

Better
Health
Briefing

19

**Health and
access to
health care of
migrants in
the UK**

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Key messages

- 1 The growing size and diversity of the proportion of the UK population who were born overseas have important implications for meeting health needs and for planning and delivering health services
- 2 As part of a commitment to reducing inequalities in access and in health outcomes, government policy has focused largely on addressing ethnic inequalities in health. Less emphasis has been placed on the possible impact for migrants of factors such as country of birth, language and length of residence and immigration status in the UK
- 3 Although there is some research focus on the health needs of specific groups of migrants, such as refugees and asylum seekers, there have been relatively few attempts to gather evidence on health outcomes, needs, care and barriers to care of broader categories of migrants, including those who come to study, to work or for family reasons, and more established groups
- 4 There is particular evidence of barriers to health care arising from restricted entitlement for some vulnerable migrants. Political concern over 'health tourism' negatively affects the delivery of, and access to, health care for migrants. These issues require further research and the implementation of specific policies and good practice.

Introduction

The health status of migrants and their access to health care are key indicators, alongside housing, employment and education, of their 'integration' within receiving societies. Health is also important for other integration outcomes, such as civic participation. However, there is insufficient emphasis in mainstream health research or policy on the factors that affect health outcomes and access to health care relating to migrant experience or status per se. By bringing together available evidence, this briefing outlines some important issues for the health of migrants in the UK today. It also suggests ways in which research, policy and practice might address barriers to health, well-being and health care in meeting the needs of migrants.

1 The size and diversity of the UK population born overseas

Over the past two decades there have been considerable changes relating to countries of birth, nationalities, reasons for migration, settlement patterns and legal status of people in the UK who were born abroad (Commission on Integration and Cohesion, 2007). However, it is important to recognise short-term fluctuations in size and diversity according to world economic and political patterns and labour market needs. The large-scale movement of labour migrants and their families from former British colonies in the Caribbean, Asia and Africa from the 1950s to the 1980s has shifted to a vastly more diverse pattern. In addition to continuing family and labour migration from former colonies, increasing numbers of people fleeing political conflicts in parts of Africa, Asia and Eastern Europe in the 1980s and 1990s sought asylum in the UK. Large numbers of people from Eastern and Central European countries also sought better work opportunities here as their countries joined the European Union (EU) in 2004 and 2007 (Vertovec, 2006). Migration statistics show how numbers and proportions have changed. In December 2008, the proportion of those born outside the UK stood at around 11 per cent of the resident UK population, an increase of 2 per cent since 2004. In 2008, the most common country of birth for people born outside the UK was India,

followed by Poland. Between 2004 and 2008, the number of UK residents born in India increased by around a quarter, while there was a fivefold increase in the number of UK residents born in Poland (ONS, 2009).

An important element of recent demographic change has been the settlement of migrants in 'new immigrant gateways'; that is, in parts of the country that historically have not been large-scale migrant receiving areas (Waters and Jimenez, 2005). The precursor to this phenomenon was the dispersal of asylum seekers to housing around the UK to ease pressure in London and the South-East from the late 1990s onwards (Hynes, 2009); however, the recent settlement patterns are more strongly associated with the arrival of migrants from EU accession countries. Many work in agricultural and food-processing industrial sectors located in largely rural or semi-rural areas some distance from the metropolitan urban centres of past migration waves (Anderson *et al.*, 2006). This has led to pressure on the organisation of public services in local areas unused to a sudden population increase (Audit Commission, 2007; Institute of Community Cohesion, 2007).

Different types of migrants – job seekers, students, those who migrate for reasons of marriage and family reunion, refugees, asylum seekers, undocumented migrants and recent EU migrants – may have differing health needs (including differences in need for information) and differing entitlements to access health care. Such diversity constitutes a real challenge both for health policy makers and for service commissioners and providers, in terms of service planning and delivery, particularly at a local level.

The need to move beyond a limited focus on ethnic inequalities in health

2

The current research evidence on the health of migrants, particularly recent migrants, is limited, especially at national level; there is far greater focus on minority ethnic groups, increasing numbers of whom are born in the UK. Moreover, much of the research and administrative evidence on inequalities in health outcomes and access to care, which feeds into health policy and practice, is based on ethnicity. It does not take sufficiently into account the country of birth, date of arrival, nationality, language and immigration status of people who were not born in the UK (Fitzpatrick *et al.*, 2005; Sproston and Mindell, 2006; Commission for Healthcare Audit and Inspection, 2008; Healthcare Commission, 2008; Marmot *et al.*, 2010). Where there is a mandatory requirement to collect information on ethnic group, as in hospital admissions, there was around 86 per cent coverage of ethnicity in Hospital Episode Statistics nationally in 2007–2008 (The Health and Social Care Information Centre, 2009). In primary care, incentives have recently been provided to general practices to collect ethnic group data from patients (Warburton, 2008). An exception lies in birth and death registrations, which record country of birth but not ethnicity, although the recent linkage between birth certificates and hospital birth notifications means that it is now possible to analyse infant mortality by both baby's ethnicity and mother's country of birth (Gray *et al.*, 2009).

The government's Public Service Agreement (PSA) target to reduce health inequalities (primarily measured by reduction of inequalities in infant mortality by social class and in life expectancy by area) is set out with reference to cross-cutting social determinants of health, such as child poverty, education, income, employment, housing quality and area deprivation (DH, 2008). Ethnic group differences in health determinants and outcomes are reported, with the exception of mortality data (Acheson, 1998; DH, 2008). The recent Marmot Review of 'health inequalities in England post-2010' does consider the complex patterning of health associated with ethnic groups in relation to the continuing evidence of a social gradient in health (Marmot *et al.*, 2010). However, this report has recently been criticised for not sufficiently addressing the impact of ethnic diversity and racial discrimination on health outcomes, thereby missing opportunities to influence health policy and practice towards equitable outcomes for minority ethnic populations (Salway *et al.*, 2010). It is significant that in the Marmot Review there was even less focus on migrants than on minority ethnic groups, possibly because the necessary 'migration variables' were not available. This has implications for policy and practice recommendations. A more comprehensive collection and analysis of data is needed in order to understand whether, and why, migration factors, interacting with ethnicity and socio-demographic factors, may mean that migrants have different needs and meet with different barriers compared to minority ethnic groups.

3 Evidence on the health of migrants

Where there has been a specific focus on the health of recent migrants, this has often been on particular groups, such as asylum seekers and refugees. Of particular concern have been:

- the physical and mental impact of conditions in countries of origin, especially where there has been experience of war;
- the physical and mental trauma of the migration and settlement processes, including isolation, loss of social status and insecurity of immigration status in the receiving society;
- greater susceptibility to infectious diseases such as tuberculosis, depending on countries of origin or transit and living conditions during and after migration.

(IPPR, 2005; Health Protection Agency, 2006; Johnson, 2006; Piachaud *et al.*, 2009)

Comparison of migrant health with minority ethnic health is linked with evidence that the health status of some migrants deteriorates over time in receiving societies. The concept of 'acculturation' – the adoption of norms, values and behaviours that prevail in the receiving society – has been used to explain changes in the health behaviour of migrants that have negative consequences on health outcomes in the longer term. Examples are higher levels of smoking, including in pregnancy; lower levels of breast feeding; and diets with a higher fat content (Zaman and Mangtani, 2007; Gilbert and Khokhar, 2008; Hawkins *et al.*, 2008).

Other accounts avoid the limitations of using models of acculturation to explain migrants' health, particularly the unidimensional emphasis on changes in values, norms and beliefs (Abraldo-Lanza *et al.*, 2006), and focus more on structural barriers to good health and to access to and uptake of health care in the receiving country, largely using local evidence. These barriers include:

- low income and poverty leading to a lack of a decent standard of life (such as poor nutrition);
- sub-standard and overcrowded housing in local areas of deprivation where many recent migrants live;
- poor health and safety practices in some industries employing migrants;
- lack of access to reliable transport for accessing services;
- inadequate information on how to access health services, such as immunisations and screening, and lower uptake of these compared to UK-born groups;
- lack of knowledge about or denial of entitlement to primary health care, particularly for failed asylum seekers and undocumented migrants;
- inadequate language and other support;
- cultural insensitivity on the part of some health care providers.

(Webb *et al.*, 2004; Spencer *et al.*, 2007; Cassidy, 2008)

Importantly, some of these barriers cut across length of residence in the UK, thus having an impact on both recent migrants and established residents (Jayaweera *et al.*, 2005). Such evidence suggests that social determinants of health play as important a part in explaining health outcomes for migrants as for minority ethnic groups, but the way in which being a migrant relates to the social gradient in health has not received the attention that has been given to ethnic inequalities.

4 Entitlement to free health care

At a time when both numbers and diversity of migrants in the UK are increasing, there is an imperative need to fully understand and address both the levels of discrimination and the consequences of restrictions imposed by immigration status in relation to access to health care, and the impact of this on health outcomes. This is highlighted in evidence on pregnant women and recent mothers among vulnerable migrants, such as failed asylum seekers, those in detention, trafficked women and undocumented migrants, who are particularly dependent on health services at this period of their lives, but have been classified as not ordinarily resident and therefore may be refused access to maternity care by health care providers (McLeish, 2002; Bragg, 2008).

The Confidential Enquiry into Maternal Deaths (2003–2005) found that Black African mothers, most of whom were recent migrants (including asylum seekers and those with unclear immigration status), were more than five times more likely to die than white mothers. Late booking for, or no access to, antenatal care and a lack of access to translation services were some of the factors associated with mortality (Lewis, 2007).

Organisations in the voluntary sector campaign for welfare rights for vulnerable migrants and/or run projects enabling access to health care for those who lack information about their rights or are denied access by health care providers (Medact, 2007; Médecins du Monde, 2007). Such organisations operate within a framework of ongoing debates about 'health tourism' (i.e. overseas visitors arriving in the UK for the sole purpose of obtaining free NHS care); confusion among health care providers around government charging policies for health care for those not deemed 'ordinarily resident'; and changes in legislation that may have negative implications for entitlement to welfare rights for increasing numbers of migrant groups (Cassidy, 2008; Migrant Rights Network, 2009). The latter includes the latest proposal of the UK Border Agency and the Department of Health to refuse entry to, or the right to remain in, the UK for migrants subject to immigration control who have unpaid debts to the NHS (UKBA, 2010). More research and a specific focus by policy and practice are needed in order to understand and address the possible link between poor health outcomes among vulnerable migrants and barriers to health care access, including lack of entitlement.

Points for improving policy and practice

Policy makers and service commissioners and providers at a local level should make concerted efforts to:

- Establish centralised systems of data collection on the health outcomes and service use of people in local areas – for instance, through Primary Care Trust information systems – that wherever possible include 'migration variables' (e.g. country of birth, length of residence in the UK, language use, nationality and immigration status) as well as ethnicity and socio-demographic information (recognising that migration data collection can be sensitive).
- Gain information about the health needs of and barriers to health care access and uptake among diverse groups of migrants. This could be done in part through the experiences of statutory and voluntary organisations, those representing different migrant groups in local areas and migrants' own welfare networks. Primary research that provides evidence on age, gender, socio-economic status, ethnicity, religion, language and country of birth is also important. The establishment of Regional Strategic Migration Partnerships (RSMPs) is potentially a means towards that end, but evaluation of outcomes is needed (DCLG, 2009). A particular effort should be made, in research and in service provision, to reach those more vulnerable groups who are less likely to register for primary care because of inadequate information or insecure legal status. Places of religious worship, such as churches, mosques and temples, may contribute to effective mapping, particularly of those who do not have a legal immigration status and are helped to access services by religious institutions.
- Adopt a community development-based approach incorporating the following key elements (BME Health Forum, 2009): a focus on improving access as an outcome in itself; a focus on user and community empowerment as outcomes; a focus on partnership working across disciplinary and departmental boundaries; a recognition of timescales involved in addressing barriers to effective access to health care; and a move away from an emphasis on measurable health outcomes as a short-term objective and success indicator.

Examples of good practice

1 Mapping migrant populations in the regions

(a) Rodger, E. and Chappel, D. (2008) *New Arrivals in North East England: Mapping migrant health and NHS delivery*, Durham University/Stockton on Tees: North East Public Health Observatory.

(b) Ricketts, A. (2008) *Health & Migration in the North West of England: An overview*, Manchester: North West Regional Strategic Migration Partnership.

These are examples of detailed reports using available information to map the size, diversity and health-related circumstances of the migrant population at a regional level, including in areas experiencing large-scale in-migration for the first time. Such reports are generally produced by a consortium of organisations, including regional Public Health Observatories (PHOs) and RSMPs. While restricted in scope and detail by limitations in available data, they nevertheless provide useful background information for policy makers and local service providers and point to information gaps at a local level (see also Example 4).

2 Linking records: NHS numbers for babies and birth registration

Hilder, L., Moser, K., Dattani, N. and Macfarlane, A. (2007) 'Pilot linkage of NHS numbers for babies data with birth registration', *Health Statistics Quarterly*, 33, pp. 25–33.

A positive step has been made in England and Wales towards combining ethnic variables and migration variables in health data, by linking birth outcome data, recorded at place of birth, with birth registration records, through babies' unique NHS numbers. This has made it possible to analyse health outcomes for babies, such as gestational age at birth and birth weight, as well as infant mortality, by socio-demographic variables of parents, including both the mother's and the father's countries of birth and the baby's ethnic category.

3 Project London

www.doctorsoftheworld.org.uk/projectlondon/default.Asp

This project organises a free clinic in East London for vulnerable people, a large proportion of whom are migrants, who face barriers to accessing health care. In 2006–2007, nearly 1000 service users were seen at the clinic. Many had been refused GP registration and primary care (including some who were clearly entitled to care), because of lack of knowledge and understanding of government regulations among administrative staff. The project provides a valuable service in ensuring that users are registered with a GP and receive the care they need.

4 Regional Strategic Migration Partnerships (RSMPs)

(For example, West Midlands Strategic Migration Partnership
www.wmleadersboard.gov.uk/migration-documents)

Regional Strategic Migration Partnerships were initially set up as the main regional policy forum in the UK around issues of dispersal, accommodation and support of asylum seekers and the integration of refugees. In 2007, their remit was expanded to include other recent migrant groups. They work closely with central and local government, statutory service providers and voluntary, community and migrant organisations in local areas for the coordination and provision of advice, support and services for migrants and to ensure that migration issues are a key part of local plans (DCLG, 2009). In most regions they include specific task groups: for instance, in health, housing and employment.

Conclusion

The changing size, diversity and needs of migrants in the UK have yet to be sufficiently addressed in academic research and mainstream health policy and practice. It is important to move beyond a framework of ethnic differences and inequalities in health and to consider a range of factors that may explain the experiences and needs of migrants, including those who are most vulnerable and are restricted in their entitlement to free health care in the UK. This is important to the goal, set out in the Marmot Review (Marmot *et al.*, 2010), of creating a fairer and more just society.

Resources

Websites

Mighealthnet: Information network on good practice in healthcare for migrants and minorities in Europe

http://mighealth.net/index.php/Main_Page

The aim of the Mighealthnet project is to promote exchange of knowledge on migrant and minority health and access to health care through developing interactive databases in participating countries in Europe.

NHS Evidence: ethnicity and health

www.library.nhs.uk/ethnicity

NHS Evidence: ethnicity and health is a website that aims to provide the best available evidence on health needs and access to health care of migrant and minority ethnic groups, and on the management of the health care service for these groups.

Refugee Council

www.refugeecouncil.org.uk

The Refugee Council is the largest organisation in the UK supporting asylum seekers and refugees and working with them to ensure that their needs and concerns are addressed.

Publications

Institute of Community Cohesion (2007)

Estimating the Scale and Impacts of Migration at the Local Level, Local Government Association, available at:

www.lga.gov.uk/lga/aio/109536

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. and Geddes, I. (2010) *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, The Marmot Review, available at:

www.ucl.ac.uk/gheg/marmotreview

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