



WORKERS ON THE MOVE 3

European migrant workers and health in the UK: The Evidence

By Alex Collis, Neil Stott & Danielle Ross

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A2	2007 EU Accession Countries (Bulgaria and Romania)
A8	2004 EU Accession Countries (Poland, Czech Republic, Slovakia, Slovenia, Latvia, Lithuania, Estonia and Hungary)
BMI	Body Mass Index
CEE	Central and Eastern European
CINDI	Countrywide Integrated Noncommunicable Diseases Intervention
EEDA	East of England Development Agency
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
EU-15	pre-2004 accession countries which include Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the UK
FHU	Family Health Unit (Portugal)
GDP	Gross Domestic Product
GP	General Practitioner
HC	Health Centre
HMO	House of Multiple Occupation
HPF	Health Promotion Foundation (Poland)
ILO	International Labour Organisation
META	Mobile Europeans Taking Action
NHF	National Health Fund
NHS	National Health Service
PCT	Primary Care Trust
STD	Sexually Transmitted Disease
TB	Tuberculosis
VHI	Voluntary Health Insurance
WHO	World Health Organisation

Foreword

European migrants play an important role in the Eastern region and beyond. Migrants provide local employers, including the NHS, with a much needed workforce as well as adding to the diversity of our communities. Norfolk NHS is attempting to better understand the needs and issues of our many communities – including European migrants – to ensure our services continue to be relevant, responsive and of the highest quality.

Workers on the Move 3 reports the findings of a primary research project carried out by the team at Keystone Development Trust which explored the health needs, concerns and issues of European migrants who come to live and work in Thetford and the surrounding area. NHS Norfolk is committed to listening and learning, and the results of this research fill some key gaps in our knowledge. The following report draws a number of valuable conclusions which we can use to develop and improve the

services we provide not only to migrant communities, but also to existing communities across Norfolk.

I would like to thank the authors and team who have supported them in this valuable work, as well as all those who participated in the study – both migrant workers and health professionals – for their important contributions. I would also like to thank Thetford Healthy Town for supporting the project, funded through the Department of Health.

Sheila Childerhouse

Chair
Norfolk NHS



About Keystone Publications

The Keystone Publications series is aimed at understanding issues in challenging policy areas that have a direct impact on communities and promoting dialogue amongst practitioners, policy makers and academics. Keystone Publications are intended to be thought provoking interventions in policy debates, as well as reporting on primary research. The publications are co-authored by academics and practitioners, often with the support of volunteer researchers and editorial assistants.

Migrant workers, housing and growth in the Eastern region (2008) highlighted the issues around housing and migration as well as reporting on primary research with European migrants. *Workers on the Move 2* (2009) focused on European migrants and health, and provided a review of what is known about migrant health issues in the UK as well as home countries health systems and issues. *Learning from the Past* (2009) concentrated on community building in new towns and communities. *Workers on the*

Move 3 (2010) reports on primary health related research with migrants. All publications are available at www.keystonetrust.org.uk. *Work Matters: Work, worklessness and community: A review of the issues* and *The Big Society Challenge* will be published in 2010.

Keystone Publications are produced by Keystone Development Trust, which delivers diverse social projects through generating income from its own not for *private* profit social enterprises as well as public and other funds. Keystone is a *community regeneration charity*.

Keystone aims to deliver projects which fill local people with **passion**, keep money in their **pockets** and create great **places** to live. The Trust aims to deliver;

- **Work** and preparation for work
- **Fun**
- Community led **homes**
- **Extra help** for those in the greatest need

CHAPTER 1: Executive Summary

Background and rationale for the research

- 1.1. Major concerns have been raised in the media about the potentially negative impact of increased migration to the UK on the already overstretched NHS, and scare stories about 'health tourism' have become a regular occurrence, particularly since the accession of ten new countries to the European Union (EU) in May 2004 and January 2007. The potentially negative impact on levels of community cohesion has remained a key consideration for policy makers, with the suggestion that access to healthcare could become a key flashpoint for tensions.
- 1.2. However, there is *no reliable evidence to support claims of health tourism*, and little research has been conducted on migrant workers' access to and uptake of health services. This research aims to further develop our understanding of the health needs of migrant workers living in Thetford and the surrounding area, as well as their experiences and perceptions of local health services. We also consider migrant workers' uptake of and attitudes towards health promotion activities, both at home and in the UK, and examine the relevance for this group of projects such as Change4Life and the Healthy Town programme.

Methodology

- 1.3. Keystone's research team carried out a desktop literature review which explored a wide range of existing research evidence and both policy and academic literature on migration and health. This evidence was used to design the data collection tools for the primary research; 100 structured questionnaires were completed by META migrant worker clients, which were followed up by a series of focus groups. We also surveyed a total of 31 local health service providers and commissioners, using a combination of structured telephone interviews and an e-questionnaire.

Migration and health – the existing evidence

- 1.4. The development of healthcare provision in sending countries has been highly variable, both in the pace and scope of change. Some may be less familiar with the gatekeeping role of general practitioners, which could affect their use, expectations and experiences of primary care in the UK.
- 1.5. Many of the countries from which migrant workers come to the UK have identified similar public health concerns to those addressed by the Healthy Town Project – in particular high levels of tobacco and alcohol use, and issues around diet, obesity and physical activity. Even with the extensive reforms to healthcare systems in some of the sending countries, many remain focused on treatment rather than prevention, and the priority which national governments have given to health promotion has been variable.

- 1.6. Several studies have considered migrant workers' access to and uptake of primary care services and have found that low proportions of migrant workers are registered with a GP, often arguing that this is because they are unaware of which services are available or of how to register. Other studies have suggested that it is due to a continued preference among migrant workers for accessing care in their home countries.
- 1.7. A range of factors have been identified which can inhibit migrant workers' knowledge of or access to primary care services, perhaps the most significant of which is a lack of English language skills. The provision of translation and interpreting services is a central part of facilitating access to health care among migrants who have fewer language skills. Where these services are not in place, migrants are often forced to rely on family, friends – and sometimes community 'gatekeepers'.
- 1.8. Low rates of GP registration can have a range of repercussions; for instance, if migrant workers are not registered with a GP it becomes more difficult for them to access preventative services such as screening programmes, or child health appointments.

Migration and health – findings from the current research

- 1.9. Most migrant workers we talked to were registered with a GP, a change from the findings of earlier studies which indicated low registration rates. Reasons for non-registration varied, but the most common reason was that they had not been ill and had not needed to visit a doctor (47.8%). However, a small minority indicated that it was because they did not know *how* to register, suggesting that some migrants may still experience difficulties accessing information on available healthcare services. Levels of registration varied between different groups of migrant workers, and were lower among A2 and A8 migrant workers, possibly due to the fact that the Portuguese community has been resident in the area longer.
- 1.10. Even where respondents were registered with a GP, levels of usage of this service have remained low; 66.2% of our questionnaire respondents had only visited their GP between 1 and 2 times in the past year and a further 13.5% had not made any appointments.
- 1.11. Registration with dentists was more problematic; questionnaire respondents were much less likely to have accessed dental care with only 31.6% currently registered with a dentist, which is less than half the rate of GP registrations.
- 1.12. Most migrant workers reported that healthcare provision in their home countries was significantly different from and often of poorer quality than the services available in the UK. Major differences noted included cost,

shorter waiting times for appointments, and the high quality of maternity and ante-natal care provided in the UK. However, feelings on the quality of UK services were not unequivocally positive. Many were critical of the comparatively short time allowed for appointments and also of differences in prescribing patterns such as an apparent tendency to rely on prescribing mild painkillers.

- 1.13. Participants also had particularly mixed views on the differences between the ways in which chronic conditions were managed or treated in the UK and their home country. Conflicting advice, diagnoses and different treatment styles and outcomes were a frequent problem.
- 1.14. Levels of tobacco and alcohol consumption were high among our sample, particularly among male respondents and those from CEE countries. Interest in accessing formal smoking cessation assistance initiatives was limited.
- 1.15. Consumption of fresh fruit and vegetables varied widely among our sample, with many respondents not meeting the 5 a day 'target'. A high proportion also regularly consumed large amounts of salt, as well as high fat dairy products including whole milk and butter.
- 1.16. When we explored the possible reasons behind these eating patterns, focus group participants not only told us that the expense of buying good quality fresh food was a major factor, but also suggested that many migrant workers were used to a national diet or cuisine that did not rely heavily on foods from these groups – often because they were prohibitively expensive in sending countries.
- 1.17. A high proportion of our sample never exercised. The main reason given for this was lack of time (rather than a lack of facilities), followed closely by lack of interest. Moreover, a relatively high proportion of our sample engaged regularly – and for substantial periods of time – in more sedentary activities such as watching television, using the computer or playing video games.
- 1.18. Very few migrant workers were aware of any health promotion campaigns introduced by national governments, either in the UK or in sending countries, apart from a small minority who mentioned the 5-a-day campaign. This was seen as an area in which home country governments rarely invested either time or funds.
- 1.19. Front-line service providers reported a wide range of health needs among their migrant worker patients, although many felt that their needs were not markedly different to those of other patients. However, child health, family planning/sexual health, and primary care mental health services were identified as particular 'growth' areas of demand. Concerns were also raised around the potentially negative health impact of migrant workers' living conditions, especially on the well-being and development of children in migrant worker families.
- 1.20. The majority of professionals surveyed felt that they were able to provide migrant worker patients with an equal level of service. Most respondents also felt confident in their knowledge of migrant workers' entitlements to UK healthcare. Respondents were much less confident in their knowledge of health systems in sending countries, and several felt that this gap in understanding could cause problems –

particularly where a migrant worker patient brought different cultural expectations of services to a consultation.

- 1.21. Interpreting and translation services were seen as a vital part of improving the service offered to their migrant worker patients. Despite the emphasis placed by respondents on translation and interpreting, delivery of this service was often inconsistent.

Discussion, conclusion and recommendations

- 1.22. This research has also identified a number of priorities for both future research and service provision. Studies such as this need to be replicated across the region as well as nationally in order to help build a robust evidence base on migration and health. Given the current uncertainty about length of stay, the picture needs to be updated regularly as part of a sustained programme of research. Longitudinal research is needed as well as snapshot studies such as this one.
- 1.23. There are a number of areas of where more knowledge is needed;
- mental health needs and patterns of help-seeking behaviour
 - child health and development, given the apparent increase in numbers of family joiners
 - housing, homelessness and the links to ill-health
 - lifestyle issues such as tobacco and alcohol consumption

CHAPTER 2: Introduction

Migration is a key issue in the UK. European migrants provide much needed labour in many regions including the east of England. Mobile workers are bringing a diversity and vibrancy to many areas and communities which do not have a history of in-migration as well as adding to the cultural mix in our cities. While extensive work has been undertaken through Keystone/META (Mobile Europeans Taking Action) to better understand the needs of migrant workers arriving in the area, we still know very little either about their health needs, concerns and issues or the potential impact of new arrivals on local services⁵. This research aims to develop our understanding of the health needs of migrant workers living in Thetford and the surrounding area, as well as their experiences and perceptions of local health services. The project also considered migrant workers' uptake of and attitudes towards health promotion activities, both at home and in the UK, and examined the relevance to this group of projects such as Change4Life and the Healthy Town programme – as well as exploring alternative ways of reaching these new communities.

2.1. Migration and health – the UK policy context

Major concerns have been raised in the media – particularly since the accession, in May 2004, of eight new states to the European Union – about the potentially negative effects of increased immigration on the NHS, and the 'health implications of migration have become, quite literally, front page news'¹. Scare stories about 'health tourism' are an apparently regular occurrence; for example, in June 2004 an article published under the headline 'Invasion of the Health Tourists'² reported that one in ten patients seen by GPs were not entitled to free medical treatment, and warned that further action was needed to 'weed out the cheats and take the pressure off the overstretched Health Service'. Five years later, similar concerns were being raised over the proposed changes to the rules on medical care available to failed asylum seekers which could, it was warned, open the 'floodgates' to further health tourism³. The NHS, it was suggested, was being 'routinely exploited' by immigrants at a total annual cost of £200 million. While much of the media coverage has centred on asylum seekers or refugees, new arrivals from EU accession countries – despite the fact that they are entitled to free care – have also been seen as placing an increased strain on health services.

However, there is a lack of evidence in support of these claims of health tourism. Until recently, little data has been collected on migrants' use of UK health services – particularly from the perspective of migrants themselves – and this should be a priority for future research. Previous research has found that rather than representing a burden on the health service, migrant workers are in fact 'generally net contributors to public finances', and to the health care sector in particular⁴. In calling for a more informed,

constructive debate on this issue, a recent IPPR report noted that 'migrant health personnel have provided an important means to meet staff shortages and to *reduce cost pressures* within the health system'⁵. There is clear evidence of this contribution at a regional level; for example, a recent study of migrant working in the East of England found that both the NHS and private sector relied heavily on the employment of migrant workers in both qualified and unqualified nursing roles, with most care homes in the region employing between half a dozen and two dozen migrant workers as health care assistants⁶. The value of this contribution has been recognised in other regions; in the North West, a Department of Health regional public health group report found that in 2006, approximately 6,200 accession nationals were registered as care workers across the UK⁷.

The contribution of migrant health professionals has also been acknowledged at central government level; recently the Department for Communities and Local Government stated that migrants often play a 'key role in the delivery of public services', accounting for 17% of health care staff and 18% of social care staff⁸. The report also recognised that the migrant worker population, which is generally young and healthy, was currently unlikely to make substantial demands on health care provision. Nonetheless, ministers still sounded a warning that 'there is a balance to be struck between the long-standing NHS principle of free universal healthcare and considerations of fairness – and there have been some concerns about the possibility of 'health-tourism''⁹. Consequently, the government has restated its commitment to 'keep these rights of access under consideration'. The Institute for Community Cohesion also recently claimed that in fact the impact of increased migration on health services 'is increasing albeit from a low

base'¹⁰. The potential effect on levels of community cohesion is a key consideration for policy makers. A recent study of the reception and integration of new communities found that health care usage could become a key flashpoint for tensions between new arrivals and established communities, and was 'noticeably acute in rural areas'¹¹ where there was a pre-existing strain. However, the report still found that 'current pressures do not reflect the magnitude of those reported in national and media discourse'¹².

Conversely, concerns have been voiced over the health inequalities experienced by some migrants – even those from accession countries who are entitled to free care, as long as they are registered on the Workers' Registration Scheme (WRS). A number of news stories have recently been published which highlight the destitution and subsequent health risks suffered by A8 migrants who have fewer English language skills and are unable to access employment which is sufficiently well-paid and secure to allow them to register on the WRS – thereby making them ineligible for medical assistance. For instance, one story highlighted the growing problem of TB among homeless A8 migrants¹³, arguing that 'a confusing and inflexible benefits system and exploitation by cash-in-hand bosses have condemned them to the squalor of a candle-lit, derelict garage – and a serious illness that could kill them and become a serious public health threat.'

Little is currently known about the health needs of migrants, particularly about those of migrant workers. Our level of knowledge of linked issues – such as housing – faced by migrant workers is growing¹⁴. However, this has not been matched by investment in research focusing on health needs and issues. Consequently, as a scoping report published recently by the East of England Regional Assembly (EERA) argues, the health

sector is 'lagging behind other sectors in addressing the needs of this particular group'¹⁵. Moreover, the 'lack of strategic recognition of this agenda locally, regionally and nationally ... results in the issue not being addressed within mainstream health policy and service provision'¹⁶. It is therefore essential that further *sustained* research is carried out – not only to ascertain the facts of migrants' use of health services, in order to counteract allegations of health tourism and promote cohesion between existing communities and new arrivals, but also to better meet those new arrivals' particular health needs. This research represents the first step towards a more developed understanding of migrant worker health needs in this region, but further work will be needed in order to understand the experiences and perspectives of different groups across the region. For instance, secondary data analysis recently carried out by Keystone for a needs assessment of migrant workers in Cambridgeshire indicated that while *some* groups (such as Poles) appear to be returning home, increasing numbers of *other* groups (such as Latvians and Lithuanians) are arriving in the East of England¹⁷.

There is a current debate around length of stay among migrant workers across the UK, and despite the publication of various research findings, the overall picture remains unclear. A number of studies have suggested that rates of migration are slowing significantly, and that migrant workers are now less likely to stay in the UK long-term. For instance, in 2008 a report published by the Institute for Public Policy Research (IPPR)¹⁸ estimated that by December 2007 over half the migrant

workers who arrived in the UK after May 2004 had left the country, either returning home or moving on to a different country, and that 30,000 fewer A8 migrants had arrived in the second half of 2007 as had in the second half of 2006. However, other reports such as the interim findings of the EEDA longitudinal study¹⁹ have revealed a more fluid and complex picture, with few migrant interviewees having fixed plans regarding length of stay. More often, interviewees fluctuated between short-term and longer-term stays, which could be influenced by a wide range of factors; some reasons were economic, but social and personal reasons were also cited. Significantly, however, health was not cited as a major pull factor in deciding to come to the UK.

This uncertainty makes estimating future levels of demand for services, and planning service provision, particularly problematic. There is a delicate balance to be maintained between soothing the anxieties of local communities – which can often find expression in complaints about 'health tourism' – and meeting the health needs of new arrivals. Moreover, it is vital to understand migrants' health needs as soon after migration as possible, in order to minimise the inequalities of access described above. Health, along with employment, education and housing, has also been identified as 'one of the four primary means and markers of integration'²⁰. If migrant workers are planning to stay in the UK, even where their stay is temporary but long-term, it is essential that their health needs are routinely considered – along with projected levels of demand for and access to service provision.

2.2. What do we know?

Migration and health in Thetford and the East of England

Currently there are major gaps in the evidence base on health and migration in the East of England generally, and in Thetford in particular – a picture that is consistent with the comparative lack of information on migrant workers' health needs, issues and experiences across the UK. Much of the evidence that *does* exist is anecdotal, and relatively little has been achieved so far in terms of sustained research into the health needs and experiences of migrant workers to the region. Developing knowledge in this area to support the 'particular health and wellbeing needs' of 'hard to reach'²¹ groups including migrant workers, and enabling 'fair and equal access'²² to services were identified as key priorities for NHS Norfolk's Strategic Plan for 2009 – 2014. Keystone's META advice team have recently begun to collate data on the health needs of clients, and are starting to build up an overall picture of access to services. The data collected for the months between January and June 2010 are summarised below in table 1;

Table 1: Health data for clients to Keystone's META advice service (Jan – June 2010)

Aware of health services	620
Not aware of health services	27
Registered with GP	532
Not registered with GP	115

There are three main conclusions which we can draw from this data, the first of which is that levels of awareness of health services among migrant workers appear high. This may well be a result of the overall improvements in information provision about services which have been achieved regionally, particularly the provision of language-appropriate information. However, it should be noted that this data *only* covers those migrant workers who are more confident in accessing Keystone's advice service; it may equally be that there are other sections of the migrant community who are less confident in accessing advice – and healthcare provision. The second conclusion which we can draw from the available data is that migrant workers in Thetford do not appear to be experiencing difficulties in registering with a GP. This conclusion is certainly supported by the experiences of both the Polish and Portuguese advice workers at Keystone, who have reported that the majority of clients have little difficulty in registering with GPs, although they *have* reported clients experiencing difficulties in making appointments with opticians and dentists. However, it is also clear from this data that although levels of awareness are high, a small but significant minority (13.7% of META clients during this period) are aware of the available health services, but remain unregistered with a GP. There are several potential reasons for non-registration, including a preference for using services in their home countries, lack of space on GP lists, or simply that migrant workers have not *needed* to consult a GP.

2.3. Summary – what do we need to know?

There is an urgent need for further research into these issues, so that local health providers can start to respond to and plan for the health needs of migrant workers in the region. This primary research carried out for this report addresses this need and adds to the growing evidence base on migration and health, linking up with some of the other work that is happening regionally and nationally such as the Health Needs Assessment currently underway at the University of East Anglia (UEA)²³.

The main aims of this research were to explore the following key areas;

- the health needs, issues and concerns of migrants
- migrants' attitudes to health services, both at home and in the UK

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

The research for this project was conducted in two main stages. Stage 1 involved a focused literature review followed by the publication of a discussion paper, *Workers on the Move 2: European migrant workers and health in the UK – a review of the issues*²⁴. This review provided the basis for the second stage of the research which involved fieldwork with both migrant workers and a range of healthcare professionals, including both providers and commissioners.



CHAPTER 3: Research methods

3.1. Stage 1: Review of the existing literature

The initial desk-based stage of the project explored a wide range of existing research evidence and literature on migration and health. While the review covered issues relating to all categories of migrants, *including* asylum seekers and refugees, there was a particular focus on the literature relating to migrant workers. Our review also considered both UK research and examples drawn from the international literature; for instance, there is a wealth of evidence from studies carried out in other countries on the mental health effects of the migration process. As well as reviewing the academic literature, we also considered selected policy documents published in both the UK and the range of EU countries which were the focus of our research, as well as international publications from bodies such as the World Health Organisation. We also searched the websites of health ministries and public health bodies in sending countries to identify examples of policy responses²⁵.

A number of main areas were identified which were subsequently used to structure the discussion paper and data collection tools used during the fieldwork stage of the project.

- health systems and policies in sending countries
- key health promotion issues/concerns including
 - tobacco
 - alcohol
 - diet, nutrition and physical exercise
- examples of health promotion programmes in sending countries, particularly smoking cessation schemes and healthy eating campaigns
- health and migration in the UK, including
 - access to primary care services (including GPs, maternity and child health, screening and immunisation)
 - information, interpreting and translation services
 - cultural differences and expectations of services
 - mental health
- domestic violence²⁶

3.2. Stage 2: Fieldwork with migrant workers

This stage of the research involved both a structured questionnaire and a series of focus groups carried out with migrant workers from a range of sending countries between January and April 2010. During the literature review we also considered the range of methodological approaches and data collection tools used which included questionnaires, individual interviews and focus groups. Subsequently we decided to adopt a mixed methods approach, which allowed us not only to identify broad patterns from the quantitative data, but also to then explore them in greater detail in the qualitative stage of our fieldwork²⁷. The two data collection methods used (questionnaires and focus groups) are discussed in greater detail below with a particular focus on design, sampling technique, ethical considerations and additional issues such as translation.

3.2.1. Questionnaire²⁸

The migrant worker questionnaire was divided into two main sections;

- experiences of health services in the UK – including access to/use of primary care, knowledge of UK services and major differences from provision in home countries.
- health behaviour – this part of the questionnaire was further divided into two sections on smoking/drinking and diet/exercise.

This questionnaire used mainly closed-ended questions²⁹, although a limited number of open-ended questions were also included to supplement the mainly quantifiable data with further information on less well understood topics such as individual respondents' awareness of health promotion campaigns in their home countries, or their perceptions of the

differences between health services at home and in the UK³⁰. A major concern in designing the questionnaire was the potential for 'research fatigue' among this group of respondents. Migrant workers have increasingly been the focus of a large number of high profile research projects across the UK, but *particularly* in the East of England, and there is a real danger of over-research leading to potential problems in recruiting samples for future projects. Consequently we were conscious of the need to minimise the number of questions included and clearly structure the questionnaire, in order both to maximise our response rate and to preserve the 'field' for other researchers.

The questionnaire was translated into both Polish and Portuguese in order to encourage responses from non-English speakers; those with fewer language skills had been identified in the literature review as likely to experience greater difficulty in accessing health services, making it particularly important to gain the views of this group. A convenience sample of potential respondents was identified from the migrant worker clients who accessed Keystone's META drop-in service during the fieldwork period³¹. At the end of consultations, clients were asked by META advisers to consider completing a questionnaire and where possible advisers completed the questionnaires with clients. However, due to the sensitive nature of some of the topics covered we also felt it was important to offer clients the option to complete the questionnaires at home and then return them to Keystone Reception at a later date³². A total of 150 questionnaires were distributed and 98 were returned, giving us a response rate of 65.3%.

One major advantage of our sampling technique was that META is seen among the migrant worker community as a trusted source of advice, meaning that clients may be more willing not only to complete a

questionnaire but may also feel more comfortable doing so. However, it should also be noted that this pragmatic choice of sampling technique could also bias the resulting data; by only including those who had accessed the META service there is a danger that we excluded a key group of potential respondents³³ with particularly acute support – and health – needs³⁴.

3.2.2. Focus groups

Three focus groups were held during March 2010; the 18 participants who took part in these groups were recruited from an initial 'pool'³⁵ identified from questionnaire respondents and other clients who subsequently accessed the META service after the initial period of quantitative data collection. Participants were initially contacted by text message two weeks before the groups were due to take place, which was followed up by a 'reminder' phone call one day before. Although migrant workers who completed the questionnaire were not offered an incentive³⁶ it was decided that due to the greater time commitment required from those participating in the focus group (which lasted for a maximum of one and a half hours) it was important to provide some form of incentive for taking part; therefore all focus group participants received a £10 high street shopping voucher. All focus groups were held outside of normal working hours³⁷ both to maximise the numbers of migrant workers likely to be able to attend and to minimise any inconvenience to them and potential intrusions into participants' precious leisure time.

A topic guide for the focus groups was developed from the literature review as well as an initial analysis of the questionnaire data. This topic guide was structured

similarly to the questionnaire and was divided into the following three sections³⁸;

- health services at home
- health services in the UK
- perceptions of health at home and in the UK (potential effects of migration)³⁹

Focus group discussions were audio recorded with participants' consent and subsequently fully transcribed and analysed thematically. Observational notes were also made during focus groups in order to assist the process of data analysis – for example, where particular issues prompted particularly lively debate or disagreement.

It was initially anticipated that separate focus groups may be needed for different groups of migrant workers, such as women and men or those of different nationalities who might have specific health needs or experience particular difficulties in accessing health services⁴⁰. However our initial analysis of the questionnaire data indicated that health needs and experiences cannot be neatly categorised according to gender or nationality, and that there is a considerable *variety* of experience. Accommodating all the potential categories of participant would have meant arranging a much larger number of focus groups which was not feasible within this project. Consequently a more pragmatic approach was adopted, and groups were broadly arranged according to the languages spoken by participants. Translation support was provided at all three focus groups by META staff so that participants with varied levels of English language ability could be accommodated. This was important in order to allow as wide a range of participants to be included as possible; however it is equally important to note that this inevitably meant a loss of some of the discursive 'flow' particular to focus groups.

3.3. Stage 2: Fieldwork with health professionals

In order to balance out the information gathered on migrant workers' perceptions and experiences of health services, we also carried out a survey of health service professionals (which included both providers and commissioners) using a structured questionnaire which respondents were able to complete online using Survey Monkey⁴¹. To obtain our sample we carried out an initial scoping review of primary care providers such as GPs and dentists in Thetford and surrounding towns such as Brandon. However, in order to maximise our response rate this was subsequently expanded to cover primary care provision across Norfolk and parts of Suffolk, and included areas such as Wymondham, Attleborough, Norwich and Bury St Edmunds⁴². We then telephoned this list of providers in order to identify key contacts (generally practice managers); these contacts were then emailed a letter which further explained the purpose of the research and included a link to the e-questionnaire⁴³. Given the widely publicised pressures on primary care providers' time and the relative frequency

with which they are approached to participate in research studies, potential respondents were given the option of nominating one member of each category of staff⁴⁴ to complete the survey – it was hoped that this would maximise our response rate, given the difficulty experienced by other researchers in recruiting professional respondents.

We were keen to investigate not only the views and experiences of front line professionals but also commissioners' perceptions of the demands placed by migrant workers on local provision, and the difficulties experienced in meeting these needs. Consequently, we carried out a scoping review of commissioning arrangements in both NHS Norfolk and NHS Suffolk and identified a list of relevant contacts. Where possible we noted the contact details of those professionals with particular responsibility for migrant health⁴⁵. Equality and Diversity managers and key figures in public health were also contacted, as this is often where the responsibility for migrant health lies. We also contacted commissioning managers across a range of services which migrant workers might use, such as mental health, sexual health, primary care and children's services.

CHAPTER 4: Migration and health – a review of the literature⁴⁶

A structured interview schedule was designed specifically for this group; the original intention was to distribute this electronically – however, given the length of time taken to collect responses from providers, and the low response rates noted among health commissioners in other studies we opted to conduct short structured telephone interviews instead, which were arranged at the convenience of the respondents and used the questionnaire as a guide. This strategy boosted our response rate, with 12 respondents from the commissioning side eventually taking part in the interviews. Interview discussions also helped us identify additional contacts.

In this section we consider the existing research evidence and literature on migration and health including the health issues and problems which migrant workers in the UK might face, their utilisation of health services and any barriers to access – as well as covering issues around health promotion. It has been suggested that migrant workers experience barriers to accessing and using health services in the UK because of cultural differences between the UK system and the system they have been used to at home – particularly with regard to the function of primary care provision. In section 4.1 therefore we explore the development of healthcare systems in sending countries, and identify a number of differences from the UK system which might affect migrant workers' experience of and attitudes towards provision in this country.

Following on from this, we highlight some of the some of the main health issues identified in sending countries, particularly those countries (Poland, Portugal and Lithuania) from which most migrants to the Thetford area originate. Levels and patterns of tobacco and alcohol consumption are discussed, as well as issues around diet, nutrition and physical exercise – along with the associated health risks/consequences. Information on a range of health promotion initiatives introduced in these countries is also included along with the results of any project evaluations, as well as any lessons which can be learnt around influencing health choices and behaviours, and which could be applied to the Healthy Town project.

Section 4.2 considers the range of health issues which might be experienced as a consequence of migration, and the potential implications for services in the UK. Despite widely expressed concerns, the initial indications are that the migrant worker population is relatively healthy and makes few demands on health services – indeed, it has been suggested that migrants often enjoy an initial health advantage over existing communities (this is often described as the 'healthy migrant effect'). In this section we consider whether migrants are in fact *disadvantaged* health-wise, particularly with regard to access to primary care services, and also whether the stresses of migration can adversely affect their mental health.

CHAPTER 4.1: Health at home

Since their transition in the 1990s to a democratic system of government, health systems in the majority of sending countries in Central and Eastern Europe (CEE)⁴⁷ have undergone extensive reforms, with wide-ranging changes to health care organisation, financing and delivery. Health systems in these countries were usually highly centralised, hierarchical state organisations which raised revenue through taxation. While the primary objective of these health systems was to ensure free access for all citizens to comprehensive care, by the early 1990s significant inequalities in health outcomes between different groups had started to emerge. Systems were usually supply-oriented, and often failed to meet the health needs of significant sectors of the population. During this period, many of the countries discussed here had particularly poor infant and adult mortality rates – a trend from which they are still recovering⁴⁸. Since healthcare reforms began in these countries, establishing a more equitable and efficient health system has been highlighted as a particular policy priority, and there has also been an increasing focus on health promotion. However, the pace and scope of change in the different countries has been

variable⁴⁹. Major differences remain between the organisation, funding and delivery of healthcare in sending countries and the UK system. The main *cultural* difference – and one which can cause problems for migrant workers living in the UK – is that, while the role of primary care providers has expanded, and there is more evidence of GPs acting as gatekeepers, most CEE countries retain the possibility of direct access to specialists (within hospital or outpatient settings) .

The following section gives an overview of the organisation and delivery of health services in the sending countries as well as the implementation and progress of reform, and aims to give an idea of the wide-ranging differences in quality and coverage of healthcare available to their populations. There is also a particular focus on the countries from which the majority of Thetford's migrant population is drawn: Poland, Portugal and Lithuania, along with the Czech Republic and Slovakia. The Latvian and Estonian systems are also discussed briefly due to the relatively poor health outcomes and high levels of inequality among their populations.

4.1.1. Health systems and policies

Czech Republic⁵⁰:

The Czech health system underwent extensive reforms in the 1990s, although the pace of change has slowed in recent years. Health services are based on a system of universal social insurance, with an element of co-payments and additional voluntary health insurance (VHI). There has been a particular focus on re-developing the primary care system, with four main groups of doctors as the first point of contact for Czech citizens: adult GPs, GPs for children and adolescents (paediatricians), ambulatory gynaecologists and stomatologists. As of 2005, Czech nationals were able to re-register with a primary care physician every three months, with no restrictions on choice of physician. In 1992, the Czech government also introduced a National Programme of Health Restoration and Health Promotion, which included smoking cessation initiatives and healthy diet projects, including a programme for healthy schools.

However, despite these improvements and innovations, significant criticisms have been made of the increasingly residualist nature of the Czech healthcare system⁵¹. For example, from January 2008 all patients must now pay a €1 fee for each visit to the doctor – with no exemptions for children or pensioners – as well as prescriptions for drugs, and each stay in the hospital. While this fee remains low, it has been seen as representative of a general trend away from universal provision.

Estonia⁵²:

In 1993, the new government established a Ministry for Social Affairs which included a Department of Public Health to focus on health promotion and improving negative

trends such as the relatively high mortality rate among working-age men. A number of health promotion initiatives have been launched since then, including the Heart Health Project and an Anti-Smoking Project. However, despite extensive structural change and initial evidence of the positive impact of new health programmes – for instance, life expectancy has increased and rates of certain diseases such as TB and STDs have dropped – there has been little sustained improvement across a range of health indicators, and there are still substantial inequalities in health outcomes. A 2002 study⁵³ also found a continued association between membership of a lower socio-economic group, lower life expectancy and lower levels of access to/utilisation of health care – as well as growing educational and ethnic differences (between native Estonians and Russians) across a range of health behaviours such as tobacco and alcohol consumption. Funding of health promotion initiatives has also remained static since 2001, and despite several high profile campaigns there has been little overall decrease in levels of tobacco and alcohol consumption.

Lithuania:

The Lithuanian health care system has also gone through a period of major transformation since the early 1990s. While the overall aim has been to increase the efficiency of healthcare provision, Jakušovaite et al. (2005) argue that the changes needed to ensure this happens have not yet been fully implemented, with the result that there are still significant inequalities in access and outcomes. For example, the equality target outlined in the Lithuania Health Programme (1998), which stated that by 2010 socio-economic differences in access to healthcare – particularly differences between rural and urban areas – should be reduced by 25%, has not been met.

Latvia⁵⁴:

During the process of decentralisation, the main focus in Latvia was on establishing a network of primary care providers – before that point, care had generally been provided in acute settings. Healthcare is now provided through a tax-funded social insurance system (the Government has experimented with a variety of social insurance models). Over recent years, since the introduction of additional user charges, the private share of healthcare spending through VHI has increased. While the current system is seen as better than the centralised model of provision that preceded it, and there is – in theory at least – a commitment to universal entitlement, concerns have been expressed about continued and significant inequalities in health outcomes between different sections of the population, with those in higher income brackets able to purchase shorter waiting times and better quality care. Consequently Latvia has the highest level of income-related health inequality – certainly among the Baltic states – with significant numbers of Latvians unable to access the necessary care⁵⁵.

While the number of GPs and dentists practicing in Latvia has risen since the 1990s, the overall number of doctors, as well as midwives and nurses, has steadily declined – Tragakes (2008) has suggested that this is due to the fact that salaries remain comparatively low, and medicine is not seen as a particularly prestigious profession.

Poland:

At the beginning of the 1990s, the Polish health care system was 'over-centralised, over-specialised and costly'⁵⁶, as well as being poorly managed. Levels of public dissatisfaction with healthcare provision were particularly high, and the issue of health service reform became a policy

priority. This period marked a 'radical shift to a decentralised, insurance-based system' under the Strategy for Health programme (1994)⁵⁷. There were also major changes in the coverage and function of primary care, with GPs – or 'family doctors' – taking on more of a gatekeeping role. In 1999 a new obligatory health insurance system was introduced, which operated through 16 regional 'sickness' funds. However, there were a number of concerns about the efficiency of this system and in 2003 it was abolished; health insurance is now administered by the regional branches of the National Health Fund (NHF).

While many positive changes were made during this period of transition, and key reforms implemented, progress towards more equitable provision and outcomes has been 'slow and piecemeal'⁵⁸. Consequently, despite the increased emphasis on primary care provision and family medicine, the number of specialists still exceeds the number of GPs – possibly because of the relatively low pay that GPs receive⁵⁹. There is still a high level of private spending on health care (27.5%), with the result that those groups which are less able to purchase higher quality services are at risk of experiencing poorer health outcomes and limited access⁶⁰. Particular criticism has also been levelled at what is seen as a serious under-investment in public health and preventative services⁶¹. The Polish Chamber of Physicians warned in 2004 that if levels of pay and working conditions did not improve, there would be an 'exodus' of Polish doctors to Western Europe after accession to the EU; an opinion survey conducted at the time found that almost a third of doctors planned to work abroad in Western European countries⁶². Over recent years the Polish health care system has become increasingly destabilised; for example, there has been a series of strikes by health care providers in protest at low levels of pay and the underfunding of

services (with Poland spending one of the lowest amounts in Europe on health care as a percentage of GDP).

Portugal:

Portugal has a national health service (NHS), managed by the Ministry of Health⁶³, with the aim of providing a guaranteed universal right to health care which is (mostly) free at the point of use, although there is an element of co-payments and co-insurance for things such as medicines. The NHS also overlaps with a number of 'health subsystems' providing special public and private insurance schemes for certain professions.

Primary health care is mainly delivered through publicly funded and managed health centres (HCs), each of which covers an average of 28,000 patients – although this can vary widely between fewer than 5,000 and more than 100,000 patients. HCs have an average of 80 staff each, although again this can vary widely from over 200 staff to just one⁶⁴. Care is usually delivered by GPs and nurses, although some centres offer specialised care. Patients can choose between providers in a geographical area and, while the majority register with a GP in their residential area, some register with a GP near to their place of work. As in the UK, GPs operate on the basis of patient lists, which are on average approximately 1,500 patients. However, concerns have been raised that – despite the relatively comprehensive coverage of primary care services – many Portuguese residents prefer to access secondary and specialist care directly, leading to an excessive burden on emergency departments⁶⁵. There are also a number of issues with equality of access for poorer and geographically isolated sections of the population, and there are also indications that the population has a generally low opinion of the quality of primary care provision⁶⁶.

There have been some recent reforms of the primary care system to improve quality of and access to care, such as the implementation (since 2006) of a system of Family Health Units (FHUs) which are voluntarily formed multidisciplinary primary care teams. However, Barros and de Almeida Simões (2007) note that, despite the focus on primary care, the role of hospitals as the centre point of health care delivery has remained unchanged, with many Portuguese residents accessing emergency care rather than visiting a primary care provider. The apparent underfunding of primary care provision has been heavily criticised, and barriers to access for some sections of the population have been noted; for example, an estimated 750,000 Portuguese residents (representing approximately 7% of the population) have no GP⁶⁷.

Slovakia:

As with most of the other countries discussed here, Slovakia's health system has undergone a process of decentralisation, although progress has been slower than in other countries⁶⁸. Within the primary care system there are four 'types' of doctor; GPs for adults, GPs for children and adolescents (paediatricians), gynaecologists and dentists. All of these act as gatekeepers to specialist services, although patients can self-refer to ophthalmologists in cases of eye injury and for spectacles. In some cases, patients can also go directly to psychiatrists, geneticists and specialists in sexually transmitted diseases. Patients with a chronic condition who are registered with a specialist clinic also have direct access to the relevant specialist provision, and do not need to be re-referred by their GP. Slovakian residents also have the right to change their primary health care physician every six months.

Since 1995 there has been an increased focus on health education and promotion⁶⁹, and in 2000 a new State Health Policy was published which aimed to incorporate the WHO 'Health for All' objectives⁷⁰. However, a lack of clear lines of responsibility for funding and implementing programmes has meant that progress in improving public health outcomes has been mixed⁷¹.

4.1.2. Key health issues

This section will highlight some of the main health issues identified in sending countries, focusing in detail on areas prioritised within the Change4Life and Healthy Town initiatives such as levels and patterns of tobacco and alcohol consumption, as well as issues around diet, nutrition and physical exercise – along with the associated health risks/consequences. Information on a range of health promotion initiatives introduced in these countries is also included along with the results of any project evaluations, as well as any lessons which can be learnt around influencing health choices and behaviours, and which could be applied to the Healthy Town project.

A. Tobacco:

Several of the countries discussed here have comparatively high rates of smoking, often despite anti-smoking publicity campaigns and smoking cessation initiatives introduced by national governments⁷². The chart below (Fig. 1), which uses data collected by the International Labour Organisation (ILO), shows smoking prevalence in a range of European countries. While rates in CEE countries are not as high as those in some of the former Soviet Republics they are still higher than the European average, with particularly high rates among female populations, among whom smoking rates are generally lower. For instance, at 22.0% the prevalence of smoking among adult women in Slovenia is almost equal to the prevalence of smoking among men (24.0%). Poland (23.0%), Bulgaria (23.0%) and Hungary (24.6%) also have relatively high rates of smoking among women. Rates of smoking among men are high in many of the countries: for example, 47.3% of Latvian men smoke, as do 42.1% of Lithuanian men, 41.1% of Slovakian men, 40.9% of Estonians and 37.0% of Polish men. Similarly, a report published by the

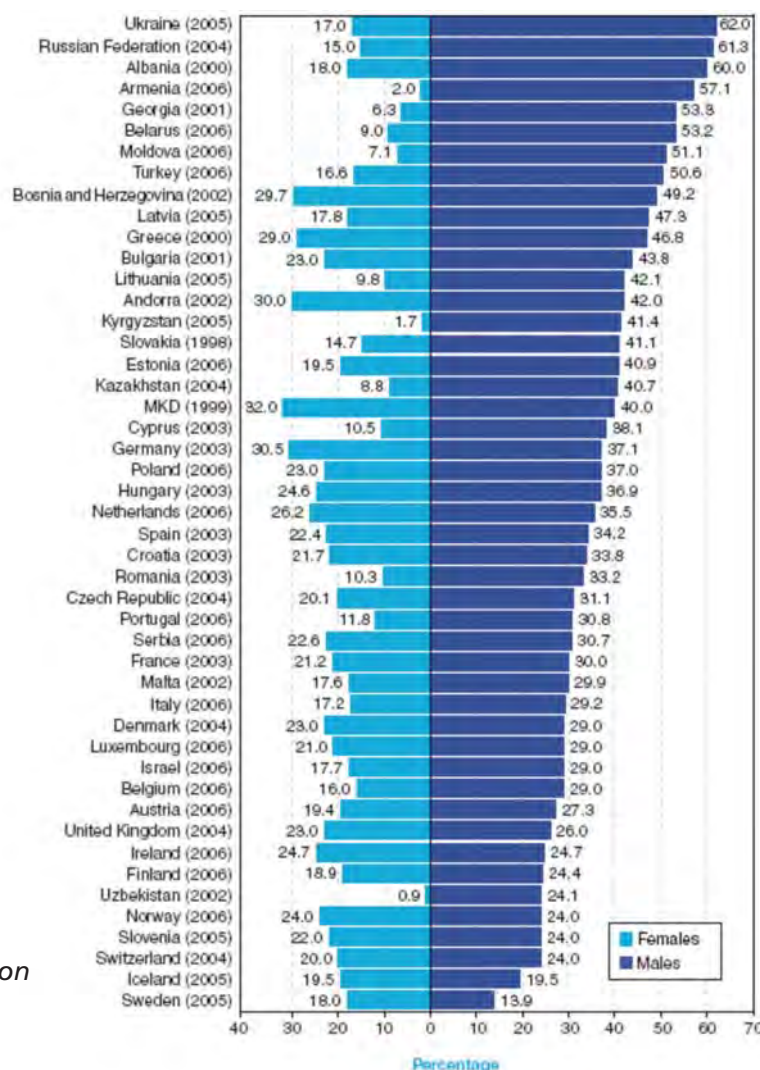
Estonian National Institute for Health Development⁷³ showed high levels of daily smoking among males of all age groups – for example, 51.1% of 25 to 34 year olds and 52.5% of 35 to 44 year olds.

Levels were lower among women, but were still high – particularly among slightly older women, with just 19.5% of 25 to 34 year olds identified as daily smokers compared with 27.2% of 35 to 44 year olds and 23.6% of 45 to 54 year olds. Daily smokers were also disproportionately represented among those who had no health insurance, and might therefore be less able to access appropriate medical care when needed.

Previously, levels of tobacco consumption in Portugal were comparatively low – indeed, Portugal had the lowest smoking rate in the Eur-A group⁷⁴. This is due partly to the country's comparatively early introduction of strict bans on smoking on public transport and in public facilities, as well as tight controls on tobacco advertising. However, rates have now caught up to some extent. Consequently, while smoking is still relatively uncommon among girls and young women, it is increasing.

Fig. 1: Prevalence of (all) smoking among adult populations of European countries

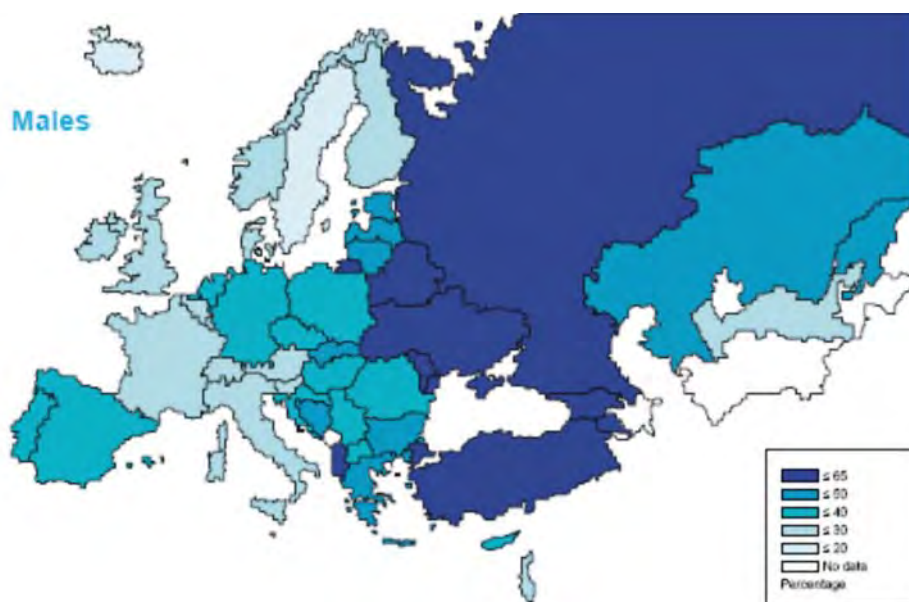
Source: World Health Organisation (2008: 93)



The two maps below (Fig. 2 and Fig. 3) also show that patterns of heavy (daily) smoking are fairly high in several sending countries, although there are significant inter-country differences, and intra-country differences between patterns of male and female smoking. Smoking rates among men in Estonia, Latvia and Lithuania fall into the

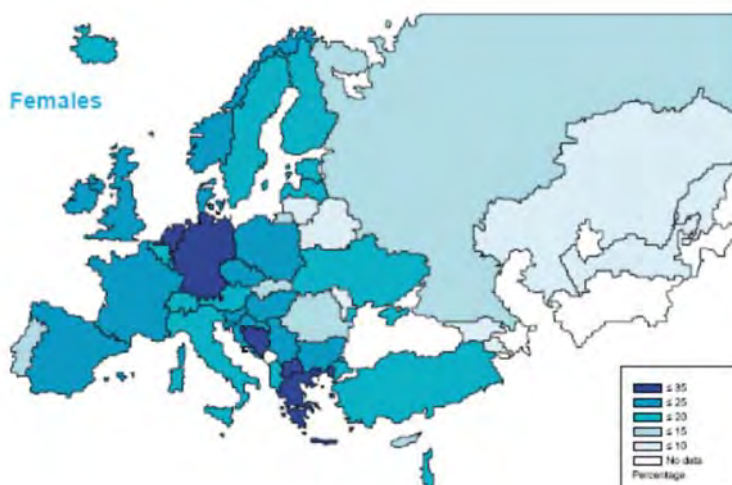
second highest bracket, yet the second map shows that the rate of regular, heavy smoking among Lithuanian women is one of the lowest, and that smoking among Romanian women is also relatively rare – compared with Germany, for example, where the rate of smoking among adult women is particularly high.

Fig. 2: Regular daily smokers (males) aged 15 years and over



Source: World Health Organisation (2008: 93)

Fig. 3: Regular daily smokers (females) aged 15 years and over



Source: World Health Organisation (2008: 93)

Smoking among younger age groups has also been identified as a problem in a number of sending countries. For example, a study of tobacco use in Lithuania found that since 1994⁷⁵ the prevalence of smoking among teenagers (aged 11 to 15) and adult women had increased significantly⁷⁶. Rates of (all) smoking among Lithuanian women also rose dramatically between 1994 and 2002 from 6.3% to 12.8%, with a particular increase among young women from 4.3% to 14.3% – although if we refer to the maps above, the prevalence of *heavy* smoking remains comparatively low. The number of boys smoking at least once in the previous month rose from 11.3% to 23.6%, with a particularly steep increase among 15 year old boys among whom smoking rates rose from 23.0% to 46.8%, while there was an equivalent increase among girls of the same age from 7.7% to 30.3%. The European School Survey Project on Alcohol and Other Drugs (ESPAD)⁷⁷ reported similar findings on tobacco use among students; particularly high rates were noted in Bulgaria, where 40% of students reported having smoked in the past 30 days, the Czech Republic (41%) and Latvia (41%) – compared with a study average of 29%. Conversely, rates were *lower* than average in Portugal, where just 19% of students smoked.

Policy-makers and researchers have consistently raised concerns about the high prevalence of tobacco use in Poland, particularly among *daily* smokers – in the 1980s it was estimated that after Hungary, Poland had the highest rates of lung cancer in Europe, while the rate of lung cancer among middle aged Polish men in particular was one of the highest in the world⁷⁸. It has been suggested that under the totalitarian regime, information on the tobacco-related health issues was heavily censored and that public awareness of the health risks around smoking was fairly low⁷⁹. Despite some improvements in the 1980s, the situation deteriorated further in the early 1990s;

political change and the introduction of free market principles had the effect of making a wider range of cigarettes *more* readily available, meaning that their consumer appeal rose. A tobacco marketing drive halted the slight decline in rates of smoking that had been achieved during the 1980s and tobacco use became more prevalent, with a particular increase in the numbers of young smokers (such as those aged between 11 and 15). Towards the end of the decade, however, policy-makers began to focus on the health risks of tobacco use and to discourage smoking. The Polish government adopted various EU standards and recommendations on tobacco advertising and marketing, such as the publication of health warnings, and also recognised the need for regular collection of data on smoking patterns as well as public education on the health risks and development of smoking cessation support initiatives.

A recent study of tobacco use among Polish migrants living in Dublin⁸⁰ found a higher smoking rate among migrants than Irish residents, which contradicts the idea of a ‘healthy migrant effect’ (see section 6). Higher rates of smoking were found particularly among those migrants who were employed, had only primary level education and had been overseas for a period longer than two years. At 50.9%, the study predicted higher levels of tobacco use among men rather than women – although the rate was still comparatively high among female migrants at 39.8%. Rates were particularly high among 19 – 40 years olds, with almost 20% of Polish men aged under 20 identifying themselves as smokers. Furthermore, Polish migrants were more likely to be *heavy* smokers⁸¹ (20%) than Irish nationals (10%).

Perhaps most significantly, the study found that while 50% of Polish respondents were planning to quit smoking, *only 8% had sought medical advice on smoking*

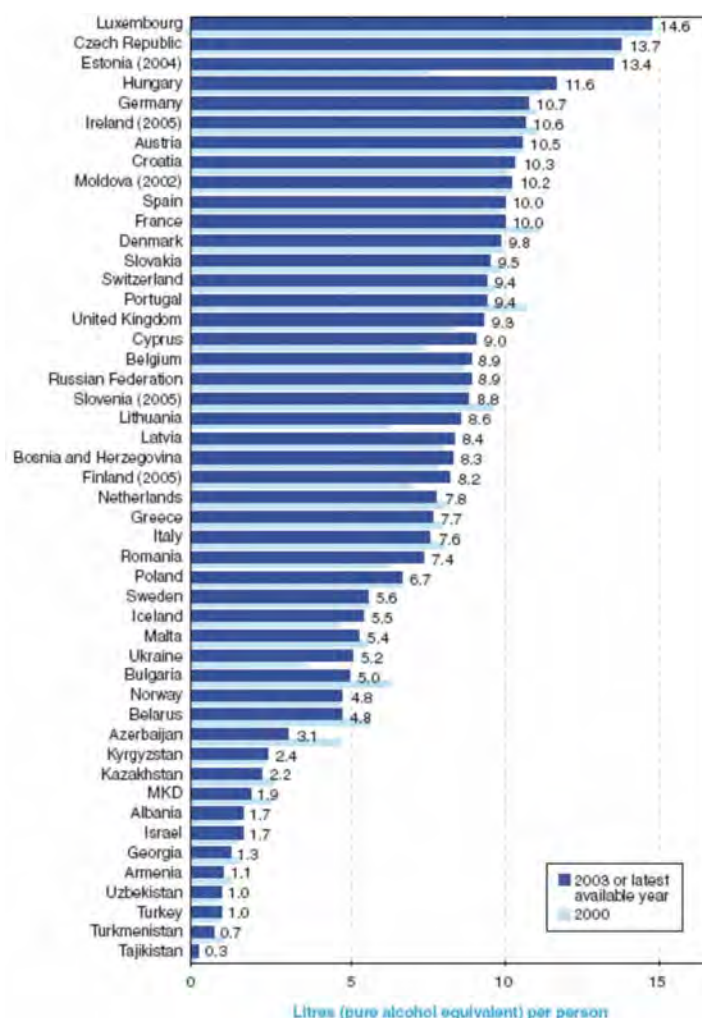
cessation. Any future research would need to investigate this further, and examine the possible reasons for this non-help seeking behaviour – which could then be used to inform and develop smoking cessation initiatives. Decisions about smoking among Polish respondents in this study were influenced by a wide range of factors *besides* receiving information about the negative health effects.

In contrast to the Irish smokers surveyed, migrant smokers were relatively well educated and usually employed, often with high incomes. The authors of the study argued that changes in migrants' economic situation after Poland's accession to the EU, which meant that many had higher levels of disposable income, could equally influence tobacco use. They also talk about something called the 'bargain effect'; the ease of travel between Ireland and Poland, where cigarettes are relatively cheap⁸², could also act as an inducement to smoke. If, as has previously been suggested, migrant workers are adopting increasingly transnational lifestyles (see section 4), this trend may become more marked and it would be useful for the planned research to explore this issue further and assess the potential implications for smoking cessation initiatives.

B. Alcohol

High levels of alcohol consumption and drinking patterns have also been identified as a major public health concern across Europe. The chart below (Fig. 4) sets out data on total alcohol consumption, with particularly high levels in several sending countries such as the Czech Republic, Estonia and Hungary. Moreover in some of the countries – for example, Lithuania and Estonia – levels of alcohol consumption *rose* between 2000 and 2003. Concerns have been raised around particularly high levels of alcohol consumption in the Baltic Republics of Latvia, Lithuania and Estonia; for example, one study found that Estonia had a particularly high rate of *heavy* drinking (over 80g per day) especially among men, with one in ten identified as a heavy drinker⁸³. Research has found that a high percentage of Latvians consume particularly strong varieties of alcohol and that the country has raised levels of binge drinking, particularly among adult men, 23.7% of whom reported drinking to excess (a slight rise from 22% in 2004)⁸⁴. Figures published by the World Health Organisation (WHO) also indicate that while levels of alcohol consumption in Portugal are decreasing, they still remain significantly higher than the Eur-A average⁸⁵. An investigation into alcohol use and associated harm in Slovenia found that between 1982 and 2002, there had been an overall *decrease* in annual alcohol consumption per capita, from 11.5 litres to just 9.8 (representing a 15.1% drop), although the rate of decrease had slowed dramatically since 1991⁸⁶.

Fig. 4: Total alcohol consumption in European countries



Source: World Health Organisation (2008: 99)

Despite this apparent improvement, the authors of this study argue that rates of consumption remain high compared with other European countries, and these findings were replicated in a subsequent study which found that Slovenia was third overall in the WHO group of countries, with rates of alcohol consumption over 10 litres per person (which also included Lithuania, Portugal and the Czech Republic)⁸⁷. This research also identified one third of adult male Slovenians and one in ten adult women as 'risky' drinkers, with between 10 and 15% of all adults identified as alcoholics.

It is important to recognise that within these overall patterns there are significant differences according to a range of socioeconomic characteristics including age, ethnic group, education and income level. For example, in all three Baltic Republics rates of alcohol consumption decreased significantly with age, with fewer than one in twelve women over 50 identified as heavy drinkers⁸⁸. In Lithuania, there has been a particularly steep rise in levels of alcohol consumption among children and adolescents⁸⁹. Hence studies have shown that in 2002, 13.4% of boys and 6.5% of girls reported consuming alcohol on a regular basis – rates which increase rapidly

with age, so that rates among 15 year olds were significantly higher (27.3% of boys and 12.9% of girls). The ESPAD study⁹⁰ reported similar findings while also highlighting major differences between countries. In Bulgaria, although the proportion of students who reported drinking in the past 12 months was around the European average, at 45% the proportion who had been *drunk* was higher. Latvian students were above study averages for both tobacco and alcohol consumption; Polish students, however, reported levels of drunkenness (31%) *lower* than the ESPAD mean. Students in Portugal were also less likely to report having been drunk (26%). Romania in particular was identified as a 'very low prevalence' country, with only 26% of students reporting being drunk, and those who did drink only drinking comparatively low volumes of alcohol. Data on problem drinking in Estonia indicates significant and growing differences between ethnic groups, with Estonians reporting higher rates than Russian nationals; in Lithuania, however, levels were higher among Russians than Lithuanians⁹¹.

Problem drinking has had particularly marked health consequences in a number of the countries discussed here, the long-term effects of which are still becoming apparent. For example, between 1990 and 1995 deaths from cirrhosis of the liver *doubled* in both Estonia and Latvia (with a 50% increase in Lithuania)⁹². In 2000 there were 170 alcohol-related deaths per 100,000 population in Lithuania, 172 per 100,000 in Estonia and 180 per 100,000 in Latvia, rates which were *triple* the EU-15 average. Similarly in Hungary there were 160 alcohol-related deaths per 100,000 population, which was double the EU-15 average⁹³. Furthermore, while recorded consumption rates have dropped in several countries, levels of *unrecorded* consumption have either remained stable or risen.

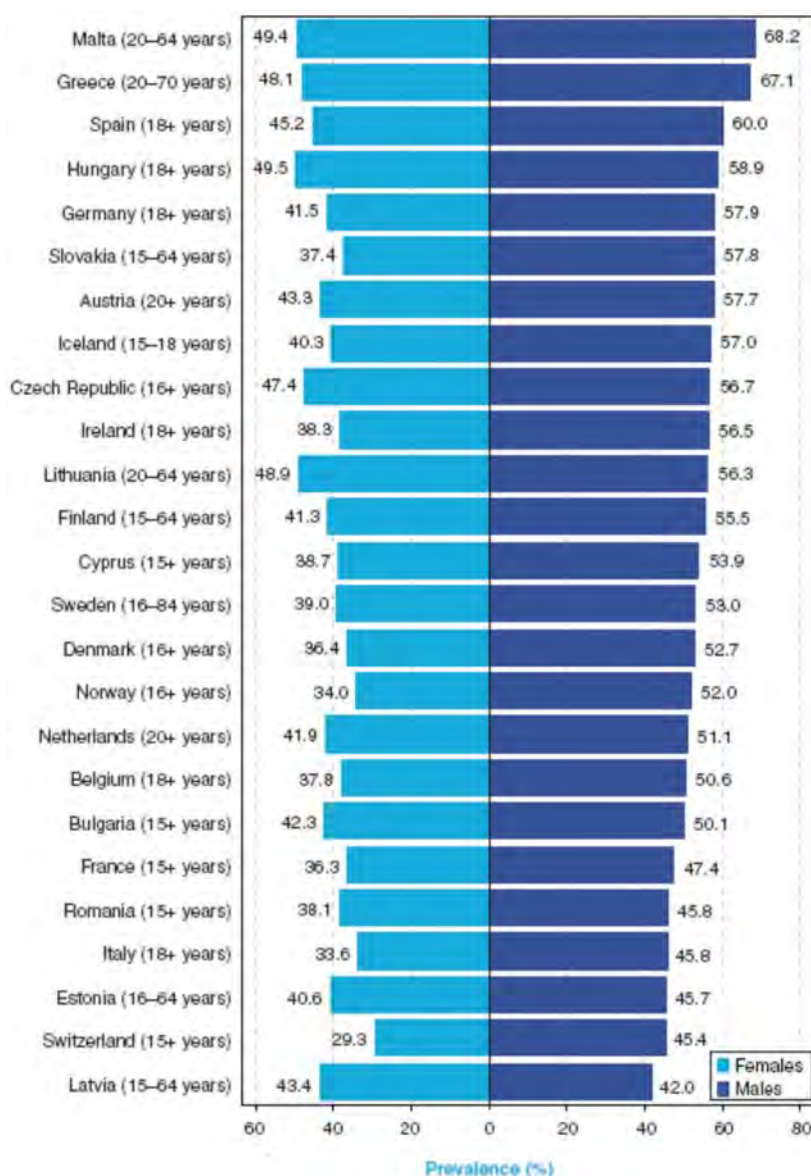
In Slovenia, the standardised death rate for liver cirrhosis is high, at 38.9 per 100,000 inhabitants over 15 years of age; rates of hospitalisation/absences from work due to the direct impact of alcohol are also high, and result in an estimated 'economic burden' of between 2 and 3% of national gross income⁹⁴. While *overall* there has been a decrease in alcohol-related mortality in Slovenia, this is still an issue for concern and is subject to 'substantial yearly oscillations'⁹⁵.

C. Diet, nutrition and physical exercise

Poor diet, physical inactivity and prevalence of overweight and obesity are significant issues in a number of sending countries. There are indications that the obesity 'epidemic' identified in Western European countries is now beginning to 'migrate' eastwards⁹⁶, and that poor diet and the associated health consequences – such as the effects on mortality rates, and levels of associated morbidity (such as increased levels of cardio-vascular disease) – is becoming an increasingly prevalent problem in a number of CEE countries.

In many of these countries there has been a 'dramatic decrease' in rates of physical activity, along with significant changes in eating habits⁹⁷. For example, the number of Hungarians who are obese (with a body mass index (BMI) over 35) has doubled since 1989, while 75% of men in the Czech Republic and 80% of Latvian are overweight (with a BMI over 25). Similarly, 56% of Bulgarians and almost 50% of the Slovakian population are overweight. According to Spitzer (2004), this is partly a legacy of food policies introduced under the previous political regime which were geared towards the production and consumption of large amounts of meat and fat.

Fig. 5: Prevalence of overweight among adults in European countries (latest available year for the period 2000 – 2006)



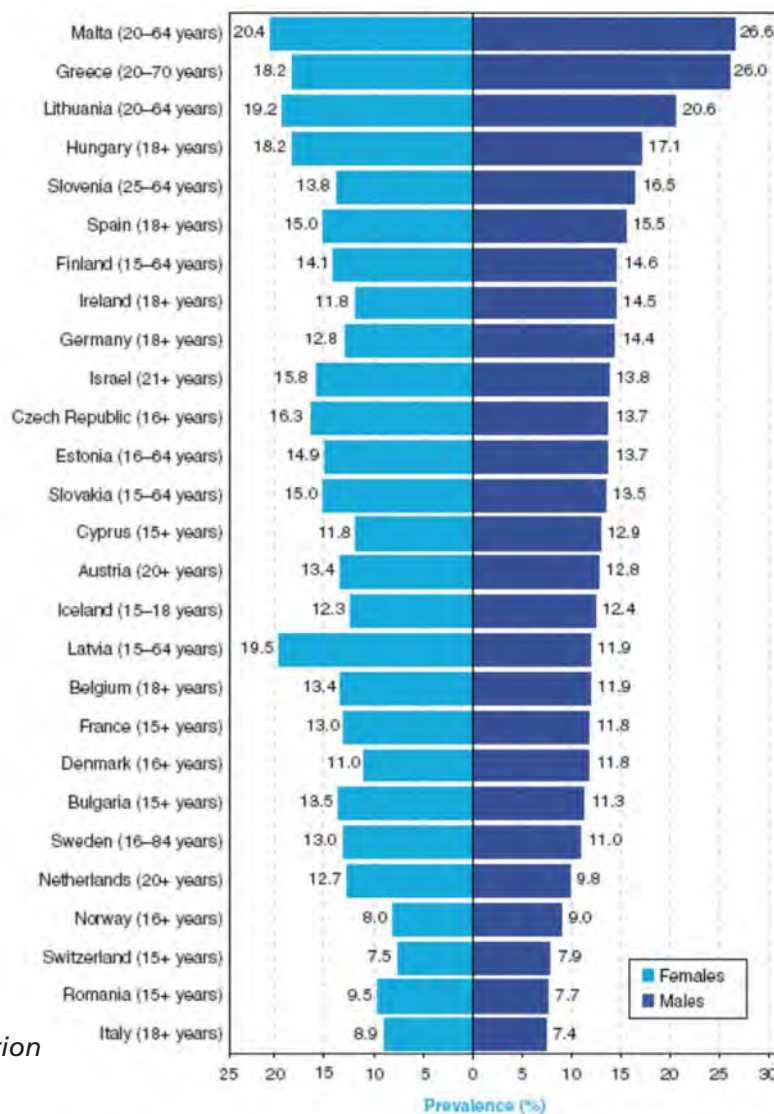
Source: World Health Organisation (2008: 95)

As the two charts shown (Fig. 5 and Fig. 6) indicate, there is a high prevalence of overweight and obesity in several of the countries considered here. However, it should also be noted that these patterns are far from simple and uniform across the countries discussed in this report, and that there are key differences *within* countries across a range of socio-economic factors⁹⁸. As fig 5 shows, relatively high proportion of adult Hungarian women in Hungary are overweight (49.5%), with similar patterns identified in Lithuania (48.9%) and the Czech Republic (47.4%) compared with other European countries

such as Norway (34%) and Switzerland (29.3%). The variation is less marked among men, although a number of sending countries have high proportions of overweight men such as Hungary (58.9%), Slovakia (57.8%) and Lithuania (56.3%), while others such as Latvia (42.0%) and Estonia (45.7%) have *lower* proportions.

When we look at the data for levels of obesity in fig. 6, it is possible to observe similar patterns. For example, the prevalence of obesity is particularly high among Lithuanian and Latvian women at 19.2%

Fig. 6: Prevalence of obesity among adults in European countries (latest available year for the period 2000 – 2006)



Source: World Health Organisation (2008: 96)

and 19.5% respectively, compared with just 8.0% in Norway and 7.5% in Switzerland. Interestingly, prevalence of both overweight and obesity are relatively low in Romania and (to a lesser extent) Bulgaria.

Obesity among children and young people has also been identified as a particular policy priority at European level⁹⁹, with concerns raised around recent increases in levels of physical inactivity, including the increasing amount of time spent engaged in sedentary activities such as watching television and using computers¹⁰⁰. Significantly, some of the countries on which this report focuses

have lower rates of adolescent overweight and obesity – for instance, fewer young people in Lithuania and Latvia are overweight (5.1% and 5.9% respectively) while very small proportions are obese (0.4% and 0.5%). Rates are also fairly low in Poland, where 7.4% of young people are overweight and 1.1% are obese, Estonia (6.5% overweight and 1.0% obese) and the Czech Republic (9.1% overweight and 1.0% obese). However, rates are much higher in South-West European countries including Portugal¹⁰¹, where 15.0% of young people are overweight and 3.0% are obese (see Table 2 below).

Table 2: Food intake and physical activity by country

Source: Janssen et al. (2005: 128)

Country	High fruit intake*	High vegetable intake*	High sweets intake*	High soft drink intake*	Physically active [∞]	High TV viewers	High computer users
Czech Republic	42.5	27.9	25.2	28.6	42.4	47.0	26.1
England	27.1	28.6	31.6	38.1	41.8	51.9	37.2
Estonia	20.1	15.4	28.4	9.8	25.2	63.0	32.4
Hungary	31.7	15.1	34.1	32.5	29.3	39.1	22.8
Latvia	24.0	28.7	27.6	15.6	30.1	62.6	26.7
Lithuania	22.2	30.1	18.9	10.2	42.7	57.3	23.3
Poland	46.1	36.3	36.4	25.4	35.3	52.5	31.8
Portugal	48.8	26.9	22.5	33.5	25.4	52.8	25.4
Scotland	34.2	33.4	45.1	46.9	39.9	50.1	38.8
Slovenia	39.0	25.7	26.4	39.6	40.8	39.6	22.7
Wales	23.0	21.1	26.7	36.5	36.5	53.0	32.8

* percentage of study participants who reported consuming food item once per day or more often

[∞] percentage of study participants who reported participating in 60 minutes or more cumulative physical activity on 5 or more days per week (ave. of last week and typical week)

Poland:

There are indications that obesity is a growing problem in Poland, with a number of associated health risks; for example, rates of cardio-vascular disease are the leading cause of death in Poland (accounting for 56% of all deaths). Among Poles aged 15 and older, 10% of males and 11% of females are clinically obese. For males in this age group the average BMI is 25.2, meaning that the average Polish man is overweight¹⁰², and a total of 31% of the adult population is reported to be physically inactive¹⁰³. A

recent study identified a particular increase in obesity among adult women in the Lower Silesian region between 1993 and 2003 from 8.9% to 15.0%, while the proportion of women who were overweight also rose from 30.7% to 34.0%¹⁰⁴.

However, over the same period the proportion of men who were overweight *fell* sharply from 44.2% to 24.0%. There are also significant regional variations in prevalence of overweight and obesity, with particularly high rates in the eastern part of the country (see Table 3 below).

Table 3: Prevalence of overweight and obesity in women and men depending on the region of Poland

Source: Milewicz et al. (2005: 114)

	Women		Men	
	Overweight (%)	Obesity (%)	Overweight (%)	Obesity (%)
Lower Silesia	45.0	22.5	39.0	15.75
Upper Silesia	35.0	25.0	45.0	20.0
Lublin	32.9	36.1	39.6	23.6

The same study also found that young people in Poland were less likely to be overweight or obese, while rates were particularly high among the 40 to 60 age group.

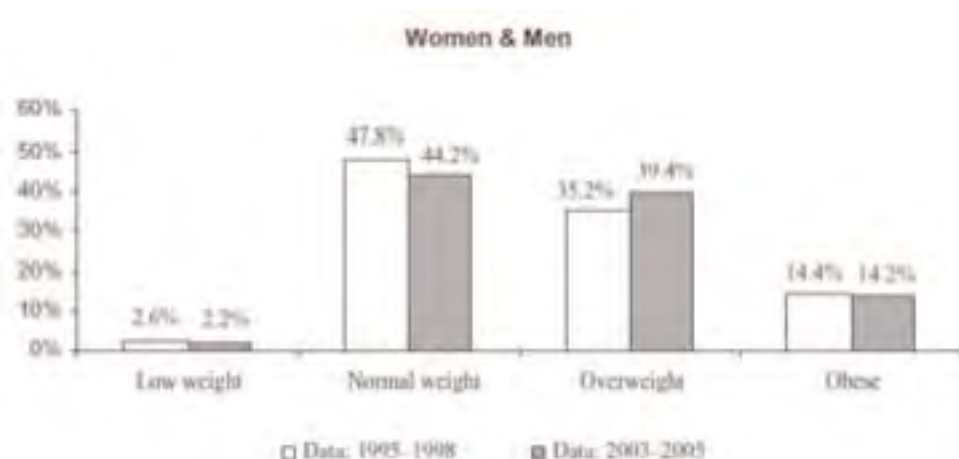
Portugal:

Since the first nationally representative survey was undertaken between 1995 and 1998, data has consistently indicated a high prevalence of overweight and obesity in Portugal¹⁰⁵. As shown in the graph below (Fig. 7), the overall proportion of Portuguese who are either overweight or obese has also risen significantly from 49.6% (1995 to 1998) to 53.6% (in the 2003 to 2005 survey). The results for 2003 to 2005

indicate that 38.6% of adults (between 18 and 64 years) are overweight, while a further 13.8% are obese¹⁰⁶. More men (60.2%) than women (47.8%) are overweight or obese, and older adults are more likely to have a weight issue¹⁰⁷. Levels of obesity among children and young people have also been highlighted as a significant problem, with 31.5% of 7 to 9 year olds identified as either overweight or obese which is a particularly high rate compared with other European countries, and is second only to Italy (36%)¹⁰⁸. Similarly, data published by the World Health Organisation indicates that 15% of boys and 6% of girls in Portugal are 'pre-obese', figures which are considerably higher than the Eur-A average¹⁰⁹.

Fig. 7: Prevalence of body mass index categories in 1995-1998 and in 2003-2005 (by gender) in Portugal

Source: do Carmo et al. (2007: 15)



There is also an apparent link between the prevalence of overweight/obesity and educational or income level, although caution must be exercised in drawing any firm conclusions about causality. Nonetheless, it has been found that the chance of being overweight or obese decreases with the level of education; 45.1% of Portuguese women with 'low' levels of education were identified as obese, compared with 37.9% of women in the 'medium-low' bracket, 31.1% with a

'medium-high' level of education and just 25.9% of women who had the highest level of education¹¹⁰.

There are a number of heightened health risks associated with these overall trends. For example, 45.6% of the sample in one of the studies mentioned here¹¹¹ suffered from various weight-related illnesses and conditions such as cardio-vascular disease, with 22.2% at very high risk of becoming ill. The costs of treating weight-related illnesses

have been estimated as making up 3.5% of the country's total expenditure on health¹¹². However, despite the fact that prevalence of overweight and obesity has been recognised as a significant problem in Portugal for the past ten years, policy responses have had little apparent effect¹¹³.

Lithuania:

There is a sizeable body of research looking at diet and nutrition in the three Baltic republics, which has indicated generally high levels of overweight and obesity, comparatively low levels of fruit and vegetable consumption and a worrying association with major health problems such as cardio-vascular disease and a range of cancers¹¹⁴. The mean fat intake among Latvians, Lithuanians and Estonians remains high and has often exceeded recommended levels, comprising between 15 and 30% of the dietary energy of people in those countries¹¹⁵.

In Lithuania, the prevalence of overweight and obesity has increased significantly in recent years. According to data collected by the FINBALT survey¹¹⁶, in 2002 49.1% of all Lithuanians were overweight, while 16% were obese¹¹⁷. More men (57.4%) than women (42.4%) were overweight and, while levels of obesity among men rose from 10.6% in 1994 to 16.2% in 2002, there was a slight¹¹⁸ decrease among women from 18.9% (1994) to 15.8% (2002). Nonetheless, levels of obesity among Lithuanian women remain high compared with other European countries. Levels of obesity also increased sharply with age; research has identified 0% of men aged between 20 and 24 as obese compared with 30.1% of those aged between 55 and 64, while among women levels rose from 2.6% of those aged between 20 and 24 to 29.7% of 55 to 64 year olds. Moreover, the overall population is also relatively sedentary; among Lithuanians aged between 19 and 65, only 64% of men and 57% of women are physically inactive¹¹⁹.

A number of positive trends have been observed in the nutritional habits of Lithuanians. For example, consumption of vegetable fat rather than animal fats such as butter, lard and whole milk has increased, as has consumption of dark bread, fresh fruit and vegetables¹²⁰. Between 1994 and 2002, the proportion of Lithuanians using vegetable oil in their cooking rose from 31.3% to 83.2% of men and from 47.7% to 92.6% of women¹²¹ while use of lard and butter decreased over the same period from 46.2% to 11.2% of men and from 30.8% to 4.8% of women. Regular consumption of fresh fruit and vegetables (on a minimum of three days per week) increased from 18.1% of men and 24.8% of women in 1996, to 45.7% of men and 55.8% of women in 2002. Lithuania scores highly on this indicator compared with Latvia and Estonia; in 1999 it was reported that 70% of Lithuanians consumed fresh fruit and vegetables daily compared with 43% of Latvians and just 34% of Estonians¹²².

However, beneath this superficial improvement there are several important differences, particularly relating to gender, educational level and income group – particularly with high prices restricting the opportunity to make healthy food choices. Lithuanian women are more likely to consume fresh fruit and vegetables, fish and cereals, and to use vegetable oil rather than animal fats in their cooking. Research has also shown that Lithuanians who are better educated have healthier dietary habits, such as consumption of fish, fruit and vegetables, and use of vegetable oil for cooking, and are more likely to be physically active¹²³. Men and women with lower levels of education have been found to consume more whole milk, while higher educated women consume meat less often; hence the odds of eating meat daily are 41% lower among women educated to university level. However, a higher level of education does not always influence healthier dietary habits.

For example, Lithuanians with a higher level of education were more likely to consume butter rather than margarine with bread – and better educated Lithuanian men have also been found to consume more cheese¹²⁴.

Lithuanians living in cities have been found to eat fresh fruit and vegetables more regularly; for example, 53% of men and 61% of women living in cities eat fresh vegetables on at least three days per week compared with 36% of men and 42% of women living in villages¹²⁵. Conversely, men and women living in rural areas were more likely to favour ‘heavy’ foods with high fat and sugar contents¹²⁶, and less likely to consume fresh fruits or berries at least three times per week at 12% of men and 18% of women, compared with overall consumption rates of 36% (men) and 44% (women)¹²⁷. The nutritional deficiencies discussed above have serious health implications, and are responsible for a significant proportion of the country’s disease burden.

Latvia and Estonia:

Among Latvians over 15 years of age, 9.5% of men and 17% of women (almost 14% of the overall population) are identified as clinically obese¹²⁸, while 41% of men and 33% of women are pre-obese. In all, an estimated 50% of the adult population is overweight. Levels of physical activity are relatively low; among respondents in a recent study, only 38.2% of men and 29.8% of women engaged in a minimum of 30 minutes of exercise causing mild breathlessness at least 2-3 times per week¹²⁹. Similarly an earlier piece of research found that high proportions of respondents from the Baltic region – particularly Lithuanians (60%), but also 52% of Latvians – only took part in sedentary leisure activities such as reading or watching television¹³⁰. Only 8% of Latvian respondents engaged in physical activity, such as jogging or cycling, which caused them to break into a sweat. The

overall prevalence of overweight and obesity among Estonians is slightly lower than in Latvia and Lithuania; among the population aged 19 and over, 10% of men and 6% of women are clinically obese, while 32% of men and 24% of women (28% of the overall population) are pre-obese. In all, 35% of the adult population is overweight¹³¹.

A range of poor dietary habits has been identified in both countries; for example, higher proportions of Estonians in one study reported cooking with butter rather than vegetable oil¹³². Reported levels of salt consumption were also disproportionately high; in Latvia, 78% of men and 59% of women used salt regularly. Rates were slightly lower in Lithuania (63% of men and 44% of women) and Estonia (57% of men and 48% of women) yet were still relatively high, and one in nine men overall reported always adding salt to their food before tasting it¹³³. However, there are indicators of several positive changes in dietary habits¹³⁴. For example, a study conducted by the National Institute for Health Development in Estonia¹³⁵ found that overall Estonians were:

- using less animal fat (24.4% of men and 40.0% of women)
- using more vegetable fat (20.5% of men and 32.8% of women)
- eating more vegetables (22.2% of men and 37.5% of women)
- consuming less sugar (19.6% of men and 33.1% of women)
- consuming less salt (18.7% of men and 27.4% of women)

However, behind this overall trend, there are important differences according to a range of socio-economic variables. For example, Estonians living in major cities such as Tallinn rather than rural areas, those in higher income brackets or with higher levels of education, or those with health insurance coverage were significantly more likely to change their dietary habits.

4.1.3. Health promotion initiatives

Even with the extensive reforms highlighted above (see section 5.1), many of the new health systems are still focused on treatment rather than prevention¹³⁶. Policy making has tended to focus on introducing new legislation and tightening up regulation, rather than actively promoting health. The low level of physical activity among Latvians has been attributed partly to the low priority it is given as a health promotion strategy among health professionals¹³⁷. Similarly it has been suggested that few Lithuanian GPs give advice to overweight or obese patients

on diet-related strategies to improve their health¹³⁸, although there is a relative lack of data to support this conclusion. Data published by the WHO in 2002 showed that only 13% of Lithuanian smokers were advised to stop smoking by their GP, and only one in five women and one in ten men received advice on changing their dietary habits.

Certainly the need to provide more lifestyle counselling has been identified as a key priority for primary care training in several countries. Table 4 below gives an overview of the major policy and legislative developments in each of the sending countries.

Table 4: Major policy and legislative developments on health promotion and obesity prevention in sending countries¹³⁹

Bulgaria	• Action Plan for 2005 – 2010 (launched in 2004) to enhance the health of the population by improving nutrition and reducing the risk of diet-related chronic diseases • introduction of new standards for the nutritional content, marketing and labelling of foods, and incentives to encourage the production and sale of healthy foods • launch of a new information and education campaign by the National Centre of Public Health Protection to publicise principles of healthy nutrition • promotion of physical activity among children through initiatives such as Education Through Sport (2004) and Sport at School (2006)
Czech Republic	• National Council for Obesity established as a permanent advisory body to Department of Health to implement the national action plan, based on WHO recommendations. This has working groups on issues including nutrition and food, community programmes and education, child obesity, physical activity and the treatment of obesity • new dietary guidelines established in 2005 • National Cycling Strategy introduced in 2004 • introduction of the 'Keep it Balanced' campaign (2006) focusing on healthy diet and physical activity. This initiative is organised by the Ministry of Health with support from the National Public Health Institute, along with a range of commercial and health insurance providers

Estonia	• adoption in 2002 of the Healthy Nutrition Action Plan (2002-2007), which highlights a number of areas for action including food accessibility, local food for local consumption, food safety, nutrition in specific population groups, and the links between overweight/obesity and chronic diseases • introduction of the National Strategy for the Prevention of Cardio-Vascular Disease (2005 – 2020) in 2005 which aims to enhance healthy lifestyles and choices by developing a comprehensive system of health education • introduction of various health promotion projects such as the Healthy Heart and Anti-Smoking schemes • provision of rye bread and fruit in school meals since 2006 • Sport for All scheme (2006-2010) introduced in 2006 to promote physical activity
Hungary	• introduction of the National Public Health Programme (2003 – 2013) including a National Nutrition Policy Framework (2005) and National Food Safety Programme (2005) • work in schools including the regular distribution of a healthy eating newsletter to 5th grade students, and the introduction of a National Healthy School Canteen Programme (2005) • an information campaign run across stores in a major supermarket chain which highlights healthy foods, drinks and sports equipment. Customers are able to access advice on lifestyle, and have their blood pressure, sugar levels and body weight measured
Latvia	• introduction of the national Healthy Nutrition plan (2003-2013) to encourage consumption of fruit and vegetables, legumes, and berries and to keep the public informed on issues such as healthy nutrition and lifestyles, physical activity and food hygiene • formulation of specific dietary guidelines for certain groups (such as 0 to 2 year olds, or 2 to 18 year olds) • establishing a Nutrition Council (2006) • moves to regulate the marketing of food/drink which is of low nutritional value such as soft drinks, sweets and salty snacks
Lithuania	• introduction in 2004 of a state food and nutrition strategy/action plan (2003-2010) • moves to regulate/control food labelling, marketing and advertising • attention has also been paid to reducing the prevalence of chronic diseases related to poor nutrition • promotion of sport in schools and communities
Poland	• revision of the 1990s National Health Programme for the period from 2006 to 2015 • introduction of a National Programme for the Prevention of Overweight, Obesity and Non-Communicable Diseases through Diet and Improved Physical Activity 2007–2016 • creation of a National Centre for the Promotion of Healthy Diet focusing on, amongst other things, the improvement of diet and physical activity among primary and secondary schoolchildren • introduction of a national information initiative 'Food, Nutrition, Health' under National Food and Nutrition Institute to encourage healthy choices • a joint initiative between the Ministries of Health and Sport to promote physical activity • 'Put Your Heart on Its Feet' campaign to promote the benefits of increased physical activity
Portugal	• introduction of a National Health Plan (2004-2010) including a National Programme Against Obesity • introduction of the 'Move It' campaign to promote physical activity

Romania	• organisation of a 'Day of The Heart' (September 2002) with a range of activities including blood pressure and blood sugar measurements for the general public, staff employed at government offices and workplaces (e.g. the timber industry) • introduction of campaigns aimed at prevention of cardio-vascular disease such as 'A memorable day: the day you quit smoking', 'Take Care of Your Heart' and 'Your health is up to you'
Slovakia	• implementation of the Health State Policy (updated 2006) and National Health Promotion Programme, with a focus on the promotion of healthy lifestyles and reduction of non-communicable diseases • introduction of the National Programme for Sport Development (2001) and 'Move It' campaign • proposals for a National Obesity Prevention Programme
Slovenia	• introduction of a National Nutrition Policy Programme with three major strands; food safety, sustainable food supply and balanced/preventative nutrition • drafting of a National Plan for Physical Activity (2006) • introduction of various local level initiatives such as 'Let's Live Healthily' and the Mura programme (see below) • setting up of the 'That's Me' web site for young people to give information on nutrition and physical activity • introduction of a Healthy Nutrition and Physical Activity for Secondary School Teachers Programme (2004-2005) to promote the inclusion of health and nutrition issues in the curriculum • introduction of National Institute for Public Health standards for healthy nutrition in schools • introduction of the Body Weight for Adolescents and Getting Active plan (2004-2006) which monitors body weight and physical activity among 13 to 16 year olds through systematic checks • introduction of tighter controls on the sale of alcohol such as a prohibition on the sale of distilled alcohol before 10.00 a.m. and the appointment of a Council for Alcohol Policy (2003) within the Ministry of Health

Despite these extensive policy developments, political commitment to long-term funding and follow-up of projects can be patchy. For example, in Estonia between 0.5% and 1% of the health insurance budget is earmarked by government for health promotion work – however, the government has been slow to increase this budget despite evidence of significant and continued health inequalities¹⁴⁰. Projects have generally focused on raising individual awareness and changing individual attitudes rather than addressing some of the underlying socio-economic issues behind poor health. As critics have noted, despite a number of

campaigns around alcohol and tobacco consumption and some evidence of positive impacts, this remains limited and overall progress has been 'unremarkable'¹⁴¹.

The authors of an article discussing measures targeting problem drinking in Slovenia note that there are few *sustained* public information campaigns in place¹⁴². National alcohol policy is criticised as both poorly coordinated and targeted, with the majority of campaigns being both localised and short-term, and as comparing unfavourably with approaches in other countries. At the time when the article was written (2006) there was still no national

alcohol action plan. Controversially the ban on alcohol advertising was lifted and alcohol consumption continued to be shown as a positive lifestyle choice; as the authors note, popular media figures in Slovenia have often been portrayed as consumers of alcohol. Much of Hungarian health promotion has focused on issues around food in schools, and has involved measures including the proposed regulation of school canteens and vending machines¹⁴³. However, policies have been difficult to enact due to the powerful influence of the food industry lobby, and rather than implementing the compulsory directive which was their initial plan, the government have allowed the industry to continue to self-regulate.

In addition to these implementation difficulties, there is also evidence that health promotion initiatives are failing to bring about the desired behavioural changes among their target populations. For instance, while there has been a growth in the overall numbers of Latvians expressing a willingness to give up smoking¹⁴⁴ – which would suggest that smoking cessation campaigns have enjoyed an element of success – this has not always translated into action. Research has shown that many Latvians were unaware of health promotion campaigns; just 26.1% of men and 31.3% of women surveyed for a recent study had heard of the Healthy Heart campaign, while a mere 13.8% of men and 16.6% of women had heard of Family Health Week. Relatively few had any knowledge of the Healthy Food promotion scheme introduced by the Health Promotion Agency (just 27.1% of men and 30.8% of women), or the Iodine Salt campaign (17.9% of men and 19.7% of women). Awareness of anti-smoking campaigns such as Quit & Win (see section 5.3.2 below) was slightly higher (49.6% of men and 52.0% of women)¹⁴⁵. However, levels of participation in such initiatives remained low (just 11.9% of men and 9.3% of women surveyed)¹⁴⁶. The

reasons behind this type of non help-seeking behaviour are extremely complex, although the authors of the Latvian research indicated that it was at least partially due to the fact that the majority of respondents (78.8% of men and 78.1% of women) thought of health promotion as a question of personal responsibility, rather than education providers or health professionals. Neither legislative changes, nor the broadcasting of health-related information via the media, were seen as particularly successful in effecting behavioural change. However, despite such apparently negative trends, it has nonetheless been possible to identify a number of apparently successful health promotion projects which have been introduced by sending countries.

A. Smoking cessation and tobacco control (Poland)

As already discussed, rates of tobacco consumption are high in Poland (see section 5.2.1) and have been identified as a particular policy priority by the Polish government. With the recent introduction of a Health Promotion Foundation (HPF), a number of smoking cessation programmes have been implemented. For example, an annual competition has been held in Poland for those participants who quit smoking since the beginning of the year. Entrants submitted a postcard to the HPF talking about their experience, and the successful entrant won a one week trip to Rome which included an audience with the Pope. The Ministry of Health has also worked with other agencies to promote the benefits of smoking cessation. For instance, the Catholic Church has acted as sponsor of an annual anti-smoking campaign. Schools are also heavily involved in smoking-related health promotion projects, and target both pupils and parents¹⁴⁷.

Smoking cessation initiatives are heavily publicised, and are well recognised among

Poles; according to one study, between 80 and 90% were aware of these initiatives¹⁴⁸. Levels of public and media support for the postcard competition were particularly high, with television coverage of the winner's trip to Rome. There have been reports of positive effects on smoking behaviour, and an associated fall in the related mortality rate. Hence the total Polish mortality rate fell by 10% between 1991 and 2000, with roughly one third of that drop attributed to a reduction in levels of cigarette consumption¹⁴⁹.

However, despite these ostensibly positive results it is also acknowledged that smoking cessation remains a policy priority and that further action is needed to reduce overall smoking rates.

B. Quit & Win Smoking Cessation

'Quit & Win' is an international smoking cessation initiative organised as part of the WHO Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme¹⁵⁰, which began in 1994 – since then, the National Public Health Institute (KTL) in Finland has also coordinated international Quit & Win competitions. In 2002, the competition involved around 660,000 smokers from 77 countries worldwide with all 27 CINDI countries organising their own Quit & Win competitions, and a further 15 CINDI countries running an optional competition for health professionals to get them to quit smoking and recognise their value as role models for their patients. The table below (Table 5) shows results from some of the participating CINDI countries, which include all of the A10 countries as well as Portugal¹⁵¹. The United Kingdom has also participated.

The competitions have been more successful in some countries than in others; for example, the one year abstinence rate for

Poland after the 2000 competition is particularly high at 43%, compared with relatively low figures for Latvia (9.4%) and Romania (7.2%). Other countries, such as Bulgaria, Hungary and Poland, have been more successful at recruiting health professionals – and in 2002 the prize for the optional health professional contest went to Lithuania. In 2002, all countries organised Quit & Win smoking cessation competitions, with related events. For example, in the Czech Republic a climb of the country's highest mountain, Mt. Snezka, was organised for World No Smoking Day, with politicians and prominent doctors taking part. In Hungary five smoking cessation competitions were organised throughout the year, with over 4200 adults and 358 14 to 17 year olds taking part.

Peer educators were also trained to deliver 15 anti-smoking and 9 anti-alcohol programmes in secondary schools. The Lithuanian health ministry gave particular priority to smoking cessation initiatives targeted at children and adolescents after a 2001 survey revealed that almost 50% of boys and 25% of girls aged 12 to 18 were regular smokers. In Kaunas an anti-smoking campaign 'Don't start and win – quit and win' was launched and around 2300 children registered as participants. Smokers were asked to stop smoking for a minimum of one month, and others had to commit to not starting to smoke for the same period. Over 50 winners received a trip to a water park in Poland. Other campaigns were organised to publicise the risks associated with passive smoking, such as the 'I was born a non-smoker' campaign which was introduced for No Smoking Day (31st May), with all newborns receiving campaign t-shirts. As part of a further campaign, 'Let Me Grow Up Healthy', hundreds of children's shoes were arranged on the pavement outside the Lithuanian Parliament to symbolise the risks to which passive smoking exposed them.

Table 5: Results from countries participating in the 2000 and 2002 international

Quit & Win competitions

Source: adapted from World Health Organisation (2002: 33)

Country	2000 Participants	2001 One year abstinence rate %	2002 Participants	2002 Health professional participants
Bulgaria	3601	26.0	4162	867
Czech Republic	2024	15.4	1518	34
Estonia	481	19.3	318	-
Hungary	7831	12.3	4205	986
Latvia	824	14.3	234	16
Lithuania	911	9.4	522	87
Poland	3730	43.0	6000	575
Portugal	1215	-	1764	-
Romania	1323	7.2	1412	160
Slovakia	1657	13.6	626	60
Slovenia	700	-	1416	74

C. 'Get the Best from Your Food' (Portugal)¹⁵²

The 'Get the Best from Your Food' scheme was introduced as part of the Portuguese Health and Food Programme in September 1997, which aimed to provide education and information on health and nutrition. 'Get the Best from Your Food' was launched in schools by the Ministry of Education, and targeted pupils aged between 6 and 16 years. Pupils aged between 6 and 10 years were presented with leaflets containing games and stories, as well as a poster about 'Ideas to flavour your life' which was designed like a Christmas advent calendar, and had windows which pupils could open to uncover information on a variety of health/nutrition topics. The poster format was aimed at allowing teachers to talk to their classes about a different topic or theme each day for a month; each morning the topic window was opened and then the theme for that day's lessons was developed by the whole class¹⁵³. Examples of topics included the benefits of water, the

importance of sharing meals with friends and family, and the value of getting enough sleep; not only were topics nutrition related, but students were encouraged to make links between nutrition and their general well-being as well as social life/interaction.

D. 'Let's Live Healthily' and MURA Project (Slovenia)

In 2007, the Slovenian government introduced a National Health Enhancing Physical Activity Programme (2007-2012) with the central goal of improving nutrition and levels of regular physical activity among the general population¹⁵⁴ as well as reducing rates of obesity and associated health risks. Under this policy a number of new health promotion programmes have been introduced or existing projects expanded, including the 'Let's Live Healthily' and MURA projects. Both projects run in the Pomurje region of the country, which has the lowest level of GDP per capita as well as the highest percentage of long-term unemployed, and the lowest level of educational attainment.

Pomurje also has the lowest life expectancy in Slovenia, the highest number of years of life lost per 1000 people under 65 and a particularly high incidence of heart and coronary disease and tumours¹⁵⁵.

The MURA programme originally operated in eight communities in the Beltinci municipality (in 2001) but now runs in over 50 communities. MURA's central aim is to enable inhabitants of rural communities to take a more active role in health promotion, and it incorporates a range of activities such as the incorporation of healthy lifestyle topics into a life/social skills programme for young people who have dropped out of school, and the setting up in 2004 of a consortium of fruit and vegetable producers to run organic farming centres. The programme also promotes Nordic walking as both a tourist activity *and* a way for locals to get fit. Initial results from the programme are encouraging; for example, the National CINDI Health Monitor Survey for 2001-2004 showed some positive changes in nutritional habits in the region such as higher rates of consumption of fresh fruit and vegetables, as well as good fats like olive oil, as well as lower rates of consumption of animal fats, fried foods, sugar and added salt.

'Let's Live Healthily' also targets adults in rural communities within the Pomurje region, and encourages communities to take an active part in health promotion. The programme incorporates a wide range of activities such as weekly walking and cycling events, food events including pumpkin and bean holidays¹⁵⁶, where residents are shown how to prepare the same traditional foods but in healthier ways, and the creation of demonstration gardens where local residents can learn how to grow their own food. There is a basic programme of thirteen workshops on a range of topics including physical activity and health, nutrition (using the food pyramid and healthy plate), self-supply with vegetables and growing herbs,

and demonstrations of healthy food preparation. Participants are also able to access blood pressure testing and lifestyle counselling before meetings.

Every effort is made to ensure these events are as accessible as possible; for instance many are held in the early evening when working adults are better able to attend. Health topics are explained to participants in the relevant dialect where appropriate, and care is taken to recruit local programme coordinators who are familiar with the lifestyle and culture of the community. 'Let's Live Healthily' is also implemented through a partnership approach which incorporates local authorities, health providers, schools and kindergartens, pharmacies, community groups and local churches. Announcements about events are often made during church services and priests are frequently involved in running them.

Initial evaluations of the project have reported positive changes in health behaviours among participants. Approximately 90% of participants changed their lifestyles significantly after completing the basic programme, by changing their eating habits and becoming more physically active. 70% of participants were reported to be consuming less animal fat and almost two thirds reported eating more fresh fruit and vegetables, while roughly half had increased their levels of physical activity. The weekly walks in the Razkrižje municipality, which were reported to regularly attract between 50 and 100 participants, were found not only to increase levels of physical activity but also to promote social interaction.

Summary:

The development of healthcare provision in sending countries has been highly variable, both in the pace and scope of change, and migrant workers in the UK will have

experience of a wide range of systems. Significantly, some migrant workers may be less familiar with the gatekeeping role of general practitioners, which could affect their use, expectations and experiences of primary care in the UK. Some migrants may also have experienced significant inequality of access to services in their home country, and as a result may have additional health needs.

Many of the countries from which migrant workers come to the UK have identified similar public health concerns to those addressed by the Healthy Town Project – in particular high levels of tobacco and alcohol use, and issues around diet, obesity and physical activity. Even with the extensive reforms to healthcare systems in sending

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



CHAPTER 4.2: Health in the UK

We are starting to learn more about migrant workers' use of and access to public services in the UK, such as housing – and the likely demands new arrivals are likely to make on those services. The first volume in Keystone's 'Workers on the Move' research series, published in 2008¹⁵⁷, explored migrant workers' housing needs and experiences. Results from the primary research highlighted a number of key issues around exploitation in employment and housing, and potential problems with neighbourhood tensions and community cohesion – as well as potential effects on migrant workers' physical and mental health. The main findings of this piece of research were that despite concerns that migrant workers would begin to place an increasing burden on the already overstretched public housing sector, the majority lived in private rented accommodation and made few demands on affordable housing provision. The report also uncovered evidence of significant 'overcrowding, insecurity and exploitation'¹⁵⁸, all of which are likely to directly affect both physical and mental health of migrant workers. For example, overcrowding in houses in multiple occupation (HMOs) may put occupants at an increased risk of contracting communicable diseases, while other issues such as damp could also affect the respiratory system. The additional stress from living in unsuitable conditions or from the threat of eviction, which is a very real fear for many migrant workers as their accommodation is often tied to their employment, could lead to serious mental health issues.

While the evidence base on the effects and implications of increased migration to the UK in general (and the East of England in particular) is undoubtedly growing, there is a clear gap in our knowledge about the health issues faced by migrant workers and their use of health care services. The initial indications are that migrant workers make relatively few demands on services, and that

accessing healthcare is not a major motivation for those who come to the UK¹⁵⁹. Research has consistently indicated that the majority of migrant workers coming to the UK are young, single and in relatively good health and are therefore unlikely to make substantial demands on health services¹⁶⁰. New evidence¹⁶¹ has also shown that health reasons can often cause migrants to return home temporarily in order to access services, *rather* than accessing health care provision in the UK. However, the profile of the migrant population in our region is changing, with potential implications for health services, and there are indications of raised levels of demand in some areas. There is anecdotal evidence, for example, that health visitors are seeing a rise in the number of migrant worker *families* on their caseloads. More research will need to be done into the health needs, issues and concerns of migrant workers in order to plan more effectively for future levels of demand, and to enable local providers to respond more effectively to the needs of new arrivals – and to balance them against the needs of local communities.

Several studies in both the UK and other countries such as Canada have also discussed what is known as the 'healthy migrant effect'. According to this theory, while migrants *on arrival* have an initial health advantage over the native population – which would tally with the research evidence in the UK of a young, healthy migrant worker demographic – their health can deteriorate with length of their stay in a country. For example, while migrant women in the USA – particularly Hispanic mothers – were found to be initially less likely to experience premature births or to have low birthweight babies, they gradually lost this relative health 'advantage'¹⁶². Similarly research on immigrants living in Canada¹⁶³ found that they were initially less likely to be overweight or obese, but that the likelihood of them becoming overweight or obese

changed with their length of residence, eventually converging with levels among native Canadians.

This has implications not only for health care providers (in terms of increased levels of demand for services) but also for health promotion initiatives which should be designed with the needs of the migrant population in mind. For example, a study of women who had recently migrated to Canada found that while they were initially less likely than Canadian women to engage in health risk behaviours or be overweight, immigrants who had lived in the country for ten years or more experienced a similar prevalence of chronic conditions and long-term disability. Their engagement in high risk health behaviours – such as the consumption of a high fat diet, or tobacco/alcohol use – also increased with length of residence. Recent immigrants were also less likely to attend screening appointments for cervical and breast cancer, and to participate in regular physical activity.

It is widely argued that migrant workers from CEE countries only see their stay in the UK as a temporary one, and that increasing numbers are leaving either to return home, or move to a third country – particularly with

the recent economic downturn. A recent study from the Institute of Public Policy Research (IPPR)¹⁶⁴ estimated that over half the migrant workers who arrived in the UK after May 2004 had left by December 2007 and that the rate of new arrivals has slowed significantly, with 30,000 fewer migrants arriving in the second half of 2007 compared with the same period twelve months earlier¹⁶⁵. If these trends persist, then it is unlikely that demands on health services will increase significantly. However, the evidence regarding length of stay among migrant workers to the UK is far from clear, and it should not be assumed that levels of demand for health care provision will remain low. Recent evidence published by EEDA on migration to the East of England¹⁶⁶ has shown that migrants' intentions regarding length of stay are both flexible and contingent on a wide range of factors and can change frequently; health provision will need to be sufficiently flexible to be able to respond to any fluctuations in the migrant worker population.

The following sections map the current evidence base on the health needs and outcomes of migrants, and set the agenda for the issues which the proposed research will investigate¹⁶⁷.

4.2.1. Access to primary care provision

Several studies have considered migrant workers' access to and uptake of primary care services and have found that low proportions of migrant workers are registered with a GP, often arguing that this is because they are unaware of which services are available or of how to register. For instance, a 2006 study of migrant working in South Lincolnshire found that only 53.3% of respondents were registered with a GP. This research also found evidence of some migrant workers who had been in the UK for up to 5 years who were still unaware of the services available to them, and who did not know how to contact either a GP or NHS Direct¹⁶⁸ – in some cases going directly to accident and emergency departments for medical care¹⁶⁹. Similarly, another 2007 report – *Migrants' Lives Beyond the Workplace*¹⁷⁰ – found that only 33% of migrant workers surveyed knew how to register with a GP, and only 19% were aware of how the UK health system works. Research on migrant working in Glasgow has also indicated that demand for primary care services in the area remained low, with just 58% of respondents reporting that they had registered with a GP¹⁷¹, while an assessment of health needs among migrant workers in Wisbech carried out in 2005¹⁷² found that only 60% were registered – with the rest reporting that they would go to the local accident and emergency department.

Results from more recent research have shown that a higher proportion of migrant workers are now registered with a GP in the UK although the proportion of those actually *using* services remains relatively low. For example, a recent study of migrant working in Peterborough found that 87% of survey respondents were registered with a local practice¹⁷³, with particularly high levels

of registration among Portuguese respondents (98%) suggesting that this increases with length of settlement in the UK. Much smaller numbers of migrant workers reported accessing other services such as walk-in centres (14%) or NHS Direct (10%), midwives (12%) and health visitors (7%). Just 6% reported having used an accident and emergency department, contradicting the common assertion that migrant workers not registered with GPs are instead going directly to the hospital with routine health problems.

This picture was repeated in a questionnaire survey of inner city London A&E attenders, which found that only a small proportion (4.0%) of respondents identified themselves as Polish, while a further 0.8% were Portuguese, 0.5% were Czechoslovakian¹⁷⁴, 0.5% were Hungarian, 0.2% were Lithuanian, 0.1% were Bulgarian and 0.1% were Romanian¹⁷⁵. In a study of new communities in Dereham, 84% of migrant workers were registered with a GP¹⁷⁶, with few reporting any difficulties in registering. A high proportion (72%) also reported that they had a sound understanding of how the UK healthcare system works. Interestingly (and unusually) 78% had also *visited* a doctor in the UK. However, levels of awareness and uptake of other services remained comparatively low; for example, only 3% had accessed NHS Direct¹⁷⁷. Levels of registration with UK dentists have also remained consistently low – just 53% in the Peterborough study¹⁷⁸ – although this proportion also appears to be rising; in the 2007 report mentioned earlier¹⁷⁹ just 11.9% of respondents were registered.

Despite this apparent increase in numbers of migrant workers registering with a GP, current evidence also indicates that few are actually *using* this service – meaning that the projected increase in pressure on overstretched public resources has not, in fact, materialised. For example, in the North

West, while significant pressures on GP registrations have been noted in some areas – mainly in large urban centres such as Liverpool – the overall pressures on the NHS have been ‘minimal’¹⁸⁰. Although registered with a GP, many migrant workers are not visiting them simply because they have not *needed* to. This may be because of high levels of self-reported health among this group – one study based in Edinburgh¹⁸¹ found that most respondents regarded themselves as healthy, and over half knew how to access the necessary services although few were registered with a GP, mainly because they did not see the need to register. Similarly, the majority of respondents in the Peterborough study mentioned earlier considered themselves to be in either ‘good’ or ‘excellent’ health, with 90% reporting that neither they nor their family members had any health problems¹⁸².

4.2.2. Information, interpreting and translation

A range of factors have been identified which can inhibit migrant workers’ knowledge of or access to primary care services, perhaps the most significant of which is a lack of English language skills. The provision of language appropriate information is now widely recognised as good practice in provision of services to migrant workers, and is particularly relevant in health settings. Research has shown that migrants who had received comprehensive and accessible information were more likely not only to have registered with a GP (54%) but to have actually *used* the service (51%) compared with those who had not received any information, only 26% of whom registered with GP, while just 24% had actually visited their GP¹⁸³. Preliminary findings from the ongoing EEDA longitudinal study have also indicated a link between poor self-reported health and lower levels of English language competency¹⁸⁴.

The provision of translation and interpreting services is a central part of facilitating access to health care among migrants who have fewer language skills. Where these services are not in place, migrants are often forced to rely on family, friends – and sometimes community ‘gatekeepers’ – which raises a number of confidentiality concerns. Currently there is a lack of rigorous data collection on access to translation and interpretation services in health settings¹⁸⁵, it would be particularly important for any future research to collect this information by talking both to migrants accessing services and to healthcare professionals about their experiences of using interpreters during consultations¹⁸⁶.

4.2.3. Expectations of services and cultural differences

Evidence is emerging that migrants' expectations of health provision in the UK often remain unsatisfied. Migrant workers in the Lincolnshire research study mentioned earlier frequently expressed 'deep disappointment' with the level and quality of services available to them¹⁸⁷. Similarly Spencer et al. (2007) reported that migrants were often highly critical of healthcare provision. Yet again, a survey of health needs among migrant workers in Dumfries and Galloway found that a high proportion of respondents identified health services in general, and access to GPs and dentists in particular, as the 'worst' aspect of living in the UK¹⁸⁸. This dissatisfaction can often be due to differences in the respective functions and coverage of primary and secondary care between the UK and a migrant's country of origin. A recent study of migrant workers in Leeds found that despite high levels of GP registrations a high proportion reported experiencing difficulties due to the major 'differences in routine medical policy and practice' between the UK and their home country¹⁸⁹ – frequently in relation to the respective functions and coverage of primary and secondary care.

While the majority of countries have developed and extended the role of primary care providers over recent years (see section 5.1), it is often not as established a feature as it is in the UK and is 'unusual in a global setting'¹⁹⁰. Consequently there is often an element of confusion among new arrivals regarding the 'concept and role of the GP and their gatekeeper function in making referrals to secondary care'¹⁹¹. Respondents in the Leeds study were particularly critical of the lack of direct access to specialists and long waiting times for GP appointments, and the fact that in their home countries

patients could not only get an appointment with a GP much more quickly but were more likely to see the same GP at each consultation¹⁹². Significant differences in prescribing practice between the UK and migrants' home countries were also raised as an issue, particularly the reluctance of GPs here to prescribe antibiotics, which many respondents observed could be purchased over the counter in countries such as Poland. The routine prescription of Paracetamol was heavily criticised;

'Doctors don't do anything. They only give painkillers... it's like 'you've chopped your arm off? It's ok, here you have some Paracetamol.'¹⁹³

It is not yet clear whether A8/A2 migrants are not accessing GP services in the UK because of their continued preference for accessing care in their home countries, as has been suggested. Returning home for treatment can offer migrant workers 'the possibility of accessing more familiar, and in their view, more appropriate treatments more quickly'¹⁹⁴ – a trend which may well offset any additional demands on health-care services from increased migration to the UK.

Again, there is currently little consistent and rigorous data collection on migrant workers' attitudes towards health services. However, there have been a number of small-scale local studies which indicate that migrants often expect onward referrals at an early stage, or to be able to directly access specialist provision. Sometimes migrants arrive at individual appointments with multiple family members, or expect nurses and GPs to be able to provide help with other matters such as completing benefit claims¹⁹⁵. Conversely, healthcare professionals are themselves often unaware of how health systems in sending countries are organised, or of differences in prescribing patterns¹⁹⁶. Appointments with

migrant workers can raise a range of other issues around cultural competence – for example, GPs might lack confidence in their knowledge of patients' entitlements or find themselves under increased time pressure during appointments due to language issues. However, yet again the evidence here is either small-scale or anecdotal, and it would be a priority for future research to investigate these issues further.

4.2.4. Other primary care initiatives (child health, screening)

Low rates of GP registration can have additional repercussions. For instance, if migrant workers are not registered with a GP it becomes more difficult for them to access preventative services such as screening programmes. The mobility of migrant populations also makes arranging follow-up appointments particularly problematic. For example, regular child health checks such as neonatal audiology screening, primary and catch-up immunisations, or scheduled developmental checks can easily be missed¹⁹⁷. Problems have also been highlighted with late presentation for antenatal care. While there is some suggestion of increased pressure on maternity and child health services¹⁹⁸, the current evidence base for this remains weak. Despite a consistent picture of migrant workers from CEE countries as young, single and childless, there is now some evidence to suggest that an increasing proportion are starting families in the UK¹⁹⁹ – with the potential for an increase in the workload of certain primary healthcare professionals such as midwives and health visitors²⁰⁰. If migrant workers are beginning to settle in the UK and to bring up families – even where their stay is temporary though long-term – health visitors will play an important role in accessing migrant worker populations and building confidence in health services. For example, the ongoing community health needs assessment being carried out by the team at UEA as part of the Thetford Healthy Town project noted that breastfeeding rates are particularly low among the Portuguese community, and that health visitors have a key role to play in supporting women from these communities in breastfeeding their babies²⁰¹.

4.2.5. Mental health, stress and migration

There is increasing recognition of the potential links between migration and mental ill-health. This was recently identified as a key priority for action at EU level during the Portuguese presidency which took health as its theme, and acknowledged that 'migration is in itself a risk factor, thus it is not surprising that migrants have high rates of alcoholism, drug addiction and suicide, among others'^{202 203}. However, there has been extensive criticism of the general dearth of research and 'severe lack of monitoring' reported on mental health services for migrant groups²⁰⁴. The lack of systematically collected data means that our knowledge of migrants' mental health status remains limited, although there are initial indications of increased levels of mental health issues, including depression and anxiety caused by the strains and losses which are part of the migration experience²⁰⁵. At a regional level, a recent report into migrant health needs in the East of England made the point that it is both 'difficult and dangerous' to make generalisations on this issue; while mental health difficulties are not an inevitable consequence of migration, where they do occur the consequences can be severe²⁰⁶. Consequently, more work needs to be done in order to further our understanding of the mental health issues experienced by migrants, and to inform better service planning and provision²⁰⁷.

While there is an extensive literature discussing the specific mental health difficulties faced by asylum seekers and refugees, much less is known about the experiences of migrant workers. However, some initial evidence is beginning to emerge; stakeholder interviews in a report on migrant working in the East of England found that there was a growing perception that migrant workers 'did not necessarily cope leading to

mental health problems caused by stress ('they struggle the best they can')²⁰⁸. More recent research has also suggested that while many migrant workers had not experienced particular stresses, the small number of questionnaire respondents who reported that they were coping 'badly' (4%) or 'fairly well' (31%) 'might be at risk of experiencing situations which may affect their mental health, aspirations and length of stay'²⁰⁹.

Research into the consequences of migration for A8 nationals in Scotland found that migrant workers – particularly those in manual or low skilled employment – often experienced significant levels of stress, with potentially negative consequences for their physical and psychological health²¹⁰. This evidence, the author argued, directly contradicts the idea of the 'healthy migrant' effect²¹¹ which leads to 'the assumption that migrant workers are likely to be particularly healthy, resilient and resourceful'²¹².

The key stress factors identified were:

- *communication difficulties* (many of those interviewed for the research arrived with very little English, which limited their opportunities for social interaction)
- *unfamiliarity with the new environment and culture*
- *work-related stress* (including initial uncertainty about whether they would find employment, low wages and lack of overtime pay, poor working conditions, high workloads and long/unsociable hours leading to 'burn out', split shifts, night shifts, and working in positions for which they were considerably overqualified)
- *practical stress* (such as continued financial hardship, high living expenses and accommodation costs)
- *social stress* (e.g. loss of social contact and interaction)

Interviewees also reported that they were often unable to rely on networks of co-

nationals for both practical and emotional support, as has been previously suggested. Rather this study found that often migrants came to the UK with high expectations and 'took advantage' of those already living here; interviewees described the expectation that they would support fellow Poles – who, they argued, were interested only in money and work, rather than genuine friendships – as particularly 'onerous'.

Consequently 'competition, envy and a lack of cooperation and loyalty were seen as common features of the Polish migrant community'²¹³. The article concludes by arguing that these 'high acculturative demands' and migrant workers' 'increased vulnerability' makes them a 'specific target group for health promotion, prevention and health care'²¹⁴, and calls for a holistic response to their needs which considers not only their physical health, but also the relevant psychological and social factors²¹⁵.

The following chart (Fig. 8) summarises the range of complex and overlapping factors which could potentially impact on migrants' mental wellbeing.

Fig 8: Factors and sub-factors affecting migrants' mental health and well-being

Source: adapted from World Health Organisation (2002: 33)²¹⁶



Findings from research carried out in other countries may also have some relevance here. For instance, a study of Romanian immigrants in Bologna found that many exhibited 'a high prevalence of distress and psychotic symptoms, related to health problems' – and also linked to other issues such as poor housing, reduced opportunities for social interaction and low levels of integration²¹⁷. Another study of Thai migrant workers in Israel²¹⁸ also identified a clear association between migration stressors and symptoms of psychological distress, with respondents who had poor relationships with other Thai co-workers or were particularly homesick reporting particularly high levels of psychological problems – which suggests that the support of fellow migrants can be a key protective factor. A review of research into the health of migrants in the US found that overall migrant women often had lower rates of mental health problems than American women – a trend which is indicative of a healthy migrant effect. Where worse mental health outcomes were identified, this was usually among older migrants. However, the study also found that some groups of migrants in fact experienced worse mental health outcomes than the native population – for example, Hispanic immigrants were found to be more likely to experience symptoms of depression – again reminding us of the difficulty of making generalisations about the links between migration, stress and mental ill health.

Research carried out in Dumfries and Galloway²¹⁹ identified a range of strategies employed by migrants to counteract such stresses, including taking opportunities for social interaction (for example, smiling was seen as a form of protection against mental ill health), taking physical exercise, early rising/not sleeping too much, relaxation, planning for the future and giving/receiving respect. When asked about the advice they would give to friends, family or colleagues

suffering from depression, respondents advocated taking an active rather than a passive approach and mentioned taking a holiday, talking with friends, or going home for a holiday. Few would recommend going to a GP to discuss their problems, partly as a result of cultural differences in understandings of mental health;

'In Poland nobody would go to the doctor or to mental health services if they were depressed. It is a fear of what other people might think – they would be seen as a freak if they were using mental health services so they will not use those services here either. You would have to be really hearing voices or something before anyone would go.'²²⁰

These conclusions largely correspond with the findings of studies which have considered the links between migration and mental health among other ethnic groups, and in other national contexts. A study of mental health issues experienced by recent Chinese immigrants to the UK found that over 60% of questionnaire respondents reported symptoms of poor mental health²²¹. Many respondents had limited opportunities for leisure and social contact, often due to long working hours, and this social isolation was seen as directly affecting their mental health – for example, although the result was not statistically significant, a link was drawn between having more interaction with British friends and better mental health. Respondents also indicated that where there was a significant 'discrepancy between expectations and initial experiences'²²² of migration, mental health outcomes could also be negatively affected. As with many migrant groups, a significant number of respondents expressed specific concerns around accessing help, with 63.4% experiencing moderate or extreme difficulties in using health services.

4.2.6. Domestic Violence

What is domestic violence?

The Government defines domestic violence [or domestic abuse] as: 'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'²²³ According to a recent report, domestic violence accounts for 16% of all violent crime, with 77% of the victims being women²²⁴. The report also states that, on average every week, two women are killed by a current or former male partner.

The costs of domestic violence

Aside from the costs of human suffering, there are quantifiable economic costs attributable to the role of domestic violence in society. A 2004 study estimated that domestic violence creates an annual cost of £1 billion to the criminal justice system, representing one quarter of the criminal justice budget for violent crime²²⁵. The cost to social services is estimated to be £0.25 billion and housing costs £0.16 billion. With regard to financial implications to the healthcare system, the cost of physical healthcare treatment resulting from domestic violence is thought to be £1,220,247,000 and the cost of treating mental illness and distress is £176,000,000²²⁶. The charity Woman's Aid have suggested that this amount is a significant underestimate, as public services do not collect specific data on the extent to which services are used as a result of domestic violence²²⁷. The figures also exclude the cost of support given by the voluntary sector.

Health implications

As the above statistics suggest, experiences of domestic violence can have a significant and adverse effect on women's health. For

example, the World Health Organisation reports that women who suffer domestic violence are significantly more likely to report poor or very poor health than women who have never experienced such abuse²²⁸. They also report that victims of abuse are more likely to experience difficulties walking and carrying out daily activities, pain, memory loss and dizziness.

Further to the more obvious physical effects of domestic violence, women suffering such abuse may also suffer from additional mental health issues. A 1999 study states that a meta-analysis of 18 studies found that those subjected to domestic violence had a rate of depression of 48% and a suicide rate of 18%²²⁹. The study also reported an average rate of post-traumatic stress disorder among victimised women of 64%. The psychological impact of domestic violence and its link to women remaining in abusive relationships is explored at some length by Lenore Walker's theory of the 'Battered Woman Syndrome'²³⁰.

The issues for abused women

The 'Battered Woman Syndrome' is a controversial model with some commentators arguing that it is the '...lack of socio-economic alternatives for women rather than "learned helplessness" that makes leaving violent men so difficult'²³¹. It is true that there are a number of practical rather than psychological factors that point to why women remain in abusive relationships, for example, lack of economic resources and access to low cost housing or women's refuges. A study by the charity Shelter found that domestic violence was the most quoted reason for becoming homeless, with 40% of all homeless women naming it as contributing to their homelessness²³². Sanghvi & Nicolson argue that many women do attempt to seek help to escape but the response from state institutions is 'woefully inadequate'²³³. Such

problems are further exacerbated in situations involving children and further compounded by concerns surrounding taking children away from their father or even losing them in a custody battle.

The problem does not necessarily end when violence is reported. In the UK a man charged with domestic violence can be released on bail and even if he is subject to an injunction, practically speaking, he is not prevented from returning to the victim²³⁴. He would not be subject to sanctions until the police are made aware of breach of an injunction or bail conditions, or worse, a further incident. It seems some women feel that attempting to leave their partners is futile as he will always find them. This is supported to some degree by the fact that on average, two women per week are killed by a male partner or *former* partner²³⁵. A report published by the Home Office states that 7% of women said the worst incidence of violence occurred after they had stopped living with their abusive partner, demonstrating that '[f]or a small but significant minority, leaving the relationship is the most dangerous time of all'²³⁶. In a report by Women's Aid, 76% of separated women reported suffering post-separation violence²³⁷. The Law Commission agree that evidence shows '[m]any abused women learn that if they attempt to leave, they will be followed and forced to return, to face even greater hostility and more serious violence'²³⁸.

The issues for migrant women

The private nature of domestic violence makes it likely that many incidents of abuse remain unreported or undiscovered. This secrecy intensifies the potential of prejudice for women as it perpetuates the notion that it is a taboo subject, or that women are somehow to blame for the abuse. Society often fails to acknowledge that shame and isolation play a large part in women remaining with their abusive partners and in many cases keeping the violence a secret. There is little doubt that

geographical or emotional isolation from friends and family plays a significant part in the problem for women of all races and social backgrounds, and it is not difficult to see how such factors are exacerbated for migrant women in the UK, presenting additional difficulties in seeking out and receiving services and support.

The Law Commission report that during their discussions with psychiatrists, it was commented that many cases of violence are not simply a matter of the physical abuse inflicted, but also the man's wish to exercise dominance and control over the woman²³⁹. Once again, for migrant women, the man's ability to exert dominance and control is heightened by the potential isolation of migrant women, but also by the fact they are often dependant on their working partner or family members for housing and income²⁴⁰. Migrant women who do not work outside the family home are likely to face additional barriers in forming independent social support networks, developing language skills, gaining knowledge of their legal and welfare rights or having any kind of financial independence; all socio-economic factors that potentially impact on a woman leaving an abusive situation.

Language barriers present an obvious problem for migrant women wishing to receive assistance, for example communicating with police and witness support and also in gaining basic knowledge of services available to them. However, discussion with local service providers suggests that the issues preventing many women successfully escaping abusive situations penetrate deeper than this. In the first instance it is an issue of building trust with migrant women, especially between them, the police and witness support services, in order to encourage them to initially report the crime, but also to pursue prosecution of the perpetrator. There is also suggestion from service providers that in certain cases, where women are entirely financially dependant on

their spouse, they are reluctant for them to be removed from the family home as it effectively constitutes the removal of the 'bread winner'. With this in mind it would seem then that the issue is not simply one of isolation or fear of reporting the violence, but the necessity to live and provide for themselves and their families. It is in this area that there appears to be a lack of services able to meet such women's needs. This is especially true where women have no recourse to public funds.

Women with no recourse to public funds

One of the most concerning issues is those women who have little recourse to public funds due to their immigration status. European migrants originating from the accession countries (also known as the A8 Countries) must work, as a 'registered worker' under the Worker Registration Scheme (WRS) continuously for 12 months before they are entitled to certain welfare benefits, such as income support and housing benefit. Therefore when women are not able to fulfil these requirements, they are often left in a situation with little or no support and without the practical assistance of facilities such as emergency housing.

Preliminary Conclusions

On the whole, there is relatively little specific national information available regarding European migrants and domestic violence in England and Wales. This does not, however, mean it is not an issue. Discussions and work by local and national services providers highlight the fact that it is a very real concern, especially in cases of those with no recourse to public funds²⁴¹. It will be interesting to note the developments of both research and policy surrounding this area in the coming months. Although not covered specifically in this research, domestic violence within the migrant worker community will be the subject matter of a future publication in the 'Workers on the Move' series.

CHAPTER 4.3: Summary

There are major gaps in our knowledge of the health needs and experiences of migrant workers. While concerns have been raised – both in political debates and in the media – about the additional burden increasing numbers of new arrivals might place on already overstretched public services, research so far has generally shown not only that migrant workers make few demands on healthcare services but also that they in fact make a significant contribution to the NHS as a significant proportion of its workforce. There is little evidence to suggest that the ready availability and high quality of healthcare in the UK acts as a major factor in migration decisions – in fact, migrants often prefer to access care in their home country. Moreover, there is a lack of systematically collected evidence on the health needs of migrants, making it difficult for service providers to plan adequately for the requirements of new arrivals.

The primary research phase of this project focused on three main areas;

Access to and utilisation of health services in the UK

Given this lack of knowledge about migrant workers' use of health services and the likely level of demand for services among new arrivals, a major aim of this research was to piece together a fuller picture of the current migrant community's knowledge and use of healthcare services. We therefore asked respondents²⁴² about their use of a range of services, such as whether they were registered with a GP or a dentist, whether they had had any contact with other practitioners such as midwives and health visitors, and whether they had used other services such as NHS Direct or the out of hours service. We also asked about migrant workers' use of acute services – for example, whether they had accessed emergency care rather than going to a GP, or whether they had stayed overnight in hospital.

We also explored respondents' perceptions of the services available to them in the UK, and how these compared with provision in their home countries; we were particularly keen to assess the suggestion, in some research, that many migrants are disappointed in the quality and availability of services and prefer to access care at home instead. Finally, we considered barriers to accessing primary care services, particularly any issues that might arise around availability and quality of interpreting services, and the provision of language-appropriate information. As a counter-balance to this evidence from migrant workers, we also explored professional views on the difficulties of providing and commissioning services for these new arrivals. Our professionals' questionnaire/interviews therefore collected information on professionals' knowledge of migrants' entitlements, their experiences of using interpreting and translation services, and any barriers experienced in treating migrants, such as expectations and cultural differences (such as those noted in the literature around the gatekeeping role of GPs in the UK).

Health needs, issues and concerns

It has often been assumed that new arrivals to a country enjoy a health advantage over the native population (the 'healthy migrant effect'), and certainly the *initial* evidence gathered on migrant workers coming to the UK would suggest that they are comparatively young and healthy. This research therefore aimed to explore more fully how migrant workers to the area perceive their own health, along with any health problems they might experience, including any deterioration in their health which has occurred since arriving in the UK .

There is a wide range reasons why migrants may not access health services or seek help with their health problems; this may be

because of a lack of information or language skills, or because of migrants' perception of the quality of provision; it may also be because of previous negative experiences – or simply because they do not perceive any need. Sometimes migrants may access health services at home, or they may prefer to deal with problems independently. The primary research also considered the various reasons for non-help seeking behaviours, and in the discussion of our findings we consider potential improvements to provision which could address these issues.

Health promotion

Research in other countries has emphasised the lack of priority given to health promotion by primary care practitioners, and the fact that health is seen as an issue of *personal* responsibility. The primary research explored this further, assessing the attitude of respondents towards seeking dietary or lifestyle advice on areas such as smoking cessation from primary care providers. The questionnaires and focus groups also explored migrant workers' awareness of and response to health promotion initiatives in the UK, such as Healthy Town and Change4Life, and considered potential reasons for lack of engagement and barriers to participation in health promotion projects such as timing and targeting of events.



CHAPTER 5: Migration and health – migrant workers' experiences

5.1. General information on sample characteristics

98 questionnaires were completed in total²⁴³, by migrant workers living in Thetford and the surrounding area – including nearby towns such as Brandon – who accessed Keystone's META service between January and March 2010. Respondents were also invited to take part in the subsequent focus group discussions. It was not the aim of this essentially exploratory project to draw any firm causal links between specific characteristics of migrants (such as nationality, gender, age or household information) and health needs or levels of access to services. Questionnaire respondents and participants in the subsequent focus groups were therefore only asked for basic personal information, such as gender and age (questionnaires) and nationality (questionnaires, focus groups)²⁴⁴. This information is summarised in the three tables below;

Table 6: Nationality of questionnaire respondents²⁴⁵

Nationality	No.	%
Portuguese	36	36.7
Polish	33	33.7
Lithuanian	16	16.3
Latvian	8	8.2
Slovakian	2	2.0
Total	95	96.9²⁵⁶

Table 7: Age of questionnaire respondents

Age	No.	%
18 to 25 years	11	11.2
26 to 35 years	24	24.5
36 to 45 years	26	26.5
46 to 55 years	30	30.6
over 55 years	4	4.1
Total	95	96.9

Table 8: Gender of questionnaire respondents

Age	No.
Male	49
Female	46
Total	95

The breakdown of questionnaire respondents by nationality is broadly reflective of the main groups of migrant workers living in Thetford which has sizeable Portuguese, Polish and Lithuanian populations as well as significant numbers of Latvians and Slovaks. Most of the questionnaire respondents (86.7%) were currently living in Thetford, while 10.2% had settled in the nearby town of Brandon. All of the focus group participants lived in Thetford and the majority (10) were Polish, while a further five were Portuguese. One Slovakian and two Lithuanian nationals also took part. Eight focus group participants were female, and ten were male, and their ages ranged from 24 to 58 years. Length of stay in the UK among focus group participants ranged from 6 months to 10 years.

5.2. Health services in the UK

The vast majority of questionnaire respondents (75.5%) were registered with a GP. Of the 23 respondents who were not registered with a GP, the most common reason given was that they had not been ill and had not needed to visit a doctor (47.8%). However, 11 respondents also (11.2%) stated that they were not registered with a GP because they did not know *how* to register, suggesting that some migrants may still experience difficulties accessing information on available healthcare services²⁴⁷. Only one respondent said they were not registered because the surgery lists were full, and only one respondent preferred to visit the doctor in their home country – contrary to research evidence cited elsewhere, and the perception of some policy-makers.

The majority of the Portuguese questionnaire respondents (88.8%) were registered with a GP²⁴⁸. Only four Portuguese respondents were not registered, all of whom cited a perceived lack of need as the reason. Of those respondents who were not registered with a GP, 4 were Latvian, 6 were Lithuanian and 7 were Polish²⁴⁹. Again, a significant proportion of respondents from CEE countries who were not registered with a GP (47.4%) stated that this was because they had not needed to visit the doctor. However, a further 47.4% stated that the reason was because they didn't know how to register, which suggests that new arrivals from these countries may experience particular difficulties in accessing the relevant information.

Even where respondents were registered with a GP, levels of usage of this service have remained relatively low with 66.2% visiting their GP between 1 and 2 times in the past year and a further 13.5% not making any

appointments. In comparison, just 21.6% had visited their GP between 3 and 5 times, and 13.5% had made 5 or more appointments. All of the 18 focus group participants were registered with a local GP, and a higher proportion (14 participants) had used this service in the past year – although for the majority this had meant fewer than 3 visits. Although there was a high rate of GP registrations among the focus group participants, some also talked about difficulties they had experienced in accessing the necessary information – and how they had needed to rely on friends to steer them in the right direction.

Out of those questionnaire respondents who had visited their GP in the past twelve months, 32.0% stated that they hadn't needed an interpreting service. Of those who did need language support during consultations, only 10.7% stated that an interpreter had not been made available to them although a further 20% stated that family or friends had interpreted on their behalf²⁵⁰ suggesting that, while coverage of interpreting and translation services is generally comprehensive, significant gaps in provision still remain.

Registration with dentists was much more problematic, although it should be noted that the low rates of registration are partly a reflection of general patterns across the UK and across ethnic groups – many UK citizens, for example, are not registered with a dentist. However, our questionnaire respondents were much less likely to have accessed dental care with only 31.6% currently registered with a dentist – less than half the rate of GP registrations. The range of reasons given for non-registration was much wider, and many more were unaware of how to register with a dentist. Out of the 66 respondents who were not registered 39.4% stated that this was because they hadn't needed to visit the dentist. However, compared with GP registrations a worryingly

high proportion (31.8%) stated that this was because they did not know how to register. Only 1 respondent had been unable to register because the dentist did not have any spaces. The expense of dental treatment was also raised as an issue by a small number of respondents, although again this is an issue which also deters UK citizens from accessing dental care.

In contrast to the findings on GP services, there was a marked preference among a significant minority of questionnaire respondents (18.4%) for accessing dental care in their home countries. This was more common among respondents from CEE countries, and only 4 (22.2%) who expressed this preference were from Portugal²⁵¹. 20 respondents (almost a quarter of our sample) were not registered either with a GP or with a dentist – again, this was much more common among respondents from CEE countries (70%). This finding was *not* echoed in the focus group data, which showed that participants – particularly from CEE countries – were highly critical of the quality of dentistry services available in their home countries.

Uptake of other healthcare services was also low in comparison with GP services; for example, only 19 respondents reported having had contact with a midwife or health visitor. 19 also said that they had visited a Walk In Centre. 20 respondents had accessed an accident and emergency department, the majority of whom (75.0%) were Portuguese. Relatively few respondents (17) had had an overnight stay in hospital, and only a small number of these (4) were younger women who may have been more likely to stay in hospital overnight after giving birth. In fact 11 of those who had stayed in hospital overnight were men, and 6 were aged 40 and over. Few respondents had any knowledge of the NHS Direct Service (23.5%) and fewer still had actually used this service (13.3%).

Few respondents had any knowledge of the UK health system before coming to the UK, contrary to accusations of health tourism levelled at migrant workers – out of our sample, the overwhelming majority (81.6%) had no prior knowledge of the services and benefits available to them. Most questionnaire respondents (72.4%) reported that provision in their home countries was significantly different from the services available in the UK, although rather fewer were able to pinpoint these differences specifically. The most common differences noted include cost – migrant workers, particularly those from Portugal where there is a high level of co-payments despite the existence of a national health service, were often surprised to find that the majority of care in the UK remains free at the point of use. The cost of prescriptions is apparently higher in Portugal, and free prescriptions for those on certain benefits are not available. Waiting times for appointments were also reported to be much shorter by several respondents, particularly in comparison with the Portuguese system.

The quality of consultations was also mentioned by several respondents, with particular focus on the more ‘sympathetic’ attitude of GPs in the UK. Respondents’ feelings on the quality of UK services were decidedly mixed and while many praised the service provided by GPs others were much more critical, particularly of the comparatively short time allowed for appointments; as one Lithuanian questionnaire respondent noted simply, “It’s better in my country”.

These themes/findings were largely echoed by the discussions which took place among focus group participants, who generally compared the quality of UK services and the care they had received very favourably with what was available to them at home. For instance, waiting times for appointments in Poland are apparently extremely long, with

participants noting routine waits of up to twelve months to see a specialist. Participants in all three groups discussed the issue of cost; participants talked about the need to pay for their appointments in Portugal, comparing this unfavourably with the British system. Although in Portugal, such payments are not overly expensive (participants estimated the current rate to be roughly €7), they argued that by the time this expense had been added to the cost of prescriptions, then accessing healthcare could become prohibitively expensive for some groups. They also noted that care is free up until age 15 or 16, and that their elderly parents still had to pay for care – albeit at a reduced rate. However, experiences varied – for example, one participant also talked about the fact that he had been able to access free healthcare in Portugal, because he had been a blood donor²⁵². He did not agree with others in the group that UK GP services were of better quality, an issue on which participants were strongly divided.

“In my opinion, in Portugal it’s the best ... very, very best”
(Portuguese, male, aged 50)

UK services were generally seen in a positive light, although several participants talked about some access difficulties, such as having to ask repeatedly for access to an interpreter – rather than being offered this by the practice. They compared the UK system favourably with the Polish and Lithuanian systems, which participants felt had deteriorated rather than improved since the reforms of the late 1980s and early/mid 1990s. Where participants in the two Polish-speaking groups stated that they would prefer to access services at home, this was always because of the language issue rather than because they perceived the *quality* of those services to be better than what was available to them in the UK. Discussions centred on the lack of sustained investment

in healthcare provision by the Polish and Lithuanian governments, and participants also talked about the previous system in Poland, under which companies and state-run industries had provided a doctor for their employees – the quality of care under this system was seen as being much higher.

Participants had very mixed views on the differences between the ways in which chronic conditions were managed and/or treated in the UK and their home country. One woman talked in detail about her experiences of treatment for cardiopathy both in the UK and in Portugal; in Portugal her treatment had been expensive, because she had been liable for the costs of x-rays, consultations and medication – and she was very relieved to find that this was not the case in the UK. She had recently been awarded Incapacity Benefit in the UK; however, when she returned to Portugal for a brief holiday and an emergency had meant she had had to access medical help there, she showed the service providers her exemption certificates from the UK but was told they were non-transferrable;

“Portugal is Portugal, and England is England”
(Portuguese female, aged 52, living in Thetford)

She felt that the way cardiology staff in the UK had treated her, and their overall manner, had been much more helpful and that they were ‘always smiling’ and had also made sure she had had access to an interpreter²⁵³.

This experience was not shared by her fellow participants²⁵⁴, one of whom had experienced great difficulty in securing a referral to the specialist he needed to see for a long-standing musculo-skeletal condition. He stated that although Portuguese doctors had told him he would need an operation, the doctor he saw in the UK only prescribed

physiotherapy. As he worked in a very physically demanding job, his condition continued to cause him a high level of discomfort;

“I asked what they can do. They said wait, and when you have more pain come back ... I walk during the days I think 25 miles in my job”
(Portuguese, male, aged 50)

This issue of conflicting advice and differences in treatment styles between the two countries, and the confusion it often caused, was a common theme throughout the focus group discussions. For example, in another of the groups a Polish respondent talked about how her husband, whom Polish doctors had advised he would need an operation to alleviate the pain from a bad back, had only been offered rehabilitation by the UK specialist to whom he had been referred. Several major differences were noted between the UK system and home country systems; in particular, differences in prescribing practice was raised as an issue by a number of participants. They felt that ‘routine’ (rather than specialist) services²⁵⁵ were often less responsive to their needs, and frequently expressed their displeasure at being sent to see a nurse, rather than a doctor. Although, after further discussion and careful probing, they began to talk in more positive terms about the quality of

terms received from nursing staff, they still found this unusual compared with services at home – and ultimately saw the doctor/GP as more knowledgeable. However they *also* felt, despite their frequent criticisms of the overall organisation and distribution of health services/resources, that consultations with a doctor in home countries were often more thorough. In an echo of Cook et al.’s (2008) findings, participants were particularly critical of what they saw as a tendency among UK GPs to over-prescribe Paracetamol rather than giving them a thorough examination;

“In Portugal it is ... “Look! Show!”. Here? Only Paracetamol!” [all laugh]
(Portuguese, male, 55, living in Thetford)

Other differences to the systems in their home countries had, however, proved a pleasant surprise for participants. For example, several spoke very favourably not only about the quality of maternity and ante-natal care provided in the UK but also about the fact that care was largely provided by a midwife who often saw the woman throughout her pregnancy and delivered the baby – this was a different experience for most, who were used to a system where care was provided much more formally, and by a doctor.

5.3. Health behaviours – smoking and drinking

35.7% of the sample (35 respondents) identified themselves as current smokers, while 24.5% (24 respondents) were ex-smokers. 39 respondents had never smoked. Levels of smoking were particularly high among questionnaire respondents from CEE countries (68.6%) and among male respondents (68.6%). Younger respondents were less likely to smoke – just 37.1% of current smokers were aged 35 – while 22.9% were aged between 36 and 45, and 34.3% were aged between 45 and 55.

Levels of smoking among the sample were mainly ‘heavy’ or ‘moderate’, amounting to 65.7% of the sample. Current Department of Health guidelines define heavy smoking as the consumption of 20 or more cigarettes per day; according to these guidelines, out of those respondents who smoked 31.4% would be classed as heavy smokers. Moderate smoking is defined as the consumption of between 10 and 20 cigarettes per day; 34.3% of our sample who smoked can be classed as moderate smokers. 34.3% of the sample can be classed as ‘light’ smokers, consuming up to 10 cigarettes per day. Smoking levels among questionnaire respondents are summarised in table 9 below.

Table 9: Smoking levels among questionnaire respondents

Cigarettes per day	No.	%
0 to 10	11	31.4
11 to 20	13	37.1
21 to 30	10	28.6
30+	1	2.9
Total	35	100.0

Only a small proportion of smokers (20%) identified themselves as actively ‘trying to quit’ smoking, while a further (11.4%) were ‘actively *planning* to quit’. A further 31.4% expressed some interest in quitting, and indicated that they were ‘thinking about but not planning to quit’. This data suggests that there is considerable potential for developing smoking cessation interventions with migrant communities; however, a further 22.9% stated that they had no interest in quitting, suggesting that patterns of tobacco consumption among this group are well established and that such initiatives may encounter continued resistance. It was beyond the scope of this study to consider the reasons for non-take up of smoking cessation advice and support²⁵⁶. However, Keystone is currently setting up a smoking cessation service and it would be useful to consider this in any evaluation of the scheme²⁵⁷.

Our results also suggest that migrant workers are unlikely to consult either their GP or another health professional for smoking cessation advice. In the past 12 months, just 2 of the smokers in our study stated that they had done so²⁵⁸. A slightly higher number (11 respondents) stated that they were *planning* to consult either their GP or another health professional about ways to stop smoking; however, the majority (77.1%) indicated that they were not planning to seek medical advice. When asked about previous attempts to quit smoking, the majority (80%) of respondents identifying themselves as current smokers reported that they had tried to quit in the past. 53.6% of those respondents had made between 1 and 2 attempts, while 14.3% had tried between 3 and 5 times and a further 14.3% had made 5 or more attempts. Only 22.9% of smokers (8 respondents)²⁵⁹ indicated that they had approached a health professional for smoking cessation support, all of whom had accessed support in their home countries,

and none of our respondents had taken up smoking cessation advice in the UK. However, when asked, none of the respondents were able to identify specific smoking cessation initiatives in their home countries (either government-led or independently run) such as the Quit and Win project (see section 5.1.3 above).

Just over half of respondents (51.0%) stated that they consumed alcohol. Levels of alcohol consumption among the sample were comparatively low, with only 9 respondents (18.0%) stating that they drank alcohol daily²⁶⁰. A further 16 (32.0%) reported drinking alcohol once or twice per week, while 26 (52.0%) stated that they only drank alcohol once/twice per month or less. 26.0% of those who consumed alcohol reported that they had not had a drink in the past week, 44.0% had had between 1 and 5 drinks, while 16.0% had consumed more than 5 drinks²⁶¹. None of these respondents were aware of government guidelines on alcohol consumption, or of how many units the alcohol they had consumed represented.

5.4. Health behaviours – diet and exercise

Healthy eating

Government drives to transform the eating habits of communities have been at the centre of recent health promotion campaigns such as the ‘5-a-day’ campaign, and more recent schemes such as Change4Life and Healthy Towns. In *‘Healthy Weight – Healthy Lives: A Cross-Government Strategy for England’*, the focus was on five main areas including promoting healthier food choices – for example, reducing the consumption of foods that are high in fat, sugar and salt, and increasing consumption of fresh fruit and vegetables – and building physical activity into our lives²⁶².

Many of the health problems on which these campaigns have focused, such as high rates of diabetes, cancer and cardio-vascular disease, have also been recognised as major public health issues in sending countries (see section 5.2) and national governments have, to varying extents, addressed these problems by implementing a range of health promotion projects. In this section of the questionnaire we therefore attempted to map our respondents’ dietary and exercise habits, and also measure their awareness of these health issues at home and in the UK, as well as their knowledge of any public health campaigns introduced either by their own or by the UK government. Focus group participants were also asked about their awareness of major public health issues, both at home and in the UK, and of any associated campaigns.

Consumption of fresh fruit and vegetables varied widely, with many respondents not meeting the 5 a day ‘target’ (see fig. 9 and fig. 10). 39.8% of respondents ate fresh fruit on five or more days per week, whereas

31.6% ate fresh vegetables on five or more days per week. Fresh vegetable consumption tailed off dramatically, with 35.7% only eating them on two or three days per week, and a further 35.7% only eating them one day per week. When we asked focus group participants the possible reasons behind this, most argued the expense of buying good quality fresh food

was a major factor, but also suggested that many migrant workers were used to a national diet or cuisine that did not rely heavily on foods from these groups – often because they were prohibitively expensive in sending countries too. Participants in the Polish speaking groups also observed that Polish cooking is particularly high in fat.

Fig. 9 Questionnaire respondents' weekly consumption of fresh fruit

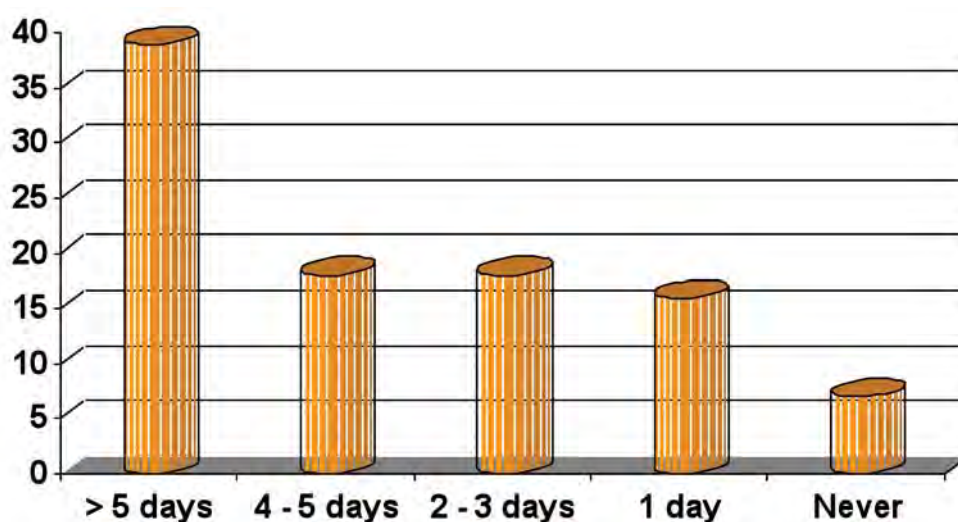
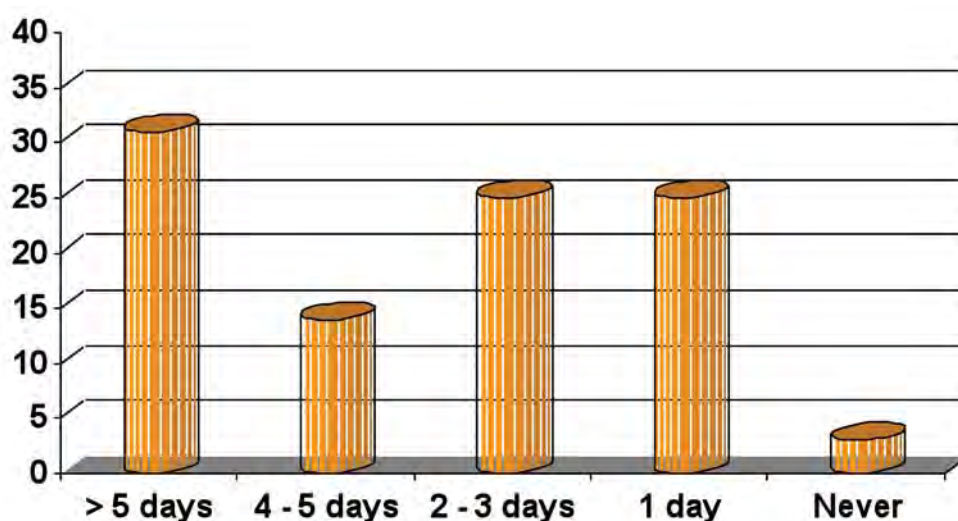


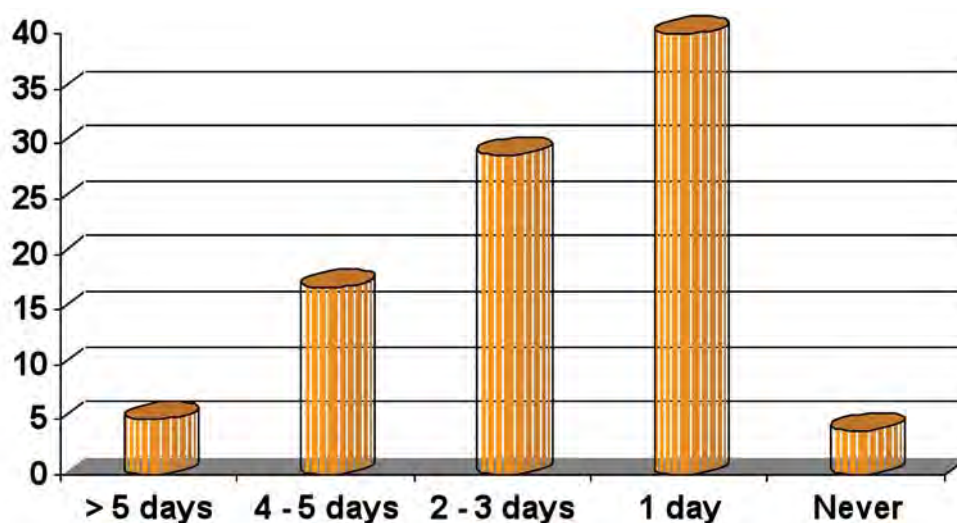
Fig. 10 Questionnaire respondents' weekly consumption of fresh vegetables



We also asked respondents about their consumption of other foods which have been identified as unhealthy in public health campaigns such as Change4Life, with varying results. For example, consumption of

fried foods (such as chips) was moderate, with 42.9% only eating these items on 1 day per week and a further 29.6% eating them on two or three days per week (see fig. 11).

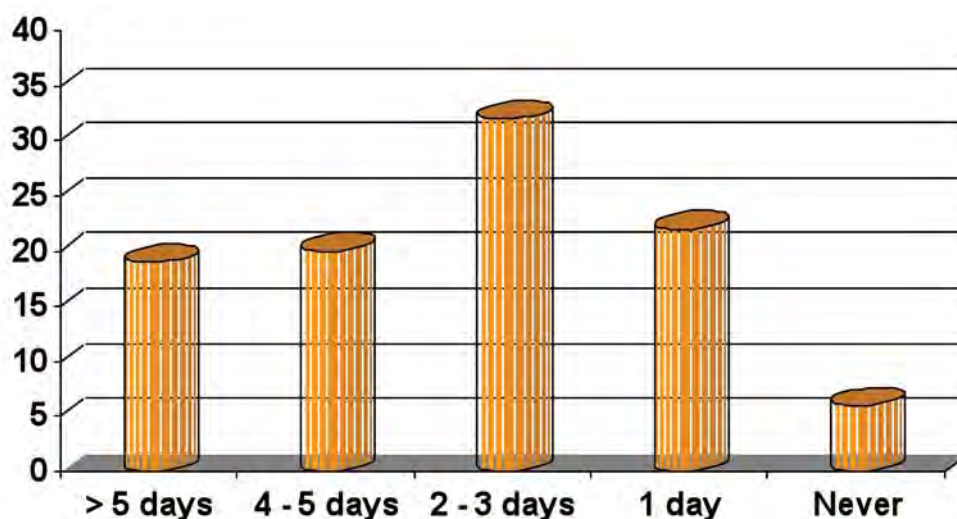
Fig. 11 Questionnaire respondents' consumption of fried foods



However, consumption of sugary foods such as cakes, biscuits and pastries was higher (see fig. 12) with 19.4% of our sample consuming them on five or more days per week, 20.4% consuming them on three or four days per week and 32.7 consuming them on two or three days per week. Similarly, a high proportion of our sample

added sugar to hot drinks; 73.5% added sugar to hot drinks such as tea or coffee, and of those respondents 60.8% added two or more teaspoons of sugar. Some respondents, even those who were only adding one teaspoon of sugar were drinking 5 or more hot drinks per day, meaning that their total sugar intake could be very high²⁶³.

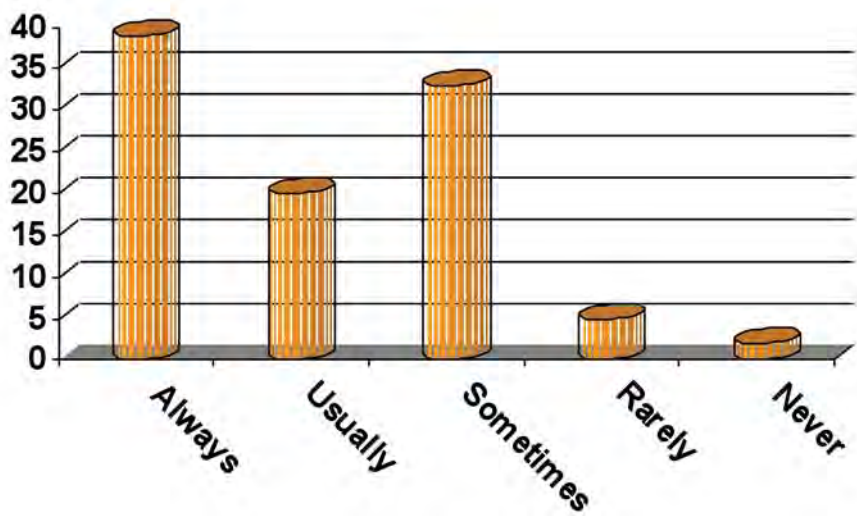
Fig. 12 Questionnaire respondents' consumption of sugary foods



We also asked respondents about their salt consumption, levels of which appear to be particularly high (see fig. 13) with 39.8% of our sample reporting that they ‘always’ added salt to their food and a further 20.4%

‘usually’ adding salt to their food. Of these, 29.6% ‘sometimes’ added salt before *tasting* the food and a further 20.4% ‘always’ did so.

Fig. 13 Questionnaire respondents’ consumption of added salt



A high proportion of respondents also consumed high fat dairy products such as whole milk and butter; 42.9% preferred to drink whole milk, 48.0% preferred to use butter and 23.5% choosing full-fat margarine. Whilst the eventual size of some of the sub-samples by nationality was insufficient to include the data in our cross-tabulations, we have also produced a table which shows some of the internal variations behind the aggregate figures discussed here (see table 11) between the main nationalities represented in our sample. For example, if we look at the table we can see that consumption of salt and sugary foods was particularly high among Portuguese respondents, indicating possible areas where future information campaigns might need to be targeted.

Eating habits also appeared to be somewhat erratic, possibly due to the long working hours and shift work undertaken by a high proportion of this group. For example, given

the emphasis on regular mealtimes in much of the health promotion literature, we asked questionnaire respondents how often they found themselves skipping meals. The proportion who did so was relatively high; only 12 respondents *never* skipped meals compared with 26.5% (28 respondents) who skipped meals five or more times a week. A further 20.4% (20 respondents) skipped meals three to four times a week. We also asked respondents about *how* they eat, i.e. whether they ate alone or communally²⁶⁴; proportions here were relatively high with 40 out of the 98 respondents reported that they sat down to a meal with their family or members of their household every day. However, there were still 15 respondents who did *not* manage to do this at all, and a further 16 who only ate communally on one day a week.

The data on exercise patterns were also particularly revealing (see fig. 14); for example, a very high proportion of our

respondents (36) never exercised, and a further 18 exercised on only one day per week. The main reason given for this was lack of time (rather than a lack of facilities), followed closely by lack of interest. Moreover, a relatively high proportion of our

sample engaged regularly – and for substantial periods of time – in more sedentary activities such as watching television, using the computer or playing video games²⁶⁵ (see fig. 15).

Fig. 14 Exercise patterns among questionnaire respondents

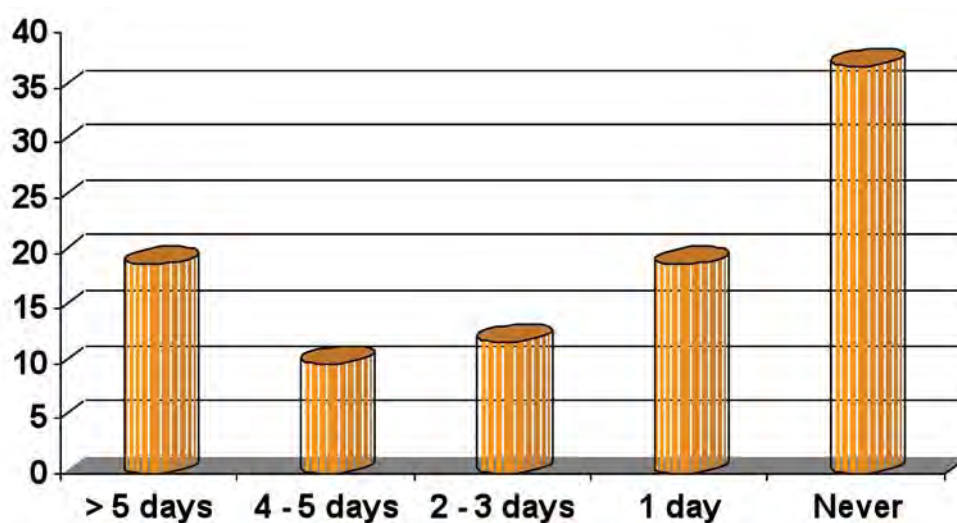
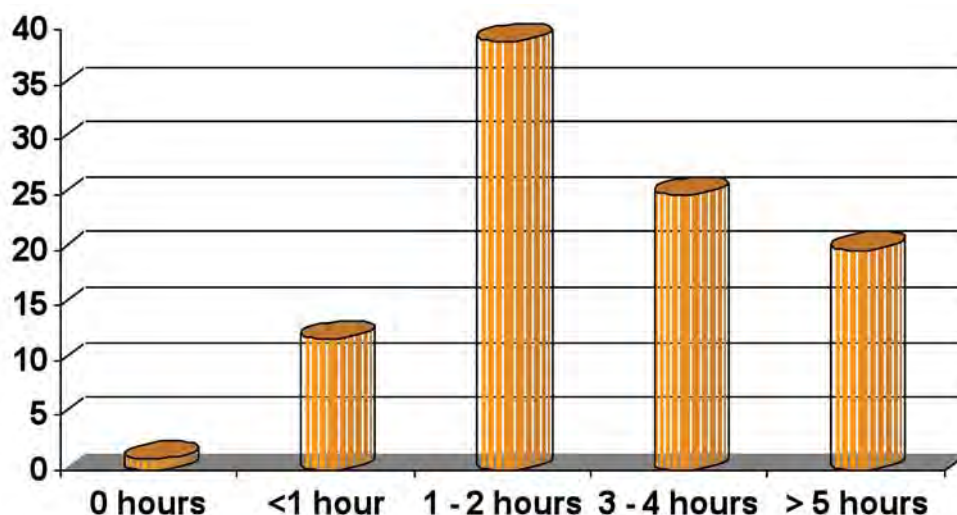


Fig. 15 Sedentary activities among questionnaire respondents



Very few respondents were aware of any health promotion campaigns introduced by national governments, either in the UK or in sending countries – apart from a minority who mentioned the 5-a-day campaign; this finding was echoed by the focus group participants who also discussed the fact that this was not an area in which governments in their home countries invested either time or funds. For example, the majority of

participants in the two Polish speaking groups held the opinion that their government did not support anti-smoking campaigns because of the value of the tobacco business to the national economy;

“They make too much money from cigarettes, so they don’t want to help people to stop smoking”
Polish, male, aged 38

Table 11: Healthy eating and physical activity patterns among questionnaire respondents²⁶⁶

Country ²⁶⁷	High fruit intake ²⁶⁸	High vegetable intake ²⁵⁴	High intake of fried foods ²⁵⁴	High intake of sugary foods ²⁶⁹	High salt intake ²⁷⁰	Physically active ²⁷¹	Engaging in sedentary activities ²⁷²
Total ²⁷³	58.2	45.9	22.5	39.8	38.8	28.6	45.9
Lithuania	31.3	50.0	25.0	50.0	43.8	25.0	50.0
Poland	24.2	39.4	27.3	21.2	21.2	27.3	36.4
Portugal	25.0	41.6	19.4	58.3	50.0	33.3	55.6

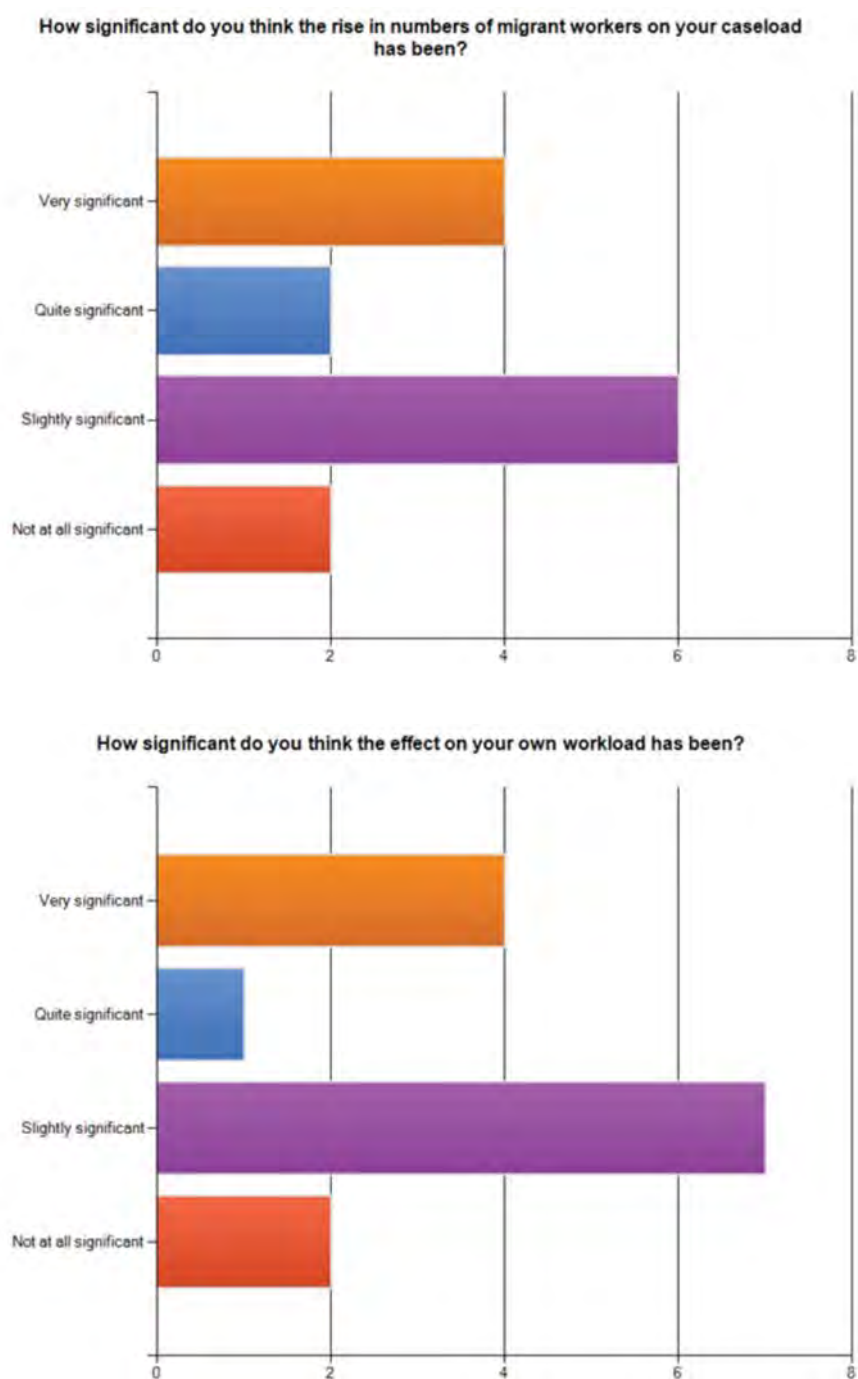
CHAPTER 6: Migration and health – the professionals' view

In total, 19 service providers completed the online questionnaire; this included 5 GPs, 5 practice/surgery managers, 3 nurses, 1 midwife, 2 health visitors, 1 speech and language therapist, 1 school nurse and 1 podiatrist. Unfortunately, although we contacted a range of dental surgeries in the area, none completed the questionnaire – this continued gap in our knowledge is something which future research would need to address. Of the front-line professionals who did complete the questionnaire, 11 worked in Thetford and 4 in Brandon. Other areas of the region covered by our respondents included Bury St. Edmunds, Haverhill and Newmarket (1), Litcham (1), Dereham (1), Wymondham (1) and Norwich (2)²⁷⁴.

6.1. Meeting the needs of migrant worker clients

Questionnaire respondents differed widely in their perceptions of the effect which increased migration to the area had had on their caseloads (see fig. 16 below). The majority (6) felt that this effect had only been 'slightly significant'. However, a further 4 respondents felt that new arrivals had had a 'very significant' effect on their practice's caseloads²⁷⁵. Respondents were similarly split when asked about the effects on their own workload (see fig. 17 below); the majority (7) felt that this had been 'slightly significant', while a further 4 felt that the effect had been 'very significant'. Most respondents felt that these changes had taken place over the past 1 to 2 or 3 to 5 years²⁷⁶ – since the EU accession of the A2 and A8 countries. However, while an increase in numbers of A8/A2 migrant workers arriving in an area can clearly put a certain amount of pressure on local services such as healthcare provision – particularly in rural areas – our data suggests that this is far from the overwhelming burden on provision regularly reported in the media. In the telephone interviews carried out by our research team, service commissioners frequently talked about how a steep rise in migrant numbers could make planning service delivery especially problematic – particularly when, given the acknowledged pitfalls of current migration statistics and the apparent trend of migrant workers returning home (or leading increasingly transnational and 'circular' lives), it is so difficult to ascertain accurate numbers and therefore to predict levels of demand.

Fig. 16 Service providers' perceptions of the effects of increased migration on healthcare provision



A number of commissioners also reported anecdotal evidence of migrant workers directly accessing A&E departments, rather than consulting a local GP. However, there is still a lack of definitive, large-scale data available on A&E usage, although levels remained low among our migrant worker sample (as it has been in several other small-scale studies). Some commissioners we spoke to also mentioned the absence of a coordinated approach and distinct lack of information-sharing about meeting migrant worker health needs as a particular barrier to effective service planning.

Front-line professionals who responded to our questionnaire reported a wide range of health needs among their migrant worker patients. In particular, child health, family planning/sexual health, and primary care mental health were identified as particular 'growth' areas of demand for services. Several respondents also raised concerns around the potentially negative health impact of migrant workers' living conditions, and some reported having patients who they felt were becoming unwell because of living in poor quality, overcrowded accommodation – either because of physical conditions (such as damp causing respiratory problems), or because of the stress placed on them by their situation. One respondent expressed particular concerns about the potential impact of such living conditions on the children of migrant worker families. We also have anecdotal evidence from our telephone interviews that sexual health is becoming more of an issue among this group; respondents indicated that there are an increasing number of migrant sex workers in Norfolk, who may be particularly vulnerable health-wise and may not openly access screening services. It was felt therefore that there was likely to be a significant level of unmet need in this area. However, a significant proportion of our questionnaire respondents felt that health needs among their migrant worker patients

were not markedly different to those of other patients.

'They appear to have the same health issues as all of our clients'

Half the service providers we asked allowed extra time for appointments with migrant worker clients; however, equally, half did *not* allow any extra time – even given the language barrier and the widely acknowledged difficulty of conducting consultations through an interpreter (see section 7.2 below). Nonetheless, the majority of respondents (12) felt that they were able to provide migrant worker patients with an equal level of service, although four respondents reported that they felt they were not managing to do this. Most respondents felt reasonably confident in their knowledge of migrant workers' entitlements, and had received a good deal of information about this; 4 respondents were 'very confident' in their knowledge, while a further 9 were 'quite confident. However, they were less confident in their knowledge of health systems in sending countries, with 4 reporting that they had only 'a little knowledge' and 9 stating that they had no knowledge at all. This is perhaps unsurprising but, given the comments our respondents made about migrant workers having different cultural expectations of services in the UK, it would be useful if UK professionals understood a little more about where those expectations might stem from. Only 2 respondents could offer any concrete examples of provision in sending countries; one GP talked about how they had gleaned a few facts from looking at the records of their migrant worker patients – for example, scans and x-rays are relied on much more heavily by non-UK doctors, whereas in the UK doctors rely more heavily on clinical judgement.

Respondents were also asked to list, in order of importance, the three things which they felt would enable them to improve the

service they offered to their migrant worker patients; unsurprisingly, language and translation issues (see section 7.2 below) were prominent on several 'lists';

- 'If the client speaks English ... cheaper interpretation services' (Nurse, Norfolk)
- 'Translation services, in person, for all surgeries' (GP, Norfolk)
- 'Information leaflets available in other languages' (Podiatrist, Norfolk/Suffolk)
- 'That it should be compulsory for the migrants to learn English on arrival in the country ... they are no more demanding than any other patient and are treated just the same' (Practice Manager, Norfolk)
- 'Interpreters provided by the referrer ... interpreters to translate any advice sheets – not out of our budget!' (Speech therapist, Suffolk/Norfolk)
- 'The main difficulty is language barrier, even with interpreters I am not sure that clients always fully understand what is said' (Nurse, Norfolk/Suffolk)

However, some respondents prioritised other issues, mentioning the need for an increased flexibility and improvements to cultural awareness and understanding of how migrant workers accessed and experienced health services;

- 'an understanding of the primary care health system in other countries' (Practice Manager, Norfolk)
- 'more understanding of their cultural norms' (Health visitor, Norfolk)
- 'a migrant worker representative on our Patient Participation Group' (Practice Manager, Norfolk)
- 'more time' (Health visitor, Cambridge)

6.2. Barriers to accessing services

The main barriers which can prevent migrant workers from accessing healthcare provision are summarised in fig. 10 below²⁷⁷. Service providers (36.8%) were particularly concerned about a lack of awareness among migrant workers about the services available to them; despite the evidence presented by a range of studies (*including* our own) indicating an increasing rate of GP registrations among migrant workers, it is apparent that *some groups* remain unaware of their entitlement to primary care provision or unsure of how to access such services (see section 6.2). One major recommendation put forward by questionnaire respondents was to build on the existing improvements to information dissemination, and raise awareness further still – using language-appropriate literature/publicity;

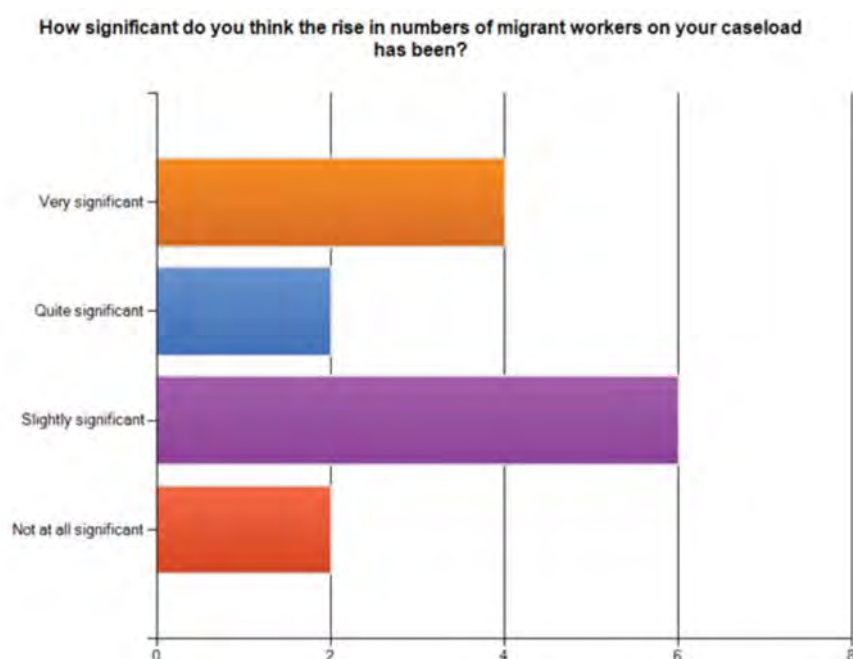
- 'Educate migrants re what is available to them and where to access services' (Nurse, Norfolk/Suffolk)
- 'A standard form explaining to migrant workers exactly what can and more importantly cannot be done within General Practice and the NHS in general' (Nurse, Norfolk/Suffolk)
- 'Clear explanatory posters to migrants as to how local services work; 'what to expect' (and a few words even on what we don't do)' (GP, Norfolk)

6 respondents (31.6%) also emphasised the importance of cultural differences in understanding of health needs and services as a barrier to access; enhanced awareness was seen as needed – not only from practitioners but also on the part of migrant workers. A significant minority (21.1%) equally felt that migrant workers can have

unrealistic expectations of the services available to them. Few professionals, either providers or commissioners, felt that migrant workers were not accessing services because

they had a negative perception of service quality or because they preferred to access care in their home country – or because there was no space for them on patient lists.

Fig. 17 Barriers to accessing health services experienced by migrant workers



Other issues were raised – particularly the fact that the long hours worked by some migrants can make accessing care difficult. One of the commissioners we talked to also felt that maintaining levels of child health development was becoming a problem, and reported that ensuring that children in migrant worker families were correctly immunised was difficult. This was felt to be due, in part, to the fact that migrant workers are not accessing the same media as other residents of the local area – and are therefore not getting the same ‘messages’ about immunisation²⁷⁸. Issues around getting across public health messages on disease prevention were also mentioned, with another participant talking about how difficult it had been to distribute information to migrant workers about the recent swine flu outbreak.

Both commissioners and providers highlighted the problem with accessing dental services which we have already discussed above (see section 6.2). One interviewee pointed out the difficulties experienced in getting children from migrant worker families to access regular dental checks via the school, and in educating families on the importance and potential benefits of regular checks – meaning that the oral health needs of many children remained unmet.

Language difficulties and a widespread lack of available translation and interpreting services were also prioritised by 5 questionnaire respondents (26.3%). Practices varied widely in the availability and provision of this facility; only 3 respondents stated that their practices ‘always’ provided an interpreter. The majority (9) provided an

interpreter 'sometimes', while only 2 respondents 'never' offered this to patients. Where an interpreter was *not* made available, this was usually because of cost or a lack of availability – as one respondent noted, they were not always noted by the referrer that a translator was required, while one of the health visitors in our sample pointed out that often families want to be seen at short notice, leaving them little time to arrange an interpreter. Few GP practices employed a translator, although one did report having staff who were able to translate when on duty if necessary.

On the commissioning side, it was observed that there had been a steady increase in demand for interpreting and translation services within NHS Norfolk, with this year seeing a record 73,000 requests for translation services. This was across a *range* of languages, but the highest level of demand was recorded among Portuguese patients, followed by the Polish community.

It was also noted that despite low levels of registration with dentists among migrant workers (see section 6.2), requests from local dental surgeries were starting to increase, albeit from a very low base. One alarming finding from this data was that, despite the widespread recognition among our professional respondents of the importance language as a barrier in accessing services, many surgeries were still not translating patient information into the relevant languages²⁷⁹. Information which was translated included not only previous medical records and documentation from home countries, but also information on family planning, diabetes and postnatal depression as well as generic practice leaflets. Generally it appears that information is translated into Portuguese and Polish, but often not into Latvian and Lithuanian – this would need addressing, particularly given the potential for increasing numbers of new arrivals from these two countries (see section 3.1).

CHAPTER 7: Discussion, conclusions and recommendations: setting priorities for service development and a future research agenda

This final section draws together the key findings from our primary and secondary research, highlighting the main themes to emerge from our data and considering the relevance of our findings to initiatives such as Change4Life and the Healthy Towns project. We also suggest ways in which local service providers and commissioners might move forward and develop policy in order to better understand and meet the needs of new communities, and the ways in which research can support this.

It is often suggested that many A8 and A2 migrant workers are returning home, *and* that the migrant workers population in the UK is young, single and relatively healthy, with the clear implication that the health needs of this group do not need to be considered in any great depth when planning local service delivery. However, as we have already argued, while regional and local level data does indicate that *some* migrant workers (such as Poles) *are* leaving, others (such as Latvians and Lithuanians) are arriving in increasing numbers. Moreover, there is evidence that migrant workers are starting families or that their families are beginning to join them here. Demand for services is likely to change, and it is important that local service providers and commissioners are better prepared in order to meet these new sets of health needs.

There are a number of key themes which have emerged from both the primary and secondary research undertaken for this project. Using our findings, we identify below several priorities for the development of local service provision as well as a number of areas where further research is needed in order to extend our knowledge of issues around migration and health, as they are experienced by migrant workers coming to live and work in our region.

What does this research tell us about the health needs, issues and concerns of migrant workers?

- Access to healthcare services:** Our evidence suggests that the majority of migrant workers are now registering with a local GP and do not necessarily directly access emergency treatment instead, as is commonly suggested²⁸⁰. However, the actual usage level of primary care services remains minimal. Migrant workers who are *not* registered with a local GP generally state that this is because they have not needed to make an appointment. Accessing dental care appears to be much more problematic for many migrant workers. There are also a number of cultural factors which can affect migrant workers' experience of these services; for example, different understandings of the GP's role as gatekeeper to specialist provision or differences in consultation styles and prescribing practices between the UK and home. Where available, interpreting and translation services work well although provision is sometimes inconsistent. GP surgeries do not always provide migrant workers with information in their own language, often due to the cost of obtaining translations.
- Healthy behaviours and attitudes to health promotion:** Few migrant workers we spoke to were aware of any health promotion initiatives, either in the UK or in their home countries. There was also evidence among our sample of a range of what are labelled as 'unhealthy' behaviours; for instance, high levels of salt and sugar consumption as well as low levels of regular exercise.

- **Health tourists?** The quality and availability of healthcare in the UK is *not* a significant ‘pull’ factor in migration decisions. Few of our questionnaire respondents or focus group participants had any prior knowledge of the UK system before arriving in the area, and similar conclusions have been drawn by other studies²⁸¹.

Where do we go from here?

- **Building a robust evidence base:** This research represents only an initial step in developing our understanding of the health needs and issues experienced by migrant workers. The scope of this project was fairly limited and focused only on Thetford and the surrounding area, given that these were the priorities of the research funders. We have focused on a relatively small area of the Eastern region²⁸²; however, pockets of local knowledge such as this need to be brought together in order to inform a more strategic approach – both regionally and nationally. This research could be usefully replicated across other counties in the East of England, and it would also be interesting to compare our results with evidence emerging from other areas of the UK in order to identify any common issues or experiences – or any differences.

Given the current uncertainty about length of stay among migrant workers, and the difficulty of predicting levels of demand for services, the picture on migration and health (obtained by ‘snapshot’ studies such as this one) needs to be updated regularly as part of a sustained programme of research. As we have already noted, access to health care is vital to effective integration and if migrant workers are planning to stay in the UK – even where their stay is temporary but long-term – it is essential that their health needs are routinely considered as part of service planning and commissioning.

- **Developing knowledge in specific areas of service provision – mental health:** There is still a lack of evidence on how the stresses involved in the migration process affect migrant workers whose experience, although different to that of asylum seekers and refugees, brings its own stresses and difficulties. There is already limited evidence which shows increased levels of depression and anxiety among this group²⁸³; this contradicts the idea of a ‘healthy migrant effect’ discussed in section 4. Partly because of the necessarily broad scope of this research which prevented us from looking at mental health issues in any detail, and also partly because of the methods used which were not suitable for discussing such sensitive topics, it has not been possible to draw any conclusions here. However, this should be a priority area for future research which also needs to consider patterns of help-seeking among migrant workers with mental health issues along with attitudes towards and experiences of using formal services.
- **Developing knowledge in specific areas of service provision – child health:** Until now, the general picture of the migrant worker population in the UK has been that they are young, healthy and single with few dependants. While this remains true *overall*, there is equally now evidence that the picture is starting to change. Not only has there been a growth in the number of ‘family joiners’²⁸⁴ with more migrant workers bringing over their partners and children, but more migrant workers are now settling in the UK and starting new families²⁸⁵. If this is true then certain primary healthcare professionals such as midwives and health visitors will play an important role in accessing migrant worker populations and building confidence in health services.

Yet despite the apparent increase in demand for child health services, there is still very little data available except the evidence from several small scale studies, much of which remains anecdotal. Further large-scale, systematic and sustained research is needed to explore migrant workers' experiences of accessing child health services. One way of doing this would be to design a mixed-methods study which focused on migrant workers across the East of England and might combine the following elements;

- a quantitative analysis of the available data on new births to foreign-born mothers which could be used to assess the extent of any increase in pressure on maternity and child health services, as well as any patterns or localised pressures in certain areas²⁸⁶;
 - qualitative, in-depth interviews – or focus groups – with migrant worker parents focusing on their experiences of using maternity and child health services, including any barriers;
 - qualitative, in-depth interviews – or focus groups – with child health professionals such as midwives and health visitors, focusing on their experience of working with these parents;
 - non-participant observations of consultations between migrant worker parents and child health professionals.
- **Developing knowledge on specific health issues – housing, homelessness and health:** Few migrant workers are accessing social housing²⁸⁷, and the majority live in private rented accommodation where conditions are often poor and there is a major problem with extreme overcrowding²⁸⁸. A 2005 report on migrant workers in the east of England cited one example of someone who was sharing a four bedroom

property with fourteen other people – at a cost of £35 per week each. In our first volume in the Workers on the Move Series, we found that despite clear evidence of poor living conditions, migrant workers are often unwilling to complain about standards for fear of falling foul of their landlord or even losing their job, if the accommodation is tied to employment.

Although the available data is sketchy there are emerging signs of a growing homelessness problem among migrant workers, and particularly among A8 nationals. Migrant workers can become homeless when their initial temporary housing arrangements fall through, or as a result of losing their jobs. However, migrant workers' experiences of homelessness have largely remained hidden. There is often a certain assumption of self-sufficiency, and because they are not (for an initial 12 month period at least) entitled to any statutory housing assistance, they are not counted in with the existing homeless population – making it difficult to assess the level of need. Migrant workers who do not register on the Workers Registration Scheme cannot access housing support. Moreover, even when registered, if migrant workers cannot prove a continuous twelve month period of employment they are not eligible for assistance – meaning that many are becoming destitute.

Homelessness among migrant workers is however becoming an increasingly pressing issue – not only nationally, but regionally and locally as well. For example, a recent article in The Observer newspaper²⁸⁹ highlighted a growth in A8 homelessness in Boston, Lincolnshire where job losses are resulted in migrant workers losing accommodation and resorting to rough sleeping, which is recognised as a particular problem in the area. One source contacted by the newspaper estimated that there were

as many as twelve makeshift camps or 'shanty towns' around Boston. More locally, shortly before Christmas 2009 Mariusz Fidos, a 33 year old Polish migrant, died from hypothermia on Barnham Common in Thetford where he had been sleeping rough in a makeshift tent. Even in 2006, a report by Norwich based charity St Martin's Trust reported an increasing number of approaches for assistance and emergency accommodation from migrant workers²⁹⁰.

Research is now starting to engage with the issues around homelessness among migrant workers. However, the focus is generally on London and the South East and other urban areas and there is a real need for research which will investigate homelessness in rural regions such as the East of England. Not only would this research need to tackle the thorny issue of how to 'count' homelessness among the migrant worker community, but also consider how best to design support services to ensure that their needs are adequately met.

- **Developing knowledge on specific health issues – domestic violence:** As noted in section 5, experiences of domestic violence can have a significant and adverse effect on women's health. Further to the more obvious physical effects of domestic violence, women suffering such abuse may also suffer from additional mental health issues. The private nature of domestic violence makes it likely that many incidents of abuse remain unreported. Geographical and emotional isolation from friends and family plays a significant part in the problem for women of all races and social backgrounds, and it is not difficult to see how such factors are exacerbated for migrant women in the UK, presenting them with additional difficulties in seeking out and receiving services and support.

Migrant women may face additional barriers in forming independent social support networks, developing language skills, gaining knowledge of their legal and welfare rights or having any kind of financial independence; all socio-economic factors that potentially impact on a woman leaving an abusive situation. Language barriers present an additional problem for migrant women wishing to receive assistance, for example communicating with police and witness support and also in gaining basic knowledge of services available to them. Where women have no recourse to public funds²⁹¹, they are left in a situation with little or no support and without the practical assistance of facilities such as emergency housing.

As with homelessness, little is currently known about the experiences of migrant workers and it is vital that further research is carried out in this area. This topic will be the subject of the next volume in the Workers on the Move Series.

- **Developing knowledge on specific health issues – smoking:** Migrant smoking cessation work has begun in Norfolk and elsewhere. Early indications are that community and work place focused activity is the most productive as long as the smoking cessation workers have the appropriate language skills. It will be important to gather the learning from such projects to enable effective interventions across the country.
- **Developing knowledge on specific health issues – alcohol:** Alcohol consumption amongst some migrants appears to be affecting health. Alcohol consumption patterns are of concern within home countries. Migrant alcohol consumption, particularly in public, appears to be a 'flashpoint' issue in local communities. However we do not know a lot about drinking patterns or effective health promotion work with migrant communities on this issue.

- **Dispelling the concerns of local communities:** As already noted, access to health care can have a negative effect on levels of community cohesion and can become a key flashpoint for tensions between new arrivals and established communities. Evidence such as the data collected for this study could be used to dispel some of these fears and tensions, and counter-balance the negative media discourse – for example, if it was made more widely known how little pressure migrant workers exert on health services and how much of a contribution they make by meeting staff shortages and reducing cost pressures.
- **Improving cultural competence:** More work needs to be done to address these issues; for example, one easy way would be to produce an information sheet letting professionals know about the different ‘backgrounds’. Information could also be designed for a migrant worker audience, highlighting the key differences between health systems at home and in the UK. Careful thought would need to be given to how this could be publicised.
- **Targeting health promotion:** Initiatives such as Thetford Healthy Town and Change4Life had little resonance with the migrant workers we spoke to. Further work and consultation with migrant workers is needed to explore the complex reasons behind this, and also to assess what sort of projects would be more effective in reaching the target audience and improve participation levels. Future projects should explore appropriate ways of promoting exercise, given the lack of time cited by many of our questionnaire respondents as a major contributing factor. More work is needed not only on diet and exercise, but also on smoking cessation; we need to understand particularly what factors influence smoking cessation, what type of service is needed (if for example, as data not only from our study but also the literature shows, the tendency is *not* to use formal services such as GPs).

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CHAPTER 9: Appendices

HEALTH AND MIGRATION SURVEY

We would like to invite you to take part in this survey, because we are interested in hearing more about your experiences of visiting the doctor – both at home and here in the UK. We would also like to know more about your views on other health issues, such as diet, exercise and smoking.

This research has been sponsored by the Thetford Healthy Town project, and will be carried out by Keystone staff. The results will appear in a report, which will be used to identify potential improvements to health services. You will not be identified by name at any point in this report, and all information that you give us will be kept strictly confidential. You do not have to take part in the research, and will be able to withdraw from the research at any time, just by telephoning us (on 01842 754639) or by telling one of the META advisers – you do not have to give a reason, and this will not affect the service you receive from Keystone/META in any way.

Please answer the questions only as they apply to you, rather than giving us information about the experiences of your partner/spouse or your children. The questionnaire will take roughly 15 minutes to complete. Once you have answered all the questions, please return this form to a member of Keystone staff or drop it into the office. If you are unsure about any of the questions, please ask a member of staff who will be able to help you – you can also call either Alex or Danielle on the numbers below.

Thank you very much for taking the time to fill in this survey.

Alex Collis (Keystone Research Manager)
Tel: 01842 754639
Mob: 07982 490695

Danielle Ross (META Manager)
Tel: 01842 754639

Appendix A – Migrant Worker Questionnaire

A. Health Services in the UK:

Q1) Are you registered with a local doctor in the UK?

- No ☐ (go to Q2)
Yes ☐ (go to Q3)

Q2) If you are not registered with a doctor, why is this? (you can tick more than one answer)

- I haven't been ill ☐
I don't know how to register ☐
The doctor didn't have any spaces ☐
I prefer to visit a doctor in my home country ☐

Q3) In the past 12 months, how often have you visited the doctor? (tick one answer only)

- 1 – 2 times ☐
3 – 5 times ☐
More than 5 times ☐
I haven't visited the doctor ☐

Q4) When you visited the doctor, were you able to use an interpreter if you needed one?

- Yes, an interpreter was provided for me ☐
Yes, family/friends interpreted for me ☐
No ☐
I didn't need an interpreter ☐

Q5) Are you registered with a local dentist?

- No ☐ (go to Q6)
Yes ☐ (go to Q7)

Q6) If you are not registered with a dentist, why is this?

- I haven't needed to visit the dentist ☐
I don't know how to register ☐
The dentist didn't have any spaces ☐
I prefer to visit a dentist in my home country ☐
It is too expensive to visit the dentist ☐

Q7) Have you had any contact with a midwife/health visitor?

- No ☐
Yes ☐

Q8) Have you ever visited an emergency department?

- No ☐
Yes ☐

Q9) Have you ever stayed overnight in hospital?

No ☐
Yes ☐

Q10) Do you know about the NHS Direct service?

No ☐
Yes ☐

Q11) Have you ever used this service?

No ☐
Yes ☐

Q12) Have you ever visited a Walk-in Centre?

No ☐
Yes ☐

Q13) If you need help/support with any health problems, where do you go?

Q14) Did you know anything about health services in the UK before you arrived here?

No ☐
Yes ☐

Q15) Are health services in the UK different to health services in your home country?

No ☐ (go to Q17)
Yes ☐ (go to Q16)

Q16) If so, what are the main differences?

Q17) Do you have any children?

No ☐ (go to Q19)
Yes ☐ (go to Q18)

Q18) Does your child need any help with their health at school/nursery or at home?

No ☐
Yes ☐

If so, would you be interested in taking part in some other research about this?

No ☐
Yes ☐

(please fill in your contact details at the end of this form)

B. Smoking and drinking:

Q19) Which of the following describes you?

- a current smoker ☐ (go to Q20)
- an ex-smoker ☐ (go to Q22)
- I have never smoked ☐ (go to Q30)

Q20) How many cigarettes do you smoke per day?

Q21) At the moment are you:

- trying to quit ☐
- actively planning to quit ☐
- thinking about but not planning to quit ☐
- not thinking about quitting ☐

Q22) In the past 12 months, have you talked about ways to quit smoking with a doctor/other health professional?

- No ☐
- Yes ☐
- I haven't seen a doctor/other health professional ☐

Q23) Are you planning to talk to a doctor/other health professional about ways to quit smoking?

- No ☐
- Yes ☐

Q24) Have you tried to quit smoking in the past?

- No ☐
- Yes ☐

Q25) How many times have you tried to quit smoking?

- 1 – 2 times ☐
- 3 – 5 times ☐
- more than 5 times ☐

Q26) Did you get help from a doctor/other health professional with this?

- No ☐
- Yes (in my home country) ☐
- Yes (in the UK) ☐

Q27) Did this help to stop you smoking?

- No ☐
- Yes ☐

Q28) Do you know about any government-run programmes in your home country to help people quit smoking? Please give details in the box below:

Q29) Keystone is currently setting up a new smoking cessation service. Would you be interested in taking part/receiving further information on this service?

No ☐

Yes ☐

(please fill in your contact details at the end of this form)

Q30) Do you drink alcohol?

No ☐

(go to Q34)

Yes ☐

Q31) If so, how often do you drink alcohol? (please tick only one answer)

Every day ☐

Once or twice a week ☐

Once or twice a month ☐

Less than once a month ☐

Q32) What sort of alcohol do you drink? (you can tick more than one answer)

Beer ☐

Wine ☐

Spirits ☐

Other ☐

Q33) How many alcoholic drinks did you have in the past week?

Q34) Do you know how many units this is? (please give a number)

C. Diet and exercise:

Q35) How often each week do you eat fresh fruit?

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q36) How often each week do you eat fresh vegetables?

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q37) How often each week do you eat sugary foods (e.g. cakes, biscuits, pastries and sweets?)

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q38) Do you add sugar to hot drinks such as tea or coffee?

- No ☐ (go to Q41)
- Yes ☐

Q39) If so, how many teaspoons do you add?

Q40) How many hot drinks do you have per day?

Q41) How often do you add salt to your food?

- Always ☐
- Usually ☐
- Sometimes ☐
- Rarely ☐
- Never ☐

Q42) Do you add salt to your food before tasting it?

- No ☐
- Yes (sometimes) ☐
- Yes (always) ☐

Q43) How often each week do you eat fish or white meat? (e.g. chicken)

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q44) How often each week do you eat red meat? (e.g. lamb, beef, pork)

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q45) How often each week do you eat fried food? (e.g. chips)

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q46) Which type of milk do you prefer to drink?

- Whole milk ☐
- Semi-skimmed ☐
- Skimmed ☐
- Don't use ☐

Q47) Which of the following do you usually use?

- Butter ☐
- Margarine (full-fat) ☐
- Margarine (low-fat) ☐
- Don't use ☐

Q48) How often do you find yourself skipping or missing meals?

- Once or twice a week ☐
- Three or four times a week ☐
- Five or more times a week ☐
- Never ☐

Q49) How often do you manage to sit down to a meal with your family or people you live with?

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q50) How often each week do you exercise?

- Every day ☐
- Four or five days a week ☐
- Two or three days a week ☐
- One day a week ☐
- Never ☐

Q51) If you do not exercise, what is the reason for this? (you can tick more than one answer)

- I don't have enough time ☐
- I don't enjoy exercising ☐
- There aren't many opportunities to exercise where I live ☐
- Other reason ☐

Q52) How much of your free time do you spend watching television, playing video games or using the computer?

- Less than one hour a day ☐
- One to two hours a day ☐
- Three to four hours a day ☐
- Five or more hours a day ☐
- None ☐

Q53) Have you ever been concerned about your weight?

- No ☐
- Yes ☐

Q54) If so, have you ever seen a doctor about this?

- No ☐
- Yes ☐

Q55) Do you know of any healthy living campaigns in the UK? (if so, please give details below)

Q56) Do you know of any healthy eating campaigns in your home country?
(if so, please give details below)

D. About you:

28) Gender

Male

☐

Female

☐

29) Nationality

30) Age

Appendix B – Migrant Worker Focus Group Topic Guide

- Welcome and thanks, brief overview of the research 5 minutes
 - Brief introduction to the focus group method (incl. translation)
 - Format of the group (break, two halves, UEA study)
 - Ground rules (confidentiality, timekeeping)
 - Any questions?
 - Group introductions, then open up discussion
- A. Health services at home 10 – 15 minutes**
- Can you tell me a bit more about health services in your country? How have these changed?
 - What is it like going to see the doctor there? How does that work?
 - What is it like going to see the dentist there/ How does that work? (any other services used)
 - How is it different from going to see the doctor/dentist in the UK? (ask for examples)
 - Has this ever caused you any difficulties?
 - Do you ever still go and see your doctor in Poland/Portugal? (explore reasons)
- B. Health services in the UK 10 – 15 minutes**
- Did you know much about health services in the UK before you came here?
 - How did you find out this information?
 - Have you ever had problems finding the information you needed? (ask for examples)
 - Check whether people are registered with GPs (explore barriers and reasons for non-registration, also positive contact – ask for examples)
 - What other services have you used? What was that like?
- C. Perceptions of health at home and in the UK 10 minutes**
- Does anyone think their health has got better since coming to Thetford/the UK? Worse? (explore reasons, ask for examples)
 - Are people generally healthy in your home country? What do you think are the main health problems people have? (ask for examples, explore reasons – cover smoking, alcohol, diet and exercise/obesity and overweight)
 - Examples of health debates in home countries? (healthy eating, lack of exercise)
 - Examples/awareness of health promotion campaigns (government, other organisations) in home countries e.g. Quit and Win (Portugal and Poland), Let Me Grow Up Healthy (Lithuania)
 - Explore channels used to access this info e.g.
 - schools
 - advertising (newspapers, television, internet)
 - others?
 - Examples/awareness of health promotion campaigns (government, other organisations) in the UK (check awareness of healthy living campaigns e.g. Healthy Town, 5 a day – explore channels used to access this info)
 - Experiences of consulting medical professionals (e.g. GPs) re. health issues esp. diet (UK, home). Is this seen as helpful?
- Debrief and close**
- remind participants of how data will be used (report feeding into future service developments)

Appendix C – Health Professionals Questionnaire (Providers)

HEALTH AND MIGRATION SURVEY

SERVICE PROVIDERS

We would like to invite you to take part in this survey because we are interested in hearing more about your experiences of delivering health services to migrant worker communities within the Thetford area, and beyond. We would also like to hear about your perceptions of the health needs of migrant worker communities, and any effects these may have had on your own professional practice. By 'migrant worker' we mean people from Portugal or any of the A8/A2 countries (Poland, Lithuania, Latvia, Slovakia, Hungary, Estonia, Slovenia, Czech Republic and Romania, Bulgaria).

This exploratory piece of research has been sponsored by the Thetford Healthy Town project, and is being carried out by Alex Collis, Keystone's Research Manager. The results will appear in a report, which will be used to identify potential improvements to health services as well as any areas for future research.

You will not be identified by name in this report, and we would only include the area where you work (e.g. Thetford, Brandon) and your job description (e.g. Health Visitor, GP). All information which you give us will be kept strictly confidential, and we would not ask for information on individual cases at any point. You are also under no obligation to take part in the research, and you can withdraw at any point simply by contacting Alex.

Please answer the questions on the attached short questionnaire, which should only take 10 minutes to complete. Please tick only one answer unless otherwise directed. Once you have completed all the questions, we would be grateful if you could email the form back to Alex using the email address below. If you prefer, you can also access the questionnaire online by following this link: <http://www.surveymonkey.com/s/HealthandMigration>

Thank you very much for taking the time to fill in this survey.

Alex Collis (Keystone Research Manager)
Tel: 01842 754639
Mob: 07982 490695
alex.collis@keystonetrust.org.uk

Q1) Are you a:

- GP ☐
- Dentist ☐
- Nurse ☐
- Midwife ☐
- Health Visitor ☐
- Practice Manager ☐
- Other (please specify below) ☐

Q2) Where do you work? (you may tick more than one option)

- Thetford ☐
- Brandon ☐
- Norwich ☐
- Wymondham ☐
- Attleborough ☐
- Other (please specify below) ☐

Q3) How significant do you think the rise in numbers of migrant workers on your caseload has been?

- Very significant ☐
- Quite significant ☐
- Slightly significant ☐
- Not at all significant ☐

Q4) How significant do you think the effect on your own workload has been?

- Very significant ☐
- Quite significant ☐
- Slightly significant ☐
- Not at all significant ☐

Q5) Have these changes occurred over the past:

- 6 months ☐
- 6 – 12 months ☐
- 1 – 2 years ☐
- 3 – 5 years ☐
- + 5 years ☐
- No change ☐

Q6) Do you allow extra time for appointments with migrant worker clients/patients?

- Yes ☐
No ☐

Q7) Do you provide an interpretation/translation service to migrant worker clients/patients?

- Yes (always) ☐ (go to Q9)
Yes (sometimes) ☐ (go to Q9)
No ☐ (go to Q8)

Q8) What prevents you from offering an interpretation/translation service to migrant worker clients/patients? (you may tick more than one option)

- Availability of service ☐
Cost of service ☐
Quality of service ☐
Other (please specify below) ☐

Q9) Do you employ translators within your practice?

- Yes ☐
No ☐

Q10) Do you translate any of your patient/client information?

- Yes ☐
No ☐ (go to Q12)

Q11) If you do, what sort of information do you translate and into which languages?

Q12) What factors do you think might prevent migrant workers from accessing your services? (please tick all that apply)

- Language issues/lack of available translation and interpreting services ☐
- Lack of space on patient lists ☐
- Migrant workers aren't aware of the services available ☐
- Migrant workers prefer to use health services in their home country ☐
- Migrant workers have a negative perception of the quality of services ☐
- Migrant workers have unrealistic expectations about the services available ☐
- Migrant workers have different cultural understanding of health/healthcare ☐
- No barriers ☐
- Other (please specify below) ☐

Q13) Do you feel that you are able to provide the same level of service to your migrant worker patients/clients as to your other patients?

- Yes 0
- No 0

Q14) What do you think are the main health needs of your migrant worker clients/patients?

Q15) How confident are you in your knowledge of migrant workers' entitlements to NHS treatment?

- Very confident ☐
- Quite confident ☐
- Not very confident ☐
- Not at all confident ☐

Q16) How much knowledge do you have of health systems/services in migrant workers' home countries?

- A lot ☐
- Quite a lot ☐
- Only a little ☐
- None at all ☐ (go to Q18)

Q17) If you have some knowledge, what do you know?

Q18) What three things do you think would help you enhance/improve the services you provide to migrant worker clients/patients? (please list in order of importance)

Thank you very much for taking the time to fill in this questionnaire. We are planning to carry out a small number of short telephone interviews (15 minutes) over the next fortnight to explore some of the issues raised further. Please give your name and contact details below if you would be able to take part.

Name: _____

Phone number: _____

Email address: _____

Appendix D – Health Professionals Questionnaire (Commissioners)

A. Introduction:

1. Briefly go over the purpose and scope of the research (European migrants, exploring the range of health needs and concerns esp. access to primary care, and the implications for provision of services locally)
2. Factual questions – clarify job role and responsibilities, area covered and identify whether any direct responsibility for migrant health issues/services

B. Main questions:

3. How significant do you think the rise in numbers of migrant workers coming to the area has been? (ask what sort of time frame this covers – is it a recent change, or more longstanding)
4. What sort of impact has this had on commissioning of local health services?
5. Are there any particular challenges your service/trust has faced? (questions 4 & 5 may naturally be answered together – if so, just let interviewees talk and elaborate) mention translation and interpreting here if they do not raise the issue themselves

prompts:

- do particular national groups pose specific challenges (Polish? Portuguese? Lithuanian?) Ask for examples of local knowledge here if possible.
- Are particular services affected (e.g. A&E services, mental health services)? Why is this? Is it because migrant workers prefer to access acute care directly rather than going through GPs? (media/public perception)
- Ask about dentistry services (initial data from migrant questionnaires) – explore possible reasons
- Raise length of stay issues if possible. If migrant workers are returning home, then perhaps the problem will simply go away? Or do interviewees think that some migrant workers are beginning to settle – what sort of impact do they think this might have on commissioning of services, or do they not foresee a problem?

IMPORTANT HERE TO FOLLOW CUES GIVEN BY INTERVIEWEES – WORK WITHIN BROAD QUESTION ‘AREAS’ RATHER THAN ASKING A SET LIST OF SPECIFIC QUESTIONS.

C. Conclusion:

6. Any additional points to add?
7. Any questions about the research? (e.g. would participants like to be kept informed or would they like a copy of the findings)
8. Any additional contacts re. migrant health?

CHAPTER 10: References

- ¹ Hampshire (2005)
- ² Hope and Merrick (2004)
- ³ Martin (2009)
- ⁴ Legrain (2009)
- ⁵ Kelly et al. (2005)
- ⁶ McKay and Winkelmann-Gleed (2005)
- ⁷ Department of Health Regional Public Health Group (2008)
- ⁸ Department for Communities and Local Government (2008)
- ⁹ *ibid*
- ¹⁰ Institute of Community Cohesion (2007)
- ¹¹ Pillai (2007)
- ¹² *ibid*, pp. 26
- ¹³ Gould and Wearn (2008)
- ¹⁴ See, for example, Wiles et al. (2008) and Robinson et al. (2007)
- ¹⁵ Collis and Stallabrass (2009: 5)
- ¹⁶ *ibid*
- ¹⁷ Collis (2010)
- ¹⁸ Pollard et al. (2008)
- ¹⁹ Schneider and Holman (2009)
- ²⁰ Johnson (2006: 57)
- ²¹ NHS Norfolk (2009: 12), see also Battersby, J. (n.d.)
- ²² *ibid*, pp. 13
- ²³ The focus groups carried out for this project were run jointly with the research team from the UEA; in the first half of the groups participants discussed the issues being considered by Keystone's research project while in the second half (after a refreshment break) questions focused more specifically on children's services which were the focus of the UEA research.
- ²⁴ Collis et al. (2010)
- ²⁵ Particularly to ascertain whether there were any instances of programmes like the Change4Life and Healthy Town initiatives.
- ²⁶ Domestic violence issues were not included in the migrant worker questionnaire and focus groups, but will be the subject of a future publication in the Workers on the Move series.
- ²⁷ We had originally intended to carry out both individual interviews and focus groups, but it was decided to conduct only focus groups in order to maximise the number of participants.
- ²⁸ The English language version of this questionnaire is included in Appendix A at the end of this report.
- ²⁹ Some sections of the questionnaire were developed from questionnaires used in studies identified by the initial literature review; for example, the questions on smoking cessation were adapted from Kabir et al. (2008) – see additional file 2.
- ³⁰ For example with question 28 it was decided that, due to the potentially wide range of nationalities among our sample, it would be more useful to ask respondents to independently identify examples of smoking cessation programmes rather than attempting to compile an exhaustive list. This approach also had the advantage of allowing respondents to volunteer information independently, rather than 'leading' their responses. Again in question 16, which asked respondents what the main differences were between health services in the UK and in their home countries, we deliberately did not attempt to anticipate their responses with a list of pre-defined categories. In the event a number of common themes did emerge, but we were also able to observe a range of conflicting opinions between co-nationals.
- ³¹ Due to the lack of a reliable sampling frame (for example, with the Workers Registration Scheme significantly undercounting numbers of migrant workers) this was felt to be the best possible sampling strategy.
- ³² This also gave potential respondents the chance to consider their participation at greater length, meaning they were better able to give fully informed consent.
- ³³ those unaware of or unable to access such information and advice services – for example, migrant workers only recently arrived in the area, or those with particularly poor English Language skills.
- ³⁴ i.e. those unaware of or unable to access such information and advice services – for example, migrant workers who have only recently arrived in the area or those with particularly poor English Language skills.
- ³⁵ see Krueger, R.A. and Casey, M.A. (2009) *Focus Groups: A Practical Guide for Applied Research (4th edition)*. London: Sage for further information on designing the composition of focus groups.
- ³⁶ as the burden on respondents was felt to be minimal.
- ³⁷ Between 9 and 5 on weekdays. However, it should be noted that shift patterns, long

working hours and frequent changes – often at short notice – to working patterns meant that many migrant workers were unable to participate.

³⁸ The focus group topic guide is available in appendix B at the end of this report. In order to manage the process efficiently, timings are suggested for each section although there was flexibility within this framework.

³⁹ Participants were asked briefly about awareness of health promotion initiatives both in the UK and at home – however, as our initial analysis of the questionnaire data had indicated extremely low levels of awareness among respondents, this was not included as a major focus of the topic guide.

⁴⁰ It was also felt that where discussing sensitive issues, it might be more appropriate not to hold mixed focus groups. However, it has been widely recognised that such issues – for example, sexual health or use of drug/alcohol services – may be better explored through individual interviews anyway (see McFarlane 2005). Moreover, due to the exploratory nature of this study it was felt that it would not be possible to explore such issues in depth (but rather to flag them up as priorities for future research)

⁴¹ The providers' questionnaire is included as a Word document at the end of this report in Appendix C; the commissioners' questionnaire is included in Appendix D.

⁴² Secondary care providers were not included in this survey, although this should be a priority for future research, particularly as another priority identified within NHS Norfolk's Strategic Plan was the need to work with A&E departments to ensure they give relevant information to migrant populations about the range of services available to them *other* than A&E services.

⁴³ Letters were followed up by a telephone call by way of reminder roughly two weeks after the letters were sent.

⁴⁴ such as doctors, nurses, reception staff, pharmacy staff and child health staff such as midwives and health visitors.

⁴⁵ Which is often subsumed within the more general 'BME' category.

⁴⁶ The issues covered in this section formed the basis of *Workers on The Move 2: European Migrant Workers and Health – A Review of The Issues*. This section will also consider new

evidence and literature which has emerged since its publication earlier this year.

⁴⁷ these are Poland, Slovakia, Slovenia, Latvia, Lithuania, Hungary, the Czech Republic, Estonia, Bulgaria and Romania.

⁴⁹ See, for example, Georgieva et al. (2007), Hlavacka et al. (2004), Jakušovait et al. (2005), Koppel et al. (2008), Kuszewski and Gericke (2005), Rokosová and Havá (2005) and Tragakes (2008).

⁴⁹ Habicht et al. (2009)

⁵⁰ Rokosová and Havá (2005)

⁵¹ Saxonberg and Sirovátka (2009)

⁵² Polluste et al. (2005)

⁵³ Kunst et al. (2002)

⁵⁴ Tragakes et al. (2008)

⁵⁵ Habicht et al. (2009)

⁵⁶ Lenain (2000)

⁵⁷ Girouard and Imai (2000)

⁵⁸ Lenain (2000): online

⁵⁹ Kuszewski and Gericke (2005)

⁶⁰ *ibid*

⁶¹ *ibid*

⁶² Burgermeister (2004)

⁶³ Barros and de Almeida Simões (2007)

⁶⁴ Bentes et al. (2004)

⁶⁵ *ibid*

⁶⁶ Bentes et al. (2004) reported findings which indicated that 30% thought provision was of poor quality.

⁶⁷ Barros and de Almeida Simões (2007)

⁶⁸ Hlavacka et al. (2004)

⁶⁹ *ibid*

⁷⁰ Gulis et al. (2005)

⁷¹ *ibid*

⁷² There are important differences *between* countries as well – for example, a study of smoking in Baltic countries by Pomerleau et al. (1999) found that rates of *daily* smoking (as opposed to overall smoking) were higher in Estonia than Latvia and Lithuania.

⁷³ National Institute for Health Development (2005)

⁷⁴ World Health Organisation (2006)

⁷⁵ For this study, smoking rates were measured in 1994, 1998 and 2002.

⁷⁶ Grabauskas et al. (2002)

⁷⁷ Hibell et al. (2009)

⁷⁸ Zatonski (2003)

⁷⁹ Zatonski argues that there was real difficulty in mounting successful information campaigns, due to the fact that large sections of the media were closely controlled by

- government.
- ⁸⁰ Kabir et al. (2008)
- ⁸¹ Defined by the study as smoking 20+ cigarettes per day.
- ⁸² This is particularly pertinent given the recognition in recent research (e.g. Eade et al. 2006; Vertovec 2007; Schneider and Holman 2009) that many migrants are leading increasingly transnational and mobile lives.
- ⁸³ McKee et al. (2000)
- ⁸⁴ Pudule et al. (2007)
- ⁸⁵ The WHO Highlights on Health Series divides countries up into different reference groups. The Eur-A group comprises those European countries with very low child mortality and very low adult mortality rates. Currently there are 27 countries in this group – Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Germany, Greece, Finland, France, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom. The Eur-B+C group consists of those countries with low child mortality and low or high adult mortality rates (currently Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan).
- ⁸⁶ Sesok (2004)
- ⁸⁷ Susic et al. (2006)
- ⁸⁸ McKee et al. (2000)
- ⁸⁹ This was also highlighted as an issue in Slovenia by Susic et al. (2006).
- ⁹⁰ Hibell et al. (2009)
- ⁹¹ McKee et al. (2000). See also Kunst et al. (2002)
- ⁹² McKee et al. (2000)
- ⁹³ Arnaudova (2004)
- ⁹⁴ Susic et al. (2006)
- ⁹⁵ Sesok (2004: 468)
- ⁹⁶ Spritzer (2004)
- ⁹⁷ For example, the increased availability and consumption of junk food.
- ⁹⁸ In-country differences will be discussed separately below.
- ⁹⁹ Janssen et al. (2005)
- ¹⁰⁰ Interestingly, this study – which compared prevalence of overweight and obesity among school-aged youth in 34 countries – found no direct link to diet, and consumption of fruit and vegetables.
- ¹⁰¹ This is also the case in North American countries – and Great Britain.
- ¹⁰² The corresponding figure for women is 24.4.
- ¹⁰³ Arnaudova (2004: 128)
- ¹⁰⁴ Milewicz et al. (2005)
- ¹⁰⁵ do Carmo et al. (2007)
- ¹⁰⁶ do Carmo et al. (2006)
- ¹⁰⁷ *ibid*
- ¹⁰⁸ Padez et al. (2004) cited in do Carmo et al. (2006)
- ¹⁰⁹ World Organisation (2006)
- ¹¹⁰ do Carmo et al. (2007)
- ¹¹¹ do Carmo et al. (2006)
- ¹¹² do Carmo et al. (2007)
- ¹¹³ *ibid*
- ¹¹⁴ Pomerleau et al. (1999)
- ¹¹⁵ *ibid*
- ¹¹⁶ This is a collaborative system for monitoring health related behaviour, practices and lifestyles in Estonia (since 1990), Finland (since 1978), Latvia (since 1998) and Lithuania (since 1994). This survey aims to monitor health behaviours such as smoking, alcohol consumption, food habits and physical activity.
- ¹¹⁷ Grabauskas et al. (2003)
- ¹¹⁸ i.e. not statistically significant
- ¹¹⁹ Arnaudova (2004)
- ¹²⁰ Kriau ionien et al. (2008); see also Grabauskas et al. (2003)
- ¹²¹ Grabauskas et al. (2004)
- ¹²² Pomerleau et al. (1999)
- ¹²³ Grabauskas et al. (2003; 2004)
- ¹²⁴ Grabauskas et al. (2004)
- ¹²⁵ Grabauskas et al. (2007)
- ¹²⁶ Kriau ionien et al. (2008)
- ¹²⁷ Grabauskas et al. (2007)
- ¹²⁸ Arnaudova (2004)
- ¹²⁹ Pudule et al. (2007)
- ¹³⁰ Pomerleau et al. (1999)
- ¹³¹ Arnaudova (2004)
- ¹³² *ibid*
- ¹³³ However, respondents also showed high levels of awareness of the potential health risks.
- ¹³⁴ See, for example, Polluste et al. (2005).
- ¹³⁵ National Institute for Health Development (2005)

- 136 Spitzer 2004
- 137 Pudule et al. (2007)
- 138 Klumbiene et al. (2006)
- 139 adapted from World Health Organisation (2007); also Polluste et al. (2005)
- 140 Polluste et al. (2005)
- 141 *ibid*
- 142 Susic et al. (2006)
- 143 Nagy (2009)
- 144 Pudule et al. (2007)
- 145 *ibid*
- 146 The potential motives for this type of non-participation are too complex to discuss in great depth here, but any planned research would certainly need to consider this theme.
- 147 However, these health promotion initiatives have run in parallel with a number of legislative changes and tighter regulation of the marketing and selling of tobacco such as the complete ban on tobacco advertising introduced in the late 1990s and the ban on selling cigarettes to under 18s.
- 148 Zatonski (2003)
- 149 *ibid*
- 150 CINDI also organises the FINBALT health monitor mentioned earlier.
- 151 World Health Organisation (2002)
- 152 See <http://www.fao.org/DOCREP/X2650T/x2650t07.htm>
- 153 Teachers also received a guide containing information on each theme, with suggestions for appropriate related activities to help them structure sessions.
- 154 Republic of Slovenia Ministry of Health (2007)
- 155 Buzeti and Zakotnik (2008); see also Belovi et al. (2008)
- 156 For example, on Pumpkin Day in Lipovci a competition is held for amateur cooks who are invited to submit recipes for healthy pumpkin dishes.
- 157 Wiles et al. (2008)
- 158 *ibid*, pp. 50
- 159 Schneider and Holman (2009)
- 160 see, for example, Audit Commission (2007)
- 161 Schneider and Holman (2009)
- 162 Wingate and Alexander (2006)
- 163 Hyman and Guruge (2002)
- 164 Pollard et al. (2008)
- 165 *ibid*, pp. 5
- 166 Schneider and Holman (2009).
- 167 These 'themes' were also used to structure the questionnaire completed by our migrant worker sample (see Appendix A).
- 168 11.6% of those surveyed had telephoned NHS Direct.
- 169 Zaronaitė and Tirzite (2006)
- 170 Spencer et al. (2007)
- 171 Stevenson (2007)
- 172 Sargeant (2005)
- 173 Scullion and Morris (2009)
- 174 It is not clear whether the fieldwork for this research was carried out *before* the accession of the A8 countries to the EU, in which case the number of A8 citizens using A&E departments is likely to be lower anyway – certainly the survey was conducted before the accession of Bulgaria and Romania, and a similar study should now be repeated. It is possible, for example, that A2 nationals may be more likely to present in acute settings because of the greater restrictions placed on their rights to access public services in the UK.
- 175 Hargreaves et al. (2006)
- 176 Whiteley (2009)
- 177 Unusually, a relatively high proportion (38%) had also used an A&E department.
- 178 Scullion and Morris (2009)
- 179 Spencer et al. (2007)
- 180 Pemberton and Stevens (n.d.)
- 181 Orchard et al. (2007)
- 182 Scullion and Morris (2009)
- 183 Spencer et al (2007)
- 184 Schneider and Holman (2009)
- 185 However, there is a certain amount of *anecdotal* evidence.
- 186 This should also consider the difficulties faced by health professionals in building relationships with their clients when they have to communicate via an interpreter or translator.
- 187 Zaronaitė and Tirzite (2006: 107)
- 188 McFarlane (2005)
- 189 Cook et al. (2008)
- 190 Maffia (2008)
- 191 Johnson (2006: 62)
- 192 Cook et al (2008)
- 193 Cook et al. (2008: 35)
- 194 *ibid*, pp. 38
- 195 Taylor and Newall (2008)
- 196 Johnson (2004)
- 197 Drennan and Joseph (2004)
- 198 Taylor and Newall (2008)
- 199 Cook et al. (2008); Hunt et al. (2008); Scullion et al. (2009); Glossop and Shaheen (2009)

- ²⁰⁰ Of our questionnaire respondents, 63.3% were parents. The questionnaire did not ask specifically whether these were school age children, as it was not the aim of this research to explore questions relating to child health provision in the UK compared with services at home. The experiences of parents and children in areas such as education and health will be the subject of a third volume in the Workers on the Move series. Therefore, it is not possible to state what proportion of parents in our study were likely to use these services; although 37 out of those who indicated that they were parents were aged between 23 and 45 and may have been supposed to have younger children, although this is a tentative indication – for instance, their children may have remained in their home country while the parents came to Thetford to work. It is therefore impossible to say from this data how many young families there were among our sample – and to guess at the potential impact on the workload of child health professionals.
- ²⁰¹ Rechel and Houghton (forthcoming)
- ²⁰² Padilla and Pereira Miguel (2007)
- ²⁰⁸ ‘Others’ includes disorders such as anxiety, dermatitis, sleep-related problems, hypochondria and paranoia.
- ²⁰⁴ Watters (2002)
- ²⁰⁵ Shah and Beinecke (2009)
- ²⁰⁶ Collis and Stallabrass (2009)
- ²⁰⁷ Mental health was also identified as a key priority in a recent health needs assessment exercise in Wisbech (Sergeant 2005).
- ²⁰⁸ Holman and Schneider (2007), pp. 27
- ²⁰⁹ Schneider and Holman (2009)
- ²¹⁰ Weishaar (2008)
- ²¹¹ See also Pernice et al. (2009), who argued that mental health among immigrants during the initial post-arrival period was no better than that of native-born Canadians – often as a result of underemployment, occupational stress or dissatisfaction and wider stresses relating to the migration process.
- ²¹² *ibid*, pp. 1254
- ²¹³ *ibid*
- ²¹⁴ *ibid*, pp. 1255
- ²¹⁵ Another key priority identified in this study is the need for more longitudinal studies to investigate the relationship between migration and mental health outcomes, rather than relying on cross-sectional or snap-shot data.
- ²¹⁶ Bowden et al. (2007)
- ²¹⁷ Tarricone et al. (2009)
- ²¹⁸ Griffin and Soskolne (2003)
- ²¹⁹ McFarlane (2005)
- ²²⁰ *ibid*, pp. 54-55
- ²²¹ Huang and Spurgeon (2006)
- ²²² *ibid*, pp. 373
- ²²³ Home Office 2009: online
- ²²⁴ Nicholas et al. (2007)
- ²²⁵ Walby (2004)
- ²²⁶ *ibid*
- ²²⁷ Women’s Aid (2007: online)
- ²²⁸ World Health Organisation (2005)
- ²²⁹ Golding (1999)
- ²³⁰ Walker (2000)
- ²³¹ McColgan (1993)
- ²³² Jones et al. (2004)
- ²³³ Sanghvi and Nicolson (1993)
- ²³⁴ McColgan (1993)
- ²³⁵ Nicholas et al. (2007)
- ²³⁶ Walby and Allen (2004)
- ²³⁷ Humphreys and Thiara (2002)
- ²³⁸ Law Commission (2003)
- ²³⁹ *ibid* (pp. 187, FN 14)
- ²⁴⁰ This situation is particularly relevant to those women from A2 and A8 countries.
- ²⁴¹ See, for example, http://www.islington.gov.uk/DownloadableDocuments/HealthandSocialCare/Pdf/duties_to_support_manchester_conference_report.pdf
- ²⁴² The issues/areas outlined here were explored initially with questionnaire respondents, but also followed up in greater detail with interview *participants*.
- ²⁴³ 35 English questionnaires were completed, 32 Polish questionnaires and 31 Portuguese questionnaires.
- ²⁴⁴ The intention was to explore whether different groups (men/women and older/younger) experienced or accessed health services differently and to use any clear patterns which emerged from the questionnaire data in order to plan the focus group stage of the fieldwork. For example, if women had reported a particular set of experiences in visiting the GP, then it may have been appropriate to hold a separate focus group with that group of participants. This strategy was not practical given the relatively small scale of the project and the small sample size. However, some differences in understandings of health and experience of health services (both at home and in the UK) between national contexts *did*

emerge, and it therefore was decided that the focus groups should be organised as far as possible according to nationality. In the event, one Portuguese group was held, one Polish group and one group with Slovakian, Polish and Lithuanian migrants.

²⁴⁵ All percentages have been rounded up, and so totals may exceed 100%.

²⁴⁶ Three respondents completed the questionnaire anonymously and did not give information on nationality, age or gender.

²⁴⁷ It should be noted here that this study did not ask respondents when they had arrived in the UK, and it may be that this minority who were not registered with a GP because of this lack of knowledge were more recent arrivals.

²⁴⁸ This is in direct contrast to findings from previous research which indicated a problem of under-registration with GPs among this group (see DCLG and Breckland Council 2009).

²⁴⁹ The 3 anonymous respondents were also not registered with a GP.

²⁵⁰ Respondents were not asked whether these family members were children (the pressures placed on children interpreting for their parents has been raised as an area of concern in the literature), and future research could investigate this issue more closely.

²⁵¹ while 7 (38.8%) were Polish, 3 (16.6%) were Latvian and 5 (27.7%) were Lithuanian.

²⁵² Blood donors are exempt from charges, as long as they make a minimum of one donation per year.

²⁵³ She had, however, had a negative experience of mental health services in the area and felt that the threshold which she needed to reach in order to qualify for certain input was too high – and that there was little preventative assistance.

²⁵⁴ Indeed, she herself had experienced the variability in quality of service between different UK health services and talked about negative experiences she had had as a mental health service user.

²⁵⁵ Primary rather than secondary care services.

²⁵⁶ The number of smokers in our sample was too low to draw any reliable conclusions here.

²⁵⁷ The evaluation would need to consider the reasons of those either not taking up the service or dropping out at an early stage.

²⁵⁸ A further 3 questionnaire respondents had not visited their GP at all during the past year.

²⁵⁹ including those respondents who identified themselves as ex-smokers.

²⁶⁰ Given the sensitivity of this question it is possible that this figure is an underestimate, despite respondents being given the option to complete the questionnaire anonymously (focus group participants were not asked about this).

²⁶¹ This data was missing for a further 7 respondents.

²⁶² Department of Health (2008) *Healthy Weight, Healthy Lives – A Cross Government Strategy for England*. London: DoH

²⁶³ Focus group respondents also noted that rather than teaspoons the Portuguese often use particular sachets of sugar, especially in local Portuguese coffee shops, which are much larger than standard UK sachets and contain around 2 teaspoons of sugar – their actual intake of sugar could in fact be much higher than our data indicates, which is particularly worrying given the high incidence of diabetes in Portugal (see section 4.1)

²⁶⁴ Eating as a *social* rather than a purely functional activity.

²⁶⁵ Again, this is contrary to the aims of programmes such as Change4Life and Healthy Towns.

²⁶⁶ Both the questions in this section and the table used to display the resulting data have been developed from Janssen et al. (2005).

²⁶⁷ This table does not include either the small number of Slovakian respondents or those respondents who did not disclose their nationality.

²⁶⁸ High intake is defined as the percentage of questionnaire respondents who reported consuming a particular food item more than three days per week.

²⁶⁹ High intake signifies the percentage of respondents who reported consuming sugary foods such as cakes, biscuits, pastries and sweets more than three days per week.

²⁷⁰ High salt intake signifies the percentage of respondents who reported ‘always’ adding salt to their food.

²⁷¹ Percentage of respondents exercising more than three days per week.

²⁷² Percentage of respondents spending three or more hours per day watching television, playing video games or using the computer.

²⁷³ Total percentages were calculated using the entire questionnaire sample of 98 migrant workers.

²⁷⁴ Some professionals covered multiple areas, so this number adds up to more than 18.

²⁷⁵ It should be noted here that as the study focused primarily on Thetford we did not attempt to draw any conclusions from this data about whether these perceptions were linked to area, i.e. whether a larger effect was perceived in areas which, unlike Thetford, did *not* have a particularly history of migration and where the effects might perhaps be more immediately noticeable. A study which looked at migrant worker's access to health services across the whole region would be able to answer such questions.

²⁷⁶ 5 and 7 respondents respectively.

²⁷⁷ Again, respondents were asked to rank these in order of importance.

²⁷⁸ The migrant worker participants in this study were not directly asked about immunisations for their children – child health was not the focus for the study, and we were conscious of not overlapping with the regional work on child health being carried out by the team at UEA. However, several of our focus group participants who were parents did mention this issue – the majority were well informed in this area, and were aware of where and when to take their child for immunisations.

²⁷⁹ To our knowledge, no research has yet been done specifically on this topic. Part of the difficulty here is that A&E departments do not

routinely collect information on patients' migrant status. However, providing the necessary ethical permissions could be obtained, one particularly valuable piece of research for the future might involve an observational study of an A&E department (or several departments) which looked at the ways in which migrant workers accessed and used these services.

²⁸⁰ for example, Schneider and Holman (2009).

²⁸¹ Due to the fact that the research was commissioned by NHS Norfolk as part of the evaluation of the Thetford Healthy Town initiative.

²⁸² Again, respondents were asked to rank these in order of importance.

²⁸³ Weishaar (2008)

²⁸⁴ Cook et al. (2008, pp. 11)

²⁸⁵ White (2009)

²⁸⁶ This could be compared with data available for other regions of the UK.

²⁸⁷ See, for example, Holman and Schneider (2009; 2010).

²⁸⁸ Wiles et al. (2008).

²⁸⁹ Barber, S. (2010) 'Jobless migrants living in shanty towns offered free flights home' *The Observer*, 7th February 2010.

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²⁹¹ For instance, when they are not WRS registered.



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