MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report United Kingdom

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This report was produced within the framework of the IOM’s EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GIRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

‘Equity’ between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country’s ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1–4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

<table>
<thead>
<tr>
<th>Section</th>
<th>Key indicators</th>
<th>Text</th>
</tr>
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</table>

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three ‘neighbour’ countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

¹ For the definition of these indicators please see p. 21 of the WHO document General statistical procedures at http://bit.ly/20Kd8JS
1. COUNTRY DATA

<table>
<thead>
<tr>
<th>KEY INDICATORS</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2014)</td>
<td>64,351,155</td>
</tr>
<tr>
<td>GDP per capita (2014) [EU mean = 100]</td>
<td>108</td>
</tr>
<tr>
<td>Accession to the European Union</td>
<td>1973</td>
</tr>
</tbody>
</table>

**Geography:** The United Kingdom consists of islands (including the northern one-sixth of Ireland), and its 243,610km² territory is located in Western Europe, between the North Atlantic Ocean and the North Sea, northwest of France. The terrain consists mostly of rugged hills, low mountains, and rolling plains. It is the third most populous country in the EU, with a population density of 255,6/km², while 82,6% of the population lives in urban areas. The biggest cities are the capital London (10,3 million), followed by Manchester (2,6 million), Birmingham (2,5 million), and Glasgow (1,2 million).

**Historical background:** In the 19th century the British Empire stretched over a quarter of the earth's surface. The first half of the 20th century saw the UK’s strength seriously reduced by two world wars, as well as the Irish Republic's withdrawal from the union. The second half of the century witnessed the dismantling of the Empire and the UK rebuilding itself into a modern European nation.

**Government:** The UK is a constitutional monarchy and Commonwealth realm, divided in 27 two-tier counties, 32 London boroughs and the City of London, 36 metropolitan districts, 56 unitary authorities (including four single-tier counties). The Scottish Parliament, the National Assembly for Wales, and the Northern Ireland Assembly were established in 1999. The UK joined the EU in 1973. In a referendum held on 23rd June 2016, UK citizens voted by 52% to 48% to leave the European Union (turnout: 72% of the 46,5 million electorate).

**Economy:** Banking, insurance, and business services are key drivers of British GDP growth. Manufacturing has declined in importance but still accounts for about 10% of economic output. The 2008 global financial crisis hit the economy particularly hard and the recovery has been sluggish; GDP in real terms did not return to its pre-crisis level until the middle of 2013, while the annual rate of growth in 2013 – 2016 was 1,9%, 3,1%, 2,2% and 2,0%. Unemployment fell from 8,5% in 2011 to 4,9% in 2016.

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3 [http://ec.europa.eu/info/sites/info/files/ecfin_forecast_winter_1317_uk_en_0.pdf](http://ec.europa.eu/info/sites/info/files/ecfin_forecast_winter_1317_uk_en_0.pdf)
2. MIGRATION BACKGROUND

<table>
<thead>
<tr>
<th>KEY INDICATORS (2014)</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign-born population as percentage of total population</td>
<td>12,5</td>
</tr>
<tr>
<td>Percentage non-EU/EFTA migrants among foreign-born population</td>
<td>65</td>
</tr>
<tr>
<td>Foreigners as percentage of total population</td>
<td>7,8</td>
</tr>
<tr>
<td>Non-EU/EFTA citizens as percentage of non-national population</td>
<td>47</td>
</tr>
<tr>
<td>Inhabitants per asylum applicant (more = lower ranking)</td>
<td>2.014</td>
</tr>
<tr>
<td>Percentage of positive asylum decisions at first instance</td>
<td>47</td>
</tr>
<tr>
<td>Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)</td>
<td>42</td>
</tr>
<tr>
<td>Average MIPEX score for other strands (MIPEX, 2015)</td>
<td>56</td>
</tr>
</tbody>
</table>

Britain has always been a country of immigration. An eighteenth-century poet once described the origins of “that vain ill-natured thing, an Englishman” (Defoe 1701) as derived from an “amphibious mob”, starting with the Romans (AD 43) and including Scandinavian, French, and other European influences before contemporary (post-1945) immigration from the former British Empire (now Commonwealth) and more recent refugee settlements. At the same time, since the dawn of the 20th century there has been concern about and opposition to the use of welfare services by migrants – since the origins of the ‘Aliens Act’ in 1905 (aimed at Russian Jewish refugees) which prohibited them from relying on ‘the parish’ (i.e. the forerunner of the present welfare state). Historians report serial moral panics and rumours about such use or abuse, as well as concerns about public health (Bivins 2007).

At the same time, the legitimacy of the claims of British subjects (now citizens) to access the post-war NHS has never been in question, and the national opposition to holding identity documents has meant that enforcement of special requirements to prove entitlement has militated against separate provision or exclusion of migrants. The development of ‘culturally competent’ or specific services to address the health inequalities associated with UK citizens of black or minority ethnicity (BME – formerly ‘New Commonwealth’) origins has also meant that many services are better prepared to meet the specific cultural needs of diverse migrants, if not invariably their language support needs. However, the target group for these policies is defined in terms of ethnicity, not migrant status (Johnson 2012a).

Britain’s ties to former colonies account for much of post-war immigration. Commonwealth citizens were guaranteed the right to reside in the UK until increasingly restrictive laws were passed in 1962, 1968 and 1971. In the post-war boom of the 1950s and 1960s, many other migrants came as ‘guest workers’ from Southern and Eastern Europe, some of whom stayed; there is also a long tradition of migration from Ireland. There has also been substantial emigration from Britain, and it was not until the mid-1980s that it became a country of net immigration (Sommerville et al. 2009). However, the oil crisis of 1973 and the resulting economic stagnation, as well a strong undercurrent of resentment against
newcomers, kept immigration down to moderate levels in the 1980s and 1990s. After the oil crisis the main types of migration from non-Western countries became family reunion (especially from former colonies) and seeking asylum. In the 1990s, due in particular to the breakup of Yugoslavia, the dramatically increasing numbers of asylum seekers led to more restrictive criteria for acceptance – a pattern seen in many other European countries.

From 1979 to 1997 Conservative governments were in power. This party has always harboured a faction opposed to immigration: perhaps the best-known representative of this was Enoch Powell, sacked from the Shadow Cabinet the day after he gave a speech in 1968 prophesying ‘rivers of blood’ if immigration from the Commonwealth was not drastically reduced. British discussions about migration have been dominated by the concept of ‘race’. In most other European countries this notion is sternly disapproved of because of its association with the Nazis, but in Britain the key legislation combating discrimination was called the ‘Race Relations Act’ (passed in 1965 and amended in 1968, 1976 and 2000).

The landslide election victory of Tony Blair’s ‘New Labour’ in 1997 ushered in a period during which the government wholeheartedly encouraged immigration and promoted multiculturalist policies. The 2000 Race Relations (Amendment) Act resembled the EU’s 2000 Race Equality Directive against discrimination: both measures made equal access to opportunities and services mandatory, while forbidding both ‘indirect’ and ‘direct’ discrimination. The 2006 Equality Act transposed all the relevant EU Directives into one integrated framework, which in the 2010 revision covered the ‘protected characteristics’ age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, as well as pregnancy and maternity.

However, since the end of the 1990s a backlash against multiculturalism has been gaining strength – in Britain as elsewhere. The government responded by introducing tighter controls on immigration and placing more emphasis on integration, but the basic reason why the migrants kept on coming was economic – the UK’s vigorous growth up to the economic crisis of 2008. Immigration was also encouraged by enlargements of the EU in 2004 and 2007. Figure 1 shows how migration from the countries now comprising the EU28, together with that from non-EU28 countries, have combined to lift the percentage of migrant stock from 8.1% in 2000 to 13.2% in 2015 (data from UN DESA, 2015).

Following the 2008 crisis unemployment rose sharply, reaching a peak of 8.5% in 2011. Increasing public hostility to migrants was one of the factors leading both to the defeat of the ‘New Labour’ government in 2010 and the narrow vote in favour of leaving the EU in the ‘Brexit’ referendum of June 2016. The latter vote was widely interpreted as mainly a demand for less immigration, even though (as Fig. 1 shows) most immigrants to the UK do not in fact come from the EU. Since 2000, immigration from outside the EU28 has been twice as high as that from inside: in other words, two-thirds of UK migration was not affected by EU membership, and will not necessarily decline when the UK leaves the EU (unless there is a new economic crisis). There continues to be confusion in both debates and policy discussions between the impact of stocks of existing residents of migrant origin and flows. The steepest increase in total migration was between 2000 to 2010, under New Labour, but the rate of increase after the crisis and the change in government was only slightly lower than before. It is extremely difficult to predict future economic and migration trends at the moment, because nothing is known about the terms under which Britain will leave the EU.

Figure 1. Migrant stock in the UK as a percentage of total population, 1990-2015

The next diagram (Fig. 2) shows the countries of birth of the 11 largest migrant groups in the UK in 2015, using data from UN DESA (2015). The great variety of countries of origin can be seen from the proportion of migrants (‘others’) not belonging to the largest groups: over half (52%). Altogether, 161 countries are represented in the UK by more than 1000 migrants. In London over 250 languages are spoken, making the capital the most linguistically diverse city in the world (Baker and Eversley 2000).

Figure 2. Origins of migrant population – United Kingdom
3. HEALTH SYSTEM

**KEY INDICATORS (2013)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure per person (adjusted for purchasing power, in euros)</td>
<td>2.384</td>
<td>⬤⬤⬤◯◯</td>
</tr>
<tr>
<td>Health expenditure as percentage of GDP</td>
<td>9.3</td>
<td>⬤⬤⬤◯◯</td>
</tr>
<tr>
<td>Percentage of health financing from government</td>
<td></td>
<td>NHS</td>
</tr>
<tr>
<td>National health system (NHS) / social health insurance (SHI)</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)</td>
<td>10</td>
<td>⬤⬤⬤⬤⬤</td>
</tr>
<tr>
<td>Score on Euro Health Consumer Index (ECHI, 2014)</td>
<td>718</td>
<td>⬤⬤⬤⬤◯</td>
</tr>
<tr>
<td>Overall score on MIPEX Health strand (2015)</td>
<td>64</td>
<td>⬤⬤⬤⬤⬤</td>
</tr>
</tbody>
</table>

The British National Health Service (NHS) was created in 1948 as a universal UK-wide service covering all aspects of health care and social support, funded out of central government taxation and a specific tax levied on those in employment (with match-funding from employers) known as National Insurance.

The founding principle of the NHS was that all services should be ‘free at the point of use’, and that barriers to uptake should be minimised in order to reduce health inequalities and provide a healthy workforce free from the fear of debt incurred through seeking treatment. In the absence of any form of national identity registration, users (i.e. all legal residents) were issued a ‘National Health Service number,’ and these continue to be issued at birth: those in work are issued such a number when they commence work for the first time, and retain this throughout their life, although these, while sometimes used interchangeably, are not technically required for access to health care. Hospitals still issue their own ‘user numbers’ to patients on admission and use these to track individual records. As noted, the British have a long-standing antipathy to Identity Cards (Johnson 2012a), and this has prevented, so far, the introduction of closer forms of regulation and entitlement checking – although this has now been embedded in new legislation not as yet successfully implemented.

It is important to note that while the NHS was created as a national system, there has been a degree of devolution of government of the four constituent parts of the United Kingdom, and consequently, conditions have now diverged slightly between the four nations (England, Scotland, Wales, and Northern Ireland). Immigration is a national issue common to the whole United Kingdom, but the three ‘mainland’ states (England, Scotland, and Wales, also known collectively as Great Britain) differ from Northern Ireland in that there is, historically, a strong identification as ‘Irish,’ and some largely unmoderated migration between the south (Ireland or Eire) and the northern quarter of that island. There has also been a continuity of administration of Health and Social Care (‘welfare’) by local health boards in Northern Ireland, rather than the reorganisations which have characterised the administration of health in Great Britain. Welsh health policy is now largely under the administrative control of the Welsh Assembly, which has maintained cost-free access to certain services, while in Scotland the Scottish parliament has developed and to a large extent followed a more distinctive policy from the English
pattern, and has not introduced many of the so-called ‘reforms’ prevalent south of the border. This report has been scrutinised by experts from the academic, voluntary (migrant-oriented), and health sectors in each of these administrative regions, and where they have identified locally significant differences in the situation of migrants relative to national citizens, or different and/or additional services for people of minority ethnic origin, these are reported on.

NHS funding has always been a political bone of contention, since almost all of it (83% in 2013) comes from the public purse. After decades of underfunding, New Labour more than doubled spending on the NHS between 1997 and 2010, leading to many improvements though not to any increase in productivity. The usual criticism of NHS (‘Beveridge’) systems is that they are excessively ‘top-down’ and rigid: without competition there are too few incentives to improve quality and efficiency, because the State owns all the service providers as well as paying for them. However, this does not have to be the case, as the recent history of the NHS shows. A ‘purchaser-provider’ split, first introduced in 1992 and greatly extended by the Health and Social Care Act of 2012 (Cylus et al. 2015), allows service providers – whether State-owned or privately-owned – to tender competitively for services. Except in Scotland and Wales, this so-called ‘internal market’ involves an intermediary body (NHS England for clinical services, Public Health England for public health provisions) that commissions services through an intermediary (a Clinical Commissioning Group or Local Authority).

The downside of this arrangement – a familiar feature of ‘Bismarckian’, i.e. social health insurance (SHI) funded systems, and one which is regarded by their proponents as a virtue – is that it may impede ‘top-down’ control of services. The MIPEX Summary Report (IOM 2016:78) showed that countries with a tax-based system tend to be significantly more active in implementing policies to achieve change. In the early days of the New Labour government in a raft of policies was implemented to raise the standard of health services for ‘BME groups’ (Ingleby 2006; Williams & Johnson 2010). Decades before that, ‘culturally competent care’ was already a well-established priority in the UK, and many initiatives, often led by professionals with a BME background, were introduced on an ad hoc basis. Like other former colonial powers, the UK also has a strong tradition of medical anthropology, which provided theoretical underpinning for these initiatives. But the devolution of powers to local commissioners in the UK has eroded the ability of the NHS to impose standards for service delivery to migrants and minorities. Indeed, the traditional distinction between ‘Beveridge’ and ‘Bismarck’ systems is no longer as clear-cut as it was (Kutzin 2011). In principle, the combination of local commissioning with firm implementation of the Equality Act should result in the best of both worlds: but as we shall see, this has not happened.

Since 2010, little effort has been made at national level to maintain the high level of responsiveness to diversity that has been built up over the last 30-40 years, although the Scottish Health Service continues to emphasize the health of minority ethnic groups (Lorant & Bhopal 2011). Financial cutbacks have been the order of the day, while few politicians are willing to risk showing too much enthusiasm about Britain’s remarkable diversity. Nevertheless, as will be seen in Sections 7 and 8, the levels of responsiveness and measures to achieve change in the UK are still the highest in all countries studied. In strong contrast to this are the increasing efforts described in Section 5 to exclude non-EU/EFTA migrants from free health care coverage, and the neglect of policies to help migrants find their way to care (Section 6).

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4. USE OF DETENTION

The UK immigration detention system is one of the largest in Europe. In 2015 alone, approximately 32,400 migrants — including children — entered detention. These numbers do not include persons detained in police cells, prison service establishments, and short-term holding rooms at ports and airports.

The 1971 Immigration Act first introduced administrative detention in the UK. Under article 16 of the Act, a person “may be detained under the authority of an immigration officer pending his examination and pending a decision to give or refuse him to leave to enter” or “pending his removal” in case of denial of the right to enter the territory of the UK.

The most recent law dealing with detention is the 2016 Immigration Act, which

1) restricts access to services for undocumented migrants;
2) restricts support services for migrants whose asylum application has been rejected only to those who are “poor and face a genuine problem in leaving the UK”;
3) proposes some reforms in response to criticism of the UK detention system. The 2016 Immigration Act and ‘detention service orders’ foresee the provision of automatic bail hearings after four months in detention, as well as the limitation of detention of pregnant women to 72 hours.

The Immigration Act defines immigration detention as an administrative measure which should therefore not be punitive. In addition, according to the UK Visas and Immigration Enforcement Instructions and Guidance, “Detention must be used sparingly and for the shortest period necessary.”

Nevertheless, the UK opted out of the EU Returns Directive, which set the maximum length of immigration detention at 18 months, and the country is the only EU Member State not to have imposed limits on the length of time a person can spend in immigration detention.

In the UK system, the Home Office is the authority responsible for legal custody over immigration detainees, although operations at detention centres are delegated to various governmental and private entities.

Detention facilities

There are various immigration detention facilities spread throughout the country. Indeed, in the last few years, the country’s immigration detention capacity has grown considerably, reaching approximately 4,300 places in 2015. According to the Global Detention Project (GDP), four main types of detention

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6 Migration Observatory, Immigration Detention in the UK, 2016.
7 1971 Immigration Act, Article 16.
9 UK Visas and Immigration, Enforcement Instructions and Guidance, Chapter 55, 2013.
infrastructure can be identified in the UK: Immigration Removal Centres (IRCs); Short-Term Holding Facilities (STHFs); prisons and police stations; and ‘pre-departure’ facilities for families.

- **Immigration Removal Centres (IRCs)** are used as long-term detention facilities. Nine facilities of this type were operational on UK territory as of October 2016. Seven IRCs are managed by private contractors and two by the National Offender Management Service (NOMS).

- **Short-Term Holding Facilities (STHFs)** are used to detain people for up to seven days. Many of them are located in or near airports or other points of transit. Residential STHFs are used to house people for up to five days, with the possibility of extension up to seven days. Non-residential STHFs are located or associated with airports.

- **Prisons and police stations** are also used as immigration detention facilities, where non-citizens who have completed criminal sentences can be detained for up to seven days pending deportation. According to an agreement between the National Offender Management Service and the Home Office, there are around 400 prison beds that can be used for immigration detainees, although other estimates put the real number of individuals detained at up to 600.

- **Accommodation for children and families** was created through legislative changes in 2010 which were meant to end the use of IRCs to house families. Different types of alternative solutions have been explored: ‘open accommodation’, semi-secure ‘pre-departure accommodation’, as well as pilot projects using existing accommodation schemes currently housing asylum seekers.

In addition to these facilities, one could add short-term facilities used for less than 48 hours and thus not included in the GDP data, like the Dover dock, which is in fact “one of the busiest immigration custodial sites in the UK.”

**Conditions of detention**

Various observers have criticized the conditions of immigration detention in the UK. A lot of criticism focuses on the **prison-like nature of immigration detention facilities**. Furthermore, the **lack of time limit for immigration detention** has an extremely negative impact on the mental health of detainees.\(^\text{12}\)

It has been observed that people placed in UK immigration-related detention often suffer **serious mental health deterioration**, including post-traumatic stress disorder and depression.\(^\text{13}\) According to the ‘Shaw Review’ – an independent review on people in detention commissioned by the Home Office – two points can be highlighted in this regard:


\(^{13}\) Medical Justice, Mental Health in Immigration Detention Action Group, Initial Report, 2013.
1) immigration detention has a negative impact upon detainees’ mental health;
2) the longer the detention continues, the more negative impact it has on the mental health of detainees.\textsuperscript{14}

Self-harm and suicide are common issues among people detained in UK detention facilities. The Bail for Immigration Detainees campaign group estimated 393 suicides in detention centres and 2,957 detainees on suicide watch in 2015.\textsuperscript{15}

In addition, many critics argue that the UK immigration detention system does not provide sufficient protection to vulnerable groups. For instance, elderly people, individuals with disabilities, serious medical conditions or mental illnesses are too frequently detained in detention centres which are not equipped to accommodate these groups. Children’s health is also at risk in detention, and children often show severe and lasting psychological and physical trauma after being detained.\textsuperscript{16}

Rule 35, which is part of the UK Detention Rules, is meant to protect detainees injuriously affected by detention, survivors of torture and detainees with suicidal intentions. According to this rule, medical practitioners are obliged to inform the Home Office when these types of situations are detected. In this case, the Home Office is obliged to review the individual’s detention and, if appropriate, release the detainee. However, according to Medical Justice, “forms are often not initiated when they would be appropriate, and then the majority appear to be ignored by the Home Office anyway.”\textsuperscript{17}

\textsuperscript{14} Stephen Shaw, \textit{op. cit.}
\textsuperscript{16} All Party Parliamentary Group on Refugees, \textit{op. cit.}
\textsuperscript{17} Medical Justice, \textit{Mental Health in Immigration Detention Action Group: Initial Report 2013}. 
5. ENTITLEMENT TO HEALTH SERVICES

Score 39  Ranking ⚫⚫⚫⚫\

A. Legal migrants

Inclusion in health system and services covered

Before the introduction of the Immigration Act (2014), NHS care was free at the point of supply for all who were ‘ordinarily resident’ in the UK. Migrants who did not have this status had to pay for hospital treatment, but could obtain free primary care and emergency care (with some additional exemptions). The Immigration Act has been implemented in phases and has drastically reduced the entitlements of migrants to free (hospital) care.

Migrants from EU/EFTA countries with a European Health Insurance Card (EHIC) are always entitled to free NHS treatment, the costs of which are recovered from their home country. For Third Country Nationals (TCNs), however, the criteria for ‘ordinary residence’ have been made stricter. Whereas previously only TCNs on a temporary visitor visa were excluded from claiming ‘ordinarily resident’ status, cases are now assessed individually on the basis of a long list of criteria, beginning with:

……living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as ‘settled’.

TCNs are also required to be current residents with indefinite leave to remain in order to qualify for free NHS treatment on the basis of ordinary residence. On average, it takes five years to achieve this status. NHS bodies are obliged to assess the legal status of patients. If they do not meet the criteria for ‘ordinary residence’, or if they are a TCN without indefinite leave to remain, they are classified as an ‘overseas visitor’ and must be charged for care.

The Immigration Act also introduced another change in migrants’ entitlements, which was not implemented until April 2015. TCNs coming to the UK for longer than six months now have to pay a ‘health surcharge’ when they submit their immigration application. This must also be paid by TCNs already in the UK who apply to extend their stay. Once the surcharge has been paid, they are entitled to free health services as if they otherwise satisfied the ‘ordinarily resident’ criterion. The amount of the surcharge “has been set at £200 per person per year and £150 per year for students, payable upfront at the point of applying for immigration permission, and for the total period of time for which migrants and their dependants are seeking permission to stay in the UK.”

The government has announced a consultation on future plans to introduce charges for GP services, accident and emergency care, as well as ambulance services, which are currently free.

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As a general rule, the Immigration Act relates to all four nations equally, and there are few differences in entitlement between them, although Scottish policy remains more liberal in respect of practice, provision, and central support for specialist provision (and in still encouraging immigration). In all areas, local autonomy operates to some extent, and areas of greater migration tend to have more facilities available, due to the relative strength of community-based NGOs and also political pressure from citizen residents of minority background requiring culturally sensitive care from Local Authority-led services.

All children are entitled to free prescriptions, eye tests and glasses, and dental care if under 16 (or 19 if in full-time education), but not to unconditional full NHS treatment.

**Special exemptions**

Exemptions apply to certain services and categories of persons.\(^{21}\) The following services are always free (except when the overseas visitor has travelled to the UK solely for the purpose of seeking treatment):

- Accident and Emergency (A&E) services, this includes all A&E services provided at an NHS hospital, e.g. those provided at walk-in centres or urgent healthcare centres. This does not include those emergency services provided after the overseas visitor has been accepted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitor is exempt from charge in their own right.
- Services provided outside an NHS hospital, unless the staff providing the services are employed by, or working under the direction of, an NHS hospital.
- Family planning services (this does not include termination of established pregnancy).
- Diagnosis and treatment of specified infectious diseases (diagnosis remains exempt even if the outcome is negative).
- Diagnosis and treatment of sexually transmitted infections.
- Treatment required for a physical or mental condition caused by:
  - Torture
  - Female Genital Mutilation
  - Domestic Violence
  - Sexual Violence

The following categories of migrants are exempt from charges:

- Children born in the UK to an exempt person up to the age of three months;
- Refugees, (those granted asylum, humanitarian protection, or temporary protection by the UK);
- Asylum seekers, (those applying for asylum, humanitarian protection, or temporary protection whose claims, including appeals, have not yet been determined);
- Individuals receiving support under section 95 of the Immigration and Asylum Act 1999 (the 1999 Act) from the Home Office;

• Failed asylum seekers receiving support under section 4(2) of the 1999 Act from the Home Office or those receiving support under section 21 of the National Assistance Act 1948 from a Local Authority;
• Children who are looked after by a Local Authority;
• Victims, and suspected victims, of human trafficking, as determined by the UK Human Trafficking Centre or the Home Office, plus their spouse/civil partner and any children under 18, provided they are lawfully present in the UK. That is, the exemption only applies where EU law does not provide them with a right to an EHIC or PRC of their own – in practice this is likely to be only when their same-sex marriage or civil partnership is not recognised by the insuring member state;
• Anyone in whose case the Secretary of State for Health determines there to be exceptional humanitarian reasons to provide a free course of treatment. This exemption also applies to their child and/or companion who is authorised to travel with them, for whom the exemption is limited to treatment that cannot await their return home;
• Anyone receiving compulsory treatment under a court order or who is detained in an NHS hospital or deprived of their liberty (e.g. under the Mental Health Act 1983 or the Mental Capacity Act 2005), who is exempt from charge for all treatment provided, in accordance with the court order, or for the duration of the detention;
• Prisoners and immigration detainees.

The UK also has reciprocal agreements with 30 countries which exempt their citizens from health charges in the UK.  

Barriers to obtaining entitlement
As can be seen from the above, the criteria for entitlement to free treatment are highly complex and may depend on possession of documentary evidence (to be submitted to the NHS body assessing entitlement). Administrative discretion may be exercised at many points during these assessments, as well as by primary care providers making a judgement about care that is ‘immediately necessary’.

B. Asylum seekers

Inclusion in health system and services covered
Because they are regarded as ‘ordinarily resident,’ asylum seekers are in theory entitled to the full range of NHS services. Historically, some Primary Care Trusts and Local Authorities have used special funding (within the NHS budget) for ‘locally determined’ priorities, which have included GP surgeries targeted at asylum seekers, homeless people and refugees, with additional services. These are not technically supported any longer, but may exist locally as a historic hangover.

Special exemptions
None are necessary because there are no restrictions on entitlement.

Barriers to obtaining entitlement
Acceptance by a GP remains discretionary, subject to the normal rules about ‘catchment areas’. Frequent relocation of asylum seekers living in Home Office provided accommodation, however, can disrupt this.

C. Undocumented migrants

Inclusion in health system and services covered
In principle, UDMs are only entitled to emergency care. Informal exceptions to this rule may be made, but do not have the status of policy.

Special exemptions
See under ‘legal migrants’.

Barriers to obtaining entitlement
Decisions regarding ‘emergency care’ are subject to administrative discretion. Acceptance by a GP remains discretionary (see under ‘asylum seekers’, above). Decisions on whether to issue a bill, and how rigorously to demand payment, are also subject to administrative discretion.

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24 http://bit.ly/1MMTEND
6. POLICIES TO FACILITATE ACCESS

Score 42  
Ranking ●●○○○

Information for service providers about migrants’ entitlements
The former Health Protection Agency used to maintain a comprehensive information centre on the web, called Migrant Health Guide, and to issue press releases and announcements in professional circulations. On 1 April 2013 the HPA was taken over by Public Health England. The original document is now only available from the archives, where the version of 2014 is ‘permanently preserved’.

The Migrant Health Guide was mainly intended for primary health care practitioners, but was available on the open web and contained information on entitlements. The current policy situation is immensely complicated and changes all the time. There are frequent reports that health service staff are confused and badly informed about current entitlements. While the usefulness of preserving information from 2014 for posterity is therefore questionable, the Guide has recently been revised and re-issued (June 2017), although this has not yet been widely publicised.25

Service providers can consult information for migrants available on the web, but apart from the circulars produced by the Department of Health in England, little of this information is up-to-date.

Information for migrants concerning entitlements and use of health services
The latest information is available on the (English) Department of Health website and the website ‘NHS Choices,’ but accessing it requires some search skills and understanding of specialised concepts. Some documentation may be available, though not consistently, in printed form through local benefit offices, health centres, immigration authority offices, and selected voluntary bodies. In general, there is highly localised and sporadic information provision, with additional problems due to recent NHS reorganisations. Locally based community sector bodies such as the London-based ‘No Recourse to Public Funds’ network, produce their own guides to entitlement.26

The Scottish Government website has a page that gathers together Overseas Visitors healthcare legislation and guidance, but this has not been updated since December 2013.27 COSLA (the Convention of Scottish Local Authorities) has information for services to use, but its most recent version is from 2012.28 The ‘Welcome to Wales ‘ pack produced for the Welsh Assembly appears to have been written more than 10 years ago, and there are currently no plans to update it.

Only In Northern Ireland does up-to-date and accessible information about entitlements to health care seem to be available. The NICEM (Northern Ireland Council for Ethnic Minorities) and Northern Ireland Strategic Migration Partnership have produced an overview on rights and entitlements (NISMP 2015),

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27 http://www.gov.scot/Topics/Health/Services/Overseas-visitors
while the Law Centre Northern Ireland has published a briefing on accessing healthcare for migrants in Northern Ireland (LCNI 2013).

**Health education and health promotion for migrants**

Such materials tend to be locally produced by the new Local Authority-based offices, which have taken over responsibility for Public Health matters (in a form of joint funded setting) — and are produced in locally relevant languages such as Arabic, Urdu, Punjabi, Chinese, Polish, and so-on. Many are published on local websites, and some are now seriously out of date (like the material mentioned above). The Refugee Council (refugeecouncil.org.uk) does maintain its own official site, which offers some advice, but this is out of date (April 2013). The NHS Choices website contains a page on health information in other languages, but a migrant would have to understand English and be fairly skilled in website navigation to find it.

In Wales, most information is provided in only in Welsh or English, although Public Health Wales was persuaded that leaflets about measles should be published in several migrant languages. Different localised Area Health Boards, particularly in dispersal areas, are more pro-active: for example, Newport and Swansea have a dedicated asylum nurse and Cardiff Health Access Practice does initial screening of all asylum seekers and some health information is shared at that point.

NHS Health Scotland produces leaflets and NHS Inform produces health information in other languages, and are looking at online translation as well. NHS Health Scotland’s primary list of languages (routinely produced) is Polish, Chinese (Mandarin/Simplified or Traditional depending on target audience), and Urdu. The secondary list (produced on request) is Russian, Latvian, Lithuanian, Punjabi, Hungarian, Slovakian, Romanian, and Arabic. Other requests are considered.

There do not appear to be specific translated materials produced in Northern Ireland.

Due to reorganisation, many previously available resources seem to have disappeared, but they may still be available locally or on the gov.uk archive site. There is little specific targeting, although West Midlands health authorities report that they have targeted certain migrant groups in relation to eye health and diabetes as part of a national screening programme. Non-governmental agencies are more proactive and most targeted information relating to non-communicable diseases is produced by third sector agencies (charities) with interests in those conditions, e.g. RNIB (sight loss), Arthritis UK, etc. However, these activities are not usually government-funded.

There are many research reports on these issues (e.g. Bhui et al. 2015, Liu et al. 2012), but no properly formulated recent formal national policy or initiatives which exist beyond local ad hoc ones, or condition-specific reports. Diabetes screening is reported to have adopted locally some measures including mobile clinics, translated letters and similar outreach. ‘No report’ does not mean that there are no obstacles, and many reports suggest that there are multiple obstacles. One major problem is the lack of adequate data to address the issue, and other aspects of social exclusion: some official government reports have addressed and/or prioritised action to address these.

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29 http://www.nhs.uk/aboutNHSChoices/aboutnhschoices/accessibility/Pages/other-languages-section.aspx
30 http://www.wales.nhs.uk/sitesplus/888/page/66425
31 http://www.nhsinform.co.uk/
Provision of ‘cultural mediators’ or ‘patient navigators’ to facilitate access for migrants

There have been some local initiatives of this type, but they are not officially sanctioned, and are generally funded by local service providers along with similar initiatives for homeless people or Gypsy/Travellers (analogous but not identical to Roma), and are usually short-term. The terms ‘cultural mediator’ or ‘patient navigator’ are not used: ‘link workers’ was once popular, and ‘community based facilitator’ (CBF) or similar terms have been employed, especially in relation to health promotion and mental health. When available, such provision is normally either for refugees and recognised asylum seekers, or defined on a cultural basis. As a part of the Developing Race Equality (DRE) strategy of the National Institute for Mental Health Improvement (NIMHE), funding was provided for ‘CBFs’, but this has now ceased. Few remain in employment under that scheme.

Is there an obligation to report undocumented migrants?

As a rule, most healthcare professionals would regard provision of ‘personal identifying information’ about patients as a breach of their professional duty of confidentiality, unless pressed with a legal warrant. But although individual healthcare professionals are not required to report UDMs, “the confidential patient records of more than 8,000 people have been handed over by the NHS to the Home Office in the past year [2016] as part of its drive to track down immigration offenders.”

This is because health and other organisations are now required by law to collect this information and to make it available to the government, although this is being resisted. Regulations provided for in the Immigration Act 2014 suggest data linkage between health records and Home Office/UK Borders Agency (UKBA) databanks. Changes to immigration rules in October 2011 meant that migrants with unpaid NHS debts of over £1,000 can be refused re-entry or extension of stay. This would involve hospitals sharing information with UKBA.

Are there any sanctions against helping undocumented migrants?

There are no reported legal or organisational sanctions against healthcare professionals or organisations assisting undocumented migrants. NHS Hospital Trusts are obliged to protect revenues by charging migrants using non-urgent care services, but this is poorly enforced at present. There are pressures to change to a more rigorous approach.

33 http://bit.ly/2vdpsTw
Interpretation services

There is no legal right in health care to interpreter support, although some local trusts and other service providers, including primary care GPs, may offer it to all users on the basis of language need and medical safety, rather than legal status. There was an expectation that this would be provided through NHS agencies, and for a short time the NHS had a block contract for interpreter support, but this has lapsed. It was never fully implemented or taken up.

When available, such services are either for refugees and recognised asylum seekers, or groups defined on a cultural basis rather than by legal status, such as ‘non-English speakers.’ The best provision is still in London, but even there, it is not universal or always of ‘gold standard.’ Central & North-West London NHS Trust maintains a bank of paid interpreters, many of whom would not be legally recognised as qualified interpreters by the national body (National Register of Public Service Interpreters), being trained only to level 3. There is a very large reliance on the linguistic skills of the very diverse mix of staff in the NHS, and many Trusts do maintain registers of language competent staff, not all of whom are medically or linguistically qualified, and few of whom are paid or insured for this role.

In Scotland’s main cities, (Glasgow and Edinburgh) there is a centrally organised interpreter service, partly in response to significant numbers of asylum seekers in the former, mostly provided as face-to-face professional interpretation.

A national (UK) lobby group supported by the linguists’ professional bodies has been arguing for regulation and recognition of registered interpreters but this has not yet been effective, although in criminal justice cases there is such a right to provision, and some protection of professional rights backed by EU legislation.

Requirement for ‘culturally competent’ or ‘diversity-sensitive’ services

Theoretically, the Care Quality Commission and professional standards do require these to be available, but there is little evidence of their enforcement or action taken against those not meeting the standards. The rights are nevertheless enshrined in the Equality Act (2010) and NHS standards, notably the ‘Personal Fair & Diverse’ and EDS2 (‘Equality Delivery System’) toolkits and CQC inspection guidelines, and there are some basic standards laid down in, for example, the GMC ‘Duties of a Doctor’ guidelines, or NICE advice on specific health procedures. While ‘migrant status’ is technically listed in the Equality Act, none of these documents tends to refer explicitly to this issue under the heading of migration or migrant status. However, widespread non-compliance does not remove the legal obligation.

Within Scotland, this issue is felt to fall within the purview of the obligation for an Equality Impact Assessment (EQIA) for all new and changed policies in public authorities in Scotland. This is legally

35 http://www.edinburgh.gov.uk/languages
backed by the Equalities Act 2010 (specific duties [Scotland]) regulation 2012.\textsuperscript{36} Many public sector bodies have adapted EQIA processes to include consideration of wider potential impacts, e.g. Health Inequalities Impact Assessment (HIIA), Scottish Human Rights Commission (SHRC) rights impact assessment.

**Training and education of health service staff**

There is no overall requirement to provide such training, although there are some service-specific guidelines and enforcement or at least testing of fitness to practice by inclusion of questions and competences in professional examinations, e.g. for GPs, and by specific medical schools. These are not embedded in national core competences for professional formation (basic) training, except locally. Some growing awareness of Equality and Diversity issues is required as part of ethics as a competence, but generally ‘CC’ training remains voluntary and ‘post-qualification.’\textsuperscript{1}

One ‘third sector’ agency – TS4SE - has created an open-access, free training resource toolkit which provides information and practical tips for effective engagement with patients from migrant, refugee, and minority communities, as well as working with interpreters: *Improving Access to Healthcare for Migrants: a toolkit for healthcare staff.*\textsuperscript{37}

In Scotland, national training on cultural competency is provided by NHS Education for Scotland (NES).\textsuperscript{38} As well as cultural competency training available from NES, local boards often have their own custom-tailored cultural competency training. Some mostly non-clinical NHS staff are required to demonstrate general equality and diversity competence in annual appraisals through training and/or practice.

**Involvement of migrants**

Migrants are involved in service delivery and indeed are essential for the functioning of the health service for the majority ‘autochthonous’ population. Where they work, they are likely also to be employed in specialist roles supporting other healthcare for migrants (such as the equivalents of ‘cultural mediators’). There is no policy directive on this, although skills required tend to be associated with migrant origin. This operates similarly in respect of service design and information provision supported by official government funding, sometimes through lucky accident or outworking of other policies such as the expectation that all health research funded by official NHS bodies has ‘user’ input (Johnson 2012b). Migrants primarily contribute as ‘manpower’ for health care, and through NGOs. Thus, some migrant-led NGOs sponsor research and may get official support for this sometimes through local or national ‘SLAs’ (Service Level agreements), which may be unstable, but do represent some official recognition and support: REF (The Race Equality Foundation) is recognised as a strategic partner of DH and contributes to policy making in that role.

**Encouraging diversity in the health service workforce**

There have always been some recruitment measures to encourage participation of people with a migrant background in the health service workforce: indeed many of the present UK minority ethnic population derive from earlier recruitment campaigns by the NHS in ‘sending societies’ such as India, Mauritius, and the Caribbean.

\textsuperscript{36} http://bit.ly/2nCny2n
\textsuperscript{37} http://ts4se.org.uk/migrants-healthcare.html
\textsuperscript{38} http://www.bridgingthegap.scot.nhs.uk/values-and-principles,-policy-and-practice/cultural-competence.aspx
The NHS Employers organisation sponsors the ‘personal fair and diverse’ (PFD) toolkit and other similar initiatives, and equality of opportunity/antidiscrimination legislation protects on grounds of race, religion, etc., but not on citizenship or migrant status as such. However, there are a number of pressures to incorporate migrant labour at all levels, largely driven by cost and availability, but also recognising that a diverse workforce reflecting the various cultural backgrounds of users can be an advantage. This means that from time to time, based on a skills/needs analysis, a few posts may be created and filled to address issues arising from specific user needs, which require filling by people with the matching cultural backgrounds of migrants. The NHSE ‘Strategic Forum’ on Equality & Diversity has held regular workshops and supports publications encouraging a more diverse workforce.39

Development of capacity and methods

NICE (the official NHS quality and operational standards body) guidelines encourage this when a case can be made for greater clinical effectiveness, and support from NHS ‘health technology’ and other funding streams has been given to research and service developments with these objectives. Many of these have focused on prevention interventions such as screening, but there has also been investment in health promotion and mental health, while FGM has been a priority since 2015. Reports of NIHR-sponsored research are published in the NIHR Journals Library,40 where calls for new projects are also listed. One influential report was a systematic review of ‘adaptation of health promotion interventions’ (Liu et al. 2012).

There continue to be a number of other funding opportunities for research and development relating to migrant/minority ethnic health, frequently supported by disease-specific or other non-profit and/or independent/charitable funds, such as:

- Lankelly Chase (independent foundation) call for proposals for £GBP 1,25 million for a five year programme to design and deliver a knowledge hub on ethnic inequality in mental health.41 This was eventually awarded in 2017 to a consortium of University Centres.
- NIHR (NHS central body for research funding) research brief on Interventions to promote healthy eating in minority ethnic groups.42
- IOSH (The national body for research into health and safety at work) (2014).43
- The Scottish Migrant & Ethnic Health Research Strategy group, which includes Scottish government representatives, has developed a five year strategy for research priorities.44

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39 http://www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce
40 http://www.journalslibrary.nihr.ac.uk/hta
41 http://lankellychase.org.uk/black-and-ethnic-minorities/
42 http://www.nets.nihr.ac.uk/funding/phr-commissioned
43 https://www.iosh.co.uk
44 http://www.healthscotland.com/resources/networks/SHERRS.aspx
8. MEASURES TO ACHIEVE CHANGE

Score 83  Ranking ⬤⬤⬤⬤●

Data collection
Collection of information about migrant status, country of origin or ethnicity is mandatory. Ethnicity data is theoretically required for all patients admitted to the hospital, although recording levels are below 80% in general. Country of birth is recorded on birth and death certificates, but ethnicity is not. Country of origin and migrant status have never been recorded in general, although this may need to change as a result of new legislation and regulations such as the Immigration Act noted above.

Support for research
In terms of research, while migrant status is rarely considered, there have been several major studies of ethnicity and health, and national datasets now include ‘ethnicity’ questions which permit analysis of large public datasets (including the national decennial Census, which also asked about ‘passport’) by ethnic origin, giving some evidence of health status, etc.

There are examples of data linkage studies, notably in Scotland (where Census data includes date of arrival) by Raj Bhopal,45 and the DH birth registration system (NN4B Numbers for Babies) is used by the National Perinatal Epidemiology Unit at Oxford to conduct record linkage studies examining perinatal outcomes. But this is not widespread. Data security and confidentiality concerns tend to take priority over research. Some specific exceptions and examples (e.g., on cancer for the national Cancer Equality Network), do exist.

Aspinall (2014:33) provides a useful summary of issues associated with vulnerable migrants, data, and policy initiatives/instruments such as JSNAs (Joint Strategic Needs assessments) required from all health and local authorities, along with strategies to ‘reduce health inequalities,’ as a policy priority.

‘Health in all policies’ approach
While there is no formal ‘Health in all policies’ approach, some equality in health concerns may be addressed insofar as the Equalities Act covers and requires all public agencies to address race and faith equality, and to have Equality Impact statements.46

Whole organisation approach
Commitment to providing equitable health care for migrants or ethnic minorities is present in all departments of service provider organisations and health agencies, under the Equalities Act (cf. previous item).

Leadership by government
Action plans are largely focused on reducing the need to be concerned with migrant health, but there are some policies in relation to minority ethnic groups in which public health issues are concerned, (e.g.

45 http://bmjopen.bmj.com/content/4/10/e006120.full
screening for HIV, TB – see Coker 2003) in order to reduce health inequalities due to low take-up in relation to selected conditions.

**Involving stakeholders/migrants’ contribution to health policymaking**

Migrant bodies have no formal role in policy development, but some ‘ethnicity’ groups do have a degree of standing – notably the Race Equality Foundation (REF) – which is recognised as a strategic partner by the Department of Health, and other bodies such as Afiya Trust and Runnymede Trust may be asked to contribute to specific consultations. Generally, ‘migration’ issues are ignored, although when ‘race equality’ concerns are raised, there is more scope for discussion. Nearly all the previously operative specialist ‘centres of excellence’ (academic/clinical) have been closed down or merged into mainstream bodies, and have less migrant focus. NHS Employers have a Strategic Forum which has some representatives of diversity NGOs, and the NHS Equality & Diversity Council is also populated with representatives of a selection of minority ethnic NGOs, but these have little formal influence on the direction of policy, and are not widely known; They are active more in the field of employment than service delivery at present.

There are many migrant rights charities/Third Sector bodies which are active nationally and locally – for example, Migrants’ Rights Network,\(^47\) the Ethnic Health Initiative, Afiya Trust, and the Race Equality Foundation, which also produces authoritative reports and is (as noted above) recognised by DH as a strategic partner. See also, for example, the Westminster, Kensington and Chelsea BME Health Forum.\(^48\) These local initiatives frequently impact on wider discussions and are widely shared around the sector. There are also regional ‘Strategic Migration Partnerships’ funded by the Home Office, whose primary role is to provide an ‘enabling’ function and leadership, single point of contact and coordination role on issues related to migration in UK regions and nations. Most have membership at strategic and operational levels from health bodies and are involved in various initiatives to promote access to health for migrant groups, depending on regional priorities and political pressures. Some of the SMPs (three of the 12) have active committees dealing with health issues. These SMPs include migrant organisations, local authorities, police, employer groups, and some health bodies. RSMPs have been in existence since 2001, and continue to be funded by the HO to carry out their enabling function, although they are not widely known, and some appear to be dormant.

Other opportunities to impact policy may occur, for example when Parliamentary groups (‘APPGs’) are investigating specific issues, many groups including migrant rights groups, take an active part in lobbying and presenting evidence. Maternity Action was very active in relation to migrant women’s health, especially following two reports on maternal mortality/morbidity (CEMACH, CEMACE)\(^49\) when migrant women turned out to be particularly vulnerable, and NICE issued specific guidelines on this risk factor.\(^50\)

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47 http://migrantsrights.org.uk/
48 http://www.bmehf.org.uk/
49 http://www.hqip.org.uk/national-programmes/a-z-of-clinical-outcome-review-programmes/cmace-reports/
50 https://www.nice.org.uk/guidance/cg110
CONCLUSIONS

Overall, the situation is that while the policy environment is hostile to migrants in general, and public antipathy to population movement is widely expressed, the ‘facts on the ground’ may contradict this. The NHS and entire welfare apparatus is dependent on migrant labour, as it has been since the origins of the NHS in 1948, and since at the most recent decennial Census around one in five of the population declared their ‘ethnic identity’ to be other than ‘White British’, there is a political counter-current which promotes recognition of cultural diversity and specific needs. This has led to the creation of services which are more appropriate for migrants, and to social or political alliances with shared interests. In addition, there is explicit recognition that inequality is a ‘bad thing’ and should be addressed, and (as with earlier initiatives on inner city poverty) these priorities also benefit migrants including those recognised (asylum seekers and refugees) and unrecognised (UDMs), as well as ‘economic’, EU, and other migrant groups and their descendants.

The current situation is somewhat paradoxical, because despite extensive legislation obliging services not only to discourage discrimination, but actually to monitor their progress towards doing so, the government is highly responsive to that section of the public which feels integration is something only migrants have to do – not the receiving society. The concept of ‘path dependency’, referring to the way organisations often carry on along a certain path for many years after the original policies have been abolished, may help to understand why so much effort is still being put into adapting health services to migrants and minorities; on the other hand, this may testify to the effectiveness of the laws that oblige services to do so. Whatever the explanation, the UK’s scores on Sections 7 (Responsiveness) and 8 (Measures to achieve change) are the highest in the whole EQUI-HEALTH sample of 34 countries.

It is therefore all the more striking that the scores on Sections 5 (Entitlements) and 2 (Policies to facilitate access to services) are so low. Before the change of government in 2010 and the passing of the Immigration Act of 2014, these scores would also have been very high: but firm political determination to eliminate any possibility that migrants might ‘exploit’ the NHS (even those who pay taxes and NI contributions into it like everybody else) has reduced entitlements, and many measures to bridge the gap between migrants and health services have lapsed into disuse. What the future will bring to migrant and minority health in England is therefore highly uncertain. In Scotland, however, there seems to be more concern to keep up the drive towards equitable policies (Lorant & Bhopal 2011).

Postscript (July 2017)

Following a narrow vote (52:48) in the ‘Brexit’ advisory Referendum in June 2016, taken as a mandate to leave the EU by the UK Government, and seen as a protest largely against free movement of labour rules, and the subsequent failure by the Government to increase its majority in a snap election in June 2017, there has been little actual change in policies relevant to migrant health or its implementation. However, the effect of uncertainty over the future for EU Nationals has led to a dramatic fall in arrivals and settlement, and a drop of 96% in the number of EU national nurses registering for work in the
NHS. Similar effects are causing concern in social care (where 7% of the adult social care workforce is of non-UK, EU national origin) and other sectors.

The impact on care provision for migrants is difficult to assess beyond the loss of language-competent staff, but the persistent climate of hostility in ‘tabloid’ newspaper headlines and the rhetoric of some politicians creates its own form of barrier to service use and enjoyment as well as potentially threatening mental health. At the same time, the climate of opinion is adversely affecting the morale of staff, including doctors from both within and outside the EU/EEA, as they feel that they are viewed differently by their patients. There were reports that the Prime Minister had commissioned a report on ‘racial inequalities’ from the Cabinet Office, including development of a website where data on ethnic inequalities across health, education, employment and more would be made readily available. This appears to have encountered delays and it is unlikely that it will explore the issue of ‘migrant’ status as well as ‘race’ or ‘ethnicity’. Again, this may reflect the ‘climate of opinion’, and that also may change, as organisations such as ‘Just Fair’ (a consortium of around 80 voluntary sector bodies with concerns around human rights issues) and ‘Doctors of the World’ (MdM) campaign on behalf of migrants’ rights in health care and data protection.

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53 http://bit.ly/2bnKY1a
54 http://ind.pn/2u9RzcG
55 http://www.just-fair.co.uk/


http://www.journalslibrary.nihr.ac.uk/hta/volume-16/issue-44

DOI: https://doi.org/10.1093/eurpub/ckq061

http://bit.ly/2nUB1i2


http://www.migrationinformation.org/Profiles/display.cfm?ID=736


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