# IDRICS

**Institute for Diversity Research, Inclusivity, Communities and Society**

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# 'Best Practice in Data-Gathering to support migrant health: an over-view and lessons from the UK context'

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# Health Access UK

- GP and nurse consultations in primary care, treatment provided by a GP and other primary care services are free of charge to all

- For secondary care services, the UK's healthcare system is residence-based:  entitlement to free healthcare is based on living lawfully in the UK on a settled basis

- Free health care determined by 'ordinary residence'. (e.g. available to EEA nationals in the UK); but non-EEA nationals subject to immigration control require 'indefinite leave to remain'

- Refugees/Asylum Seekers and those with humanitarian protection or temporary protection status (and their dependents) are exempt from charges. As are rejected asylum claimants supported  under the 4(2) Immigration and Asylum Act 1995

# Services Free to All

- A& E services (excluding following admittance to hospital)

- Diagnosis/treatment communicable diseases e.g HIV, TB; Middle East Respiratory Syndrome (MERS)

- sexually transmitted infections

- family planning services

- treatment of physical or mental conditions caused by torture, FGM, sexual or domestic violence

- palliative care services (provided by charities/NGOs)

# Contextualising UK Migration

- Migrant (non-UK born) population (2018-19). Net migration to UK increased by approx. 226,000 (intention to stay > 12 months)

- Some decline in EU migration since 2016 (lowest rate since 2013)

- Increase in non-EU migration – study given as primary reason - by 219,000

- Increase in grants of humanitarian protection up 29% from previous year to 18,519

- Giuntella et. al. (2018) suggest that reasons for migration impacts health outcomes for migrants compared to UK born population.

- E.g. Refugees/asylum seekers have worse outcomes than UK born, whilst those migrating for work, study, family reunification etc have better health outcomes.

- In 2017 9.8/1000 residents of UK were  migrants (Eurostat 2019). WHO 2018 13.4% of residents were international migrants/'migrant stock')

- August 2019 – Migration Statistics Quarterly Report (ONS)

- **Main sources of data on migration flows:**

  - International Passenger Survey (IPS);

  - Labour Force Survey (LFS)

  - Annual Population Survey (APS) triangulated against NINOs

  - Relatively limited health datasets (GP data GMS1 + new patient checks) record of country of birth and (limited) ethnicity, date and address when first came to UK but *not* (typically) duration of current  period of residence.

  - Problematic issues/barriers to health access re data-sharing between the DH and Home Office  use of patient data to track down undocumented migrants – 2017-2018. Amended so data-sharing could only occur in cases of 'serious crime' investigations – awaiting new MoU (as of late 2018)

  - UK household longitudinal survey (UKHLS)  - 40,000 households (5,500 BAME) annual data collection + ethnic minority (5 main categories) booster sample (6,000) + Immigrant and Ethnic Minority booster sample (numbers not specified) .

# Challenges: Data Gathering on migrant health status

- Nb: presentation excludes discussion of pre-entry screening of Refugees + asylum seekers

- Problematic issue of how 'migrant' is defined – e.g. foreign born (which may include children of UK national parents)

- Duration of stay/self-defined intention of settlement etc? (cf diverse definitions)

- Issues of return/pendulum migration and undocumented migrants or those using others papers

- Citizenship status + second generation (migrant heritage) + ethnic/national minorities (e.g. Roma/BAME populations)

- EU migrants – in some UK administrative data sets may only be included as 'White Other'

- CCG funding – and atomisation of response to Strategies e.g. PHE 'TB Strategy' 2015 and PHE migrant health guide (updated 2019) https://www.gov.uk/topic/health-protection/migrant-health-guide

- Issues around necessity of 'real-time' data capture for administrative planning/commissioning purposes

- Research findings repeatedly indicate that EEA migrants often prefer to receive treatment in home country Greenfields, (2018; 2017) FRA, 2012 (inequalities/multiple discrimination in health care study) potentially limiting data capture of treatment/conditions
- The Guardian (graphic below) published 1-4-19 report on EU migrants' attitude to use of NHS services
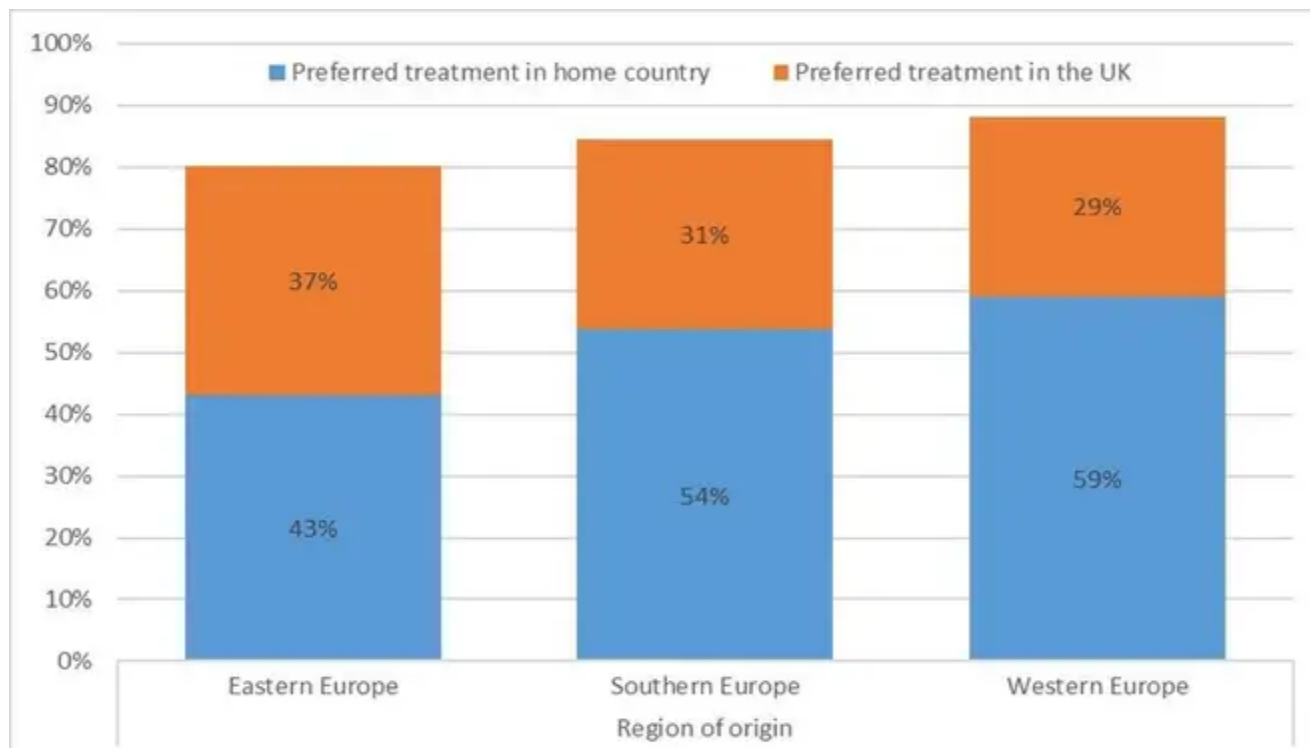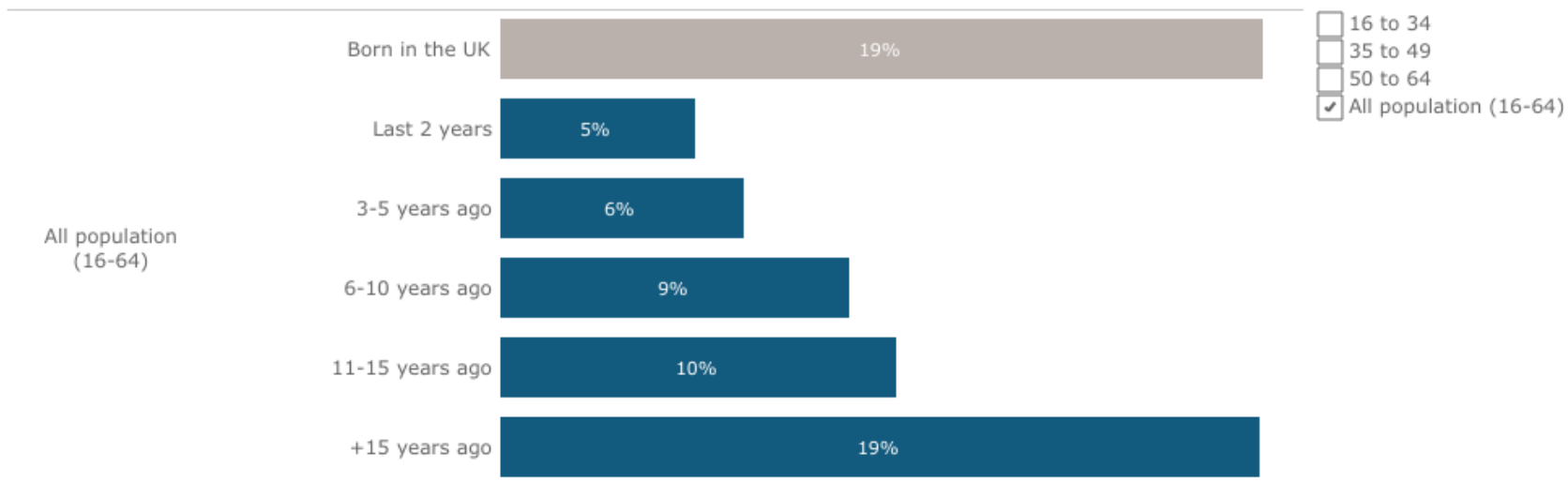
# Triangulation of data to explore intersectionality

- Migration Observatory briefing (August 2019) reports (utilising data-sets above) report that the 'young, healthy migrant' effect (15%< self-reporting of long-term health condition amongst migrants than UK born population) is mitigated as migrant populations age.

- By age 50-64 more non UK born residents report long-term health conditions than do UK born with particular populations significantly over-represented e.g.Pakistani and SE Asian migrants.

- Migrants resident in the UK for >15 years report similar rates of long term limiting health conditions to UK born residents.

## Prevalence of *limiting* health problems by years since migration and age, 2018
Age 16 to 64



Born in the UK — 19%
Last 2 years — 5%
3-5 years ago — 6%
6-10 years ago — 9%
11-15 years ago — 10%
+15 years ago — 19%

All population (16-64)

Legend:
☐ 16 to 34
☐ 35 to 49
☐ 50 to 64
☑ All population (16-64)

Source: Migration Observatory analysis of the Labour Force Survey 2018.
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. Population above age 64 excluded due to small sample size in some of the categories.

THE MIGRATION OBSERVATORY AT THE UNIVERSITY OF OXFORD

# Case Study Example

- Ongoing research – area of the UK with very high and diverse EAA migrant population (farm and factory labour predominantly)

- Mixed methods research utilised

- Difficulties in accessing health data, problems with engagement from (many) health professionals

- NGO datasets (and interview data) indicate changing demographics/nationalities from those captured in education and health administrative data;

- High levels of worker mobility; very poor housing; limited access to health service re shift work

- Unhealthy behaviours – alcohol use; smoking; poor diets

- Timelag in (often inaccurate) data and limited forward planning (health services) – e.g. dementia care for older dependent migrants

- Roma typically enumerated under nationality not ethnicity.. (generally far worse health status of Roma than their co-nationals)

# The SDOH Rainbow
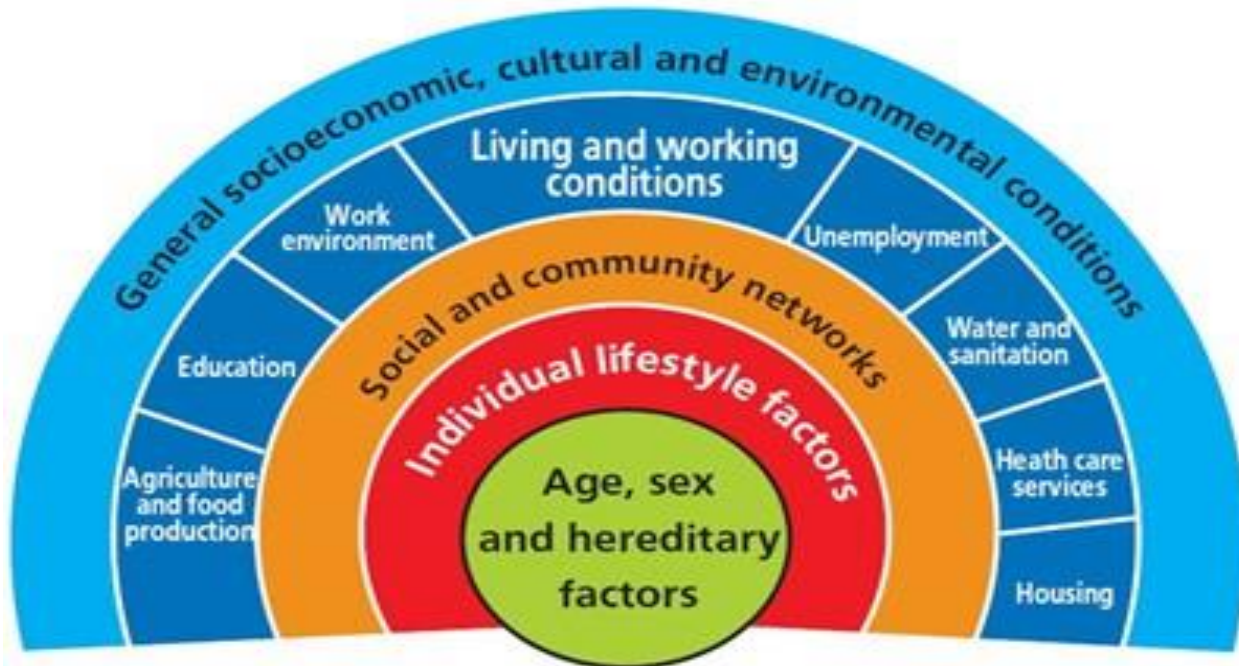


The Determinants of Health (1992) Dahlgren and Whitehead

- Dahlgren and Whitehead's (1992) *in* 'Policies and Strategies to Promote Social Equity in Health' Stockholm: Institute of Future Studies.

# Health Exclusion of Marginalised Migrant Groups

- Interplay between the diverse SDOH creates (over time) a 'vicious spiral' of:

- Insecure Accommodation

- Higher Disease Burden/Increased Morbidity

- Lower life expectancy (Disengagement from health services)

- Lower engagement with paid employment/education

- Higher caring burden (typically larger families – or conversely single-person household)

- Increased rate of poor health habits/poor health literacy

- (Conversely) Self-help/resilience

  - Self-Evident that all aspects of life for excluded groups impacted by SDOH = minimised ability to proceed towards 'self-actualisation' in situations of disadvantage

# Summarising UK practice

- **+** innovative in relation to collecting data and range of data-bases available
- Broad (and bold) focus on ethnicity in data gathering and service provision **-** Lack of joined-up thinking
- Challenges in accessing real-time or flexible data
- Variables in data collection across different regions and countries
- Quality of data/service delivery depends often on CCG priorities or core public health professionals
- **+/-** Sheer complexity of diverse populations, duration of migrant population and intersectional issues, creates challenges in identifying a clear overall picture

# QUESTIONS??

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