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Promoting migrant health as a universal right in the United Kingdom

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Abstract

Migrants arriving in the United Kingdom (UK), many of whom experience vulnerability before and during migration, face a double burden of communicable and non-communicable diseases shaped by cumulative exposures in their countries of origin, across the migration journey, and compounded by fragmented access to care upon arrival. Despite improvements in pre-entry health assessments, post-arrival provision in reception centres remains inconsistent, with significant gaps in infectious disease screening, mental health support, medication continuity, and timely registration with a general practitioner (GP). Community-led initiatives like Doctors of the World's *Safe Surgeries* and the *Oxford Refugee Health Initiative* promote inclusive healthcare access, yet remain limited in scale. Using a social determinants of health (SDH) lens, this perspective highlights how structural barriers—including overcrowded accommodation, language challenges, and unclear entitlements—undermine the effectiveness of existing health policies and widen inequalities. We propose an essential care package for UK migrant reception centres that integrates early screening, stable access to medicines, mental health assessment, environmental health measures, and robust continuity of care for non-communicable diseases through clear referral pathways into the National Health Service (NHS). Embedding this approach within current public health infrastructure would reduce preventable morbidity, strengthen health system efficiency, and advance the UK's commitment to Sustainable Development Goals. Strengthening care at the point of arrival is therefore critical to promoting health equity and ensuring that no one is left behind.

Keywords Migrant health, Health inequalities, Social determinants of health

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Background

Migration trends and drivers

Migration has long shaped societies, economies, and cultures worldwide. In recent decades, both the scale and complexity of migration have intensified, driven by economic disparities, armed conflicts, political instability, and climate change. These forces have contributed to a sustained rise in international migration, which nearly doubled from 154 million in 1990 to 304 million in 2024, representing approximately 3.7% of the global population [1]. The increase in migration has been uneven: Europe and Asia each host around 86–87 million migrants, while Africa accounts for roughly 9%, with notable increases in Northern and Sub-Saharan regions [2–4].

Migration has been defined differently in different contexts, and a distinction has been made between international and internal migrants [5]. In this paper, we adopt the United Nations' definition of international migrant as a person who moves across national borders to reside in a country other than their origin, regardless of reason or legal status, including work, education, family reunification, or protection from conflict [6]. Refugees—persons forced to flee due to persecution, conflict, or human rights violations—are legally protected under international law [7]. The focus here is on migrants with heightened vulnerabilities, including refugees, asylum seekers, undocumented migrants [8], stateless persons, and victims of trafficking.

A substantial portion of global migration is forced. By the end of 2022, 108.4 million people were displaced due to persecution, conflict, or violence, including 35.3 million refugees and 5.4 million asylum seekers—the largest annual increase recorded [9]. Geopolitical crises, such as the 2022 Russian invasion of Ukraine, can rapidly escalate displacement, with over 11 million people affected in that year [9].

Vulnerable migrants often face barriers to essential care, reflecting gaps in health systems. Their health outcomes are a barometer for inclusiveness, highlighting the need for universal health coverage regardless of immigration status [10]. This aligns with several of the Sustainable Development Goals (SDGs) [11]: SDG 3 (health and wellbeing), SDG 10 (reduce inequalities), SDG 16 (peace, justice, and strong institutions), and SDG 17 (partnerships for implementation), reinforcing the moral imperative of leaving no one behind in health and social policy [10].

UK migration policy and reception conditions

The UK has experienced a marked rise in migration in recent years. Net migration reached a peak of 906,000 in the year ending June 2023 [12], before decreasing to 431,000 in 2024—a level that remains substantially above the pre-2020 averages of 200,000–300,000 [13].

Asylum applications have also increased, reaching 84,200 in 2024 (108,100 individuals), and 88,700 by June 2025 (111,100 applicants), the highest since records began in 1979 [14]. Small boat arrivals continue to contribute substantially to these figures, with an estimated 43,000 crossings recorded by mid-2025, placing sustained pressure on the UK asylum system [15].

UK asylum and refugee policy is shaped by domestic legislation and international obligations, including the 1951 United Nations Refugee Convention [16], the 1967 Protocol relating to the Status of Refugees [17], and the European Convention on Human Rights [18]. These frameworks enshrine the principles of non-refoulement, the right to seek asylum, and protection for stateless individuals and trafficking survivors [16–18]. However, recent legislative changes, particularly the Illegal Migration Act 2023 [19], have prompted concerns regarding the UK's commitment to these obligations. The Act restricts asylum claims for irregular arrivals, mandates detention and removal, and limits access to public services, including housing and healthcare. United Nations agencies have warned that these policies disproportionately affect vulnerable groups, including unaccompanied minors and trafficking survivors, and risk undermining established refugee protections [19–21].

Reception conditions have also deteriorated along with these policy shifts. Facilities have frequently been reported to be overcrowded, poorly managed, and below acceptable standards [20, 21]. The government's increased reliance on repurposed military facilities—such as Napier Barracks, Wethersfield, and Cameron Barracks—and on contingency hotel placements has drawn considerable criticism due to poor living conditions, heightened mental health risks, and high operational costs [22]. Although the number of asylum seekers in hotels has declined from over 56,000 in September 2023 to around 32,000 in March 2025—representing 31% of all accommodated individuals—hotel use remains widespread and contentious [23–26].

Upon arrival in the UK, asylum seekers undergo an initial screening by the Home Office, the UK government department responsible for immigration, asylum, and border control, and are placed in short-term reception centres intended for 3–4 weeks. In practice, prolonged processing timelines and limited housing capacity have led to extended stays beyond the mandated period, leading to issues of overcrowding, poor sanitation, and limited healthcare access [27]. The case of Manston Reception Centre in Kent exemplifies these challenges: opened in February 2022 for short-term stays of up to 5 days, it soon housed over 4000 people—nearly three times its intended capacity—with reports of diphtheria outbreaks and a death due to illness [28, 29].

Following initial processing, many individuals are relocated to temporary accommodation, such as hotels, often situated in isolated or under-sourced areas. These settings have been associated with social isolation, limited transport, lack of translation services, and minimal community support, which amplify the risk of mental distress [30]. These challenges further disrupt continuity of care and lead to delayed access to primary and mental health services, particularly for individuals with complex needs [31].

Double burden of communicable and non-communicable diseases

Migrants with compounded vulnerabilities, as the groups outlined above, often experience challenging migration journeys and reside in overcrowded, unsanitary environments with limited access to healthcare, increasing their vulnerability to infectious diseases [32–34]. A population-based study of UK-bound refugees found that latent tuberculosis affects between 9 and 45%, while active tuberculosis was reported in up to 0.09% (92 per 100,000) of the population [15]. The study also reported hepatitis B prevalence at 2.04% and hepatitis C at 0.41%, with higher rates observed among individuals from Sub-Saharan Africa and those with a history of blood transfusion or torture [35]. Mental health disorders are similarly widespread. A systematic review and meta-analysis of 5143 adult refugees and asylum seekers across 15 countries, including the UK, reported prevalence rates of 31.5% for post-traumatic stress disorder, 31.5% for depression, and 11% for anxiety disorders [36]. These mental health conditions remain prevalent after resettlement and are influenced by post-migration living difficulties—including legal insecurity, social isolation, and limited access to culturally appropriate mental health services—which contribute to the chronicity of symptoms among refugees and asylum seekers [37, 38].

In addition to these challenges, non-communicable diseases are increasingly prevalent among migrant populations, including hypertension, diabetes, and obesity [39–41]. Refugees and asylum seekers are particularly vulnerable to these conditions due to prolonged exposure to stress, poor nutrition, limited access to healthcare, and social isolation [42]. A review of cardiovascular and metabolic risks in migrant populations found that the prevalence of hypertension and diabetes is significantly elevated among refugees and migrants compared to host populations [43], with susceptibility to metabolic syndrome driven largely by environmental stressors and acculturation-related lifestyle changes [44].

Continuity of care poses a major challenge for migrants with non-communicable diseases. Treatment interruptions often occur during transit and frequently persist after arrival due to delays in general practitioner (GP) registration, difficulties in navigating the National Health Service (NHS), and inconsistent access to interpreters and culturally appropriate services [45–47]. Many refugees report running out of essential medications for conditions such as diabetes, hypertension, and asthma during the initial weeks in the UK [48, 49]. Gaps in care are linked to administrative barriers, dispersal policies, and frequent relocations within asylum accommodation systems [48, 49]. Consequently, refugees and asylum seekers frequently arrive with poorly controlled chronic conditions, compounded by social determinants such as poverty, discrimination, and limited access to preventive care throughout the migration cycle [50–52].

Models of migrant healthcare

Globally, countries have adopted distinct models of care for refugee and migrant populations, reflecting different legal frameworks, healthcare infrastructure, and sociopolitical priorities [53]. The World Health Organisation identifies four main models:

1) Mainstream services—refer to the standard primary healthcare available to the general population, delivered by the usual public and private providers, with refugees and migrants accessing these services either immediately or after a waiting period, depending on the country
2) Specialised-focus services—dedicated healthcare streams designed to meet the specific needs of refugees and migrants who may not access public healthcare, delivered by a varied workforce including specialised clinicians and trained health assistants
3) Gateway services—transitional healthcare supports that provide basic health checks, information, and referrals to help refugees and migrants access primary care, delivered either onshore or offshore by health workers performing prescribed assessments
4) Limited services—basic healthcare provisions, often delivered by charities, non-governmental organisations, and international organisations under host country agreements, typically staffed by volunteer workers with high turnover and variable funding

These models reflect broader policy orientations: specialised clinics may offer efficiency and targeted care but risk creating parallel systems, while mainstream integration promotes equity and sustainability but requires investment in cultural competence and infrastructure.

In the UK, refugees and migrants primarily access mainstream NHS services, but access is often uneven due to language barriers, limited knowledge of the system, transport challenges, and perceived discrimination [46,

54]. To address these gaps, gateway services (e.g. initial health assessments) and specialised-focus services (e.g. refugee clinics, mental health support) exist, though coverage is inconsistent [55].

The World Health Organisation and the United Nations High Commissioner for Refugees recommend hybrid, inclusive models that combine mainstream, gateway, and specialised services, ensuring continuity of care, cultural competence, and access to interpreters and community support [56–58]. This mixed-model approach reflects best practice for integrating refugees into health systems while addressing structural and cultural barriers.

Strengthening migrant health assessments in the UK

Overview of migrant health guidelines

Several frameworks provide guidance for the health assessment of newly arrived migrants in the UK. The BMJ Practice Pointer by Knights et al. advocates a holistic, trauma-informed, and person-centred approach, recommending screening for communicable diseases such as tuberculosis, hepatitis B and C, HIV, and parasitic infections, alongside catch-up vaccinations aligned with the UK schedule [59]. It also addresses non-communicable diseases, mental health, nutritional deficiencies, oral health, and reproductive health needs [59]. Knights et al. emphasise empathy, trust-building, continuity of care, and practical measures such as longer appointments, professional interpretation services, and culturally sensitive consultations—particularly for individuals who have experienced trauma or displacement [59].

The UK Government's Migrant Health Guide, published by the Office for Health Improvement and Disparities, offers a structured checklist for primary care practitioners [60]. It encourages consideration of migration history, country of origin, social circumstances, and potential exposure to discrimination, all of which influence health outcomes [60]. The guide includes country-specific risk profiles for infectious diseases and chronic conditions and advises documentation of ethnicity, language needs, and interpreter requirements in electronic health records [60].

The Pre-entry Health Assessment Protocol applies only to refugees and individuals arriving through designated resettlement schemes [61]. It focuses on screening prior to arrival but excludes asylum seekers and irregular entrants as pre-arrival screening is not feasible for these groups. Both the BMJ Practice Pointer and Migrant Health Guide stress that access to healthcare upon arrival should be based on clinical need rather than immigration status [59, 60].

Despite the availability of these resources, implementation and uptake remain inconsistent across regions and healthcare settings [62]. Barriers include low GP registration rates—only 32.5% of new entrants to the UK register with a GP—with asylum seekers and individuals from African and American regions among the least likely to register [63]. Administrative and systemic obstacles such as complex registration processes, lack of awareness of entitlements, language difficulties, and fears around immigration enforcement further impede access [64, 65]. Misinterpretation of NHS policy is widespread: a study found that 62% of GP surgeries incorrectly refused to register undocumented migrants, demanding proof of address, identification, or legal status—despite NHS guidance stating these are not required [66]. These barriers reflect a persistent gap between policy and practice, compounded by misunderstanding of NHS charging exemptions among healthcare professionals.

Efforts to overcome these challenges include policy clarification and training initiatives aimed at improving practitioner awareness of NHS charging exemptions and inclusive registration standards.

Community-based initiatives to improve migrant health

In response to systemic gaps in healthcare access for migrants, several community-led initiatives have emerged to bridge the divide between policy and practice. Two notable examples are Doctors of the World's *Safe Surgeries* programme [67] and the *Oxford Refugee Health Initiative* [68]. Doctors of the World UK launched the *Safe Surgeries* initiative in 2018 to support GP practices in removing barriers to registration and care for migrants, including refugees, asylum seekers, and undocumented migrants. The programme provides a toolkit [67] with seven practical steps for inclusive registration, emphasising that lack of ID, proof of address, or immigration status should never prevent access to care. Participating practices receive training, translated materials, and policy guidance to ensure compliance with NHS England's inclusive registration standards.

The *Oxford Refugee Health Initiative* is a student-led outreach programme that pairs medical students with newly arrived refugee and asylum-seeking families [68]. These students act as health advocates, supporting families in navigating the NHS, managing appointments, and accessing psychosocial resources. The *Oxford Refugee Health Initiative* also provides interpreter access and promotes cultural competence among future clinicians, supervised by senior volunteers. The initiative has been praised for improving healthcare access and enhancing understanding of migrant health needs among medical trainees. It represents a scalable model that could be adapted to the UK.

While these initiatives offer vital support, their reach remains limited compared to NHS services. Rather than

issuing another call for an overarching national strategy, a more immediate priority is to address two persistent barriers—low GP registration rates and limited practitioner awareness of NHS charging exemptions—that continue to undermine the impact of existing guidance. Scaling up existing programmes such as *Safe Surgeries* and the *Oxford Refugee Health Initiative* could provide an immediate, evidence-based solution. The *Safe Surgeries* model has already demonstrated success in reducing registration barriers through training and policy guidance, while the *Oxford Refugee Health Initiative* offers a scalable framework for advocacy and navigation support. Expanding these initiatives nationally—through targeted funding, integration into local health systems, and partnerships with medical schools—would complement existing guidelines and help ensure equitable access to care for all migrants.

Updated pre-entry health assessment protocol

The UK Government's Pre-entry Health Assessment Protocol, updated in March 2025, provides a structured, evidence-based framework for identifying and addressing the health needs of refugees and individuals arriving under designated resettlement schemes [61]. These assessments, conducted by the International Organization for Migration, now feature several significant enhancements aimed at improving health outcomes and ensuring a more inclusive and preventive approach. Key updates include the phased rollout of the Global Mental Health Assessment Tool—Primary Care Version, which replaces multiple previous mental health screening tools, offering a more consistent and trauma-informed approach to psychological evaluation. The protocol also introduces Special Educational Needs and/or Disability guidance, ensuring that individuals with neurodevelopmental or learning challenges are identified early and supported appropriately. Infectious disease screening has been expanded, with universal testing for hepatitis B, hepatitis C, HIV, and syphilis now recommended for all individuals covered by the protocol. Immunisation efforts have been aligned with the UK schedule, prioritising measles, polio, and hepatitis B vaccines, especially for individuals from high-risk regions.

Despite these improvements, significant limitations remain in terms of scope and inclusivity. It applies only to individuals arriving through specific resettlement pathways such as the UK Resettlement Scheme and the Afghan Citizens Resettlement Scheme, and does not extend to asylum seekers or undocumented arrivals. This exclusion leaves substantial gaps in health coverage for vulnerable populations who may have experienced significant trauma and face barriers to accessing care upon arrival [61].

Infectious diseases such as tuberculosis, hepatitis B and C, HIV, and syphilis are more prevalent among migrants [69], exacerbated not only by conditions in countries of origin but also by poor access to clean water, sanitation, and hygiene (WASH), and limited vaccination coverage during transit and at reception [70]. The updated protocol mandates universal screening for several infectious diseases, including hepatitis B and C, HIV, and syphilis, replacing less effective tools like urinalysis. However, it notably excludes respiratory viral infections such as influenza, respiratory syncytial virus, and COVID-19. While these illnesses often present with acute symptoms and may be easier to detect clinically, their omission from pre-entry assessments is concerning given the high transmission risk in reception settings characterised by overcrowding and poor ventilation [71]. Environmental conditions at the point of entry, including overcrowded and poorly ventilated reception centres, further increase the risk of transmission and severe disease outcomes [72]. These settings also often lack the infrastructure to support timely linkage to primary care, infectious disease specialists, and vaccination programmes—critical components of post-arrival care that are essential for both individual and public health.

Vaccination coverage is a critical yet under-addressed component of migrant health. The European Centre for Disease Prevention and Control [73] recommends catch-up vaccines for migrants with incomplete records, and the UK's 2025 Pre-entry Health Assessment Protocol [61] aligns with this by requiring immunisations against measles, polio, and hepatitis B for eligible individuals. These vaccines are cost-effective and help prevent outbreaks. However, challenges remain: evidence from a small-scale UK qualitative study of primary care professionals ($N=64$) suggests that adult migrants are often excluded from vaccination initiatives, hampered by unclear or incomplete records, lack of staff training and financial incentives, fragmented delivery models, and unreliable care pathways—highlighting that catch-up efforts rely on ad hoc, opportunistic approaches rather than systematic programmes [74]. While NHS policy entitles asylum seekers, refugees, and even undocumented migrants to register with a GP and receive routine vaccinations free of charge [60], practical barriers such as registration refusals and fear of immigration checks mean coverage remains inconsistent.

Recommendations for an essential care package for migrant reception centres in the UK

Despite incremental improvements in the UK Pre-entry Health Assessment Protocol, there remains no unified or standardised approach to healthcare provision for migrants immediately following arrival. Healthcare

delivery within reception settings is fragmented, with non-governmental organisations, such as Doctors of the World, providing limited and uneven coverage that cannot substitute for comprehensive NHS services. Although migrants are legally entitled to NHS care after arrival, access is frequently delayed by barriers including lack of GP registration, language discordance, limited health system literacy, and uncertainty regarding healthcare entitlements. As a result, the potential public health gains of pre-entry screening are undermined by weak integration with post-arrival care pathways, particularly for individuals outside formal resettlement programmes. These systemic gaps underscore the need for a consistent, system-led approach to early health assessment and continuity of care across all migrant reception settings.

To address these challenges, we propose a system-wide, evidence-informed approach grounded in the social determinants of health (SDH) framework [75]. This framework recognises that health outcomes are not solely determined by biomedical factors, but are shaped by the social, economic, legal, and environmental conditions in which individuals live. Migrants frequently experience multiple, intersecting structural vulnerabilities—including insecure housing, overcrowded living conditions, linguistic and cultural barriers, precarious legal status, disrupted social networks, and limited access to healthcare—that interact cumulatively to increase health risks [76]. These determinants not only influence exposure to disease, but also shape access to timely diagnosis, treatment adherence, and long-term health outcomes [76].

Reception centres represent a critical upstream intervention point within this framework. Early, structured interventions can mitigate the adverse health effects of displacement and social exclusion before they become entrenched. Applying an SDH lens shifts the focus from reactive, episodic care towards preventive, equity-oriented service design that addresses both immediate health needs and the broader conditions that generate health inequalities. In this context, healthcare provision within reception centres should be viewed as part of a wider social protection response, integrating health assessment with measures that promote dignity, accessibility, and continuity of care.

Based on this framework, we propose an essential care package for UK migrant reception centres [77–79]. These core components represent practical, feasible measures that align with existing health system capabilities:

1. Routine and early screening for infectious diseases—including HIV, hepatitis B and C, and parasitic infections—aligned with national programmes (e.g. tuberculosis screening), alongside catch-up vaccination initiatives and meaningful linkage to care.
2. Early diagnosis and treatment of acute infections such as COVID-19 and other respiratory illnesses, including influenza.
3. Mental health screening with facilitated access to treatment, including referral pathways and interim support from third-sector organisations while awaiting NHS appointments.
4. Environmental measures to reduce infection risk, such as avoiding overcrowding, preventing room-sharing by non-family members, and ensuring adequate sanitation and washing facilities.
5. Identification and proactive support for high-risk individuals, including pregnant women, children, the elderly, and those with chronic conditions (e.g. diabetes).
6. System-wide strategies to reduce health inequalities, including provision of professional interpreters, translated resources, culturally relevant health promotion materials, extended appointments where necessary, and mechanisms to support continuity of care, particularly for individuals with chronic conditions.

Together, these components define a minimum standard of care that all reception centres should be required to deliver, addressing current inconsistencies and reducing reliance on ad hoc or charitable provision.

Ensuring continuity of care—particularly for non-communicable diseases—is a central pillar of this essential care package. Many migrants arrive with poorly controlled chronic conditions following prolonged treatment interruptions during transit. Delays in NHS registration, frequent relocations within asylum accommodation systems, and difficulties accessing medications further compound health risks. Embedding medication reconciliation, rapid prescribing pathways, and automatic GP registration within reception-centre processes would substantially reduce avoidable deterioration and prevent long-term complications.

Implementing a prompt, standardised, and auditable reception-centre protocol—aligned in ethos with the Pre-entry Health Assessment Protocol—would strengthen early identification of health needs while supporting universal access to care. Importantly, reception-centre interventions must be embedded within a longer-term continuum of care that recognises migrant health as a life-course issue shaped by ongoing structural determinants. Targeted service design at the point of arrival, combined with seamless integration into NHS pathways, offers a cost-effective and equitable strategy to reduce preventable morbidity, safeguard public health, and uphold the UK's commitments to inclusive and rights-based healthcare.

Conclusions

Newly arrived migrants in the UK experience a substantial and intersecting burden of communicable diseases, non-communicable conditions, and mental ill health, shaped by displacement, social exclusion, and fragmented access to healthcare. Despite recent improvements to pre-entry health assessment protocols, post-arrival healthcare provision within reception settings remains inconsistent, with delays in GP registration, poor continuity of care, and reliance on ad hoc or charitable services leaving many health needs unmet. These gaps undermine both individual health outcomes and broader public health objectives.

This paper proposes an essential care package for migrant reception centres that operationalises a social determinants of health approach through early infectious disease screening, mental health assessment, environmental health protections, and—critically—mechanisms to ensure continuity of care for non-communicable diseases. Embedding rapid primary care registration, medication reconciliation, and clear referral pathways within reception-centre processes offers a pragmatic and cost-effective strategy to prevent avoidable morbidity, reduce downstream pressures on emergency and secondary care, and strengthen health system efficiency.

Positioning reception centres as the first step in an integrated, life-course care pathway—rather than as isolated assessment points—aligns migrant health provision with principles of universal health coverage and equity. Strengthening continuity of care at the point of arrival is therefore not only a clinical imperative, but a necessary investment in population health, social cohesion, and the principle of leaving no one behind.

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LBN and MP developed the concept behind the paper; LS drafted the manuscript. All authors read and approved the final manuscript.

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