The Health of EU Migrant Children in the UK

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POLICY BRIEF

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Abstract

This paper provides an overview of the research evidence on EU migrant children's access to health services in the UK. It focusses on evidence on the physical and mental health status of EU migrant children, their health behaviours post-migration, the social determinants that influence migrant children's health outcomes and, issues in their access to and use of UK health care services post-migration.

Key points

- Data on the health of EU migrant children is very patchy, with no reliable figures on the number of migrant children who suffer from poor physical and mental health, despite the fact that being a recent migrant impacts on an individual's health.

- Children's health behaviours and engagement with health services post-migration are strongly influenced both by their families' views of healthy behaviours and experiences of health services pre-migration. Healthy behaviours promoted in schools may be in dissonance with culturally-specific values and beliefs.

- Migrant children's barriers to use of health services include differences in provision between health systems across countries, language barriers and issues of access to interpreters, and limited access to information. Transnational use of health services is a feature of family life for many European migrants.

- Not all children coming from one country have the same health experiences or outcomes. Different social and economic circumstances, rather than cultural factors, are the main contributing factors to migrant children's unequal health outcomes. Children's experiences of health post-migration are affected by neighbourhood characteristics and opportunities available locally to engage in health-promoting behaviours such as outdoor play.

There remains a need for substantial policy and practice development in relation to the health of migrant children.

Key recommendations include:

- To build a comprehensive picture of the health of migrant children in the UK, data on children's health needs to be recorded including: country of birth / origin; length of stay in the UK, and health conditions which are likely to occur or worsen a result of family migration (e.g. mental ill health)

- Practice needs to focus on making health services more accessible to migrant groups, especially new arrivals, by providing better information about services available, signpost and makes rules of engagement explicit, and prepare a more culturally-diverse and culturally-sensitive workforce. In addition, health practitioners need specialist training in working with new migrant groups.

1.   Introduction

In this briefing, we refer to migrant children as those born outside the UK, who have relocated to the UK with their families from one of the European Union countries. EU migrants have full entitlement to health care in the UK, as all 28 EU member states have either publicly sponsored or regulated universal health care. Since 2011, a directive on cross-borders healthcare promotes co-operation between Member States and access to safe and high-quality cross-border healthcare for European citizens. This briefing summarises the evidence on the various health experiences of EU migrant children and access to healthcare services post-migration.

2.   The health of European migrant families

The last two decades have seen significant changes in migratory patterns to the UK, in terms of migrants' country of origin, reasons for migration and settlement patterns (Castles and Miller, 2013). Between the 1950s and 1980s, Britain experienced large scale migration of labour migrants from former British colonies of the Caribbean, Asia and Africa. In the past decade, with the expansion of the European Union, labour migrants have come from Central and Eastern Europe, particularly Poland. Recent population figures indicate that over 7.5 million people, or 12 per cent of the UK population, were born abroad (ONS, 2013), with the most common countries of birth being Poland, India and Pakistan.

The impact of migration on public services is a key issue which frames current debates on immigration (Spencer, 2011). While some claim this had led to pressure on public services (Institute of Community Cohesion, 2007), others raise concerns that the health of migrants needs more attention, due to their low uptake of health care (Rolfe and Metcalf, 2009; Collis

et al., 2010). It is generally perceived that European migrants are mostly young and healthy, which may explain their low service use. The 'healthy migrant effect' may also be due to self-selection, as migrants are likely to consider their health before deciding to move abroad. Migrants have, however, a higher risk of deteriorating health over time through the so-called 'health acculturation' (Ronellenfitsch and Razum, 2004), which occurs independently of improvements in their socio-economic condition. Overall, data on migrants' health are scarce, mainly because migrants are not a homogenous group and country of birth and immigration status are not recorded consistently when health services are accessed.

While studies on adult migrants' health are limited overall, studies on migrant children's health in the UK are almost non-existent. Elsewhere, studies of migrant children have reported on the unique situations which contribute to their increased risk of mental health.   Research with immigrant adolescents has reported on their increased difficulties concerning physical health, mental health and social isolation, with significantly higher scores on all scales of psychological distress and psychological problems (Sandhu and Mooza, 2013). Eastern European migrants may also be taught not to ask for help and may perceive mental health difficulties as taboo and worry about the stigma of accessing support, despite evidence that they present an increased risk of somatic complaints and illnesses such as depression, anxiety and suicide ideation (Robila, 2010). Beisser *et al.* (1998) have identified several unique situations that may contribute to the mental health issues of migrant children. These include: adapting to family separation; disruption to education and language issues; and pressure to adapt to new customs while also conforming to their parents' expectations in relation to values from their homeland. Some migrant children also experience racism in schools and neighbourhoods (Devine, 2009), which may result in poor self-esteem and self-worth and feelings of marginalisation.

3.   **Migrant children's health behaviours and engagement with health services post-migration**

Evidence suggests that adult European migrants engage with health services less regularly than the majority population (Spencer *et al.*, 2007; Collis *et al.*, 2010). Despite public speculation that migrants add pressure on services (Delanti *et al.*, 2011), there is very little systematic evidence in the UK on services accessed by migrants, patterns of use and views of services available (Collis *et al.*, 2010). There is also limited evidence on how migrants' health behaviours alter as a result of family migration and changes to their family income and cultural influences in the new society.

Children are strongly influenced by their families' ideas about health and healthy behaviours. Bassani (2007) emphasises the role of shared values among individuals in the creation of social

capital. In the case of migrant families, their cultural values and knowledge shape their beliefs about health and health practices. While some authors claim that unchanged dietary habits, health beliefs and practices in migrants may be indicative of an emotional attachment to their home culture (Son, 2013), others have emphasised the socioeconomic factors and inequalities which make positive health practices more affordable to the middle classes (McKendrick *et al.*, 2014; Nazroo, 2014). Parents and children may wish to adopt healthy behaviours and eating habits, but factors such as local availability of healthy foods or sports activities will influence their opportunities to do so.

4.   Migrant children's barriers to health access

In our research conducted with Eastern European migrant families in Scotland (Sime and Fox, 2014; Sime, 2014), children and their parents appeared relatively content with the accessibility and availability of health services. However, they also highlighted underlying barriers that often prevented them from accessing health services.   Many of the interviewees talked about uncertainty over their families' entitlement to health care and treatment, especially immediately after their arrival, cultural differences in provision and approaches to treatment and the language barrier, which often made medical visits stressful. The main barriers to health access reported by migrant children and their families include:

- *Lack of adequate information on entitlements and services available*
We asked Eastern European migrant children if they accessed healthcare services available in the community, such as specialist or well-being clinics, pharmacies, or spaces for leisure which could help promote better health. We reported overall limited knowledge among new migrants of services available locally. Many new migrants were not certain of their entitlement to access health services, although all are free at point of use. They also relied on Accident & Emergency (A&E) care 'if something happened' and were not always registered with a doctor or dentist. Children from countries which had limited rights in terms of access to the employment market and welfare benefits were affected by their families' restricted access to healthcare. If families have arrived in the UK illegally or overstayed their visa, having to provide documentary evidence of residence was sufficient to put them off from accessing health care for themselves and their children, due to a fear of deportation.

Often, access to health services is mediated by schools, who send home information, bring interpreters into school to explain to parents what other services are available locally or actively mediate access for the families, by helping them register with doctors or dentists or filling in registration forms for families.

- ***Cultural differences in provision and rules of engagement with services***

Previous experiences of the health system in the homeland will influence migrants' behaviours in relation to how the health system in the new country is accessed, expectations about how accessible services are and perceptions of the medical staff. We reported elsewhere (Sime, 2014) on health practitioners' views that differences in provision led to disappointment among migrants, who often complained about waiting lists, restricted access to specialists and different approaches to treatment. These different approaches to treating conditions also led some families to adopt more informal approaches towards solving health problems, such as relying on family and friends for advice and treatment. A common complaint is on the perceived 'Paracetamol culture' where practitioners prescribe mild painkillers for conditions commonly treated with antibiotics in other countries. Other approaches include: emergency visits to the homeland to access doctors and dentists and to avoid 'waiting lists' in the UK or high charges for private care; or asking family members to post medicines or check a diagnosis with known medical staff in the homeland.

- ***The language barrier***

Language is a key barrier to migrants' access to health services. Their developing competence in English affects their ability to access information on services and entitlements, and their experience of interacting with medical practitioners and understanding treatment options. For practitioners, working with families through an interpreter poses challenges in terms of establishing rapport, collecting information, explaining treatment and time pressures In addition, the need for an interpreter or the limited availability of interpreters for less common migrant languages may delay appointments and deter families from engaging with services. Researchers (Glinos *et al.*, 2010; Miggee and Gilmartin, 2011) have highlighted how migrants' feelings of unease about local care provision due to perceived social, cultural, religious and linguistic differences and lack of trust prompt people to seek care in more familiar contexts, such as from health providers in their country of origin.

5.   Differences in children's experiences of health post-migration

Children's life experiences post-migration are configured by a range of factors, which include their parents' values, aspirations and employment opportunities. Family income influences, for example, their access to good quality housing (Rolfe and Metcalf, 2009) or the type of neighbourhoods in which they live (McGhee *et al.*, 2013). The fact that many migrants may be employed in low-skilled jobs, despite having high qualifications, means that migrant children may be marginalised due to the complex interactions that result at the juncture of age, ethnicity, social class and place. By being forced to access low cost accommodation in areas of high

deprivation, migrants' access to services is affected by their status as new arrivals. Services are often of poorer quality in deprived areas and migrants may feel at risk in terms of personal safety when trying to access these. Putnam (2000) argues that individuals' participation in associational activities, such as clubs and sports activities, encourages them to interact together and contributes to their accumulation of social capital. Participation in the community is also an opportunity for children to develop networks with other ethnic groups, and use these as a route to better access community resources. However, networks of access to resources may be built in ways that privilege some 'insiders' (i.e. the established communities) over newcomers. In some cases, due to cultural differences in service provision, migrant children rely on information from their friends and their limited experience of services to assist with parents' decisions and actions. The roles they have to take on to facilitate their families' engagement with local services required complex skills and confidence and involve activities usually reserved for adults. These new roles may also pose a risk to children's mental health.

A key aspect reported by research is that as migrants rapidly access better work and become more familiar with the system, they are able to build networks of support and work experience and become more competent speakers of English. Research with Eastern European families (Sime and Fox, 2014; McGhee *et al*., 2013) has reported on families' narratives around temporary, transitional housing arrangements, such as residing in poorer areas, with a view of moving on to better opportunities once their work opportunities improve. Other migrants, employed in high skilled jobs immediately after arrival, reported increased opportunities to access better services – however, issues in terms of access to information on services, uncertainty over entitlements and rules of engagement were also a feature of affluent migrants' lives.

6.   Implications for policy and practice

Working with migrant families in a health context poses specific challenges for practitioners and requires them to take a holistic approach. Family migration poses significant challenges for children and young people and impacts on their health, health behaviours and well-being. Culture plays a significant role in how migrant families engage with services, from issues of deciding to engage and trust practitioners, to adopting healthy behaviours and values and interacting with service providers. This suggests that health services need to be delivered in a culturally sensitive manner, with service providers considering cultural diversity in all aspects of their work, including communication of information on services available, hiring of culturally diverse staff, policy and service development and training provided for existing staff. As it is currently difficult to gain a comprehensive picture of the health of migrant children in the UK, data on children's health needs to record variables such as country of birth / origin and length

of stay in the UK, and monitor progress in treating conditions which are likely to develop as an immediate effect of migration, such as mental health issues.

Services designed for mono-lingual and/or mono-cultural populations may not necessarily meet the needs of increasingly diverse populations. Migrants have complex and varied attitudes and approaches to engaging with services. Views on their engagement with health services need full consideration in order to inform healthcare policy and practitioners' behaviours. The evidence suggests that health care provision for migrant groups does not always take account of migrants' previous experiences of health care and the likely impacts of family migration on their health and health behaviours. Migrants' views of health services and expectations are often mapped on their prior experiences and this must be considered by healthcare professionals in the UK. It is clear that differences in provision and expectations about the rules of engagement with services need to be made more explicit to newly arrived migrants, in order to better engage them in health promoting behaviours and gain their trust. Practitioners need to review what prevents children and their families from making efficient use of the full range of health services.

For migrant children, considering factors such as the nature of the migratory experience, cultural distance, time of residence in the new country, socioeconomic position, age, gender and resilience may help explain different health behaviours, attitudes to services and health outcomes. Healthcare providers must be sensitive and alert to the personal factors which affect migrant children and their families' decisions to engage with services and to work with them to tailor provision whenever possible. Research shows that some families choose to use services transnationally or seek help from informal networks when they lack trust in health services in the UK. Accessing health care through multiple routes indicates the active role migrants adopt in making decisions about their use of health care provision; they are not passive receivers of the services available. They weigh carefully the decisions made by health care providers in the UK and can seek a second opinion from practitioners in their homeland.

Migrant children are at a crossroads of influences in terms of the health behaviours they should adopt, attitudes about health service utilization and levels of trust in health practitioners. While their parents might value more the health care system they are familiar with and they understand better, children will be expected to engage in sometimes different health behaviours by their schools. Health practitioners working with newly arrived migrant children should be mindful of the multiple influences which impact on their expectations and beliefs and engage them in conversations to dispel any myths and address any concerns they might have. As young people develop their understanding of how health care operates in their new country, it is likely that their perceptions and beliefs will change over time. Also, as children's linguistic competence in English is sometimes more advanced than that of their parents' due to their schooling, migrant

children may in time become mediators of cultural knowledge about services available to their families (Sime and Fox, 2014).

There is no question that differences between the health systems across EU countries, the language barrier, different cultural practices around health and illness and a certain element of distrust towards the effectiveness of care are all factors which can discourage migrants from making effective use of UK health services. For practitioners, gaining a fuller understanding of migrants' use of health services and their motivations for the decisions behind these choices, as well as a view of migrants as active agents in seeking health care in a more mobile Europe, are keys to overcoming the structural and cultural barriers which may limit migrants' engagement with services. In relation to migrant children and young people, health practitioners should strive to make their engagement with the health services a positive experience and take their past experiences and views into account when considering improvements in delivery.

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