



GOVERNMENT OFFICE
FOR THE NORTH WEST



Health & Migration

in the North West of England

An Overview: November 2008





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Note

The picture of migration is constantly changing; policies and available data are frequently updated; information presented here was correct at time of publication but readers should be aware of the speed at which it may become out of date.

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Introduction from the Chair of the Health Interest Group

This report provides insight into the impact of migration on the health of people in North West England and into the health of migrants themselves. It is the beginning of work that will be carried on to support Primary Care Trusts, NHS Trusts and Local Authorities in the North West to better understand the needs of migrants, to plan to meet those needs and to work with people from migrant communities to contribute positively to the health of the whole community.

Within each borough, recent arrivals from overseas will constitute a relatively small proportion of the population. This report points out that the group is heterogeneous with varying needs depending on the reason for migration and so will require different forms of support and means of accessing health and social care services. Also that population churn, the constant changing of the make up of the population of recent arrivals, is a feature that requires a flexibility of response from services and a commitment to engage and re-engage with this population on a regular basis.

Although a relatively small proportion of the population, recent arrivals will contribute to a developing and dynamic culture around health that will become manifest in health related behaviour such as smoking, alcohol use, diet and taking physical activity.

Within small geographic areas it is possible that the impact on such culture is greater than elsewhere. There is an opportunity to work with this change to build a momentum towards a positive health culture that could contribute to a wider development in any given borough.

The report also recognises that there is the potential for a small population of recent arrivals to become marginalized. It will be a task for PCTs, NHS Trusts and local authorities to prevent this by ensuring that health and social care services are confident in what they can offer and ensuring that recent arrivals are supported to access services to which they are entitled.

Understanding your community of recent arrivals, who they are, where they live and what they need to achieve good health and wellbeing is central to the development of Strategic Commissioning Plans and Local Area Agreements. This report provides initial insight and suggestions for how to get a better understanding of the recent arrivals in your borough.

Alan Higgins

Director of Public Health, Oldham

Chair of the Health Interest Group of the NW Regional Strategic Partnership



Summary

The rapid and large increase in numbers of people coming to the UK since the expansion of the European Union (EU) in 2004 has stimulated a lively general interest throughout the United Kingdom and the Northwest (NW) - fanned by an intense debate in the media.

The facts and figures may be difficult to establish, but it is clear that the number of people moving out of and into the UK and the NW region is in constant flux and likely to remain so for the foreseeable future. People movement has become as important a factor as births and deaths in the regional demography.

It is also clear that international in-migration has brought economic and social benefits to the region. Migrant workers make valuable contributions to many sectors, including the NHS and Social Care services - both of which are dependent on workers from overseas.

Recent arrivals from overseas form a diverse group. In the Northwest, approximately 25 per cent are students, 25 per cent are people joining family or friends. The remainder include migrant workers, returning British Nationals and a small number of asylum seekers and refugees. The proportion of migrant workers that come from countries joining the European Union in 2004 is small (around 16 per cent nationally); most are young and in employment; just under half are women. Their durations of intended stay are variable and may change.

Behind the percentages and numbers are the individual people with individual needs and aspirations who are becoming members of local communities. Identifying and meeting the needs of these new arrivals and balancing them with those of other community members is an integral aspect of serving the whole community effectively, ensuring equality and promoting cohesion.

The health of recent arrivals from overseas is affected by their diverse circumstances of migration, how they live in the UK, their lifestyle, ethnicity and country of origin. Whatever their diversity as a group, recent arrivals share a number of common issues such as a desire for integration, language and cultural challenges, different experiences of healthcare in country of origin and lack of knowledge of the services available to them through the NHS and other agencies. There are individuals and groups, such as asylum seekers and refugees, the Roma people and minority groups who may be at particular risk of marginalisation.

The health and well-being issues of refugees and asylum seekers in general have already been well-established. For migrant workers, other recent arrivals and their families the issues are less clear, although the influence of wider determinants such as housing, employment situation, service access and socialisation are apparent. The available research on migrant health is relatively small. Current data systems generally do not incorporate specific information on country of origin and ethnic monitoring is not widespread. PCTs and NHS Trusts have a vital role in contributing to the multi-agency pooling of qualitative and quantitative information, in particular from community staff such as GPs, community development workers, health visitors and midwives.

The numbers of people moving in and out of the region, the places they have come from, the length of time they stay or are away; the rules and guidance on immigration, on entitlements to services, public perceptions and media portrayal are constantly changing. The experience of this dynamic situation and changing demography varies from place to place and from service to service.



Common themes that are important to varying degrees in many areas include:

- Some issues for recent arrivals such as barriers to accessing services overlap with those of established BME communities
- New approaches in health promotion and service provision may be required to address an increasing diversity of health needs and cultural backgrounds
- Ensuring effective communication and consultations with non-English speakers requires more staff time
- There is a desire for better access to translated material, interpretation and cultural competence training
- Services are at different levels in their needs assessments, capacity to respond and provision of tailored and equitable services. Some, that are serving disadvantaged communities, are already facing challenges in providing an equitable service
- Voluntary organisations and faith groups play a significant and integral part in addressing many of the wider determinants
- Healthcare workers would appreciate further clarity on the complex regulations governing entitlement to health care, and support in exercising non-discriminatory practice. The results of the forthcoming public consultation on access to NHS by foreign nationals should provide this
- There is little evidence that the wider UK population is at risk of significant levels of disease transmission from affected arrivals from overseas but some migrants bear a disproportionate burden of infectious diseases such as TB, HIV, Hepatitis B, malaria and enteric fevers.

The recent demographic changes and emergence of new community groups has highlighted some challenges. It has also stimulated much innovative work across the region and drawn the spotlight to a number of excellent established and new projects and services - a few of which are presented in this report. There are many more from which NHS Trusts and their partners can draw on or adapt.

This report does not present a complete picture but it does identify some of the key issues, putting forward a number of proposals that will make a difference for recent arrivals from overseas as well as the communities they live in. Commissioners and Providers working together within PCTs, NHS Trusts and their partner agencies, and in particular through Local Strategic Partnerships, can determine the specific priorities of their local area

A number of the following high impact changes will already be embedded within local practice, reflecting the long-held principles and values that are being reaffirmed in the proposed NHS constitution¹ - those of equality, choice, empowerment and free of charge. They uphold World Class Commissioning, in particular the competencies of working with community partners, engaging with public and patients and stimulating the market. They form part of the vision of Our NHS, Our Future² for a personalised and fair NHS and complement the aspirations of Healthier Horizons for the North West³ for equality of access, improved data and information systems and cross-sectoral flexible commissioning.

1. Department of Health (2008) The National Health Service Consultation.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085814

2. <http://www.ournhs.nhs.uk/>

3. NHS Northwest (2008) *Healthier Horizons for the North West* <http://www.northwest.nhs.uk/projects/healthierhorizons>



10 High Impact Changes

- 1. Carry out multi-agency mapping of local communities** (through Joint Strategic Needs Assessment) - how many recent arrivals from overseas, gender, where they live, what their needs and potential contributions are with a particular focus on marginalised groups; horizon scanning and incorporating flexibility into Local Area Agreements, PCT and NHS Trust Service Plans
Guidance on Joint Needs Assessment (2007) DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097
- 2. Strengthen the collection, analysis and interpretation of ethnic group data** to better understand the health and well-being needs of local communities and for equitable, effective provision of services.
A Practical Guide to Ethnic Monitoring in the NHS and Social Care. (2005) DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4116927
- 3. Strengthen links and partnerships with migrant groups, voluntary organisations and social enterprises** working with recent arrivals from overseas, to enable services to listen, respond to needs and positively influence health outcomes.
More Responsive Public Services? A Guide to Commissioning Migrant and Refugee Community Organisations. (2008) HACT / JRF <http://www.jrf.org.uk/bookshop/details.asp?pubID=941>
- 4. Incorporate Health Equity Audits and Equality Impact Assessments as normal practice**
Health Equity Audit. A Guide for the NHS (2003) DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138
- 5. Better signposting for recent arrivals** and better information for staff to raise awareness about services available, how the NHS works and how to access it
- 6. Provide accessible, locally appropriate interpreting service in all departments** - a telephone interpreting service as a minimum provision will enable assessment, care and support to be shaped around individuals
- 7. Make cultural competency a regular and mandatory part of staff training** built into equality and diversity strategies
Cultural Competency Toolkit. A resource pack for clinicians who care for people from ethnic minority backgrounds (2007) West London Mental Health NHS Trust <http://www.wlmht.nhs.uk/docs/general/CCTK.pdf>
- 8. Identify senior level champions** to ensure commitment to migration issues and their incorporation into policy development, planning and forecasting
- 9. Develop strategies to attract and retain migrant workers** within the NHS and partner organisations in order to reflect local community profiles and contribute to filling posts that cannot be filled by local recruitment
Towards Race Equality in Health. A Guide to Policy and Good Practice for Workforce Development (2007). Race for Health http://www.raceforhealth.org/resources/publications/guide_workforce_development
- 10. Review the impact of community cohesion on local health and health service provision and consider strategic contribution**
Guidance on the NHS role in Community Cohesion is forthcoming and will soon be available on the websites <http://www.dh.gov.uk> and <http://www.nwph.net>



Context

The NW is the largest English region outside of London and the South East. It has a population of approximately 6.7 million - greater than that of Scotland and Wales combined. Over a third of people (36%) live in Greater Manchester, followed by 21% in Merseyside, 20% in Lancashire, 13% in Cheshire and 8% in Cumbria⁴.

The region is characterised by its varied geography, architecture, work and life opportunities, cultures and people groups, income levels and health status. Most of the region is rural but the majority of people live in urban areas. It has a long history of people-movement - both in and out of the region - and like the rest of the UK, is influenced by global migration.

This report was born out of a desire to improve understanding of the dynamic and complex situation of health in relation to migration in the NW. Available literature and quantitative data sources were explored. Information and views were sought from key stakeholders in a range of statutory and third sector organisations across the NW including in Liverpool, Wigan, Kendal and Cheetham in Manchester - places that reflect the diversity of historical and current demography and migration issues.

The report aims to:

- Increase awareness of some key issues
- Foster a region-wide sharing of good practice
- Propose some high impact changes for NHS organisations and their partners

It will also set the agenda for future work of the Health Interest Group as part of the North West Regional Strategic Partnership (NWRSP).

Terminology

There does not appear to be an agreed definition of many of the terms found under the migration umbrella and there is no common understanding. This report will use the following generic terms:

Recent arrivals from overseas describe people moving to the UK. It incorporates specific groups such as students, asylum seekers, refugees, migrant workers and people joining family members. It broadly covers the previous 9 years during which time the Home Office system for dispersal of asylum seekers changed and 10 countries joined the European Union (EU). See appendix 5 for accession countries.

Migrant worker describes “any individual who arrives in the UK either with a job or with the intention of finding one”⁵.

A refugee, according to the United Nations is someone who,

*“owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.”*⁶

However, the UK Border Agency's official 'refugee status' is accorded only to someone whose application for asylum has been successful and they have been given permission to live in the UK.

Asylum seeker is a term restricted by the UK Border Agency to someone who has fled to the UK, made themselves known to the authorities, applied for asylum and is waiting for results of that application. We also use it in this report for others who may have fled to the UK for fear of persecution but have not made themselves known to the authorities or whose application has been unsuccessful. The latter are commonly known as refused or failed asylum seekers.

See appendix 4 for further terminology.

⁴ NWRA (January 2005) *Action for Equality - celebrating diversity and creating opportunity for all in the North West of England: A consultation paper*

⁵ Migrant Workers North West www.migrantworkersnorthwest.org/index.html

⁶ UNHCR (1951) *Convention & Protocol Relating to the Status of Refugees*



Migration and Demography

Key Points

- Future patterns of migration are difficult to predict but net in-migration is likely to continue until at least 2011
- Migration has become as significant a factor as births and deaths in demographic change
- Localities within the Northwest are affected differently, with several areas of super-diversity and high population turnover
- Migration and asylum are global, national, regional and local issues
- A pattern is emerging of marginalised people migrating to areas of deprivation
- Recent arrivals from overseas are not an homogenous group
 - International students make up approximately 25% percent of recent arrivals from overseas - with a proportion accompanied by families
 - People joining family members or friends also make up approximately 25%⁷
 - Asylum seekers and refugees are small in number, coming to the UK to seek safety
 - The majority of migrant workers are young and a higher proportion are men
 - There are an unknown number of men, women and children without documentation; some of whom are destitute

Migration refers to people movement within countries as well as between countries. It has always occurred but the speed and low cost of modern travel offers opportunity for more people to move house, home and workplace. Urbanisation, falling birth rates in developed countries and economic globalisation have also contributed to the recent and rapid changes⁸.

More than 10 percent of the UK's population was born overseas. In the case of many European countries the percentage is significantly higher such as in Switzerland (23.8 per cent), Sweden (12.4 per cent) and Ireland (11 per cent).



The UK has a long history of people movement - both immigration and emigration. An estimated 5.5million British-born people lived outside of the UK in 2007⁹, many of whom access services in other countries. Before the 1980s, the numbers of people emigrating outnumbered those immigrating. During the last 10 years both have increased, with a resultant net population increase, in part due to the enlargement of the EU and free movement for its members. Recent analyses suggest that the rate at which people are coming to the UK from the new European countries is slowing down and that many are returning¹⁰. While migration patterns may change, population movement is very unlikely to diminish¹¹ and has become as significant a factor of demographic change as births and deaths. This has evident implications for communities and service providers.

7 NWDA (2008) *Demography, Migration & Diversity in the NW*

8 TUC (2005) *Refugees and migrant workers: understanding the international movement of people*

9 Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*

10 IPPR (2008) *Migrants: Floodgates or Turnstiles?*

11 Byrne J., Tankard J. et al (2007) *New European Migration: Good practice guide for local authorities*



The Northwest Perspective

The NW is characterised by its differences, and migration is one of a number of factors contributing to its demographic diversity. A few significant points are:

- Approx 8% of households in the NW move within the region each year
- Across the region, ageing has been minimal but varied. In some rural areas of Cumbria and Cheshire the average age of the population is rising. In urban areas such as Greater Manchester it is remaining static. The future picture will change as the 'baby-boom' generation retires within the next 10-20 years - moving out of the workforce and becoming increasingly dependent¹²
- Of the NW's population, 5.5% are foreign nationals - approx 233,000 people. The proportion varies across the region - in Manchester it is 13 per cent, 3 per cent in Lancashire and 5 per cent in Liverpool
- In 2005, the NW BME population was 11%
- International in-migration is greater to urban areas but many localities have seen significant change such as a five-fold increase between 2001 and 2006 in GP registrations in Crewe and Nantwich of people born overseas, compared with a 1.5 fold in Manchester but there has been no significant change in Blackburn with Darwen¹³



- A number of rural and semi-rural areas, such as Crewe & Nantwich, Vale Royal Chorley, Ribble Valley, Fylde, Wyre, Lancaster, parts of Lake District & S. Lakeland are experiencing net in-migration
- International students at Higher Education Institutes in the NW make up approximately a quarter of recent arrivals from overseas (25,000 in 2005/6) predominantly in urban areas such as Manchester and Merseyside
- Approximately 25% of recent arrivals from overseas are people coming to join family or friends¹⁴
- There is no Local Authority within the NW that is included in the top 10 UK areas of highest volume of internal and international migration per 1,000 population¹⁵
- Some urban areas such Manchester, Liverpool, Lancaster, Chester and Blackpool experience high population movement or "churn"
- There is migration of marginalised groups (including 'undocumented' migrants) to localities of traditional migration¹⁶ and some areas of higher deprivation

¹² NWDA (2008) *Demography, Migration & Diversity in the Northwest*

¹³ Office for National Statistics www.statistics.gov.uk

¹⁴ NWDA (2008) *Demography, Migration & Diversity in the Northwest*

¹⁵ Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*

¹⁶ Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*



Who are the Recent Arrivals from Overseas?

People choose to move or migrate for any number of reasons - to study, to work, to join family members, for a better life. Others are forced or obliged to move. Recent arrivals from overseas make up an extremely varied group in terms of ethnicity, nationality, education, skills and income levels, expectations, levels of vulnerability and in the way migration itself affects them.

This report recognises recent arrivals in four broad groups - migrant workers, asylum seekers and refugees, people joining family members and international students although individuals and families may reasonably come under one or more category and move from one to another over time.

In terms of health and well-being, the attention is focused on just two - those of asylum seekers / refugees (plus their families) and migrant workers (plus their families).

Students

We have chosen to delay looking at the specific health issues of this group of recent arrivals - based on the premise that international students are likely to be young (and therefore relatively healthy), able to speak English (and therefore able to socialise and access services), have a reasonable income and are in the UK for a time limited period. There are however, reports of increasing numbers with mental health issues and a number of spouses and children of students who are marginalised. It should also be noted that the recent increase and large numbers of international students (some of whom may also be workers), will impact on local services and economy

Extended Families

Future work may also include looking at the health and wellbeing issues of people who are joining family members already established in the UK. As a form of migration, this phenomena is not new; communities and services are more accustomed to welcoming people from familiar backgrounds and services have had longer period to adapt. That said, in some traditional immigrant communities, up to a quarter have arrived in the last 10 years.

Migrant Workers

Migrant workers bring additional skills, contribute to businesses, support local regeneration and economy¹⁷ and many contribute to society through service provision eg. care workers and by paying taxes¹⁸. They may include:

- Nationals of the European Economic Area (EEA) who have a right to travel, live and work in UK
- Nationals of other countries requiring a work permit (obtained by employer)
- Commonwealth working holidaymakers aged 17-30yrs who can work in the UK for up to 2 years
- Students from outside the EEA who can undertake part-time work whilst enrolled on courses in the UK

Since May 2004 members of the accession (A8) countries who joined the EU have had freedom of movement and access to work - the UK, Sweden and Ireland chose not to place restrictions on the number of people from those states who could migrate for work. However, in 2011 when other European countries will no longer be able to apply restrictions, there will be more choice for people to work elsewhere. They may move from the UK or the NW. See appendix 7 for a brief outline of the new immigration system.

Migrant workers in the Northwest

The number of migrant workers from the new European countries make up a small percentage of the total number (approximately 16 per cent nationally)¹⁹. However, in 2005/06, the number of people registering for a National Insurance Number (NINo) in the NW included approximately 45 per cent from the accession countries. See table on page 12.

They vary in their intentions to stay and length of stay. NINo applications offer an indication of recent trends in migrant worker movement but does not capture numbers of short term or transient workers.

17 McVeigh, R. (2007) - *Migrant Workers and their Families in Northern Ireland: A Trade Union Response*

18 Pemberton, S., Stevens, C. (2006) *Supporting Migrant Workers in the North West of England*

19 Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*



The national percentages of NINo registrations for men and women is 53.5 per cent and 46.4 per cent respectively and the range of countries of origin is wide. See table on page 14.

There is a regional predominance of A8 workers from Poland but this is not reflected in all localities. For instance there are similar numbers of people from Lithuania and Poland in Pendle; while in Rossendale NINo registrations in 2005/06 were equal for people from the Czech Republic and Poland.

Also significant is the rapid rise in NINo registrations in certain localities such as Cumbria where in 2002/3, 800 people registered rising to 3,000 in 2006/7. In Cheshire too there has been a similar dynamic picture with 1,700 people registered in 2002/3, rising in 2006/7 to 5,500.

Asylum Seekers and Refugees

Asylum seekers arrive in the UK as a result of fleeing another country and in order to find protection. The Home Office (HO) is responsible for determining asylum claims and for providing people with accommodation and support if needed while their claim is considered. See appendix 7 for a brief outline of the asylum system. Their numbers are relatively small and the proportion they comprise of international in-migration is reducing. However, their circumstances and experiences before fleeing from their home country, plus other factors increase the risk of vulnerability and marginalization from mainstream society. This demands that they should not be subsumed within the broader migration picture.

The UK, along with 141 other countries, has signed the 1951 Refugee Convention established after the second world war. Since then and as a result, many vulnerable people fleeing persecution have been offered protection. The UK contributes to this international approach through the work of the HO, local authorities and a wide variety of third sector and other organisations that play a part in supporting people while their claim for asylum is being considered.

Asylum seekers and refugees in the Northwest

The total number of refugees living in the Northwest is not known. Once a person has been granted “leave to remain”, refugee status or some form of protection they are free to move around the country in the same way as UK citizens. Many refugees seek work at the earliest opportunity which may result in greater initial mobility of individuals than amongst longer-established communities.

At the end of 2007, 6,715 asylum seekers were supported in dispersal accommodation in the Northwest (mainly in Greater Manchester and Liverpool), representing 20 per cent of the UK total. Although this figure is likely to comprise the great majority of supported asylum seekers in the region, it does not include people in receipt of subsistence only support, Section 4 (hard cases) support, Section 98 (initial accommodation) support or Unaccompanied Asylum Seeking Children in receipt of Local Authority support.

The origin of asylum seekers varies according to world events. In the NW, asylum seekers and refugees are currently mostly from Eritrea, Afghanistan, Iran, China, Somalia. The majority are young men but there is an increasing proportion of women. Children may arrive with family members or be unaccompanied.

Undocumented

At any time, there are numbers of people in the UK without documentation or recognised permission to stay. These range from visa-overstayers to clandestine migrants to trafficked persons to failed asylum seekers. For obvious reasons, the numbers are not known but recent studies suggest that the level in the UK is somewhere between those of France and Italy, ie. 400,000 - 500,000 people, accounting for 14% - 17.5% of the total migrant population²⁰. It is reasonable to assume that this group are distributed across the UK and that an unknown proportion will live in the NW at any given time.

Views of people consulted in the Northwest

The responses from consultations in the region confirm some of the recent demographic changes as a result of migration - particularly recent international in-migration.

20 Flynn, D., Williams, Z. (eds) (2007) *Towards a progressive immigration policy*, London: Compass



Their information was from various sources ranging from anecdotal, based on seeing more diversity on the street and client-group changes, to proxy measures such as increased demand for interpretation and from caseload profiling.

The most striking feature is the diversity of recent arrivals and the differences across the region. In some areas, the changes have been most noticeable in the last 2 years.

The town of Kendal in Cumbria, for example was described as almost exclusively 'white' with a small Asian community, a few Chinese and Phillipinos. Within the last two or so years there has been a noticeable increase of East European workers - mostly Polish but also Romanian, Lithuanian, Latvian and Ukranian. In nearby predominantly 'white' Windermere, there has been a noticeable increase in young men coming to the area - mainly from Poland.

The population of Wigan was described by several respondents as 'white working class' with small South East Asian and Chinese communities and some international students. Wigan was introduced to asylum seekers for the first time in 2000 with the dispersal system. More recently, there has been an increase in migrant workers - mostly Polish but also a large Slovak community and some from Thailand, the Caribbean and Russia.

Other areas that have a long history of ethnic diversity have also seen recent changes. For example, Cheetham (in Manchester) has seen an increase in both the numbers of recent arrivals from overseas and their diversity. Traditionally, white British with a large Pakistani community, Jewish, Afro-Caribbean and North African communities, there are also a significant number of students, particularly from the Phillipines and Malaysia. In the early days of the Government's dispersal programme Cheetham was one of many areas across Greater Manchester that welcomed asylum seekers from a wide variety of countries including Kosova, the Czech Republic, Kurdistan, Croatia and French Speaking African states. More recently migrant workers, and some refugees granted leave to remain in the U.K. have settled in the area.

Some areas with a long standing but smaller proportion of BME groups have also seen an increase in numbers and diversity. Liverpool for example, has long-established Somali, Chinese, Yemeni & Bengali communities plus Black Caribbean and transient communities.

One respondent was able to identify some trends since the arrival of Kosovan refugees around 2000, followed by a number of Kurdish asylum seekers and since then increasing ethnic diversity of recent arrivals from overseas, including people from Senegal, Croatia, Macedonia, Poland.

Useful Publications and Websites

Department for Work and Pensions www.dwp.gov.uk

Office for National Statistics
www.statistics.gov.uk/default.asp

Migrant Workers North West
www.migrantworkersnorthwest.org

UK Border Agency www.bia.homeoffice.gov.uk

Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*. LGA

NWDA (2008) *Demography, Migration & Diversity in the NW*

Skiskandarajah, D., Cooley, L. & Kornblatt, T. (2007) *Britain's Immigrants: an economic profile*. IPPR

Johnson, M. (n.d) *Cohesion Mapping of Community Dynamics: Final Report*, COHDMAP

Pemberton, S., Stevens, C. (2006) *Supporting Migrant Workers in the North West of England*. MSIO

“Migrant workers bring significant benefits to the economy, generating in total over £40 billion every year. The evidence shows that industries such as fruit picking and residential care would collapse without migrant labour”

Simon Milton, Chairman of the LGA (press release 11 Dec 2007)

“The council of Europe has estimated that Europe will need 160 million foreign workers over the next 25 years to compensate for labour shortages; to maintain current standards of living and sustain pensions. UN estimates suggest the alternatives to increased immigration for a number of European and Asian countries is their own populations working until 77 years of age.”

TUC (April 2005) *Refugees and migrant workers: understanding the international movement of people*



Data and Information - the NHS role

Key Points

- National data collection systems are being established but are likely to take 5 or more years to set up; currently there is no single source of robust migration data
- There are established sources that can usefully contribute to local estimation
- The NHS has a key role in data collection (in particular, ethnic monitoring) for its own use and for sharing with local services in relation to migration patterns

Work is ongoing but it is widely acknowledged that the movement of people in and out of the UK is currently not possible to measure accurately²¹. Data sources are numerous but tend to be specific to organisational needs and are rarely compatible with each other. See appendix 6 for data sources. Information that is disaggregated by ethnicity, country of origin and gender is more difficult to access.

Several studies have combined data sources to make useful estimates at national and regional levels but accuracy becomes more difficult and is less reliable at local level²². However, there are various local sources of quantitative and qualitative information. General Practices (GPs), schools, businesses, third sector organisations and faith groups are often the first to recognize local population changes.

Local mapping, combining this information with data from national sources supports the estimation and assessment of local communities. A number of services and local authorities across the region are already undertaking activities that contribute to this.

They include:

- Caseload or patient profiling
- Monitoring and forecasting service language demand by interpreting service
- Developing a "Stats and Mapping" project
- Multi-agency fora such as Local Strategic Partnerships bringing together local and service specific information

Ethnic monitoring is an important component in mapping local population²³ (although it does not in itself identify recent arrivals from overseas). Current recording by services is very patchy and has a number of shortcomings.

In the NW, not only do NHS services not detail ethnicity in 35% of episodes²⁴ but the current 16-code national standard does not take into consideration important differences within ethnic categories, so that Ugandan, Somalian, Nigerian all come under the 'black African' category and the majority of people from the new European countries are incorporated within 'white other'.

Population of NW by nationality of all residents, 2006

Nationality	Estimate
UK	6,388,000
Irish Republic	35,000
India	26,000
Pakistan	19,000
Poland	18,000
China	9,000
Bangladesh	7,000
Former USSR etc	7,000
USA	6,000
Nigeria	6,000
Phillippines	6,000
Other Africa	5,000
Other Nationalities	92,000
GRAND TOTAL	6,623,000

Source: Office for National Statistics²⁵

21 Audit Commission (2007) *Crossing Borders: Responding to the local challenges of migrant workers*; Byrne, Tankard et al (2007) *New European Migration: Good practice guide for local authorities*; Dept. for Communities and local Government (2008) *Managing the impacts of migration; a cross-departmental approach*

22 Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*

23 Department of Health (2005) *A Practical Guide to Ethnic Monitoring in the NHS and Social Care*

24 APHO (2005) *Indications of Public Health in The English Regions 4: Ethnicity & Health*

25 Office for National Statistics (2007) <http://www.statistics.gov.uk>



Good Practice

Liverpool Patient Profiling Initiative

In Liverpool, Patient Profiling has become core business for 97 GP practices within the PCT. The enhanced profiling incorporates ethnicity, language, religion and access needs for all newly registered patients and those on disease registers. General Practices are offered support, training and tool kits. The tool kits include data collection templates, information on BME health, leaflet advice in different languages and community group contacts.

The project has contributed to geographical profiling and confirmed that local communities include people from 279 different ethnic groups, from 147 countries with 81 different spoken languages, 48 read languages and 54 religions.

By cross-matching the profile information with CHD, BMI, Diabetes and smoking status, a much clearer, more useful and equitable picture has been obtained; differences in ethnicity-related health status and gaps in health care can be identified. The process has enabled improved service provision and reduction in health inequalities through:

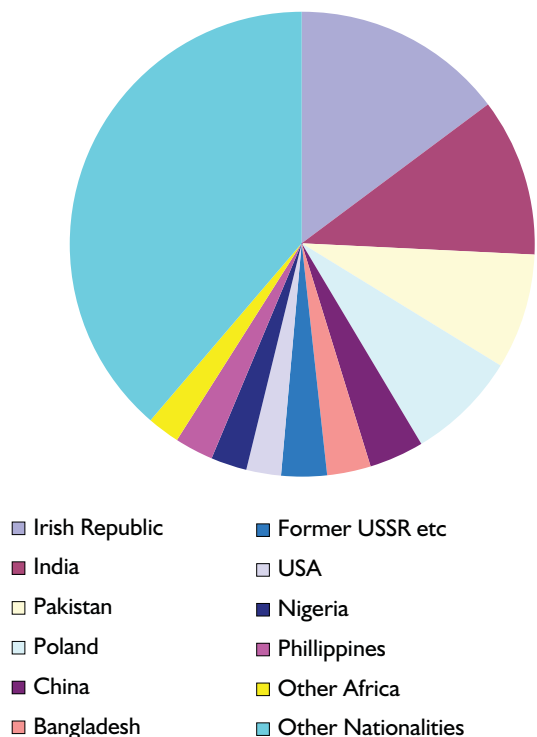
- Enabling equitable commissioning
- Developing health equity audit tools
- Ensuring services are relevant
- Identifying 'hot spots' for health promotion and targeted services
- Helping PCTs and general practices better understand patients

The Patient Profiling Report can be found at:
http://www.liverpoolpct.nhs.uk/Library/Publications/Patient_Profiling_report.pdf

Northwest residents - proportion by nationality*



Proportions of non-UK nationals resident in UK*



* in 2006. Source: Office for National Statistics (see previous page)



National Insurance Number registrations in respect of non-UK nationals in the North West during 2004/5-2006/7

Local Authority	2004/05	2005/06	2006/07
Allerdale	190	540	480
Barrow-in-Furness	70	130	130
Blackburn with Darwen	700	1070	1250
Blackpool	610	1380	1390
Bolton	1670	1980	2010
Burnley	220	320	400
Bury	630	1110	1250
Carlisle	560	720	810
Chester	690	1230	1150
Chorley	170	210	310
Congleton	130	270	190
Copeland	90	140	160
Crewe and Nantwich	730	1380	1390
Eden	230	440	360
Ellesmere Port & Neston	200	330	290
Fylde	210	330	290
Halton	130	300	280
Hyndburn	200	420	500
Knowlsey	140	190	270
Lancaster	830	1320	1100
Liverpool	2880	4450	4780
Macclesfield	460	790	760
Manchester	7210	10810	11370
Oldham	870	1330	1330
Pendle	330	670	780
Preston	1000	1460	2090
Ribble Valley	80	140	210
Rochdale	700	1180	1380
Rossendale	90	180	170
Salford	1680	2920	3220
Sefton	1050	1470	1110
South Lakeland	590	1000	1000
South Ribble	160	270	330
St Helens	180	470	560
Stockport	660	880	1050
Tameside	490	910	1030
Trafford	1050	1670	1730
Vale Royal	350	430	400
Warrington	520	1160	1390
West Lancashire	340	800	610
Wigan	660	940	1130
Wirral	630	860	860
Wyre	300	340	280
Total	30680	48940	51580

Source: Department for Work and Pensions²⁶

²⁶ DWP www.dwp.gov.uk/asd/asd1/niall/nino_allocation.asp

NINo Registrations of non-UK Nationals in 2006/07 by Local Authority and country of origin

Local Authority

Country of origin

	All	Poland	India	Slovak Rep	Pakistan	Australia	Rep. of Lithuania	France	South Africa	Germany	China P. rep.	Italy	Nigeria	Czech Rep.	Rep of Latvia	Portugal	Hungary	Spain	USA	Bangladesh	Rep of Ireland	Philippines	New Zealand	Others
Bolton	2,010	490	330	80	200	10	60	20	20	30	30	10	90	60	.	50	120	10	10	10	10	20	.	
Bury	1,250	580	30	50	140	10	20	10	20	20	10	20	10	80	20	10	20	10	10	10	10	10	.	
Manchester	11,370	3,050	500	530	1,200	170	200	240	80	260	470	140	470	390	120	100	60	230	90	150	160	40	40	
Oldham	1,330	320	30	60	300	10	20	20	10	20	10	.	20	40	10	30	10	10	10	210	10	10	.	
Rochdale	1,380	530	50	40	350	20	10	20	10	10	10	10	20	10	10	60	10	10	.	50	10	10	.	
Salford	3,220	1,430	100	170	60	50	40	90	20	50	120	50	80	120	40	70	40	30	30	20	30	30	20	
Stockport	1,050	380	50	20	50	30	10	20	20	20	30	20	10	20	10	20	10	10	10	10	20	30	10	
Tameside	1,030	490	40	40	90	10	.	10	10	10	30	10	10	30	.	10	10	10	.	70	.	10	.	
Trafford	1,730	610	150	90	110	50	10	40	50	40	50	10	10	40	10	20	30	20	20	10	30	20	20	
Wigan	1,130	390	90	140	10	20	100	20	20	10	20	10	10	20	30	10	10	10	10	.	10	10	.	
Knowsley	270	100	20	20	.	.	.	.	.	10	10	.	10	10	10	.	10	.	.	.	10	10	.
Liverpool	4,780	1,590	430	220	100	70	90	90	30	110	180	60	100	230	40	40	40	100	30	30	160	30	20	
St. Helens	560	200	10	140	.	.	10	.	.	10	10	10	10	10	10	.	30	10	10	.	10	10	.	
Sefton	1,110	560	40	40	10	20	50	10	40	10	20	10	10	30	40	30	20	20	10	10	20	30	.	
Wirral	860	390	50	30	10	20	10	20	10	10	20	10	10	10	.	.	20	20	10	20	10	20	10	
Halton	280	130	.	30	.	10	.	10	.	.	10	.	.	.	10	.	.	.	10	.	10	10	.	
Warrington	1,390	730	60	190	20	20	.	10	40	20	30	.	.	20	20	.	20	10	10	.	10	50	10	
Blackburn with Darwen	1,250	540	200	40	200	.	30	10	.	10	10	.	.	10	40	10	10	.	.	10	.	.	.	
Blackpool	1,390	990	60	10	10	10	20	10	10	10	10	10	10	20	30	20	10	20	10	10	10	20	.	
Chester	1,150	520	80	50	10	30	20	40	20	30	10	30	10	20	.	10	20	40	20	10	30	10	20	
Congleton	190	80	.	10	.	10	.	10	10	.	10	.	.	.	.	.	10	.	.	.	.	10	.
Crewe and Nantwich	1,390	1,030	40	90	.	10	20	10	10	20	10	.	.	10	10	10	.	10	10	10	10	30	.	
Ellesmere Port & Neston	290	130	10	40	.	.	10	.	20	.	10	.	.	.	.	10	.	.	10	.	.	10	.
Macclesfield	760	280	40	70	10	20	20	10	20	10	10	20	.	20	10	10	20	10	10	.	10	30	10	
Vale Royal	400	230	20	10	.	.	.	.	10	.	.	.	.	10	.	10	10	.	.	.	10	20	.
Allerdale	480	180	10	40	.	10	80	10	30	.	10	.	.	.	.	.	20	10	10	.	.	10	10
Barrow-in-Furness	130	40	10	10	.
Carlisle	810	430	20	60	.	10	20	10	10	20	20	10	30	20	10	40	.	10	.	10	10	10	10	
Copeland	160	60	10	10	.	.	10	10	.	.	.	.	.	10	.	.	.	.	10	.	.	10	.
Eden	360	180	20	10	.	10	.	.	30	10	.	.	.	10	20	.	10	.	.	.	.	10	10
South Lakeland	1,000	410	40	80	.	30	10	10	50	20	10	10	.	50	30	.	40	30	10	.	.	30	20	
Burnley	400	90	20	30	90	.	10	10	.	10	10	.	10	10	10	10	.	.	.	30	.	10	.	
Chorley	310	170	10	10	20	10	.	.	.	.	10	.	.	.	10	.	10	.	.	.	.	.	.
Fylde	290	110	10	10	.	10	.	.	10	10	10	20	.	10	30	.	.	10	10	.	.	10	.	
Hyndburn	500	310	.	10	100	.	10	.	10	.	.	.	.	.	10	.	.	.	.	10	.	10	.
Lancaster	1,100	540	70	20	10	10	20	10	10	30	50	10	20	20	.	10	10	10	20	.	10	10	.	
Pendle	780	280	.	50	210	10	70	.	20	10	10	.	10	20	20	.	10	.	.	.	.	10	.
Preston	2,090	920	330	50	130	10	40	30	20	20	190	20	10	10	40	20	60	10	10	10	20	.	.	
Ribble Valley	210	110	.	20	.	.	.	10	10	10	.	.	.	.	.	.	.	.	10	.	.	10	.
Rossendale	170	50	10	.	20	.	.	.	.	.	10	.	.	20	.	.	.	.	.	20	.	.	.
South Ribble	330	160	.	20	10	.	10	.	10	10	10	10	.	.	10	.	40	.	.	.	.	20	.
West Lancashire	610	350	20	20	.	10	20	.	10	.	.	.	.	10	50	20	20	.	10	.	10	20	.
Wyre	280	40	130	10	10	.	.	.	.	10	.	.	.	10	.	.	.	10	.	10	10	10	.

Notes:

- Numbers are rounded to the nearest ten.
- Totals may not sum due to rounding.
- Numbers are based on 100% data from the National Insurance Recording System (NIRS).
- Local authority is assigned by matching postcodes against the relevant postcode directory.
- Local authority counts are based on the most recently recorded address of the NINO recipient.
- “-” denotes nil or negligible.
- Overseas Residents - Foreign nationals who have registered for a NINO but reside abroad.
- 2,260 cases are recorded as from countries which have dissolved (USSR, Czechoslovakia, Yugoslavia). These have been allocated pro-rata to their successor countries.
- 450 cases had no country of origin recorded and are labelled “Not Specified”.
Source: 100% sample at 14 May 2007 from the National Insurance Recording System (NIRS)²⁷.



Overseas Nationals NINo Registrations in UK (in thousands):

Year	2003/04		2004/05		2005/06		2006/07	
Gender	F	M	F	M	F	M	F	M
Subtotal	185.0	185.7	208.8	230.9	303.5	358.9	331.4	382.1
Total	370.7		439.7		662.4		713.5	

Source: Department for Work and Pensions²⁸

Top 10 Countries:

2003/04		2004/05		2005/06		2006/07	
India	31.3	Poland	62.6	Poland	171.4	Poland	222.8
South Africa	18.4	India	32.7	India	46.01	India	49.3
Australia	17.1	Pakistan	20.3	Rep of Lithuania	30.9	Slovak Rep	28.8
Pakistan	16.8	South Africa	19.3	Slovak Rep	27.4	Pakistan	25.3
Portugal	14.0	Australia	16.6	South Africa	24.0	Australia	24.4
China Peoples Rep	13.3	Rep of Lithuania	15.8	Australia	23.8	Rep of Lithuania	24.1
France	13.1	France	13.3	Pakistan	22.3	France	20.2
Spain	11.9	China Peoples Rep	12.6	France	17.2	South Africa	16.9
Poland	11.2	Portugal	12.2	Rep of Latvia	14.3	Germany	15.2
Philippines	10.7	Slovak Rep	11.5	Germany	13.4	China Peoples Rep	13.2

Source: Department for Work and Pensions²⁹

Asylum seekers supported in dispersal accommodation in the North West

Year (as at end of)	Numbers in dispersal accommodation
2000	3,420
2001	8,155
2002	10,310
2003	8,135
2004	6,430
2005	6,130
2006	6,515
2007	6,715

Source: UK Border Agency³⁰

Asylum seekers residing in the North West when granted 'leave to remain' in the UK

Year	Granted asylum applicants
2007	1,253

Source: UK Border Agency³¹

28. DWP National Insurance Number Allocations to Overseas Nationals Entering the UK 2006/07

29. DWP National Insurance Number Allocations to Overseas Nationals Entering the UK 2006/07

30. Asylum Statistics United Kingdom 2000 - 2006 (Table 8.5 in each annual report); Asylum Statistics: Fourth Quarter 2007 United Kingdom (Table 10) <http://www.homeoffice.gov.uk/rds/immigration-asylum-stats.html>

31. Central Stakeholder Team, UK Border Agency



Health and Wellbeing

Key Points

- Recent arrivals from overseas want to integrate into communities and workplaces but some experience exclusion and disadvantage
- Level of English affects integration and access
- Partnership working, services and community groups vary in locality, quantity and capacity
- Voluntary organisations and community groups play a large part in influencing determinants of health and service access but a number face uncertain futures and funding
- Policies on immigration, asylum, health and social care, community cohesion an impact on individual and community health
- Better signposting to services and health promotion is wanted by service users and providers in some areas
- There is literature on health and needs of some ethnic groups but less is available on the compounding factor of migration itself and new country influences
- A number of men, women and children experience extreme marginalisation

The Wider Determinants

Recent arrivals from overseas experience similar health and well-being issues to the rest of the UK population - many of which are related to wider determinants such as level of income and social inclusion. Their health and well-being is affected by age, gender, genetic factors, ethnicity, country of origin, circumstances of migration, circumstances in the UK and lifestyle. Vulnerability, resilience and coping factors are different from individual to individual.

Certain issues are common to migrant workers, asylum seekers and refugees. They include:

- A desire to integrate and live life in a new community
- Separation from family and sense of isolation
- English language level influencing integration and access
- Education level often higher than employment or non-employment reflects³²
- Experience of exclusion and disadvantage as members of minority groups³³
- Differences in culture, beliefs, lifestyle, health practices
- Different expectations - which may be higher or non-existent - of services, including the NHS
- Lack of awareness on entitlements and infrastructures and difficulty in negotiating various systems such as transport, employment and public services
- Different experiences of health service provision in home countries, including preventative care such as screening and immunisation
- Susceptibility to stereotyping, racism, media presentation, public perception which hinder or support social integration

³² Pemberton, S., Stevens, C (2006) *Supporting Migrant Workers in the North West of England*

³³ NWDA (2008) *Demography, Migration & Diversity in the NW*



There is a wealth of services and projects across the region aimed at influencing wider determinants to support better health and opportunities. These include:

- Service development and services targeted at marginalised groups
- Advice centres recruiting volunteers from new communities
- 'Signposting', describing services, entitlements, responsibilities (in one or more European language) via welcome packs
- 'Introductory sessions' by services such as fire, police, health
- Social participatory research
- Establishment of multi-agency groups - some independently; some as sub-groups of / or with representation from Local Strategic Partnerships (LSPs)



Ethnicity, culture and lifestyle

While there is an increasing body of literature on the health issues of established minority ethnic groups living in the UK³⁴, accessible information on ethnicity-related health issues, attitudes and lifestyle patterns of recent arrivals from overseas - particularly for minority groups and those from refugee-generating countries is limited. The World Health Organisation website presents some country information³⁵ and a number of European information-sharing networks are being developed.

Cultural practices and what is considered 'normal' differ within and between countries. Female genital mutilation (FGM) for example, is prevalent in Sudan; the use of 'khat' (a mild stimulant) is common amongst Somali, Yemeni and Ethiopian men. The prevalence of smoking in some new European countries is higher than in the UK but beliefs and practices may change over time. One study shows that the proportion of immigrant women adopting practices similar to women in the new country - such as smoking and alcohol consumption - increases with time.³⁶

Such diverse and changing health behaviours have implications for, not only the health of those individuals, but for health promotion and equality strategies.

Marginalisation and discrimination

Recent arrivals from overseas include men, women and children who may have a number of compounding factors influencing the level of marginalisation and discrimination they experience - specifically unaccompanied children, the elderly, those of minority ethnic, faith, sexual orientation groups, the disabled (including survivors of torture) the undocumented (including trafficked, exploited, destitute) and the detained

It seems likely that the experience of migrant workers from the accession countries (who are predominantly white) have different experiences of ethnic discrimination or racism from migrant workers and asylum seekers / refugees from elsewhere in the world (who are predominantly non-white).

34 Available via eg. <http://www.library.nhs.uk> and www.kingsfund.org.uk/library

35 World Health Organisation www.who.int/countries/en/

36 Pereira, K (2008) *Migration and health behaviour during pregnancy*. BMJ



The Roma - the largest minority ethnic group in Europe who form a percentage of the Bulgarian, Slovakian, Hungarian, Romanian populations - are considered to be at high risk from social exclusion³⁷. Their life expectancy may be 10 years lower than in non-Roma and child mortality is 4 times higher³⁸.

Destitution

In the NW, there is a sense that the numbers of people from abroad, experiencing destitution has recently increased and is likely to continue to do so with the changes in accessibility to services and legal employment. Destitution may be temporary but is harmful to physical and mental health with some individuals resorting to self harm and suicide; it may lead to increased vulnerability, particularly for women and children, and a diminishing sense of self worth and potential to contribute to society³⁹.

Vital support is offered by voluntary organisations, community groups, individual friends and contacts but some may be becoming overstretched.

Apart from any ethical consideration for individuals, destitution is likely to have a negative impact on service providers as the provision of preventative services and health promotion becomes difficult, resulting in a greater likelihood of more costly curative treatments or emergency measures. Destitution can also have a negative impact on social cohesion⁴⁰.

Community cohesion

Community cohesion is supported by a number of factors including: community members' perception of equality in access to public services, adequate facilities for all, influence over decision-making at local level, freedom from crime and a sense of community spirit⁴¹. A number of national reports explore community cohesion in relation to migration⁴².

Partnerships and multi-agency working

Third sector and faith organisations are often the first port of call for recent arrivals from overseas; they are important barometers of change, often work as informal preventative services influencing the type and number of services used by recent arrivals and fill in gaps left by statutory services.

Public Policy

The movement of people is determined by national policies as well as international patterns of economy, conflict and human rights violations. In the UK, there are a number of policies, reports and Acts of Parliament that directly relate to migration, entitlements to services and environmental issues. These can impact on the health of recent arrivals from overseas and are listed in the appendices.

Good practice

Homeless and Vulnerable Persons Team

The needs of specific vulnerable groups of people and a gap in services was identified in Wigan a number of years ago. In partnership with the strategic health authority, local authority, voluntary and faith groups, the PCT service has been evolving and now incorporates a team including community nurses, a psychiatric nurse, health visitors, support workers and assistant practitioners. Team members have a special interest around themes such as alcohol, substance misuse, domestic violence, alternative therapies and with specific marginalised groups such as BME, homeless, travellers, Roma. The work is pro-active and outreaching. A nurse-led 'One-Stop Shop' offers health needs assessments, food, clean clothes, health-promoting and diversional activities, peer support plus some GP consultations. Annual reviews, case studies and qualitative evidence demonstrates the positive impact on the health and wellbeing of marginalised individuals.

37 NWRA (2005) *Action for Equality - celebrating diversity and creating opportunity for all in the North West of England: A consultation paper*

38 McKee, M (1997) *The health of gypsies*. BMJ

39 Dumper, H (2006) *The Destitution Trap: Research into destitution among refused asylum seekers in the UK*

40 Dumper, H (2006) *The Destitution Trap: Research into destitution among refused asylum seekers in the UK*

41 Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*

42 Hudson M., Phillips J., Ray K., Barnes H (2007) *Social Cohesion in Diverse Communities*. JRF; D'Onofrio & Munk (2004) *Understanding the stranger*. ICAR; Department of Communities and Local Government (2008) *Guidance for Local Authorities on community cohesion, contingency planning and tension monitoring*. London: DCLG



Good practice

Cheetham Hill Advice Centre

Cheetham Hill Advice Centre has been serving the people of Cheetham and Crumpsall for over 30 years. Managed by a local voluntary committee and supported by partners (including Manchester City Council and the government's flagship Goldstar programme⁴³) it has developed and responded to the changing local population. The centre aims to "enable local people to make their own decisions about their life and future and bring about improvements in their standard of living". It provides help, advice and support on a wide range of issues such as benefits, employment, housing, consumer, financial and family concerns, immigration and asylum, education, access to health and other local services.

Last year, several families from Eastern Europe who were living together in overcrowded, unhealthy accommodation were supported to find appropriate housing, access to work, schools and health services.

Local residents are actively encouraged to become involved as volunteers and training is offered. One recent arrival from overseas describes how "volunteering gives him the opportunity to help others...and ...has made him part of a community"

Read more at: www.cheethamadvice.org.uk/

Useful publications and websites

Kings Fund: Black and Minority Ethnic Group:
http://www.kingsfund.org.uk/health_topics/black_and.html

Migrants Rights Network: www.migrantsrights.org.uk

Bindra, R. (2007) *Guidance on Joint Strategic Needs Assessment*, London: Department of Health

Pemberton, S., Stevens, C (2007) *Economic Migration to Housing Market Renewal Areas in North West England - Opportunity or Threat? Case studies of New Heartlands (Merseyside) and Oldham and Rochdale HMR Pathfinders*, Liverpool: Merseyside Social Inclusion Observatory

Perry, J., El-Hassan, A. for HACT (2008) *More Responsive Public Services? A Guide to Commissioning Migrant and Refugee Community Organisations*, York: Joseph Rowntree Foundation

"The only way to achieve equity of access is to work with non-governmental organisations who have access to migrant groups."

German Minister of Health. EU Conference Lisbon 2008

43 The GoldStar Project is designed to encourage and enable voluntary organisations and projects throughout England to realise the potential of volunteers.
<http://www.goldstar.org.uk/>



Asylum Seekers and Refugees - how is their health affected?

Key Points

- The broad health and wellbeing issues for asylum seekers and refugees are well-established but a number continue to have poorer health
- There is a diverse range of services for asylum seekers and refugees within the Northwest
- Awareness of specific issues, needs, and services for asylum seekers is limited in some areas but there is a strong motivation for updating.
- Aspects of the asylum process may be detrimental to the health of individuals

Local studies⁴⁴ confirm the broad health issues which may be experienced by asylum seekers and refugees⁴⁵. These include an increased risk of the following, which could be counter-acted by well-targeted preventative work:

Mental health issues

- Depression, post traumatic stress disorder (PTSD) and anxiety resulting from experiences of war, social unrest, torture, harsh treatment including domestic abuse, rape and sexual abuse
- Fear of detention and / or forced return
- Multiple loss and powerlessness, uncertainty about future, social factors, and discrimination experienced in the UK can also further compromise mental health

Physical health issues

- Impairment or disability as a consequence of torture or previous injury
- Communicable and chronic diseases. Poor health care facilities in country of origin may have hampered screening, early diagnosis and treatment of eg. hypertension, diabetes. Immunisation may be incomplete or absent
- Dental health - generally poor with dental disorders common
- Sexual health - includes sexually transmitted infections, unwanted pregnancies, complications as a result of female genital mutilation (FGM), HIV, abuse
- Maternal and child health. Amongst migrant women, maternal mortality rates are higher than the general population and in women who are seeking asylum they are 3 times more likely to die⁴⁶
- Nutritional health may be poor with resultant vitamin deficiency disorders such as rickets and anaemia

Gender-based health issues

- Women seeking asylum may have experienced persecution, domestic violence, honour killings, sexual violence including rape and torture prior to arriving in the UK
- This may have rendered them more vulnerable to exploitation (including sexual) and enforced prostitution⁴⁷
- Research indicates there are proportionally higher levels of deprivation and fear amongst asylum-seeking women⁴⁸

44 Davison, H. (2004) *Healthcare for Asylum Seekers, Refugees & Immigrants: What is and is not happening in North Cumbria*, NW(E) Consortium (2003) *Asylum Seeker/Refugee Health Conference*; Manchester Health Watchdog (2007) *Access to Health Services for Asylum Seekers in Manchester: Progress Report and Proposals*; Conway, S., Maffia C. Consultation on Access and Barriers to Health Services. Salford PCT

45 Wilson, R., Sanders, M., Dumper, H. (2007) *Sexual health, asylum seekers and refugees: A handbook for people working with refugees and asylum seekers in England*; Faculty of Public Health (2008) *The health needs of asylum seekers*. FPH

46 Taylor B., Newall D. (2008) *Maternity, mortality and migration: the impact of new communities*. West Midlands Strategic Migration Partnership & Heart of Birmingham PCT

47 Burnett A., Peel M (2001) *Asylum seeker and refugees in Britain: Health needs of asylum seekers and refugees*. BMJ

48 Adhana, L. (2006) *The Health and Well-Being of Women and Child Asylum Seekers and Refugees in Wigan*



Socio-environmental factors influencing health

The numbers of asylum seekers are relatively small and many have no family, or friends with whom to share social contact and support. Family reunion may be extremely difficult due to events in asylum seekers' home countries. The HO disperses asylum seekers in need of accommodation to available housing across the country. This, and the potential for them to be moved to other accommodation elsewhere may further hamper access to existent family and/or social contacts as well as disrupting professional and supportive relationships. This can be difficult for asylum seekers themselves and time consuming for professionals.

Asylum seekers tend to be keen to settle into and contribute to their local community, and are likely to be regarded as good neighbours by those around them. However, some asylum seekers and refugees in the NW have experienced hostility from individuals within established communities. Asylum seekers and refugees may be reluctant to report hate crimes to the police so the extent of harassment is not clear.

Support provided to asylum seekers by the UK Border Agency includes accommodation and utilities. Financial support provided under s95 is lower than income support to reflect the temporary nature of support to asylum seekers and the fact they do not pay utility bills. A single asylum seeker without dependants, over the age of 25 currently receives £42.16 per week⁴⁹. Section 4 Support is provided in the form of self-catering accommodation and vouchers to the value of £35 per person per week to purchase food and essential toiletries. There are also provisions for additional payments which came into force in January 2008⁵⁰. These new regulations provide for a variety of additional payments including extra help for pregnant women and new mothers.

Asylum seekers do not have permission to work during the period their application is being considered unless they have been waiting 12 months or more for an initial decision and the reason for the delay in making an initial decision is not attributable to the asylum applicant; their dependents cannot have paid employment. For some, this has meant unemployment for several years with the concomitant health consequences. A recent change in the asylum system means that asylum seekers can now undertake a number of hours voluntary work.

Once refugee status or some form of 'leave to remain' in the UK is granted, HO asylum support ends and individuals become eligible for work and state benefits. Refugees have the same rights to work and benefits as UK nationals; some may be highly skilled but barriers to employment or claiming benefits may be considerable eg. due to limited language skills. In some cases, individuals may be left without accommodation (albeit temporarily) and therefore be more vulnerable. From October 2008 the Refugee Integration & Employment Service will be offered to asylum applicants receiving a positive decision. The service delivered by Refugee Action aims to support refugees to integrate and become economically self sufficient. Families with dependent children should be able to access local authority homeless assistance as they fall within a 'priority need' category. Refugees, whatever their current employment status may also be overcoming the effects of years of deprivation.

⁴⁹ www.bia.homeoffice.gov.uk/asylum/support/cashsupport/currentsupportamounts/

⁵⁰ Footnote The Immigration and Asylum (Provision of Services or Facilities) Regulations 2007 can be accessed at http://www.opsi.gov.uk/si/si2007/uksi_20073627_en_1



Housing

Most asylum seekers are placed in accommodation operated under contract to the HO and are dispersed across the country on a no choice basis depending on the availability of asylum accommodation. Some are occupying properties that would otherwise be hard-to-let, in areas of deprivation.

Policy

The UK asylum system provides individuals with accommodation and support, including referral to health services, whilst their claim is being considered. However, concerns have been expressed that aspects of the asylum system itself are detrimental to the health of individuals⁵¹. The HO has made progress in speeding up decision-making on new and long-standing asylum claims. However, there remain some concerns⁵² and it was noted by several respondents that many asylum seekers are unaware of their 'case-owner'; they and their advocates have difficulties accessing the asylum service.

Detention

A number of asylum seekers are held in Immigration Service removal centres bringing specific health implications, particularly for children. Several studies⁵³ have found a considerable number of detainees experience a range of physical and mental health problems including PTSD, depression, self-harm, suicide attempts and suicides. Others have undiagnosed medical conditions, suffer interrupted treatment or experience the deterioration of a condition. There are no removal centres in the NW but one reporting centre is also a short-term holding facility which is non-residential⁵⁴.

Services for asylum seekers and refugees

Across the NW, diverse services focus on the specific health and well-being needs of asylum seekers. These range from specific support provided by statutory services such as local authorities, specialist or designated health visitors, specialised GPs, health trainers; targeted service provision or projects like cancer screening and co-ordinated statutory and voluntary services like Welcome Centres. Voluntary organisations such as Refugee Action and MRSN, play an essential part in supporting asylum seekers to access services and facilitating empowerment towards wellbeing.

Other organisations seek to address very specific health and well-being needs such as the Medical Foundation for the Care of Victims of Torture. These groups tend to be located in Greater Manchester and Merseyside - areas with a history of asylum seeker support.

There are a number of supportive networks within and between agencies such as the inter-agency work co-ordinated by Manchester City Council's Multi-agency Refugee Integration in Manchester (MARIM)⁵⁵.

Several Local Authorities in the region participate in the Gateway Protection Programme initiated in 2003 to support people assessed by United Nations High Commission for Refugees (UNHCR) as being vulnerable and at risk while in refugee camps abroad. Their health issues can be acute but their use of primary care services may be less than that of other asylum seekers.

General awareness across the region of the specific needs and services available for asylum seekers and refugees is patchy. This is unsurprising, given the small numbers concentrated in relatively few localities. In some of these areas, those questioned acknowledged a lack of awareness and a desire to be 'updated'.

51 Dumper, H (2006) *The Destitution Trap: Research into destitution among refused asylum seekers in the UK*; BMA Board of Science and Education (2002) *Asylum Seekers: meeting their healthcare needs*

52 Refugee Council Briefing (2007) available from www.refugeecouncil.org.uk

53 BID (2007) *Immigration Detention in the UK - key facts and figures*; Amnesty International (2005) *Seeking asylum is not a crime: detention of people who have sought asylum, UK*; Crawley, H., Lester, T. (2005) *No Place for a Child, Children in UK immigration detention: Impacts, alternatives and safeguards*

54 Dallas Court is a Reporting Centre and short-term non-residential Holding Facility in Salford

55 MARIM found at: http://www.manchester.gov.uk/site/scripts/documents_info.php?documentID=402



Good Practice

Wellbeing Project

Many refugees are isolated, have little social contact and live with extreme levels of stress as a result of experiences in their home countries. Living with uncertainties and challenges in the UK can add to that stress. Building on the experience and success of an initial project, the aim of Refugee Action's Well-being Project is to promote the positive well-being of refugees and reduce the incidence of enduring mental health problems.

Three strands of the project will contribute to the improvement of mental well-being and self-esteem. They include:

The provision of activities such as countryside walks, swimming, cookery courses

Supporting the development of new activity groups in partnership with other organisations

Supporting access to established activities such as football clubs, swimming clubs and dance groups

The Well-being project is one of ten programmes across the northwest that are part of the Big Lottery funded 'Target: Well-being' project.

<http://www.refugee-action.org.uk/ourwork/projects/Wellbeing.aspx>

Useful publications and websites

Merseyside Network for Change
www.merseysidenetworkforchange.org

Manchester Refugee Support Network
www.mrsn.org.uk

Refugee Access www.refugeeaccess.info

Department of Health
<http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=asylum+seeker>

NHS Network: Asylum Seeker and Refugee Health Care www.networks.nhs.uk/networks/page/256

Refugee Action www.refugee-action.org.uk

Refugee Council www.refugeecouncil.org.uk

Faculty of Public Health (2008) *The health needs of asylum seekers*. FPH

Burnett, A., Fasil, Y (2000) *Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers*, London: Directorate of Health and Social Care

Dumper, H. et al (2006) *The Destitution Trap: Research into destitution among refused asylum seekers in the UK*, Refugee Action

“It is a refugee's most cherished dream to return home and live in dignity and security”

Kofi Annan, UN Secretary General, 2004 (in TUC *Refugees and migrant workers: understanding the international movement of people*)



Migrant Workers - how is their health affected ?

Key Points

- The health and wellbeing needs of migrant workers are not well-established
- May have different patterns of health-affecting behaviour such as alcohol consumption, smoking, diet
- The current demographic profile (young adults, employed; more men than women) may change, altering prevalence of health and well-being issues

Given the diversity and relatively recent arrival of some migrant workers it is unsurprising that available literature on health and wellbeing issues is limited. Many respondents in the consultation commented on this. However, the body of research is increasing and networks sharing information are developing.

Socio-environmental factors influencing health

Most migrant workers have no dependents with them⁵⁶ although an increasing number are being joined by their families or are having children in the UK. Although most are employed, some work long, unsocial hours and experience uncertainty in work tenure which may hinder their capacity to access services⁵⁷.

Migrant workers from the EEA are not entitled to claim benefits such as income support and job seekers allowance until they have worked (and been registered) for 12 months continuously prior to their claim. One Citizens Advice Bureau (CAB) consulted has seen an increase in clients from A8 countries reporting that most problems are employment and work-permit related; some are earning less than the minimum wage.

There is also evidence of exploitation in a variety of forms, from unscrupulous employers, migrant worker on migrant worker and trafficking. The TUC commission on vulnerable employment suggests women, people from BME and disabled groups are more likely to experience insecure and unjust employment. It estimates there are nearly 260,000 vulnerable workers in the North West⁵⁸.

The unknown number of people working outside the legal framework may also be open to exploitation. Several organisations are working to address this, including Migrant Workers Northwest and the TUC.

The susceptibility of migrant workers to occupational harm is difficult to assess since a higher proportion are in employment that is either unregulated or is in itself higher risk⁵⁹. The 2004 tragedy of the 23 Chinese cockle-pickers who died in Morecambe Bay is just one example of migrant worker loss of life in the North West.

Workplace discrimination and feelings of being treated 'less than equal' are reported by migrant workers⁶⁰. There is some talk of imported racism. In contrast to some media presentation, there is little evidence of tension between migrants and the indigenous population⁶¹ although isolated cases of hate crimes have been reported.

Housing

Migrant workers from A8 countries mainly live in privately rented flats or houses with a number of them being multiple-occupancy and of poor quality. In general there is little evidence of increased pressure on social housing provision⁶² although in some areas, the lack of accommodation in private sector and increasing numbers of migrant workers becoming entitled to access social housing, has resulted in extended waiting lists.

56 Institute of Community Cohesion (2007) *Estimating the scale and impacts of migration at the local level*

57 McVeigh, R (2007) *Migrant Workers and their Families in Northern Ireland: A Trade Union Response*

58 TUC (2008) *Hard Work, Hidden Lives: the Short Report of the Commission on Vulnerable Employment*

59 McKay S., Craw M., Chopra D. (2006) *Migrant Workers in England and Wales*

60 Pemberton, S., Stevens, C (2006) *Supporting Migrant Workers in the North West of England*

61 NWDA (2008) *Demography, Migration & Diversity in the NW*

62 Pemberton, S., Stevens, C (2007) *Economic Migration to Housing Market Renewal Areas in North West England - Opportunity or Threat? Case studies of New Heartlands (Merseyside) and Oldham and Rochdale HMR Pathfinders*



Services for migrant workers

People working with migrant workers have identified a lack of specific support for migrant workers as distinct from refugees and asylum seekers⁶³.

An increasing number of services and support resources such as introductory sessions and welcome packs are being introduced, that signpost, describe services, entitlements and responsibilities in one or more European languages. A number have been initiated by local authorities or charities and faith groups.

Some are expanded from refugee and asylum seeker support networks. Advice centres, including CABs have seen an increase in use by recent arrivals from overseas. There is a strong desire to provide this essential support but insecure funding and resources means capacity is sometimes limited.

Good Practice

Welcome Packs

Partnerships within Lancashire have developed Welcome Packs for people moving to the area from overseas and other parts of the UK. The packs have been adapted and translated for the specific needs of the different communities in East Lancashire (English, Polish, Czech and Lithuanian), Lancaster (English, Chinese and Polish), West Lancashire (English, Portuguese and Polish) and South Ribble (English and Polish); they include useful information on health and well-being, employment, housing, police and emergency services, local services and community networks, financial, education, travel. The health and well-being section outlines how to register with a GP, access emergency services, NHS Direct, pharmacies, dental and optician services.

<http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=2966&pageid=6037&e=e>

West Lancashire has had several years' experience of welcoming migrant workers to the area. A welcome pack was designed in 2005 as part of a multi-agency strategic plan which also included outreach work. The pack has recently been updated and includes additional requested information following consultations with migrant workers. They considered the pack to be "really useful" and the revised format will be launched in October. Packs will be distributed to GPs, employers, churches, schools, libraries and available online at:

<http://www.westlancsdc.gov.uk/business.aspx>

Useful publications and websites

Migrant Workers Northwest
www.migrantworkersnorthwest.org

Trade Union Congress www.tuc.org.uk

Citizens Advice Bureau & TUC (May 2007) *Living and Working in the UK: Your Rights*, (for people coming to work in the UK from the A8 countries), London: TUC Migrant Workers Project

TUC (May 2008) *Hard Work, Hidden Lives: the short Report of the Commission on Vulnerable Employment*, Trade Unions Congress

"Migrant workers are an asset to every country where they bring labour. Let us give them the dignity they deserve as human beings and the respect they deserve as workers"

Juan Somavia, Director General of the ILO (in McVeigh, Robbie (2007) Migrant Workers and their Families in Northern Ireland: A Trade Union Response)

63 Pemberton, S., Stevens, C (2006) *Supporting Migrant Workers in the North West of England*



Health Services and Migration

Key Points

- NHS benefits hugely from workers from overseas
- Migration and demographic change offer opportunities for service enhancement and professional development
- Good practice and learning is going on within the region
- The impact of demographic change and migration varies according to the locality and specific service
- Services are at different stages in understanding, needs, capacity to respond and provision of tailored service
- Some localities serving disadvantaged communities are already facing challenges in providing an equitable service
- Communication and consultations with non-English speakers takes more time
- New approaches in health promotion and service provision may be required to address a diversity of health needs and cultural backgrounds

Since its establishment, the NHS has benefited from the work of doctors, nurses and ancillary workers from overseas. Today, the NHS and social care sectors are dependent on recent arrivals from overseas and longer-established ethnic minorities⁶⁴. Of all doctors in the UK, 38 per cent qualified abroad and nearly half of new dentists are from abroad⁶⁵.

In the UK as a whole in 2004, 44,000 health care staff from overseas were issued with work permits⁶⁶ and in 2006 approx 6,200 nationals from accession countries registered as care workers⁶⁷.

No exact figures on the numbers of recent arrivals from overseas working in the Northwest's health and social care services, but approximately 8.4 per cent are from BME groups of which a proportion will include recent arrivals from overseas. There are migrant workers from the A8 countries registered as GPs, nurses, doctors, medical specialists, care workers and dental practitioners⁶⁸.

A local study undertaken in 2006 suggested there was little evidence that migrant workers increased strain on services apart from a reported increase use of Health Visitor services in Crewe and Nantwich⁶⁹. A later study implied the same - with no additional strain being reported by doctors and dentists. Some health practitioners identified an increasing number of families - women and children - joining workers and the likely implications for service demand⁷⁰.

It is clear that the impact of recent international in-migration is both service and locality specific. The following examples illustrate this:

- A midwife interviewed felt that there was no significant impact other than an increased use of interpreting service, whereas the health visitor in the same locality was having to prioritise visits from a high number of already marginalised clients. The GP surgery also had increased use of interpreting service but was working within capacity
- A health visitor in another locality considered that an increase in the number of recent arrivals had not affected the capacity to provide the health visitor 'universal service'
- A midwifery service has seen an increased number of babies born to non-English speaking mothers so the use of interpreters has increased. There was no reported impact on the same hospital A&E department

64 McGregor (2007) 'Joining the BBC (British Bottom Cleaners)': *Zimbabwean Migrants and the UK Care Industry*, Journal of Ethnic and Migration Studies; International Organisation for Migration (2005) *World Migration 2005: Costs and Benefits of International Migration*, Section 2. UN

65 Bell, M., Ford, I., McDougall, D. (2008) *A Warm Welcome? Public Services and managing Migration in London: Scoping Research and Introductory Report*. London Asylum Seekers Consortium

66 TUC (2005) *Refugees and migrant workers: understanding the international movement of people*

67 Byrne J., Tankard J. et al (2007) *New European Migration: Good practice guide for local authorities*

68 NWDA (2008) *Demography, Migration & Diversity in the Northwest*

69 Pemberton, S. & Stevens, C. (2006) *Supporting Migrant Workers in the North West of England*

70 Pemberton, S., Stevens, C. (2007) *Economic Migration to Housing Market Renewal Areas in North West England - Opportunity or Threat? Case studies of New Heartlands (Merseyside) and Oldham and Rochdale HMR Pathfinder*



- One of the urban A&E departments has seen an increased number of recent arrivals from overseas and with them, increased complexity and a number of uncommon illnesses being treated
- One A&E staff member reported inappropriate use, but that this was not restricted to people from overseas. A current audit in one of the urban localities is suggesting that most A&E use is appropriate
- One GP sees a higher proportion of students as situated near the college; another GP sees a higher proportion of asylum seekers and refugees as a number live in the catchment area
- An infectious diseases centre in one hospital attracts use of other services by their client group
- In one locality with a large proportion of recent arrivals from overseas, the demographic change and 'cultural shift' seemed to be resulting in increasing numbers of babies being breastfed

It is sometimes heard that recent arrivals from overseas use services inappropriately. Whilst it is likely that some people access services in a similar manner to the way they are accustomed to in their home country, which may differ from that in the UK, inappropriate use did not feature highly during the consultations.

The increased time required to communicate with non-English speakers and the resulting impact on workload is a factor experienced widely across all services and localities. The perception of the level of this impact varied considerably and may be dependent on one or more compounding factors, not simply the number of non-English speakers accessing the service.

Broadly, these factors were:

- Presence or absence of systems to support interpretation and translation
- Experience of staff in communicating with non-English speakers
- Pre-existing level of service strain
- Complexity of individual health needs
- Service-user understanding and expectation of UK health system

- The speed at which the service and staff have had to adapt to change and become accustomed to diversity

Other issues highlighted by those questioned were:

- Reaching their own targets may be affected by the impact of differing client needs
- High expectations of health care services in the UK held by some recent arrivals from overseas
- Some people return to their country of origin for medical treatment
- A number of people do not access services - either because they do not know about them or they are unable to access them
- The emotional stress of building relationships and supporting people with complex needs
- Quality (and equality) can be reduced when services are stretched

How health services are adapting

A variety of different strategies are being employed by staff to meet the needs of their new client groups and address inequalities across the region. Examples of service provision adaptations include:

- Learning new ways to communicate (including learning Polish)
- Searching out translated material
- Exploring appropriate interpretation methods (one-to-one / telephone)
- Expanding existing services to incorporate recent arrivals from overseas
- Starting new projects - combined with other agencies or service specific
- Developing improved ways of monitoring - interpreter use / caseload profiling
- Increasing the capacity of overseas payment / private patient staff
- Protected regular time for staff training

Several people commented on how working with recent arrivals from overseas was rewarding, professionally stimulating and an opportunity for development.



Given the current ambiguous and uncertain situation, it is unsurprising that a number of respondents found it difficult to answer the question on how or if they would be able to provide a service to meet the needs of new population groups in the future.

For some, adapting to the changing demography has happened in the same way as many previous service changes, by just getting on with it. For those, it was possible to see future changes being accommodated. For others, despite their experience and adaptability, the increase in numbers of recent arrivals from overseas is combined with a rapid population turnover, high proportion of non-English speakers and people with complex health and social needs resulting in additional pressure on stretched resources. This contributes to the argument for targeted resources to reduce resultant disparities in health.

A number of suggestions on managing future changes were put forward by respondents and included:

- Recruitment of bilingual workers
- Data collection systems that support prediction of trends and inform planning
- Emphasis on profiling and looking at future needs
- Opportunities to be pro-active rather than reactive and be more involved in preparation and planning
- Investment proportionate to meet identified needs





Research and recommendations on the specific issues related to working with refugees and asylum seekers can be applied to work with other recent arrivals from overseas. They include:

- Time to establish effective communication
- Appropriate use of trained interpreters
- Viewing people as individuals
- Providing practical and emotional support
- Training and supervision for health workers (eg. mythbusting effective cross cultural practice)
- Translated resources
- Targeted resources and/or funding
- Co-ordinated working between statutory and third sector organisations

Good practice

REACHE Northwest

Reache NW works with NHS organisations and higher education bodies to assist asylum seekers and refugees in registering appropriate professional health related qualifications and seeking employment in the NHS.

It provides support in a number of ways which may include career guidance, English language courses, CV and interview preparation, access to computers, clinical updates, apprenticeship and work placements for doctors, nurses, dentists, pharmacists and other allied professionals.

For one doctor who qualified in his home country and gained a paediatric specialism in France, Reache has provided “overwhelming support” during the 5 years it took him to meet GMC requirements. He is now happily working as a clinical medical officer.

Based at Salford Royal NHS Foundation Trust and funded by NHS Northwest, The Refugee and Asylum Seeker Centre for Healthcare Professionals Education (REACHE Northwest) has been recognised for innovation and excellence in healthcare, winning awards for Education and Training (GMSHA, 2005) and as Outstanding Learning Providers (NIACE, 2008).

www.reache.wordpress.com

Useful publications and websites

Arai, L. (2005) *Migrants & public services in the UK: a review of the recent literature*, Centre on Migration - Policy & Society

Hargreaves, S. (2007) *The impact on and use of the UK's National Health Service by New Migrants*. Thesis (PhD) London: The International Health Unit, Imperial College

Arya, A., White, C. (2007) *Towards Race Equality in Health: A Guide to Policy and Good Practice for Workforce Development*, Race for Health

Perry, J., El-Hassan, A. Azim for HACT (2008) *More Responsive Public Services? A Guide to Commissioning Migrant and Refugee Community Organisations*, York: Joseph Rowntree Foundation

“Addressing migrant and minority health issues can help improve health services generally. This is because migrant and minority health issues make explicit what is important in health care in general: the patient's point of view on health care and health.”

M Sullivan (2003) *Social Science and Medicine*



Access to Health Care

Key Points

- Regulations governing entitlement to NHS care are complex, resulting in some confusion and inconsistent application of guidance. Healthcare workers would appreciate further clarity and support in their desire to exercise non-discriminatory practice
- Some recent arrivals from overseas are unclear how the NHS differs from health care provision in their country of origin
- Non-English speaking recent arrivals from overseas may experience similar barriers to accessing services as established migrants
- Staff and services are not at a consistent level in their ability to communicate with non-English speakers and people from diverse backgrounds
- Certain specific localities acknowledge gaps in awareness of equality and diversity issues
- Provision of tailored services will require access to interpretation, cultural competence training and translated material

Access to the health care is influenced by geographical, cultural, financial and other factors. The issues for recent arrivals from overseas overlap with those of established BME communities where work continues to reduce disparities in access to health. For this overview we took a broad look at equality strategy awareness, language and culture, eligibility for health service.

Arai⁷¹ suggests that health workers do not know how to deal with migrant groups which is further compounded by a confusion over entitlements (see below). This is true in some cases, but as a generalisation, masks the considerable number of health workers who do have experience and have established successful projects and work - particularly in those areas with a history of international in-migration.

Language and Culture

Managing communication between staff and service users whose first language is not English, is one of the most fundamental concerns for many health workers. Inadequate communication has an obvious impact on the health care of non-English speakers.

Translation (*written material*)

The lack of translated material was frequently mentioned by respondents, although not by those accustomed to working with marginalised, non-English-speaking groups. This may point to a difficulty in obtaining material either through lack of awareness or funding as much as the actual lack of material. Less material seems available in languages of some of the more recent arrivals from the accession countries although there is a rapidly increasing amount in Polish.

A number of organisations and services have commissioned the translation of specific materials. In one case, a GP practice did so for a new patient questionnaire, but inviting completion in Polish has led to difficulties in translating the responses. The practice proposed that a central translation service, accessed via fax or email would enable a speedier and perhaps more accurate service.

Interpretation (*spoken communication*)

Several PCTs and NHS Trusts have well-established interpreting services that provide unrestricted access to either in-house (for the most commonly spoken languages) or commissioned interpreters, and/or in the case of some rare languages - telephone links to country of origin in addition to a telephone service such as Language Line⁷².

71 Arai, L. (2005) *Migrants & public services in the UK: a review of the recent literature*

72 <http://www.language-line.co.uk>



A number of respondents reported using family members or 'making do' with patients' minimal English. This was in part due to difficulties in accessing interpreters but also a lack of awareness about using family members and the implications for equality and confidentiality. The difficulties of discussing sensitive issues such as domestic violence, rape, child protection through interpreters was noted. As was, the health assessment (for example level of depression or degree of head trauma) and management of people from different cultures.

In one locality, the midwifery and A&E departments had no access to interpreters and were using the Red Cross multi-lingual phrase book⁷³ and sometimes Language Line. Another midwifery service had unrestricted access to interpreters for clinic and one-to-one work but not for health promotion group work such as parentcraft. GPs were using various interpreting services or none - a telephone interpreting service was the most common.

Funding restrictions may limit the use of interpreting services by voluntary organisations. Rates of pay for interpreters differ according to the organisation, contributing to competition where the pool of interpreters is small. The experience and level of training of interpreters varies.

Social and cultural communication

There is a general recognition that effective communication and equity of health access goes well beyond the provision of written material and interpreting services.

How health services are adapting

A number of services and projects have been developed including:

- Incorporating members of new communities into community development and link- worker teams
- Active recruitment of bilingual staff including assistant practitioners, health visitors, team assistants, community nurses, midwives and GPs plus others (mostly speaking the 'older' languages)
- Staff members learning new languages
- Voluntary sector provision of English lessons
- GP 'double appointments' for non-English speakers

A number of people highlighted that they would appreciate:

- More information on the expectations and experiences of health services in home countries
- More information on the specific health needs of ethnic minorities including recent arrivals from overseas - highlighting asylum seekers and refugees
- Training on how to work together with interpreters
- Cultural awareness or competence training
- Opportunity for more outreach work and community organisation capacity building

73 <http://www.redcross.org.uk/shop/product.asp?id=59825>



Equality Strategy Awareness

Most respondents during the consultations were aware that their services had equality (single or otherwise) strategies but several acknowledged that there was a gap between strategy and implementation at the front-line. A number mentioned that equality and diversity training had recently become mandatory as a 'one-off' during induction of new staff. At least two respondents were aware of their PCT's implementation of equality impact assessments and /or health impact assessments of new policies and strategies.

Eligibility and Access

The rules underpinning entitlement to health care services are complex and not generally well understood. This is further complicated by considerable changes of policy and of NHS organisational structures. As a result there is an understandable inconsistency and discretionary application.

Most recent arrivals from overseas are entitled to free health services but entitlement is dependent on a number of factors, including:

- Reasons for being in UK such as to live, work, study, visit, holiday
- Length of time in (or away from) UK
- Country of origin such as from the European Economic Area or from a country with bilateral healthcare agreement
- Type of service being used



Secondary Care

The current charging and entitlements systems are the result of the NHS (Charges to Overseas Visitors) Regulations 1989⁷⁴ brought together with the amendments made in 2004⁷⁵.

In 2004, the Department of Health issued guidance on charging: Implementing the Overseas Visitors Hospital Charging Regulations: Guidance for NHS Trusts Hospitals in England⁷⁶. A brief version of the DH guidance on hospital treatment is outlined in Appendix 8.

Decision making on entitlement to free hospital treatment lies with the hospital providing treatment. Broadly speaking, hospital service charging is centred around whether a person is considered to be 'ordinarily resident'.

"Anyone who is deemed to be ordinarily resident in the UK is entitled to free NHS hospital treatment in England.

"Ordinarily resident" is a common law concept interpreted by the House of Lords in 1982 as someone who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled"⁷⁷

This is commonly understood as someone who has lawfully lived in the UK for at least a year before accessing the service. Anyone who is not "ordinarily resident" is considered an "overseas visitor" whatever their nationality. As such they are liable for charges, unless they fulfill certain criteria for exemption. Hospitals may ask for documentation to establish entitlements and individuals may choose what to supply.

74 http://www.opsi.gov.uk/si/si1989/Uksi_19890306_en_1.htm

75 <http://www.opsi.gov.uk/si/si2004/20040614.htm>

76 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080313

77 http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/Browsable/DH_074374



Exemption criteria include:

- Currently working for an employer whose principle business is in the UK
- Self employed with principle business in UK
- In full-time study of at least 6 months or substantially funded by UK
- (exemptions also apply to spouses, civil partners and children if living in the UK permanently)
- Asylum seekers (who have formally applied for asylum)
- Anyone granted 'discretionary leave to remain', 'humanitarian protection' or 'refugee status'

Additionally, in April 2008 a high court judge ruled that failed asylum seekers may be considered as 'ordinarily resident' and therefore not necessarily liable for charges⁷⁸.

The following treatments are free to all:

- Treatment given in an accident and emergency department (excludes emergency treatment given elsewhere in the hospital)
- Treatment given in a walk in centre providing similar services to those of an accident and emergency department of a hospital
- Treatment for certain communicable diseases (excluding HIV/AIDS where it is only the first diagnosis and connected counselling sessions that are charge free)
- Compulsory psychiatric treatment
- Family planning services⁷⁹



⁷⁸ http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_084479

⁷⁹ http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/Browsable/DH_074374



Primary Care

Increasing evidence demonstrates that access to primary care is fundamental to achieving individual and population health^{80,81}. Universally accessible primary care can reduce the need for hospital care, support the reduction of health inequalities⁸² and promote community cohesion.

When registering with a GP, the same criteria apply to refugees and asylum seekers as to anyone else⁸³. GPs have discretion as to whether undocumented persons, including refused (failed) asylum seekers are registered. A number of the stakeholders consulted for this overview report, suggest that various factors including this ambiguity has led to inconsistent implementation. As a result, some people who are entitled to register are denied the opportunity and others find it difficult. There is a desire for more clarity and support.

The Department of Health and Home Office are currently jointly reviewing the rules governing access to the NHS by foreign nationals. The review was announced in March 2007, is near completion and will be followed by a full public consultation. There are plans to ensure that future entitlement rules are communicated clearly to and understood by primary care services and GP practices⁸⁴.

Good Practice

How to use the NHS

The Black Health Agency have recently launched a short film clip on "How the NHS works" for refugees, asylum seekers and other recent arrivals from overseas. Filmed in English, but with voice-overs in French, Polish, Arabic, Somali, Urdu, Sylheti, Kurdish and Farsi/Dari, the film clip is available in DVD format and via the internet. It covers simple messages such as registering with a GP, keeping appointments, requesting interpreters and using NHS Direct for advice. The film was written by Dr Pip Fisher, a GP working with asylum seekers, and most of the acting and voice work was done by refugee health professionals giving their free time to help their own communities. It is hoped that more languages will be added in the future. For more information and to request copies of the DVD contact the Black Health Agency.

www.blackhealthagency.org.uk

Useful publications and websites

Health for Asylum Seekers and Refugees Portal
www.harpweb.org.uk

Multikulti www.multikulti.org.uk/en/health/

UK Border Agency www.bia.homeoffice.gov.uk

Farah, W. 'Health services: a new immigration injustice?'
In Flynn, D., Williams, Z. (eds) (2007) *Towards a progressive immigration policy*, London: Compass

Home Office (2007) *Enforcing the Rules; a strategy to ensure and enforce compliance with our immigration law*.

Introduction to the National Health Service (DH)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122587

80 Commission on Social Determinants of Health (2008) *Closing the gap in a generation. Health equity through action on the social determinants of health*. WHO
http://www.who.int/social_determinants/en

81 Smith R., for Mayor of London (2007) *Reducing health inequalities - issues for London and priorities for action*. GLA
<http://www.london.gov.uk/mayor/health/docs/finalissuesforlondon2007.pdf>

82 Johnson A. (2007) Speech in the House of Commons, by Rt. Hon Alan Johnson MP Secretary of State for Health, 12 September 2007: The Healthy Society.
http://www.dh.gov.uk/en/News/Speeches/DH_078397

83 <http://www.dh.gov.uk/en/Healthcare/International/AsylumseekersAndrefugees/index.htm>

84 See note of 20 Oct 2008 referring to the obsolete circular, HSC 1999/018 *Overseas visitors' eligibility to receive free primary care*
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004148



Communicable Disease

Key Points

- There is little evidence that the wider UK population is at risk of significant levels of transmission of disease from affected migrants, especially during normal social contact. Ethnic minority populations with close links to high prevalence countries may be at higher risk
- For certain infections, the major burden of disease falls upon particular groups of people who were not born in the UK
- Migrants may have a disproportionate burden of other infectious diseases but this does not mean that they have a very high prevalence of infectious diseases
- Migrants remain at increased risk of some diseases for a significant time after entry. This is probably a combination of: infection in country of origin, transmission within minority communities in the UK, ongoing travel to country of origin and socio-economic circumstances in the UK
- The health of migrants is affected by their country of origin (in particular the prevalence of disease), the circumstances of migration and their circumstances within the UK. All three need to be considered when local projections are made

This section looks at infectious diseases and migration, based on both surveillance and research. data to aid this task: many surveillance systems do not collect any information on migration status, and for those that do, the information is limited. For this reason, this section does not focus on new entrants but uses country of birth other than UK as a proxy for migrant. Key diseases were identified from work undertaken by the Health Protection Agency (HPA) nationally⁸⁵, based on the numbers affected, the seriousness of infection and the availability of data. These diseases were tuberculosis, HIV, hepatitis B, malaria and typhoid fever.

Tuberculosis

- In 2006 in the North West, there were 754 cases of tuberculosis (TB)
- Tuberculosis in UK has increased slightly in recent years, predominantly due to cases born outside UK
- The majority of cases (59%) of tuberculosis in the NW are in those born abroad. Those not born in the UK are younger and more likely to have non pulmonary disease
- Migrants have an increased relative risk of tuberculosis, although absolute risk remains relatively low. Being a migrant increases risk irrespective of ethnicity
- From surveillance and fingerprinting data, there is no evidence of transmission from the non UK born population to the white indigenous population
- The majority (82%) of new entrants to the UK who develop TB do so at least 2 years after arrival

85 Health Protection Agency (2006) *Migrant Health: Infectious diseases in non-UK born populations in England, Wales and Northern Ireland*



HIV

- In recent years, the number of non UK born individuals living with HIV in England, Wales and Northern Ireland has risen
- In the North West in 2006, there were 488 new diagnoses of HIV. Of those where country of infection known, 72% were infected abroad
- In 2004, around 70% of those diagnosed with HIV in the UK, for whom a country of birth was reported, were born outside the UK
- The majority of non UK born individuals diagnosed with HIV were black Africans from sub-Saharan Africa who acquired their infection through heterosexual contact in their country of origin in contrast to the UK born HIV positive population which is predominantly white men who have sex with men
- Of those seen for HIV care in the North West, 19% are not UK nationals. Non UK nationals seen for HIV care are more likely to be female and heterosexual than UK nationals seen for HIV care
- Nationally and in the North West, migrants are diagnosed late in the course of their infection, although this is not seen in asylum seekers
- Migrants from high prevalence countries have higher relative risks of HIV but their absolute risk remains low
- In the North West, use of specialist hospital services by HIV positive asylum seekers differs little from HIV positive persons who are not asylum seekers, but they do use voluntary sector services more

Hepatitis B

- Acute hepatitis B mainly occurs in young adults (aged 15-24) and is acquired through drug use and sexual exposure. Transmission within the UK gives rise to only a small proportion of all new chronic infections
- Chronic hepatitis B is predominantly in migrants from endemic countries
- Person to person transmission does occur within the UK in particular ethnic minority communities

Malaria

- Malaria predominately affects those who were not born in the UK, and particularly those visiting friends and family
- This highlights the fact that migration is not a single short term risk factor but a risk factor with an ongoing effect on disease patterns

Enteric Fever

- The majority of cases of enteric fever in the UK are in persons of Indian, Pakistani or Bangladeshi ethnicity, either UK or non UK born, who have travelled from the UK to their own or their family's country of origin to visit friends and relatives
- New entrants also bear a disproportionate burden of infection





Communicable disease: what action should be taken ?

PCT and NHS Trusts

Planning

- Consider the local migration patterns and associated burden of disease, including infectious diseases within Joint Strategic Needs Assessments
- Consider the needs of migrants within any specific plans or services for any of the diseases outlined above

Service Development and Delivery

- Ensure health services for infectious diseases reflect the needs of those most affected by these diseases, including primary and secondary care, and travel health advice
- Working with HPA, promote pre-travel advice, particularly regarding typhoid and malaria to those visiting friends and family in endemic countries
- Work with community organisations representing migrants groups to develop appropriate services, raise awareness of disease and address stigma
- Follow guidelines for prevention and treatment of infectious diseases for migrants as for any other group, though any particular needs they have should be taken into consideration
- Working with the HPA, develop health services that meet the needs of, and are accessible to, new entrants. This includes initial health screening (including for TB) and raising and maintaining the awareness of diseases such as TB and of how to access health services when necessary

Working with communities

- Work to inform the general UK population about infectious diseases in non-UK born people and their very low risk of being affected through normal social contact

HPA North West

- Maintain current surveillance systems that collect data on country of origin, including TB, HIV, and enteric fever
- Identify gaps in current surveillance systems relating to migration where this would influence public health action, and review current surveillance systems based on this
- Work with Primary Care Trusts to improve data on the coverage of hepatitis B immunisation given to HbsAg positive mothers, and promote uptake in this group

Useful publications and websites

Health Protection Agency www.hpa.org.uk

Health Protection Agency (2006) *Migrant Health: Infectious diseases in non-UK born populations in England, Wales and Northern Ireland, A baseline report - 2006*, London: Health Protection Agency Centre for Infections

Welfare, William (2008) *Migration and Infectious Diseases in the North West*, Greater Manchester Health Protection Unit accessible at www.nwph.net



Health and the NWRSMMP

The NWRSMMP has an advisory and development role in promoting a strategic and coordinated approach to migration via a number of sub-groups and working parties, including health, community safety, asylum seeker and refugee, children, information and data. These groups are undertaking thematic assessments, which inevitably overlap and interlink

The Health Interest Group has a multi-agency membership (see appendix 2) and aims to:

- Promote access to appropriate health and social care services for migrants
- Assess the impact of migration on health, well-being and service delivery
- Support the reduction of inequalities between migrant groups compared with the wider population
- Contribute to the development of coherent migration strategies

It proposes to support Public Health Networks, PCTs, NHS Trusts and the Regional Strategic Migration Partnership on the high impact changes and other issues:

- Establish a region-wide communication plan that promotes awareness of migration and the needs of recent arrivals from overseas
- Develop a region-wide programme to understand the needs of health and social care services in relation to information, data and good practice
- Contribute to a regional strategy that addresses the specific needs of asylum seekers and refugees
- Influence regional policy to meet the health and well-being needs of recent arrivals from overseas

Future work may include:

- Clarify the entitlements to health care for overseas visitors and raise awareness of the Primary Care Access Review Consultation
- Develop intelligence on the impact of migration on community based services such as GPs, Social Care, Mental Health, Ambulance Service, dentists, pharmacists, orthoptists and other allied health professionals
- Improve understanding of the health impact of growing populations of international students and their families and other recent arrivals from overseas joining relatives
- Recognise the impact of international in-migration and demographic change on health inequalities
- Identify the specific additional needs in areas of high deprivation with rapid and frequent people movement
- Research the vital perspective of recent arrivals themselves



Appendices

Appendix 1

Abbreviations

A (8)	Accession (countries joining EU)
A & E	Accident and Emergency
BIA	Border & Immigration Agency (now amalgamated into UKBA)
BME	Black and Minority Ethnic
CAB	Citizens Advice Bureau
CHD	Coronary Heart Disease
EEA	European Economic Area
EU	European Union
GP	General Practitioner
HIA	Health Impact Assessment
HIG	Health Interest Group (sub-group of RSMP)
HV	Health Visitor
JHU	Joint Health Unit
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAA	Local Area Agreement
LSP	Local Strategic Partnership
MSIO	Merseyside Social Inclusion Observatory
MRSN	Manchester Refugee Support Network
NAM	New Asylum Model
NASS	National Asylum Support Service
NI	National Indicator
NINo	National Insurance Number
NWDA	North West Development Agency
NWPHG	North West Public Health Group
PCT	Primary Care Trust
PSA	Public Service Agreement
RSMP	Regional Strategic Migration Partnership
UKBA	UK Border Agency
UNHCR	United Nations High Commission for Refugees
WRS	Workers Registration Scheme



Appendix 2

Health Interest Group

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Donna Hewitt - Refugee and Asylum Seekers Development Manager, Salford PCT

Alan Higgins (chair) - Director of Public Health, Oldham PCT

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Appendix 3

Contributors

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Appendix 4

Definitions and Glossary (for guidance only)

According to the 1951 Convention relating to the Status of Refugees, a **refugee** is a person who

“owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..”

However, In the UK, 'refugee status' is given to someone whose application for asylum has been successful and has been given permission to live in the UK - now limited to 5 years '**leave to remain**'.

An **asylum seeker** is someone who has fled to the UK, made themselves known to the authorities, applied for asylum and is waiting for results of that application from the Home Office (who decides whether or not that person qualifies for protection under the 1951 UN Convention on Refugees).

Elsewhere in the world and within many UK organisations, the term **refugee** implicitly incorporates **asylum seekers** and the terms are used synonymously

A **refused (failed) asylum seeker** is someone whose application to the Home Office for asylum has been rejected and also refused on appeal. They may also be described as '**unsupported**' or '**undocumented**' or '**end of process**' or '**former asylum seeker**'.

Migration describes groups of people moving, and may be used to refer to movement within countries as well as between countries. Sometimes specified, eg. '**international in-migration**' which describes the movement of people from overseas to the UK.

Migrant describes people moving residence (temporarily or longterm) within and between countries but is generally understood to mainly consist of people crossing country borders

A **short term migrant** has been described as staying at least 3 months but less than 12 months - for the purposes of study or work (but may be interpreted to include people taking extended holidays)

Long term migrant staying for a period of at least 12 months

An **immigrant** is someone who has chosen to settle in a country other than their country of origin and takes up permanent residence

An **emigrant** is someone who has been given permission to live permanently in a country other than their own

A **migrant worker** is a person engaged in a remunerative activity in a country of which (s)he is not a national. Similarly, an **economic migrant** is someone who has migrated to another country for the primary for the purpose of work.

'**Irregular**', '**undocumented**', '**unauthorised**', are terms used to describe people who have no recognised permission to enter and/or remain in the UK. The group includes - people who have 'overstayed' a visa, people who have entered the UK clandestinely (including those who have been 'trafficked'), people who have been exploited by employers or agencies, refused (failed) asylum seekers or asylum seekers who have not met the criteria for official recognition (ie made an application to the Home Office).

The term **illegal worker** is sometimes used and may refer to overseas visitors or foreign nationals or students who do not have the right to work in the UK. The term '**illegal**' in reference to asylum seekers is considered inappropriate; '**irregular**' or '**undocumented**' is the preferred terminology.

An **overseas visitor** is someone who is '**not ordinarily resident in the UK**' and can be of any nationality.

Health tourist - someone who comes to the UK for the sole purpose of accessing free NHS treatment.



Exceptional Leave to Remain has now been replaced by '**Humanitarian Protection**' and '**Discretionary Leave**'

Humanitarian Protection can be accorded to people who, if removed to country of return would face serious risk to life (may include refused (failed) asylum seekers). Usually for 3 years, after which further '**Leave to Remain**' may be applied for.

If someone is granted **Indefinite Leave to Remain** (also known as permanent residency), there are no limits to their stay in the UK. Recent changes now mean that asylum seekers who have been given refugee status are given a 5 year **Limited** (as opposed to indefinite) **Leave to Remain** which may be extended.

Discretionary Leave is granted for specific reasons such as in cases where it would be inappropriate or unlawful to return someone to their country of origin or for reasons of health or family ties or for Unaccompanied Asylum Seeker Children (UASC). Granted for up to 3 years or until a child reaches 17.5 years old.

For further explanations see the following websites:

Borders and Immigration Agency
www.ind.homeoffice.gov.uk

Department for Health www.dh.gov.uk

Refugee Action www.refugee-action.org.uk

UNHCR, The UN High Commission for Refugees
www.unhcr.org

MEDACT www.medact.org

Trade Unions Congress www.tuc.org.uk

Joint Council of the Welfare of Immigrants
www.jcwi.org.uk

Immigration Advisory Service www.iasuk.org

Health for Asylum Seekers and Refugees Portal
www.harpweb.org.uk



Appendix 5

Countries and their nationals' rights to movement and work in the UK

EU 15 Countries - Spain, Sweden, Greece, Portugal, Ireland, Austria, France, Germany, UK, The Netherlands, Italy, Luxembourg, Denmark, Belgium, Finland

EU15 nationals can enter other member states without a visa for a period of up to 6 months, therefore no entry requirements to UK required. Free movement rights. Full rights to work.

European Economic Area - European Union Countries, Norway, Iceland, Liechtenstein.

No entry requirements to UK required. Free movement rights. Full rights to work (except for nationals of Accession Countries - see below)

Accession 10 Countries (May 2004) - Malta, Cyprus, A8 Countries

No entry requirements to UK required. Free movement rights. Full rights to work (except for nationals of A8 Countries - see below)

Accession 8 Countries (May 2004) - Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia

No entry requirements to UK required. Free movement rights. Restricted access to work in EU countries during transitional period until 2011. Unlike other EU countries, the UK has not applied any limiting measures for A8 nationals to access work. May need to register with WRS

Accession 2 Countries (Jan 2007) - Romania, Bulgaria

No entry requirements to UK required. Free movement rights. Transitional measures regulating access to work. Require accession worker card unless exempt

Commonwealth Countries - 53 countries

Require visa to enter UK which may include conditions such as being able to maintain and accommodate themselves and dependents without recourse to public funds. May enter as worker (work permit required), or self-employed, student, working holidaymaker, retired person, as a spouse, civil partner or fiancé of someone entitled to reside in UK.



Appendix 6

Data Sources

Census - ONS

Provides detailed information but is out of date as last one conducted in 1999.

The Annual Population Survey (APS) and Labour Force Surveys - ONS

Provides numbers of UK and Foreign Nationals within Local Authority boundaries by gender, nationality and age, country of birth but probably underestimates, as some people are unwilling to respond and the response rate from minority groups is lower.

The International Passenger Survey (IPS)

Originally designed to provide data for tourism and business purposes, not to measure demographic change. Interviews more than 250,000 people a year arriving or departing from UK ports but measures 'movement' and is not representative of actual numbers; it is a small sample reliant upon voluntarily given information and is only undertaken at specific ports. It is not useful for identifying characteristics (that change) of people such as where they are planning to stay or live within the UK or nationality status.

Workers Registration Scheme (WRS) - UKBA

Provides information on numbers of migrant workers from the A8 countries only. Is available at Local Authority level but not in the public domain, with breakdown by nationality, gender, age and occupation. Has some limitations - workers may be double counted if registered with more than one employer. Registration is not needed after working legally for at least 12 months. It does not accommodate movement from place of registration and does not include dependents.

Accession Worker Cards - UKBA

Introduced only for Romanian and Bulgarian (A2) workers

Work Permits - DWP

Issued to employers who want to fill posts and are unable to find suitable workers within the EEA. Usually for 6 months. Requested by employer not employee. Not yet available for estimating numbers.

Residence Permits - DWP

Issued to people from EU countries excluding A10 citizens

National Insurance Numbers (NINo) - DWP

Allocated by Department for Work and Pensions (through Job Centre Plus) for overseas nationals. Required for employment purposes such as administration of tax and national insurance or to claim tax credits, benefits. Does not account for movement from Local Authority where NINo received. Does not include dependents. Does not include workers who choose not to apply.

Pupil Level Annual School Census (PLASC) - LEA

Provides information on movement in and out of schools within Local Education Authority areas - gender and first language spoken - but school age only

Higher Education Statistics Agency

Asylum Seeker - UKBA

Provides information on supported asylum seekers. Local authorities may have breakdown by gender, age, status, country of origin.

NHS

The central national patient database is under development

General Practitioners / Primary Care Trusts

Transfers between GPs/PCTs in different areas are used by ONS for population flow estimates. GP registrations of people whose previous address was abroad (Flag 4) may include place of birth, however these are not always completed, if a city is recorded (as opposed to country) it is not always recognised by the system. Not all recent arrivals from overseas register with GPs

None of these sources account for those people who are "undocumented".



Appendix 7

The Immigration and Asylum Systems

The immigration and asylum systems in the UK have undergone several significant changes within the last 10 years; the responsible Home Office body has changed its name from the Immigration and Nationality Directorate to the Border and immigration agency and since April 2007 to 2008 has become the UK Border Agency (UKBA). The latest strategy published in 2005 is part way through its 5 year term.

Immigration system

The previous 80+ routes into working and living in the UK are being streamlined. Rights to entry and entitlements when in UK are dependent on a number of factors including whether as a visitor, a student, a national of the EEA member states or joining family members with an intention to settle. Workers from outside the EEA and students will be channelled through one of 5 tiers of the new 'Points-based system' as highly skilled, skilled, low skilled, student or temporary worker. Criteria for entry through one of these tiers may change according to UK workforce need.

For details on immigration system see:

<http://www.ind.homeoffice.gov.uk/>

Asylum system

People who applied for asylum prior to April 2007 are channelled through the Case Resolution Directorate. Since that date, people seeking asylum have been channelled through the new model (NAM). After presenting themselves to the immigration authorities at a port of entry or one of the Asylum Screening Units (Croydon and Liverpool), they are interviewed and screened and formal asylum application commenced. In most cases, they are transferred to an 'initial accommodation centre' (in the NW, this is in Liverpool), where a preliminary health assessment is available. Asylum seekers (apart from a very small minority who may be detained) are later provided with 'dispersal accommodation' across the Northwest. An allocated case-owner follows through the various stages until a decision is made which the Home Office aims to be within 6 months.

People who fail in their claim for asylum cannot always be returned quickly to their country of origin. However, most will still qualify for HO support if they agree to return when this is possible, or if they are unable to travel due to some other reason such as ill health.

For more details on the asylum system see:

<http://www.ukba.homeoffice.gov.uk/asylum/>

For brief description on applying for asylum see:

http://languages.refugeecouncil.org.uk/pdf/English/Applying_for_asylum-English.pdf

For the Refugee Council's briefing on the New Asylum Model see: <http://www.refugeecouncil.org.uk/NR/rdonlyres/BAD3EAD5-5267-4038-9B16-E99362400DCD/0/Newasylummodel.pdf>

HM Government (2005) *Controlling our Borders: Making migration work for Britain. Five year strategy for asylum and immigration.*



Appendix 8

ARE YOU VISITING THE UNITED KINGDOM?

DID YOU KNOW THAT YOU MAY HAVE TO PAY FOR HOSPITAL TREATMENT WHILST HERE?

Hospital treatment is free to people who live lawfully in the United Kingdom (UK). If you do not normally live here and you do not meet one of the exemptions from charges then you will have to pay for treatment you might need. This is regardless of whether you are a British citizen or have lived or worked here in the past or have been issued with an HC2 certificate.

IF YOU ARE NOT COVERED BY ANY OF THE EXEMPTION CATEGORIES LISTED IN THIS LEAFLET IT IS ADVISABLE TO ENSURE YOU HAVE ADEQUATE HEALTH INSURANCE TO COVER THE DURATION OF YOUR STAY IN THE UK.

How do I know if I have to pay?

The law says that the hospital providing treatment must decide if each patient is entitled to free NHS hospital treatment. The hospital will ask you to provide evidence to confirm your eligibility. If the hospital decides that you can receive free NHS treatment you will still have to pay for statutory NHS charges such as prescription charges unless you are otherwise exempt. **If the hospital decides that you are not entitled to free NHS treatment, charges will apply and cannot be set aside. This will include the full cost of any prescribed medication even if you are in possession of an HC2 exemption certificate.**

What do I have to pay for?

You will have to pay the full cost of all the treatment you receive, including emergency treatment, given by staff at a hospital or by staff employed by a hospital. However, there are some services that are free of charge to everyone:

- Treatment given only in an Accident and Emergency (A&E) department or in a NHS Walk-in Centre providing services similar to those of an A&E department (excludes emergency treatment given elsewhere in the hospital)
- Treatment for certain infectious diseases (excluding HIV/AIDS where it is only the first diagnosis and connected counselling sessions that are free to everyone)
- Compulsory psychiatric treatment
- Family planning services

Who does not have to pay?

People Entitled to Full NHS Hospital Treatment free of charge -

- Anyone who is working in the UK for an employer who is based in the UK or is registered in the UK as a branch of an overseas employer (this includes self employed people). You must be actually working, not just looking for work
- Any unpaid worker with a voluntary organisation offering services similar to those of a Health Authority or Local Authority social services department



- Any full time student on a course of at least 6 months duration, or, if less than 6 months, a course substantially funded by the UK government
- Anyone who has come to live permanently in the UK. If you make an application for permanent residence after you get here you are chargeable until your application is approved
- Anyone who has been lawfully living in the UK for twelve months immediately prior to treatment
- Refugees and asylum seekers whose applications are still being considered
- Anyone employed on a ship or vessel registered in the UK or working offshore on the UK sector of the Continental Shelf
- Anyone who receives a UK war disablement pension or war widows pension
- Diplomatic staff working in embassies or Commonwealth High Commissions in the UK
- Members of Her Majesty's UK armed forces*
- UK Civil Servants working abroad who were recruited in the UK and employed by Her Majesty's Government*
- Anyone recruited in the UK who works abroad for the British Council or the Commonwealth War Graves Commission*
- Anyone who is working abroad in a job financed in part by the UK Government in agreement with the Government or a public body of some other country or territory*
- Anyone working abroad for not more than 5 years as long as they have lived legally in the UK for ten continuous years at some point (including self employed people)
- Anyone working in an EEA country member state and contributing compulsory (not voluntary) UK national insurance contributions (class I or II)
- Anyone who is a national of an EEA member state, a refugee or stateless person or their dependant or survivor living in an EEA member state who is referred to the UK for specified treatment with an EC form E112 or E123
- Anyone who is referred by their home country authorities for specified treatment in the UK under the terms of a bilateral agreement
- Anyone who is detained in prison or by the Immigration Authorities in the UK
- Serving NATO personnel, posted in the UK, who are not using their own or UK armed forces hospitals
- UK state pensioners who have lived lawfully in the UK for 10 continuous years at some point, who now live for not more than 6 months each year in another EEA member state and not less than 6 months each year in the UK
- Missionaries working overseas for an organisation principally based in the UK, regardless of whether they are receiving a wage or salary*
- The spouse or civil partner and any dependent children of anyone who is exempt under the above criteria, if they are living permanently with the exempt person. Coming to visit the exempt person for a few weeks or months does not give exemption

* These categories of exemption provide that the spouse/civil partner/dependent children are exempt from charge in their own right so that the principal exempt family member does not have to be in the UK with them at the time of their treatment.



People Entitled to Some NHS Hospital Treatment - *this is limited to treatment required for any condition that occurred after arrival in the UK (including pre-existing conditions which acutely exacerbate whilst here).*

- Anyone, including a refugee, stateless person or a member of the family of any of them, who normally lives in another EEA member state and is visiting the UK[#]
- Anyone, or the spouse, civil partner or child of anyone, receiving a UK state pension who has either lived legally in the UK for 10 continuous years at some point or has worked as a UK Civil Servant for at least 10 continuous years
- Anyone, or the spouse, civil partner or child of anyone, who is a national of a country that has signed the European Social Charter but is not entitled to be provided with services under a bilateral agreement (currently Turkey) and is genuinely without the means to pay for their treatment
- Anyone, or the spouse, civil partner or child of anyone, who has lived legally in the UK for 10 continuous years at some point but who is now living in another EEA member state or in certain countries with which the UK has a bilateral healthcare agreement
- Anyone who is entitled to receive industrial injury benefit from Israel if the treatment is in connection with the industrial injury
- Anyone living in a country with which the UK has a bilateral healthcare agreement (some bilateral healthcare agreements are limited to nationals of that country)

[#] Also includes treatment for chronic conditions, including routine monitoring.

Bilateral Healthcare Agreement Countries -

European Economic Area countries (EEA):

Austria, Belgium, Bulgaria, Cyprus (Southern), Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Republic of Ireland, Romania, Slovakia, Slovenia, Spain, Sweden, UK, plus Iceland, Liechtenstein and Norway. Switzerland by special arrangement.

Nationals of, and UK nationals in, the following countries:

Armenia, Azerbaijan, Bosnia, Croatia, Georgia, Gibraltar, Yugoslavia i.e. Serbia & Montenegro, Kazakhstan, Kirgizstan, Macedonia, Moldova, New Zealand, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Residents irrespective of nationality of the following countries:

Anguilla, Australia, Barbados, British Virgin Islands, Channel Islands, Falkland Islands, Iceland, Isle of Man, Montserrat, St. Helena, Turks and Caicos Islands.

This leaflet is a general guide and not a full statement of the current regulations. Please ask at the hospital providing treatment for further information or see the Department of Health website at: www.dh.gov.uk/overseasvisitors



Appendix 11

Policies, reports and acts of parliament that directly relate to migration and impact on the health of recent arrivals from overseas.

Migration

The Immigration, Asylum and Nationality Act 2006

UK Borders Act 2007.

Controlling our borders: Making migration work for Britain. Five year strategy for asylum and immigration. (2005) HM Government

Health

NHS (Charges to Overseas Visitors) Regulations 1989 and The NHS (Charges to Overseas Visitors) Charging (amendment) Regulations 2004

Human Rights Act 1998

Our Shared Future (2007) Commission on Integration and Cohesion www.integrationandcohesion.org.uk

Commissioning framework for health and well-being (2007) Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England (2005) Department of Health
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4106477

The NHS in England: The operating framework for 2008/9 (2007) Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

Our NHS Our Future: NHS Next Stage Review - Leading Local Change (2008) Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084644

Tackling Health Inequalities: A Programme for Action (2003) Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

Relevant Public Service Agreements

- PSA 3: Ensure controlled, fair migration that protects the public and contributes to economic growth.
- PSA 9: Halve the number of children in poverty by 2010-11, on the way to eradicating child poverty by 2020
NI 116: Proportion of children in poverty
- PSA 12: Improve the health and well-being of children and young people
- PSA 15: Address the disadvantages that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief
NI 140: Fair treatment by local services
- PSA 18: Promote better health and well-being for all
- PSA 19: Ensure better care for all
- PSA 21: Build more cohesive, empowered and active communities
NI 1: % of people who believe people from different backgrounds get on well together in their local area
NI 2: % of people who feel that they belong to their neighbourhood
NI 4: % of people who feel they can influence decisions in their locality



Appendix 12

Equality Impact Assessment for Health and Migration in the NW of England: an overview. August 2008

An initial discussion on the potential impact on equality of the report was held with members of the Health Interest Group. It was agreed that there would be a likely impact within some of the realms. Adaptations to the report were made. The draft statement was circulated amongst other stakeholders for comments which were amalgamated into the interim assessment for inclusion in the published report.

Summary of the purpose and aim of the report

In order to further clarify the regional picture of migration and health, the report was commissioned by the Northwest Public Health Group, funded by the Department of Health (Asylum Co-ordination Team), written by the Regional Health and Migration Co-ordinator seconded for the purpose, and steered by a multi-agency sub-group of the NW Regional Strategic Migration Partnership. The aims of the report are to have:

- An overview of health and well-being issues and needs of recent arrivals from overseas
- A clearer picture of the current service provision to address those health and well-being needs
- An understanding of the impact of migration on health and social care provision
- An initial exploration of the impact of migration on the health and well-being of people living within the region.

The report will set the agenda for future work of the Health Interest Group, with the intention of raising awareness of key issues, fostering a regional sharing of good practice and making recommendations to NHS bodies, Local Authorities and other relevant organisations within the region.

Assessment

Race

The report is thought likely to impact differently on people on grounds of their race and the differential impact is likely to be positive and medium. Ethnic origin influences health inequalities which arise from differences in physiology, access to services, diet and lifestyle as well as social experiences of housing, income level and employment⁸⁶. One aspect of the report focuses on particular health issues for people from different countries. Although not synonymous, in this context, 'country of origin' is likely to have considerable cross-over with ethnicity/race. The report aims to increase awareness of potential differences, propose needs assessments that take into consideration those differences and stimulate consideration of targeted or reconfigured services to ensure equity of health outcome.

The report is thought likely to help eliminate unjustifiable discrimination. By highlighting current inequalities and by raising awareness of particular issues (that are likely to be related to ethnicity) such as the impact of wider determinants, access to services; by providing suggestions on equitable assessment (ie. including all marginalised groups, irrespective of ethnicity) the report will support the elimination of unjustifiable discrimination.

The report is thought likely to help to eliminate harassment. One of the contributory factors of harassment and racial tension is a perceived inequity of service provision⁸⁷. The report advocates cultural competency training and equality diversity strategies that will stimulate further understanding amongst staff and support them in presenting balanced information and in myth-busting.

The report is thought likely to promote good relations between people of different groups. Language barriers can be contributory factors in disharmony between people of different groups⁸⁸. By acknowledging differences, by advocating the essential role of interpreters and the importance of cultural competency/ equality and diversity training, the report encourages the steps toward good relations between people of different groups.

86 Department of Health (2008) *Equality Impact Assessment - Health Inequalities: Progress and Next Steps*. London: DH

87 Hudson M., Phillips J., Ray K., Barnes H. (2007) *Social cohesion in diverse communities*. York: Joseph Rowntree Foundation

88 Department for Communities and Local Government (2007) *'What works' in community cohesion*. London: DCLG



Disability

The report may impact differently on people on grounds of their disability. The differential impact is likely to be positive and low. The current status of data collation does not facilitate the estimated proportion of recent arrivals from overseas who have disabilities. It seems likely that migrant workers and international students who are generally young and in employment do not incorporate a high percentage. Asylum seekers and refugees are at increased risk of poor physical and mental health⁸⁹ of which a proportion will have disabilities. Preventative care and support can mitigate against the risks of poor mental health⁹⁰.

The report highlights the importance of prevention and also advocates for local needs assessments with a focus on marginalised groups (as recommended in JSNA guidance⁹¹) of which some people with disabilities will be part. It is not clear if or how the wider determinants and services that are used by people with disabilities may be influenced by the changing local demography eg. by increasing or decreasing the accessibility or resource availability.

Gender

The report is thought likely to impact differently on people on grounds of their gender. The differential impact is thought likely to be positive and low. It is acknowledged that health risks, needs and contributions of women and men may be different. Some people seek asylum on the grounds of gender-related issues; some face increased vulnerability within their own and new community. The report highlights some specific gender-related issues such as domestic violence and female genital mutilation. It recommends pro-active inclusion of marginalised groups in local needs assessment and the consideration of incorporating recent arrivals from overseas in equality impact assessments of new projects and services.

Age

We are unable to judge whether the report is likely to impact differently on people on grounds of their age. The specific needs of children who have arrived recently from overseas are being addressed by another sub-group of the RSMP. The majority of migrant workers, asylum seekers and refugees are between the ages of 20 - 45 years⁹². There are known to be specific vulnerabilities for elderly migrants⁹³ and this has been noted in the report for attention.

Sexual orientation (lesbian, gay, bisexual, transgender)

We are unable to judge whether the report is likely to impact differently on people on grounds of their sexual orientation. It is known that some people seek asylum from being persecuted as a result of their sexual orientation and it is likely that some face increased vulnerability within their own and/or new community⁹⁴. The numbers are not known. It is also likely that LGBT from some ethnic minority groups are at increased risk of marginalisation. The report highlights the need for local needs assessment to include a focus on marginalised groups of which lesbian, gay, bisexual, transgender people may be part.

*It is unclear if the report will help eliminate unjustifiable discrimination, harassment and promote good relations between people of different groups in terms of **age, disability, gender, religion or belief, sexual orientation or transgender**.* The report is a broad regional overview with recommendations; specific local needs assessment and activities are beyond its remit. However, by highlighting the value of cultural competency training (that raise awareness and understanding of differences between people groups) good relations may be promoted and the reduction of discrimination and harassment supported.

89 Faculty of Public Health (2008) *The health needs of asylum seekers. Briefing statement.* London; FPH

90 Burnett A, Fassil Y. (n.d.) *Meeting the health needs of refugee and asylum seekers in the UK.* London: Directorate of Health and Social Care

91 Bindra R. (2007) *Guidance on Joint Strategic Needs Assessment.* London: Department of Health

92 NWDA (2008) *Demography, Migration and Diversity in the Northwest.* Experian / NWDA

93 Goddard M. (2008) *Quality In and Equality of Access to health care services. Country Report for England.* York: European Commission

94 Rocca S. (2008) [online] *Asylum on the grounds of sexual orientation and gender identity.* UK Lesbian and Gay Immigration Group, Stonewall. http://www.stonewall.org.uk/information_bank/immigration_and_asylum/2216.asp [accessed 04 Aug 2008]



Religion or Belief

The report is thought likely to impact differently on people on grounds of their religion or belief. The differential impact is thought likely to be positive and low. Belief systems influence lifestyle, perceptions of health, type of provision and access to health services. General health inequality issues may be more strongly related to ethnicity⁹⁵ than religion or belief. Through advocacy of cultural competency training (that will include belief systems), the report may contribute to increased awareness of differences and thus, that services may need reconfiguring to ensure equity of health outcome.

Action plan

It will not be possible to measure the likely impact on equality issues directly attributable to this report. There are many other factors and policy at play. However it may be possible to obtain an informed perception of influence.

As part of the report evaluation (which will include a sample survey of report recipients to determine degree of perceived influence) questions relating to equality impact - specifically ethnicity, age, disability, gender, religion or belief, sexual orientation or transgender - will be incorporated. This will be undertaken by the Regional Coordinator for Health and Migration between one and two months following dissemination.

⁹⁵ Department of Health (2008) *Equality Impact Assessment - Health Inequalities: Progress and Next Steps*. London. DH



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