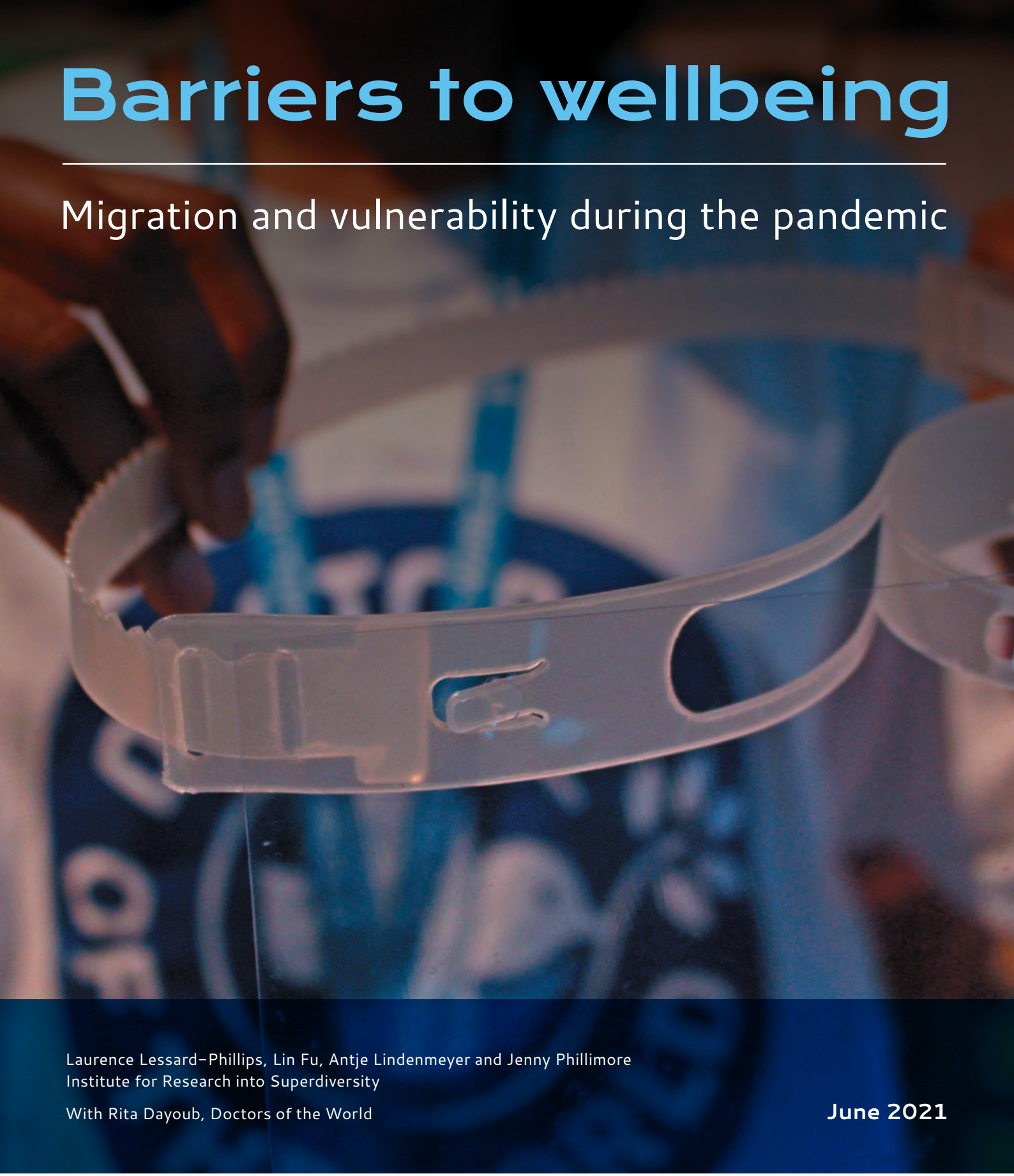
Barriers to wellbeing

Migration and vulnerability during the pandemic



Laurence Lessard-Phillips, Lin Fu, Antje Lindenmeyer and Jenny Phillimore
Institute for Research into Superdiversity

With Rita Dayoub, Doctors of the World

June 2021

Doctors of the World
University of Birmingham | IRiS Institute for Research into Superdiversity
Nuffield Foundation

Contents

Acknowledgements

This work was undertaken as part of the Vulnerable Migrants' Wellbeing Project funded by the Nuffield Foundation with further funding from the ESRC IAA funds.

The Nuffield Foundation is an independent charitable trust with a mission to advance social well-being. It funds research that informs social policy, primarily in Education, Welfare, and Justice. It also funds student programmes that provide opportunities for young people to develop skills in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Nuffield Council on Bioethics and the Ada Lovelace Institute. The Foundation has funded this project, but the views expressed are those of the authors and not necessarily the Foundation. Visit **www.nuffieldfoundation.org**

Finally we wish to thank the service users of Doctors of the World UK programmes, who generously shared their time and experience to support data collection and DOTW volunteer and staff for their role in data collection.

Executive Summary

COVID-19 and measures taken to control it has disproportionately impacted the health and wellbeing of disadvantaged and excluded populations. In order to understand these impacts, we conducted a mixed methods study which analysed data collected by Doctors of the World (DOTW) UK before and during the pandemic. DOTW UK is a non-governmental organisation who run clinic and advocacy programmes that provide medical care, information and practical support to excluded people. Therefore, an analysis of the data outlining the experience of their service users will highlight the situation of individuals at risk of vulnerability, especially with regard to their wellbeing, identify barriers and issues that may be linked to vulnerability, and provide potential solutions to deal with such barriers.

DOTW UK offers advice on how to access primary care as well as health and social advice through its London-based clinic services. Volunteers collect a range of data from service users on demographics and factors such as wellbeing, health, housing, and migration status. The data is mostly questionnaire-based but includes volunteers' free-text notes. On 17th March 2020 there was a switch from service face to face provision to telephone assistance and a free advice line. We use the period prior to that date as our comparative 'pre-pandemic' period, to explore potential differences between these two time periods. For our analysis, we are applying a mixed methods approach that uses both quantitative/numerical data and free-text notes from all interactions from April and July 2020, which we classify as qualitative data.

Many participants lived on a low income, in insecure accommodation and were without legal status, and were more likely to describe their health as bad or very bad than the general population. Many reported barriers to accessing healthcare and requested help to register with a GP. The main differences between the pre-pandemic and pandemic periods were:

- **The number of average consultations per month dropped from 170 to 50 after the move to a telephone based service**
- **Service users were much more likely to find themselves in inadequate housing**
- **A greater number of service users had some form of health coverage but still found it difficult to access care**
- **The percentage of undocumented service users decreased while the percentage of asylum seekers increased (potentially due to more asylum seekers living in contracted/ hotel accommodation)**
- **There was a significant increase in service users reporting 'bad' or 'very bad' health**

Consultation notes showed additional barriers to GP registration. These findings suggest that service users' circumstances had become more difficult during the pandemic. The necessary move to telephone clinics removed the offer of drop-in clinics which may explain a decrease in non-documented services users seeking support. Given the reduction in numbers, it is likely that those who made contact were more likely to perceive their health as bad. Given the large drop in service users and the complexity of resolving problems around access to health services it is likely that significant unmet need remains while services are remote.

In order to provide support for disadvantaged and excluded populations policymakers and service providers should ensure:

- **All migrants, asylum seeker and refugees can access the healthcare services they are entitled to, especially GP registration**
- **Some face to face provision of services is reinstated and alternatives to accessing online registration are made available**
- **Providers of initial and contingency (hotel) accommodation for asylum seekers provide information and support to access NHS services**
- **GP surgeries continue to register new patients throughout the pandemic**
- **Wifi or data is provided for people living in poverty so that they are not excluded from services as they move online**
- **Migrants and practitioners knowledge of the healthcare system, especially awareness of the charging exception, is increased.**

Introduction

The COVID-19 pandemic has had –and continues to have– tremendous impact on wellbeing, especially amongst people at risk of vulnerability such as ethnic minorities, homeless people, undocumented migrants and asylum seekers. This report examines the wellbeing of vulnerable migrants during the early months of the pandemic (March-September 2020). It explores the characteristics of individuals at risk of vulnerability during that period: their health status and their wellbeing needs as well as the healthcare barriers they have experienced. Findings are reported from a mixed methods study which analysed data drawn from Doctors of the World (DOTW) UK service data collected before and during the pandemic. The analysis was undertaken in order to highlight the situation of individuals at risk of vulnerability, especially with regard to their wellbeing, identify barriers and issues that may be linked to vulnerability, and provide potential solutions to deal with such barriers.

The work undertaken for this report forms part of a larger project funded by the Nuffield Foundation entitled 'Vulnerability, migration, and wellbeing: investigating experiences, perceptions, and barriers', which uses a longer timeframe to look at the wellbeing of individuals at risk of vulnerability.[1] The project comprises a team based at the Institute for Research into Superdiversity at University of Birmingham and DOTW. Preliminary results were discussed in November 2020 as part of the ESRC's Festival of Social Science.[2]

This report is organised as follows. It starts by summarising the context around the pandemic, including the healthcare and policy context. It then describes the data and methods in detail. The following section discusses results of the analysis across the broad themes of general demographics, healthcare access, health status, accommodation situations, and barriers to healthcare. Finally, the last section presents recommendations for policymakers and practitioners.

Context

COVID-19 and measures taken to control it has disproportionately impacted the health and wellbeing of disadvantaged and excluded populations and has exacerbated the health inequalities experienced by these groups (DOTW UK, 2020). In the UK higher rates of infection and mortality are evident for Black, Asian and Minority Ethnic (BAME) groups (Godin 2020). Concerns have been widely expressed that forced migrants across the globe, many of whom live in crowded, sometimes makeshift accommodation with poor access to food, sanitary items and healthcare and those who are dependent on Non-Governmental Organisations (NGOs) or the informal labour market, may be at particular risk and particularly unable to access the materials and care they needed to stay safe from infection (Aultman 2019). Migrants at risk of vulnerability, including refugees, asylum seekers and undocumented migrants (*see table of definitions below*) have been identified as being at risk of being adversely impacted by the COVID-19 pandemic (DOTW UK, 2020a).

Table 1: Table of definitions

Migrants' categories	Definitions
Refugees	Someone who has a "well- founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion," and the UK government agrees it is not safe for them to return to their country of origin.
Asylum seekers	Someone who has made a claim for protection on the basis of the Refugee Convention or Article 3 of the European Convention of Human Rights and is waiting for the outcome of their claim.
Refused asylum seekers	This is someone whose asylum application has been unsuccessful. Some refused asylum seekers voluntarily return home, others are forcibly returned and for some it is not safe or practical for them to return until conditions in their country change.
Undocumented migrants	This is someone who does not have legal papers to support their presence in the UK. This may include people who have overstayed their visas or entered the country without declaring themselves to the Home Office. Some will be trafficking victims or working in exploitative conditions.

1 https://blog.bham.ac.uk/vulnerabilitymigrationwellbeing

2 https://www.youtube.com/watch?v=Kzn-CkjzLv4&list=PL5TjiPIpilP9js50AOPVL8oumy4A7Ov_1&index=9

The health needs of migrants at risk of vulnerability are widely documented (Jayaweera, 2014). This population group are at increased risk of poor physical and mental health and wellbeing for a range of reasons including their life experiences pre-migration, during their migration journey, and post-migration within their host country. England's hostile environment policies impact wider determinants of health including healthcare access, employment and education opportunities, housing access and financial circumstances (Liberty, 2018). The COVID-19 pandemic and its associated restrictions and control measures have compounded the existing challenges (DOTW UK, 2020) and are widely acknowledged to have exacerbated existing inequalities in the general population.

Changes to health service provision in response to the COVID-19 pandemic increased healthcare access barriers generally but especially those experienced by vulnerable migrants (Medact et al., 2020). In addition to pre-existing GP registration, language and cultural challenges, many also experience digital exclusion which precludes access to the remote clinic consultations that are increasingly the main mode of healthcare offered under pandemic conditions. Undocumented migrants are subject to the NHS Overseas Visitor Charging Policy (Gov.UK, 2015). However due to the complexity of the regulations confusion around eligibility exists on the part of service providers and other migrant groups (DOTW UK, 2020). The fear of unaffordable bills and data sharing by the NHS with the Home Office deters many migrants at risk of vulnerability from accessing healthcare (DOTW UK, 2017). While COVID-19 diagnostic tests and treatment are exempt from the NHS Overseas Visitor Charging policy this is not widely known and fear persists amongst some migrant communities (DOTW UK, 2020; Medact et al., 2020).

In addition, the pandemic has resulted in an economic recession and associated increased unemployment, the effects of which are felt hardest by those with limited financial resilience. Many migrants are at high risk of poverty and destitution with many ineligible for government support. The relationship between poverty and health and wellbeing is well recognised (Aragona et al., 2020; Behbahani et al., 2020; Karim et al., 2020).

Published academic research on the broad themes of migration, vulnerability and wellbeing during the COVID-19 pandemic in the UK context has shown that the pandemic has had an impact on the wellbeing of migrants, especially those from what is frequently labelled a "Black and Asian Minority Ethnic (BAME)" background. For example, Hu (2020) found that the economic wellbeing of BAME migrants had been negatively affected by the pandemic, thus increasing their risk of vulnerability. Shen and Bartram (2020) reported that, although migrant men had better mental wellbeing than their native-born counterparts before the pandemic, migrant men experienced worse mental wellbeing with reduction in working hours and job or income loss during the pandemic. Germain and Yong (2020) highlighted that ethnic minority and migrant women were facing increased barriers to healthcare services access in England during the pandemic. Moreover, marginalised groups had poor access to the internet, resulting in increased vulnerability, as remote consultations gradually became the dominant communication method between clinicians and patients. The vulnerability of undocumented workers had also worsened, with increased financial hardship generated by the inability to work, and difficulty social distancing due to crowded living arrangements, and fear of accessing the NHS services.

Thus it is widely reported that the COVID-19 pandemic has had an adverse impact on the wellbeing of migrants increasing risks of vulnerability. We explore the effects of the pandemic further in our analysis of the DOTW UK data looking at the categories of migrants who accessed DoTW's services and outlining the services that they required.

Data & methods

The data used in this report comes from service user data collected by DOTW UK from their clinics. DOTW UK is a non-governmental organisation working to empower excluded people to access healthcare. As part of this mission DOTW UK offers advice on how to access primary care as well as health and social advice through its London-based clinic services. On 17th March 2020 there was a switch from service face to face provision at their permanent and mobile clinic sites, to telephone assistance and a free advice line (which has continued since this time). As part of their interactions with service users, volunteers collect a range of data including about demography, wellbeing, and health. The data is mostly questionnaire-based and separated into four sections: a service user information form, a social form, a medical form (if a medical consultation is needed), and free-text notes for any relevant information about the consultation (see Lessard-Phillips et al., 2019 for some details). This information is inputted onto the DoTW system by the volunteer either during or after the interaction.

For the purpose of this report, we are applying a mixed methods approach that uses data from the service user information form that have been matched to the social form[3] between January and September 2020, which are quantitative/numerical data. We also use the free-text notes from all interactions from April and July 2020, which we classify as qualitative data.

Whilst the match between the service user and social forms is not complete, we have managed to link the forms for 750 service users in the data, thus our sample size for the quantitative analysis constitutes those 750 service users. Thus we do not have information about the whole population of DOTW service users engaging with their services in this period, but a large share of users. The data contains missing information on some of the variables, which we exclude from the calculations. The effective sample sizes used in our analyses are mentioned throughout the figures, or in the appendix. For the qualitative data, we analysed the content of 61 sets of notes for April and 59 notes for July. The range of the information within those notes vary greatly, from a few words to a page of text, and are useful to bring context to our quantitative results.

Whilst the available quantitative data cover the first 9 months of 2020, our results focus on what we have termed the 'pandemic' period, which coincides with the DOTW move to telephone consultations on 17th March 2020. We use the period prior to that date as our comparative 'pre-pandemic' period, to explore potential differences between these two time periods. For this aspect of the report, we used descriptive statistics, usually percentage distributions given the nature of the variables used, to portray the situation during the pandemic. The variables used are grouped by the following themes: general picture (including consultation information, demographic information, economic situation, geographical location, health coverage); immigration status; reasons for consultation; health status; housing situation; and barriers to healthcare. For each percentage provided we also compute 95% confidence intervals to assess differences across answer categories. We then compare these percentages to the percentages in the pre-pandemic period, using a chi-squared test to assess the difference in answer distributions across the two periods. The chi-squared test results are statistically significant at the 0.01 level unless specified. When appropriate, we also compare the various results across immigration statuses, using confidence intervals and chi-squared tests for assessing significant differences. We use a minimum cell count of 5 observations when presenting the results. The free-text notes are analysed using a guided content analysis approach (Hsieh and Shannon, 2005) based on the broad themes outlined above. Relevant information from the notes was extracted and assigned to the themes to enable us to identify patterns in both sets of data.

Two questions about mental health were asked in the questionnaire. One is little interest or pleasure in doing things, and the other is feeling down, depressed or hopeless. Based on these two indicators, the ultra-brief depression screener Patient Health Questionnaire-2 (PHQ-2) was developed (Kroenke et al., 2010). Through assigning scores of 0, 1, 2, and 3 to the response categories of 'not at all', 'several days', 'more than half the days', and 'nearly every day', respectively, PHQ-2 was calculated as the total value of two indicators, ranging from 0 to 6. The cut-off point for PHQ-2 is 3, and a score of 3 or greater means that the full PHQ-9 depression scale and a clinical interview should be provided to this service user to determine whether a mental disorder is present.

3 via a unique consultation identifier – note that any repeat consultations with the same service user are also excluded so that we only have unique service users in the data

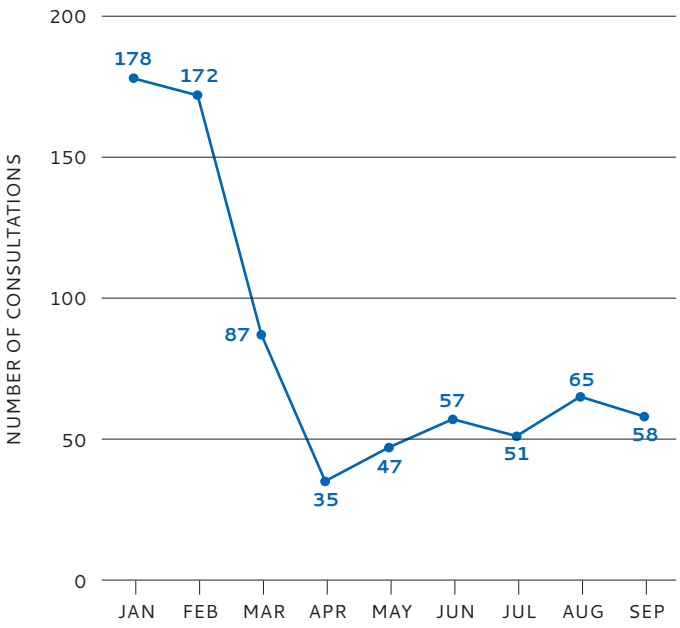
Results

General picture

Number of consultations

As mentioned, the total number of unique service user consultations from January 2020 to September 2020 with information linked to the social questionnaire was 750 (Figure 1). 17th March was defined as the start of the pandemic period. The total number of consultations from the beginning of January to 16th March was 428, and the corresponding number between 17th March and end of September was 322. The average number of consultations per month dropped drastically from approximately 170 before the pandemic to 50 during the pandemic. This drop is most likely due to the move to telephone consultations, which can be linked to issues in terms of access and provision of the service.

Figure 1: Number of Consultations (N=750)



Source: DOTW Service User data, January–September 2020

Basic demographics

During the pandemic, males accounted for approximately 52% of the total consultations, and females accounted for approximately 48%, which was not a significant difference. Figures from before the pandemic show that a slightly higher percentage of women attended the clinics, but this difference was, again, not statistically significant. Figures from earlier years (see, e.g., Lessard-Phillips et al., 2019) show a roughly similar distribution.

During the period of the pandemic, just over half (50.9%) of the service users were young adults, aged from 18 to 34 years old. Adults aged between 35 and 59 accounted for 41.3% of total consultations. Service users over 59 or younger than 18 years old accounted for 4.7% and 3.1% of overall consultations, respectively. Whilst there appears to be a change in the age distribution of service users during and before the pandemic, the only group showing a significant increase in its share of service users during the pandemic is the 18-34 age group, whereas there has been a significant decrease in the share of service users in the 35-59 age group. This might relate to younger people being better able or more willing to utilise virtual rather than face to face interactions.

Comparing the characteristics of services users before and during the pandemic, we found that, during the pandemic period, a significantly lower proportion of middle-aged (35-59 years) undocumented people with secure tenancy and no healthcare coverage used the services provided by DOTW. With regard to wellbeing status, there was a significantly reduced share of service users having fair or better general health during the pandemic.

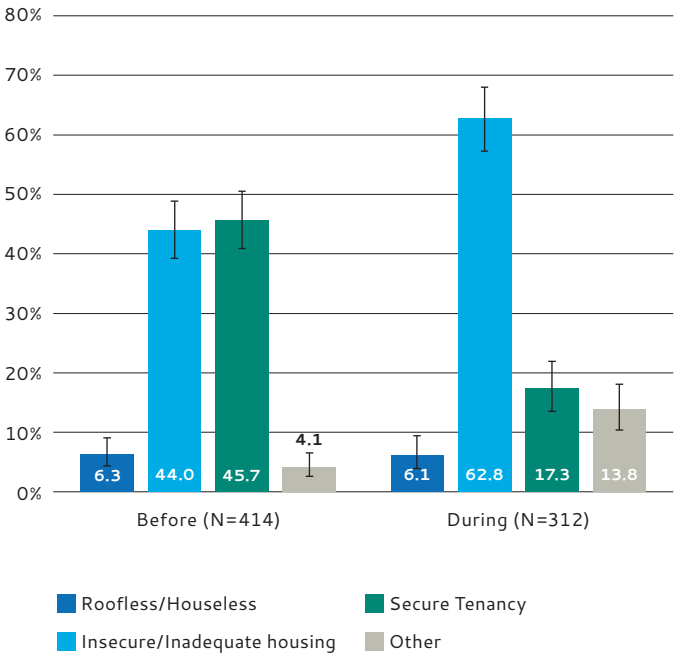
Economic situation

During the pandemic period, just over 9 out of 10 service users reported that their monthly income was lower than the poverty line, set at 836 pounds per month, a slight, but not significant (only significant at the 0.05 level), increase from before the lockdown, showing that financial situation is a big issue for service users. From the consultation notes, most of the service users do not have access to employment income.

Housing situation

As we have highlighted above, the financial situation of the service users is quite precarious, regardless of the pandemic. Yet, if we look at the housing situation of service users before and during the pandemic (Figure 2), we see quite a change in the share of service users finding themselves in inadequate housing (from 44% before the pandemic to 62.8% during) as well as threefold decrease in the share of service users with a secure tenancy.

Figure 2: Housing Situation (N=726)



Source: DOTW Service User data, January-September 2020

The analysis of the consultation notes show that most service users live in shared rented accommodation with friends or family; for many, the rent is paid by other members of the family. The free text notes indicate that most service users appear safe where they are, with some experiencing difficulties with regard to living in exploitative circumstances or being uncertain about the stability of their housing situation.

Among asylum seekers, there were many in hotel accommodation (from the questionnaire data, around 46% of service users identified as asylum seekers were deemed to be in an 'other' type of housing), which could generate issues with GP registration. During the pandemic the asylum dispersal system was slowed down and evictions from dispersal accommodation ceased. There was a shortage of contracted accommodation resulting in many recently arrived asylum seekers being housed in contingency accommodation, with over 40 hotels in use in London alone so it is likely the "other" accommodation was in hotels.

Geographic location

As expected given the main location of the clinics, most service users resided in London, both before and during the pandemic. The shift to remote interactions might make DoTW's services more available to users outside of London. However the remote consultations provided by DOTW after the pandemic shows that only 17.6% of the service users resided outside of London, a lower, but non-significant decrease compared with the pre-pandemic period (21.3%).

Health coverage

From the social questionnaire, healthcare coverage information was collected from service users by asking 'Do you have any healthcare coverage at the moment?'. This question represents service users' perception but not their entitlement. The answers ranged from full healthcare coverage, partial healthcare coverage, emergency care only, to no healthcare coverage (charged full cost or excluded from all healthcare services). Before the pandemic, the overwhelming majority of service users did not have healthcare coverage (89% of 308 service users with valid information), whereas a lower share of service users during the pandemic were reported as not having some sort of health coverage (72.1% of 197 respondents with valid information). This decrease in the share of service without health coverage, and thus the increase of service users with some sort of health coverage using the DOTW service, is statistically significant.

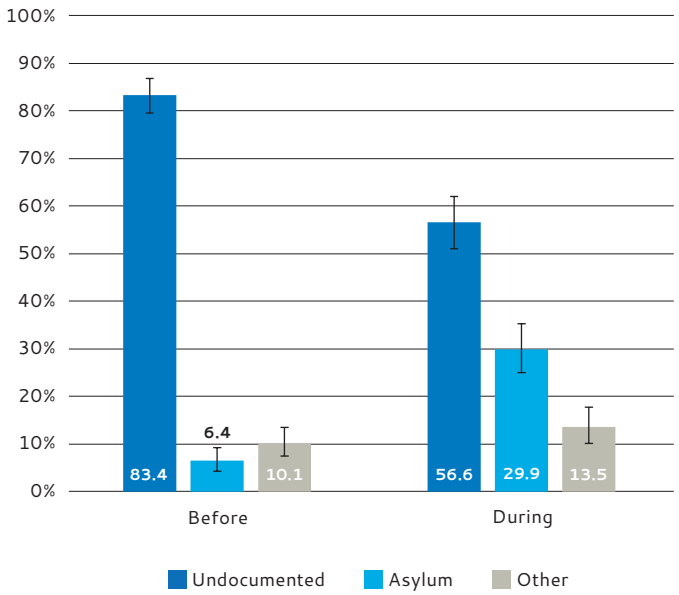
Immigration status

Given the focus of this report, we now turn to the immigration status of the service users. Note that, among all service users, about 95% have a reported immigration status. Given the size of the sample, the immigration statuses included in the social questionnaire have been grouped into three main groups:

- Undocumented/no legal status: non-EU refused asylum, non-EU no legal status;
- Asylum seekers and refugees: service users with ongoing asylum claims, or who have been granted refugee status;
- Other: Nationals/citizens; EU citizens; non-EU with a valid visa; other.

If we look at the distribution of service users across immigration statuses during the pandemic (Figure 3), 56.6% of service users did not have legal status in the UK, compared to 83.4% before the pandemic. With regard to asylum seekers, 29.9% of service users during the pandemic were asylum seekers, a difference from the pre-lockdown figure, where only 6.4% of services users were identified as asylum seekers. These differences between the two time periods are statistically different. There were similar shares of service users with other immigration statuses among service users before and during the pandemic.

Figure 3: The Immigration status of service users (N=715)



Source: DOTW Service User data, January-September 2020

Analyses from the consultation notes state many reasons for the immigration situation of service users using the clinic. For many, this seems to be due to irregular or precarious immigration status, which some are in the process of trying to regularise. There were a few instances of service users seeking advice because of the disruption that the pandemic has caused to their travel plans. Among UK citizens using the service, these were mostly linked to DOTW's homeless outreach programme. It is possible that the number of asylum seekers seeking support related to an increase in the number of asylum seekers being housed in London in this period and greater use of hotel accommodation from wherein it is difficult to access GP registration. During the pandemic some asylum seekers living in contracted accommodation were given access to wifi and thus were in theory able to engage with DoTW's remote services. The relative decrease in service users who were undocumented may relate to the difficulties gaining remote access when living on low incomes and perhaps not able to afford wifi or data.

Reasons for consultation during the pandemic

The social questionnaire provides us with information about the reasons for the service users needing a consultation. During the pandemic, the most frequently mentioned reasons for consultations were as follows:

- Help with GP registration;
- Help with NHS costs;
- Queries about antenatal care;
- Queries about immigration;
- Queries about A&E and walk-in clinics; and
- Queries and advice about secondary care (including charging).

Some 38% of 750 SUs have mentioned multiple reasons for engaging with DoTW (38.08% before the pandemic and 37.89% during the pandemic).

Compared to the period right before the pandemic, and consistent with previous years, GP registration is the main reason mentioned for consultation. The percentage of GP registration was at 86.7% before, and 76.4% during, the pandemic. During the pandemic, the percentages of GP registration are 77.27%, 86.02%, and 61.9% from undocumented, asylum and others. Before the pandemic, the percentages are 89.61%, 88.46%, and 78.05%. Help with NHS costs was a highly ranked reason in both periods, with queries about antenatal care being mentioned more often during the pandemic. From the analysis of the notes, the need for GP registration is linked to many reasons, from simply wanting registration in case a health problem should arise (sometimes because of prior registration refusal), or requiring medication, to more complex situations, including multiple acute health problems and/or the need to be classified as extremely vulnerable to receive further help during the pandemic. There were also a few instances of service users needing help with secondary care, especially with regard to bills.

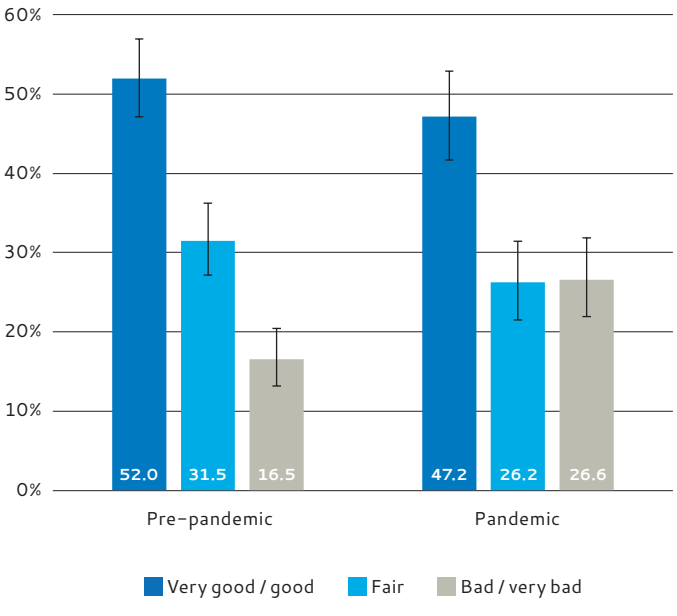
Out of the 750 data entries some 53 service users declared a pregnancy. Of those 26 were more than 12 weeks pregnant. 41 of those women had not accessed antenatal care. Specifically, of the 27 women 12 weeks or less pregnant the vast majority had not accessed antenatal care. More than half (57.69%) of 26 women more than 12 weeks pregnant had not accessed antenatal care. Pregnant service users needed either registration with antenatal services or a termination; several of these had also lost their jobs in care or hospitality due to the pandemic.

Health status

Given the focus on wellbeing during the pandemic, we also looked at the health status of service users, through measures of general health (Figure 4) as well as mental health (Figure 5). During the period of the pandemic, 47.2% of service users reported having very good or good general health, 26.2% fair health, and 26.6% bad or very bad general health. With regard to the latter, this represents a significant increase compared to the period prior to the pandemic (from 16.5% of respondents). The increase in proportion of service users presenting with bad or very bad health may suggest that those who persevered in trying to reach DoTW during the pandemic were those in greatest need. Others may have delayed trying to access care in the hope their condition would improve.

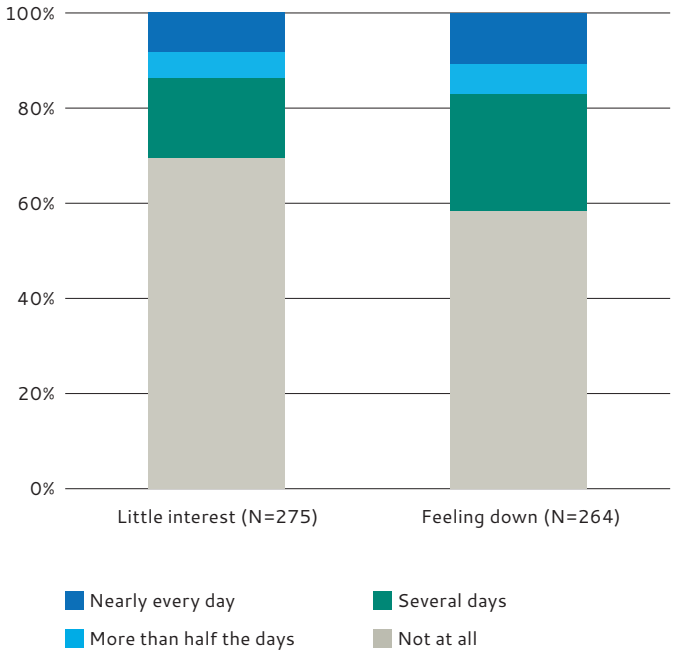
With regard to mental health, the share of service users having some level of little interest in doing things or feeling down on a regular basis was similar to the pre-pandemic period (Figure 5). Also, 15.28% of 674 service users with valid information had PHQ-2 scores of 3 or greater, which means that these service users were screened positive and should conduct a further test to determine whether they meet the criteria for a mental disorder. Once again, the shares of service users with PHQ-2 at 3 or greater were similar before and during the pandemic.

Figure 4: General health before and during the pandemic (N=705)



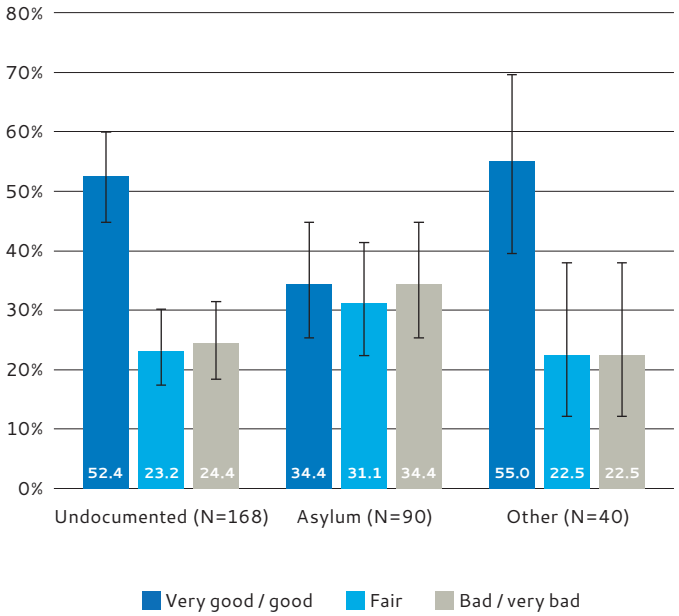
Source: DOTW Service User data, January-September 2020

Figure 5: Mental health of service users during the pandemic



Source: DOTW Service User data, January–September 2020

Figure 6: General health by immigration status during the pandemic (N=298)



Source: DOTW Service User data, January–September 2020

If we break health status down by immigration status (Figure 6) for general health, we can see that during the pandemic, the general health by immigration status varied slightly (but only significant at the 0.10 level). Whereas the general health profile of undocumented and other service users were relatively similar, the health profile of service users within the asylum seeker/refugee category was more skewed toward poorer general health outcomes, especially with regard to the low level of reporting of very good or good general health.

Looking at differences in mental health outcomes by immigration status, undocumented migrants had a slight, but not significant (only significant at the 0.05 level), higher share of having PHQ-2 scores at 3 or greater compared with asylum seekers during the pandemic. there was a lower proportion of asylum seekers reporting no instance of little interest in doing things compared to the undocumented service users. A higher proportion of asylum seekers reported feeling down for several days compared to undocumented service users.

Barriers to healthcare

We conclude this section on evidence with an overview of the barriers to healthcare access mentioned by the service users during the pandemic (when access was either required or an issue) as identified from the free notes. The most often mentioned barrier to healthcare mentioned is linked to the *lack of understanding of knowledge of the healthcare system*. This was especially the case, from the notes, with regard to antenatal care. The second most often mentioned barrier was that *of administrative barriers*, especially with regard to GP registration. This was exemplified in the consultation notes by practices demanding proof of ID and address, which in some instances could be problematic (due to, for example, expired ID documents or living in precarious accommodation). In most instances, DOTW-issued letters would suffice. Other administrative barriers included practices stating that they were not registering new patients due to the pandemic and difficulties with registering over the phone or online. On the latter point, technological or financial barriers also impeded GP registration (such as availability of internet or phone credit; access to a phone or printer). A few service users worried about *fear of arrest or immigration enforcement* on the part of the Home Office. There were also linguistic barriers, either with regard to needing an interpreter or not having confidence in speaking English. Finally, financial barriers and denial of healthcare coverage were also mentioned. In the case of the former, this was linked to the ability to pay for medication or secondary care, or even having to access healthcare privately.

There were many barriers encountered by the service users, most of which were resolved by using the DOTW service (who try to either signpost to appropriate service or help with GP registration). Seeking resolution could also be a lengthy process, even for people with a high level of knowledge of the system. It is important to note here that, before and during the pandemic, the main barriers mentioned remained more or less the same, with issues related to financial barriers and denial of healthcare coverage being more often mentioned during the pandemic. Yet, our findings highlight the needs of some of the people most at risk of vulnerability during the pandemic (which has most likely remained if not increased since), and where barriers may arise – and may need engaging with.

Discussion

Our analysis of the DOTW data showed that as the COVID-19 pandemic and associated lockdown conditions evolved and DOTW moved their services to remote provision changes were evident in the numbers of service users who contacted the service, the profile of service users, their health status and the reasons why they made contact. There was a significant drop in service users indicating that a shift to remote services may have impacted on the ability of users to access services. The change in user profile with a higher proportion of asylum seekers in contact and a lower proportion of undocumented migrant was notable. The slowdown in dispersal and move to shift asylum seekers in hotels in London without a structured mechanism for them to access healthcare may have been an explanatory factor. DOTW was able to reach out to the clusters of asylum seekers in hotels which may have facilitated access. Further a reduction in levels of contact by undocumented migrants may have related to them being more difficult to reach to share news of a change in service delivery mechanisms but might also reflect poor access to data or telephones especially given the loss of employment in the precarious sectors known to employ more undocumented migrants. Further pre-pandemic, most people accessing the DOTW service did so following word of mouth information sharing, and drop in / no appointment clinics were a key feature of the service intended to meet the needs of a patient group that is mistrustful of authorities and thinks they aren't entitled to healthcare services (i.e. undocumented migrants). So during the pandemic this key adaptation – which particularly suits undocumented people- was lost.

A further notable change was in the proportions of service users reporting good or poor health with a clear shift to a deterioration in general health. Given the reduction in numbers it is likely that those who made contact were those who had greater levels of need. In addition more asylum seekers reported poor health than pre-pandemic. Such a change may relate to the changes in housing practice but also explain why a greater proportion sought support from the service.

The nature of services sought changed little from pre-pandemic although there was an increase in women seeking access to maternity care or termination. DOTW was largely able to resolve the concerns of those in contact but it is important to note that often resolutions took a great deal of time and expertise with DOTW engaging in multiple interactions to achieve a resolution. That many barriers were systemic and so complex to resolve is worrying. Given the large drop in service users during the period of our analysis and the complexity of resolving problems around access and understanding it is possible that significant unmet need remains while services are remote.

Limitations

Our data analysis covers what might be described as the early pandemic period. Over time it is possible that service users became more accustomed to remote provision and began to return to the service in larger numbers. A limitation to this report is that the quantitative analysis covers a large share of DOTW service users instead of the whole population, because of the incomplete match between service user and social forms due to missing information of certain service users. The qualitative data only constitutes the notes made by volunteers which provide 'snapshots' of the service user's situation at different stages of their journey but not the opportunity to probe or ask additional questions.

Policy recommendations

- Remote provision clearly does not enable contact from all migrants requiring support to access healthcare. As the UK returns to a greater degree of normality reinstating some face to face provision is important to ensure all needs are addressed.
- The increase in asylum seeker users and deterioration in general health in this group points towards potential problems with a) access to healthcare for those housed in hotels b) the health of those living in hotels. The Asylum Providers Accommodation contract should be amended so the statement of requirements includes people in initial / contingency accommodation receiving support to register with a GP following the HA Select Committee recommendation.[4]

4 https://publications.parliament.uk/pa/cm5801/cmselect/cmhaff/562/56208.htm#_idTextAnchor087

- Individuals living in initial and contingency accommodation should be provided with information in a language they understand on:
  a. their right to NHS services
  b. how to access prescription medication
  c. how to use NHS services
  d. how to access COVID-19 information and testing services.
- Provision of wifi or data should be a priority for people living in poverty so that they are not excluded from services as they move online.
- GP surgeries should be encouraged to continue to register new patients throughout the pandemic.
- Policymakers should ensure access to healthcare, especially GP registration, for all migrants, asylum seeker and refugees.
- Increasing migrants' and practitioners' understanding and knowledge of the healthcare system, especially awareness of the charging exception. This is vital for both healthcare professionals and individuals at risk of vulnerability. Clear guidance should be provided on the government website in different languages.
- Given that not everyone has been vaccinated, it is necessary to distribute free face masks to individuals at risk of vulnerability, because they often rely heavily on public transport and lack resource to purchase PPE.

Appendix

This section contains the questionnaire that has been used in the quantitative study. All the questions used in this report are highlighted with grey colour.

Quantitative questionnaire

Home Page data

2	**Service user number**	*(free text)*			
4	**What is your sex?**	☐ Not asked	☐ Male	☐ Female	☐ Other
5	**What is your date of birth?**		☐ Not asked	*(dd/mm/yyyy)*	☐ Don't know
6a	**What is your nationality?**	☐ Not asked	*(ISO)*	☐ Stateless	
		☐ Not applicable	☐ Don't know		

Name

Address

Phone number

DOB

Social form

2	**Service user number**		*(free text)*		
3	**Consultation date**		*(dd/mm/yyyy)*		
	Interpreter required?				
	☐ [1] No		☐ [2] Yes – language [drop down]		
	☐ [2a] Yes – provided by phone ☐ [2b] Yes – present				
	Borough				
	Borough drop down list				
7	**How would you describe your accommodation?**				
	☐ Not asked	☐ Roofless (without a shelter of any kind, sleeping rough)	☐ Inadequate house (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)	☐ Houseless (with a place to sleep but temporary in institutions or shelter)	☐ Insecure house (without tenancy agreement / risk of eviction, with friends and family, longer term homeless accommodation)
	☐ Household with secure tenancy (personal room, flat or house)	☐ Other	☐ Don't know		
8	**On average, how much money do you have a month (before housing costs)?**				
	☐ Not asked	☐ Over £836	☐ Under £836	☐ Don't know	

9a	**What is your immigration status?**				
	☐ Not asked	☐ National or citizen	☐ EU/EEA citizen– living in the country under 3 months	☐ EU/EEA citizen – living in the country over 3 months and not exercising treaty rights	☐ EU/EEA citizen – residing over 3 months and exercising treaty rights
	☐ From outside EU/ EEA – with current asylum or human rights claim	☐ From outside EU/ EEA – refugee status (inc. Humanitarian protection and discretionary leave)	☐ From outside EU/ EEA – refused asylum or human rights claim	☐ From outside EU/ EEA –with a valid visa or work permit	☐ From outside EU/ EEA: No legal status
	☐ Don't know	☐ Other			
9b	**[for non-nationals] How long have you lived in this country (since you last entered the country)?**				
	☐ Not asked	*(years; months)*	☐ Not applicable (national)	☐ Don't know	
10	**How is your health in general? Is it…**				
	☐ Not asked	☐ Very good	☐ Good	☐ Fair	☐ Bad
	☐ Very bad	☐ Don't know			
	Over the last 2 weeks, how often have you been bothered by any of the following problems?				

		Not asked	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**	Don't know
11a	**Little interest or pleasure in doing things**	☐	☐	☐	☐	☐	☐
11b	**Feeling down, depressed or hopeless**	☐	☐	☐	☐	☐	☐

12	**Do you have any healthcare coverage at the moment? (service user's perception, not their entitlement)**				
	☐ Not asked	☐ Yes – full healthcare coverage	☐ Yes – partial healthcare coverage (more than emergency care only, less than full coverage)	☐ Yes – for emergency care only	☐ No healthcare coverage (charged full cost or excluded from all healthcare services)
	☐ Other	☐ Don't know			
13	**Have you experienced any obstacles / barriers when accessing healthcare? (tick all relevant boxes)**				
	☐ Not asked	☐ No – did not try to access healthcare because not needed	☐ No – had good/easy access to healthcare services	☐ Lack of understanding or knowledge of the system and rights	☐ Administrative and documentation barriers
	☐ Denied health coverage	☐ Denied health care by a healthcare provider	☐ Financial barriers (healthcare services, medication or insurance too expensive)	☐ Language barriers	☐ Fear of arrest / immigration enforcement in healthcare services
	☐ Deterred by previous experience of discrimination or stigma	☐ Other barrier / obstacle	☐ Don't know		
14a	**Are you pregnant?**				
	☐ Not asked	☐ Yes	☐ No	☐ Not sure	
14b	**How many weeks pregnant are you today?**				
	☐ Not asked	*(##)*	☐ Not sure	☐ Not applicable	
14c	**Did you receive antenatal care prior to this visit?**				
	☐ Not asked	☐ Yes	☐ No, no antenatal care received	☐ Not sure	☐ Not applicable (e.g. if seeking a termination of pregnancy)

11 (d) Would you like information about contraception / family planning?					
☐ [1] Yes – given information	☐ [2] Yes – accessed via DOTW GP	☐ [3] Yes – booked in for appointment with consultant	☐ [4] Yes – given condoms	☐ [5] No – declined	☐ [6] No – not offered
Do you have any children?					
Yes – home country	Yes – UK (record details if u18)	No	Not asked		
When did you last see a dentist in the UK					
☐ [1] Never	☐ [2] Last 12 months	☐ [3] 1–2 years	☐ [4] 2+ years	☐ [5] Not asked	
When did you last have an eye test in the UK					
☐ [1] Never	☐ [2] Last 12 months	☐ [3] 1–2 years	☐ [4] 2+ years	☐ [5] Not asked	
Would you like screening today for HIV and STIs?					
☐ [1] Yes – informed consent gained and screening completed	☐ [2] No – screening declined	☐ [3] No – screening not offered			
Would you like to be invited back for a chest x-ray?					
☐ [1] Yes	☐ [2] No – declined	☐ [3] No – not offered			
What have you been helped with today?					
GP registration	ANC referral	ToP referral	Secondary care access – advice	Secondary care access – charging advice	
Help with NHS costs (HC1 form)	How to get immigration advice	How to get destitution support	Foodbank referral	How to access A+E / walk in centre	
How to access counselling	How to access a dentist	How to access an optometrist			

References

Aragona, M., Barbato, A., Cavani, A., Costanzo, G., Mirisola, C., 2020. Negative impacts of COVID-19 lockdown on mental health service access and follow-up adherence for immigrants and individuals in socio-economic difficulties. Public Health 186, 52–56. https://doi.org/10.1016/j.puhe.2020.06.055

Aultman, J.M. (2019) How Should Health Care Professionals Address Social Determinants of Refugee Health? AMA Journal of Ethics, 21 (3): 223–231. doi:10.1001/amajethics.2019.223.

Behbahani, S., Smith, C.A., Carvalho, M., Warren, C.J., Gregory, M., Silva, N.A., 2020. Vulnerable immigrant populations in the New York metropolitan area and COVID-19: Lessons learned in the epicenter of the crisis. Academic Medicine 95, 1827–1830. https://doi.org/10.1097/ACM.0000000000003518

DOTW UK, 2017. Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances. DOTW UK, London. https://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/Research_brief_KCL_upfront_charging_research_2310.pdf

DOTW UK, 2020a. A rapid needs assessment of excluded people in England during the 2020 COVID-19 pandemic. DOTW UK, London. http://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/05/covid19-full-rna-report.pdf

DOTW UK, 2020b. Delays and destitution: An audit of Doctors of the World's hospital access project (July 2018-20). DOTW UK, London. https://www.doctorsoftheworld.org.uk/wp-content/uploads/2018/11/Delays-and-destitution-An-audit-of-Doctors-of-the-Worlds-Hospital-Access-Project-July-2018-20.pdf

Galam, R., 2020. Care and solidarity in the time of Covid-19: The pandemic experiences of Filipinos in the UK. Philippine Studies-Historical and Ethnographic Viewpoints 68, 443–466. https://doi.org/10.1353/phs.2020.0028

Germain, S., Yong, A., 2020. COVID-19 highlighting inequalities in access to healthcare in England: A case study of ethnic minority and migrant women. Feminist Legal Studies 28, 301–310. https://doi.org/10.1007/s10691-020-09437-z

Godin, M., 2020. *Black and Asian Groups More Likely to Die From Coronavirus* (n.d.). Time. Available at: https://time.com/5832807/coronavirus-race-analysis-uk/ (Accessed: 11 May 2020).

Hu, Y., 2020. Intersecting ethnic and native-migrant inequalities in the economic impact of the COVID-19 pandemic in the UK. Research in Social Stratification and Mobility 68, 100528. https://doi.org/10.1016/j.rssm.2020.100528

Jayaweera, H., 2014. Health of migrants in the UK: What do we know? Migration Observatory Briefing.

Karim, M.R., Islam, M.T., Talukder, B., 2020. COVID-19's impacts on migrant workers from Bangladesh: In search of policy intervention. World Development, 136, 105123. https://doi.org/10.1016/j.worlddev.2020.105123

Kroenke, K., Spitzer, R.L., Williams, J.B. and Löwe, B., 2010. The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. General Hospital Psychiatry, 32(4), pp.345-359.

Lessard-Phillips, L., Lindenmeyer, A., Phillimore, J., Hamid, F. and Jones, M.L., 2019. Vulnerable migrants and wellbeing: A pilot study. https://mk0nuffieldfounpg9ee.kinstacdn.com/wp-content/uploads/2019/11/Final20report20-20February20201920-20Project20433831.pdf

Liberty, 2019. A guide to the hostile environment: The border controls dividing our communities–and how we can bring them down. https://www.libertyhumanrights.org.uk/wp-content/uploads/2020/02/Hostile-Environment-Guide---update-May-2019_0.pdf

Medact, Migrants Organise, New Economics Foundation, 2020. Patients not passports - Migrants' access to healthcare during the coronavirus crisis. Medact. https://www.medact.org/2020/resources/briefings/patients-not-passports-migrants-access-to-healthcare-during-the-coronavirus-crisis/ (accessed 3.22.21).

Shen, J., Bartram, D., 2020. Fare differently, feel differently: mental well-being of UK-born and foreign-born working men during the COVID-19 pandemic. European Societies. https://doi.org/10.1080/14616696.2020.1826557

Doctors of the World (DOTW) UK is part of the Médecins du Monde international network, an independent humanitarian movement. DOTW has been a registered charity in England and Wales since 1998 and runs clinics providing medical care, information, and practical support to people unable to access NHS services. Our patients include refugees, asylum seekers, survivors of human trafficking, people experiencing homelessness, sex workers, migrants with insecure immigration status and Gypsy, Roma, and Traveller communities.

The Nuffield Foundation is an independent charitable trust with a mission to advance social well-being. It funds research that informs social policy, primarily in Education, Welfare, and Justice. It also funds student programmes that provide opportunities for young people to develop skills in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Nuffield Council on Bioethics and the Ada Lovelace Institute. The Foundation has funded this project, but the views expressed are those of the authors and not necessarily the Foundation. Visit **www.nuffieldfoundation.org**

The University of Birmingham is ranked amongst the world's top 100 institutions. Its work brings people from across the world to Birmingham, including researchers, teachers and more than 6,500 international students from over 150 countries.

doctorsoftheworld.org.uk

6th Floor, One Canada Square, London, E14 5AA
(Hosted rent free by Canary Wharf Group plc)
020 7167 5789 · info@doctorsoftheworld.org.uk