



Migrant-inclusive healthcare delivery in the UK: Lessons learned from the COVID-19 Pandemic

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The COVID-19 pandemic has highlighted the health inequalities experienced by many underserved migrants in the UK, but has also generated unique opportunities to reflect on lessons learned in migrant-inclusive healthcare delivery.¹ Some underserved migrant communities (foreign-born nationals including asylum seekers, refugees, undocumented migrants, low-skilled labour migrants) were at additional risk of infection and over-represented among COVID-19 cases and death, due to a range of risk factors such as working in low paid, precarious, and public facing jobs, living in overcrowded accommodation and facing barriers to healthcare.^{1,2} Although exemptions for free COVID-19 treatment and vaccination irrespective of immigration status were quickly put in place, they were undermined by unclear or delayed messaging to these communities and healthcare staff. The pandemic, however, clearly demonstrated that it was possible to rapidly design and implement more inclusive approaches to service delivery and public health communications.^{2,3} Reflecting on the UK context, we discuss lessons learned in reducing access barriers, improving services delivery, building trust within migrant communities, and recommendations for ensuring migrant-inclusive healthcare in the UK and Europe.

The pandemic exacerbated longstanding legal and access barriers that some migrants face when seeking healthcare. Migrants in England were less likely to use primary care than non-migrants before and during the first year of the pandemic,⁴ as General Practices (GPs)

ceased new registrations or, contrary to official guidance, demanded proof of address, identification, or evidence of immigration status when registering.⁵ This restricted access to COVID-19 vaccination when roll-out began, which often required GP registration and an National Health Service (NHS) number.^{2,5,6} For registered migrants, shifts from in-person to remote consultations posed challenges due to limited translation support and barriers to accessing care online.^{2,6} However, as the vaccine roll-out gathered momentum, various inclusive vaccination campaigns began, including walk-in community vaccine centres with flexible timetables and mobile vaccination vans, outreach targeted at populations with low GP registration, providing assistance with GP registration at vaccination points, and working with community partners to ensure accessibility.⁷ A period of research and reflection is now needed to formally evaluate what approaches to inclusive service delivery worked for future pandemics and importantly for current routine vaccine programmes.

Rapid and clear public health messaging is key to an effective pandemic response. While Public Health England translated COVID-19 guidance into multiple languages from March 2020, there was a need make these translations rapidly available and to widen the selection of languages and formats.⁶ Innovative communications campaigns from third sector organisations included DOTW COVID-19 Vaccine Confidence Toolkit which was co-designed with migrants and translated into twenty languages, information sessions at community and religious centres, and social media campaigns about vaccination delivered by migrant and ethnic minority healthcare workers across London.^{6–8} Public health messaging works better if it is co-designed with communities and delivered by trusted groups.^{6,8}

Some migrant communities have a well-founded distrust of official bodies. The UK's 'hostile environment' resulted in a suite of policies aiming to make life untenable in the UK for individuals without immigration status. Policies that restrict healthcare access such as charging for secondary care and data sharing between

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On behalf of the Doctors of the World Expert Consortium on Refugee and Migrant Health (members listed at the end of the comment)

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the NHS and immigration enforcement have impacted some migrants' willingness to access NHS services.^{3,6} The introduction of increasingly draconian immigration policies, such as the policy to send certain refugees to Rwanda, has exacerbated fear in public welfare services further.⁷ Rebuilding trust with migrant communities was and will continue to be key, and examples of good practice seen during the pandemic in the UK include partnerships with community groups, no questions-asked access to testing and vaccination, and clear communication on healthcare entitlements.^{8,9}

Given the disproportionate impact of the pandemic on migrants, we call on the UK COVID-19 Inquiry to properly consider the experiences of migrants, including those with insecure immigration status during the pandemic.¹⁰ Panel 1 summarises a call for action in key areas of relevance to the UK and other European countries. The pandemic has demonstrated that the UK, and other countries across Europe, can integrate underserved migrants into an emergency health response, with a wider acceptance now that migrants deserve access to routine healthcare. As has been seen in the UK, building migrant-inclusive health is politically challenging. However, without an inclusive approach, our ability to respond adequately and equitably to any future emergencies will be severely hampered.

Key areas requiring action:

1. Action by governments to address the structural barriers that lead to the marginalisation of certain migrant groups, including action on the intersection of ethnicity, gender, disability, sexuality, and age.
2. Any national reviews of the impact of COVID-19 on populations should include the experiences of migrants.
3. Action to ensure universal healthcare access for all migrants, including inclusive healthcare data systems that are not shared with immigration authorities.
4. There is an urgent need to improve migrant-disaggregated datasets pertaining to health and vaccination.
5. Any healthcare organisations or governments managing future health emergency responses should ensure any interventions and messaging are co-designed with local migrant communities to ensure maximum uptake and access.
6. Governments and healthcare systems should ensure all public health messaging is culturally and linguistically appropriate, and available in a range of languages and formats with routinely available translation teams to ensure rapidly updated information is available to all migrant communities.
7. Action by local and national media, advocacy, and governmental organisations to reframe the narrative on migration.

Doctors of the world expert consortium on refugee and migrant health members

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Declaration of interests

All authors declare no conflict of interests.

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