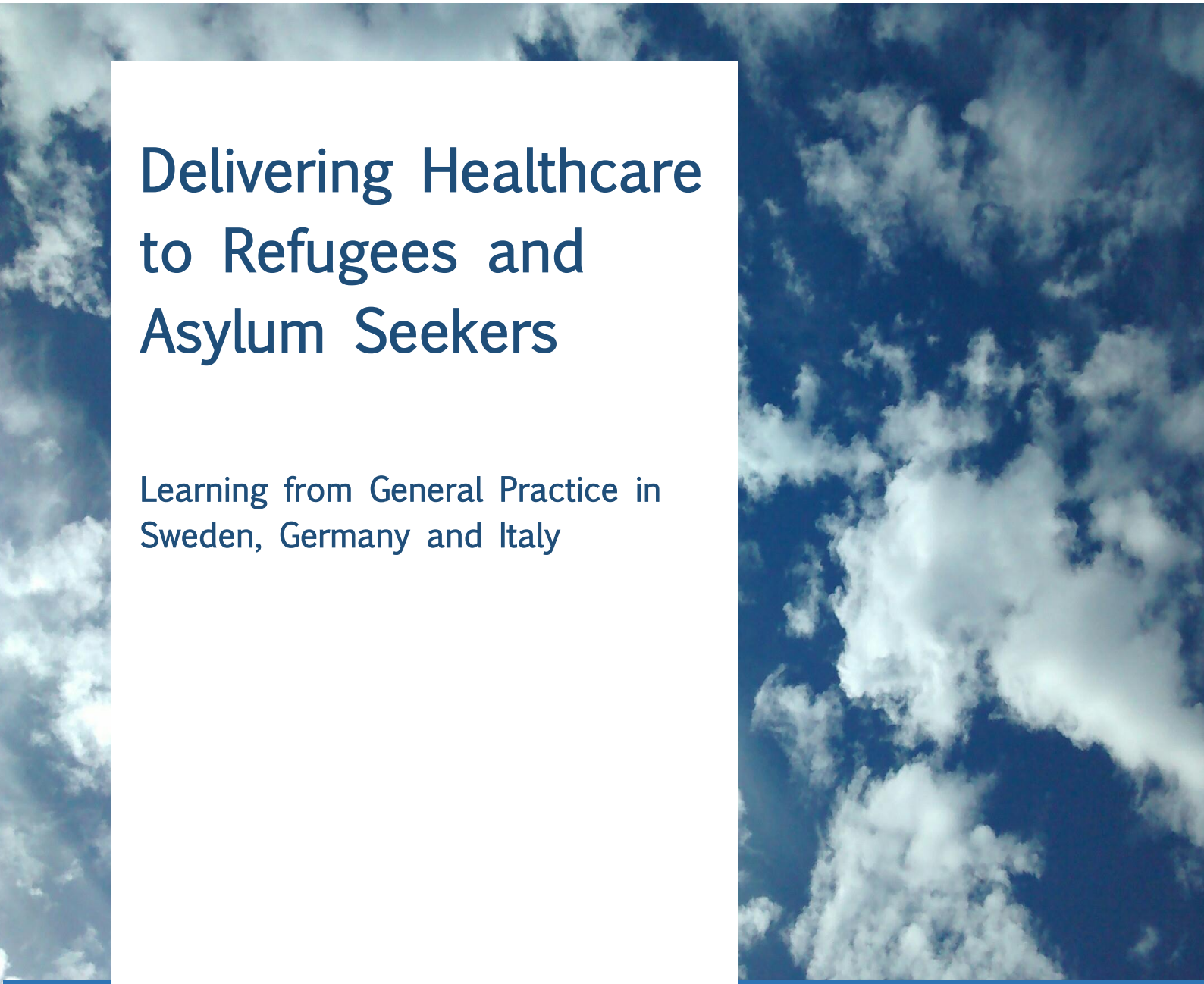

Delivering Healthcare to Refugees and Asylum Seekers

Learning from General Practice in Sweden, Germany and Italy

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WINSTON CHURCHILL MEMORIAL TRUST

Contents

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About the Winston Churchill Memorial Trust

The Winston Churchill Memorial Trust runs the Churchill Fellowships, a unique programme of overseas research grants. These support UK citizens from all parts of society to travel the world in search of innovative solutions for today's most pressing problems.

About the author

I was awarded a Fellowship by the Winston Churchill Memorial Trust in 2018. At the time I completed this project, I was working for the Care Quality Commission (CQC): England's regulator for health and social care services. At CQC, I led qualitative research and analysis projects relating to the GP and Acute sectors. It was working on CQC's *The state of care in general practice 2014-2017* report that sparked my interest in the role of general practice in meeting the needs of patients whose circumstances might make them vulnerable. From April 2019, I will be continuing my career in health-related research as Principal for Population Health at Greater Manchester Combined Authority. The views shared in this report are mine, not those of my current or former employers.

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Executive summary

This report presents findings from research completed as part of a Winston Churchill Memorial Trust Fellowship. The aim of the research was to explore how GPs in Sweden, Germany, and Italy are responding to the needs of refugees and asylum seekers. To achieve this, face-to-face interviews were held with GPs, primarily, from each country. Conversations were also held with academics and others with interest and expertise in the subject. The research was carried out in September and October 2018.

Migration policy and attitudes towards migration are topical issues in all three countries. Some interviewees were concerned about the impact of policy, and in some instances the rise of anti-migrant rhetoric, on refugees', asylum seekers', and undocumented migrants' rights to access healthcare. Interviewees highlighted a range of further challenges affecting migrant groups' experience of primary care, including: social determinants of health; perceived cultural differences; gender; language; and wider issues in the GP sector, such as staffing.

The research highlighted a variety of approaches that have emerged in response to these challenges. These included: information and support for GPs; cultural mediation between patients and healthcare professionals; multidisciplinary team working within GP services; and holistic approaches.

The project also sought to understand the impact and effectiveness of these approaches; however, the interviews and conversations revealed little in the way of formal evaluation and limited regulation and oversight of general practice in all three of the countries visited. Significantly, the project did not involve interviews with patients and therefore the research offers only a partial perspective.

There is no 'formula' for ensuring that general practice meets the needs of refugees and asylum seekers; neither can the approaches identified in this report necessarily be transferred to England. The research does, however, highlight approaches and principles that are important in meeting the needs of refugees, asylum seekers, and other patients whose circumstances may make them vulnerable. These include: multidisciplinary team working; recognising consultations as cross-cultural encounters; and holistic approaches to healthcare.

Achieving this requires not only skilled and motivated staff, but also: investment in the GP sector, including efforts to sustain and grow the workforce; training and development for GPs; and due consideration by Clinical Commissioning Groups in the commissioning of GP services. There is also an important role for regulators. The commitment of England's regulator for health and social care services, the Care Quality Commission, to embed a human-rights based approach within its regulation of GP services is an ambition to be welcomed.

1. Introduction

General practice is the first point of contact for most patients in the NHS and has potential to play a key role in supporting refugees and asylum seekers through the treatment of physical and mental health; however, some GP services in the UK struggle to manage the rights and needs of refugees and asylum seekers to access the NHS[1]. Existing research has identified a range of barriers to these patient groups' access to general practice. These include: differing experiences and expectations of primary care; a lack of shared language between patients and GPs; cultural differences between patients and GPs; patients' lack of awareness of primary care; and GPs' lack of awareness of refugees' and asylum seekers' rights to access primary care.

The aim of this project was to explore how other European countries are responding to these challenges and to consider what learning can be applied within England. To that end, the project sought to answer the following question:

> *What can the UK learn from how general practice in Sweden, Germany, and Italy has responded to the needs of refugees and asylum seekers?*

In doing so, the project explored the following sub-questions:

1. *What are the perceived challenges in delivering general practice to refugees and asylum seekers?*
2. *How have these challenges been overcome through policy and/or practice?*
3. *What has been the impact and effectiveness of such policies and/or practice?*

This report presents findings, reflections, and conclusions from research conducted in Sweden, Germany, and Italy in September and October 2018.

[1] http://www.rcgp.org.uk/policy/rcgp-policy-areas/asylum-seekers-and-vulnerable-migrants.aspx

2. Methodology

The research involved semi-structured interviews with GPs, primarily, in each of the three countries. Representatives from voluntary sector organisations were also interviewed and informal conversations held with academics and others with interest and expertise in the subject. Interviews were held face-to-face.

Potential interviewees were identified with the support of a representative of the European General Practice Research Network[2] (EGPRN) who agreed to act as 'gatekeeper', providing contact details for representatives from each country. As the EGPRN representative was based in Germany, they kindly agreed to arrange interviews with GPs with whom they had contact. For Sweden and Italy, a 'snowball sampling' approach was used with the initial contacts, recommended by EGPRN, being asked for suggestions for other local organisations and individuals with whom to make contact. In Sweden, interviews were arranged with the support of a 'gatekeeper'.

In addition to the interviews, meetings were held with numerous experts that had knowledge and experience of migrant health issues. Experts were identified via word-of-mouth and relevant literature.

The research did not involve interviews with patients. Whilst the views and experiences of refugees and asylum seekers would have been very valuable in answering the research questions, there were significant ethical considerations given refugees and asylum seekers are potentially vulnerable groups: discussing physical and mental health needs, and any associated traumatic experiences, could have proven upsetting to participants.

Furthermore, language barriers could have made it difficult to ensure informed consent had been sought. Given this, it is an important caveat to this report that it presents findings from a professional, GP perspective, rather than that of people that have used GP services.

[2] https://www.egprn.org/

3. Context

Across Europe, the rights of refugees and migrant populations to access healthcare is often restricted based on legal status; irregular migrants, in particular, have increased difficulty in accessing healthcare. This is despite the right to health being recognised as a human right. Whilst Italy's national health service offers, at least in theory, full access to all migrant groups without charges, in Sweden and Germany irregular migrants are restricted to urgent care, or 'care that cannot wait'.

In all three countries, migration has been high on the political agenda especially since what has become known as the European 'migrant crisis' of 2015 which saw thousands of migrants arriving in Europe following often perilous journeys via the Central Mediterranean and Eastern Mediterranean routes.

Across Europe, there has been a rise in populist and often anti-migrant rhetoric. At the time this project was conducted, Sweden was trying to form a new government following an inconclusive general election in September 2018. The election saw the Swedish Democrat party, a right-wing, populist party, increase its vote share to become the third largest party in Sweden. In Germany, the right-wing populist party, Alternative for Germany, became the third party in the federal parliament following elections in 2017. In Italy, a general election in 2018 had resulted in a hung parliament with the populist League party emerging as the main political force. Since then, a series of restrictive measures have been introduced to reduce the protection provided to migrants and make deportations easier, whilst ships rescuing migrants from the Mediterranean Sea have been blocked from Italy's ports.

4. Findings

The starting point for discussion in most of the interviews was the current social and political context: the apparent rise, in varying degrees, of populist, anti-migrant politics in Sweden, Germany, and Italy. The interviews also explored the challenges that GPs and other health professionals encounter in working with refugees and asylum seekers. Interviewees also discussed irregular migrants; both specifically and in reference to 'migrant groups/patients', incorporating refugees, asylum seekers, and irregular migrants.

Interviewees shared their views as to the challenges that these patient groups' experience in accessing primary health care; however, it is important to note that this reflects GPs'/health professionals' views and experience rather than the lived experiences of patients themselves. Interviewees were also asked how the challenges encountered were being met through policy and/or practice.

4.2 Societal context

Anti-migrant rhetoric

Migration policy and attitudes towards migration were topical issues in all three countries. In Germany, some interviewees highlighted what they saw as a rise in right-wing politics. One interviewee cited a recent incident in Chemnitz and subsequent anti-immigration protests and suggested that anti-refugee and asylum seekers attitudes were influenced by:

"Politics, the newspapers, the news agencies, the TV." GP, Germany

Another GP commented:

"In general, I would say [society is becoming] more right-wing and there is more populism... but I'm not sure amongst healthcare providers... they do not close their minds and may have developed a negative attitude [towards refugees, asylum seekers, and irregular migrants]." GP, Germany

However, another interviewee in Germany had a contrasting view: that, since the 'refugee crisis' of 2015, the German population (including health professionals) had adapted to changes in society.

"I think most of the people are getting used to [immigration]. It was at first a surprise for a lot of people, doctors and the general population. I think the population is getting more and more adapted." GP, Germany

In Italy, which has seen a marked rise in populist and anti-migrant politics, one GP described the challenges of negotiating this within a healthcare setting.

"What I see [as being] dramatically different is the public opinion... 10 years ago people weren't as angry with migrants... In the waiting room, I hear the old people say, 'Why do we have to divide the doctors with these people?' That is very sad to me. I respond to them and tell them that [the migrants] have the same right. But it's very difficult." GP, Italy

In Sweden, many of the interviewees were concerned about the apparent shift towards anti-migrant rhetoric and politics and what this meant for migrant groups' access to healthcare

in the future (see more in section 4.3). One interviewee, from a service that focused on refugee and asylum seeker healthcare, reported having been targeted by what they described as *"extremists"*:

"What is happening in society is affecting us. We have letters threatening us, [saying] 'We will burn down your clinic'." Service coordinator, Sweden

Role of health in integration

Whilst not a key focus for the project, several interviewees reflected on the role of health in supporting migrant groups' integration into their community and society.

"It is easier to engage someone that is in good health." GP, Italy

"The health service is the first step to integration. When people come to Italy, they are in a centre and the centre will deal with everything... Health is the first official office they encounter." Anthropologist, Italy

One GP in Germany suggested that learning the German language was vital for integration and recognised that poor health could inhibit this:

"The first step is to learn German and if you have pain you cannot learn German... Good health is important for the first step of learning German and the next step of finding work." GP, Germany

Another interviewee felt that health was *"very important"* for integration and that this went beyond just their physical health:

"Being healthy doesn't mean only having good blood pressure, it means having dignity and to have social rights. A refugee to be healthy must have a place to live, the opportunity to establish networks... they do not have familiar networks, friends because it's not automatic that they live together." GP, Italy

This points towards the importance of wider determinants of health, explored further in section 4.3 of this report.

4.3 Challenges

Access and rights

Interviewees from all three countries cited access issues as inhibiting refugees', asylum seekers', and irregular migrants' experience of primary healthcare. Some highlighted practical factors, such as GP surgeries' opening hours not aligning with the shift patterns of patients working in low-pay industries:

"They have sporadic access to us. We can't make plans... They work more than the Italians... They have different working hours. They might be free in the evenings, but we aren't working in the evening." GP, Italy

In Germany, one interviewee highlighted that finding a GP willing to accept new patients can be difficult:

"[It is a challenge] to find healthcare provider that are willing to treat them... Not in a malevolent way, that they don't want to treat non-German speakers, but it's demanding in the GP office and in many areas it's a matter of capacity." GP, Germany

Others highlighted that, for some refugees, asylum seekers, and irregular migrants, navigating the health system was a barrier to accessing primary healthcare particularly for those that are newly arrived and becoming accustomed to a new way of life:

"If you turn the coin around and if we *were forced to leave our native country to a foreign country, we would face a new culture, a new environment… It is a chaotic situation. This is the same thing that people that come here experience." GP, Sweden*

Similar views were held by interviewees in Germany:

"The biggest problem is to understand the system, to understand that they need to make an appointment. After a few months they know how it works." GP, Germany

"[It is a challenge for patients] to know where and at what place to get the insurance papers and to get into the social and health system." GP, Germany

This was echoed by interviewees from the voluntary sector, including an organisation that provided healthcare, primarily, to irregular migrants:

"The biggest challenge is [irregular migrants'] lack of knowledge… a lack of understanding of how everything is, the healthcare system." Representative of an NGO, Sweden

Some interviewees were keen to highlight they were speaking from their professional experience, not from lived experience. One GP's impression, from working with patients from migrant backgrounds for many years, was that to try to navigate the system:

"[Refugees, asylum seekers, and irregular migrants] take help from people that came here before, such as members of their family. Some people do not know anybody, and they are left to try to make friends who have contact with healthcare, to find out 'Where do I go?', and so on." GP, Sweden

Others perceived patients' anxiety as a factor inhibiting their access to primary care. For irregular migrants, in particular, some interviewees suggested that patients are concerned about sharing personal details for fear of 'the authorities':

"They are so scared to stand in front of receptionist and say, 'My name is…' and everything, it is so challenging. They try to go [to GP surgeries] but they are asked 'Where do you live? When were your born?' Often, they lie and it's very hard to go back for follow up… To prove your identity is a challenge for them and us." Representative of an NGO, Sweden

"For irregular migrants it's really difficult to come to primary care because they want to seek help but they are scared that they will have some contact with other authorities." GP, Sweden

From the health system perspective, interviewees noted that GP surgeries were not always aware of patients' rights to access primary healthcare, especially irregular migrants, resulting in difficulties for patients in registering:

"For undocumented migrants, they come to the reception with no papers or ID cards. And then there is usually confusion… Things are getting better since the new law, but there are still problems." GP, Sweden

"Sometimes the person in the practices aren't aware of the rights of the undocumented. It is getting better but still, they are not up to date on the legislation… [Practices'] focus is 'we have to register the patient' but that's not that important, what's important is their health. It can be difficult to access primary care." GP, Sweden

In both Italy and Sweden, asylum seekers and refugees are required to pay a fee for aspects of primary healthcare. Whilst comparatively small, interviewees highlighted that the costs could prove prohibitive for patients with little money and no income:

"Once they have the asylum request you can have a GP… In Italy we pay a small user fee for blood tests, or analysis or secondary care… it's small but not so small for persons who have nothing." GP, Italy

"It costs 50 kroner to go to the doctor and 50 kroner for your medications… 50 kroner could be too much money. [Money] should never stop a person from [accessing primary healthcare]." NGO representative, Sweden

In Germany, several of the GPs interviewed suggested that refugees' and asylum seekers' access to healthcare was perhaps too generous:

"For now, I think we do enough; I think we do more than enough… Sometimes I fear I do more for the immigrant than for the German patient." GP, Germany

"They have good access. Maybe the access is too easy." GP, Germany

"The money is not a problem, but it's not really fair for people living here… How can you explain to mother of German child [that they will have to pay for medicines once the child is 13] and that a refugee that has never paid insurance but gets more? German patients comment…" GP, Germany

Whilst there appears a contrast between the views of interviewees in Sweden and Italy (which advocated an open system) and the more conservative views of the German interviewees, this may be as a result of differences in the samples. In Sweden and Italy, most of the interviewees were actively involved in migrant health due to professional and personal interest whereas most of the interviewees in Germany were not.

Wider determinants of health

Interviewees in Italy, especially, highlighted the importance of wider determinants of health. Some expressed frustration that their ability to improve patients' health was inhibited by factors outside of their control as GPs; namely, the working and living conditions of some refugees, asylum seekers, and irregular migrants.

"Maybe they live and work in poor conditions and we can't take care of these determinants of health." GP, Italy

"[We] can do very good work within outpatients, but if you sleep in a room without heaters, you have one bath for 50 persons, nobody that's taking care for all the other life needs, we cannot do anything." GP, Italy

It was not within the scope of the project to explore housing provision for refugees, asylum seekers, and irregular migrants; however, anecdotally, interviewees in Italy described very poor quality, and sometimes dangerous and unsanitary, accommodation. One interviewee, an Italian GP, described how in trying to help a patient with anxiety, medication and psychological therapies can only go so far if the individual has: *"...no place to sleep"*. They called for a more *"holistic approach"* within the Italian health service; an approach that is not necessarily widespread and is not encouraged through current medical training.

Perceived cultural differences

Some of the GPs interviewed referred to perceived cultural differences between GPs and their patients from refugee, asylum seeker, and irregular migrant backgrounds; these differences were felt by some to present challenges to the doctor-patient encounter. In Sweden, one GP reflected that patients from these backgrounds expect the doctor to play a *"dominant"* role:

"So, when we ask them, 'What do you think?', then it's like 'You're supposed to know'. That's a big difference, what they expect from you. Here, we think they should say what they think or want... and they get confused [as it is not what they are used to]". GP, Sweden

Others, however, were keen that cultural differences were not over-emphasised:

"There are differences in culture but [as a GP] you shouldn't over emphasise them... you can never grasp all of the different cultures in the world, it's impossible. You have to stick to some basic principles." GP, Sweden

"The cultural differences are not so important." GP, Italy

Some GPs commented that patients from refugee and asylum seeker backgrounds tended to have high expectations regarding access to medication, tests, and scans:

"The biggest problem is the big wish list." GP, Germany

"There are great expectations [for] blood samples, CT scans, sometimes even though there are no symptoms. They know a lot is available, so now they have arrived here... [they have] high expectations. They want check-ups, search for anything! They want to be checked over." GP, Germany

One GP highlighted, however, that these expectations were not limited to refugees and asylum seekers:

"The big expectation is to get medication and X-rays. And that can be difficult to explain why it's not

needed. But that can be the same for Swedish patients, it causes conflict." GP, Sweden

GPs interviewed in Germany, in particular, suggested that patients from refugee and asylum seeker backgrounds behaved differently from German-born patients; this was attributed to cultural difference and was perceived to be a problem. Behaviours cited as problematic included patients bringing family members to appointments and patients' unfamiliarity with the 'norms' of using GP services, including waiting for appointments:

"Most of the time they bring their whole family. That's another problem. You don't have one person, you have the whole family. They come with this patient then they say, 'Oh, I have this problem'. We explain that they need an appointment, we try to push them that they have to wait for an appointment like the others." GP, Germany

"It's difficult that they don't live to our rules. We have times for our work and every day the first hour you can come without an appointment. But most of them come outside of that time. You can write it down but they don't understand. I think it's the culture of them; they don't use the hard timetable that we do in Europe, that's a really hard problem." GP, Germany

One interviewee cited cultural differences in the way that illness is experienced and articulated as being a challenge:

"The way they talk about pain... the way they talk about pain is very dramatic. I don't know how to judge the pain. Is it something serious? Or the way they are?" GP, Germany

In Italy, one interviewee, an anthropologist who works alongside GPs and other health professionals, reflected on the importance of recognising health as a social and cultural construct:

"[Patients from migrant backgrounds often] have different reasons [for the causes of] their diseases. It's very important when the physician and the person come from different countries to try to understand what [the patient] thinks about health and about disease and what [the patient] thinks about the cause of the disease. Every person has different learning inside their school, their family... there may be traditional doctors with traditional drugs and so on." Anthropologist, Italy

Many more interviewees highlighted different understandings of mental health/ill-health as being a challenge particular to their treatment of refugees, asylum seekers, and irregular migrants. Interviewees reported that patients from these backgrounds often presented with psychosomatic symptoms, such as headaches and stomach aches, of mental health problems including depression, anxiety, and stress. Several of the GPs interviewed described how it was often difficult to explain to patients that their symptoms may be caused by their mental health. This was thought to be because mental health is understood differently within different medical cultures:

"In many countries there isn't a concept... When they come here they speak about their psychological illness via their body.... They have problems with the stomach... every problem is their body [rather than their mental health]." Anthropologist, Italy

"They think if they have headache every day there must be a problem inside. We make a lot of examinations. A lot of migrants get an MRI [scan] only to show them that everything is normal." GP, Germany

Others highlighted the stigma associated with poor mental health and the difficulty this can cause in ensuring patients get the right treatment:

"In some cultures, they don't have a word for depression... so maybe rather than the depression the culture is that you have an evil spirit or something and other explanations for why someone might be depressed or anxious... It's not very easy to make them go to psychologist because that is a big taboo. It's easier to make them take medication... you might know it's better for them to see a psychologist, but they aren't ready for it and they say, 'But I'm not crazy!'; so that is a big challenge sometimes." GP, Sweden

"The difficulty in talking about mental problems because it's surrounded by stigma. We have stigma in Sweden too, but it's slowly getting much better... In Somali, there is no word for depression." GP, Sweden

In Germany, one GP highlighted that a lack of psychological services generally, and specifically services which accommodated non-German speakers, was a significant challenge:

"We have no psychiatry or psychotherapy. It must be done in the mother language. You need, for psychotherapy, [a psychotherapist that speaks] their home language and we have nothing." GP, Sweden

Gender

Some of the GPs interviewed, particularly in Germany, referred to challenges related to patients' gender and some patients' (from migrant backgrounds) reluctance for women and girls to be treated by male doctors. This sometimes resulted in male relatives joining appointments and sometimes 'speaking for' the female patient:

"Another problem is if the small girls come in with their dads or uncles... the nurses have to do [the examination, because a male GP is not deemed appropriate]." GP, Germany

"Sometimes the men speak better English, better German. The women are at home with the children, they have a lot of children, therefore it's easier to speak to the men not the women." GP, Germany

One German GP cited how a lack of female staff could present difficulties, an issue exacerbated by the tendency for single-handed practices:

"Most of the physicians' offices in Germany, the GPs' offices, are single-handed so of course there may be also transcultural problems, especially

regarding the physical examination of women... I can easily cover in my GP office because we have a female GP who I can delegate the examination to so that it fits with the patient's needs." GP, Germany

Conversely, a female GP reflected that gender was not a challenge; she had not encountered any reluctance amongst male patients to be treated by a woman, even for 'intimate' health concerns:

"They have symptoms that I am surprised they present to a female doctor... urogenital symptoms and problems. There is a lot of respect towards doctors, lot of trust and respect. I am surprised." GP, Germany

Language

Perhaps unsurprisingly, language was commonly cited by GPs interviewed as being a challenge in consultations with patients from refugee, asylum seeker, and irregular migrant backgrounds.

"The challenging thing is you have to understand them. That's one basic thing, to have a good interpreter." GP, Sweden

"I think the major is problem is with the language, of course." GP, Germany

Several interviewees described difficulties in accessing interpreters.

"It's a problem that interpreters are only paid if you are an asylum seeker and the costs are covered by the state. When the state will provide an interpreter if it's necessary for medical treatment. If you are insured in healthcare insurance company, you will not be refunded if you need an interpreter." GP, Germany

"Our problem is to understand the people and very often we don't have an interpreter here, so we aren't sure what they want at this moment." GP, Germany

"Most GPs can't speak other languages... We only have translation in some places but it's not easy to call on it. You have to plan in advance." GP, Italy

Some of the GPs interviewed described how lack of shared language with their patients made it difficult to ascertain patients' medical histories, for example:

"It's a problem [the language barrier]. It takes a lot of time. It takes a lot of time to ask everything, to get the history of health problems. Sometimes they have translators, family or kids, or they bring a translator with them. But often they don't speak so good. So, it can be hard to know what they need or want... It's more complicated because of the language. It's helpful if they come with people that can translate and know that you need the bring medical history, the type of medications." GP, Germany

One interviewee highlighted that language barrier inhibited the treatments available to migrant patients with mental health problems: being unable to speak German prevented patients from accessing talking therapies:

"If people stay for a long time, their language gets better and I hope they can speak to a German-language

psychotherapist. In the meantime, we give them medication." GP, Germany

Wider issues in the GP sector

Interviewees in all three countries highlighted wider issues in the GP sector that they believed were barriers to good quality care for all patients, including refugees, asylum seekers, and irregular migrants. In Sweden and Italy, some GPs reflected on what they described as the fragmentation of healthcare and general practice, in particular. One GP in Sweden cited the increasing use of locum GPs as one way in which the sector is being fragmented:

"In Sweden today there is unfortunately a fragmentation in healthcare... Many doctors are [choosing to be] employed by private firms who will pay their salary and it's double the salary [they would receive directly from the state]." GP, Sweden

They went on to describe the negative impact that they felt this had on the doctor-patient relationship:

"For the patient with a delicate story, looking for trust, they see one of these doctors and after a month [the doctor has] gone. And the relationship is broken and that's a catastrophe for healthcare." GP, Sweden

In Italy, fragmentation was described in relation to the multiplicity of unions and societies, each with different views and perspectives, that sought to represent the sector; interviewees felt that this undermined the sector and weakened its 'voice':

"In Italy we have very big fragmentation within GP population: a lot of different unions and scientific societies, professional societies. They are fighting. Some are powerful, some are not so powerful." GP, Italy

"[The unions] care about money not quality. [They have] small interests." GP, Italy

One interviewee suggested that there was a generational divide in Italy between older GPs that held positions of influence in the societies and unions and younger GPs that held different views on healthcare:

"[One society] is held by the seniors and is old fashioned. It's not centred on the person but on the disease." GP, Italy

In Sweden, Germany, and Italy staffing issues were cited as challenges facing the GP sector:

"We have the same number of GPs as Norway and their population is only half that of Sweden... We wish there were more doctors choosing to work in primary care. So, we are understaffed." GP, Sweden

"Yes [staffing is an issue], depending on the area. In my area, there is a shortage of GPs. GP offices are full so we can in a way pick the patients." GP, Germany

In Italy, this was framed by one interviewee as another facet of the generational divide:

"Most of our doctors are retiring. In some areas we have a lack of GPs. In other regions, there are too many... and there are younger doctors that

can't access the work. There is generational conflict." GP, Italy

Future challenges

When asked to look to the future and anticipate future challenges in meeting the needs of migrant patients, interviewees' views were mixed. For some, the challenges were related to wider concerns about the health sector:

"I think the main challenge is human resources... in hospitals and ambulatory settings. Nurses are underpaid. This will be the main challenge for asylum seekers and German people... there are no special challenges arising for asylum seekers and refugees." GP, Germany

However, in Sweden and Italy in particular, interviewees expressed their concern about the political climate, namely the rise in anti-migrant policies and rhetoric, and the impact that this would have on refugees, asylum seekers, and irregular migrants amongst other populations whose circumstances might make them vulnerable:

"I think, generally, we are in a moment of big challenge in Italy. We have a political background that is not open to refugees and migrants, but also any other kind of vulnerability. We are not investing all these sectors... health, school, integration, and social services that could reduce inequalities. The government is promoting austerity. It is a systemic problem." GP, Italy

"I'm afraid [the government] will maybe change other things [so that] we cannot give them the healthcare we want to give. I hope not! I think it's very important that torture patients have a good healthcare system and treatment and there is attention for them within primary healthcare, that they're not afraid to ask for support... and [that, as a doctor] you can guide them with their health problems." GP, Sweden

In Italy, one GP described how they wanted to see *"more attention to ethical positions"* within medical training; they also highlighted what they saw as doctors' responsibility to *"influence our national and local government"*.

5. Responses

This section of the report describes the approaches that have emerged in response to the challenges outlined above.

Training, information, and support

Very few of the GPs interviewed reported receiving any specialised training or support regarding how to best meet the needs of refugees, asylum seekers, and irregular migrants. GPs typically turned to the internet, and national/regional government websites, to find out about migrants' right to access treatments and services, when required. Some GPs in Sweden and Italy described speaking to colleagues for advice and support; in Germany, where single-handed practices are common, opportunities to discuss issues with colleagues were limited.

In Italy, one GP had been trained in 'migrant care' as part of a special pathway in their medical training. This involved spending six months in a service providing specialist care to vulnerable people including refugees, asylum seekers, and irregular migrants. Through this, they had enhanced their knowledge and awareness of migrant health issues and had also established a network of colleagues that they remained in touch with and sometimes sought advice from. However, this experience was not typical of most GPs' training; rather, it reflected the specialist interest of the interviewee and others that had chosen to specialise in migrant healthcare.

There were examples, however, of specialist services that existed to promote better healthcare for patients from migrant backgrounds via training and support for healthcare professionals, including GPs. These are highlighted in the boxes below.

Transcultural Centre, Stockholm

The Centre, funded by the Stockholm County Council, exists to provide support to health professionals (including GPs) and dental care staff concerning issues of:

- Health and culture
- Migration and refugee status
- Assessment and treatment

This is provided via advice, consultations, and supervision for healthcare professionals in Stockholm. Services are provided free of charge via telephone and face-to-face appointments, both at the Centre and at healthcare locations. The Centre encourages health staff to reflect on their own cultural position and how it interacts with the cultural positions of their patients.

The National Institute for Health, Migration, and Poverty, Rome

The Institute was established in 2007 by the Ministry of Health to support Italy's National Health Service in responding to the needs of people living in poverty and migrants by tackling inequalities in

health. It does this by: developing health care models to be shared with the Italian regions; and with direct health care assistance through its healthcare centre in Rome (more detail below). It also leads a national network of health professionals across the country on the issue of health, migration, and poverty.

Cultural mediation

As explored earlier in this report, the consultation as a cross-cultural encounter between GP and patient was a commonly cited barrier; in Italy and in Sweden, two specialist services had developed inventive responses to the challenge.

The National Institute for Health, Migration, and Poverty, Rome

In addition to promoting good practice in migrant healthcare, regionally and nationally, the National Institute for Health, Migration, and Poverty also provides healthcare services to patients in Rome. The centre is home to multiple healthcare professionals, including dermatologists, gynaecologists, ear nose and throat specialists, paediatricians, infectious diseases doctors, and psychologists. All services are provided in the framework of the public health system and accessible without charge to Italian and migrant vulnerable population groups such as homeless people, refugees and asylum seekers.

What makes the Institute so interesting is that, alongside the wide-range of medical professionals, it has employed - for many years - two Anthropologists. The role of the Anthropologist is to negotiate the cross-cultural encounter between the patient and the medical professionals.

The Anthropologists achieve this by talking in depth with the patients about their experience of, and attitudes towards, health and illnesses/diseases; from this, they communicate their findings to the medical professionals, enabling them to better understand their patients' needs and perspectives. The health professionals are also supported by the 20 Transcultural Mediators, directly employed by the Institute, who provide mediation both during the clinical consultations and during the Anthropologists' in-depth conversations with patients, if needed.

Transcultural Centre, Stockholm

In addition to support and advice for health professionals, the Centre also provides health communication for newly arrived refugees and migrants on a wide range of subjects, including: the impact of migration on health; healthy eating; sexual health; and parenting. The programme is delivered by a team of Health Communicators: bilingual health advisors with professional medical backgrounds and, crucially, personal experience of migrating to Sweden.

The Health Communicators are uniquely placed to empathise with new arrivals to the city and help them to get to grips with their entitlements and how to navigate the health system, but also to develop an understanding of the 'medical culture' in Sweden. Often this differs significantly from the medical culture of their homeland. The Centre has its roots in Transcultural Psychiatry: a branch of psychiatry concerned with the cultural context of mental health problems.

Multidisciplinary team approaches

In Italy and Sweden, many interviewees cited multidisciplinary team (MDT) working as having an important role in meeting the needs of refugees, asylum seekers, and irregular migrants.

One GP in Italy, who worked in a primary healthcare service which housed a range of health professionals plus non-health professionals (social workers), reflected:

"[MDT working] makes a difference for vulnerable persons, not just migrants and refugees, but all patients… chronic patients, old people… everything is very simple. The actors are there, I just have to close the door and to open the door and I have the social services working in front of me." GP, Italy

This was echoed at the National Institute for Health, Migration, and Poverty where the blend of health professionals, social workers, Anthropologists, and Transcultural Mediators were fundamental to the Institute's approach.

"The power is the team. We are all different people, we know our differences and what we can bring. We bring a way to work together. It's a very good experience. We want to show this to other agencies; this is our aim." Institute staff member, Italy

Indeed, an Anthropologist at the Institute reflected positively on their experience of working with Transcultural Mediators:

"We work very well as a team. When a patient speaks with us, we work together." Anthropologist, Italy

In Sweden, too, there were positive examples of healthcare professionals working together to meeting the needs of refugees, asylum seekers, and irregular migrants:

"We have physiotherapists that are here three days a week. We have a dietician two days a month. Then we have diabetic nurse and we have asthma and lung diseased nurse. We have a nurse for the elderly who does home visits. We have paediatric nurses, seeing as we have so many children here… They have six [paediatric] nurses, [treating children from] new born to five years: we have this special centre. [It is] a very diverse set of staff. We have a good team work where we can discuss patients. I think it's a great help." GP, Sweden

The same GP described how the practice had three psychologists and a member of staff that provided patients with help and support regarding social

and financial issues. The practice also invites representatives from other agencies into the practice on a regular basis to assist with patients' wider concerns. It was highlighted that this degree of MDT and multi-agency working was not, however, typical of most GP practices in Sweden; rather, it had developed in response to the needs of the local population.

Another GP, at a centre in Gothenburg that provides specialist support for refugees and asylum seekers reflected:

"I think it's the most important thing in our centre, that we are multidisciplinary. It is very easy for us [as GPs] to talk with psychologists and counsellors. We have meetings where we talk about patients and their treatment. That's very important for us. When working together you can give more than when you see the patient yourself. With more eyes, you see more, there are different perspectives." GP, Sweden

Holistic approaches

Some interviewees described how holistic approaches were used in the treatment of refugees, asylum seekers, and irregular migrants. These involved giving due consideration to patients' wider well-being beyond their physical health; this included determinants of health such as housing and social relationships:

"It's very important... we try to think of a comprehensive pathway, not just medical but social issues for example; so, we ask a lot about families, which other languages they are speaking." GP, Italy

At the National Institute for Health, Migration, and Poverty in Rome, an interviewee described how part of the role of the team was to:

"Try to respond to the practical needs of the patient... If [the patient] has some problem trying to contact their parents, we put them in touch with the office of Rome or international associations to see if there's possibility to contact their parents.... We also work with other offices outside of the health service to respond to the practical needs of persons [including learning Italian and meeting people from their home country]." Anthropologist, Italy

In Germany, one GP described having recognised and acted on a patient's lack of social networks and opportunities:

'If they don't have social connections, I go to the internet and find places where they can get help. I had one patient from Iran, he was very depressed. He told me he was playing handball in Iran and he'd like to play again, and I made a connection for him with a sports club... he had a new connection with support. This really helped him." GP, Germany

There were examples in Sweden of structured programmes that aimed to promote health literacy amongst refugees and asylum seekers, including addressing wider aspects of health. This included at the Transcultural Centre in Stockholm (see above) and at a refugee medical facility in Gothenburg.

Närhälsan refugee medical facility, Gothenburg

Närhälsan is the largest primary care provider in Sweden and is the public primary care provider in the Västra Götaland region. In Gothenburg, Närhälsan runs a medical facility for asylum seekers and new arrivals to Sweden who have been granted a residence permit. Patients are referred via the Migration Board and the Employment Service. Since 2012, the facility has been funded to perform health assessments with asylum seekers. Alongside assessing and treating patients' physical and mental health problems, the facility runs a 'health school' with the aim of increasing patients' health literacy. The programme, which is voluntary for patients to attend, involves eight sessions that explore a range of wider health issues, including: diet, oral healthcare, public health issues, stress, sleep, navigating the health system, and sexual health.

One of the ways in which some interviewees described trying to achieve a holistic approach was by working with external agencies.

"If I give an example of a refugee, a Somalian refugee who's been in Italy for 10 years. He's now 28. He lives in a squat in front of the [clinic]. He had very difficult administrative issues. He was sent to me by social workers and NGOs. In one day, we solved something that would have taken many months to solve. [However] our power is very limited because what we can do in terms of housing is limited. We do not have many resources. But [in this case] still we could do something." GP, Italy

Another GP in Italy described how referral pathways existed with external agencies, however stigma and administrative issues could prove prohibitive:

"I can usually do something... we have some institutional pathways for migrants with housing issues. We can send them to social services, but there is a big stigma. Social services are not so good. But if you aren't registered [i.e. are an irregular migrant] you can't access those services... In the last years, we have used some local voluntary associations. From my point of view, in [relying on the voluntary sector] we are not problem-solving." GP, Italy

This view was shared by one interviewee in Sweden: they were adamant that the health needs of refugees, asylum seekers, and irregular migrants should be met solely by state-funded health services rather than the voluntary sector:

"I strongly believe all healthcare should be given in the same way... I don't want us to have clinics that do teeth work [for migrant patients] in churches... I strongly believe in that. We should use all our strength to work for that. It is not the Swedish model [to have voluntary organisations delivering healthcare]... All our strength should be within system." Service coordinator, Sweden

Motivation

Amongst many of the interviews, their personal motivation and sense of ethical responsibility towards all patients, including those from migrant backgrounds, was clear. For some, working with refugees, asylum seekers, and irregular migrants was an opportunity to work with a varied and international patient population:

"I like to work in this area with people from all over the world. I have a world map in my consultation room and I add a pin for every country I have patients from... I really enjoy that. I think it's nice to meet people from other countries, it's more interesting. I hear such interesting stories." GP, Sweden

The same GP went on to say:

"I always wanted to be a doctor from a very young girl, and I always saw myself working abroad. But now I don't have to go abroad as the whole world comes to me... I can stay here but still have international patients. That is very nice for me." GP, Sweden

However, as one GP in Italy argued, meeting the health needs of refugees, asylum seekers, and irregular migrants should not be considered a 'special interest'; rather, it is a non-negotiable responsibility as a doctor:

"As doctors we have a commitment, ruled by our ethics, that we have to protect the health of everybody without any discrimination, age or nationality. It is our commitment. We have to do something, because we decided to be a doctor. It isn't easy, of course, but we have to. It's our commitment." GP, Italy

6. Reflections

The following reflections are drawn from the interviews and, also, meetings and conversations with experts.

- Impact of anti-migrant rhetoric

  Across all three countries there has been a rise in anti-migrant rhetoric politically and this is having an impact. In Sweden and Italy, healthcare professionals were concerned about an apparent shift towards greater restrictions of asylum seeker rights, including access to healthcare. Whilst in Germany, there was a sense that three years on from the Syrian refugee crisis there is no longer much political will to fund or invest in refugee and asylum seeker issues.

- Passionate staff

  Some healthcare professionals are attracted to working with patients whose circumstances may make them vulnerable (including refugees, asylum seekers, and irregular migrants) due to their personal and professional interests and demonstrate real passion and commitment to meeting these patients' needs. It is vital, of course, that the quality of care patients receive is not dependent upon individual doctors' motivations; rather, that all patients have equal access to high quality, inclusive healthcare.

- Decentralisation of powers

  In all three countries, powers over health are decentralised to the regional or local level. Whilst this presents opportunities to tailor healthcare to local circumstances, in reality this has led to a lack of coordination and problems with data sharing.

- Fragmentation of the sector

  In each three countries the GP sector is, or appears to be becoming, increasingly fragmented. In Germany, the healthcare model, in which most GP practices are independently run and single-handed, means there has not been a collective response, within the GP sector, to the challenges of meeting the needs of refugees, asylum seekers, and irregular migrants. In Italy, the multiplicity of societies and unions representing GPs, often with competing and contrasting views, means that there is no shared voice advocating for the sector. Whilst in Sweden there are perhaps signs that the GP sector is being fragmented by the use of locum staff (as a result of GP shortages) and the small but growing presence of alternative providers, such as online, app-based GP services. These various forms of fragmentation could, potentially, impact on GPs' ability to deliver good quality care to their patients, including refugees, asylum seekers, and irregular migrants.

- Role of regulation

  In all three countries there is limited regulation and oversight of general practice, certainly in comparison to England and the

work of the regulator for health and social care services: The Care Quality Commission (CQC).

- **Role of voluntary sector**

  The voluntary sector plays a notable role in meeting refugees', asylum seekers', and especially irregular migrants' health needs. In Italy in particular, given the government's increasingly restrictive approach to migrant rights, it is possible that the voluntary sector will become even more important in 'plugging the gaps'. In Germany, there was a huge voluntary sector response to the influx of Syrian refugees in 2015, however the voluntary sector does not always have the resource and strategy for longevity. It is encouraging that work is underway to develop resources that aim to promote the sustainability of voluntary sector organisations in Germany that are meeting migrants' health needs[3].

- **Consultations as cross-cultural encounters**

  Understandings of physical and mental health are influenced by society and culture: being healthy means different things to different people. To that end, consultations between GPs and their patients, including but not limited to refugees, asylum seekers, and irregular migrants, are inherently cross-cultural encounters.

- **Importance of multidisciplinary working**

  The project findings affirm that bringing together the skills and expertise of a range of health and non-health professionals is key to supporting refugees, asylum seekers, and irregular migrants; this can of course be extended to other patient group whose circumstances may make them vulnerable, such as homeless people, for example.

- **Holistic approaches**

  Multidisciplinary working can also enable holistic approaches that recognise the multi-faceted nature of health, including physical health, mental health, and social determinants of health such as housing, diet, and social support. For patients whose circumstances may make them vulnerable, addressing such determinants through holistic healthcare approaches can be important levers for health improvement.

- **Support and investment**

  The approaches advocated above can only happen where there are the right conditions. This includes health professionals having enough time to be reflective and develop in their cultural, and self, awareness, and for GP services to be able to diversify their staff profile to enable multidisciplinary teams to develop. Given the

[3] This work is being undertaken at Charité University in Berlin, led by Dr Jenny Jesuthasan and Prof Sabine Oertelt-Prigione (based at Radboud University, the Netherlands)

challenges facing the over-stretched GP sector in England, this requires concerted support and investment.

1. Message for government

To meet the needs of patients whose circumstances might make them vulnerable, including refugees and asylum seekers, GPs need enough time and resources. The sector is under-pressure: demand is growing (in part, due to an ageing population) and workloads are increasing. To date, this has not been met by increased funding or a growth in the workforce. For general practice to fulfil its full potential to meet the needs of patients whose circumstances might make them vulnerable, it is vital that the sector is adequately funded by government. Efforts to sustain and grow the workforce should consider the role of multidisciplinary teams.

2. Message for national bodies

In comparison to some of the countries visited for this project, the UK is fortunate to have a unified and influential professional body that represents the sector: The Royal College of General Practitioners (RCGP). The RCGP is in a favourable position to increase knowledge and awareness of refugees' and asylum seekers' rights to access GP services and to support GPs in delivering high quality care to these groups. This may be achieved via eLearning and in the promotion of existing resources and toolkits, including those developed by not-for profit organisations such as Doctors of the World[4].

3. Message for commissioners

This report has highlighted some of the challenges that GPs face in meeting the needs of refugees and asylum seekers; many of which are likely to be experienced by GPs in the UK. Meeting these challenges requires longer consultations and often interpreting. It is important that Clinical Commissioning Groups (CCGs) take this into consideration in the funding of GP services. This report has also highlighted the value of skills-mix within GP practices. CCGs should support GP practices in developing and testing multidisciplinary models, where appropriate, to encourage holistic approaches to meeting patients' needs.

[4] https://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/resources-for-medics/#

7. Conclusions

This project has highlighted challenges – as perceived by GPs in Sweden, Germany, and Italy – in delivering general practice to refugees and asylum seekers. These challenges included 'system' issues, such as access to and navigation of health services and the state of general practice and the wider health sector in each country. GPs also recognised the importance of social determinants of health, some of which they felt they had limited influence over. Unsurprisingly, a lack of shared language between GP and patient was highlighted as particularly challenging.

Different understandings of health between GP and patient was identified by many interviewed as a barrier, particularly in terms of supporting patients with their mental health. It is important to note that this is a partial perspective: this project does not consider the all-important patient perspective. Looking to the future, GPs had concerns about the state of the GP sector in their respective countries and some were apprehensive about what an apparent rise in populism could mean for migrant groups' rights to access healthcare. At a time where, across Europe, anti-migration policy and rhetoric is seemingly on the rise it is vital that a human rights-based approach, that recognises the right to health, is protected within general practice.

There is no 'formula' for ensuring that general practice meets the needs of refugees and asylum seekers. Neither can the approaches identified as part of this project necessarily be readily transferred to England: each is particular to the context in which they developed, including the local patient population and the local and national health system. Moreover, the project has highlighted the role that individual passion and motivation amongst GPs plays in delivering good care. The project has, however, highlighted approaches and principles that are important in meeting the needs of patients whose circumstances might make them vulnerable. These include: multidisciplinary team working; recognising consultations as cross-cultural encounters; and holistic approaches to healthcare. Achieving this requires not only skilled and motivated staff, but also investment in the sector (and wider services, such as housing and social services) and support for GPs.

The project also sought to understand the impact and effectiveness of general practice in meeting the needs of refugees and asylum seekers; however, the interviews and conversations revealed little in the way of evaluation and limited regulation and oversight of general practice in all three countries. Returning to England, the commitment of the Care Quality Commission to embed a human rights-based approach in its regulation of health and social care services, including general practice, is an ambition to be welcomed.

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