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“I think they are actually a bit racist in not giving us everything that we need in terms of medication”: Racialised governance and asylum seeker access to healthcare in England

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ABSTRACT

This paper critically examines the lived experiences of asylum seekers accessing primary and secondary healthcare in England. We employ a framework of racialised governance to assess how historical and political processes of racialisation can manifest in healthcare. It draws upon longitudinal interviews with asylum seekers currently living in the North and South of England. Our findings evidence the multiple barriers to healthcare for asylum seekers in England, including the complexity and opacity of the English healthcare system; significant difficulties accessing face-to-face appointments; denial of access to interpreters; and being dismissed and disbelieved by administrators and clinicians. We demonstrate how these barriers to healthcare can be racialised, marking asylum seekers as a racialised ‘Other’ and contributing to inadequate care. We do also, however, find positive experiences of healthcare and document cases in which poor access to healthcare among asylum seekers aligns with wider institutional resource constraints within the NHS. Nevertheless, we argue that the racialisation of healthcare is fuelled by a politically racist policy agenda, accompanied by complex and often opaque healthcare entitlements for asylum seekers, which together legitimate misinformed and, at times, prejudicial attitudes within the NHS, leading to inconsistent care for asylum seekers across NHS Trusts. We argue it is essential to listen carefully to the healthcare experiences of asylum seekers to understand how equitable and accessible services can – and should – be provided.

1. Introduction

In May 2024, the Conservative Government passed their highly controversial Rwanda Bill, permitting the forced removal of any asylum seeker entering the United Kingdom (UK) "illegally" after 1 January 2022, from a safe country, such as France. The scheme, which has been ruled unlawful by the Supreme Court, is arguably the apex of a long-standing cross-party policy agenda which has sought to demonise and deter people seeking asylum in the UK. In this paper, we assess how this racialised policy agenda manifests in healthcare. The first part of the paper establishes the complex and often opaque policy context surrounding access to health services for asylum seekers; we examine existing literature on the topic and explain why racialised governance is an insightful framework for understanding the lived experiences of asylum seeker access to healthcare. We describe our methodology before drawing on in-depth longitudinal interviews with asylum seekers living in England to explore barriers to healthcare overtime, unpicking where racialisation manifests in access to health services. Our findings not only evidence the multiple challenges experienced by asylum seekers accessing healthcare in England but underscore the complex racialisation of English healthcare as the ‘hostile environment’ agenda permeates the scope and delivery of service provision.

1.1. *Policy context*

The policy landscape surrounding asylum seeker access to healthcare is complicated and variable across the UK. Our study is based in England and, therefore, our policy analysis focuses predominantly on English rules and regulations. Across the UK, all asylum seekers with an active application or appeal are fully entitled to access NHS care free of charge and can register and receive primary care services, including General Practitioners (GPs), pharmacies, opticians, and dentists (British Medical Association, 2023); entitlement to primary care includes those who have been refused asylum. In practice, a GP will decide whether to register

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individuals who cannot provide formal identification or proof of address (Poduval et al., 2015).

All asylum seekers with an active application or appeal are entitled to secondary care in any UK nation free of charge (British Medical Association, 2023), including planned and elective care, urgent and emergency care, and certain types of specialised mental health care. Asylum seekers in England who have had their claim refused may be charged for secondary care if they do not receive Section 4(2) support from the Home Office, Section 21 support from a local authority, or support under Part 1 of the Care Act 2014. Nevertheless, refused asylum seekers in England who do not receive this support will not be charged for A&E services, the diagnosis and treatment of infectious diseases if they test positive, or care for certain types of violence e.g. sexual violence. In addition, refused asylum seekers can continue, free of charge, with any course of treatment already underway before their application was refused. For new courses of treatment, any treatment that clinicians consider is needed immediately or urgently will be provided even if payment is not made in advance of treatment. Maternity care will always be provided, even when charges apply (Office for Health Improvement and Disparities, 2023).

It is incumbent upon primary and secondary care providers to enable effective communication with patients; this includes making reasonable adjustments when a patient requires communication in a language other than English (Office for Health Improvement and Disparities, 2021). Guidance by NHS England (2019) and Public Health Scotland (2020) specifies that, if a language barrier hinders discussions around health-related matters, a professional interpreter should be offered to a patient, rather than relying on a relative or friend to interpret. Interpreters are to be provided free of charge, and arrangements should be made to ensure additional time is added to an appointment to accommodate the time used to translate (NHS England, 2019; Public Health Scotland, 2020).

Regulations surrounding healthcare provision to children of asylum seekers are also complex. According to the Royal College of Paediatrics and Child Health, ‘children and young people who are deemed not “ordinarily resident” in the UK may be charged for secondary healthcare received, unless they meet a specific exemption’ (Royal College of Paediatrics and Child Health, 2022:6). These exemptions include asylum seekers with an active application and failed asylum seekers who are in receipt of Section 4 support (ibid.). A child may also be exempt if their parent meets the criteria which classifies them as vulnerable, including refugees and victims of modern slavery (ibid.). Unaccompanied children, ‘a child who is claiming asylum in their own right, who is separated from both parents, and who is not being cared for by an adult who in law or by custom has responsibility to do so’ (ibid.: 6), are entitled to full access to NHS health services (Department for Education, 2017).

Asylum seekers in the UK are prohibited from undertaking paid employment and subject to No Recourse to Public Funds (NRPF), a form of ‘immigration’ control which prevents access to most mainstream social security benefits, public housing and homelessness assistance (Jolly, 2018). Under Section 95 support of the Immigration and Asylum Act Gov.uk, (1999), the Home Office can provide housing and financial support to a person who is seeking asylum and is destitute or is likely to become destitute within 14 days. Support will continue until the person’s asylum claim is finally determined by the Home Office or appeal courts. Asylum seekers receive £49.18 per week for each person in the household. A person who is being provided with full-board hotel accommodation, or who has arranged their own accommodation in the community, will receive a weekly allowance of £8.86 in addition to receiving food and toiletries. Emergency support under Section 98 of the Immigration and Asylum Act 1999 can be provided to a person who has claimed asylum and appears to be destitute whilst they await a decision on their application for Section 95 support (Shelter, 2024).

1.2. *Asylum seeker access to healthcare*

Existing scholarship surrounding the healthcare experiences of asylum seekers in the UK underscores the existence of multiple barriers which may inhibit asylum seekers receiving care. Despite being legally permitted to register with a GP, asylum seekers often face negative experiences when doing so, including language barriers when communicating with staff, inconsistencies between practices, and inappropriate requests for paperwork (Poduval et al., 2015). Inadequate information surrounding GP access, coupled with fears of being refused care, has resulted in many asylum seekers accessing A&E, resulting in higher overall economic costs given the greater expense incurred by the NHS from urgent care and A&E visits compared to GP appointments (The King’s Fund, 2024). There is growing agreement amongst academics that the ‘hostile environment’ policies of the 2014 and 2016 Immigration Acts underpin the increasing difficulties experienced by asylum seekers in their everyday lives (Dickson and Rosen, 2021). The Acts, for instance, prevent asylum seekers from opening bank accounts or obtaining driving licences and render renting accommodation to asylum seekers a criminal offence (Home Office, 2014; UKVI, 2016). The Acts also introduced charges for certain types of secondary care for migrants who do not have permanent residence in the UK (ibid.). These policies were established by successive governments to deter individuals, predominantly asylum seekers, from settling in the UK, by threatening them with destitution. These policies have not only fostered the marginalisation of an already vulnerable group but have amplified confusion and fear surrounding asylum seekers’ entitlements to services (Poduval et al., 2015). Migrants with ‘undocumented’ status, for instance, are three times as likely to fear being arrested upon accessing NHS services compared to those with permission to reside (Weller et al., 2019). Confusion surrounding entitlement is also present amongst healthcare providers; a lack of understanding of the current rules among NHS employees can result in asylum seekers being wrongly refused or charged for treatment (ibid.). Asylum seekers are twice as likely to be denied NHS care compared to individuals with permission to reside, leading many to seek charitable healthcare (Weller et al., 2019: 7).

1.3. *Racialisation and access to healthcare*

Analysis of asylum seeker access to financial support and services, including health services, in the UK has increasingly drawn attention to the racialised nature of the policy landscape and consequently also the lived experiences of asylum seekers (for instance, Guma et al., 2023). The concept of ‘racialised governance’ is deployed to draw attention to racialised forms of exclusion and control experienced by asylum seekers accessing services and/or financial support, and to connect contemporary policy to histories of racialisation and exclusion of certain immigrant populations. Racialised governance, which manifests through policies that target individuals based on their race or ethnicity, stems from processes of racialisation, deeply rooted in colonial power dynamics. Racialisation occurs through the marking of bodies whereby some are racialised as inferior to others (Grosfoguel et al., 2015); it facilitates the construction of colonial hierarchies of “value” which regard non-white groups as less significant (El-Enany, 2020). In the UK, this sits within a broader racialised political context in which the state itself is constructed on an explicit racialised hierarchy recently exemplified by attempts by the British government to deport ‘non-white’ citizens as part of wider changes to deter ‘irregular’ migrants (Bhambra, 2018). Concomitantly immigrants become classified according to racial “desirability”, with the least desirable becoming racially ‘Othered’, categorised as inferior and marginalised by society (Schwalbe et al., 2000).

The racialisation and ‘othering’ of asylum seekers, De Genova (2018) argues, is implicitly tied to the termination of post-Second World War-era guestworker programmes, in which, ‘postcolonial labour migration from poorer countries assumed in the 1970s what was commonly the only permissible form, that of refugees fleeing persecution and seeking asylum' (ibid.: 1766). This population of migrants and refugees, most like to be from sub-Saharan Africa, were 'disproportionately racialised as not-white, and in fact inordinately racialised as Black' (De Genova, 2018:1768). Notable here is the idea of the 'differential inclusion' in which varied categories of migrants are ranked according to their desirability (Bhui, 2016). For instance, the 1962 Commonwealth Immigration Act, welcomed migration from the predominantly white 'Old Commonwealth', while heavily restricting migration from the 'New Commonwealth' nations (Turnball, 2017). Today, the experiences of asylum seekers (themselves more likely to originate from the Global South (United Nations High Commissioner for Refugees, 2023)), denied the right to work and often rendered destitute by NRPF, contrast markedly with those who migrate to the UK for different purposes, including high-wealth investors and migrants on marriage and skilled-work visas (Morris, 2018).

Drawing on the work of Fanon (1967), Grosfoguel et al. (2015) propose that the modern world is characterised by an 'abyssal line'(2015: 638); 'those that live above the abyssal line … live in the zone of being, while those that live below the line are in the zone of non-being' (ibid). In the context of immigration, racialised migrants and asylum seekers, predominantly although not entirely from Global South countries, may comprise the "zone of non-being" (Guma et al., 2023), which legitimates processes of racialised 'Othering'. Lived experiences in the zones of being and non-being are shaped by the intersectionality of race, class, sexuality and gendered power (Davis, 1983), however the particular way in which intersectionality is articulated differs in the zone of being and non-being. In the latter, the class, sexual and gendered oppression are aggravated by racial oppression. In this way, there is a qualitative difference between how intersectional oppressions are articulated and lived in the zones of being and non-being (Grosfoguel et al., 2015).

It is evident from current scholarship that asylum seekers experience discrimination in the British healthcare system (Asif and Kienzler, 2022; Poduval et al., 2015; Shahvisi, 2019; Weller et al., 2019), amid a wider context of purposeful impoverishment as a consequence of Section 95/98 policies (Mayblin, 2020). An analytical framework of racialised governance facilitates deeper understanding of the racialised nature of this discrimination and exclusion, and illuminates the ways in which everyday encounters in healthcare are influenced by immigration policy. Existing scholarship suggests that racialised discourses, fuelled by hostile environment policies (Lonergan, 2023), may have perpetuated racism and xenophobia within the NHS and prevented immigrants, particularly asylum seekers, from accessing services (Shahvisi, 2019). Asylum seekers may face increased risk of receiving inadequate healthcare, partly due to racially discriminatory and prejudicial attitudes and behaviours within health services (Willey et al., 2022). Within the context of the UK, Asif and Kienzler (2022) argue that the structurally aggressive nature of the government's hostile environment policies has fuelled discrimination that has resulted in migrants becoming 'Othered' by NHS services. This 'Othering' has occurred through practices such as charging for secondary care, document checks, and the inappropriate sharing of private data (ibid.). The exclusion resulting from these potentially discriminatory practices racialises asylum seekers as unworthy of experiencing good health and wellbeing (Nellums et al., 2018).

Nevertheless, scoping reviews indicate that evidence on the racialisation of migrants within healthcare in the European context remains limited, emphasising the need for further exploration of the relationship between interpersonal racism within healthcare settings and institutional/societal-level racism (Pattillo et al., 2023). In this context – and informed by the conclusions of Pattillo et al. (2023) – this article employs a framework of racialised governance to explore the manifestation of racialisation in relation to asylum seekers within English healthcare.

It is important to consider the experiences of asylum seekers in the British healthcare system in the context of wider literature on race and racial discrimination within the NHS. There is an extensive literature, for instance, arguing that institutional racism and cultural dissonance limit minority ethnic service users from access to quality and effective healthcare, particularly so in antenatal and mental healthcare. In the UK, people from minority ethnic groups are more likely to have undiagnosed and untreated mental illness, enter healthcare via crisis or other aversive pathways, and receive a diagnosis of severe mental illness compared to the majority ethnic group (Cooper et al., 2013; Barnett et al., 2019; Halvorsrud et al., 2019). In recent years, the NHS has introduced a series of policies and frameworks intended to promote race equality within the NHS, including the Patient and Carer Race Equality Framework addressing racial inequalities in mental healthcare, Core20PLUS5, which explicitly re-states the need to reduce inequalities experienced by racialised groups across all parts of the health service, and the NHS equality, diversity, and inclusion improvement plan 2023 aiming to improve inclusion of racially minoritised NHS staff. Nevertheless, progress towards racial inclusion remains slow – for instance, while more staff from minority ethnic groups may be joining the workforce, their experiences in the workplace remain inequitable (Ross, 2024). The experiences of minority ethnic asylum seekers occur within this wider context of racism and racialisation in the NHS.

1.4. *Longitudinal research on asylum seekers and health*

While there is a growing body of literature on lived experiences of healthcare among asylum seekers (Lonergan et al., 2023; Poduval et al., 2015), there is relatively little that employs a longitudinal approach. The value of qualitative longitudinal research is increasingly being recognised in the social and health sciences for the depth that it allows in understanding people's lives and the ways in which it can illuminate the processes through which policy, interventions, and services can enhance, or inhibit, the wellbeing of individuals and groups (Treanor et al., 2021). The period in which our fieldwork was conducted saw a hardening of attitudes and policies towards asylum seekers, with introduction of the Rwanda Bill and an increase in the proportion of UK people responding that immigration should be reduced (from 42% in 2022 to 52% in 2023) (Richards et al., 2023). A longitudinal approach allows for insight into how these societal-level developments are experienced in everyday encounters, while also facilitating potential understanding of how access to services is navigated over an extended period, providing critical insights into the ways in which services can shape the lives of asylum seekers. More broadly, a temporal view of race and racialisation operates to counter discourse which portrays society as progressively less racist, with those levelling a charge of racism being dismissed as dwelling in the 'racist past' (Ngo, 2019). Instead, it may evidence the persistence of racism and racialisation, documenting the relatively unchanging nature of a racially divided world.

2. Materials and methods

2.1. *Research question*

How does racialisation shape the lived experience of asylum seekers in accessing primary and secondary health services in England, and how does this change over time?

2.2. *Study design*

This article emerged from a broader longitudinal qualitative study exploring the lived experience of food inequalities and mental health across England. The fieldwork took place in three cities, two in the North of England (Bradford and York) and one in the South of England (London). These three cities were chosen for their different demography – York a relatively affluent and predominantly white British city, albeit with notable pockets of deprivation; Bradford a city of high deprivation, with a large Asian and Asian British population (32%) (Office for National Statistics, 2023); and London a place of extreme wealth and income inequality and the most ethnically diverse region of the UK (Trust for London, 2023).

Participants living on a low income (self-declared) were recruited purposively through community groups, advice centres, Poverty Truth Commissions, and snowball sampling. Recruitment materials were translated into multiple languages (Spanish, Urdu, Arabic, and Punjabi) and a minority of interviews (n = 7) were conducted with the assistance of a translator. Amid the larger sample (N = 62) was a small but notable cohort of asylum seekers (N = 8) (see Table 1). All asylum seeker participants are subject to NRPF and can only receive Section 95/98 support. The interviews with these participants revealed distinct and often alarming issues, both around access to food (which we write about elsewhere - forthcoming Power and Baxter, 2024) and access to physical and mental health services, which arose repeatedly in Round 1 and 2 interviews (see below); this was the motivation for this separate study specifically addressing access to health services among asylum seekers.

Interviews with the sub-sample of asylum seekers took place between September/October 2023 (Round 1 interviews) and February/March 2023 (Round 2 interviews). All interviews with asylum seekers, bar one which took place on the phone, were conducted in person and half of these interviews were conducted with the assistance of an interpreter. Interviews lasted between 30 min and 2 h and explored in depth experiences of physical and mental health, and access to primary and secondary care, alongside lived experiences of food. The interview schedule for Round 2 explored change over time, specifically in relation to income, and access to public services, to understand the temporality of health experiences and service use. All interviews were recorded and transcribed verbatim.

The data was analysed inductively using thematic analysis (Braun and Clarke, 2006) to identify key themes; themes and codes were cross-referenced by both authors for accuracy. This initial analysis identified race and racism as key themes and subsequently the data was re-assessed, informed by a theoretical framework of racialised governance (Guma et al., 2023). The study received ethical approval from a university ethics committee and ethics were a high priority before, during, and after the interviews; we ensured that participants were fully aware about their involvement in the study before agreeing to take part, participants were able to stop the interview at any point, and signposting was available. All participants provided informed consent before taking part in an interview; names are pseudonymised and any identifying characteristics are changed. In recognition of their time and expertise, participants were provided with a £30 supermarket voucher as a thank you for participating in each interview.

Table 1
Demographic composition of asylum seeker sample.

Characteristic	Number
Gender	
Women	6
Men	2
Continent/region	
Africa	3
Middle East	1
South America	3
South Asia	1
Age	
18–24	0
25–34	1
35–44	7
45–54	0
55–64	0
65–74	0
75+	0
Children in the household under 18	
Yes	8
No	0
Language in which interview conducted	
Arabic	1
English	4
Spanish	3
Time in UK at first interview	
Under 2 years	5
Over 2 years	3
Status of asylum claim	
Granted refugee status	0
Status of claim pending	8
Asylum refused	0

3. Results

3.1. *Racialised experiences of healthcare*

Conversations with the asylum seekers in our sample revealed mixed experiences of accessing and using health services in England and intimated possible experiences of racialisation. Barriers to service use, including the availability of information about eligibility and access, language and communication barriers, and stigmatising experiences with clinicians and administrative staff, could be racialised, seemingly influenced by a wider political context which dismissed or impeded the social and health needs of asylum seekers. We did not explicitly ask participants about experiences of racism to both avoid potentially leading questions and in the light of our broader study aim which focused on food insecurity and access to services. Possibly for that reason, the term 'racism' itself was rarely used by participants, however description of lived experiences suggested multiple episodes of racism and racialisation which we explicate here in line with our theoretical framework above. Notwithstanding our small sample, our findings augment a growing body of work on inequitable access to healthcare among asylum seekers, contributing to our understanding of how health care (entitlement, access, and implementation/experience) not only reflects broader racialised immigration policies in the UK but also how healthcare (access and systems) can serve as a critical site of racialised Othering.

3.1.1. *Marginalisation and dismissal*

Participants described the difficulty of understanding the nature of service provision and accessing health services on arriving in the UK:

> “As a visitor when you come into town you will not know anywhere, you don't know where to go. It takes us some time before we can locate the service to register. It takes a bit of time.” - Amaka

Accessing primary care was beset with challenges. Multiple participants described struggles to secure in-person primary care appointments and the perception of their needs being dismissed by receptionists and GPs:

> “I requested to have an appointment with a GP but … the staff said, no, because the doctor is going to call you so I said, how you know the doctor over the phone is going to check how am I doing, how the doctor is going to check my blood pressure, the area that I am complaining, I need to have a face-to-face. So the answer that I received was not in a good way, you know what I mean, she said, okay … anyway I will try to figure it out, okay, so please wait. And then I was seen by the doctor but also the doctor saw me in a really fast appointment saying that I didn't have anything at all, that was my understanding, that she said that I didn't have anything at all, that in a few days I would feel much better.” - Carmen (via an interpreter)

A perception of not being taken seriously and of health needs being dismissed by primary care receptionists and GPs was a prominent theme. This manifested in not being able to secure face-to-face appointments, as in the case of Carmen, and either being denied medication for a perceived health need, being advised to buy their own medication, or being recommended paracetamol when the level of pain was considered to require more than this. The expectation to purchase their own medication could create particular financial pressures for asylum seekers subject to Section 95 support (Shelter, 2024):

> "I have to say that having to buy some medications that the doctor will not prescribe for me because they say that they are very cheap and I could afford to buy them like vitamins and things like that. So obviously we have less money to afford to spend and I think they are actually a bit racist in not giving us everything that we need in terms of medication." - Marcia (via an interpreter)

A perception of needs being dismissed was a recurrent theme in discussions of reproductive and sexual health. Participants reported requesting contraception or reproductive and sexual health check-ups which they were told by clinicians that they did not need, in one case resulting in an unwanted pregnancy, as described by Elena and Marcia, both via an interpreter:

> "… because before coming, she [Elena] was due to get surgery, I think to stop having children and stuff. But then she couldn't do it, so when she came here she asked for it, but they told her to take more pills and she said that she was taking pills in her home country but they were not working. But they told her no, take pills, it's going to work. And then she also asked for an injection, but they still didn't want to give her the injection, they told her to go for the pills. So if they could work on that too and she was on her pill and still got pregnant, so. Yes, because normally when she's pregnant, she finds it hard on her kids, they really suffer." - Elena

> "She [Marcia] has asked again for a smear test because she has suffered in the past from polycystic ovaries. She has repeatedly asked for an appointment and she has never been given an appointment for that." - Marcia

These recurrent themes of difficulty in understanding and accessing healthcare accompanied by feeling dismissed and marginalised by providers intimated evidence of racialised 'Othering' (see also, Asif and Kienzler, 2022) in which the experiences of asylum seekers marked them as an 'inferior' population unworthy of adequate healthcare. Notwithstanding, the severe resource pressures currently experienced by primary and secondary care in the UK (Hernandez, 2021), this 'Othering' was arguably associated with institutional and interpersonal racial discrimination, manifesting in extreme difficulty in accessing face-to-face appointments, the denial of medication and treatment, and apparent condescension from clinical and administrative staff. This reproduced the ideology, embedded in the 'hostile environment' agenda, that asylum seekers are an inferior population, whose entitlement to dignified and effective medical care can be questioned, ultimately compounding ill-health among an already-vulnerable population. It was notable that female asylum seekers experienced particular challenges surrounding both sexual health and accessing services for their children (discussed below), underscoring the intersectionality of lived experiences in the 'zone of non-being' (Grosfoguel et al., 2015).

3.1.2. Language and interpretation challenges

The denial of rights to inclusive care was particularly apparent in the case of language. Despite a legal right to an interpreter (Office for Health Improvement and Disparities, 2021), many asylum seekers described not being provided with an interpreter and struggling to communicate with receptionists and clinicians. This restricted their ability to access (primary care) appointments and compromised communication within the appointment itself, described by Elena and Marcia, both via an interpreter:

> "Sometimes, the health services, they find it hard because some of them don't use interpreters and then sometimes, you try to translate what you're saying on the phone but they don't want to touch the phone. Some of them don't even like to look at the phone, them and sometimes the people that are helping, like nurses and stuff and it's hard. She [Elena] says it's complicated, because sometimes you want an appointment, you call them but your English is not good, your pronunciation is not good. So they don't understand you then she tries to go face to face to make the appointment one day and they tell her she has to call." - Elena

> "So in every consultation she [Marcia] had asked for an interpreter because her English was very poor at the time, she asked for an interpreter and the doctor kept saying he did understand her but obviously she didn't understand him … She never had any offer, never ever had an interpreter present or by phone so she could understand what they were saying." - Marcia

Failure to adhere to these legal requirements and minimise the impacts of language barriers arguably reproduced racialised governance through everyday healthcare encounters. Asylum seekers were unable to access the relevant services they are legally entitled to and, within those services, denied the assistance that would facilitate the necessary communication in a clinical setting. While neither Elena nor Marcia explicitly described this as a form of discrimination, it is arguable that denial of access to interpreters *was* a form of discrimination, and one which marked them, as inferior to and less worthy of support than others (Grosfoguel et al., 2015).

3.1.3. Adult agency, child health and bureaucratic opacity

Overwhelmingly clear from the interviews with asylum seekers was their profound lack of agency accessing and using health services. The availability, time, and format of appointments was entirely at the discretion of administrators or clinicians and, in appointments themselves, asylum seekers were often not able to fully make themselves understood and, when they were, had their health needs ignored or dismissed. For those seeking follow-up care from a course of medication or treatment, appointments were likewise at the discretion of gatekeepers:

> "So I don't really need to see the doctor, so that was what they told me at least the last time because that other time, they gave me a bunch of I don't know if I told you, a bunch of food supplements, drugs? That if I need more they will let me know, they will book an appointment for me. So for now, I'm still waiting for that. They haven't said anything." – Eniola (Round 2 interview).

Inadequate access to services was not restricted to adults but also applied to the children of asylum seekers. Parents struggled to access appointments and appropriate medication for their children's health needs and, like adults, children were advised to take paracetamol or over-the-counter vitamins rather than prescribed medication:

> "My daughter hasn't had the vaccination she should have. Also she has a problem in the heel of her left foot and they say it's just a lack of vitamins. I've been buying her vitamins and it's not improving but they're not really looking into it." - Eniola

> "One of her [Marcia] kids, he's always complaining of knee pain and they always give him paracetamol. And from her point of view, she doesn't feel that it's okay that he's always feeling that pain and yes, but most of the time, all they tell you to do is give paracetamol." - Marcia (via an interpreter)

For children born in the UK to parents who were seeking asylum, there appeared to be a distinct lack of clarity surrounding government's responsibility towards providing care. Participants described seeking support from the local authority and health visitors but being told that their children, including babies under one-year-old, were not their responsibility, and being directed from secondary care to primary care when babies were very unwell:

> "When she [Elena] first had the baby, she's ten months now, the first five months she didn't receive help with the baby, because they said it's not their responsibility. She went to the council, but the council also said it's not their responsibility. And then the health visitor also, they spoke to her but the health visitor said they also can't do anything because it was not their responsibility. So it was really hard." - Elena (via an interpreter)

The government's guidance for practitioners indicates that the children of asylum seekers should have access to health visitors from 0 to 5 years, and that anyone should be able to access these services regardless of their immigration status (Office for Health Improvement and Disparities, 2021). It was unclear why Elena and her children had been denied support from health visitors, but it did underscore a broader confusion among both service providers and asylum seekers surrounding eligibility, which was further compounded by moves – albeit often rhetorical – to further restrict care, illustrated by recent discussions concerning financial charges for primary care (Asif and Kienzler, 2022; Nellums et al., 2018).

3.2. *Positive experiences of healthcare services*

There were, however, several positive experiences of primary and secondary care among the asylum seekers we spoke with, which appeared to be tied to either the disposition of the clinician or the severity of the illness and the consequent nature of secondary care. A woman with three children who was seeking refuge in the UK from persecution in her home country described the empathy, kindness, and attentiveness she received from her GP:

> "Oh, my GP is the best GP by far. Oh no, she's so kind. Because she's the kind of person that understands what I'm going through so she will call, talk to me. If I complain she will make sure she gives me enough medication, for my mental health she gives me enough medication. She will talk to me. Sometimes she invites me over to talk, like. She's a white person that will talk a lot. She advises me, she counsels me. She's the one that has been monitoring my condition ever since I came here. She's so helpful, she's so helpful, very, very." - Amaka

It was notable that Amaka's positive GP experience was potentially a consequence of her GP providing additional support *because* of Amaka's experiences of violence which instigated her seeking asylum. In this way, Amaka was potentially racialised by her GP, but this led to superior rather than inferior healthcare. Comparably, a participant with a daughter with a low-grade glioma described the personal assistance she and her daughter had received from an oncology nurse, which was decisive in securing accommodation close to her daughter's preferred primary school:

> "For my appeal, they'd given me the date to hear the appeal, and while I was waiting, a nurse visited me in my house … and then she just offered herself, she said, 'Oh, tell me the day when you are going to the appeal hearing, I'll be there.' So, she came to that appeal and she backed up my story, saying this is why we need the closest school, because it's convenient for her, and then I actually got the school … And not only the medical side, but they were like – how to say – she went like an extra mile to help me." - Nadesha

The high level of care experienced by Nadesha and her daughter was, nevertheless, also institutional rather than solely dependent on individual clinicians. Nadesha's daughter received regular, attentive, and high-quality care from the oncology and the paediatric neurology teams at the local hospital, which not only monitored and addressed Nadesha's daughter's health needs, but also considered her (and her mother's) emotional and social needs:

> "And then the new paediatric neurology team, they just assigned me to a course for epilepsy, so I know what's happening, and also they actually joined me to a charity which helps kids with kind of illnesses like that. They give bicycles, tablets or computers, it depends. I don't know how they check it. But you have a first preference, second preference. My phone was really old and it had no memory. … That's paediatric neurology talking to a charity. I didn't even talk about what I want, I didn't say, but when the charity called me, I said, 'Yes, I'm wanting one of these', so they've given me, so it's made it easy for school especially." - Nadesha

It was notable that both participants were positive about their experiences of healthcare spoke good or fluent English and, consequently, and in the absence of accessible interpretation services described above, were able to navigate the complex web of asylum seeker rights and entitlements and advocate on their own behalf in healthcare encounters. It was in this way that racialisation took place; asylum seekers who spoke English and could navigate a complex system were 'differently included' (Bhui, 2016), they were able to access superior care arguably because their similarity to the British population was greater than those who were unable to speak English.

3.3. *Longitudinal experiences of healthcare*

3.3.1. *Unchanging experiences*

Speaking to the persistence of racism and racialisation and counter to perceptions of progressive racial inclusion (Ngo, 2019), experiences of healthcare predominantly did not improve over time, despite asylum seekers becoming more accustomed to the UK healthcare system and better able to navigate the complex landscape of services. At best, experiences remained the same: for (the very few) participants whose experiences of primary and secondary care had been positive in the first interview, these remained positive in the second. Asylum seekers who disclosed negative experiences in their first interview had either not subsequently accessed healthcare or had continued to have negative experiences. The one exception to this was a participant (Carmen) who had experienced significant racial discrimination in her early encounters with primary care, initially unable to access a face-to-face appointment and, once this had been secured, feeling dismissed and disbelieved by the GP. Once Carmen had received a diagnosis, however, she became slotted into a system of monthly blood tests and regular prescriptions. It was notable that the service had improved for her *because* she no longer needed to access the GP directly, only the nurse administering blood tests, and also because she received administrative assistance in accessing her prescriptions from staff at the hotel in which she lived. In the case of Carmen, therefore, it appeared not that the system itself was racialised but that racialisation could – and therefore also could not – manifest in everyday encounters with clinicians and administrators

> "To be honest, now service is good because I only have to interact with the girl who is in charge of the blood tests. Not the doctor because last time I was at the doctor's surgery the girl at reception would not book a telephone appointment. One appointment that was needed for the girl was face-to-face. Then there was an occasion where the girl at reception said that it would be better if the appointment was over the phone, and I said no to that. The girl at the hotel reception will request the tablets for me and all I have to do is go to the pharmacy to collect the tablets; I do not have to request the medication myself." - Carmen (Round 2) (via an interpreter)

3.3.2. *Experiences of mental healthcare overtime*

The value of longitudinal interviews was particularly notable in understanding experiences of accessing mental health services, as well as the extent to which these may or may not have been racialised over time. A majority of the asylum seekers we spoke to experienced some form of mental health problem; often this was connected to the circumstances which instigated their migration to the UK which could be violent and traumatic:

> "So I just told her [a nurse], 'If I can get a therapist that would be lovely.' Because when I was in my country I know my PTSD has not been treated or properly looked at, I did not go to anyone, I did not seek help because it was hard for me to get out of the house without … Oh it's really, really hard; the amount of anxiety you get when you step out of the house." – Nadesha (Round 1)

It could also, however, be a consequence of life in the UK, marked by financial hardship (largely precipitated by NRPF), anxiety whilst waiting for a decision about asylum status, and work restrictions, which had a profoundly negative effect on mental health:

> "If I'm privileged to go out, work, meet people, talk to people, I will be less depressed. But sleeping, waking up, you want to get something you cannot get, you want to do this, you cannot do. And not that you are lazy … you can do what normal people do. And you couldn't get those things, as a normal human being apart from my condition, you get depressed. You get down in your spirit, you would be mad, that is it. That is it." - Amaka (Round 1)

In the first round of interviews, multiple participants disclosed that they were on medication for their mental health and on the waiting list for therapeutic services. By the second round of interviews, six months later, despite often severe mental distress from historic violence and trauma, all these participants were *still* on the waiting list for mental health services. In her first interview, Amaka spoke about her need for therapeutic care:

> "Yeah, my GP. According to her she has booked me with mental health, but they are up until now expecting them to call me. Because according to her there are a lot of patients, there are a lot of people waiting for an appointment. But like my situation, I don't sleep at night … She has been helping me with some drugs. Sometimes I take the drugs because she will make sure if I complain about the drug, the drug is finished she will send me another one, okay. So I can go and collect it from Boots you understand, so she has been helpful. Mental health, I'm still expecting their calls. To call me to at least hear me out, to hear me what's really happened. Along with my situation I lost a pregnancy." - Amaka (Round 1)

By her second interview, Amaka remained on medication for her depression and was still waiting for access to talking therapies:

> "I don't know, they said there are a lot of people in the queue. They refer me, they still refer so it's, there are a lot of people in the queue … But with the support of the medicine, the drugs they are giving me, it's helping." - Amaka (Round 2)

There was no evidence that Amaka's mental health had deteriorated during the seven-month period between her first and second interview, largely a consequence of continued assistance from her GP, family support, and the increasing period since the traumatic events which had necessitated her migration to the UK. Her mental health had not improved, however, and instead she had become accustomed to the insomnia that was a consequence of her depression and post-traumatic stress disorder.

There was little suggestion that the inaccessibility of mental health services was necessarily racialised; it instead appeared to be a consequence of wider demand for overstretched services. However, it did align with a broader model in which the health needs of asylum seekers – often urgent and serious – could be disregarded or ignored. It was notable that whilst the poor mental health of asylum seekers was partly a consequence of previous violence and trauma it was also related to current living circumstances of destitution and insecurity. These circumstances, a product of the 'hostile environment', were undoubtedly racialised, designed to discourage 'undesirable' asylum seekers from travelling to the UK. In this way, highly racialised Home Office policy created additional mental health need which could not be accommodated by under-resourced mental health provision.

4. Conclusion

The experiences of asylum seekers interviewed for this study illustrate how, despite a legal right to primary and secondary care, access to healthcare for asylum seekers in England can be inaccessible and highly variable. Barriers, many of which are also evidenced elsewhere (Chase et al., 2017; Khanom et al., 2021; Kiselev et al., 2020), include the complexity and opacity of the English healthcare system, rendering the process of knowing how and where to access services highly challenging; significant difficulties accessing face-to-face appointments, which are particularly important for people with English as a second language; denial of access to interpreters; and being dismissed and disbelieved by administrators and clinicians, often leading to a refusal to prescribe medication. There were particular difficulties in accessing mental health care which, while not inconsistent with the wider inaccessibility of mental health services in England (Cummins, 2018), were especially concerning given the histories of trauma and violence and current prevalence of severe anxiety and depression, itself often a consequence of a 'hostile environment' which created destitution and insecurity, among the asylum seekers interviewed for this study. Insights from longitudinal interviews demonstrated that experiences of physical healthcare largely did not improve over time despite increasing familiarity with the complexity and rules of English healthcare, and access to mental health services remained absent.

Notwithstanding, the depth and longitudinal nature of the interviews this is a small study; our findings, nevertheless, align with previous research, attesting not only to the barriers to accessing healthcare for asylum seekers, but also to the increasing racialisation of health services in the UK as the hostile environment agenda influences the scope and delivery of service provision for asylum seekers. Despite diversity in the asylum seekers interviewed for this study in terms of gender, time spent in the UK and English language proficiency, it was notable that all had migrated from a diverse array of Global South countries to the UK for the purpose of seeking asylum – rather than, for instance, on a marriage or skilled work visa – and it was apparent that their treatment within the English healthcare system marked them distinctly as inferior. Adults and children were often disbelieved, misunderstood, and denied access to treatment, marking them not only as a racialised 'Other' (Asif and Kienzler, 2022) but as occupying the "zone of non-being" (Grosfoguel et al., 2015). None of the asylum seekers interviewed suggested that structurally discriminatory policies cited elsewhere, including charging for secondary care, document checks, and the inappropriate sharing of private data (Asif and Kienzler, 2022), deterred them from accessing healthcare, however the consistency of the racialised barriers that were experienced suggested that they may have been embedded at an institutional level. It is possible that a politically racialised policy agenda, accompanied by complex and often opaque healthcare entitlements for asylum seekers, had legitimated discriminatory and prejudicial attitudes within the NHS, leading to inadequate healthcare for asylum seekers (Willey et al., 2022) or inability to access services (Lonergan, 2023; Shahvisi, 2019). The complexity of rules surrounding entitlements appeared to create confusion surrounding policy among some NHS and local authority employees, contributing to inconsistent care across NHS Trusts and occasionally resulting in a denial of care. Whilst there were important examples of empathetic and proactive care from clinicians and administrators, these did not mitigate the racial discrimination which was evident elsewhere. Going forward, it is essential to listen carefully to the healthcare experiences of asylum seekers to understand how services are discriminatory and how equitable and accessible services can, and should, be provided.

CRediT authorship contribution statement

Maddy Power: Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Maddie Baxter:**

Writing – original draft, Project administration, Formal analysis, Data curation, Conceptualization.

Ethics statement

The study received ethical approval from the University of York Health Sciences Research Governance Committee on 23.11.20 (Reference: HSRGC/2020/418/F).

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Declaration of competing interest

We have no interests to declare.

Data availability

The data that has been used is confidential.

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