

Asylum seekers:

meeting their healthcare needs



British Medical Association
Board of science and education

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Asylum seekers: meeting their healthcare needs

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Foreword

The board of science and education, a standing committee of the British Medical Association, provides an interface between the medical profession, the government and the public. One major aim of the board is to contribute to the improvement of public health, and it has developed a wide range of policies on the health of specific groups such as children and the elderly.

The BMA has a sustained interest in the health of asylum seekers. There is concern that the healthcare needs of asylum seekers are not being met. Therefore, it was decided to review the healthcare requirements of asylum seekers and examine the implications of the immigration process on health. This report is timely because in 2002 the government has been debating the *Nationality, Immigration and Asylum Bill*. This report is for those who make policy decisions that impact on the health of asylum seekers, and for healthcare professionals who work with asylum seekers.

A handwritten signature in black ink, appearing to read 'D. Carter', with a long horizontal line extending from the bottom right of the signature.

Professor Sir David Carter
Chairman, board of science and education
October 2002

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Introduction

The detrimental impact of the asylum process on the health of asylum seekers is a recognised concern.^{1,2,3} Although access to free medical treatment is available to asylum seekers,⁴ many have difficulty in obtaining it.^{5,6} This report reviews current and proposed immigration procedures which include the healthcare of asylum seekers. Further, it examines the specific health needs of asylum seekers and the services required to deal with them. The BMA has been involved in various initiatives in relation to asylum seekers and is concerned about their access to healthcare.^{2,3,7}

Asylum seekers can obtain status as refugees in Britain if they meet the 1951 UN convention's definition of a refugee. This means they must have a **“well founded fear of persecution on the grounds of race, religion, nationality, membership of a particular social group or political opinion.”** At present there are over 21 million refugees in the world.⁸ The majority of those seeking asylum in Britain come from countries that are in conflict (although this alone is not grounds for admission as an asylum seeker). In the UK, 72,430 applications for asylum were lodged in the financial year 2001/02, 10 per cent fewer than in 2000/01 (80,205). However, in the first quarter of 2002, 19,500 applications were lodged, 8 per cent higher than the previous quarter. The countries where high numbers of asylum seekers come from vary depending on the political climate for a given time. For example, the top three applicant countries in the first quarter of 2002 were Iraq (2,840), Afghanistan (2,350), and Zimbabwe (1,495).⁹

The asylum procedure and healthcare provision

The UK, together with other EU member states, is committed to “establishing sensible minimum standards for asylum procedures and policies as a basis for a common European asylum system”.¹⁰ There is EU-wide agreement on establishing a fair and efficient asylum procedure and minimum standards for reception conditions for asylum seekers.¹¹ In this report, the immigration procedure in the UK is examined with particular reference to the availability of healthcare and the health needs of asylum seekers at each stage.

The system for processing asylum seekers in the UK up to 2002

On arriving at a port of entry in the UK an asylum seeker is interviewed by an immigration officer. The immigration officer refers people to the port medical inspector (PMI) if they are planning to stay for more than six months and/or they look ill. Visitors with suspected tuberculosis, over 16 years old and not pregnant, are

given a chest radiograph before admission.¹² However, in practice only a small proportion are screened.¹³ In 2001, the BMA expressed concerns that lack of funding and insufficient staff in UK port medical units meant that this examination was only cursory, thereby undermining its effectiveness,⁷ with a concomitant increase in the risk to the individuals, and to public health.

Following the interview, the immigration officer decides whether the applicant is given permission to enter the country in order to claim asylum. If asylum seekers gain permission they are 'temporarily admitted' to the country and can make a formal request to seek asylum. While this decision is being made the applicant can 1) go and live with family/friends and receive no support or accommodation, or 2) request support only, or 3) request support and accommodation (the majority do this). If they fall into the last category they stay in an induction centre (usually a local bed and breakfast) awaiting dispersal to accommodation provided by the National Asylum Support Service (NASS) who contract accommodation from private suppliers. Asylum seekers are detained if an immigration officer believes that they might abscond, or if their identity or the basis of their claims needs to be established. Asylum seekers are also detained prior to removal.¹⁴

Asylum seekers who are not detained are dispersed into the community while awaiting the decision on their application. If they are detained they are sent to removal centres (formerly known as detention centres) where they are offered a health check. Some applications are selected for fast track processing at Oakington Reception Centre where the asylum seekers are detained. Asylum seekers who have their application refused and who have exhausted all avenues of appeal, are sent to removal centres to await removal/deportation. Healthcare in removal centres is regulated by operating standards. These were being reviewed in 2002 to establish the nature of the healthcare team at each centre.

Of all the applications considered in 2001, 9 per cent were recognised as refugees and granted asylum, and 17 per cent were not recognised as refugees but granted exceptional leave to remain.⁹ On 29 December 2001, 1,280 asylum seekers were detained under Immigration Act powers and 225 of these were either detained in Oakington Reception Centre, police cells, or in dual detention. Out of the remaining 1,055, 23 per cent had been detained for more than four months and 3 per cent for more than one year.¹⁵

The 2002 government proposals for processing asylum seekers in the UK

In February 2002, the government produced a white paper¹¹ entitled *Secure borders, safe haven: integration with diversity in modern Britain*. The paper outlines a new four-tier system of centres to cover all new asylum seekers from application right through to integration or removal/deportation (figure 1). It is planned that, on arrival, asylum seekers will first go to induction centres. Here, basic health screening should be available to assist in the early identification of special or immediate needs. Asylum seekers will remain in induction centres for one to seven days. Those who do not require support will then move to an agreed address, and others move to accommodation centres. It is proposed that accommodation centres provide full-board accommodation and services such as healthcare and interpretation, and accommodate a proportion of new asylum seekers from application through initial decision and any appeal. Those seeking support from NASS will stay in induction centres until their applications for support have been decided, at which time they will either be dispersed or sent to accommodation centres. In this new system, some asylum applications will be selected for fast track processing at Oakington Reception Centre. Asylum seekers will be detained in the centre whilst awaiting a decision which should take seven to 10 days. Those whose application fails will be detained in removal centres until they can be removed or deported.

The applicant will be interviewed about their history of persecution. They have five days to present evidence to substantiate their claim. It is proposed that the Home Office aims to make a decision on each application within two months, and if appealed, the courts aim to decide this within another four months.¹⁶

At the time of writing, the *Nationality, Immigration and Asylum Bill* (subsequent to the white paper) is being debated in Parliament. If the proposed system is implemented there may be some differences from the details given above.

Should asylum seekers live in purpose-built accommodation or be dispersed?

There are advantages and disadvantages with the central and dispersal systems which cater for asylum seekers whilst they either await the decision on their claim or await removal/deportation. Certain problems in the delivery of healthcare and other services, which impact on the health of those asylum seekers who live in centres or in the community, have been identified in this report such as the education of children and the lack of interpreters. These problems need to be addressed in order to ensure that neither system has a negative impact on health.

Purpose-built accommodation should have all the facilities deemed necessary to meet the healthcare needs of asylum seekers on-site including primary care, translators, and

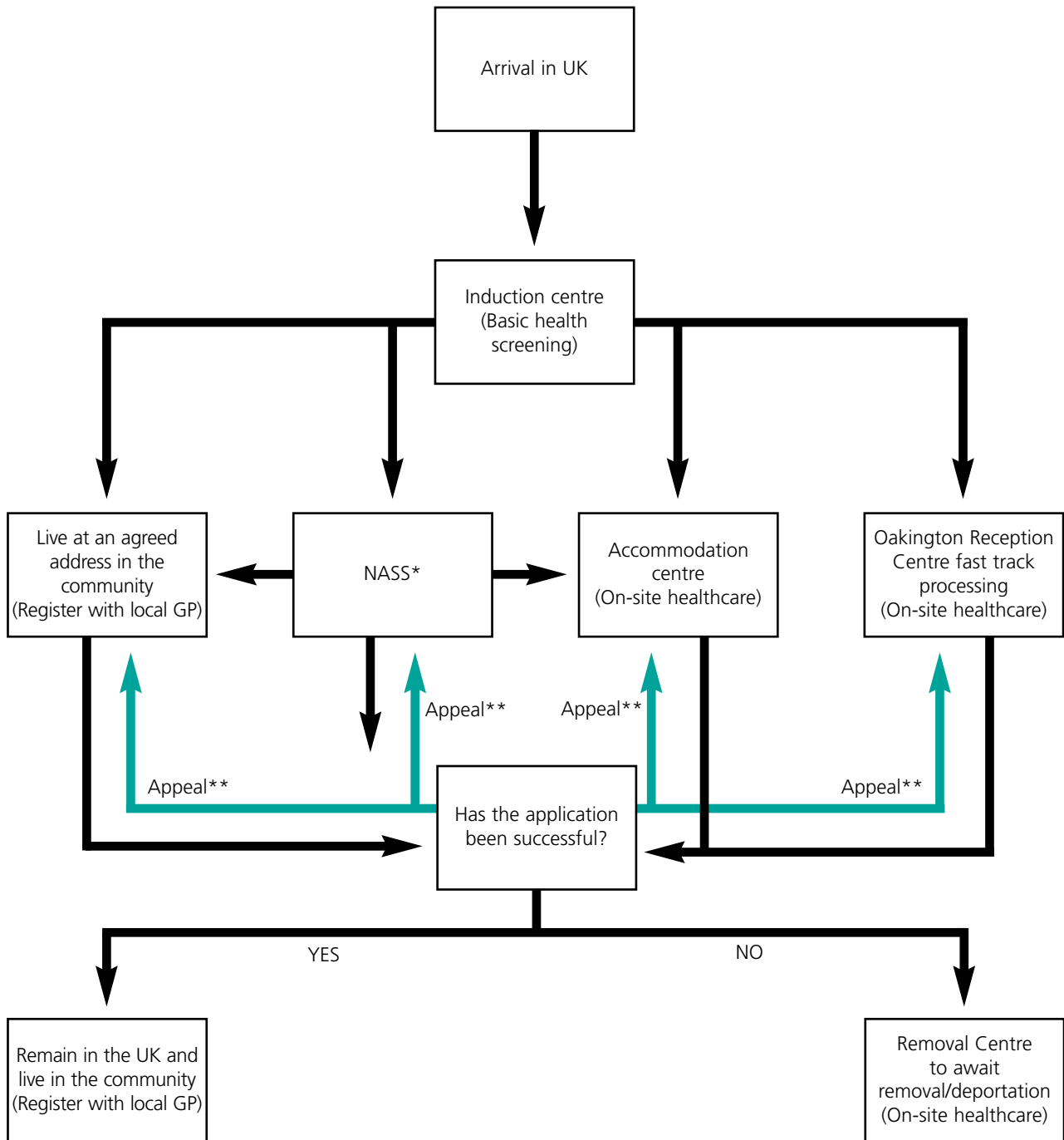


Figure 1: Flowchart of immigration process for asylum seekers, 2002

* Those seeking support from the National Asylum Support Service (NASS) remain in induction centres until their application for support is decided, at which time they either move to an agreed address or move to an Accommodation Centre.

** If there is an appeal, the applicant returns to their residence or Oakington Reception Centre until a final decision is made.

nearby hospitals. Healthcare services in the community should be equally available and an adequate standard of accommodation should be provided. In this way either system should provide for the healthcare needs of asylum seekers. Communities surrounding asylum centres, or in areas where many asylum seekers are dispersed, need the infrastructure in place to cope with the variety of needs of asylum seekers, many of whom will have different requirements from those of the resident population.

Recommendation 1

The BMA believes that the dispersal of asylum seekers should be properly resourced and managed.

Common health problems of asylum seekers

Certain health problems are common among asylum seekers and some are specific to them. The threats to health are mostly posed by diseases linked to poverty and overcrowding, whether communicable, degenerative or psychological.¹⁷ Therefore most of the health problems of asylum seekers are not specific to refugee status, and are shared with other deprived or excluded groups. Health problems that are specific to asylum seekers originate from the physical or mental torture, or other harsh conditions from which they have escaped. Asylum seekers may have experienced harsh conditions during their journey to the UK including those who enter the UK illegally using human traffickers. Many may also have become separated from their families and face uncertainty about their claim of asylum.

Health status on arrival

There is limited research in the UK about the health problems of asylum seekers, and how their health is affected by immigration controls. There is even less research on the effectiveness of refugee-specific services.¹⁸ The few studies completed suggest that one in six refugees (17 per cent) has a physical health problem severe enough to affect their life, and two-thirds have experienced significant anxiety or depression.¹ This compares with UK statistics that in 2000, 13 per cent of males and 15 per cent of females reported restricted activity due to illness or injury during the two weeks prior to interview.¹⁹ In 1998, 7 per cent of female patients and 3 per cent of male patients seen by a GP were treated for depression.²⁰

Recommendation 2

More research is needed in order to progress the debate on the impact of UK immigration controls on the health of asylum seekers.

Health while staying in the UK

Some studies indicate that the average physical health status of asylum seekers on arrival is not especially poor, when compared to the average fitness of UK residents. However, there is evidence to suggest that the health status of new entrants may worsen in the two to three years after entry to the UK.¹⁸ According to a report published by the King's Fund (2000), dispersal has left asylum seekers marginalised and impoverished, and insufficient resources have been allocated to the NHS in dispersal areas to meet the special health needs of the group. Living in poverty, with severely restricted freedom compounds their physical and mental problems.²¹ Significant numbers of asylum seekers exhibit particular health problems (table 1).

Asylum seekers are not an homogenous group. They come from a variety of backgrounds. Some asylum seekers come from countries where access to healthcare is difficult due to conflict and lack of resources. Therefore, many may not have received the appropriate immunisations and vaccinations and are susceptible to infectious diseases when held together for several months with other asylum seekers. Such infection may also spread to asylum seekers who remain in the community.¹³ However, other asylum seekers will have past experience of utilising a secondary healthcare service that, for them, provided a quicker and more comprehensive service than is provided in the UK.

Recommendation 3

A consultation exercise with key players in the field (including policy-makers, service providers, local communities and asylum seekers and refugees) should be held to strengthen research on the impact of UK immigration controls on the health of asylum seekers.

Dietary requirements

Asylum seekers have a variety of cultural backgrounds and may have different dietary requirements from the majority of people in the UK.² Therefore, asylum seekers need a full assessment of their dietary requirements on arrival. Certain foods may be difficult to find in many dispersal areas, or their unusual nature may make them particularly expensive. Mothers who are HIV positive need formula milk for their babies. In addition, asylum seekers are often housed in poor quality accommodation^{1,22} where inadequate food storage and preparation facilities may worsen their nutritional status and hence their health.

Table 1: Health problems and contributory factors experienced by some asylum seekers and refugees

<p>Communicable diseases</p> <ul style="list-style-type: none"> • Tuberculosis • Hepatitis A, B, C. • HIV/Aids • Parasitic infections <p>Effects of war and torture</p> <ul style="list-style-type: none"> • Landmine injuries • Amputated limbs • Lameness • Partial loss of vision • Hearing difficulties • Mental health problems (see column two) • Injuries arising from beatings and torture (including dental torture) • Rape/sexual assault • Malnutrition (could affect development in children) • Lack of personal protection • Conscription into the army (adults and children) • Prolonged squalor in camps • Detention • Witnessing death and torture of others • Held under siege • Forcible destruction of home/property • Disappearance of family/friends • Held hostage/human shield 	<p>Psychological and social health problems</p> <ul style="list-style-type: none"> • Depression • Anxiety • Stress • Stress-related physical ill health: <ul style="list-style-type: none"> • Heart disease • Cancer • Increased susceptibility to infection • Gastrointestinal disturbances • ‘Fear syndrome’ or fear of people in authority • Deprivation of human rights • Political repression • Harassment/racial harassment • Loss of status • Homesickness • Separation from family • Change in climate • Uncertainty around the process of claiming asylum in the UK • Lack of awareness about services available • Coping with new culture/limited or no access to community network
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Sources: 4, 17, 37, 38, 39, 40, 41, 43, 49

Men

In 2001, 54 per cent of asylum seekers were male and aged between 18 and 34.¹⁵ Asylum seekers often experience a drop in status, and men are more acutely affected by this. Depression and anxiety are common. Men granted refugee status are less likely to find work than are women. This may lead to another change in status, this time within the family, which can cause further distress. Furthermore, men are more reluctant than women to access healthcare.¹⁴

Women

Female asylum seekers face particular difficulties which are often not acknowledged.¹³ Screening and health promotion programmes tend to have a low uptake among refugee women. Female asylum seekers should be offered appropriate sexual healthcare, family planning, and maternity care that is sensitive to their culture.¹³ They should be offered a choice as to the gender of the healthcare professional and interpreter.²³

Female asylum seekers are less likely than males to speak English or to be literate²⁴ but it is important to speak with them directly, using an independent interpreter rather than a family member. They are more likely than men to report poor health or depression.²⁴ They may be lonely and isolated but often welcome the opportunity to belong to a group, where they may benefit from the contact and support.¹³

An example of a specific problem of which healthcare professionals should be aware is that of female genital mutilation (FGM). Some women (including infants and young children) will have undergone genital mutilation (main groups in the UK are from Eritrea, Ethiopia and Somalia) and this can affect sexual health and childbirth.¹³ The BMA has issued guidelines for doctors when dealing with FGM.²⁵ As appropriate, female and male asylum seekers should be educated on the dangers of FGM and made aware that it is unacceptable and illegal in this country.

Children

Children claiming asylum are particularly vulnerable and their needs and interests require special and separate attention. At a crucial time in their lives, they will have suffered significant dislocation and upheaval, including disruption of their education. Some will be malnourished. Research suggests that children whose severe malnutrition stunts their growth as infants have lower mental ability later in childhood.²⁶ Furthermore, the traumas that these children have gone through may have adversely affected their development of social skills.¹³ Effective integration into their new community could help improve these skills.¹ At present, unaccompanied children seeking asylum are cared for by the local social services departments, rather than by

NASS. They are not offered a health assessment on arrival even though they may have these particular problems, including the possibility that they may not have been given the appropriate vaccinations and immunisations.

As indicated earlier, asylum seekers are often housed in poor quality accommodation^{1,22} which itself can impact on health. There are strong links between damp mouldy housing and respiratory conditions, asthma and skin problems.²⁷ Evidence for deleterious health effects is strongest among children, with estimates that children living in damp mouldy homes are one and a half to three times more likely to suffer coughs and wheezing than children in dry homes.²⁸

The BMA is concerned that children claiming asylum are to be educated in accommodation centres, because this raises serious questions about social exclusion and long-term psychological wellbeing.²⁹ Research has indicated that the most beneficial event for a refugee child can be their becoming part of the local school community, with its attendant benefits of learning and making new friends.³⁰ Bullying is a potential hazard¹³ that must be guarded against, but it should not be used as an argument against integration. Part of the education provided for children should be culturally sensitive sexual health education, as some children will come from countries where there is none.

Support for asylum seeking children of all ages needs to be multi-faceted. The aim is to provide as normal a life as possible, provide a sense of security, and promote education and self-esteem.¹³ Helpful guidance for doctors is contained in the 1999 publication by the Royal College of Paediatrics and Child Health on the health needs of refugee children and young asylum seekers.³¹

Elderly

Elderly asylum seekers are a special group with a lower profile, but with particular needs that may be equally pressing. The vulnerability inherent in advanced age makes prompt access to healthcare essential. Older people may be more confused by the immigration process and the UK health systems than younger asylum seekers. They may be less able to learn a new language, and face the risk of abandonment if their family can no longer support them.¹⁰

Psychological health

Psychological distress is common among asylum seekers and refugees. Some people experience atrocities such as torture without developing any serious psychological sequelae beyond a natural increase in anxiety and occasional nightmares. Others show more marked signs of anxiety, depression, guilt and shame as a result of their previous

experiences and also their current situation. Some may present with symptoms of mental illness, which may be long-standing or be linked with their experiences.¹⁴ Some asylum seekers have been abused by people in authority, and so are fearful of them. Therefore special consideration is required when dealing with torture victims; healthcare professionals need to build trust. It is likely to take time as well as special expertise to engender sufficient trust for many torture survivors to be able to describe the abuse they suffered.

Prescribing and administering appropriate treatment for psychological problems and mental illness is much more problematic when there are conceptual and linguistic difficulties in describing symptoms, and cultural differences in the perception of mental health.¹ Every culture has its own framework for mental health and mechanisms for seeking help in a crisis.³² As a consequence, treatment requires specialist diagnostic and counselling skills.¹ Asylum seekers interviewed in the Carey-Wood¹ report confirmed that many healthcare professionals did not understand or did not respond to their problems, especially those related to experiences in their home country or their cultural background.

Counselling is a westernised concept and its usefulness depends on an individual's socio-economic background and cultural orientation. Many asylum seekers do not have counselling in their culture, and often have different coping mechanisms to deal with psychological trauma. Many may wish to tell their story, which in itself may be therapeutic,³³ but it should not be assumed that people must go through this in order to recover,³⁴ as some find it extremely distressing. In this respect it can be useful if members of refugee communities develop counselling skills.³⁵ Mozambican refugees describe forgetting as their usual means of coping with difficulties. Ethiopians call this "active forgetting".³⁶

Prolonged uncertainty about the decision made on an asylum claim can cause not only stress but also stress-related physical ill health. Prolongation of the stress reaction can cause heart disease³⁷ (due to raised cholesterol and blood pressure), increase susceptibility to infection³⁸ (due to reduced immune system effectiveness), cancer³⁹, and gastrointestinal disturbances^{14,40} (due to the effects of the stress reaction in gastrointestinal blood supply and gut motility).⁴¹ Asylum seekers are not allowed to work. For some this will compound their feelings of frustration and anxiety.

Studies have suggested that access by new asylum seekers to a refugee community group can reduce the severity and likelihood of mental illness.¹ If the asylum process is inefficient, and integration into society is poor, asylum seekers are more likely to become depressed. However, if they integrate well and use health services, they are less

likely to be depressed, and will have access to relevant psychological support if required.⁴⁷

Recommendation 4

The physical and mental health of all asylum seekers (including unaccompanied children) should be assessed, and appropriate treatment and/or support should be given as required.

Services that asylum seekers should receive

Considering the common health problems of asylum seekers that have been identified above, the BMA believes that asylum seekers should have the following:

- physical and mental health assessments on arrival with appropriate treatment and/or support given
- information on health services and how to access them
- access to trained interpreters
- adequate accommodation
- information to aid their integration into local communities
- an efficient immigration process so that claims are decided fairly and quickly.

Barriers to healthcare

There are certain barriers to healthcare that need to be overcome in order to adequately meet the healthcare needs of asylum seekers.

Language and culture

The most important barriers to healthcare are language and cultural differences. There are insufficient translation services in the UK, in particular in the area of mental health. Proper mental health examinations cannot be carried out without verbal communication. Furthermore, interpreters need to be aware of specific concerns in relation to women and children (see above). As some asylum seekers are illiterate (particularly women), they will not be able to read written health advice.²⁴ Somali culture, for instance, focuses more on oral communication – written Somali dates only from 1972 and story telling is an important way of disseminating information for use in health promotion.⁴² The use of family, friends and other asylum seekers as informal interpreters should be discouraged as it denies patients the right to confidentiality within their family or community.

Recommendation 5

Trained interpreters or advocates, rather than family members or friends, should be used wherever possible if language is not shared.

Time and continuity of care

Some asylum seekers may receive a number of treatments for a single condition. This may be because there is a lack of continuity of care, or because healthcare professionals have been unable to take an adequate history.⁴³ It is essential for healthcare professionals to listen carefully to their clients. However, it is not always easy for overstretched healthcare professionals to commit the necessary time,⁴³ especially when consultations using interpreters can be lengthy.

Information on health services

Asylum seekers have difficulty in finding information on health services, in particular primary care. Furthermore, a problem often faced by healthcare professionals is their own lack of knowledge about other services and support which could help asylum seekers.³¹ The multi-service centre model used in Luton can help overcome this problem (see page 14).⁵¹

Recommendation 6

Healthcare professionals need to develop a greater understanding of cultural, social and other issues relating to asylum seekers.

Exemption from charges for healthcare

Asylum seekers qualify for free medical prescriptions, dental treatment and checks, sight tests with full-value vouchers for glasses, and fares to a hospital for NHS treatment. In order for asylum seekers to be exempt from charges for these services they need to obtain an HC2 certificate by completing a lengthy form that is only available in English and Welsh. These forms should be widely publicised so that asylum seekers are aware of them at the time of application (in 2002, those on NASS support automatically received a certificate). Asylum seekers should be given advice and assistance to complete the form, and it must be made clear that the certificate is only valid for six months, at which time it can be renewed.⁴

Recommendation 7

While staying in induction centres, asylum seekers must be provided with health service information and accompanying forms in a language and format that they understand. Consideration should be given to develop systems to help illiterate asylum seekers also access this information.

Barriers to healthcare in removal centres

Concerns have been highlighted by detainee visitor groups during visits to removal centres.⁴⁴ Asylum seekers often stay in removal centres for many months.¹⁵ Problems that visitors have encountered include:

- Asylum seekers are not always taken to hospital for their appointments.
- Medical records do not always follow the applicant if they move to another centre.
- Long waiting times (several months) are experienced for some services such as dentists and opticians.
- There is a lack of uniformity in services provided to asylum seekers who stay in centres. For example, not all centres have the same access to psychologists and counsellors.
- There is a lack of translation services. Language Line* is expensive and contractors only have a limited budget. Interpreters are often other detainees and/or relatives rather than impartial professionals.
- Applicants are not always aware of their rights to choose the gender of their healthcare professional or interpreter, and in practice these standards are not always met.
- There is a lack of clarity among medical practitioners as to their duty to notify an immigration officer if an asylum seeker claims torture or shows evidence of torture (where upon the asylum seeker would be referred to a specialist centre eg The Medical Foundation for the Care of Victims of Torture).
- There is not a defined process for how a healthcare professional should deal with an asylum seeker who refuses to be screened for tuberculosis.
- The focus for treatment is sometimes based on symptoms rather than examining the root cause. For example, being given drugs such as sleeping tablets rather than investigating underlying mental health problems.

Overall, there is a lack of consistency throughout the removal centres, implementation of the operating standards reviewed in 2002 should help to resolve this. However, the BMA is concerned that detaining asylum seekers in removal centres can remind torture victims of their experiences and compound the psychological damage/torment that they have already suffered.

* Language Line is a telephone interpreting service which guarantees to find a translator for around 150 languages. However, consultations using Language Line are time consuming and therefore often block a telephone line into the surgery for some time.

Recommendation 8

Asylum seekers should not normally be held in detention.

Barriers to healthcare for asylum seekers and permanent residents in the UK

It should be noted that these barriers to healthcare are not just experienced by asylum seekers but by other UK residents too. For example, other residents may not speak or understand English and will require access to interpreters. It is important that all people have the same provision. It can cause tension where asylum seekers appear to have more provision than other members of the community.⁴⁵

Meeting the healthcare needs of asylum seekers

All asylum seekers are entitled to free medical treatment under the National Health Service. In order to attempt to meet the healthcare needs of asylum seekers a number of initiatives have been put in place.⁴⁶

Dedicated medical clinics have been set up throughout the country, particularly in those areas where there are a large volume of asylum seekers including Folkestone, Dover and Margate. These clinics are attached to existing GP practices where the staff have previous experience of dealing with refugees, and are funded from top-slicing General Medical Services (GMS) money.⁴⁷ For a six month pilot in 2002, the Home Office has funded the healthcare arrangements for newly arrived asylum seekers in Kent. Therefore, the top-sliced GMS money is only being used to fund the healthcare of the resident population of refugees. Furthermore, there are dedicated asylum teams in a number of dispersal areas such as those in Glasgow, Tyneside and Leeds. These are being funded in various ways, but most are through Personal Medical Services (PMS) arrangements.

One of the new initiatives in 2002 provides asylum seekers with systematic medical checks while in induction centres in Ashford, Kent.⁴⁸ Here, asylum seekers are screened and provided with a hand held medical record, before they are dispersed or moved to accommodation centres. This service involves taking a medical history including: major diseases; vaccinations; cervical screening; and maternity history. Staff have a basic understanding of a number of languages, and also access to Language Line,⁴⁹ and local interpreters.⁵⁰ It is difficult to staff such pilot schemes as initial funding is only for six months.⁴⁷ Another example of good practice is in Luton. Here, a team including nurses, advocacy workers, link-workers and health visitors provide a drop-in clinic with medical and non-medical services.⁵¹

Recommendation 9

A range of factors over and above their access to healthcare can influence the health of asylum seekers.

In 2002, the Department of Health set up a small team to coordinate health and social care policy for asylum seekers. The team aims to keep all those who work with asylum seekers informed of developments within the department and elsewhere. Initial work includes:

- Publishing a resource pack in partnership with the Refugee Council, for those who work with asylum seekers in healthcare, social care and mental health settings.
- Identifying the lessons and good practice from various initiatives set up throughout the country to provide healthcare services for asylum seekers.
- Working with NASS and primary care trusts to improve coordination at a local level.
- Working with HARPweb (see appendix II) in a number of ways including producing a series of translated web based resources.

Funding

There is a lack of government funding, planning and coordination of health services for asylum seekers.^{52,53} With sufficient funding many of the barriers to healthcare could be overcome. Therefore, the BMA has argued for additional payments to doctors offering an extended range of services to this group of patients. Primary care trusts can approve additional payments, funded by local development schemes under the NHS (Primary Care Act 1997), if any extended range of services is provided to asylum seekers.^{2,7}

Recommendation 10

Further discussion between the Department of Health and the Home Office is needed to arrange sufficient funding for the healthcare of asylum seekers. Central funding should provide appropriate services and staffing levels to ensure that asylum seekers' healthcare needs are met.

There is continuing debate over where it is best to place healthcare services for asylum seekers who are dispersed into the community. It would seem most appropriate that specialised services are provided on the same site as conventional GP practices. These services could be accessed either whilst claiming asylum or once recognised as refugees. The asylum seekers would initially need these specialised services. Once they became settled and more integrated into the community, they may no longer need them.⁴⁷ However, until further research is carried out there is no strong evidence base on which to decide the best option. Research such as that undertaken by the Northern and Yorkshire Public Health Observatory which looks at the service provision and needs of asylum seekers should be encouraged,⁴⁶ and their recommendations acted upon.

While it is beneficial for asylum seekers to access services of GP practices, it cannot be assumed that GP practices can absorb this extra workload without additional funds and resources. It is imperative that the healthcare professionals in GP surgeries have sufficient time and resources to meet the complex needs and language requirements of asylum seekers. For example, when trying to locate counselling services for a patient, referral to an agency some distance away may be the only option because of the language spoken.

It seems unclear which government department has responsibility for the additional funding of the healthcare services of asylum seekers. Currently some funding is from the Department of Health (eg top-slicing of GMS funds) whereas other funding is from the Home Office (eg pilot study in Kent, page 14). There is also debate over whether healthcare in the various centres should be provided by private companies or the NHS.

Conclusion

The BMA believes that whilst asylum seekers await a decision, they should have better access to healthcare including health assessments on arrival by dedicated teams. However, the healthcare needs of asylum seekers are not solely medical.⁵⁴ Sociological, economical and environmental factors can have a profound impact on health and accessibility of healthcare. For some asylum seekers, it will take time to pin-point underlying problems. Therefore, coherent and sensitive healthcare during and after the application process is imperative. Furthermore, new research needs to be conducted into the impact of the immigration process (including trafficking/illegal entry and the dispersal system) on the health of asylum seekers so that policy makers can ensure that future measures do not have a negative effect on health.

Recommendations

1. **The BMA believes that the dispersal of asylum seekers should be properly resourced and adequately managed.** Dispersal should be effectively managed so that asylum seekers are provided with adequate accommodation and not moved from place to place unless they wish to move to be nearer family members for example. In this way, they will be more likely to integrate into the community and access the services they require.
2. **More research is needed in order to progress the debate on the impact of UK immigration controls on the health of asylum seekers.** Issues to be considered are:
 - Basic demographic characteristics of asylum seekers.
 - Health on entry to the UK.
 - Health impact of immigration controls (including evaluating the impact on health of human trafficking, induction, accommodation and removal centres).
 - The potential impact of x-rays and gamma rays used repeatedly as detection measures at ports of entry should be investigated.
 - The impact on GP practices and the cost effectiveness of the government's new proposals.
 - Health impact of the resettlement process.Research into all of these areas would be consistent with, and expand on the government statement in its white paper,¹¹ that accommodation centres will be evaluated as to whether they facilitate improvements in the asylum process. Central funding should be identified for this research.
3. **A consultation exercise with key players in the field (including policy-makers, service providers, local communities and asylum seekers and refugees) should be held to strengthen research⁵⁵ on the impact of UK immigration controls on the health of asylum seekers.**

4. **The physical and mental health of all asylum seekers (including unaccompanied children) should be assessed, and appropriate treatment and/or support should be given as required.** These assessments should be carried out while the individual is staying in an induction centre before they are dispersed or moved to an accommodation centre. Important considerations are as follows:

4.1 Informed consent and understanding of procedures

- a) Healthcare professionals should obtain consent for all procedures.
- b) Asylum seekers should be informed that all health information is confidential.
- c) Healthcare professionals must appreciate that some asylum seekers have a fear of those in authority and that other healthcare professionals may have been the torturers of some asylum seekers.
- d) Medication should be presented as simply as possible¹³ (for example using a single day dose regime instead of a more frequent regime wherever possible). Healthcare professionals should be confident that asylum seekers understand how to use their medication, and that of their children if they are to administer it.

4.2 Medical assessment

- a) Assess current health status and address any immediate concerns.
- b) Test for tuberculosis. Tests for other conditions such as Hepatitis A, B,C and HIV may be deemed necessary after a full history. (It should be noted that considerable time is needed to provide appropriate pre and post counselling for Hepatitis and HIV tests. It is preferable for the same person to provide the pre and post counselling.)
- c) Take history of immunisations and vaccinations. Where there is uncertainty the appropriate vaccinations and immunisations should be given.
- d) Take maternity history. Cervical smears and family planning advice should be offered to women if appropriate. Men may also require family planning advice.
- e) Assess special needs eg for amputees.
- f) Assess nutritional needs eg malnourished children, children of HIV positive mothers.
- g) Assess psychological wellbeing and refer to the appropriate health professional if necessary.
- h) Note any evidence of physical or psychological torture or maltreatment and refer the patient to a specialist centre eg The Medical Foundation for the Care of Victims of Torture, if there is evidence of torture or if torture is alleged. (Guidance notes for examining asylum seekers have been produced by the BMA – see appendix II.)

4.3 Continuity of care

- a) To facilitate continuity of care, asylum seekers should be given a hand-held copy/duplicate medical record (including results of investigations) to take to their next doctor.
- b) Where time spent in accommodation and removal centres is prolonged, a healthcare plan based on details of health needs at examination should be drawn up for each individual.⁵⁷

5. **Trained interpreters or advocates, rather than family members or friends, should be used wherever possible if language is not shared.** Using the same interpreter for all the patient's consultations can help develop trust. Sensitivity should be exercised in selecting an interpreter, with regard to factors such as gender and political or cultural background.² The same interpreter should not be used for members of the same family as this may result in some members of that family not trusting that confidentiality will be respected. Asylum seekers may still prefer to bring a friend or family member to interpret, but the limitations of doing this should be recognised by the healthcare professional.¹⁴
6. **Healthcare professionals need to develop a greater understanding of cultural, social and other issues relating to asylum seekers.**
 - a) Healthcare professionals should be provided with training in the specific and wide ranging healthcare needs of asylum seekers,⁵⁷ with particular reference to the assessment of torture victims, and in working with interpreters.¹³
 - b) There should be UK guidelines and a regularly updated list of resources that will inform healthcare professionals on how best to deal with asylum seekers and meet their needs (for a list of available resources see appendix II).
 - c) Roles and responsibilities of those involved in working with asylum seekers must be absolutely clear.

7. **While staying in induction centres, asylum seekers must be provided with health service information and accompanying forms in a language and format that they understand. Consideration should be given to develop systems to help illiterate asylum seekers also access this information.**

The following information should be provided:

- An overview of how the health system works. Some asylum seekers would expect to go to hospital for minor ailments because primary care in their country is not well developed.
- Where to find a GP, dentist and optician and how to register.
- How to register for exemption from charges for healthcare (HC2 forms).
- Information on where to get support and information, such as the availability of advocacy workers and community groups.

8. **Asylum seekers should not normally be held in detention.** This applies especially to families, children and pregnant women. Detention can remind torture victims of their experiences and compound the psychological damage/torment that they have already suffered.^{53,58} If asylum seekers are to be detained then accommodation should be comfortable and healthcare needs should be met.
9. **A range of factors over and above their access to healthcare can influence the health of asylum seekers.** Integration into society would be aided if provisions are made to expeditiously educate adults and children (particularly in learning English). Children should be educated in the local community and preferably not moved from school to school. Asylum seekers should be provided with sufficient funds (equivalent to income support, with access to other benefits that people on income support are entitled to eg milk vouchers) on which to survive while awaiting the decision on their application. Special dietary requirements must be considered, and information should be provided on where to get any unusual items eg gluten free foods.
10. **Further discussion between the Department of Health and the Home Office is needed to arrange sufficient funding for the healthcare of asylum seekers. Central funding should provide appropriate services and staffing levels to ensure that asylum seekers' healthcare needs are met.** Funding for asylum seekers should not be provided within GMS as this will have a knock on effect on healthcare provision to the resident population. Funding arrangements should take into account that consultations with asylum seekers may on average be longer than those of the general population mainly because of the complexity of needs and language requirements of some asylum seekers. Healthcare for all asylum seekers should be of the same standard irrespective of the provider (state or private).

Appendix I: Glossary

Asylum seeker

A person whose asylum claim is submitted and is awaiting Home Office decision.

Deportation

Deportation is a technical expression and not just another word for removal. A deportation order authorises the removal of a foreign national from the UK and prevents them from returning. The order requires the subject to leave the UK and authorises his/her detention until he/she is removed. It also prohibits him/her from re-entering the country for as long as it is in force and invalidates any leave to enter or remain in the UK given him/her before the Order is made or while it is in force. The circumstances in which a person is liable to deportation are set out in the Immigration Act 1971.

Detainee visitor groups

Organisations (often charitable and/or voluntary) that, among other functions, visit asylum seekers who are being detained. Examples include the Association of Visitors to Immigration Detainees (AVID), Bail for Immigration Detainees (BID), and London Detainee Support Group (LDSEG).

Exceptional leave to remain

The Home Office accepts that there are strong reasons why the person should not return to the country of origin and grants the right to stay in the United Kingdom for four years. They are expected to return if the home country situation improves.

Indefinite leave to remain

A person is able to reside in Britain indefinitely.

General Medical Services

Provision of GP services contracted for under part 2 of the NHS Act 1977, not cash limited and nationally negotiated.

Personal Medical Services

Provision of GP services contracted for under part 1 of the NHS Act 1977, cash limited and locally negotiated.

Refugee

A person who has obtained refugee status (accepted as a refugee under the Geneva convention) and is given indefinite leave to remain in the UK. They are eligible for family reunion (one spouse and any child of that marriage under the age of 18).

Refugee community

A group of asylum seekers or refugees who interact and support each other in a given community but are also integrated into the surrounding community.

Removal

The following category of person may be removed:

- Those who arrive clandestinely and those who practise a deception amounting to illegal entry.
- Overstayers. Those who had leave to enter which has expired.
- Workers in breach. Those who are working where their leave to enter or remain prohibits it.
- Other categories of immigration offender.

People removed will not be prohibited from attempting to re-enter if they meet the necessary requirements.

Appendix II: Courses and guidelines for health professionals

Burnett A & Fassil Y. *Meeting the health needs of refugee and asylum seekers in the UK: an information resource pack for health workers*. NHS. DoH.
www.london.nhs.uk/newsmedia/publications/Asylum_Refugee.pdf

Medact run study days on *Refugee status and health*.
www.medact.org

The Medical Foundation for the Care of Victims of Torture has also produced useful publications.
www.torturecare.org.uk

Levenson R & Sharma A. *The health of refugee children: guidelines for paediatricians*, Prepared for the King's Fund and the Royal College of Paediatrics and Child Health, 1999
www.rcpch.ac.uk/publications/past_publications/refugee.pdf

British Medical Association, *Asylum applicants – medical reports: guidelines for examining doctors*, London: BMA, 1993
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British Medical Association, *Female genital mutilation: caring for patients and child protection*, London: BMA, 2001
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British Medical Association, *Confidentiality and disclosure of health information*, London: BMA, 1999
www.bma.org.uk

HARPWeb: *Health for asylum seekers and refugees portal*. This website provides a major new resource for both professional and voluntary agencies working with asylum seekers and refugees.
www.harpweb.org.uk

The websites in this report are suggested for further information only and this does not suggest an endorsement of their content in any way by the BMA. Further, the BMA can make no warranty, expressed or implied, as to the accuracy of any information or advice provided by external sources for which links are provided here. The views of other organisations do not necessarily reflect those of the BMA.

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