Improving access for refugees: A health systems approach for high-income European countries

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Millions of people across the globe have been forcefully displaced from their home countries owing to conflict and violations of human rights. This article discusses the impact of forced displacement on health inequalities, and the strategies that can be developed to support high-income European countries in improving access to healthcare, to promote better health and encourage the integration of refugees into society.

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The ongoing global refugee crisis presents various challenges for healthcare systems today. The latest statistics from the United Nations High Commissioner for Refugees identified over 22 million people as refugees, of whom more than one million entered the European Union (EU) at the end of 2015. The 1951 United Nations Refugee Convention defines a refugee as any individual who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular group or political opinion is outside the country of his nationality and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country'.[1] Forced migration exposes these individuals to numerous hardships before displacement, throughout their journey and after settlement. Social network and cultural transitions, through disruption and loss of social support, violence, harsh living conditions and uncertainty about refugee status, employment and educational opportunities, have an immense impact on their health status.[2] This is reflected in higher incidences of communicable, non-communicable diseases (NCDs) and mental illness among refugees.[3] Refugees resettling in high-income countries have high rates of depression, post-traumatic stress disorder and anxiety, and therefore addressing mental health issues in this population is vital. The most commonly observed NCDs among this group are chronic pain, diabetes and musculoskeletal, cardiovascular and respiratory diseases. Hence basic primary care services may not be sufficient to address these chronic health problems.[3]

These changes can place an immense burden on the health systems of hosting countries, in relation to resilience and the provision of adequate healthcare services.[3] The response of high-income European countries (HIECs) to overcoming barriers faced by refugees when accessing healthcare has been varied. The remainder of this editorial will discuss some of these responses, and propose solutions using the World Health Organization (WHO) health systems approach.[4]

Governance

The ability of a country to provide adequate healthcare for refugees is dependent on wider legal and policy frameworks, infrastructure of services and funding. Although most HIECs have legislative frameworks in place regarding access to healthcare for asylum seekers, few have developed laws specifically for refugees. Even in countries where entitlement to healthcare exists, there is no guaranteed access to healthcare owing to administrative barriers and the legal status of refugees. For example, difficulties could arise from not having a permanent home address, or not being able to fill out complex forms for healthcare provider registration or to obtain exemption from fees. Additionally, lack of knowledge among refugees on healthcare entitlement can create further barriers. Fear of deportation among individuals who are unable to claim asylum has also been reported.[3]

Furthermore, service providers have traditionally adopted a reactive response to the upsurge of refugee numbers, resulting in delays in receiving healthcare.[5] Limitations in the expertise of healthcare personnel at the micro level can further impede access. There is evidence to suggest that many clinicians do not feel confident in detecting and manging diseases within the refugee population. There is also a lack of research on the health status of refugees compared with the general population. The absence of a well-functioning information system can create challenges in identifying the unmet needs of refugees and improving access to and quality of care provided.[6] This highlights the fact that there is a need for better governance and leadership across EU member states in order to meet the health needs of refugees.

Finance

Healthcare financing also influences the extent to which refugees are integrated into a host country's health system, particularly if the existing system is already weak. There is limited evidence discussing the healthcare financing strategies of HIECs in response

to the influx of refugees at the macro level. In relation to the micro level, affordability at the point of contact is an important factor to consider. Although some EU countries do provide universal health coverage, refugees are not automatically entitled to these benefits. In France, refugees are provided health coverage via two schemes: the standard intervention and the optional health insurance. This ensures that any out-of-pocket (OOP) health expenses for refugees are minimal.[7] In contrast, most HIECS require individuals to pay for consultations and any treatment costs that are incurred, restricting access to healthcare. Furthermore, additional costs to service users, such as the transportation and costs of allied healthcare services (e.g. dental check-ups) can influence help-seeking behaviours and result in failure in uptake of treatments.[3]

Service delivery

There is a huge degree of variation in the entitlements of refugees to a host country's health system across Europe. Germany, the most popular refugee destination in the EU, has significantly restricted healthcare entitlements for refugees, only allowing them access to services during emergencies, pregnancy and childbirth. This is in contrast to neighbouring countries France, Austria and Switzerland, which provide refugees the same entitlements as their national citizens.[8] Furthermore, upon arrival, many host countries offer an initial health assessment that is used for screening and to prevent dissemination of infectious diseases. These assessments are currently only offered in the UK and Sweden.[9]

Another important consideration is language and cultural barriers. Refugees often have low levels of English proficiency, and hence may require formal interpreters, and additional time during appointments.[3] These services are rarely offered, given the time constraints in primary care, and if they are available, individuals may be required to pay additional charges. Additionally, poor knowledge about health conditions and treatment options, as well as reluctance to disclose sensitive information, are further barriers. There is also some evidence that lack of trust in healthcare professionals can further hinder access.[7] Despite this, few initiatives have been taken to increase the provision of multicultural services and community-based programmes that focus on improving knowledge and service utilisation within this group.

Proposed solutions

It is evident that refugees entering the EU face numerous barriers in accessing healthcare services, which should in fact be a fundamental human right. An appreciation of all the components of a health system must be made when considering potential courses of action.

The importance of having a strong, overarching governing system with specific agendas has been emphasised by the WHO. Thus, ministries of health should concentrate their efforts to develop new policies to reduce any inequalities in healthcare entitlements for refugees, in line with the Sustainable Development Goal of achieving universal health coverage.[4] Within nations, there should be a focus on supporting the local governments of areas populated with refugees in implementing these changes. Although some host countries offer an initial health assessment, there is a need to expand this type of service into all nations, and improve the overall quality of the programme, so that all health needs are assessed.[5] In addition, there needs to be a focus on the establishment of multicultural services and educational programmes that improve awareness of diseases, and provide practical support in accessing relevant facilities. Greater efforts should be made to generate integrated policies of care that include regular training for all healthcare professionals who are likely to have contact with refugees. Provision of cultural competency training for primary care staff, longer appointment times, availability of interpreters and specific health services (immunisation and screening for high-risk conditions) have been shown to improve the quality of care provided for refugees in northern England.[3] There should also be a greater focus on educating healthcare personnel on issues such as basic rights, support services and the detection of clinical conditions among refugees.

Furthermore, health authorities should develop strategies that focus on the social determinants of health among this group. In particular, provision of adequate housing facilities, protection against violence, equal access to employment and educational opportunities should be a priority. This will promote integration of refugees into society, and greater wellbeing.[10]

No health system is able to achieve its goals without appropriate financing. Governments should make efforts to review methods of financing, ensure that distribution of resources remains equitable among all subgroups of the population and reduce any OOP payments. There may also be opportunities to seek financial aid from non-governmental organisations to support any new plans for refugees. Lastly, information systems that routinely collect data on the quality of services being provided for refugees and determine any unmet health needs should be established.[4]

Conclusion

The health systems of HEICs need to be strengthened to accommodate the burden associated with the influx of refugees. There should be a paradigm shift to integrate refugees into local communities and respond to their increasing health needs. Collaboration with neighbouring countries during times of such crises is fundamental in ensuring that evidence-based mechanisms are implemented that have a positive impact on the refugee population.

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