

## **The project**

### **Aims, objectives, and relevance of the project**

The principal aim of this pilot study is to build an evidence base that allows studying the wellbeing status of individuals living in the UK that can experience vulnerability, and explore factors that may contribute to shaping this.

The objectives of the pilot project are as follows:

1. To prepare a dataset allowing for the in-depth examination of the data;
2. To examine, via descriptive analyses, the available variables in the data and their suitability for measuring wellbeing;
3. To document the results, with the aim to inform the larger project, as well as practitioners, and policy makers; and
4. With the project partners and advisory board, consider the need for, and develop, a proposal for a larger project, with an analytical, engagement, and dissemination strategy.

## **Data**

### **Background**

The data used in this project come from the clinic-based advocacy programme run by DOTW UK. Basic primary care was delivered by volunteer doctors and nurses in three clinics based in London and Brighton (the Brighton clinic is no longer running). A family clinic service dedicated to pregnant women and children was added in 2014 in response to increasing numbers of pregnant women attending the main clinic who had not received any antenatal care. Additionally, outreach clinics serving specific groups such as domestic workers and sex workers have been provided away from the main clinics in locations more easily accessible to these groups.

On attending any clinic, service users are interviewed by a clinic support worker and complete a social form. This questionnaire relates to social situation, immigration status, living conditions, self-reported health status and barriers to health care. Support workers actively assist service users to register with a general practitioner, the entry point to the national health system, and provide information on how to access other services such as legal advice or women's refuges.

A proportion of service users then see a volunteer doctor or nurse for a medical assessment during which a medical form is completed with data about health and experience of violence. Specific diagnoses are recorded using the ICPC-2 (International Classification of Primary Care – second edition) pathology classification system (World Health Organisation,

International Classification of Primary Care, Second edition (ICPC-2), available at <http://www.who.int/classifications/icd/adaptations/icpc2/en/>).

Written consent is gained beforehand that permits the collection and use of anonymised data for DOTW reports and research for advocacy purposes.

The questionnaires were devised and validated by Médecins du Monde (MdM) in collaboration with researchers based at INSERM (French National Institute of Health and Medical Research) and CNRS (The National Center for Scientific Research) (Chauvin et al., 2009). They were designed for routine data collection from countries participating in the first MdM international observatory report in 2006, and evolved from the system of data collection used by MdM in its free clinics since 1994 (Observatory report 2012). Data was initially collected only for undocumented migrants attending MdM clinics and from 2011 was expanded to include all service uses (Chauvin and Simonnot, 2012).

The social and medical forms are reviewed each year by the Médecins du Monde Observatory team to improve the quality of data and analysis that is produced (Chauvin et al., 2014). Over the years some questions have been updated or removed and new questions added to reflect recommendations made by INSERM researchers and feedback from teams in the field (Chauvin et al., 2015). The collection of data has the triple aim of improving service quality, production of good quality public health data for healthcare providers and policy makers and supporting field teams in programme monitoring (Simonnot et al., 2016).

## **Key findings**

### **Overview of the sample**

The merged dataset included 10,692 observations (1 observation = 1 consultation) across the available years. For ease of analysis, we only included unique visits in our sample for the whole period, for a raw total of 8,489 observations (1 observation = 1 unique service user in the period; this implies that the sample sizes for this dataset differ from those from the Observatory Reports, which include one consultation per individuals but may include repeated consultations across various years). The breakdown of observations per survey year can be found in Table 1. Out of the 8,489 observations in the sample, 82.9% visited a DoTW clinic once, 12.2% visited twice, 3.1% visited three times, and the remainder visited the clinic over four times during the time period covered by the data.

**Table 1 Number of observations per year**

Year	Pooled data	Observatory data
2011	1462	1449
2012	1497	1561
2013	1046	1047
2014	1284	1395
2015	1479	1601
2016	1721	1758
Total	8489	8811

If we look at Table 2, which states the main reasons for consultation, we see that most consultations are linked to administrative, legal, and social issues (one of the most common reasons for consultations appears to be GP registration). Across all years covered by the sample, 87.3% of all service users report no health cover, with a similar percentage (2011-2014 data only) not registered with a GP.

**Table 2 Reasons for consultation (N=7752)**

	% Mentions
Administrative, legal, social issue	91.2%
Medical issue	47.4%
Psychological/Psychiatry issue	1.2%
Other	6.5%

### **Demographic information and immigration situation**

We now delve into details about the demographic characteristics and immigration situation of the clinic's service users (see Table 3), which we will use to examine wellbeing profiles. Looking at the demographic characteristics, we see that service users are more or less evenly split with regard to sex and that the mean age is 35.6 years of age. Approximately 35% of services users have used interpreters during their consultation. Looking at their geographical distribution across London (Figure 1 – where darker colours indicated boroughs with the highest number of service users, which are divided in quintiles<sup>1</sup>), we see that most service users come from areas close to that of the main clinic in Bethnal Green, but that the geographical spread within London is quite broad as well. Note that just over 10% of the service users reside outside of London.

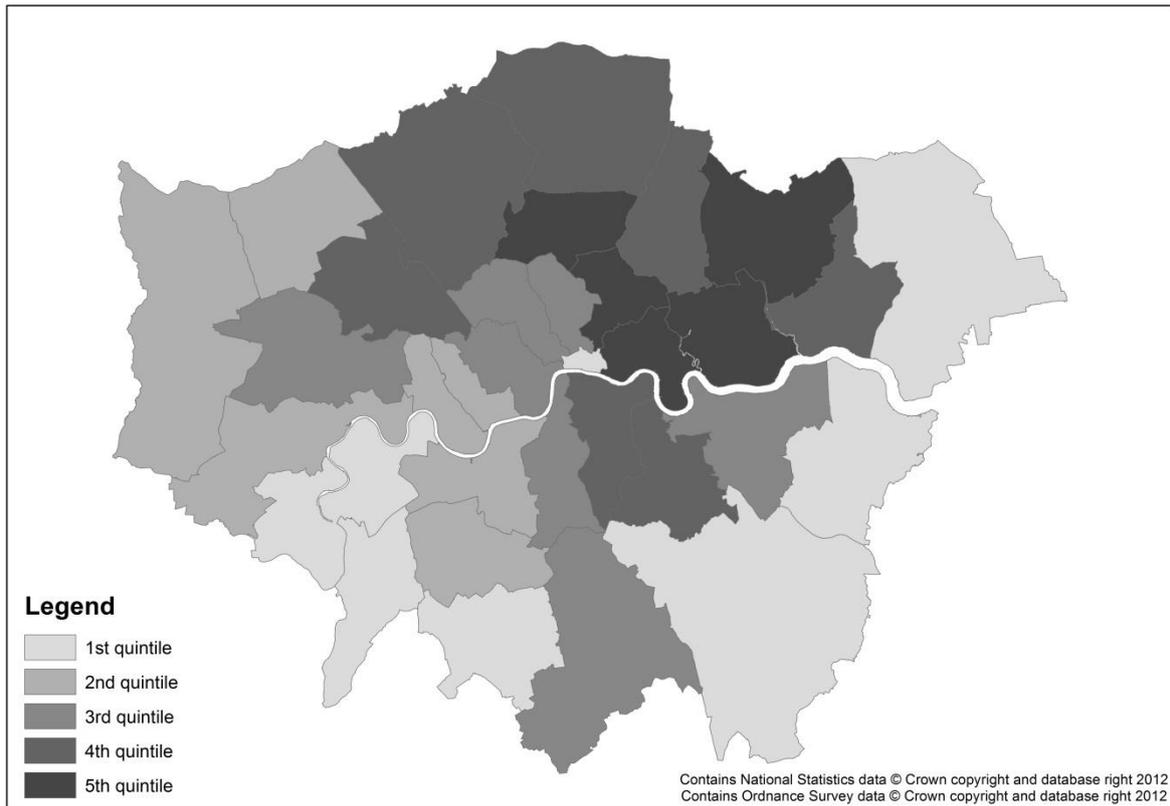
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<sup>1</sup> Quintiles divide data into 5 equal groups.

**Table 3 Demographic and immigration characteristics of service users**

Variable	Categories	%/mean	N
Sex	Female	48.3%	8226
	Male	51.7%	
Age		35.6 years	8148
Use of interpreter	No need	48.1%	8498
	No	7.2%	
	Interpreter present	24.8%	
	Interpreter over phone	10.1%	
	No information	9.8%	
Immigration status	Undocumented	58.1%	7603
	Asylum seeker	15.1%	
	Other	26.9%	
Years since last entry		5.2 years	7008
Ever claimed for asylum (or planning to)	Yes	44.5%	7129

Looking at the immigration status of service users, a large majority (58.1%) are undocumented and 15.1% are asylum seekers. Within the 'other' category of service users, of which only a small proportion (4.4%) do not require a residency permit, about half are non-EEA nationals with other types of visit or residency rights. For those not born in the UK, the mean number of years since last entry into the country is 5.2 years. Among those eligible, 44.5% of respondents have either claimed asylum or are planning to claim asylum. These are mostly current asylum seekers but also a large proportion of the undocumented service users.



**Figure 1 Borough of residence of service users**

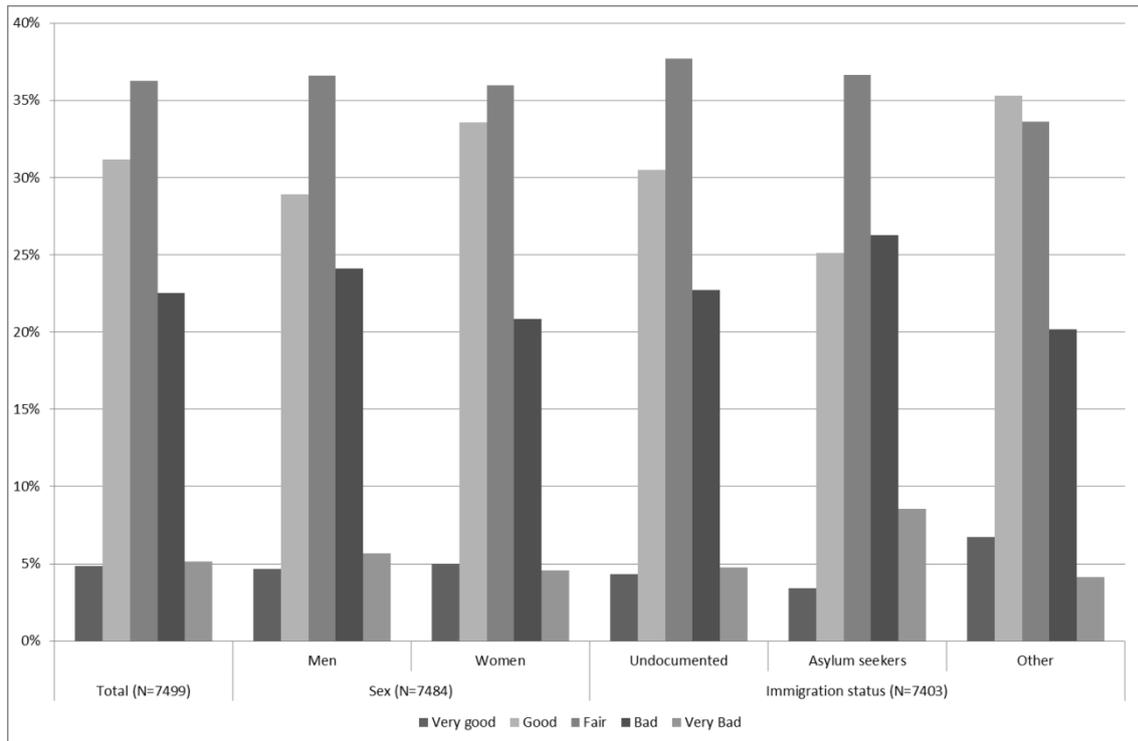
**Wellbeing: health, emotional support, living conditions, and income situation**

We now move to the wellbeing profiles of service users. Given our multidimensional approach to wellbeing, we look beyond typical indicators (usually health-related) to also include measures linked to service users’ emotional support, living conditions, and income situation.

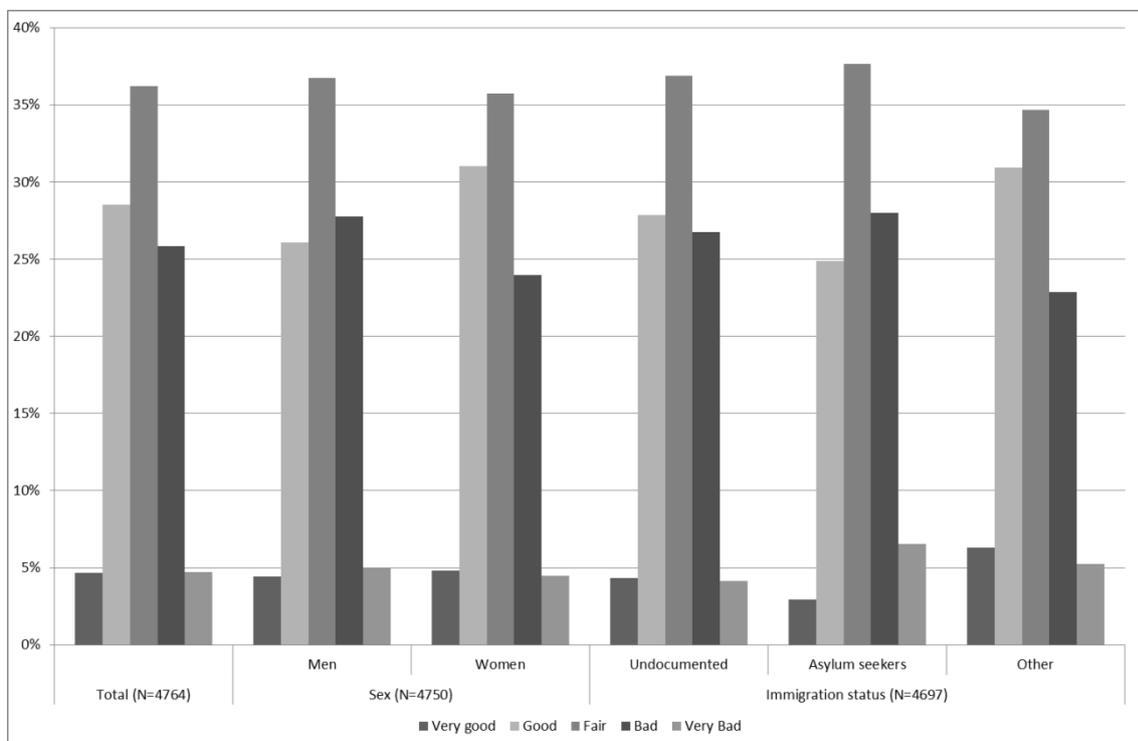
**Health**

Self-reported health status is an often used measure of wellbeing in research. In our dataset, we have three different conceptualisations of self-reported health: general (asked in all years); physical (asked from 2013); and psychological (asked from 2013). Figures 2 to 4 show the distribution of self-reported health for all service users, and for service users according to sex and immigration status. In order to provide a comparative benchmark, at least for general health, we use the 2011 Census results for England, which show that 47.2% of the population rated their health as very good; 34.2% as good; 13.1% as fair; 4.2% as bad; and 1.2% as very bad (Office for National Statistics, 2013). Despite the crude comparison, it is possible to see that this distribution of self-rated general health is quite different than that of the service users in the data. In fact, among all service users, 4.9% of services users rated their general health as very good; 31.2% as good; 36.3% as fair; 22.5% as bad; and

5.2% as very bad. Men tend to rate their health as worse than women, whereas asylum seekers appear to be the group with the most negative rating of their general health.

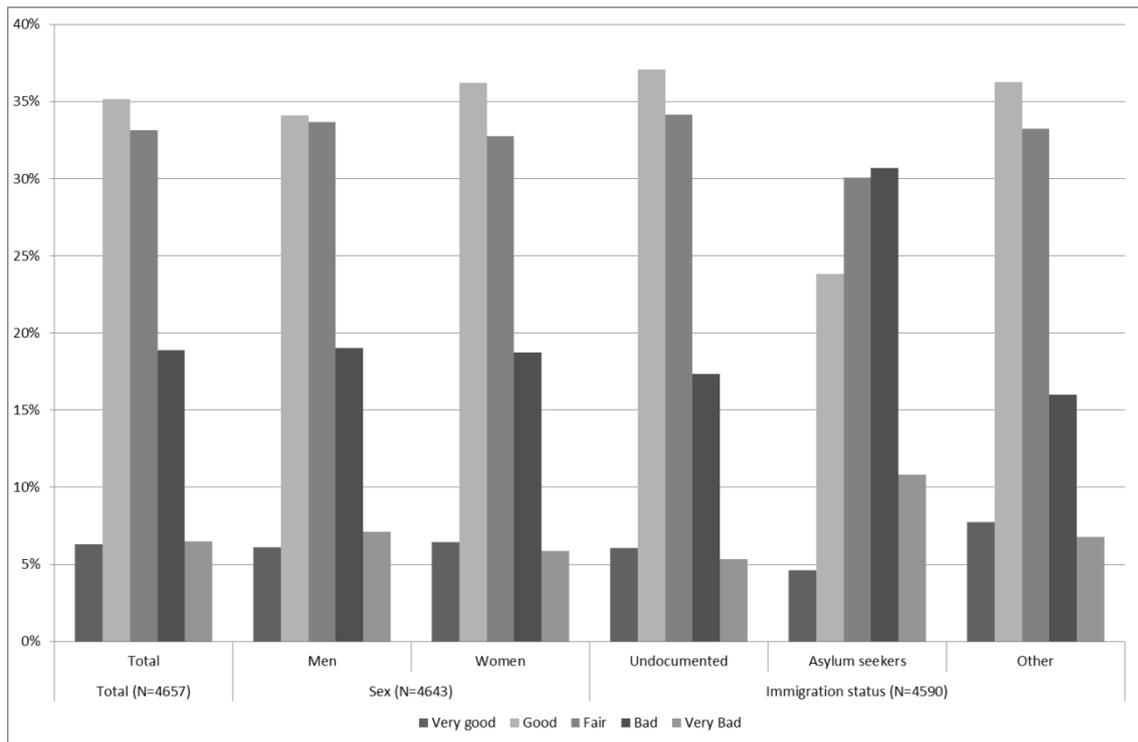


**Figure 2 General health**



**Figure 3 Physical health**

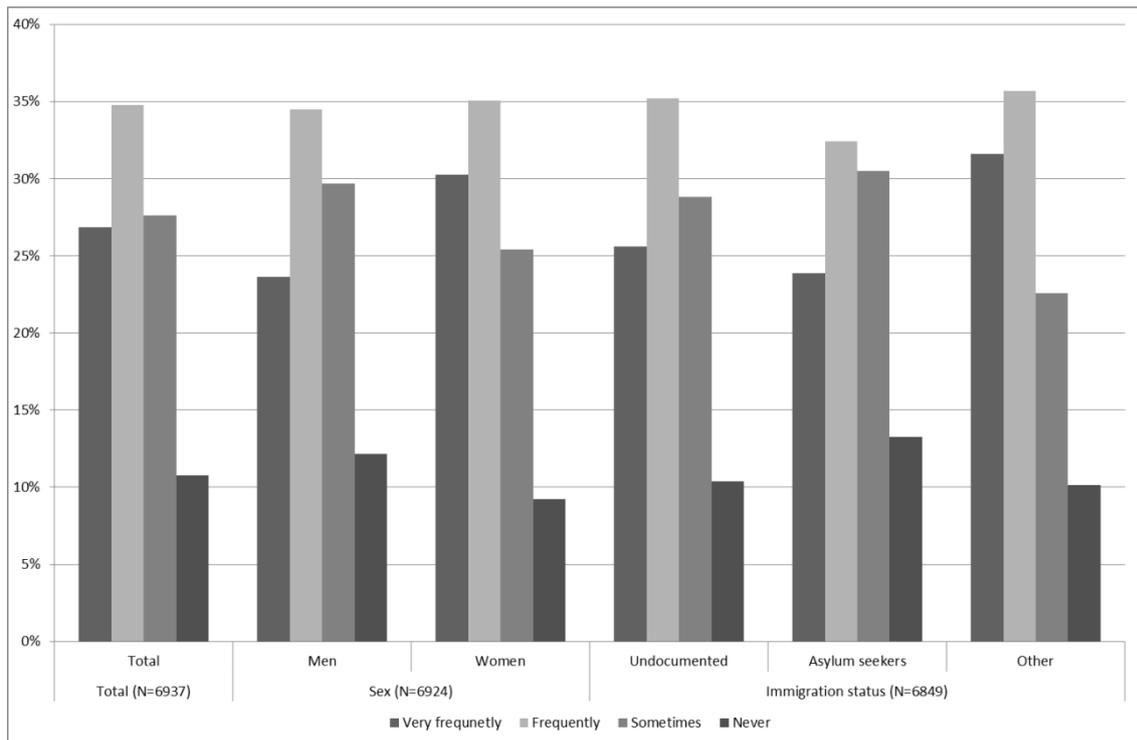
Moving on to physical health in Figure 3, similar patterns of self-rated health arise for the overall sample and between men and women. Whereas asylum seekers tend to have a more negative evaluation of their physical health, the difference with undocumented service users is, however, not as large. Looking at psychological health is where there are larger differences in evaluations for asylum seekers: theirs are much more negative than the other groups when it comes to their mental health.



**Figure 4 Psychological health**

### Emotional support

Research has shown that the presence of support networks is important for many aspects of everyday life, including integration (see, e.g., Ager and Strang, 2008). Figure 5 highlights service users' perception of the presence of emotional support in the place where they live. Just over 10% of service users feel like they do not have anyone to rely on for emotional support; this is higher for men and asylum seekers. At the other end of the scale, 26.8% of service users feel that they have very frequent access to emotional support, which is especially strong for female service users and those with 'other' migration statuses. Thus, there seem to be some specific groups who may be more at risk of isolation.



**Figure 5 Presence of emotional support**

### Living conditions

We now turn to service users' living conditions (Table 4). With regard to housing, we see that just under 88% of service users live in a personal flat or house (although it is not clear whether this is shared accommodation or not), but that a lower share of service users evaluates their accommodation as stable (64%). Just over 13% of service users, however, felt that their accommodation was detrimental to their health or that of their children.

**Table 4 Living conditions of service users**

Indicator	Categories	%
Type of accommodation (N=7565)	Rough sleepers	4.4%
	Charity/Camp/Squat/Work	4.7%
	With friends/family <sup>^</sup>	3.5%
	Personal flat or house	87.5%
Stable accommodation (N=7323)	Yes	64.0%
Accommodation affecting health (N=6709)	Yes	13.4%
Limitation of movement for fear of being arrested (for undocumented – N=4533)	Very frequently	25.6%
	Frequently	17.5%
	Sometimes	27.5%
	Never	29.5%

Note: <sup>^</sup>Living with friends and/or family has only been asked since 2014.

We also investigate whether undocumented service users tend to limit their movements for fear of being arrested. Among this sub-group of that data, just over 70% of service users tend to limit their movement, with various levels of frequency.

### **Income situation**

The income situation of service users is highlighted in Table 5. Among them, less than a third have a job or other activity that earns them a living; this rate is higher for women. Of those working, a very large proportion of service earn an income that is below the poverty limit. This implies that economic hardship is a reality for the overwhelming majority of service users.

**Table 5 Income situation of service users**

	Total	Women	Men
% with job/activity to earn a living (N=7248)	29.5%	35.1%	24.4%
% with income below poverty threshold (2013-2016, N=4234)	82.3%	77.6%	87.0%

### **Healthcare access**

We now turn to issues of healthcare access, as shown in Table 6, which are important factors in influencing wellbeing and one of the main areas of focus of the DoTW UK social questionnaire.

With regard to difficulties in accessing healthcare, 18.6% of service users indicated that they were denied access to healthcare by their provider (with a much higher share of asylum seekers reporting this); 10.6% reported they had given up seeking treatment and 1.6% reported being a victim of racism by their healthcare provider. Among service users not registered with a GP (a large proportion of service users being not registered), most did not use any healthcare services. Among those who do, A&E and Walk-in centres were the most used. In terms of the type of problems faced when trying to access healthcare, although around 45% indicated not having tried, most mentioned problems were linked to administrative issues, lack of understanding, language barriers, fears of being reported and denial of coverage.

**Table 6 Healthcare access issues for service users**

		Undocumented	Asylum seekers
% Access denied by healthcare provider (N=6630)	18.6%	16.5%	26.0%
% Given up seeking treatment (N=6526)	10.6%	11.6%	13.0%
% Victim of racism by healthcare provider	1.6%		
Healthcare services accessed by unregistered service users (N=2918, 2011-2014)			
None	59.2%		
Walk-in centres	13.6%		
A&E	29.7%		
Private clinic/GP	1.7%		
Pharmacy	1.3%		
Problems in accessing healthcare			
Did not try	44.9%		
None	4.7%		
Administrative issues	32.1%		
Lack of understanding	32.6%		
Denied coverage	10.5%		
Treatment too expensive	2.2%		
Language	16.3%		
Fear of being reported/arrested	11.8%		
Previous bad experience	1.8%		
Healthcare coverage too expensive	2.3%		

## References

- Ager A and Strang A (2008) Understanding Integration: A Conceptual Framework. *Journal of Refugee Studies* 21(2): 166–191. DOI: 10.1093/jrs/fen016.
- Chauvin P and Simonnot N (2012) *Access to health care for vulnerable groups in the European Union. Report on 2011 data from five health centres in Europe: Amsterdam, Brussels, London, Munich, and Nice and from mobile units in Patras and Igoumenitsa (Greece)*. Paris: Médecins du monde - Doctors of the World International Network. Available at: <https://mdmeuroblog.files.wordpress.com/2014/01/full-report-on-access-to-healthcare-vulnerable-population-october-2012.pdf> (accessed 27 January 2017).
- Chauvin P, Parizot I, Simonnot N, et al. (2009) *Access to healthcare for undocumented migrants in 11 European countries: 2008 survey report*. Paris: Médecins du monde.
- Chauvin P, Simonnot N, Vanbiervliet F, et al. (2014) *Access to healthcare for people facing multiple vulnerabilities in health in 26 cities across 11 countries*.
- Chauvin P, Simonnot N, Vanbiervliet F, et al. (2015) *Access to healthcare for people facing multiple health vulnerabilities in 26 cities across 11 countries. Report on the social and medical data gathered in 2014 in nine European countries, Turkey and Canada*. Paris: Médecins du monde - Doctors of the World International Network. Available at: <https://mdmeuroblog.files.wordpress.com/2014/05/mdm-intl-network-full-report-11-countries-22-may-2015.pdf> (accessed 27 January 2017).
- Office for National Statistics (2013) LC3206EW (General health by ethnic group by sex by age) - Nomis - Official Labour Market Statistics. Available at: <https://www.nomisweb.co.uk/census/2011/lc3206ew> (accessed 1 February 2017).
- Simonnot N, Rodriguez A, Nuernberg M, et al. (2016) *Access to healthcare for people facing multiple vulnerabilities in health in 31 cities in 12 countries. Report on social and medical data gathered in 2015 in 11 European countries and Turkey*. Paris: Médecins du monde - Doctors of the World International Network. Available at: [https://mdmeuroblog.files.wordpress.com/2016/11/observatory-report2016\\_en-mdm-international.pdf](https://mdmeuroblog.files.wordpress.com/2016/11/observatory-report2016_en-mdm-international.pdf) (accessed 27 January 2017).