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## **US vs. Wales: Comparing and Improving Refugee Health Policy**

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**US vs. Wales: Comparing and Improving Refugee Health Policy**

US VS. WALES: COMPARING AND IMPROVING REFUGEE HEALTH POLICY

By

Payton Ramsey

Submitted in Partial Fulfillment  
of the Requirements for  
Graduation with Honors from the  
South Carolina Honors College

May, 2021

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### **Thesis Summary**

This thesis provides a synopsis of the historical roots of current policies and legislative frameworks of refugee health for Wales and the US. Through the presentation of governmental policy documents and protocols for both nations, this research sheds light on the synergy between legislative action, entitlements, and systems that perpetuate cycles of poor health for refugees. It provides evidence that outlines challenges, successes, and failures of policymaking and health systems that solicit further improvement and reform. The overall findings elucidate not only the broken systems created by histories of discriminatory legislation, but offers a framework for future policymaking and reform.

### **Abstract**

Inadequate strides have been made to bolster the short and long-term health of growing numbers of refugees awaiting resettlement. The United Nations Higher Commission for Refugees (UNHCR), as well as many countries of resettlement, guarantee the right to health as signatories of the UN 1951 Refugee Convention, but in many situations refugee accessibility to healthcare and health resources is limited by time restrictions on benefits, immigration status, and/or financial circumstances.

This thesis provides a synopsis of the historical roots of current policies and legislative frameworks relating to refugee health for Wales and the US. Through the analysis of governmental policy documents and protocols for both nations, this thesis examines legislative action, entitlements, and systems that perpetuate cycles of poor health for refugees. It provides evidence that outlines challenges, successes, and failures of legislation and health systems that elicit further improvement and reform. The overall findings elucidate not only the broken systems created by histories of discriminatory legislation, but additional challenges related to the shortfalls of

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available resources and education such as cross-border competence of health professionals, refugee health system literacy, refugee financial security, and availability of mental health and translator services.

Findings from literature analysis and review of refugee related health policy from the US and Wales are compiled and compared in order to suggest a future framework of policymaking that eliminates current systematic barriers. This framework synthesizes the identified successes and failures in each system in hopes of providing legislative guidance for future policymakers to aid in the improvement of refugees' overall health through accessibility.

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**I. Introduction**

According to the 1967 Protocol of the 1951 Refugee Convention, a refugee is a person who, “owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (Convention relating to the Status of Refugees (189 U.N.T.S. 150, entered into force April 22, 1954)). Refugees are a sub-set of migrants defined by unique circumstances; however, each country defines this status slightly differently and applies different barriers to resources for refugee populations. The protocols of the 1951 Convention also stipulate that refugees should have access to the same or similar healthcare as host populations (Convention relating to the Status of Refugees (189 U.N.T.S. 150, entered into force April 22, 1954)). Although many countries in the global north project the façade that this guideline is being fulfilled, the harsh reality is that “inclusive” health policy in fact has hidden agendas that restrict forced-migrant populations.

The idea of restricting migrants, specifically refugees, is not new to policymakers, as almost every country in the global north that accepts refugees displays a vast history of xenophobic and discriminatory policies that usually persist within current legislation. The combination of this historically rooted restriction and the exponential growth in refugee numbers over the past decade has called into question the efficacy of refugee-related health policymaking and the ability of existing systems to ensure that these individuals do not suffer further during resettlement. The scope of this thesis does not permit the analysis of the entirety of refugee health policies for all nations of the global north, but instead provides a comparative framework and outline for two countries that share cultural roots and attitudes.

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The two countries discussed in this thesis are the United States and Wales (UK). These countries share common colonial roots and cultural attitudes as both originate from predominantly white settlement; both impose health barriers for refugees through restrictive policymaking despite their vastly different healthcare system models. Nonetheless, both countries seem to be pushing for greater resources and inclusion for refugees through agendas set in the US Biden Administration and the accepted Welsh Nation of Sanctuary Plan. Through a literature review and an analysis of refugee related health policies for both the US and Wales, I will answer the questions of which barriers define refugee health and which agendas can be amended to prioritize long-term health outcomes and accessibility. I will identify policies that adhere to UNHCR updated guidelines for providing adequate resettlement conditions and resources to maintain good health while simultaneously offering no suitable solutions to current refugee health problems.

For both countries, a history of xenophobic policymaking will continue to inform refugee health care without robust reforms designed to substantially boost refugee health. My findings will elucidate flaws in each health system type and suggest policy changes to bolster refugee health. Through answering these questions, I will find evidence that extends beyond a basic policy analysis for a singular nation by comparing legislative histories and health systems that share both many similarities and differences. Overall, my analysis and findings aim to provide a framework that bridges healthcare systems, refugee health policies, and legislative histories for the US and Wales to provide a framework for future legislative action to eliminate barriers to health accessibility and bolster refugee health.

**II. Methods**

In this study, I began a search of existing academic and grey literature by using terms “United States,” “United Kingdom,” “Refugee,” “Wales,” “Immigrant” (due to refugee information’s common grouping in articles about immigrants) in combination with the terms “Health” and “Policy.” Synonyms of these key terms were also used. The predominant search used Google Scholar, Medline, UNHCR Data, and Scopus electronic databases. Refugees were strictly defined as those legally granted refugee-status, not including asylum-seekers or stateless persons. An additional grey literature search was carried out, as well, in order to identify official government policy documents, press releases, and memos. The overall document review focused on the definition of a refugee, refugee health needs, current existing refugee policy, and future planned frameworks to augment current existing policy. Based on the literature compiled and collected that held medium to high evidence for representative refugee sampling, I evaluated policy effects on refugee health per migration phase (pre-arrival, initial arrival, post-arrival) for the United States and Wales by connecting policy implications to published public health impacts. The compiled literature that met criteria were included and analyzed in detail to showcase pertinent data and findings. Based on the findings and conclusions drawn from the presented evidence, I developed a framework for future policy to bolster refugee health. Plots were created using the PROC SGPLOT procedure within SAS statistical programming.



### **III. United States**

Restrictive immigration legislation has long been a part of the United States. The US has an extensive history of restricting immigration, beginning with the 1790 Naturalization Bill that mandated individuals to reside in the country for two years prior to applying for naturalization (Dorman, Chesnay 2018). Restrictive legislation continued to be implemented over the decades, each adding to the implicit xenophobia built into American laws and attitudes. The passage of the “Steerage Act” of 1819, directing all US ships to report immigrants on board in their manifests, was one of the first legislative actions which attempted to control the entrance of “undesirable” immigrants through government policy (Dorman, Chesnay 2018). Soon after came “The Chinese Exclusion Act” in 1882 and The Immigration Act of 1891 (Dorman, Chesnay 2018), which was the first comprehensive law to control immigration. The legislation established the ability of the federal government to deport illegal immigrants as they saw fit (Dorman, Chesnay 2018). The precedent created through centuries of xenophobic restrictive legislative policies developed a flawed framework for the future path of American immigration. The notions and motive behind these policies would later affect forced migrants. The framework set for policymakers would affect those fleeing their home nations who are faced with death.

US Policy geared toward those needing a place of refuge began before the passage of official “refugee” legislation. During the Cold War and World War 2, US congressional attitudes during the administration of FDR were hostile toward the accepting and resettling those in dire circumstances, even overturning a bill which allowed 20,000 German children to enter the US during World War 2 in 1939 (Feibel 2017). The administration and congress continued to follow the same policymaking attitudes when Cuba denied the porting of the *St. Louis*, a German ship that housed a multitude of Jewish refugees, offering no aid or solution which dictated these children’s

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future deaths in Nazi concentration camps in Europe (Blakemore 2019). Following the war, US refugee policy took a shift, not caused by guilt from the lack of American action during the holocaust, but predominantly due to the concern of the stability of post-war Europe that now housed twenty to thirty million displaced people (Feibel 2017). With these displaced people kept in mind, policymaking attitudes shifted further as the Cold War emerged and progressed. During the Cold War, the non-legal expected definition of a refugee centered around the fleeing of an individual from a communist nation (Feibel 2017). As the issue of refugees suddenly began to shift to a victory in a propaganda battle of the democratic western front, US congress passed the Displaced Persons Act in 1948 to globally showcase this democratic victory by formalizing ongoing entry for displaced persons of communist origin (Feibel 2017). Almost a decade later, the US signed the UN's 1951 Refugee Convention, accepting the convention's consensus surrounding the definition of "refugee," but still stipulating its own admission policies (Pace et al. 2015). The passage of the "Refugee Act of 1980" was the first US legislation that legally defined the term "refugee" and developed a system for resettlement and categorization for those seeking refuge within the US (Pace et al. 2015). With this act, the United States defined a "refugee" under the law by referencing definitions and guidelines stipulated during the United Nations 1951 Convention and 1967 Protocols relating to the Status of Refugees. The definition stipulates a refugee to be, "A person who is unable or unwilling to return to his or her home country because of a 'well-founded fear of persecution' due to race, membership in a particular social group, political opinion, religion, or national origin" ("An Overview of U.S. Refugee Law and Policy"). Until the presidency of Donald Trump, the US was the global leader for resettling refugees, granting refuge to over 85,000 individuals per fiscal year; however, this annual number of individuals granted refugee status

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remains variable, not always reaching the refugee ceiling set by the US Presidential Determination (Krogstad 2020).

In addition to direct refugee related policies, the US has done little to aid in decreasing the social barriers related to health, passing little broadly implemented social welfare reform to aid those of low SES other than one key piece of legislation. Under the Clinton Administration “the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)” was passed in 1996 (United States Congress 1996). The PRWORA was and still is one of the most comprehensive welfare laws passed that provides more feasible long-term benefits for refugees; however, refugee eligibility for benefits do not begin until five years after the dates of official entry (United States Congress 1996). The PRWORA initially stipulated that legal immigrants (such as refugees) had to be in the US for seven years in order to qualify for citizenship and governmentally funded healthcare coverage (United States Congress 1996). The problem with this initial policy soon became clear: after the periods of medical coverage from RMA concluded, registered provisional immigrants (RPI) began to go to emergency departments for basic healthcare needs due to non-discriminatory regulations stipulated under The Emergency Medical Treatment and Labor Act (EMTALA) (Brown 2018). A PRWORA resolution was passed shortly after in 2003 in response to this problem that shortened the seven-year minimum to five years (Brown 2018) Next there was another amendment to PRWORA that greater expanded resources to create racially culturally, and ethnically sensitive healthcare education and basic health services for RPI in local communities (Brown 2018). This legislation continues to be one of the most prominent welfare bills to affect resettled refugees in the US today. The only drawback from the PRWORA policy in place is the 52-month time period between the ceasing of RMA benefits and the beginning of federal health and welfare eligibility. It is important to note the extended nature for this crucial

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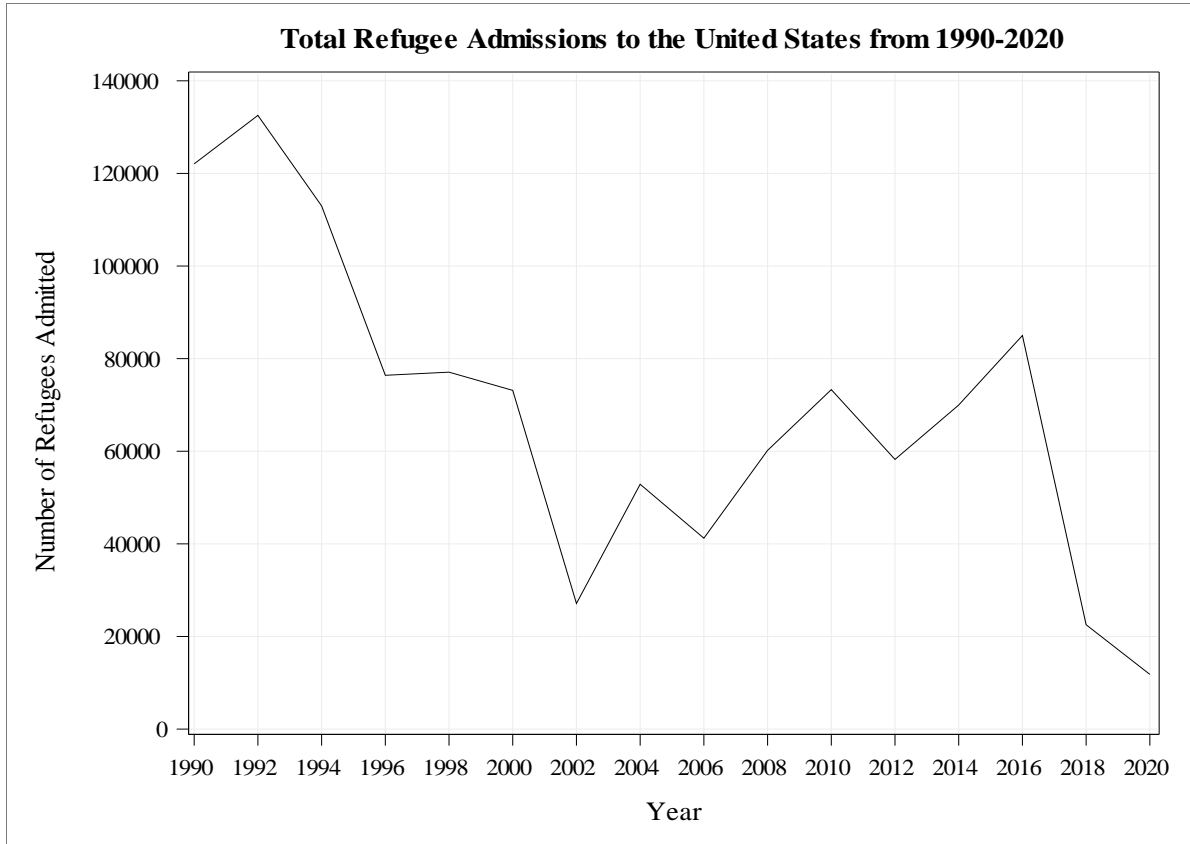
time period, especially for those refugees resettled in states where Medicaid was not expanded through the ACA.

Although the US seemed to show an inclination to aid in resettlement, barriers rooted in ingrained xenophobic attitudes remained in policymaking, often restricting refugees from satisfying all of their needs (even prior to resettlement). There has always been an ambivalence in US policy toward refugees, although there seems to be a broad cultural and political consensus of sympathy for those experiencing or escaping violence. The contradiction is illuminated through the decades of American efforts to deny or curb refugee resettlement and asylum case prevalence. With this in mind, the subject of health has always been a key part of this immigration control and de facto discriminatory mechanism. Health has historically been a means of excluding certain undesirables, prohibiting certain people from national entry based on the principles of wellness and hygiene. The following sections will explain the general protocol and policy for refugee healthcare and services in the US, as well as the continuation of barriers for refugee health that originate from American policymaking attitudes toward immigrants throughout the centuries.

**a. US Refugee Health Policy- Pre Departure**

Estimates find that almost 3 million refugees whom have been forced to uproot from their homes for various reasons have resettled in the United States since the passage of “The Refugee Act of 1980” (Downes, Graham 2011). The Office of Refugee Resettlement (ORR) under the US Department of Health and Human Services oversees policies for resettled refugees after they enter the US (Pace et al. 2015). In Figure 1, I showcase numbers of refugees resettled in the US from 1990-2020. Additionally, in figures 2 and 3, I show data that shows the most frequent nations of origins for refugees resettled in the US.

Figure 1

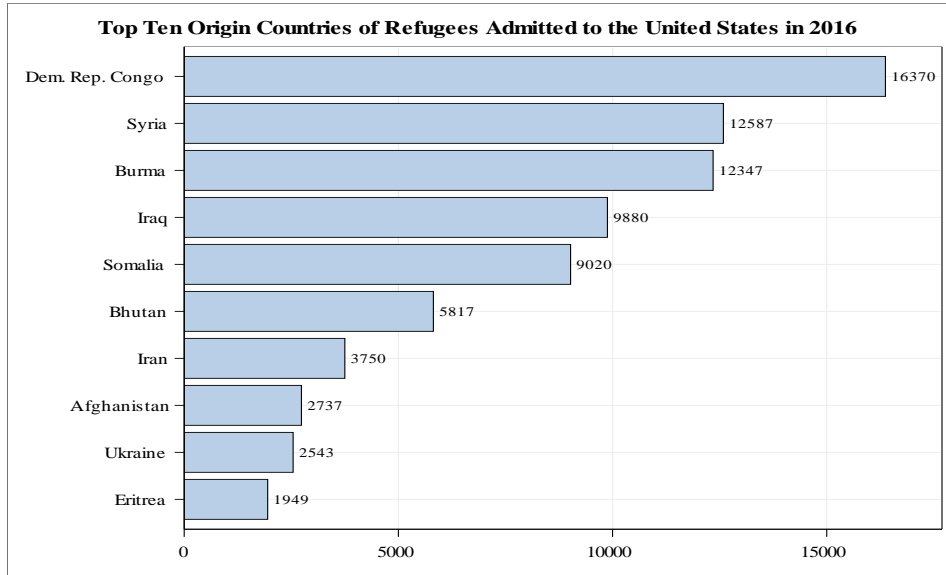


(Refugee Processing Center).

\*\*Total admissions of refugees to the United States from 1990-2020. As federal administrations and national priorities transitioned, greater and lesser influx can be seen. This range in admittance can also be attributed to international events such as wars and environmental disasters that caused a greater or lesser need for resettlement in some years.

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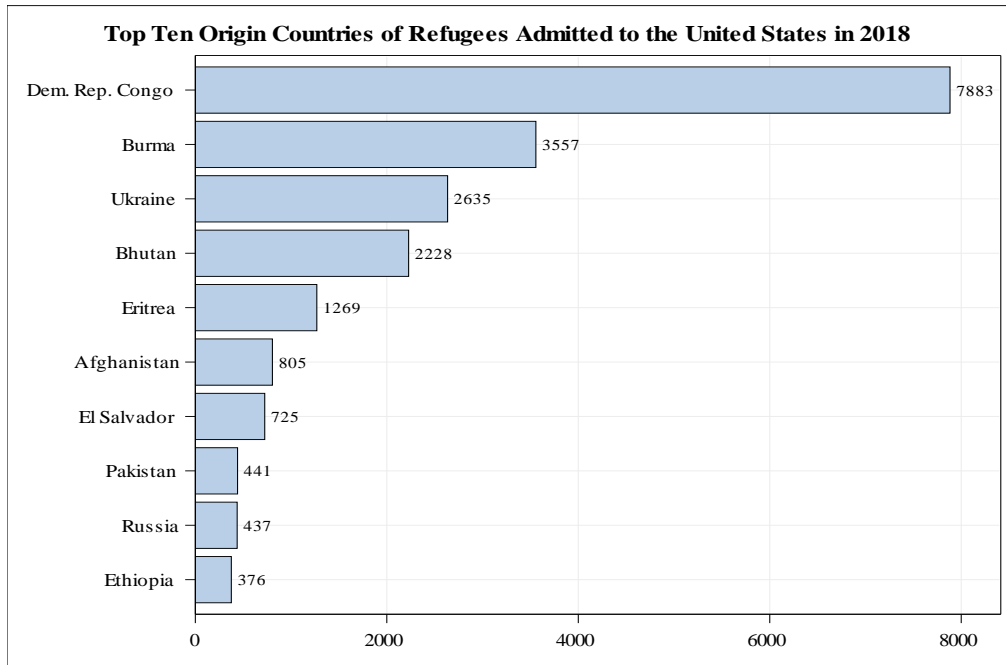
**Figure 2**



(Refugee Processing Center)

\*\*Origin countries of refugees admitted to the United States in 2016. This data was broadly influenced through the refugee ceilings and policies made under the Obama Administration. A switch in countries of origin can be seen in 2018, as the US federal administration changed.

**Figure 3**



(Refugee Processing Center)

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\*\*Origin countries of refugees admitted to the United States in 2018. This data was broadly influenced through Trump administration policies such as the “Muslim Ban” in 2018. A switch in countries of origin can be seen from 2016, a year when the refugee ceiling was greater than under President Trump.

Both the ORR and Center for Disease Control (CDC) offer and develop guidelines for medical and social screenings for potentially approved refugees (Pace et al. 2015). The general screening process that incorporates the initial medical evaluation, security clearance, and cultural orientation can span a time period of two months to several years (Downes 2011). Applicants for refugee status can be denied through these developed health-related grounds, but once the applicant is approved for resettlement in the US, he/she/they must undergo additional medical screenings by a panel physician (an overseas medical practitioner who assesses refugees health prior to their resettlement) which can preclude emigration if general health criteria of the CDC and ORR are not met (Downes 2011). The CDC defines the purpose of the medical screening/examination as, “ to determine whether the alien has: 1) a physical or mental disorder (including a communicable disease of public health significance or drug abuse/addiction) that renders him or her ineligible for a visa (Class A condition); or 2) a physical or mental disorder that, although does not constitute a specific excludable condition, represents a departure from normal health or well-being that is significant enough to possibly interfere with the person’s ability to care for him- or herself, to attend school or work, or that may require extensive medical treatment or institutionalization in the future (Class B condition)” (CDC Medical History and Physical Exam 2019). The list of Class A and Class B conditions are showcased in *Table 1*.

***Table 1-*** Classification of Health Conditions for US Refugee Applicants

<b>Class A Conditions</b>	<b>Class B Conditions</b>
Active Infectious Tuberculosis	Active noninfectious Tuberculosis

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Lepromatous or multibacillary Hansen's Disease	Inactive Tuberculosis
Untreated Syphilis	Syphilis treated within the past year
Untreated Chancroid	Other STI's treated within the past year
Untreated Gonorrhea	Current Pregnancy
Untreated Granuloma venereum	Prior treatment for Hansen's disease
Untreated Lymphogranuloma	Tuberculoid, borderline, or paucibacillary Hansen's disease
Addiction to or abuse of a specific substance* without harmful behavior	Sustained, full-remission of addiction to or abuse of specific substances
Any physical or mental disorder (including other various substance related disorders) with harmful behavior or history of such behavior likely to recur	Any physical or mental disorder (excluding addiction to or abuse of a specific substance* but including other substance related disorder without harmful behavior or history of such behavior unlikely to reoccur)

\*\*Amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, anxiolytics.

Source: US Department of State (DS-2053).2010, CDC. Domestic Refugee Health Program. 2010.

The procedure of examination entails 4 main tasks: obtaining of a medical history, the review of other records available to the physician (such as police, military, school, or employment) that may aid in the determination of a harmful behavior related to a physical or mental disorder, a review of systems able to determine the presence or severity of a Class A or B condition, and a physical examination that includes an evaluation of mental status (CDC Medical History and Physical Exam 2019). After the examination, if a Class A condition is present, the panel physician generally determines that the refugee is ineligible to resettle in the US; however, if a Class B condition is present the panel physician must bring the concern to the attention of consular authorities, as it may indicate the development of a future disability or burden to the US healthcare system due to



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the need of future medical treatment (Downes 2011). In the case that the panel physician unearths a new medical condition that is not considered “relevant to the visa medical examination,” the panel physician will recommend the patient seek treatment from another medical provider (CDC. Medical history and physical examination: technical instructions for medical examination of aliens 2011). In summary, the pre-departure health examinations provide a means for the US to protect and maintain the general public health conditions of the country by not introducing further threats of illness and disease into the nation. Once initially approved through the successful completion of this pre-departure health screening and other background check criteria, officials from the UNHCR or the Department of State/Population, Refugees and Migration (PRM) recommend individual cases to the US Refugee Admission Program (USRAP) (An Overview of U.S. Refugee Law and Policy 2020). The USRAP is a program of the Department of State that determines the individual location and state in which that refugees will be resettled in upon official approval of US refugee status (The United States Refugee Admissions Program (USRAP) Consultation and Worldwide Processing Priorities 2021). Annually, PRM requests assistance from the USRAP through the recruitment of public or nonprofit organizations that will aid further in the details and logistics of the resettlement process (The United States Refugee Admissions Program (USRAP) Consultation and Worldwide Processing Priorities 2021). These nonprofits and public agencies enter into a cooperative agreement with PRM upon departmental and bureaucratic approval (Lawton 2016). These contracted agencies are often called “voluntary agencies” or VOLAGs (The United States Refugee Admissions Program (USRAP) Consultation and Worldwide Processing Priorities 2021). These non-profit organizations contracted by the US State Department have the official goal of sponsoring and providing initial resettlement services for refugees who are arriving in the US (The United States Refugee Admissions Program (USRAP) Consultation and Worldwide

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Processing Priorities 2021). . Moreover, VOLAGs are the primary point of contact for ORR, upon arrival in the US. The VOLAGs connect soon-to-be-resettled refugees with travel logistics, resettlement locations, housing, food, primary care physicians, and other health resources upon arrival through their network of locally based affiliates that provide specialized services for refugees (Lawton 2016). The quality and quantity of resources provided by VOLAGs vary by state and specific location of resettlement. The VOLAG is the singular entity that bridges the gap between pre-departure and post-arrival healthcare and services, carrying much responsibility and potential for contributing to barriers imposed by restrictive health policies for refugees upon initial entrance into the USRAP.

**b. Health Policies During initial US Resettlement**

Based on the resettlement information indicated through USRAP, PRM, and VOLAGs, refugees are connected with differential healthcare and cultural services upon arrival in the US. There are many nuanced and divergent policies toward refugee resettlement and supportive services that vary between each state in the US (Pace et al. 2015). It must be noted that states do, in fact, hold the power to adjust policy frameworks to fit their own political and social agendas. This grants states the ability to dictate eligibility details for federally mandated Refugee Medical Assistance (RMA) and the Refugee Cash Assistance Program (RCA), vaccination requirements, further health insurance eligibility/coverage, and accessibility to specialized healthcare services such as mental health care and counseling (Angier, et al., 2015). The lack of cohesive policies and services throughout the country is one factor that makes resettlement in the US unique for every individual.

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In all states, the ORR and CDC require a second medical screening upon arrival in order to recognize and begin treatment for any condition or disease that was not recognized by the pre-departure panel physician (CDC. Medical history and physical examination: technical instructions for medical examination of aliens 2011). This examination is called “The Domestic Medical Examination,” and usually will occur within the first 30-90 days post arrival in the US. According to the CDC, “This examination provides an opportunity to identify important causes of morbidity among resettled refugees that might not have been discovered previously, and enables early referral for treatment and follow-up care” (CDC. Medical history and physical examination: technical instructions for medical examination of aliens 2011). The CDC has published further recommendations and policies in regard to the domestic examination to assist public health departments and medical professionals to perform appropriate tests and resource recommendations during refugee medical screenings. Some state Departments of Health such as that of Minnesota have partnered with the CDC to develop and establish an interactive tool for US clinicians that customizes health screening guidance for refugees undergoing the domestic medical examination based on factors such as age, sex, and country of origin (CDC Guidance for the U.S. Domestic Medical Examination for Newly Arriving Refugees 2021). This examination provides not only a more comprehensive health evaluation, but also provides an opportunity for refugees to find a medical home and primary care physician for any necessary subsequent follow-up care or specialist referrals (CDC Guidance for the U.S. Domestic Medical Examination for Newly Arriving Refugees 2021). Furthermore, this examination provides inopportunity for necessary vaccinations to be administered if needed (CDC Guidance for the U.S. Domestic Medical Examination for Newly Arriving Refugees 2021). Codification in US medical examinations allow refugees to enter the country unvaccinated, extending a generous grace period, post-entry, to

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receive all required vaccinations (Russel et al. 2017). Refugees are the only group immigrants given any such exemption in the US due to inadequate retrieval of vaccination records in country of origin, inaccurate recording of vaccination histories, illegible vaccination histories, and difficulty deciphering of vaccine names (Hong et al. 2017). CDC policy states that refugees will receive doses of required vaccines that are not accurately accounted for and clinicians should access a list of varying names of vaccines per country on the WHO website (Hong et al. 2017). The costs of this primary care visit should not weigh on refugees as it should be covered by various domestic agencies, including state and local health departments, Medicaid, the federal Vaccines for Children Program, and the Refugee Medical Assistance program of the U.S. Department of Health and Human Services' Office of Refugee Resettlement . The next sections will speak in more detail regarding these state and federal medical and cash assistance programs that allow refugees to access and pay for healthcare services.

Although the states have the ability to make slight shifts in federal health policy frameworks for refugees, there are general federally based health programs that must be universally provided for resettled refugees upon arrival regardless of state. The Title 45 Code of Federal Regulations (CFR) part 400, (Federal Register, Vol. 54, No. 22,213189 and Vol. 60, No. 124,6128195), provides federal funding for state-level medical assistance programs for resettled refugees (45 CFR Part 400 – Refugee Resettlement Program 1980). On July 1, 1989 and October 1, 1995, these frameworks of requirements for these federally based social assistance programs for refugees were set forth to the states (45 CFR Part 400 – Refugee Resettlement Program 1980). The Refugee Medical Assistance Program (RMA) and Refugee Cash Assistance Program (RCA) are two of these constant social services set forth in Title 45 CFR (45 CFR Part 400 – Refugee Resettlement Program 1980). Refugees are automatically eligible for RMA upon entrance to the US or the

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granting of their qualifying immigration status (Bruno 2011). RMA is usually available up to eight months and is directed to provide healthcare coverage for established refugees who do not meet eligibility requirements for any other healthcare program (ACA Reporting Requirements for RMA 2016). RMA was created to be a short-term transitional program that provided minimum essential coverage by the US Department of Health and Human Services (ACA Reporting Requirements for RMA 2016). The provider of coverage for RMA is the state agency responsible for both administering and meeting/reporting requirements of RMA (ACA Reporting Requirements for RMA 2016). Following the conclusion of RMA coverage, refugees are eligible to apply to health insurance through the Market Place of the Patient Protection and Affordable Care act (ACA) (ACA Reporting Requirements for RMA 2016). Although this provides a solution for the majority of refugees seeking healthcare coverage and benefits following the period of RMA, 44 percent of refugees would not be eligible for this solution due to their state of resettlement not expanding Medicaid benefits (Pace et al. 2016). This ostracizes countless refugees as not all refugees eligible for ACA insurance would have the ability to obtain it based on initial location of resettlement decided by the VOLAG. This is a barrier imposed by differential state-based policymaking decisions that affect the general health and well-being of refugees by contributing to the cycle of poverty and decline in socio-economic status (SES) for resettled individuals. After obtainment of this temporary health coverage, refugees tend to be funneled into low income jobs that often do not offer insurance, further affecting their health and accessibility to obtain high-quality healthcare services. Similarly, if employment is in fact obtained by refugees that offer a health insurance benefit option, high deductibles are frequently in place, pushing refugees to only seek healthcare services under the most catastrophic and severe circumstances. This cycle perpetually exists amongst refugees, often making their health socially determined and only defined by treatment of

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long-term needs instead of prevention. It is to be noted that this is an issue universally generalizable to the majority of those who are low income in the US, non-specific to refugees. Beyond specifically refugee health, this is an issue that US policymakers need to be aware of across all sectors to synergetic ally target and halt cycles of poverty that lead to poor health.

Following a similar framework, the RCA is an established program geared to aid refugees and other humanitarian immigrants (without minors/children) by providing cash assistance for up to eight months from the time of arrival in the US (US Department of Health and Human Services 2003). The RCA is yet another example of a federally instituted program subject to manipulation by state policymakers across the country. Unlike RMA, under a 2000 revision of Title 45 CFR, Part 400, RCA is eligible for revocation/discontinuation during its term if the individual begins to make increased earnings from employment (US Department of Health and Human Services 2003). For example, in the state of Washington, RCA eligibility rules entail that individuals must have resources totaling no more than \$6,000 (exempting the first \$10,000 of any vehicle used for transportation) (Washington State Department of Social and Health Services). Eligible individuals receive \$363 per month if single and unemployed while eligible unemployed couples receive \$459 per month. (Washington State Department of Social and Health Services). The eligibility lasts for a total of 8 months if eligibility continues to be met for the entirety of the time period (Washington State Department of Social and Health Services). If both individuals are employed, the Washington State Department of Social and Health Services count half of the earnings against the household's grant (Washington State Department of Social and Health Services). If the household earned an amount over \$839 per month then they would no longer be eligible for the RCA in the state of Washington (Washington State Department of Social and Health Services). The RCA is not a program necessarily geared toward aiding in refugee health; however, when access and eligibility

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to health insurance is restricted by state, cash influx aids in boosting SES for refugees, influencing overall health.

It is to be emphasized that geographical location of resettlement determines many health factors in the US. The varying eligibility floors and ceilings combined with variance of Medicaid access and eligibility mandated state to state have a high probability for creating consequent negative impacts for refugee health beginning at the initial geographical placement phase. The constructs of these policies and programs create short-term solutions for refugees resettling to the US, but provide no long-term support or longitudinal healthcare plan. In the following section, further policies that both directly and indirectly impact refugee health following the initial 8-month arrival benefit period will be discussed. It should be emphasized that these next structures and policies in place are a natural progression of failed policymaking frameworks and heightened radical nationalistic attitudes.

**c. Refugee Health: Post-RMA**

A multitude of policy frameworks enable short-term access to healthcare services through insurance and programs, but due to the rollbacks of the ACA through the Trump administration, variance of Medicaid coverage by state, the initiation of the loan repayment system, and many other barriers, refugees are many times left without longer-term resources or aid. Refugee access and eligibility to public aid has been a contentious issue for decades, as the problems lies at the intersection of two other largely disputed issues: immigration policy and welfare policy. Following the eight-month period that entails benefits of the RMA and RCA, refugees are often left with nothing but the continuation of repayments from their travel loan granted to them by the International Organization of Migration (IOM) but no income (Downes 2011). The interest-free

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loan from the IOM that covers transportation costs to the US begins six months post-arrival and is expected to be paid within 42 months of resettlement (Travel Loans 2020). At what expense does this untimely framework affect feasibility of refugees to prioritize and access continued health services and care? Understanding the language and cultural barriers that refugees face to obtain employment along with social stressors through constant implicit and explicit discrimination, refugee health is undeniably affected by this current framework of the American federal government and IOM. Until comprehensive legislation from the Clinton administration, refugees had no long-term assistance. While Clinton's policies remain, refugees still have an extensive time gap between federal and state aid eligibility that needs to be addressed.

The last policy that will be discussed affecting long-term health needs for refugees in the US is the Torture Victims Relief Act (TVRA) enacted in 1998 (United States Congress 1998). It is undeniable that refugees experience torture and human rights violations. This exposure to stressors inevitably lead to an increased prevalence of various mental health needs for resettled refugees. The TVRA was a comprehensive piece of legislation that amended the Foreign Assistance Act of 1961 (United States Congress 1998). TVRA authorize the Secretary of HHS to provide grants that fund rehabilitation, social and legal services to survivors of torture and research and education programs to healthcare providers to better help survivors of torture (United States Congress 1998). Additionally, the act allows the President of the United States to expand executive powers to provide financial assistance via grants to treatment centers and programs in foreign countries that aim to treat the psychological and physical effects of torture (United States Congress 1998). This policy is integral to targeting mental health conditions for refugees in the US, as mental health services are not factored into RMA and many statewide Medicaid coverages. Although torture is a large factor that can affect an individual's mental health, other factors experienced before and



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during the resettlement process can also contribute to the need for long-term mental health care and policies to support accessibility to specialized mental health resources. During resettlement refugees are being provided safer living conditions in the United States, but resettlement, including the migratory journey, can still be extremely challenging. The entire process often entails barriers in language comprehension, social isolation, and acculturation. These stressors play a role in the ubiquity of general anxiety disorders, depression, and PTSD amongst refugee populations (Keyes 2000). The causes of refugee PTSD range from singular experienced focal events to prolonged endured trauma, unfortunately including the experience of torture for many refugees (Keyes 2000). These mental health issues can be associated both with trauma suffered before and during resettlement, as well as current barriers such as xenophobia and discrimination experienced in the resettled new country of refuge. Currently the US holds no comprehensive policies to target the mental health of refugees specifically, beyond the TVRA. A recent study compiled of research from nine geographic locations 76 percent of resettling refugees received health assessments between 1997 and 1998: 78 percent of the sites surveyed offered mental health care but only 33 percent of the sites performed mental health assessments (extent of assessment was not documented) (Shannon 2012). Of the state sample, each had differential mental health screening procedures:

**Table 2-** Screening Methods and Protocol Prevalence Across States

Method of Screening	Percentage of States Sampled Use of Method
Screen for war trauma	47.7%
Inquire about torture experiences	43.2%
Inquire about war-trauma experiences	62.5%
Inquire about war-torture experiences	56.25%

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Rely on informal conversation for screening for screening war torture and trauma	68.8%
Utilize formal standardized questionnaire	4 states

(Shannon 2012).

Many respondents to the study noted that universalized tests across all states would be a useful tool in the future, as well as culturally appropriate screening tools in order to assess mental distress of refugees (Shannon 2012). For US policymakers it is worth bearing in mind the synergy between mind and body in future amendments of American refugee health policy to ensure health be a priority for those the nation is providing refuge.

#### **IV. Wales**

Throughout the centuries of British imperialism, there has been a growing belief in the existence of “the British race” and its superiority to non-white, “foreign” races (Huttenback 1973). This entrenched notion continues to exist, being translated into policymaking and political agendas surrounding immigration in the United Kingdom. The first legislation that elucidated Britain’s attitudes for external immigrants was made in 1891 (UK Library of Congress 2016). This legislation provided under the common law stated, “no alien has any right to enter this country except by leave of the Crown” (UK Library of Congress 2016). In 1905, this principle was made explicit with the “Aliens Act.” The Aliens act, which was enacted by the British Parliament, restricted immigration into Britain from areas outside the British Empire (Jewish Migration). It is generally believed that this policy was enacted in response to heavy Eastern European Jewish immigration into Britain. post 1880 (Jewish Migration). Through the agitation and increased outspokenness of many right-winged activist groups in regard to Jewish immigration, this law was put into action, eventually decreasing the influx of Eastern European Jewish immigrants by a third by the ability of Britain to refuse “undesirable” individuals (Jewish Migration). This initial

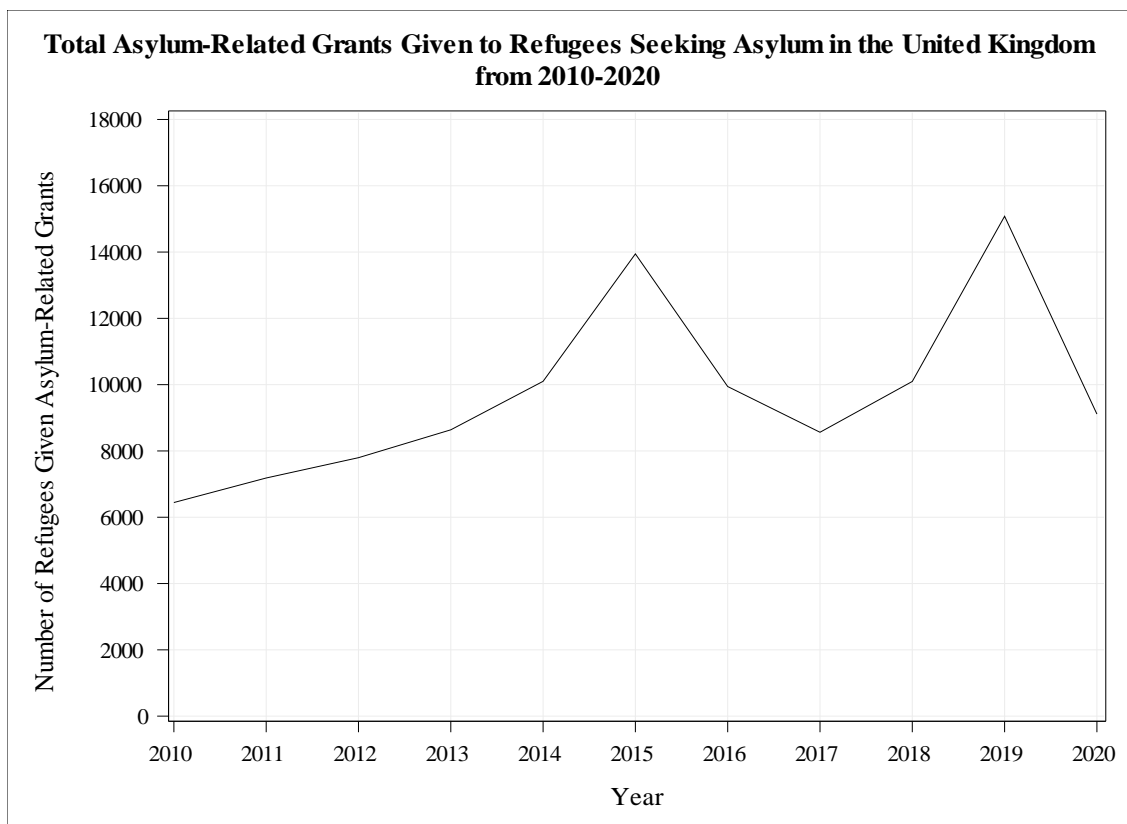
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principle in common law was even more so extended in 1914 with the Aliens Restriction Act by making the common law rule a statutory basis and implementing further restrictions on immigration (UK Library of Congress 2016). This act was longstanding until the introduction of the Immigration Act of 1971 which added the statutory immigration basis to the UK's official "Immigration Rules" (H.M.S.O 1971). These rules, which are subject to frequent change as parliament sees fit, require non-British, Commonwealth, or European Union citizens to obtain leave from an immigration officer at their initial arrival in order to enter the UK (UK Library of Congress 2016). The colonial sentiments and negative attitudes toward immigrants ingrained in British policies throughout the centuries abetted further restrictive policies when individuals began to increasingly seek refuge from violence, conflict, climate change, and disaster in the late 20th century. These restrictive attitudes created by the sovereign UK parliament eventually paved way for similar rooted policies in Wales once Wales devolved and created the "National Assembly for Wales" in 1997 (Broughton 1998).

When numbers of people seeking asylum in the UK skyrocketed in the early 2000s, the sovereign UK parliament amended the Immigration Rules further to restrict immigrant asylum seekers (Public Health Wales 2019). This mission was carried out by increasing barriers to make gratings of asylum more difficult to receive, as well as decreasing benefits that asylum applicants could temporarily receive. It is to be noted that compared to other nations, legislation regarding asylum applicants is more prevalent for the UK and Wales due to the nature of their asylum-seeking systems. The UK offers little to no official refugee resettlement programs that grant refugees the opportunity to be "selected/placed in the UK," other than a program that is specifically geared toward resettling vulnerable Syrian refugees (Public Health Wales 2019). This is not a unique system for the UK, as there are very sparse official resettlement programs across all of

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Europe. The lack of resettlement programs causes refugee status to be granted mainly through asylum seeking processes that require individuals to migrate to the UK prior to applying for “official refugee status” (Claim Asylum in the UK 2014). In figure 4, data depicting numbers of asylum seeker applications for the UK is showcased. Additionally, in Figures 4 and 5, the most prevalent origin countries for asylum seekers in the UK are showcased for the years 2016 and 2018.

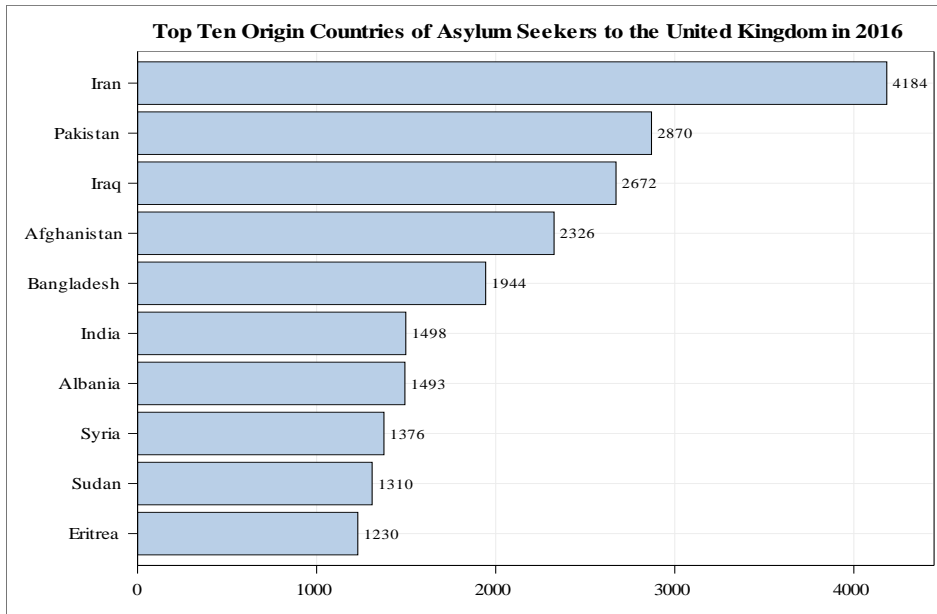
**Figure 4**

(Gov.UK 2019).

\*\*Total asylum-related grants given to individuals seeking asylum in the United Kingdom from 2010-2020. As federal administrations and national priorities transitioned, greater and lesser influx can be seen. This range in admittance can also be attributed to international events such as wars and environmental disasters that caused a greater or lesser need for resettlement in some years. This data is generalizable for the entirety of the UK, but not necessarily Wales, as disproportionate distribution of asylum seekers and refugees occurs across the United Kingdom.

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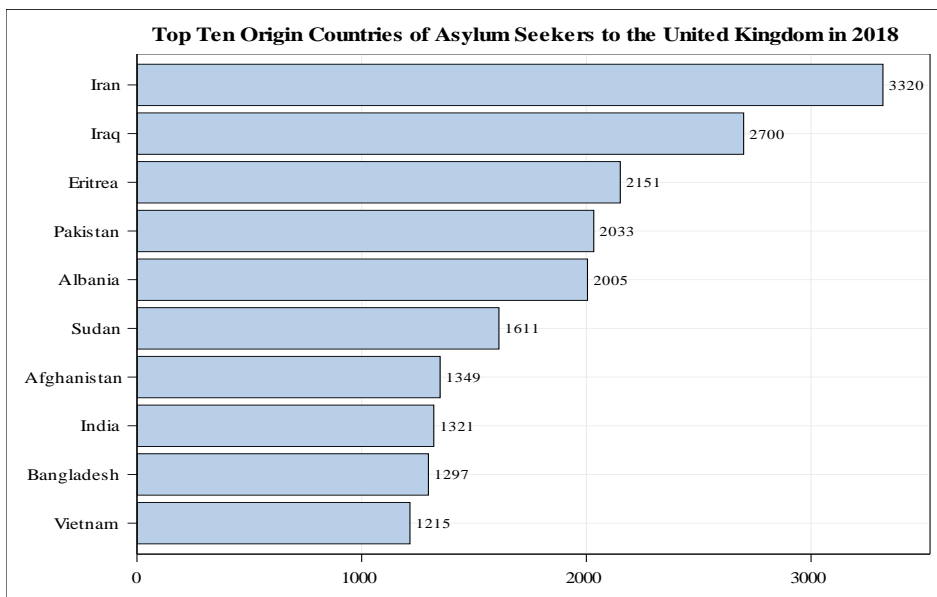
**Figure 5**



(Refugee Processing Center).

\*\*Origin countries of asylum seekers in the United Kingdom in 2016. This data is approximately consistent through the years, as seen in the data in Figure 6 from 2018.

**Figure 6**



(Refugee Processing Center).

\*\*Origin countries of asylum seekers in the United Kingdom in 2018. This data is approximately consistent through the years, as seen in the data in Figure 5 from 2016.

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The combination of waiting periods for refugee status decisions and discriminatory attitudes toward immigration and benefits cause many issues to arise for refugees who seek asylum in Wales and the broader United Kingdom. With this in mind, the following sections will outline the general protocol and policy for refugee healthcare and services in Wales, as well as the strides the Welsh Government is making to create a more inclusive Wales for refugees through the prioritization of health.

**a. Welsh Refugee Health Policy- Prior to Official Refugee Status**

The exact number of refugees and asylum seekers (RAS) that reside in Wales is unknown due to the lack of tracking statistics for individuals granted leave to remain or official refugee status (Learning Insight Asylum Seekers and Refugees 2005). Due to the system that the UK widely uses, having asylum seekers travel to Britain before filing for refugee status, there are many lapses in services and policy prior to individuals gaining refugee status. The Secretary of State and Home Department are primarily responsible for aiding in the transitional process from asylum seeker to refugee status (UK Library of Congress 2016). Although healthcare agendas have been devolved, both the primary asylum and immigration agendas are still the responsibility of the UK Government (Welsh Government, Consultation Document 2018). In the Immigration Act of 1999, Section 116 mandates that free access to healthcare be a mandatory support mechanism for RAS upon arrival (Immigration Act of 1999). This legislation was made by the UK Home Office, therefore prescribing Wales to follow suit and provide access to healthcare prior to the officiating of refugee status for RAS. Basic access to healthcare is guaranteed upon entry into Wales and the UK, but additional guidelines and policies for health are set for RAS prior to arrival to prioritize national public health (Immigration Act of 1999).

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Prior to entry, all citizens and nationals who are not of the UK or European economic area (EEA) may be subject to a health examination (Beeres et al. 2018). Policy stipulates that health examinations can take place abroad and as part of the asylum application or at arrival at the port of entry or at the location of settlement (Beeres et al. 2018). Those who are arriving from nations with a high incidence rate of tuberculosis (TB) are required to undergo TB screening under the Immigration Act of 1971 (Immigration Act of 1971). Upon the probability of TB via x-ray examination, further symptom inquiry, and sputum smears are required to rule out the presence of TB in RAS (Public Health England 2018). RAS can find TB screenings through IOM clinics and services in their countries or neighboring countries (Public Health England 2018). In addition to TB screenings, the IOM performs full health examinations for those selected for the UK Refugee Resettlement Program at the clinics pre-arrival (Public Health England 2018). The TB screening service is a program specific to individuals resettling in the UK (Public Health England 2018). IOM, with financial support of the UK Government, organizes and manages the entirety of the pre-departure tuberculosis detection program for the 8 high prevalence countries for RAS applicants planning to stay in the UK for six months or longer (Migration Health Assessments & Travel Health Assistance 2020). Comparatively to other nations, the UK's requirement of just the TB test is very simplistic, as many other nations of the global north require additional testing for other chronic diseases and disorders that may pose a public health threat (Migration Health Assessments & Travel Health Assistance 2020). Beyond the TB screening, the UK Government does not seem to have any further pre-medical screening guidance specific to the country beyond the "standard" examination provided by IOM. The exact mechanisms and protocols that the IOM uses for health examinations are not published; however, IOM stipulates that the examination consists of review of medical and immunization history, detailed physical examination and mental

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health history, clinical or laboratory investigations (chest x-ray for TB, serological tests, and chemical analysis via blood or urine), referrals or consultations with specialists as-needed, anti-fraud and corruption measures (including for services such as DNA testing and bio-sampling), HIV education and voluntary testing, arrangement of needed vaccinations, and detailed documentation of findings to deliver/report to immigration officers (Migration Health Assessments & Travel Health Assistance 2020).

External factors, such as higher prevalence of infectious diseases in refugee's country of origin and conditions of migration, are probable factors that could increase the infectious disease risk of refugees to the public health of the UK and Wales. The initial medical screening to catch these high-risk public health factors for the few refugees selected for the UK's smaller scale resettlement program entail many screenings and health history inquiries. During the medical examination a multitude of infectious diseases are tested for, although the sample is smaller in the UK than required of other nations of the Global North such as the US and Canada. It is to be noted that through data collection of the IOM in these testing clinics, yielded infectious diseases such as TB, HIV, syphilis, Hepatitis B, Hepatitis C are the key risks that should inform public health policy toward RAS (Crawshaw 2018). When these risks are minimized for RAS pre-departure, RAS are free to travel and settle in the UK under their own regard until they are granted official refugee status or under the UK's limited refugee resettlement program (Crawshaw 2018).

Asylum seekers are usually granted official refugee status within 6 months of application (Walsh 2021). Between the years 2015-2019, the United Kingdom received fluctuating amounts of asylum applications, but not all of these applicants were approved under official refugee status:



**US vs. Wales: Comparing and Improving Refugee Health Policy****Table 3-** Annual Asylum Applications in the United Kingdom

2015	2016	2017	2018	2019
40,000	39,700	34,800	38,800	44,800

\*\*(Asylum Statistics 2021)

**Table 4-** 2019 First Instance Decisions on Asylum Applications in the United Kingdom

Grants	Refusals	Totals
15,000	13,460	28,460

\*\*(Asylum Statistics 2021)

As shown in Table 4, only 52.7% of those who applied to asylum were granted status in the United Kingdom in 2019 (Asylum Statistics 2021). This leaves way for disparities to form for those refused asylum and eventual refugee status, especially surrounding overall health accessibility and well-being. Both prior and during their tenure as an asylum seeker or official refugee, healthcare is free and accessible to them under the National Healthcare System (NHS) in all 4 nations of the UK, including Wales (BMA 2020). RAS are eligible to register and receive free primary care services from a medical practitioner in the same manner as all patients of the UK (BMA 2020). Regardless of this “access,” a recent study showcased interesting results regarding the integration of RAS into connections with GPs in the NHS (Public Health Wales 2019). The study showed that “Far fewer resettled refugees reported finding registration, and booking an appointment with a GP easy, compared with other respondents, namely other refugees and all asylum seekers” (Public Health Wales 2019). The study noted that these findings warrant further evaluation, but are projected to have resulted as an effect of duration of time spent in the UK for each differential group (Public Health Wales 2019).

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Wales prevails at attempting to overturn this precedent of inequity that even seemingly accessible systems seem to harbor. NHS Wales does not discriminate or refuse the ability to register with a general practitioner (GP) based on immigration or residency status (BMA 2020). In fact, as an RAS in the UK/Wales, individuals are entitled to access the full range of secondary services at no-cost (BMA 2020). It should be noted that NHS secondary care consists of more specialist medical practitioners, including psychiatry and further mental health treatment specialists (NHS Wales). This access is non-dependent on eligibility periods, as NHS care is provided at no-costs for all RAS in Wales (BMA 2020). Rejected RAS also have free access to NHS services of Wales since the passage of the National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations (NHS Wales 2020). NHS Wales strives to provide the most equitable care possible to RAS by entitling them to the same services and access as the resident population of Wales (Nation of Sanctuary-Refugee and Asylum Seeker Plan 2019). Only in the case that exemption cannot be granted for services with NHS statutory charges, RAS will use NHS waitlists in common with the resident population (NHS Wales). One more barrier that may stand in the way of absolute equity of access to care is uncertainty from GPs in regard to entitlements for RAS, how to deal with asylum seekers mental health problems, and where to make appropriate referrals (Feldman 2006). This should be kept in mind when drafting future guidelines for NHS Wales and overall NHS services across the UK.

Overall, regardless of official status of the individual (whether it be asylum seeker or refugee), there is equitable access to the opportunity to seek health services; however, this does not account for social and cultural factors that may further harm health access. Over several years, Wales has made strides to alter social policy and develop longitudinal plans to make a more equitable nation for all, including RAS. In the following section, these Welsh guidelines and plans that will affect

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those granted official asylum or refugee status will be outlined. Additionally, the services offered to aid in these ongoing health and cultural barriers will be presented.

**b. Refugee Health: Post-Status Approval**

In current months, the Welsh Government is amending and redesigning their “Refugee and Asylum Seeker Plan,” to bolster the lives and health of RAS pre and post officiated refugee status (Nation of Sanctuary-Refugee and Asylum Seeker Plan 2019). The revision is seeks to carry out this goal by understanding the ways in which the Welsh Government can support RAS in non-devolved areas of policy and how other third sector organizations can also assist in supporting RAS, especially during their time as “refugees.” Prior to their amendments of the current RAS plan, in 2015 the Welsh Government released a “Welcome to Wales” pack for those participating in the official UK Syrian refugee resettlement scheme (Continuing NHS Healthcare- The National Framework for Wales 2019). The welcome pack was provided to give Syrian refugees information about resettling and living in Wales (Continuing NHS Healthcare- The National Framework for Wales 2019). This packet strongly targeted health promotion in the area of health system education, informing refugees of the healthcare resources, systems, and procedures of NHS Wales available to them (Continuing NHS Healthcare- The National Framework for Wales 2019). The packet is currently being revised to extend beyond the main target of healthcare accessibility to make it “fit-for-purpose” for all RAS resettling in Wales (Continuing NHS Healthcare- The National Framework for Wales 2019). The majority of refugees do not receive this packet, as many transition from asylum-seekers to “refugees,” rather than going through an official resettlement system. This could ostracize a major group and detract from the ability to access to healthcare due to the lack of understanding of how to operate the NHS system.

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It is to be recalled that in the UK asylum seekers and refugees are different and are extended different benefits. While the entitlements extended based on individual's official status may not directly correlate with health policy and access, the entitlements could aid or take away from RAS overall health status. There are two main factors that are affected once official refugee status is granted: ability to legally work and the halting of weekly cash allowances of asylum seekers. When refugee status is granted, the individual is now legally able to seek and hold employment within the UK/Wales; however, 28 days after official status is granted, weekly payments of £37.75 are halted with understanding that employment will be found (Citizens Advice 2019). The Home Office aids in this transition by connecting new refugees with Migrant Help (Citizens Advice 2019). Migrant Help is an organization that aids refugees in finding housing, accessing benefits, and connecting to a job center to secure employment (Migrant Help). There are many social factors during the employment period which could take away from one's health; however, the overall benefit from employment and increase in SES most probably out weights the few negative factors for refugees. The opportunity to seek and hold employment statistically enhances psychological well-being, social capital, and income while reducing the negative health impacts of economic hardship. The policy that authorizes refugees to hold employment is a de facto health policy that must be mentioned.

Overall, the granting of official refugee status in the UK/Wales does not change direct points of health policy limitations and benefits for RAS, but predominantly provides more opportunity to gain social capital and advance SES through access to governmental benefits and an income. Additionally, RAS will most likely have to bear the burden of high costs of transportation to health appointments and services when only managing £37.75 per week (Public Health Wales 2019). This fact is especially prominent when considering the necessity to pay for additional English-

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speaking family members to travel with individuals to health appointments in order to be an interpreter or translator for RAS patients (Public Health Wales 2019). Currently, there is much discussion in the Welsh Government to revise current plans to make social support and services better for refugees in Wales; however, no official policy has been implemented (Nation of Sanctuary-Refugee and Asylum Seeker Plan 2019). Through the coming years, it will be important to track the way in which the Welsh Government implements its plans set in the “Nation of Sanctuary – Refugee and Asylum Seeker Plan,” to observe if new reassessed policies bolster the health and resources for both asylum-seekers and refugees regardless of status.

**V. Discussion**

The international system created to protect refugees, instituted primarily on the basis of the 1951 Refugee Convention, sanctions two main key problems highlighted in this thesis: the absence of identification or recognition of responsibility of independent locations (i.e states or individual nations in the UK) toward refugees and the non-ubiquitous interpretation of the definition of basic rights across international entities. By comparing the US, an entity made up of individualized states that are pseudo-independent, and Wales, a nation that shares the same state-like responsibilities under the UK government, similar trends were seen. In both cases, each entity had the duty to grant refugees who enter their territories legal rights (Article 2-32). The comparison elucidated the way in which rights are interpreted across “independent” states and the way in which systems are broken and in need of unification across national entities. Interestingly enough, Wales has shown a higher inclination to accept refugees than other independent entities in the UK, showcased through the Welsh Nation of Sanctuary plan. Each independent nation across the UK has developed nuanced differences in policymaking attitudes toward refugees, providing refugees and

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asylum-seekers different social benefits based on geographical location as US states have too done. Moving forward, through looking at both of these pseudo-independent entities, it may be useful for each government (i.e US Government and UK Parliament) to identify and enforce key responsibilities for states and underlying nations in order to ensure refugee access to health and other socially determining social benefits be provided regardless of geographical location of resettlement.

As the United Kingdom and the United States are both signatories on the 1951 Refugee Convention, it is interesting to see the way that the definition of “rights” is differentially interpreted across the two entities. The definition is vastly illuminated through their policies and structures toward health and availability of healthcare services for refugees. The universal system of the NHS in Wales is undeniably a system that maximizes the definition of “right,” put in place by the 1951 Refugee Convention. The universally provided system is more conducive to serving long-term health needs of refugees, providing specialized services at no cost that are necessary to target unique traumas faced by refugees. The inclination that NHS Wales shows toward inclusive policy and social services showcase the overall attitude that healthcare is a right for individuals regardless of background. In contrast, the US health system for refugees is made up of short-term fixes that lack long-term solutions. Refugees are funneled into mediocre healthcare services, often needing greater specialized care, but deterred from seeking it out due to the financial burden it would implicate. The US holds a system in which policies in place seem to give refugees greater rights for only 8-months, soon stripping refugees of broad-scale entitlements and rights after a short-term in the country. This is a fascinating dynamic, as the US Government recognizes healthcare as a right for refugees initially, but then dissociates from this initial notion, casting refugees into the tumultuous employment-based healthcare system that the rest of Americans endure. I want to

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recognize that the deprivation of one right adversely affects others. In the case of US healthcare policies and services for refugees, the lack of recognition of health as a right for resettled refugees after 8-months creates cycles of poverty cofounded by poor health, therefore leading to deprivation of rights in other areas.

Overall, I found that Wales had a system and policies that were more conducive to refugees obtaining quality long-term healthcare, although it seems that there are still many negative reservations for refugees amongst British policymakers. In this case, the cultural standard by which a nation defines “rights” has the ability to transgress political sentiments, providing a larger critique for the need for broad-scale US healthcare reform for America to meet these standards.

As policymakers go forward I recommend that they focus on two main goals: coping with and easily adapting to incoming refugees, especially when there are high volumes of resettlement needed and providing longer term equitable access to healthcare, disease prevention services, and health education. Internationally, humanitarian immigration policymaking has been occurring in silos, dividing responsibilities among humanitarian aid organizations, immigration enforcement agencies, and trade/labor units. Organizations and agencies that are from the health sector have not usually been included when policy is being created. To further my recommendation, I would like to suggest amplifying the synergy amongst these organizations, including those from the health sector, in order to maximize and fulfill overall organizational goals while aiding refugee well-being. This could include developing a universal framework of medical assessment for refugees to boost physician competence to understand treatment needs and necessary future-direction and guidance for refugees to connect them to other sectors (i.e employment opportunity and specialized care). It is integral that policymakers make these strides to eliminate inequitable treatment of individuals and maximize health for all global citizens, especially resettled refugees.

## **VI. Conclusion**

It is readily apparent that refugee related health policy in its totality has been and continues to be broken, perpetuating cycles of inaccessibility, poverty, and poor-health. Overall it can be observed that refugee health is not defined by a specific to a singular location, rather intertwined to multi-national entities that preserve traditions of inequitable political frameworks and opportunities for migrants. Inequities relating to accessibility and opportunity are seemingly borderless and elicit a further call to action for all policymakers.

Throughout all policymaking fields, it is integral that international agreements which set frameworks to guarantee the right to health for all, be recognized and integrated into decision making and legislation. It is not adequate to recall these set principles for niche guidelines, as the right to health must be integrated across the broad spectrum of policymaking to stem systematic change and transitions.

The synopsis and comparison of the historical roots of current policies and legislative frameworks of refugee health for Wales and the US presented here aims to shed light on the synergy between legislative action, entitlements, and systems that perpetuate cycles of poor health for refugees and provide evidence that evokes multi-national policy improvement and reform. It emphasizes the need for further evaluation of multi-faceted systems of immigration, welfare, and health in order to eliminate restriction and promote equitable health for resettling refugees.

Regardless of the information compiled, the presentation of evidence and potential policymaking frameworks is insufficient without action to create more inclusive refugee-related health policy and multi-level interventions. Furthermore, it should be emphasized that without addressing underlying attitudes and political agendas that inform broader immigration policy



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internationally, evidence and minor intervention is not enough to promote large-scale refugee inclusion and equity.

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