Research Briefing – Background to the study

WORKERS ON THE MOVE 3

European migrant workers and health in the UK: The Evidence

By Alex Collis, Neil Stott & Danielle Ross

Migration is a key issue in the UK, with European migrants in particular bringing much needed labour to many regions including the East of England. Extensive work has been undertaken through Keystone/META (Mobile Europeans Taking Action) to better understand the needs of migrant workers arriving in the area. We are beginning to know and understand more about migrant workers' use of other public services, such as housing. However we still know very little either about their health needs, concerns and issues or the potential impact of new arrivals on local service provision.

This research aims to further develop our understanding of the health needs of migrant workers living in Thetford and the surrounding area, as well as their experiences and perceptions of local health services. We also consider migrant workers' uptake of and attitudes towards health promotion activities (both at home and in the UK) and examine the relevance of projects such as Change4Life and the Healthy Town programme for this group, as well as exploring alternative ways of reaching these new communities.

Major concerns have been raised in the media about the potentially negative impact of increased migration to the UK on the already overstretched NHS, and scare stories about 'health tourism' have become a regular occurrence, particularly since the accession of ten new countries to the European Union (EU) in May 2004[1] and January 2007. The potentially negative impact on levels of community cohesion has remained a key consideration for policy makers, with the suggestion that access to healthcare could become a key flashpoint for tensions.

However, there is *no reliable evidence* to support claims of health tourism. Very little research has been conducted on migrant workers' access to and uptake of health services, and previous research has found that rather than representing a burden on the health service the migrant worker population makes a substantial contribution to public finances – particularly within the health care sector.

Recent debates have also focused on issues around length of stay among migrant workers across the UK. The overall picture remains unclear; while a number of studies have suggested that rates of migration are slowing significantly, and that migrant workers are now less likely to stay in the UK long-term, other reports have indicated that the picture is much more complex, and that few migrant workers have fixed plans regarding length of stay. If migrant workers are planning to stay in the UK, even where their stay is temporary but long-term, it is essential that their health needs are routinely considered – along with projected levels of demand for and access to service provision.

Although currently a high proportion of migrant workers are young, single and relatively healthy, and are therefore unlikely to put a significant strain on local health services, there is evidence that migrant workers are starting families or that their families are beginning to join them here. It is therefore unlikely that the picture will stay the same, and it is important that local service providers and commissioners are better prepared to address their health needs.

Consequently, this research aimed to develop our understanding of these issues by exploring the following areas;

- the health needs, issues and concerns of migrants
- migrants' attitudes to health services, both at home and in the UK
- how migrants' health needs, issues and concerns link in with the Thetford 'Healthy Town' priorities and initiatives such as Change4Life
- health providers' understanding of migrants' health needs, and their perceptions of the potential impact of increased migration to the area on local services.

Study design and methodology

The research process involved two main stages; firstly, a desk-top literature review which explored a wide range of existing research evidence and both policy and academic literature on migration and health[2]. A number of main areas were identified which were used to design the data collection tools used during the second, fieldwork stage of the project;

- the development of health systems and policies in sending countries
- key health promotion issues/ concerns in sending countries including tobacco and alcohol consumption, and diet, nutrition and physical exercise
- examples of health promotion programmes in sending countries (e.g. smoking cessation, healthy eating)
- issues around health and migration in the UK, including access to primary care services, access to information, interpreting and translation services, cultural differences and expectations of services and mental health

Secondly, we distributed 152 structured questionnaires to META clients; out of these 100 were returned, giving us a response rate of 65.3%. The questionnaire was divided into two main sections, the first of which asked about migrant workers' experiences of health services in the UK including access to/use of primary care, their knowledge of UK services and any major differences from provision in home countries. The second part of the questionnaire focused on health behaviours such as alcohol and tobacco consumption, and also diet, nutrition and exercise.

These questionnaires were followed up by a series of three focus groups (one Portuguese-speaking and two Polish-speaking). The topic guide for these groups was developed from the literature review as well as an initial analysis of the questionnaire data, and focused on three main areas;

- health services at home
- health services in the UK
- perceptions of health at home and in the UK

We also surveyed local health service providers and commissioners; for this we developed a structured questionnaire which respondents were able to complete online using Survey Monkey or by telephone with an interviewer from Keystone's research team.

Literature review

The development of healthcare provision in sending countries has been highly variable, both in the pace and scope of change, and migrant workers in the UK will have experience of a wide range of systems. Significantly, some migrant workers may be less familiar with the gatekeeping role of general practitioners, which could affect their use, expectations and experiences of primary care in the UK. Some migrants may also have experienced significant inequality of access to services in their home country, and as a result may have additional health needs.

Many of the countries from which migrant workers come to the UK have identified similar public health concerns to those addressed by the Healthy Town Project – in particular high levels of tobacco and alcohol use, and issues around diet, obesity and physical activity. Even with the extensive reforms to healthcare systems in sending countries, many remain focused on treatment rather than prevention, and the priority which national governments have given to health promotion has been variable.

Nonetheless, a number of health promotion initiatives in sending countries have been identified which have enjoyed varying degrees of success – for example, public awareness of some projects has remained low, and projects are sometimes undermined by the lack of priority given to health promotion by healthcare professionals. Other projects have adopted strategies to maximise participation, such as timing of activities and use of existing community groups to publicise events, from which some useful lessons can be learned and applied to the Healthy Town Project.

Several studies have considered migrant workers' access to and uptake of primary care services and have found that low proportions of migrant workers are registered with a GP, often arguing that this is because they are unaware of which services are available or of how to register. Results from more recent research have shown that a higher proportion of migrant workers are now registered with a GP in the UK although the proportion of those actually *using* services remains relatively low. Although registered with a GP, many migrant workers are not visiting them simply because they have not *needed* to.

One suggestion has been that migrant workers are not accessing GP services in the UK because of their continued preference for accessing care in their home countries, although it is not clear whether this is the case. There is also evidence to show that levels of GP registration vary between different groups of migrant workers by both nationality and date of arrival; new arrivals continue to experience difficulties in identifying available services and accessing provision.

A range of factors have been identified which can inhibit migrant workers' knowledge of or access to primary care services, perhaps the most significant of which is a lack of English language skills. Research has shown that migrants who receive comprehensive and accessible information are more likely not only to register with a GP, but to actually use the service. The provision of translation and interpreting services is a central part of facilitating access to health care among migrants who have fewer language skills. Where these services are not in place, migrants are often forced to rely on family, friends – and sometimes community 'gatekeepers' – which raises a number of confidentiality concerns.

Low rates of GP registration can have additional repercussions. For instance, if migrant workers are not registered with a GP it becomes more difficult for them to access preventative services such as screening programmes. The mobility of migrant populations also makes arranging follow-up appointments particularly problematic. For example, regular child health checks such as neonatal audiology screening, primary and catch-up immunisations, or scheduled developmental checks can easily be missed. Problems have also been highlighted with late presentation for antenatal care.

There has also been an increasing recognition of the potential links between migration and mental ill-health. However, the lack of systematically collected data means that our knowledge of migrants' mental health status remains limited, although there are initial indications of increased levels of mental health issues, including depression and anxiety caused by the strains and losses which can be part of the migration experience. Key stress factors identified by previous research into this area include communication difficulties, unfamiliarity with the new environment and culture, work related stress (such as uncertainty or insecurity of employment), practical stress (such as financial hardship) and social stress (such as lack of interaction).

Evidence is emerging that migrants' expectations of health provision in the UK often remain unsatisfied. This dissatisfaction can often be due to differences in the respective functions and coverage of primary and secondary care between the UK and a migrant's country of origin. While the majority of countries have developed and extended the role of primary care providers over recent years, it is often not as established a feature as it is in the UK which can create an element of confusion among new arrivals, particularly in relation to the role of GPs as gatekeeper to secondary care services. Appointments with migrant worker patients can raise a range of issues around cultural competence for healthcare professionals who are themselves often unaware of how health systems in sending countries are organised, or of differences in prescribing patterns.

Main Findings from the primary research

Access to primary care services (migrant workers)

Most questionnaire respondents (75.5%) were registered with a GP; this is a change from the findings of earlier studies which showed that registration rates were low.

Reasons for non-registration varied; of the 23 questionnaire respondents who were *not* registered with a GP, the most common reason given was that they had not been ill and had not needed to visit a doctor (47.8%). However, 11 respondents also (11.2%) stated that they were not registered with a GP because they did not know how to register, suggesting that some migrants may still experience difficulties accessing information on available healthcare services. Only one respondent said they were not registered because the surgery lists were full, and only one respondent preferred to visit the doctor in their home country – a finding which contradicts both research evidence cited elsewhere and the perception of some policy-makers.

Levels of registration varied between different groups of migrant workers. For example, a significant proportion of those not registered with a GP came originally from CEE countries[3]. This may be partly a reflection of the fact that the Portuguese community has been resident in the area longer. However, a high proportion of CEE migrant workers

who were not registered with a GP stated that this was because they didn't know how to register, which also suggests that new arrivals from these countries may experience particular difficulties in accessing the relevant information.

Even where respondents were registered with a GP, levels of usage of this service have remained low; 66.2% of our questionnaire respondents had visited their GP between 1 and 2 times in the past year and a further 13.5% had not made any appointments. In comparison, just 21.6% had visited their GP between 3 and 5 times, and 13.5% had made 5 or more appointments. All of the 18 focus group participants were registered with a local GP, and a higher proportion (13 participants) had used this service in the past year, although for the majority this had meant fewer than 3 visits.

Out of those questionnaire respondents who had visited their GP in the past twelve months, 32.0% stated that they hadn't needed an interpreting service. Of those who did need language support during consultations, only 10.7% stated that an interpreter had not been made available to them although a further 20% stated that family or friends had interpreted on their behalf[4] suggesting that, while coverage of interpreting and translation services is generally comprehensive, significant gaps in provision still remain.

Registration with dentists was more problematic; questionnaire respondents were much less likely to have accessed dental care with only 31.6% currently registered with a dentist, which is less than half the rate of GP registrations. The range of reasons given for non-registration was much wider, and many more were unaware of how to register with a dentist. Again, in contrast to the data on accessing GP services there was a marked preference among a significant minority of questionnaire respondents (18.4%) for accessing dental care in their home countries, a finding which was much more common among respondents from CEE countries.

20 respondents (almost a quarter of our sample) were not registered either with a GP or with a dentist; again, this was much more common among respondents from CEE countries (70%).

Overall, our data showed that usage of primary care services has remained low. The availability and quality of health care does not appear to act as a 'pull factor' in migration decisions; few of the migrant workers we talked to had knowledge of the UK health system before coming to the UK, contrary to accusations of health tourism.

Comparing health services at home and in the UK (migrant workers)

Most migrant workers reported that healthcare provision in their home countries was significantly different from the services available in the UK. One of the differences most commonly noted (in both questionnaires and focus groups) was cost; migrant workers, particularly those from Portugal where there is a high level of co-payments despite the existence of a national health service, were often surprised to find that the majority of care in the UK remains free at the point of use.

Other issues mentioned included waiting times for appointments, which most migrant workers observed were significantly shorter in the UK; in the Polish-speaking focus group, participants noted that waiting times for appointments in Poland are extremely long with routine waits of up to twelve months to see a specialist.

Several migrant workers talked very positively about the quality of maternity and ante-natal care provided in the UK but also about the fact that care was largely provided by a midwife who often saw the woman throughout her pregnancy and delivered the baby – this was a different experience for most, who were used to a system where care was provided by doctors and in a much more formal and medicalised setting.

UK health services were generally discussed in a positive light; in particular, the Polish and Lithuania systems were felt to have deteriorated rather than improved since the reforms of the late 1980s and early/mid 1990s. Focus group discussions on this topic identified the lack of sustained investment in healthcare provision by national governments as a major issue.

Where focus group participants talked about preferring to access services at home, this was always because of the language issue rather than because they perceived the *quality* of those services to be better than what was available in the UK. Participants also talked about the previous system in Poland, under which companies and state-run industries had provided a doctor for their employees – the quality of care under this system was seen as being much higher.

However, feelings on the quality of UK services were not unequivocally positive; while many migrant workers praised the service provided by GPs others were much more critical, particularly of the comparatively short time allowed for appointments. There was also criticism of what participants saw as a tendency among UK GPs to over-prescribe Paracetamol rather than giving them a thorough examination. Several also mentioned their being given an appointment with a nurse, rather than a doctor; although, after further discussion they began to talk in more positive terms about the quality of terms received from nursing staff, many still found this unusual compared with services at home, ultimately seeing doctors as more knowledgeable.

Participants also had particularly mixed views on the differences between the ways in which chronic conditions were managed or treated in the UK and their home country. Conflicting advice, diagnoses and different treatment styles and outcomes were a frequent problem.

Health behaviours – tobacco and alcohol consumption (migrant workers)

35.7 per cent of questionnaire respondents identified themselves as current smokers. Smoking levels were particularly high among questionnaire male respondents and those from CEE countries. Younger respondents were less likely to smoke; 22.9% of smokers in our sample were aged between 36 and 45, while 34.3% were aged between 45 and 55. Levels of smoking among the sample were mainly 'heavy' (20 or more cigarettes per day) or 'moderate' (10 to 20 cigarettes per day), amounting to 65.7% of the sample.

There was some interest among our sample in smoking cessation. However, a significant proportion stated that they had no interest in quitting, suggesting that patterns of tobacco consumption among this group are well established and that smoking cessation initiatives may encounter continued resistance. Our results also suggest that migrant workers are unlikely to consult either their GP or another health professional for smoking cessation advice.

Just over half of questionnaire respondents stated that they consumed alcohol; levels of consumption among our sample were comparatively low, with only 9 respondents (18.0%) stating that they drank alcohol daily. A further 16 (32.0%) reported drinking alcohol once or twice per week, while 26 (52.0%) stated that they only drank alcohol once/twice per month or less. 26.0% of those who consumed alcohol reported that they had not had a drink in the past week, 44.0% had had between 1 and 5 drinks, while 16.0% had consumed more than 5 drinks.

None of the migrant workers we talked to were aware either of UK government guidelines on alcohol consumption, or of how many units the alcohol they had consumed represented.

Health behaviours – diet, nutrition and exercise (migrant workers)

We also asked respondents about their consumption of other foods which have identified as unhealthy in public health campaigns such as Change4Life and Healthy Town. Consumption of fresh fruit and vegetables varied widely among our sample, with many respondents not meeting the 5 a day 'target' (see fig. 9 and fig. 10). 39.8% of respondents ate fresh fruit on five or more days per week, whereas 31.6% ate fresh vegetables on five or more days per week. Fresh vegetable consumption tailed off dramatically, with 35.7% only eating them on two or three days per week, and a further 35.7% only eating them one day per week.

Levels of salt consumption were high, with 39.8% of our sample reporting that they 'always' added salt to their food and a further 20.4% 'usually' adding salt to their food. Of these, 29.6% 'sometimes' added salt before tasting the food and a further 20.4% 'always' did so. A high proportion of respondents also consumed high fat dairy products such as whole milk and butter.

When we explored the possible reasons behind these eating patterns, focus group participants not only told us that the expense of buying good quality fresh food was a major factor, but also suggested that many migrant workers were used to a national diet or cuisine that did not rely heavily on foods from these groups – often because they were prohibitively expensive in sending countries.

Eating habits also appeared to be somewhat erratic, possibly due to the long working hours and shift work undertaken by a high proportion of this group. The proportion of questionnaire respondents who regularly skipped meals was relatively high, and a significant minority also rarely ate communally with other members of their family or household.

A high proportion of our sample (36.7%) never exercised. The main reason given for this was lack of time (rather than a lack of facilities), followed closely by lack of interest. Moreover, a relatively high proportion of our sample engaged regularly – and for substantial periods of time – in more sedentary activities such as watching television, using the computer or playing video games.

Very few migrant workers were aware of any health promotion campaigns introduced by national governments, either in the UK or in sending countries, apart from a small minority who mentioned the 5-a-day campaign. This was seen as an area in which governments in their home countries rarely invested either time or funds.

Meeting migrant workers' health needs (professionals)

In total 19 service providers completed the online questionnaire, which included a range of professionals such as GPs, nurses, practice managers, midwives, health visitors, a school nurse, and a speech and language therapist. The majority of respondents worked in the Thetford and Brandon areas, which were the main focus of the research, but our sample also covered other areas of Norfolk and Suffolk.

Questionnaire respondents differed widely in their perceptions of the effect which increased migration to the area had had both on the caseloads at their surgery, and on their own workloads.

Front-line service providers reported a wide range of health needs among their migrant worker patients, although many felt that their needs were not markedly different to those of other patients. However, child health, family planning/sexual health, and primary care mental health services were identified as particular 'growth' areas of demand. Concerns were also raised around the potentially negative health impact of migrant workers' living conditions, especially on the well-being and development of children in migrant worker families.

There was also evidence to suggest that sexual health is becoming more of an issue among this group, with an increasing number of migrant sex workers who are likely to be particularly vulnerable health-wise – for example, they may not be openly accessing screening services meaning that there is likely to be a significant level of unmet need in this area.

The majority of professionals surveyed felt that they were able to provide migrant worker patients with an equal level of service. Most respondents also felt confident in their knowledge of migrant workers' entitlements to UK healthcare. Respondents were much less confident in their knowledge of health systems in sending countries, and several felt that this gap in understanding could cause problems – particularly where a migrant worker patient brought different cultural expectations of services to a consultation.

A lack of awareness among migrant workers about the services available to them was identified as a major barrier. Other issues were raised, such as the long hours worked by some migrants that can make accessing care difficult. It was also felt that maintaining levels of child health development was becoming a problem, with ensuring that children in migrant worker families were correctly immunised identified as a particular issue. This was linked to wider difficulties, discussed by several respondents, in conveying public health messages on disease prevention and health promotion.

Interpreting and translation services were seen as a vital part of improving the service offered to their migrant worker patients. Despite the emphasis placed by respondents on translation and interpreting, delivery of this service was often inconsistent. For example, we found that many surgeries translate only a small percentage of their literature, and that some translate none at all, largely due to the associated expense.

Commissioners we spoke to also mentioned the absence of a coordinated approach and distinct lack of information-sharing about meeting migrant worker health needs as a particular barrier to effective service planning.

Discussion, conclusions and recommendations

We are able to draw a number of conclusions from the primary data collected for this study about migrant workers' access to and experiences of health services in the UK. In Thetford and the surrounding area, levels of awareness of the services available to migrant workers are high and the majority are now registered with a GP. Accessing dental care appears to be much more problematic for many migrant workers.

However, the actual usage level of primary care services remains minimal. Migrant workers who are

not registered with a local GP generally state that this is because they have not needed to make an appointment. Professionals we spoke to were split of the issue of whether the arrival of migrant workers in the area had had a significant impact on their caseloads; however, there was no evidence of the overwhelming burden on provision regularly reported in the media.

The quality and availability of healthcare in the UK is not a significant 'pull' factor in migration decisions, and the majority of migrant workers we spoke to were not aware of the available services before arriving in the UK.

There are a number of cultural factors which can affect migrant workers' experience of these services; for example, different understandings of the GP's role as gatekeeper to specialist provision or differences in consultation styles and prescribing practices between the UK and home. Where available, interpreting and translation services work well although provision is sometimes inconsistent. GP surgeries do not always provide migrant workers with information in their own language, often due to the cost of obtaining translations.

Few migrant workers we spoke to were aware of any health promotion initiatives, either in the UK or in their home countries. There was also evidence among our sample of a range of what are labelled as 'unhealthy' behaviours; for instance, high levels of salt and sugar consumption as well as low levels of regular exercise.

Professionals identified a wide range of health needs among their migrant worker patients particularly in the areas of child health, family planning/sexual health, and primary care mental health. Concerns were also raised around the links between poor living conditions and ill health, and delays in child development. However, the majority felt that health needs among their migrant worker patients were not markedly different to those of other patients and that they were able to provide migrant worker patients with an equal level of service.

This research has also identified a number of priorities for both future research and service provision. Studies such as this need to be replicated across the region as well as nationally in order to help build a robust evidence base on migration and health. Given the current uncertainty about length of stay, the picture needs to be updated regularly as part of a sustained programme of research. Longitudinal research is needed as well as snapshot studies such as this one.

There are a number of areas of where more knowledge is needed;

- mental health needs and patterns of help-seeking behaviour
- child health and development, given the apparent increase in numbers of family joiners
- housing, homelessness and the links to ill-health
- lifestyle issues such as tobacco and alcohol consumption

Migration is a key issue in the UK. European migrants provide much needed labour in many regions including the east of England. Mobile workers are bringing a diversity and vibrancy to many areas and communities which do not have a history of in-migration as well as adding to the cultural mix in our cities. While extensive work has been undertaken through Keystone/META (Mobile Europeans Taking Action) to better understand the needs of migrant workers arriving in the area, we still know very little either about their health needs, concerns and issues or the potential impact of new arrivals on local services[5]. This research aims to develop our understanding of the health needs of migrant workers living in Thetford and the surrounding area, as well as their experiences and perceptions of local health services. The project also considered migrant workers' uptake of and attitudes towards health promotion activities, both at home and in the UK, and examined the relevance to this group of projects such as Change4Life and the Healthy Town programme – as well as exploring alternative ways of reaching these new communities.

References

1 Poland, Czech Republic, Slovakia, Slovenia, Latvia, Lithuania, Estonia and Hungary acceded in 2004, with Bulgaria and Romania joining in 2007.

2 Workers on the Move 2 (2009) KDT

3 generally Poland, Lithuania and Latvia.

4 Respondents were not asked whether these family members were children (the pressures placed on children interpreting for their parents has been raised as an area of concern in the literature), and future research could investigate this issue more closely.

5 We believe that this is the case across the UK.

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