BRIEFING

Health of Migrants in the UK: What Do We Know?

AUTHOR: DR HIRANTHI JAYAWEERA
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This briefing provides an overview of evidence on the health of migrants in the UK. The focus is on physical and mental health status, health behaviour, factors that influence health outcomes (social determinants of health) and access to and use of health care.

**Key Points**

Evidence on physical and mental health suggests there are poorer outcomes overall for non-UK born individuals residing in the UK compared to the UK population but these vary according to migration histories and experience in the country.

Changes in some health behaviours of migrants over time in the UK may not be as marked or linear as some accounts suggest.

Both socio-economic circumstances and immigration regulations affecting some migrant groups impact negatively on access to and use of health care.

It is currently difficult to gain a comprehensive account of the health of migrants because much existing evidence on health includes ethnic group but not migration variables such as country of birth, length of residence in the UK, or immigration status.

**Understanding the evidence**

The definition of migrants used in this briefing refers to all those born outside the UK and encompasses the diversity of migrant groups. This includes both recently arrived and/or temporary migrants and those who have been settled in the UK for many years. In relation to health care it ranges from those who, according to immigration, residency and citizenship regulations, have full entitlement to free health care, to those who are deemed ‘not lawfully resident’ and are denied entitlement free of charge to some health services.

The quantitative evidence on the health of migrants is limited overall, but there has been some focus on particular categories of migrants, such as asylum seekers and refugees, and on some specific areas of health, such as mental health, infectious diseases and some chronic diseases, largely from qualitative data or specialist databases. Evidence on access to and use of health care among migrants in the UK is largely from small scale, local and qualitative studies.
Physical and mental health of migrants: Important to consider diversity

There is evidence that many migrants are relatively healthy upon arrival compared with the native population but that good health can deteriorate over time in the receiving society (Rechel et al. 2013). However, there are variations in health among different migrant categories. For asylum seekers, research has focused on the physical and mental impact of conflict and war in some countries of origin; trauma associated with migration and settlement processes including isolation, loss of social status, poverty and insecure legal immigration status; and impact of government policies such as detention and dispersal in the receiving society. Local studies in the UK and systematic reviews of studies across European countries point to higher rates of depression and anxiety among asylum seekers and refugees compared to the national population or other migrant categories (Raphaely and O’Moore 2010). Particularly vulnerable groups are children, and women who have suffered sexual and physical abuse. A rare quantitative survey of women internally or internationally trafficked for sex work or domestic service in selected European countries including the UK found that 70% of women had experienced both physical and sexual abuse during trafficking and that the majority exhibited severe physical and mental health symptoms such as back and abdominal pain, headaches, dizziness, gynaecological infections, depression and anxiety (Zimmerman et al. 2008).

Registers of infectious diseases, for example TB and HIV, which are statutorily notifiable diseases in the UK, possibly provide a better source of information on health outcomes among migrants as a category as country of birth is routinely recorded. For both TB and HIV, rates are higher for non-UK born people (HPS 2011). Figure 1 shows TB prevalence rates for UK and non-UK born ethnic groups, highlighting the greater incidence of disease among South Asian (particularly Indian and Pakistani) and Black African non-UK born populations compared to other migrant groups or UK-born South Asians and Black Africans. There is evidence that the highest rates of TB among migrants occur among people who are recent arrivals in the UK, possibly reflecting prevalence rates in countries of origin, but less than a half are diagnosed within five years of arrival (PHE 2013). While reactivation of latent Tuberculosis has been identified as a significant factor, this also highlights the possible importance of other contributory factors, such as low income and poor living conditions in the UK, especially documented among recent migrants – for example, poor nutrition, sub-standard and overcrowded housing in areas of deprivation where many newly-arrived migrants live (Robinson and Reeve 2006). TB is a disease that has always been associated with poverty and deprivation (Abubakar et al 2012). However there is no robust evidence in routine surveillance systems to explore socio-economic factors affecting TB among migrants (HPA 2006).

Figure 1a
Unlike for infectious diseases, evidence by country of birth for non-communicable diseases (NCDs) is limited. While mortality data (death registration) in the UK is according to country of birth, morbidity data in disease registries and hospital records is usually by ethnicity, which makes it difficult to understand NCD patterns as opposed to deaths among migrants. There is evidence of marked and heterogeneous differences by country of birth for all-cause mortality and for mortality according to specific diseases in all age groups (Wild et al. 2007; Wild et al. 2006). However, data linkage between disease registration/hospital records and the census does provide an opportunity to examine the health status of migrants, as country of birth information is available in the latter. For instance, analyses show lower cancer incidence overall among men and women born in South Asia (first generation), compared to all men and women in the population studied (Harding et al. 1999).

Evidence on health status by immigration status is less well documented, including the health of labour and family migrants, as well as students. It is generally perceived that economic migrants in particular are for the most part young and healthy, with relatively few health problems, an argument that might apply to students as well. However, health issues in broader migrant categories include maternal and child health (see below), and health consequences of poor working conditions and inadequate safety practices in some industries employing migrants (McKay et al. 2006).

Health behaviour: change over time not necessarily linear

Interest in and public health concern around the health behaviour of migrants relates not merely to prevalence - for instance, reportedly high smoking rates among migrants from Eastern European countries (Raphaely and O’Moore 2010) - but also to change over time in the receiving society (Williams 1993). Areas of interest include smoking patterns, alcohol consumption, diet and breast feeding. Theories of ‘acculturation’ – that is, the adoption of norms, values and behaviour prevalent in the receiving society – have been deployed to explain changes in health behaviour among migrants that have longer term negative consequences for health outcomes. Evidence includes the impact of higher levels of smoking, especially in pregnancy, lower levels of breast feeding and diets with high fat content on rates of diabetes, cardio-vascular disease and cancer (Hawkins et al. 2008).

It is important however to consider who is adopting whose health behaviour in receiving contexts, structural constraints on achieving healthy lifestyles, and patterns of NCDs in countries of origin as well as pre-migration
health of migrants (Jayaweera 2013). An analysis of the health of migrant mothers in a national population based study (the Millennium Cohort Study) around nine months after giving birth revealed that ethnicity was more important than length of residence as a predictor of cigarette smoking and alcohol consumption. There were very low rates of smoking or alcohol consumption among some ethnic groups (notably Pakistani and Bangladeshi mothers). While there was a linear trend in improving socio-economic circumstances according to length of residence for mothers, this did not appear to lead to significant change in patterns of smoking and alcohol consumption, thereby challenging the use of simple linear ‘acculturation’ models to understand patterns of health of migrants over time (Jayaweera and Quigley 2010).

Access to and use of health care: negative impact of socio-economic factors and immigration status

There is relatively more evidence relating to access to and use of health care among migrants in the UK although, as stated earlier, this is largely from small scale, local and qualitative studies. The focus is on barriers to access. Barriers identified include inadequate information, particularly for new migrants unfamiliar with health care systems in the UK, insufficient support in interpreting and translating for people with limited English fluency, lack of access to reliable transport because of poverty and poor services in areas of deprivation where many recent migrants live, confusion around entitlement to some types of services particularly among migrants with insecure immigration status as well as among service providers and cultural insensitivity of some front line health care providers (Phillimore et al. 2010; Johnson 2006). Some of these barriers, such as information, language and transport, appear to cut across length of residence, affecting longer established migrants as well.

Quantitative evidence on use of services specifically by migrants is scarcer. Some studies have demonstrated lower uptake of immunisations and screening by non-UK born populations compared to those who are UK-born but ethnicity and socio-demographic factors have also been found to be important (Jayaweera & Quigley 2010; Webb et al 2004). A population based survey of mothers giving birth over a two week period in England in 2009 revealed that compared to White women born in the UK, Black and Minority Ethnic (BME) women born outside the UK booked for antenatal care later, had poorer information provision and were less likely to be treated with respect by staff (Redshaw and Heikkila 2010). The most recent Confidential Enquiry into Maternal Deaths (2006 -2008) found that Black African mothers, the largest number among whom were recent migrants including refugees and asylum seekers, had a mortality rate nearly four times that of White women (although this is a reduction from the Enquiries conducted earlier in the decade) (Lewis 2011). Key risk factors for maternal mortality included lack of antenatal care or late booking, particularly high among mothers of African–Caribbean and Pakistani ethnicity, little or no English fluency among a fifth of mothers who died, and inadequate interpretation support from maternity services. An analysis of migrant mothers in the first wave of the Millennium Cohort Study (2001–2002) showed that 7.1% of mothers born abroad giving birth in the UK had no antenatal care at all, compared to 2.4% of mothers born in the UK. There were particularly high proportions of mothers having no antenatal care among Pakistani and Bangladeshi migrant mothers.

However, regression analysis revealed that the strongest predictors of reporting no antenatal care were not country of birth (whether born in or outside the UK) or ethnic group, or for migrants, length of residence in the UK, but socio-demographic factors such as younger age, lower educational level and occupational class and living in a ward where at least 30% of the population were from BME categories (Jayaweera and Quigley 2010) – see Figure 2. This reinforces the findings of qualitative studies discussed earlier that suggest the importance of considering the wider circumstances of migrants’ lives in making sense of patterns of health and health care.
Barriers to care for irregular migrants and those with uncertain immigration status have received particular attention in both research and practice. Such migrants can include visa overstayers, refused asylum seekers, those who have been trafficked into the UK and spousal migrants escaping domestic violence. According to current rules governing access to health care these categories are not entitled to some services, for instance free hospital care, except for emergency care or treatment for HIV. Further, in accordance with a re-definition of ‘ordinary residence’ as part of the 2014 Immigration Act, all new ‘temporary’ entrants to the UK including workers on the points-based-system and their dependants, family members joining British citizens or permanent residents, and international students will need to pay an additional charge as part of their entry visa fee, to access NHS services (Grove-White 2014). At the same time, there is also expected to be more restrictions of the limited rights of some undocumented migrants – including UK-born children of undocumented parents – to some services, such as free access to Accident and Emergency hospital services, that have so far been granted on humanitarian and public health protection grounds.

Such conditionality and restrictions mean that there is currently a stratification of rights to health care in the UK (Kelly et al. 2005). Research findings also suggest concern among both non-statutory and statutory agencies, based on testimonies of migrants particularly at a local level, about the negative impact of lack of, or confusion around, entitlement on health outcomes among vulnerable groups including children and pregnant women denied access to maternity and infant health services (Oliver, 2013). Lack of access to welfare benefits and good quality housing also has impacts on wider determinants of health, as do poor nutrition and lack of transport to care facilities. At a voluntary-sector run clinic in London that aims to support migrants and others who are unable to access necessary health care, the main barriers to care were identified as: language, inhospitable and sometimes hostile GP surgery staff, lack of knowledge and understanding of regulations regarding entitlements among surgery staff, poor living conditions of migrants and stress caused by the effects of uncertain immigration status (Doctors of the World 2010).
Evidence gaps and limitations

Available data on migrants’ health in the UK, particularly at a large scale quantitative level, is limited, including data that distinguishes between economically better-off and worse-off migrants. Apart from birth and death registrations, much of the research and administrative evidence on health outcomes and access to health care is currently reported by ethnicity (Care Quality Commission 2010). The policy emphasis has been on improving data collection on ethnicity in health data, for instance in hospital and primary care data; ‘migration variables’ such as country of birth and date of arrival in the UK are usually not included in routine administrative systems. This also means that targets set by government to reduce social inequalities in health include reference to differences among ethnic groups in health outcomes and in cross-cutting social determinants of health such as education, housing quality and smoking (Marmot et al. 2010).

However, the recent Marmot Review of ‘health inequalities in England post-2010’ has been criticised for missing an opportunity to influence health policy and practice relating to minority ethnic groups. It is claimed that the report did not sufficiently address the impact of ethnic diversity and racial discrimination on health outcomes (Salway et al. 2010). There was even less opportunity in this review to understand the impact of migration factors, interacting with ethnicity and socio-demographic factors, on the health outcomes, needs and barriers to care of migrants compared to minority ethnic groups born in the UK. This has significant implications for policy and practice recommendations.

References

• Jayaweera, H. "Migration and non-communicable diseases." COMPAS blog, 12 February 2013.


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The Migration Observatory
Based at the Centre on Migration, Policy and Society (COMPAS) at the University of Oxford, the Migration Observatory provides independent, authoritative, evidence-based analysis of data on migration and migrants in the UK, to inform media, public and policy debates, and to generate high quality research on international migration and public policy issues. The Observatory’s analysis involves experts from a wide range of disciplines and departments at the University of Oxford.

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About the author
Dr Hiranthi Jayaweera
Senior Researcher, COMPAS
hiranthi.jayaweera@compas.ox.ac.uk

Press contact
Rob McNeil
Head of Media and Communications
robert.mcneil@compas.ox.ac.uk
+ 44 (0)1865 274568
+ 44 (0)7500 970081

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