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The inverse care law and COVID-19 vaccination for refugees

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A perquisite for achieving high COVID-19 vaccine uptake, not only among refugees and migrants but also in populations as a whole, is the ability of public health authorities to monitor and understand the emerging barriers and facilitators determining vaccine rollout.[1] The study in *The Lancet Healthy Longevity* by Berthe Abi Zeid and colleagues[2] is a welcome contribution to this demanding and challenging field of policy practice. Their research reports low COVID-19 vaccine uptake rates among Syrian refugees aged 50 years or older residing in Lebanon (1235 [42·5%] of 2906 participants interviewed up to March 14, 2022), and low vaccine acceptance rates among this vulnerable population group (38·1% of unvaccinated refugees were unwilling to receive the vaccine and 40·1% remained hesitant due to a fear of side-effects).[2] These worrying findings need to be interpreted with caution and within the context of a substantially lower COVID-19 vaccination prevalence (45·9%) in Lebanon compared to the average vaccination rate (80·2%) in upper-middle-income countries.

Actual figures on vaccine uptake among refugees and migrants during the COVID-19 pandemic have been very rarely reported,[3,4] since the relevant data are usually neither collected nor disseminated. However, the risk of under-immunisation of certain migrant populations (ie, foreign-born individuals) was well known even before the COVID-19 pandemic.[5] Unsurprisingly, the policy debate usually focuses on whether this risk is mostly related to the cultural norms of refugees and migrants, in an obvious attempt to shift the discussion towards individual responsibility, eventually blaming the victims for their personal attitudes.

Nevertheless, evidence from the COVID-19 pandemic shows that, in most cases, migrants were largely willing to get vaccinated, demonstrating higher COVID-19 vaccine acceptance rates than the general population.[6] Most studies covering a wide range of countries across all continents show low hesitancy rates for COVID-19 vaccination among refugees, asylum seekers, and undocumented migrants.[4] Even before the pandemic, pockets of low vaccine acceptance among migrants and refugees were reported only in specific groups, and for certain vaccines and contexts, therefore making it difficult to generalise the findings.[5]

On the contrary, what has become increasingly apparent during this pandemic is the inverse care law defined by J T Hart in 1971 as the observation that "the availability of good medical care tends to be inversely associated with the need of it in the population served".[7] In other words, health and social systems in general tend to provide fewer services and of inferior quality to those who need them most, and more services and of superior quality to those who need them less. Enough evidence exists to suggest that refugees and asylum seekers were at increased risk of developing COVID-19 during the pandemic mainly due to their overcrowded living conditions both in camps and in the community.[8,9] Moreover, they were disproportionately represented in reported COVID-19 deaths.[9] Yet, despite their increased need for protection and increased risk of infection, refugees and asylum seekers in many countries were excluded from national vaccination plans, and if included they were not prioritized.[4] In places where migrants and asylum seekers were eligible to receive a vaccine they experienced multiple access barriers such as administrative barriers, lack of health insurance and fears of entitlement, digital exclusion, language barriers and misinformation, a real or perceived risk of deportation, and an inability to cover the indirect costs of vaccination.[4–6] Some of these barriers are also highlighted in the study by Abi Zeid and colleagues,[2] since 67·1% of respondents who had not received a second dose of the vaccine reported waiting for an appointment as the main reason for not doing so.

For **data on COVID-19 vaccination rates in upper-middle-income countries** see https://ourworldindata.org/covid-vaccinations

Interestingly, 35 years after having conceived the inverse care law, J T Hart emphasised that this "is a human construct and not a law of nature" and that it is "mainly an effect of the market that subordinates human values to the pursuit of profit".[10] In the case of refugees' and migrants' care, the inverse care law is an effect either of xenophobia or low government prioritisation based on the limited political and economic power of refugees and migrants and their marginalisation in contemporary societies. However, given that the inverse care law is a human construct, it can be reversed with political will. Vaccine prioritisation of all target groups at increased risk of COVID-19 (including refugees, asylum seekers, and undocumented migrants), lifting legal and administrative barriers, promoting active engagement

of refugees and migrant communities to re-build trust, and designing of systematic, clear, and consistent information strategies are good and effective practices to reverse the inverse care law.[1]

We declare no competing interests.

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