BRIEFING
The health of migrants in the UK

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This briefing examines the health outcomes of migrants (defined as people who were born abroad) as well as the extent to which health problems impact their day-to-day activities or their jobs.

**Key Points**

Migrants are healthier, on average, than the UK born. In 2018, 26% of the foreign-born population said that they had a long-lasting health problem; this is 15 percentage points lower than the UK born (41%). Some groups of migrants in older age groups were more likely to have health problems than the UK born, however.

Migrant workers in low-skilled jobs were more likely to say that they had a long-term health problem than those in high-skilled occupations. The “health advantage” of the foreign born over the UK born was largest among low-skilled workers with limiting health conditions.

Migrants who have lived in the UK for longer are more likely to have health problems, even when comparing people in the same age groups.

The share of residents reporting a long-lasting mental health problem is 5% for the foreign born and 9% for the UK born.

Foreign-born men are more likely to smoke than UK-born men, while the opposite is true among women.

**Understanding the evidence**

This briefing examines the outcomes of people who were born abroad and have migrated to the UK. The word ‘migrant’ is used differently in different contexts. In this briefing, we use the term ‘migrant’ to refer to the foreign born, regardless of whether they have become UK citizens. For a discussion of this terminology, see the Migration Observatory briefing *Who Counts as a Migrant: Definitions and their Consequences*.

This briefing relies on the Labour Force Survey (LFS) quarterly data from 2018 and the Annual Population Survey (APS) from 2017. The two surveys collect data on respondents’ self-reported health as well as on relevant sociodemographic characteristics and labour market situation. Only respondents who are aged 16 or older are asked the questions included in the health modules. Because all the data are self-reported, it is possible that certain health conditions are misreported.

The LFS is the largest household study in the UK (39,000 households) and provides the official measures of employment and unemployment. It collects information about a wide range of topics on individuals above age 15 every quarter. The APS includes most of the same individuals as the LFS but also includes and additional boost to the sample. Some variables are not available in the APS, however, and in those cases this briefing uses the LFS instead. The LFS/APS have some important limitations. Some people are excluded, such as residents of communal establishments like hostels, and other groups may be undercounted due to survey non-response. Its response rate has declined over time, and is now below 50% (ONS, 2016); this means that people who are more likely not to respond to the survey may be undercounted. ONS analysis based on the Census suggests that non-response is a greater problem among people born outside of the UK (Weeks et al, n.d.).
**Health variables in the LFS and the APS**

The health data presented in this briefing refers to long-lasting health problems; that is, physical or mental health conditions or illnesses that are lasting or are expected to last at least 12 months. Under the Equality Act 2010, health conditions may be considered a disability if they have a substantial adverse effect on the person's ability to carry out normal day-to-day activities for at least 12 months (Equality Act 2010: Chapter 1 Section 6).

Respondents reporting a long-lasting health problem give information about the extent to which their health problem affects their ability to carry out day-to-day activities (not at all, a little, or a lot). This briefing uses the term 'limiting health problem' when the respondent has said that the health problem limits their daily activities either a little or a lot. It uses the term 'non-limiting health problem' when they have said that they have a long-lasting health condition that does not limit their daily activities.

**Data breakdowns**

In addition to country of birth, most data breakdowns include individuals’ age, which is a key determinant of their health. Both biological and social determinants have to be acknowledged in any analysis comparing the health of the foreign and the UK born, as these factors will differ across the two groups.

The briefing presents data for the UK-born and foreign-born populations either as a whole or for different country of birth groupings. The country categories are the following:

- EU-14 countries (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden).
- EU-8 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia), EU-2 (Bulgaria and Romania) and EU Other (Croatia, Malta and Cyprus) countries. Sometimes we refer to this group as new accession countries.
- Middle East and North African (MENA) countries and Central Asian countries; the largest groups in these categories were born in Afghanistan, Iran, Iraq and North Africa (Egypt, Libya, Algeria, Morocco, South Sudan and Tunisia).
- East Asian & Southeast Asian countries; the largest groups within this category were born in the Philippines, China, Singapore, Malaysia, Japan and Taiwan.
- India
- Pakistan and other South Asian countries (Bangladesh, Sri Lanka, Nepal). Most of the respondents in this category were born in Pakistan and Bangladesh.
- Sub-Saharan African countries; the largest groups within this category were born in Nigeria, South Africa, Kenya, Somalia, Zimbabwe, Ghana, Uganda and Tanzania.
- All foreign born; this category includes all the non-UK born population. Migrants born in non-EU European countries, America and Oceania are included here along with those born in the abovementioned country groupings.

About 40% of migrants in the UK were born in the EU and around a quarter were born South, East or Southeast Asian countries. See the the Migration Observatory briefing [Migrants in the UK: an overview](https://www.migrationobservatory.ox.ac.uk) for more information about the geographic origins of the foreign born population.

When considering the skill level associated with a person's job, this briefing uses a four-part classification based on the amount of training required, developed by the Office of National Statistics (ONS, 2010). This classification distinguishes between low-skilled, medium-low skilled, medium-high skilled and high-skilled occupations.
Margins of error in the estimates

Because the LFS and APS are sample surveys, the estimates come with margins of error. This means that small differences between numbers or percentages may not be statistically significant. However, all the differences between groups that are described in the text of the briefing are all statistically significant. A difference between two groups is considered statistically significant when the probability that this difference is caused by chance is very small. In that case, we assume that the differences we observe in the data are likely to exist in the population. Note that small differences between estimates for different groups may not be statistically significant, if they are not described in the narrative of the briefing.

Migrants in the UK were less likely to have health problems than the UK born, according to survey data from 2018

Migrants’ health is shaped by a wide range of factors, ranging from their pre-migration experiences; their experiences during and after migration to the UK; their work, education and socio-economic status; and their ethnicity, which affects the prevalence of certain health conditions.

Despite this general trend, the migrant population is heterogeneous and certain groups might have worse health outcomes than the average. For example, people who migrated for employment, family and study reasons have better health than the UK born, while those who migrated to seek asylum have worse health outcomes (Giuntella et al., 2018). In addition to refugees and asylum seekers, there might be other vulnerable groups with special health needs within the migrant population, whose outcomes will not be clearly visible when looking at averages in the data.

Overall, migrants in the UK are healthier than the UK born population. In 2018, 26% of the foreign-born population in the UK said that they had a long-lasting health problem, which was 15 percentage points a higher lower than the UK born (41%). The migrant health advantage over the UK born is largest with regard to limiting health problems – that is, health problems that limit respondents’ day-to-day activities (Figure 1).

Figure 1

Population with limiting and non-limiting health problems by country of birth and age, 2018
Age 16 and older

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Limiting</th>
<th>Non-limiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>25%</td>
<td>13%</td>
</tr>
<tr>
<td>Pakistan &amp; other South Asia</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>MENA &amp; Central Asia</td>
<td>22%</td>
<td>9%</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>India</td>
<td>18%</td>
<td>11%</td>
</tr>
<tr>
<td>EU-14</td>
<td>17%</td>
<td>12%</td>
</tr>
<tr>
<td>All foreign born</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>East &amp; Southeast Asia</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>EU-8, EU-2, EU Other</td>
<td>10%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Note: data on health problems lasting or expected to last at least 12 months. A health problem is considered limiting if it constrains respondents’ ability to carry out day-to-day activities.

The charts with data for different age groups can be seen in the online version of this briefing.
This difference is in part explained by the fact that the foreign born are on average younger, e.g. 88% of those born abroad, were below age 65, compared to 76% of the UK born. But even within the same age groups, the foreign born are healthier than the UK born, at least among the population below age 50 (Figure 1). For those aged 16 to 34, for example, the share of people reporting a long-lasting health problem was 12 percentage points lower for the foreign born than for the UK born.

Health varies widely by country of origin. For example, migrants from the new EU accession countries and in from East and Southeast Asia have the lowest shares with health problems that limit daily activity. In contrast, the population born in Pakistan and other South Asian countries (excluding India) are on average more similar to the UK born (Figure 1). Pakistanis and other South Asians below age 35 report fewer limiting health problems than the UK born (8% vs 14%), though their health is worse among the older age groups. For example, the share of Pakistanis and other South Asians with limiting health problems is around 15 percentage points higher than for the UK born among the population aged 50 and above.

The most common ailments among the UK population aged 50 and above with a limiting health problem are legs/arms/feet/hands problems (22% of those with a long-lasting health problem), cardiovascular conditions (19%) and back and/or neck problems (10%). The picture is broadly similar for both migrants and the UK born (not shown in the figure). However, people born in Pakistan and other South Asian countries report diabetes as their main health condition (26% of those with a long-lasting health problem). The high prevalence of type 2 diabetes among South Asians has been attributed to both biological and environmental factors (Gujral et al., 2013).

**Workers in low-skilled jobs reported fewer health conditions than those in high-skilled occupations**

It is widely recognised that people with higher incomes or other measures of socio-economic status have better health outcomes (Elo, 2009). The reasons for this are complex and not just explained by a single factor. Some low-skilled jobs increase the risk of experiencing health problems (Pampel et al., 2010) because they are physically intensive and have poor working conditions (e.g. cleaning, construction), or because low incomes mean that they are less able to purchase goods and services to improve their health (Benzeval et al, 2014). In addition, people that are unable to move out of low-skilled and low-paid jobs are more likely to experience chronic stress due to their socioeconomic situation (Layte & Whelan, 2014), which ultimately affects their overall health. Causation may also run the other way: poor health may affect economic outcomes if it limits people’s ability to work.

Both migrants and the UK born in high-skilled jobs are less likely to say they have a limiting health problem than those in low-skilled jobs (Figure 2). There is, however, no clear relationship between the skill level of the job and health for non-limiting health problems.

The health advantage of the foreign born over the UK born is apparent for both limiting and non-limiting health conditions. However, this advantage is larger among workers with limiting health conditions in low-skilled jobs (Figure 2).
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Figure 2

Population with limiting and non-limiting health problems by job skills, age and country of birth, 2018
Age 16 to 64

The charts with data for different age groups can be seen in the online version of this briefing

Note that these figures only include people who are working, and people who cannot work will not be included. There is evidence, for example, that poor health outcomes among asylum seekers may reduce their labour market participation (Kone et al, 2019).

**Migrants’ health advantage over the UK born is larger for those who recently moved to the UK**

Despite the initial health advantage of the foreign born, their health tends to converge to that of the UK born as their time spent in the UK increases (Figure 3). Note that this is based on cross-sectional data and not on data that follows the same individuals over time, however; it is thus possible that the health advantage of recently-arrived migrants results from other factors such as return migration of healthier migrants or changes in the profile of people who migrate to the UK.

Only 5% of people who migrated to the UK in the last 2 years say they have a limiting health problem, but this rises to 10% for those that moved between 11 and 15 years ago (Figure 3). The share for the foreign born that moved more than 15 years ago, at 26%, is similar to that of the UK born (25%). The convergence towards the UK born as the years of residence in the UK increase is not as stark for all age groups. Among 16 to 34 year olds, in particular, migrants still have a notable health advantage after 15 years.
The share of the population reporting a long-lasting mental health problem is 9% among the UK born and 5% among the foreign born

Overall, the share of population saying they have a long-lasting psychological condition (depression or other type of mental illness) is 9% for the UK born and 5% for migrants (Figure 4). Note, however, that there could be differences in the willingness of people from different communities to report this kind of health problem.

In general, it is more common to have both a mental and a physical health condition at the same time than a mental health condition alone (Figure 4). The prevalence of mental health problems is the highest among those aged 50 to 64. Among this age group, the highest prevalence is found among the UK born (10%) and among the population born in Pakistan and other South Asian countries (12%).
Foreign-born men are more likely to smoke than UK-born men, but the opposite is true among women

Smoking is a major risk factor for health. Overall, women are less likely to smoke than men and this is true of both migrants and the UK born. However, migrant women are less likely to smoke than UK-born women (11% vs. 14%). The opposite is true when comparing foreign-born men with the UK born (16% vs. 20%). Residents born in new EU accession countries have the highest share of smokers while those born in India have the lowest (Figure 5).

Evidence gaps and limitations

A drawback of LFS health data that is shared with other data sources on health outcomes is that they rely on self-reported measures instead of on objective indicators. Some other surveys, such as the UKHLS, have collected data on the bio-medical profile (e.g. blood pressure, weight, height, body fat, lung function, etc) of respondents sampled in the first wave of the survey. Unfortunately, this information has not yet been collected for the immigrant boost sample, as they were not part of the initial sample when the survey was launched. Collecting this type of health information for a large sample of the population is very expensive, as only qualified nurses can do it.

This briefing does not differentiate the foreign born population by reason of migration. Recent research has, however, shown that those who migrated for employment, family and study reasons have better health outcomes than the UK born, but this is the opposite for those who migrated to seek asylum (Giuntella et al., 2018).

There is limited quantitative information on how migrants engage with health services – for example, by registering with a GP or taking up preventative health services such as immunisation. The data in this briefing also does not
tell us how migration affects expenditure on health care in the NHS. Given that migrants are on average younger and healthier than the UK born, they are expected to be less likely to use the NHS and thus account for less health expenditure per person than the UK born (Oxford Economics, 2018: 24). However, the costs of healthcare will depend not just on average health outcomes but also the specific conditions people have and any additional costs associated with treating them (e.g. due to language barriers, population churn and use of primary care services).

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**References**

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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.

COMPAS
The Migration Observatory is based at the Centre on Migration, Policy and Society (COMPAS) at the University of Oxford. The mission of COMPAS is to conduct high quality research in order to develop theory and knowledge, inform policy-making and public debate, and engage users of research within the field of migration.

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