The health of recent migrants from resource-poor countries

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Abstract

The care of people who have recently migrated from resource-poor countries requires careful consideration by healthcare providers. Innovative approaches are called for to reduce the significant inequalities in health compared with UK-born and long-term migrant populations. Primary care physicians are best positioned to improve the early diagnosis of imported infections such as tuberculosis, HIV, malaria, hepatitis and enteric infections, thus avoiding the high cost of emergency presentations with advanced disease. Culturally sensitive approaches are required when managing stigmatizing diseases. Common non-communicable conditions and psychiatric morbidity should not be overlooked. Pregnant women who have recently entered the country are at risk of worse birth outcomes. A significant number of people are denied free UK National Health Service care despite their entitlement, or they do not seek it owing to a lack of awareness of their right to care; increased familiarity among healthcare workers with current recommendations may help to minimize disparities in access to care.

Keywords HIV; malaria; mental health; migrant health; MRCP; parasitic worms; poverty; primary care; refugee; screening; tuberculosis; undocumented migrants

Key Points

- Eligibility for NHS healthcare is often poorly understood by both migrants and healthcare workers
- Among recent migrants, socioeconomic deprivation, exposure to violence and the conditions of migration can contribute to ill-health
- Women who are recent migrants to the UK are at higher risk of poor pregnancy outcomes
- The non-UK-born population has rates of tuberculosis 15 times higher than their UK-born counterparts
- HIV is often diagnosed late (especially among the migrant population). In high-incidence areas in the UK, all new patients registering with a GP and all medical admissions should be offered a HIV test
- Malaria should be considered as a cause of fever in people who have migrated from, or through, malaria-endemic countries

Introduction

A significant proportion of the UK population was born abroad: over 10% overall and up to 40% in some areas (e.g. inner London). Romania is the most common country of birth of the non-UK-born population, followed by India. Migration from tropical countries is primarily from India, Pakistan, Nigeria and Bangladesh.

The proportion of all migrants to the UK seeking asylum is low — 6.5% in 2016. Despite the global refugee crisis, as of March 2017 there was a 13% fall in asylum applications from the previous year. A smaller proportion of these people will be granted leave to remain. Most asylum applications came from nationals of Iran, Iraq, Pakistan, Eritrea, Afghanistan and Syria. There has recently been a large increase in the number of unaccompanied children seeking asylum in the UK (a 78% increase between 2016 and 2017). The number of undocumented migrants in the UK is, by nature, unknown.

The reasons why people migrate can impact on their health needs, and it is therefore important to understand the different categories of migrants. Some people migrate to improve their quality of life or escape significant hardship; they are sometimes called economic migrants. Asylum-seekers register an application to claim asylum from conflict or persecution in their home country; if their application is successful, they are designated status as a refugee. If their application is rejected, they may face arrest and detention. Undocumented migrants have not registered their migration status or filed an application for asylum. Included in this group may be people who have been trafficked (transported and/or harboured as a result of coercion, abduction or fraud and for the purposes of exploitation).

Migrants are entitled to differing levels of NHS care depending on their migration status (Box 1). Most UK migrants from resource-poor countries have documented entitlement to citizenship and consequently to National Health Service (NHS) care. This includes asylum-seekers and refugees. Undocumented migrants are entitled to limited NHS care. However, they are often denied access to all healthcare because of misunderstanding and prejudice.[1] It is important to understand that eligibility is not the only barrier to accessing healthcare (Box 2).

It is important to identify the most vulnerable migrants, who are often marginalized and unaware of their entitlement to care. These

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Access to NHS care

- Anyone living in the UK can register with a GP. A person does not need to be ordinarily resident in the UK to be eligible for NHS primary care. Asylum-seekers, refugees, overseas visitors, international students and homeless people, irrespective of their immigration status, are eligible to register with a GP even if they are ineligible for free secondary NHS care (https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide accessed 16th July 2017)
    - There is no contractual requirement to provide proof of address or immigration status for GP registration. Some people, owing to the nature of their circumstances, e.g. domestic violence, trafficking or homelessness, may not be able to provide documentation
- Treatment of certain communicable diseases (including tuberculosis, hepatitis B, measles, HIV and sexually transmitted infections), compulsory mental health treatment and accident and emergency department care are available free of charge for all patients
- Asylum-seekers, refugees and those in immigration detention are entitled to receive free NHS hospital treatment
- Full entitlement to NHS care is available to women who are victims of trafficking/modern slavery and to victims of violence (domestic violence, sexual violence, female genital mutilation or torture)
- Refused asylum-seekers are entitled to completion of treatment free of charge if it was initiated before their claim was rejected
- Doctors of the World UK (www.doctorsoftheworld.org.uk) run clinic and advocacy programmes in London and provide medical care, information and practical support to marginalized people such as destitute migrants, sex workers and individuals with no fixed address

Box 1

Barriers to timely and effective healthcare in recent migrants from resource-poor countries

- **Eligibility** to healthcare — asylum-seekers are entitled to full NHS care. Failed asylum-seekers and undocumented migrants are entitled to free primary care at the discretion of the provider, to free care for emergency treatment, family planning, treatment for communicable diseases, diagnosis and treatment of HIV, and mental healthcare if detained under the Mental Health Act 1983, and to treatment as part of a court probation order (National Health Service (Charges to Overseas Visitors) Regulations 2011)
- **Cultural** — perceptions of the doctor—patient relationship can be different on both sides. Patients can have different expectations based on their experience in other countries. Doctors can misinterpret culturally sensitive complaints; for example, in some cultures, somatization is more common in psychosocial disorders
- **Language** — speak clearly and slowly when speaking to people whose first language is not English, and take care when using family members as interpreters: people may not wish to disclose confidential information in front of their family. The General Medical Council recommends using interpreting services wherever possible. Avoid using euphemisms when referring to stigmatizing diseases as this can cause misunderstanding
- **Dispersal programmes** — these result in interruption of treatment, particularly important in the case of chronic infections such as HIV and hepatitis B and C, poor continuity of healthcare and loss to follow-up
- **Poverty** — asylum-seekers, failed asylum-seekers and undocumented migrants are not permitted to work in the UK so are often destitute; many other migrants are poor. Accessing healthcare is often considered less important than finding enough money to live on, resulting in late and emergency presentations to the NHS
- **Stigma** — fear of the social implications of certain diagnoses (e.g. HIV, tuberculosis) within one's own cultural community results in delayed presentations to healthcare services, and patients can be reluctant to talk about certain aspects of their illness

Box 2

include asylum-seekers and refugees, unaccompanied children, people who have been trafficked, undocumented migrants and low-paid migrant workers. For example, in 2005—2006, an emergency room survey of newly registered migrant domestic workers found that 86% reported working >16 hours a day, 70% psychological abuse, 23% physical abuse and 71% food deprivation.

Doctors of the World UK (https://www.doctorsoftheworld.org.uk/our-clinics) helps marginalized people to access health services to which they are entitled. Clients frequently need help with general practitioner (GP) registration (Case 1).

The health risks facing migrants include those resulting from exposures in the country of origin and during the journey to their destination. The risks taken by refugees and migrants to get to Europe can be substantial, with many undertaking treacherous journeys to reach their destination; risks include exposure to poor sanitation, violence and sexual exploitation. The high prevalence of chronic infections in some migrant populations reflects infection rates in the individuals' countries of origin plus the effects of socioeconomic deprivation and reduced healthcare access in the UK. Non-communicable diseases (NCDs) are more prevalent in some groups of migrants than in the UK as a whole.

Public Health England's migrant health guide outlines the priorities for assessment of new migrants (Box 3) and has country-specific pages that highlight specific health needs relating to a person's country of origin.

Tuberculosis (TB)

Despite a fall in incidence in recent years, the UK has, according to World Health Organization (WHO) estimates, one of the highest rates of TB in Western Europe. The non-UK-born population bears a disproportionate burden of disease (72.5% of all cases), with an incidence rate 15 times higher than in people born in the UK.

The number of TB infections in new migrants has fallen, most likely because of the implementation of pre-entry TB screening since 2012.[2] Pre-entry screening is now required for migrants from countries with a high incidence of TB (>40 cases per 100,000) who are applying for a UK visa for 6 months or more. Screening involves a chest X-ray and symptom assessment with or without sputum examination in the country of origin.