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Overcoming the barriers migrants face in accessing health care

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ABSTRACT

Migrants face many barriers when accessing health care, both structural and political, leading to unmet need and poor quality care. Yet these barriers often can be overcome. This short communication reports a workshop confronting these issues at the First World Congress on Migration, Ethnicity, Race and Health. It explores the structural factors that create barriers and the competencies that health professionals need to overcome them. It then examines how one non-governmental organization did confront, successfully, a restrictive policy adopted in the United Kingdom, through advocacy and practical action. It concludes by examining the related issue of cultural competency, drawing on experiences of a mental health unit in Athens, Greece.

Introduction

How can we overcome the barriers migrants face in accessing health services? This was the subject of a workshop held at the First World Congress on Migration, Ethnicity, Race, and Health in Edinburgh in May 2018, where practitioners and researchers with both practical and theoretical knowledge outlined their experiences. In this short communication, we describe the issues discussed at the workshop, beginning with the often overlooked area of structural competence in migrant health and then examining two contemporary examples of the issues facing civil society organizations supporting migrants in need of health care. The first, from the United Kingdom (UK), examines ways of overcoming barriers to accessing care. The second, from Greece, addresses the related, and complex, issue of cultural competence.

Structural competency for migrant health

The training of health professionals has, traditionally, focused on the immediate causes of disease, such as exposure to microorganisms, trauma, or certain risk factors such as tobacco. The skills acquired in diagnosis and treatment are clearly important, but, on their own, they are inadequate to address the powerful societal, political, and economic structures that influence health. For this, health professionals need a

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different set of skills, which have been termed, collectively, 'structural competency', which can address these wider determinants of health. Those advocating this approach call for a 'shift in medical education…toward attention to forces that influence health outcomes at levels above individual interactions'[1] and, ultimately, the ability to do something about them. These 'structures' or 'social structures' include the policies, economic systems, and institutions (such as the criminal justice system and educational, welfare, and other sectors) that generate and maintain social inequities and, thus, health disparities.[2] Fig. 1 provides an example of how these structural factors adversely impact the health of one person, a farmer who has migrated from Mexico to the United States. At each stage in their journey, across borders and over time, they experience assaults on their health, but both their vulnerability to those assaults and their consequences are influenced by a wider set of structures.

On impacting health, such structures intersect with various mutable and immutable categories, including race, class, citizenship, gender, and sexuality.[3] For migrants and refugees, important economic structures include ethnically, linguistically, and culturally segregated labor markets, which directly affect their ability to choose where they live, how they work, what food they eat, and what sorts of health services they can afford. Relevant social structures include discriminatory rhetoric and treatment, social marginalization, and violence, which impact their physical and mental health. Examples of political structures include immigration policies, as seen with the UK's now abandoned policy of sharing data between health and immigration authorities, and institutionalized persecution of specific religious, ethnic, or cultural groups in both their country of origin and receiving country.

Even now, most research on immigration and health uses an individualistic, behavioral framework without paying attention to these structural factors.[4] This framework implies that it is the fault of the immigrant, migrant, or refugee population for their health problems but also their responsibility alone to fix the problems.[5] In practice, immigrants, migrants, and refugees do take care of each other, individually and collectively working to mitigate or even change these economic, social, and political structures to increase their life chances and well-being. Yet, they should not have to do so alone and clinicians, health researchers, health policymakers, and health system planners armed with the portfolio of perspectives and skills needed to achieve structural competency can do much to work alongside these communities to address the upstream determinants of the health of those they are seeking to help, with a range of relevant resources assembled by the Structural Competency Working Group and others.[6]

Access to health care in England

One of the examples alluded to above is the agreement, in January 2017, between the National Health Service (NHS) in England and immigration authorities. Despite the obvious risk of deterring those whose immigration status is uncertain from obtaining healthcare, it allowed the immigration authorities to access non-clinical patient information. One non-governmental organization (NGO), Doctors of the World (DOTW) UK, part of the Médecins du Monde international network, launched an ultimately successful campaign to suspend it. DOTW UK has run a clinic in London for 12 years for those struggling to access the NHS. More than half of the patients attending are undocumented migrants.

The agreement clearly violated patient confidentiality, at the heart of the doctor–patient relationship. As predicted, people in vulnerable circumstances were deterred from accessing health care, fearing arrest, detention, and deportation. DOTW UK's 'Stop Sharing' campaign included practical measures and advocacy. The 'safe surgeries' toolkit provides practical advice for general practices to resist this policy, for example, by not asking for a home address, using that of the practice or a patient's friend, and agreeing to register those without identification (in line with NHS England guidance).[7] Second, a petition attracting more than 70,000 signatories and a social media campaign was launched.

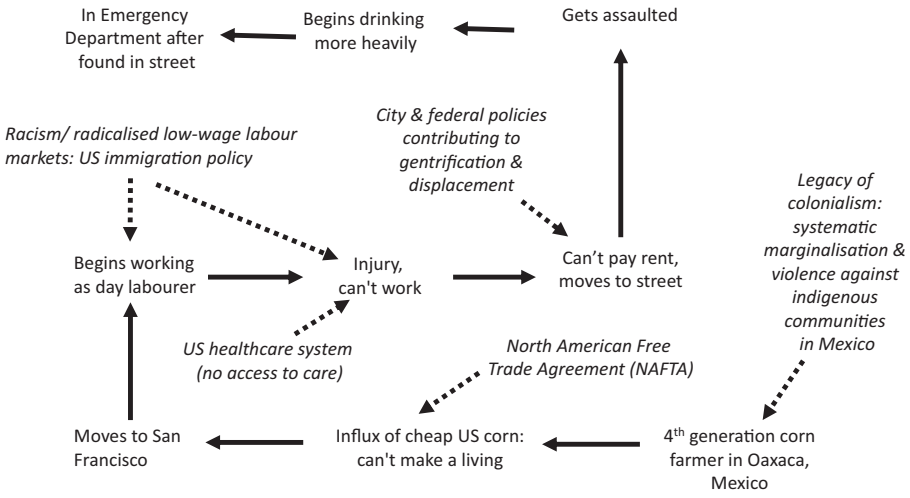

Fig. 1 – A patient journey with the patient trajectory and structural influences on that trajectory (italics, dashed arrows). Reproduced from Neff et al.,[2] with permission.

In response, a coalition of medical royal colleges, the General Medical Council, and the British Medical Association added to the pressure of the NHS and immigration authorities. In January 2018, their demands were supported by the parliamentary Health and Social Care Select Committee, which called for the agreement to be suspended immediately. Despite some resistance from the government, in May 2018, it was eventually withdrawn. The government has promised revised measures, responding to the criticism, but the details are not yet available.

Despite this victory, what the UK government has called a 'hostile environment' continues and undocumented migrants still face many barriers. Upfront charging for secondary care and some community care, including mental health services and termination of pregnancy, remains a huge deterrent. If the bill reaches £500 (€570, US$650) and remains unpaid after 2 months, the individual is referred to the immigration authorities, so patient data still remain unsafe. The human cost of these policies must not be forgotten. The DOTW UK clinic has seen pregnant women too afraid to access antenatal care, cancer surgeries canceled, and palliative care refused. Participants agreed on the need for healthcare professionals, academics, and non-governmental organizations to continue to work together, to resist these policies, ensuring that access to health care is independent of the immigration status.

Cultural competence

An example from Greece explored the related issue of cultural competence, initially defined as 'a set of congruent behaviors, attitudes, and policies that comes together in a system, agency, or among professionals and that enables them to work effectively in cross-cultural situations'.[8] It was adapted in the health sector as 'the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.[9]

The importance of cultural competency was illustrated by Babel, a Greek day center supporting migrants with mental health problems in Athens. Greece has experienced a massive influx of migrants, with more than one million passing through the country (some 'stuck' after March 20th 2016). This was accompanied by the arrival of many international organizations delivering humanitarian aid (in January 2016, 110 NGOs were registered on the island of Lesvos alone), each one with its own ways of working, with hundreds of other volunteers from all over the world. This created enormous problems of coordination among local and international actors. One reason was inadequate cultural competence.

It became clear to Babel that many groups lacked the cultural competence necessary to understand each other, raising an important question, who are 'the others' and who are 'we'? Should we only consider refugees' culture, or we should include also the plethora of the culturally different humanitarian actors?

This experience argues for a new, enhanced concept of cultural competence that recognizes the complexity involved, overcoming divisions into 'us' and 'them', taking account of different disciplinary perspectives and the biases associated with different professional backgrounds and the organizations in which people work.[10] It must go beyond 'us' (experts) fixing 'them' (patients) to include what we learn from each other.[11] Ultimately, it should include much greater awareness of the paradigms in which health professionals operate.

Discussion

The workshop documented how migrants face many diverse barriers in accessing health care. It provided a forum for sharing potential solutions, while raising awareness of issues which are often neglected, such as cultural and structural competency, which can equip health professionals to address some of the underlying determinants of the health of those they are caring for. There are also some specific lessons. The experience of DOTW in the UK shows that civil society organizations can challenge, and overcome, structural barriers to care. The experience from Greece highlights the need for all those involved in migrant health, not least in emergency settings, to consider their own cultural biases and to encourage reflection within their own organizations, between organizations, and with patients themselves. Finally, by sharing successes, as at this workshop, it is possible to galvanize the international community to continue to advocate for individuals and communities who find themselves in structurally vulnerable positions when attempting to obtain the health care they need.

Author statements

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LH worked as Doctors of the World UK health advisor at the time of the workshop and writing of the piece.

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