support staff</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>7,566</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
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<td></td>
<td>11</td>
</tr>
</tbody>
</table>

Figure 1 shows the regional distribution of respondents and highlights the concentration of practices who do treat refugees and asylum seekers in London. Whilst regions such as the North East and Midlands have a more equal distribution of practices who do and do not treat refugees and asylum seekers, other regions such as Scotland/Northern Ireland, South West and Wales have smaller proportions of respondent practices who treat these groups. This broadly reflects the concentration of asylum seekers across the United Kingdom, particularly in terms of the concentration in London, the North and Midlands.
Figure 1: Regional distribution of respondent practices according to whether they treat refugees and asylum seekers (%)

Those practices that do treat refugees and asylum seekers vary widely in the number of such patients they treat each year (table 2). Whilst the average number of refugee and asylum seeker patients is 146 per year, most practices report 50 or less, suggesting a heavy burden on particular practices and the concentration of refugees and asylum seekers in certain geographical areas, but also the dispersion of these patients to new areas and practices. Figure 2 shows that whilst an average of 74 per cent of refugees and asylum seekers are reportedly registered with the practices (not temporary patients), almost half of respondents report 100 per cent registration of refugees and asylum seeker patients.

Table 2: Number of refugees and asylum seekers seen by the practice each year

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10</td>
<td>59</td>
</tr>
<tr>
<td>Between 10 and 20</td>
<td>93</td>
</tr>
<tr>
<td>Between 21 and 50</td>
<td>76</td>
</tr>
<tr>
<td>Between 51 and 100</td>
<td>49</td>
</tr>
<tr>
<td>More than 100</td>
<td>88</td>
</tr>
<tr>
<td>Total</td>
<td>365</td>
</tr>
</tbody>
</table>
Perceived difficulties in treating refugees and asylum seekers

A range of potential difficulties in treating refugees and asylum seekers has been identified from the literature and survey respondents were asked the degree to which they experienced such difficulties. Broadly, the majority of GPs who treat refugees and asylum seekers experience most of the problems listed in Table 3. The lack of a common language and information about previous medical history were reported as being central problems associated with carrying out consultations with refugees and asylum seekers by the majority of respondents. Other problems including the length of consultations and the lack of information about eligibility and access to other local services for refugees and asylum seekers are also reported as difficulties frequently facing GPs when carrying out consultations with this group of patients.

Table 3: Difficulties experienced when carrying out consultations with refugees and asylum seekers (%)

<table>
<thead>
<tr>
<th></th>
<th>Often</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of common language</td>
<td>83.4</td>
<td>14.3</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Lack of availability of professional translators</td>
<td>50.6</td>
<td>35.8</td>
<td>9.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Lack of familiarity with cultural sensitivities</td>
<td>54.1</td>
<td>36.5</td>
<td>7.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Lack of time for consultation</td>
<td>81.5</td>
<td>13.1</td>
<td>4.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Lack of information about previous medical history</td>
<td>90.4</td>
<td>7.9</td>
<td>1.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Lack of information about other services for asylum seekers</td>
<td>71.1</td>
<td>23.8</td>
<td>4.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Lack of information about eligibility of asylum seekers for local services</td>
<td>67.2</td>
<td>21.1</td>
<td>10.3</td>
<td>1.5</td>
</tr>
</tbody>
</table>

In addition to those difficulties identified in Table 3, a number of further problems are reported by GPs who treat refugees and asylum seekers. Many respondents are concerned that they are ill-equipped to treat those
who have severe mental health and psychological problems, whilst others highlight the general lack of resources, time and local support needed to appropriately address the multiple health needs of refugees and asylum seekers. The pressure on GPs to provide non-medical advice and support, such as legal assistance, referral letters, and social support is also raised. Many GPs highlight the problem that refugees and asylum seekers have exceptionally high or ill-informed expectations of the health service in the United Kingdom. The following comments illustrate some of these concerns:

‘Very often the clinical symptoms are influenced by ongoing legal and immigration issues. Not only does it make clinical management more demanding, but often there is extra paperwork, eg letters to solicitors.’

‘Quite often asylum seekers have high expectations of the NHS in terms of demanding routine blood tests/screening tests without symptoms or medication.’

‘Great difficulties in accessing psychological support for patients with post traumatic stress.’

Communication, interpretation and translation services are a recurring problem with regard to treating patients from a non-English speaking background, but this is a particular problem in relation to refugees and asylum seekers, many of whom have complex health problems. This problem was raised by several respondents, who highlight the difficulty in arranging for translators and interpreters. Whilst some find interpreter facilities such as Language Line* to be effective and invaluable, others criticise these facilities for being difficult to use, prohibitively expensive or inconvenient.

Some respondents point to a general lack of resources including time and local support services to overcome translation difficulties and the management of primary care services to refugees and asylum seekers. The following quotes illustrate these issues:

‘Our practice experiences a high ‘do not attend’ rate of both patients and translators. There are long waiting times for other patients as a result of having to allow double appointments for language problems.’

‘Treating this group of patients with the lack of resources available actually prevents other patients being attended to. Our telephone lines into the surgery are often blocked for up to 20 minutes at a time using telephone interpreters.’

‘Lack of awareness on part of asylum seekers/refugees or interpreters regarding time constraints!! Lack of appreciation that appointments are limited to 10 minutes – often feel like they have unlimited time and I am also expected to deal with long-term ongoing problems/multiple problems in a single consultation.’

Respondents were asked whether they are able to carry out successful consultations and treat the refugees and asylum seekers they encounter. Figure 3 shows that the majority of respondent GPs state that they are able to carry out successful consultations most of the time or at least sometimes, with only a few never able to do so. Figure 4 shows that the majority of respondent GPs (93%) used family members to translate at least some of the time. Indeed, some respondents are of the opinion that professional interpreters are less effective than family members, who are often more culturally aware and sensitive.

* Language Line is a telephone interpreting service which guarantees to find a translator for approximately 150 languages.
The impact on service provision and targets

Respondents were asked whether having refugees and asylum seekers registered with their practice affects their ability to meet targets. Figure 5 shows that almost three-quarters (72%) of respondent GPs report that this does affect their ability to meet targets and a quarter state this has a big impact on their ability to meet targets. Almost half of those respondents who commented on their ability to meet targets, suggest that this is because refugees and asylum seekers refuse to attend some sessions, particularly those for procedures such as cervical smears and immunisations. This is largely due to cultural and language differences, and often reflects the different perception and priority given to screening and immunisations in some countries compared with the United Kingdom. Others report the problem of obtaining informed consent from refugee and asylum seeker patients. Furthermore, respondents state that they did not have sufficient time within the limits of a standard consultation to provide full explanations to their patients about these issues and this further exacerbated the problem. The difficulties in ascertaining the history of patients was a further issue raised. Reasons for this include the language barriers and the lack of case notes. Many respondents suggest that because refugees and asylum seekers are moved around so frequently, consistency of care is difficult and diagnosing and treating conditions effectively is a problem. The following comments illustrate these issues:
Many Muslim women do not want to have smears and it is difficult to educate them about the benefits.

‘Their [refugees and asylum seekers] health beliefs and expectations of the health service can be very different from UK patients: both regarding clinical issues and how to use and access the service.’

‘Without understanding and consent we can’t immunise, or perform cytology etc.’

‘Letters are sent to these people, but are not understood… they do not seem to understand the importance of immunisations and smears.’

Figure 5: Whether having asylum seekers registered with the practice affects ability to meet targets (%)

Almost three-quarters of respondents state that having asylum seekers in their practice does affect the service offered to other patients, and nearly a quarter felt that the service was greatly affected (figure 6). Many respondents state the length of consultations required for refugees and asylum seekers is the main issue impacting on their ability to meet the needs of other patients. Communication and language barriers mean that the often complex health problems of this patient group are more difficult to identify and treat and therefore lengthy consultations are required. Many respondents are of the opinion that refugees and asylum seekers make inappropriate demands on the health services and have high expectations, which requires additional time and effort on the part of the GP. Many respondents report that refugees and asylum seekers often require assistance with non-medical issues such as housing and legal advice and will invariably seek the assistance of the GP in such matters. Several respondents suggest that refugees and asylum seekers do not understand the concept of appointments and additional demands on time were not just made on GPs, but also on receptionists and other practice staff. As one respondent comments:

‘I am emotionally exhausted by these patients and morally challenged—so I have little left to give to others. Whilst asylum seekers undoubtedly are very needy, they swamp our appointment system with repeat consultations both from genuine clinical need and unresolvable anxiety. The service given to the other patients has suffered tremendously because they have soaked up so much of all the other health services.’
Respondents were asked what they had found to be most useful in dealing with refugees and asylum seekers and the overwhelming majority of respondents identified access to good quality, professional translators and interpreters as most useful. Others identified having support from their local primary care trust (PCT), either in the form of funding or additional services and also knowledge of local and specialist services such as the Medical Foundation, as being useful. Some respondents report that they had attended training courses on refugee issues and found these to be very helpful. Availability of a hand-held health record (HHR) for refugee and asylum seeker patients was also reported as being useful. These issues are illustrated by the following comments:

‘Interpretation! We have had to deal with Swahili and Kurdish speakers and we have had to translate medical forms without any training.’

‘A good interpreter. One or two specialist organisations have given helpful advice.’

‘Local refugees support group and a reference folder on local refugee support services. Also a ‘refugee needs’ awareness day run by an appropriate support group.’

‘I had an excellent Somalian facilitator for over a year (now left) and we had a joint clinic once a week. This has helped doctors to understand cultural issues and diagnose clinical problems better.’

Despite the numerous difficulties and problems facing GPs, many report that a great deal of satisfaction can be gained in treating and helping refugees and asylum seekers, many who have had terrible experiences. Some found that treating this group was very rewarding, citing patience and time as crucial factors required to treat refugees and asylum seekers. As the following respondents comment:

‘Patience and a caring attitude is vital. Giving them time to tell their story is key!’

‘There are patients among this group with long standing unmet clinical needs (acute and chronic) and illnesses. It is very satisfying to treat them effectively.’

‘A rewarding group of patients to treat and support.’
Respondents were asked if there were ways in which they felt they could not meet the needs of their refugee and asylum seeker patients. Language was again identified as an area in need of improvement, particularly with regard to assessing and treating mental health conditions. Many respondents report that refugees and asylum seekers are very demanding and have a complex range of questions and needs to be dealt with in a single consultation, or require help that is outside the remit of GPs such as writing referral letters and enquiring about missing family members. Language and the lack of resources including staff, time, funding, cultural support and knowledge of local services are again identified as key issues which need to be addressed if the health needs of refugees and asylum seekers are to be adequately met. The need for training on cultural awareness for health care professionals is raised by several respondents as a mechanism to improve their ability to identify problems and improve interaction with patients. Some respondents also advocate training on medical conditions, not usually seen in the United Kingdom. The following comments illustrate these concerns:

‘Limited resources and time, limited knowledge of culture and not enough secondary resources, eg mental health services.’

‘Psychological problems are very difficult to address through an interpreter and almost impossible via family member translators.’

‘Asylum seekers seem ‘lost’ and unsupported by other agencies. Our staff had to provide warm clothes for one family this winter, as we were so concerned about them.’

‘They often have a completely different illness culture, which I could not expect to understand unless I lived in their country for a while.’

Some respondents suggest that dedicated health teams or clinics would be best able to meet the needs of refugees and asylum seekers, rather than putting them into mainstream primary care. Others argue that the NHS is unable to meet the needs of the indigenous population, let alone the needs of this specialist and highly needy group:

‘Asylum seekers should not be registered with the local GP – should appoint a GP (such as homeless persons’ GP scheme) who has time and full support with specific training.”

‘Register them with a PCT run specific surgery resource. A normal British GP practice is inadequate to deal with their specific problems.’

‘A dedicated service for refugees and asylum seekers which gives them the time and information and relevant input they deserve.’

Improved information for both health professionals and refugees and asylum seekers is a further issue raised by respondents. A number of GPs suggest that resources and information should be provided on the web. A list of relevant support services would also be useful. Many believe that asylum seekers should be provided with information about the health service, including what to expect and how to access it, what their entitlements are and how they should go about being treated. The following comments reflect these issues:

‘Good leaflets (and realistic) for asylum seekers on what GP practices can and can’t do!’

‘More information to them [refugees and asylum seekers] about what doctors usually do. Also information to GPs about what services are available.’
Discussion

Managing the health needs of refugees and asylum seekers is complex and requires a sensitive approach to identifying, assessing and responding to the needs of this vulnerable group. The results of this survey show that GPs and other healthcare professionals face a number of challenges when dealing with refugee and asylum seeker patients. These challenges include language barriers, pressure of time, cultural differences and lack of resources. Refugees and asylum seekers are often perceived as being demanding, with needs that are difficult to fulfil. Whilst this may be true for some individuals – as it is in the general population- many refugees and asylum seekers are in reality reluctant to make demands.

Whilst there is no statutory restriction on access to healthcare for refugees and asylum seekers, there may be practical problems in accessing these services. As a result, refugees and asylum seekers may not seek help until they have a serious health emergency or until the condition becomes chronic. It is therefore essential that the basic facts about entitlement are understood, not only by doctors, but by all members of the primary healthcare team, especially those who have first contact with patients, eg receptionists and practice managers. Refugees and asylum seekers bring both complex clinical and social problems to a practice. There is sometimes a lack of appreciation about these problems within practices and this is often exacerbated by the absence of a common language. Staff often feel inadequate and ill-equipped to cope with these problems. Many GPs and healthcare professionals feel unable to give the time needed to manage refugee and asylum seeker’s health needs and are overwhelmed by their experiences. Yet GP services are a critical first port of call for refugees and asylum seekers. The policy of increasing dispersal of refugees and asylum seekers throughout the United Kingdom means that many GPs are now faced with new issues of patient care. Supporting GPs to meet the health needs of these groups is an important challenge for policymakers.

Communication

Effective communication is vital to effective primary care, but it is hindered by differences in culture and language. Lack of common language is the biggest barrier to care identified by GPs in this study and this concurs with the findings of other research. Female asylum seekers are less likely than males to speak English or to be literate and are also less likely to report poor health or mental health problems. Children and young asylum seekers and refugees may also face multiple disadvantages and may have little direct experience of healthcare. Whilst lack of adequate professional translation services presents barriers for all non-English speaking patients, this barrier is greater for those with psychological and emotional difficulties that can only be explored verbally.

According to a recent King’s Fund study, interpretation and advocacy services are poor and under-resourced and there are limited numbers of healthcare staff who can both translate for patients and offer them help in making decisions about treatments. Questions have been raised about the appropriateness and efficiency of current telephone interpreting services such as ‘Language Line’. Telephone interpreting services which link doctors to interpreters are available and whilst this can often be a cumbersome three-way conversation, simple technology such as speakerphones, has been shown to significantly aid the consultation. The availability of link workers to act as interpreters may also aid the communication. Whilst the availability of appropriate interpreters will ideally reduce the communication barrier between refugees and asylum seekers and GPs, there will be situations where this is not possible or realistic. Alternative techniques such as listening to patients, careful body language and the use of diagrams and written material have proved useful in enabling communication with refugees and asylum seekers.

In general practice, heavy reliance is often placed on informal solutions. The results of this survey suggest that the use of a family member or friend to translate when consulting or treating refugees and asylum seekers is common practice. Whilst the informal interpreter may be useful in obtaining background information, it might also result in inaccurate translation, as well as make it difficult for the patient to discuss sensitive issues such as sexual health, domestic violence or torture. In some circumstances, reliance on
informal interpreters can deny the patient their right to confidentiality within their family or community. These problems are magnified in cross-gender and cross-generation interpretation. Children should not be asked to interpret medical details for parents as this often results in inaccurate interpretation or incomplete information, especially where sensitive issues need to be discussed. The use of informal interpreters is inappropriate and possibly counterproductive, particularly when consulting patients with mental health problems. Nevertheless, there will certainly be situations when the use of informal interpreters is appropriate or inevitable and guidelines must be in place to advise GPs and other healthcare professionals how best to handle such situations.

**Access and awareness**

Obviously, most healthcare professionals and support staff do not fully understand what it means to be a refugee or asylum seeker or the needs of this vulnerable group. Compounding this problem, refugees and asylum seekers often do not understand how the health system works and often they learn to use the system in a piecemeal way. This inevitably leads to barriers to the delivery of appropriate care. Depending on the country of origin, refugees and asylum seekers may have very different experiences and expectations of primary care. Many will come from countries with quite different healthcare systems and the concept of free primary care, offered by a GP may be unfamiliar. In some countries, healthcare is associated with hospital care and locally based primary care services may lack credibility or be seen as second class.

Respondents to this study report a high rate of non-attendance of refugee and asylum seeker patients for appointments, often when interpreters have been arranged. In most cases this may reflect a lack of understanding of the NHS due to language and cultural differences. In some cases, refugee or asylum seeker patients may not have received the appointment letter, or were unable to read it. Appointment systems may be unfamiliar or difficult to understand for some patients.

**Service provision**

A central concern identified by GPs in this survey is the lack of previous medical history for refugee and asylum seeker patients. This is exacerbated by the lack of consistent screening and immunisation at the point of entry to the United Kingdom. The lack of information about previous treatment and uncertainty over continuity of care in the future also adds to the difficulties faced by GPs. Medical examinations at the point of entry are often cursory and the health needs of asylum seekers are not assessed in a systematic way. Follow up procedures are also poor and there is no consistent tracking of those who are screened on arrival. More needs to be done at the point of arrival to ensure that the health needs of asylum seekers and refugees are addressed adequately. Increasingly, asylum seekers are undergoing a health assessment at induction centres and are being provided with a hand-held health record. The BMA welcomes the development of a national hand-held health record which will alleviate the possibility of repeat history taking and highlight any special requirements such as the need for a translator and the language spoken.

Whilst evidence from this survey suggests that the majority of refugee and asylum seekers are registered with a practice, GPs continue to report difficulties in encouraging attendance for procedures such as immunisation and ensuring consistency of care for refugee and asylum seeker patients. Wherever possible, permanent registration must be encouraged when a refugee or asylum seeker patient joins a practice. Whilst some GPs have justified temporary registration on the grounds that refugees and asylum seekers are a mobile population, which makes permanent registration inappropriate, evidence suggests that refugees and asylum seekers may not be as mobile as sometimes thought.

Whilst the health needs of many refugees and asylum seekers can be met in a general practice setting, some have additional problems that require specialist help and support for which there are few resources, especially outside London. In some cases, refugees and asylum seekers have come from situations of torture and persecution and this results in health problems, particularly mental health problems, requiring a specialist approach. Whilst the Medical Foundation provides care and support for refugees and asylum
seekers who have experienced torture and persecution, this service is currently available in London only. Others have come from parts of the world with infectious diseases that may be unfamiliar to British GPs. These patients need care from doctors who understand their problems and who can provide treatment tailored to their needs. The appropriateness of special clinics depends on the number of patients from similar groups and the range and type of problems they bring to a practice. In some areas it may be appropriate to develop the special services jointly with other practices or with a specialist community group.

The health of refugees and asylum seekers is affected by a range of factors including experiences of torture and violence, a loss of identity and status, poor housing and living conditions, poverty and social exclusion and the responses that are needed are not solely medical. A recent study of women refugees and asylum seekers highlighted the importance role played by GPs and other healthcare staff, not only in relation to health care, but also immigration and housing matters. As one GP explains, ‘for many patients, you may be the first official in this country who is nice to them.’ The result is that refugee and asylum seeker patients may come with a range of non-medical issues, which they would like and expect their GP to help them with. Whilst these roles are often non-medical, referring refugees and asylum seekers to suitable sources of legal advice, support and assistance for social and economic problems will positively affect their general wellbeing and longer term health.

Recommendations

The results of this study highlight a number of key areas which must be addressed if the healthcare needs of refugees and asylum seekers are to be met. The aim should be to provide a sensitive and reactive service, whilst also developing proactive support for a group of patients whose culture, language and healthcare needs are often different from the local community. To assist GPs in the delivery of healthcare to refugees and asylum seekers, increased resources are urgently required in a number of key areas.

Communication

- The most fundamental obstacle to accessing healthcare is communication. Trained interpreters and advocates should be made available and used where possible to provide a sensitive service for refugees and asylum seekers. Whilst sometimes inevitable, the practice of using family members and friends as interpreters should not be relied upon or encouraged. Guidelines to help decide when and how to handle informal interpreting will help staff and patients and should form part of training.
- More regular and routine use of interpreters requires changes to administration procedures and professional training. Practices should ensure that a patient’s ability to converse in English is recorded. If a patient’s command of English is poor, the language spoken must be included in the registration form and this information used to arrange for interpreting when appointments are made. This practice needs to be incorporated into training.
- Refugees and asylum seekers must be provided with information about how the NHS works, so as to assist access to health promotion and preventative services. There is an urgent need for provision of written information, in appropriate languages, about the structure of and access routes to the NHS upon entry to the United Kingdom.

Support and training for GPs

- GPs and healthcare staff must be equipped with the skills and knowledge to deliver an appropriate service to refugee and asylum seeker patients. Useful support could take the form of information on the entitlement of refugees and asylum seekers to NHS services, backed up by awareness of the main issues that affect the health of refugees and their access to healthcare.
- Up-to-date guidance and advice must be available to GPs at both the national and local level. This should include a general information package, information about social services, education and interpreting services and a directory of key local sources of information and assistance. The Department of Health
and the Refugee Council have worked together to produce a resource pack for all frontline health staff and service planners who come into contact with asylum seekers and refugees. Web-based directories of information and services such as HARP are also vital. Further development and continual updating of resources such as these is crucial.

- The effectiveness of any information pack, such as those developed by the Department of Health and the Refugee Council, will be enhanced by widespread promotion to all GP practices and related healthcare providers.
- Culture and custom will influence the way in which some patients can be treated. GPs need training and support to develop a greater understanding of cultural, social and other issues relating to refugees and asylum seekers. Training programmes, such as ‘Equal Rights, Equal Access’, which aim to provide doctors who treat ethnic minorities with a better understanding of cultural and racial issues, should be made available to all GPs and healthcare professionals.

**Service Provision**

- Appropriate assessment, treatment and support should be provided at the point of arrival to ensure the health needs of asylum seekers and refugees are addressed adequately. All new arrivals to the United Kingdom should be subject to health checks at the point of entry to establish the health status of individuals, including screening for diseases such as tuberculosis.
- GPs should offer permanent registration to refugees and asylum seekers, rather than temporary registration, wherever possible. In offering permanent registration, they are more likely to be able to offer ongoing care and to obtain previous medical records, where they exist.
- Care needs to be taken to ensure that refugees and asylum seekers understand what is being offered when they make an appointment to see the GP. It must also be explained to them that an inability to be seen immediately by a GP does not mean that they are unwelcome. Practices who offer services to refugees and asylum seekers have an obligation to familiarise themselves with the particular needs and problems of this group of patients.
- It is important that sufficient funding is available for general practitioners providing healthcare for asylum seekers and refugees. Given the income streams available under the new GMS contract from 2004/05, and the uneven distribution of this group of patients, it seems most appropriate to deliver this funding via local enhanced services (LES) arrangements. These would enable funding to be tailored to relative need and would assist rationalisation of services. The government may need to provide an appropriate steer to PCTs in respect of this funding.
- The financial implications of providing secondary healthcare to refugees and asylum seekers must also be a key consideration. Currently, the allocation of resources to hospitals is based on Census figures, however refugees and asylum seekers are often not captured in official statistics such as the Census.
- The challenges currently facing GPs who treat refugees and asylum seekers are substantial and increasingly more GPs are being subjected to these challenges. Further research is required to address the key issues. Specifically, further research should be undertaken into the length of consultations and the extent to which additional clinical and administrative resources are utilised.

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b HARP – Health for asylum seekers and refugees is a web-based directory of information and resources concerning the health needs of asylum seekers and refugees (www.harpweb.co.uk)
References
