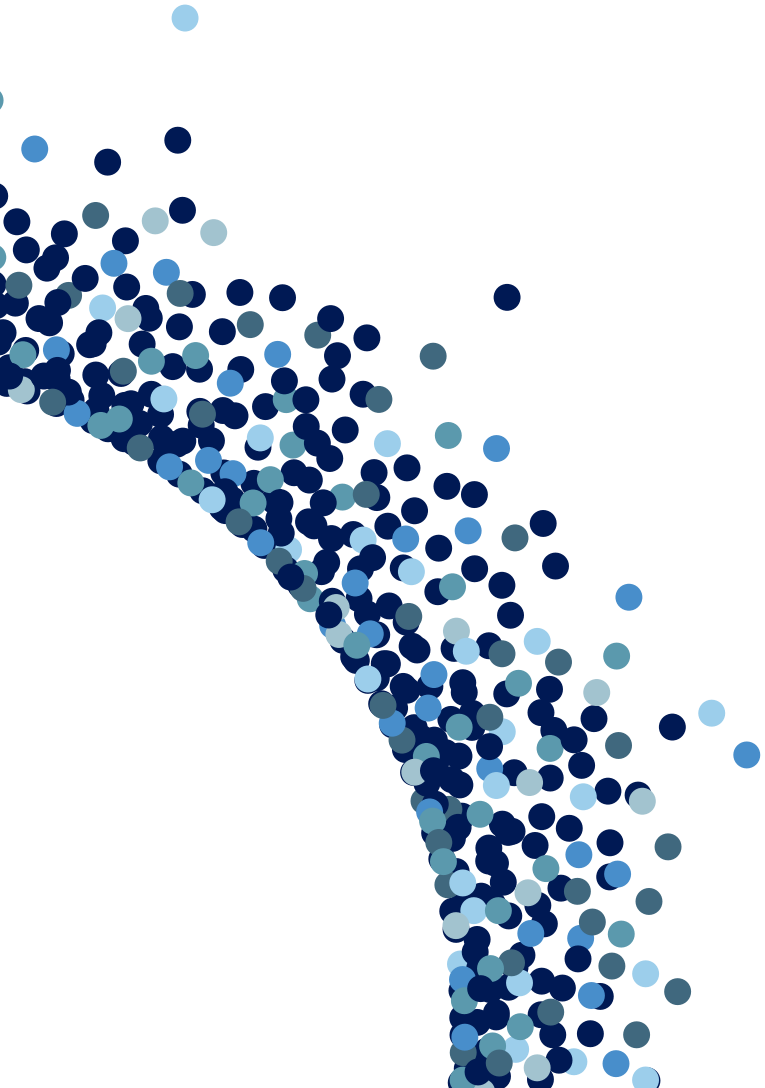
THE MIGRATION OBSERVATORY
AT THE UNIVERSITY OF OXFORD

BRIEFING

The health of migrants in the UK



AUTHORS: Mariña Fernández Reino
PUBLISHED: 17/07/2019
NEXT UPDATE: 17/07/2020

COMPAS
CENTRE ON MIGRATION, POLICY & SOCIETY

UNIVERSITY OF OXFORD

www.migrationobservatory.ox.ac.uk

This briefing examines the health outcomes of migrants (defined as people who were born abroad) as well as the extent to which health problems impact their day-to-day activities or their jobs.

Key Points

Migrants are healthier, on average, than the UK born. In 2018, 26% of the foreign-born population said that they had a long-lasting health problem; this is 15 percentage points lower than the UK born (41%).

Migrant workers in low-skilled jobs were more likely to say that they had a long-term health problem than those in high-skilled occupations. The "health advantage" of the foreign born over the UK born was largest among low-skilled workers with limiting health conditions.

Migrants' initial health advantage over the UK born is the largest among those who arrived in the UK in the last 5 years.

The share of residents reporting a long-lasting mental health problem is 5% for the foreign born and 9% for the UK born.

Foreign-born men are more likely to smoke than UK-born men, while the opposite is true among women.

Understanding the evidence

This briefing examines the outcomes of people who were born abroad and have migrated to the UK. The word 'migrant' is used differently in different contexts. In this briefing, we use the term 'migrant' to refer to the foreign born, regardless of whether they have become UK citizens. For a discussion of this terminology, see the Migration Observatory briefing Who Counts as a Migrant: Definitions and their Consequences.

This briefing relies on the Labour Force Survey (LFS) quarterly data from 2018 and the Annual Population Survey (APS) from 2017. The two surveys collect data on respondents' self-reported health as well as on relevant sociodemographic characteristics and labour market situation. Only respondents' who are aged 16 or older are asked the questions included in the health modules. Because all the data are self-reported, it is possible that certain health conditions are misreported.

The LFS is the largest household study in the UK (39,000 households) and provides the official measures of employment and unemployment. It collects information about a wide range of topics on individuals above age 15 every quarter. The APS includes most of the same individuals as the LFS but also includes and additional boost to the sample. Some variables are not available in the APS, however, and in those cases this briefing uses the LFS instead. The LFS/APS have some important limitations. Some people are excluded, such as residents of communal establishments like hostels, and other groups may be undercounted due to survey non-response. Its response rate has declined over time, and is now below 50% (ONS, 2016); this means that people who are more likely not to respond to the survey may be undercounted. ONS analysis based on the Census suggests that non-response is a greater problem among people born outside of the UK (Weeks et al, n.d.).

Health variables in the LFS and the APS

The health data presented in this briefing refers to long-lasting health problems; that is, physical or mental health conditions or illnesses that are lasting or are expected to last at least 12 months. Under the Equality Act 2010, health conditions may be considered a disability if they have a substantial adverse effect on the person's ability to carry out normal day-to-day activities for at least 12 months (Equality Act 2010: Chapter 1 Section 6).

Respondents reporting a long-lasting health problem give information about the extent to which their health problem affects their ability to carry out day-to-day activities (not at all, a little, or a lot). This briefing uses the term 'limiting health problem' when the respondent has said that the health problem limits their daily activities either a little or a lot. It uses the term 'non-limiting health problem' when they have said that they have a long-lasting health condition that does not limit their daily activities.

Data breakdowns

In addition to country of birth, most data breakdowns include individuals' age, which is a key determinant of their health. Both biological and social determinants have to be acknowledged in any analysis comparing the health of the foreign and the UK born, as these factors will differ across the two groups.

The briefing presents data for the UK-born and foreign-born populations either as a whole or for different country of birth groupings. The country categories are the following:

- EU-14 countries (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden).
- EU-8 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia), EU-2 (Bulgaria and Romania) and EU Other (Croatia, Malta and Cyprus) countries. Sometimes we refer to this group as new accession countries.
- Middle East and North African (MENA) countries and Central Asian countries; the largest groups in these categories were born in Afghanistan, Iran, Iraq and North Africa (Egypt, Libya, Algeria, Morocco, South Sudan and Tunisia).
- East Asian & Southeast Asian countries; the largest groups within this category were born in the Philippines, China, Singapore, Malaysia, Japan and Taiwan.
- India
- Pakistan and other South Asian countries (Bangladesh, Sri Lanka, Nepal). Most of the respondents in this category were born in Pakistan and Bangladesh.
- Sub-Saharan African countries; the largest groups within this category were born in Nigeria, South Africa, Kenya, Somalia, Zimbabwe, Ghana, Uganda and Tanzania.
- All foreign born; this category includes all the non-UK born population. Migrants born in non-EU European countries, America and Oceania are included here along with those born in the abovementioned country groupings.

About 40% of migrants in the UK were born in the EU and around a quarter were born South, East or Southeast Asian countries. See the the Migration Observatory briefing Migrants in the UK: an overview for more information about the geographic origins of the foreign born population.

When considering the skill level associated with a person's job, this briefing uses a four-part classification based on the amount of training required, developed by the Office of National Statistics (ONS, 2010). This classification distinguishes between low-skilled, medium-low skilled, medium-high skilled and high-skilled occupations.

Margins of error in the estimates

Because the LFS and APS are sample surveys, the estimates come with margins of error. This means that small differences between numbers or percentages may not be statistically significant. However, all the differences between groups that are described in the text of the briefing are all statistically significant. A difference between two groups is considered statistically significant when the probability that this difference is caused by chance is very small. In that case, we assume that the differences we observe in the data are likely to exist in the population. Note that small differences between estimates for different groups may not be statistically significant, if they are not described in the narrative of the briefing.

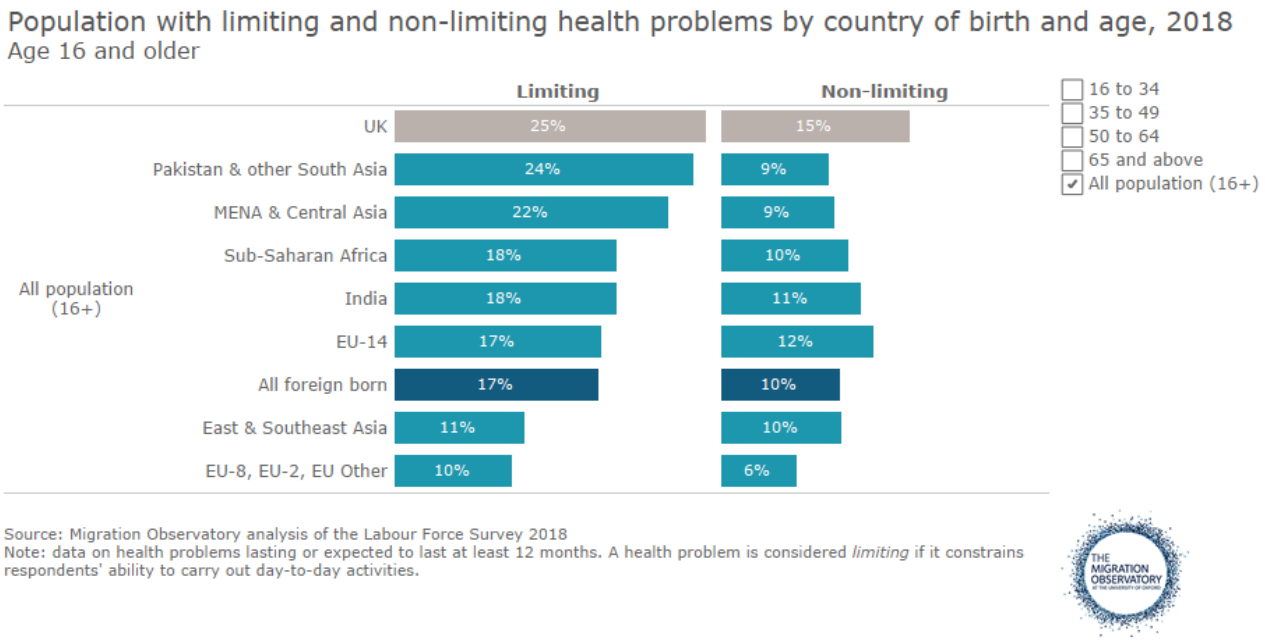
Migrants are in the UK were less likely to have health problems than the UK born, according to survey data from 2018

Studies on the health of the migrant and non-migrant populations have shown that the foreign born are, on average, healthier than non-migrants (Jasso et al., 2004; Antecol and Bedard, 2006). Those who decide to migrate tend to be younger and healthier than those who stay behind and, at the same time, the heathiest migrants are more likely to stay in their new destination rather than returning to their origin countries. This produces a 'migrant health advantage', a phenomenon that researchers have referred to as the Healthy Immigrant Effect.

This is also true in the UK. In 2018, 26% of the foreign-born population in the UK said that they had a long-lasting health problem, which was 15 percentage points a higher lower than the UK born (41%). The migrant health advantage over the UK born is largest with regard to limiting health problems – that is, health problems that limit respondents' day-to-day activities (Figure 1).

This difference is in part explained by the fact that the foreign born are on average younger, e.g. 88% of those born abroad, were below age 65, compared to 76% of the UK born. But even within the same age groups, the foreign born are healthier than the UK born, at least among the population below age 50 (Figure 1). For those aged 16 to 34, for example, the share of people reporting a long-lasting health problem was 12 percentage points lower for the foreign born than for the UK born.

Figure 1



Source: Migration Observatory analysis of the Labour Force Survey 2018
Note: data on health problems lasting or expected to last at least 12 months. A health problem is considered *limiting* if it constrains respondents' ability to carry out day-to-day activities.

Health varies widely by country of origin. For example, migrants from the new EU accession countries and in from East and Southeast Asia have the lowest shares with health problems that limit daily activity. In contrast, the population born in Pakistan and other South Asian countries (excluding India) are on average more similar to the UK born (Figure 1). Pakistanis and other South Asians below age 35 report fewer limiting health problems than the UK born (8% vs 14%), though their health is worse among the older age groups. For example, the share of Pakistanis and other South Asians with limiting health problems is around 15 percentage points higher than for the UK born among the population aged 50 and above.

The most common ailments among the UK population aged 50 and above with a limiting health problem are legs/arms/feet/hands problems (22% of those with a long-lasting health problem), cardiovascular conditions (19%) and back and/or neck problems (10%). The picture is broadly similar for both migrants and the UK born (not shown in the figure). However, people born in Pakistan and other South Asian countries report diabetes as their main health condition (26% of those with a long-lasting health problem). The high prevalence of type 2 diabetes among South Asians has been attributed to both biological and environmental factors (Gujral et al., 2013).

Workers in low-skilled jobs reported fewer health conditions than those in high-skilled occupations

It is widely recognised that people with higher incomes or other measures of socio-economic status have better health outcomes (Elo, 2009). The reasons for this are complex and not just explained by a single factor. Some low-skilled jobs increase the risk of experiencing health problems (Pampel et al., 2010) because they are physically intensive and have poor working conditions (e.g. cleaning, construction), or because low incomes mean that they are less able to purchase goods and services to improve their health (Benzeval et al, 2014). In addition, people that are unable to move out of low-skilled and low-paid jobs are more likely to experience chronic stress due to their socioeconomic situation (Layte & Whelan, 2014), which ultimately affects their overall health.

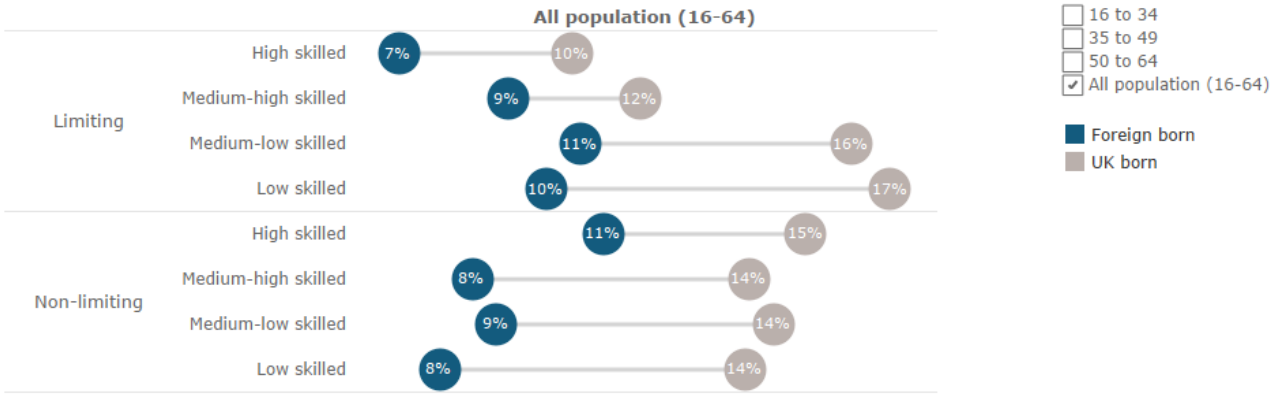
Both migrants and the UK born in high-skilled jobsare less likely to say they have a limiting health problem than those in low-skilled jobs (Figure 2). There is, however, no clear relationship between the skill level of the job and health for non-limiting health problems.

The health advantage of the foreign born over the UK born is apparent for both limiting and non-limiting health conditions. However, this advantage is larger among workers with limiting health conditions in low-skilled jobs (Figure 2).

Figure 2

Population with limiting and non-limiting health problems by job skills, age and country of birth, 2018

Age 16 to 64



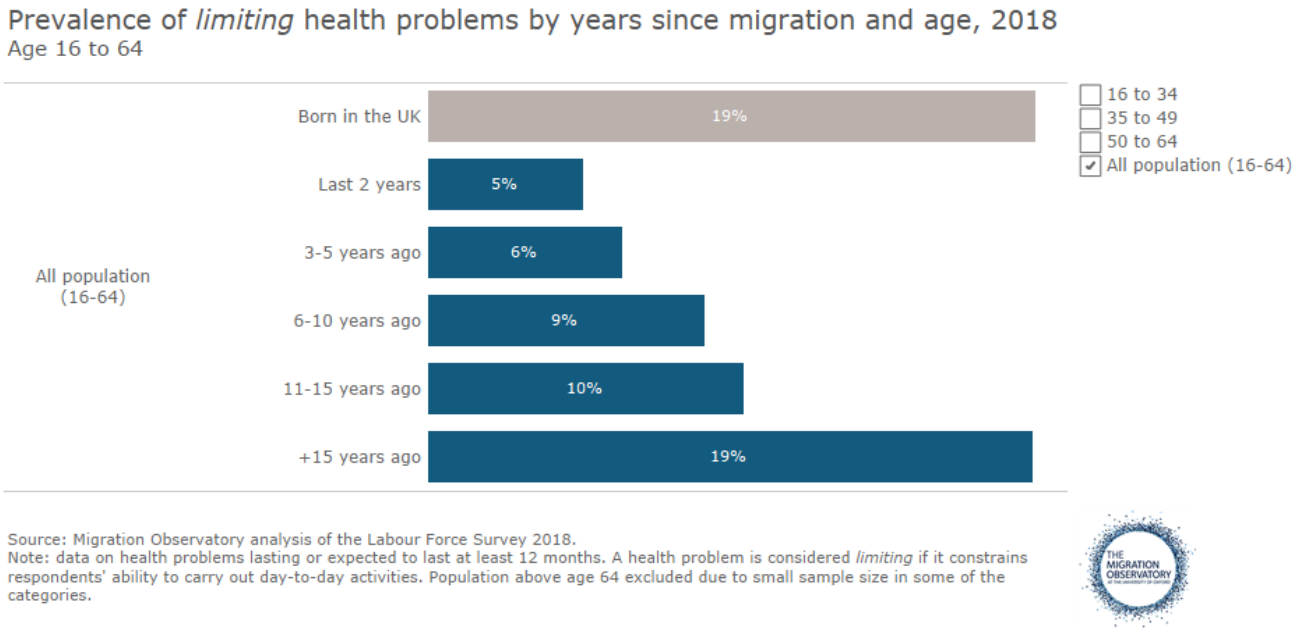
Source: Migration Observatory analysis of the Labour Force Survey 2018
Note: data on health problems lasting or expected to last at least 12 months. A health problem is considered *limiting* if it constrains respondents' ability to carry out day-to-day activities

Migrants' health advantage over the UK born is larger for those who recently moved to the UK

Despite the initial health advantage of the foreign born, their health tends to converge to that of the UK born as their time spent in the UK increases (Figure 3). Note that this is based on cross-sectional data and not on data that follows the same individuals over time, however; it is thus possible that the health advantage of recently-arrived migrants results from other factors such as return migration of healthier migrants or changes in the profile of people who migrate to the UK.

Only 5% of people who migrated to the UK in the last 2 years say they have a limiting health problem, but this rises to 10% for those that moved between 11 and 15 years ago (Figure 3). The share for the foreign born that moved more than 15 years ago, at 26%, is similar to that of the UK born (25%). The convergence towards the UK born as the years of residence in the UK increase is not as stark for all age groups. Among 16 to 34 year olds, in particular, migrants still have a notable health advantage after 15 years.

Figure 3

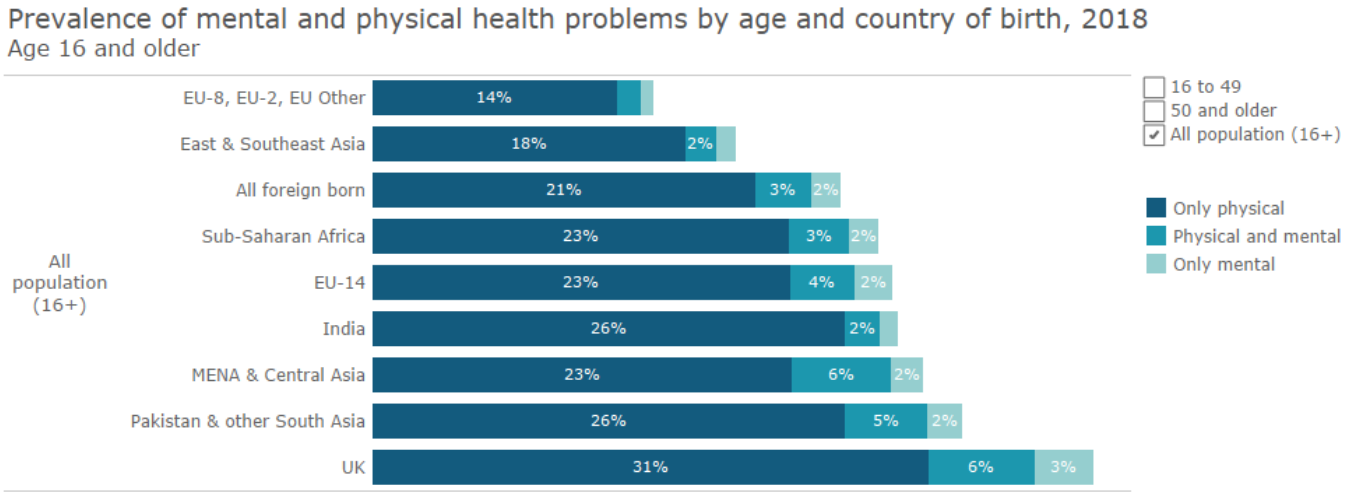


The share of the population reporting a long-lasting mental health problem is 9% among the UK born and 5% among the foreign born

Overall, the share of population saying they have a long-lasting psychological condition (depression or other type of mental illness) is 9% for the UK born and 5% for migrants (Figure 4). Note, however, that there could be differences in the willingness of people from different communities to report this kind of health problem.

In general, it is more common to have both a mental and a physical health condition at the same time than a mental health condition alone (Figure 4). The prevalence of mental health problems is the highest among those aged 50 to 64. Among this age group, the highest prevalence is found among the UK born (10%) and among the population born in Pakistan and other South Asian countries (12%).

Figure 4

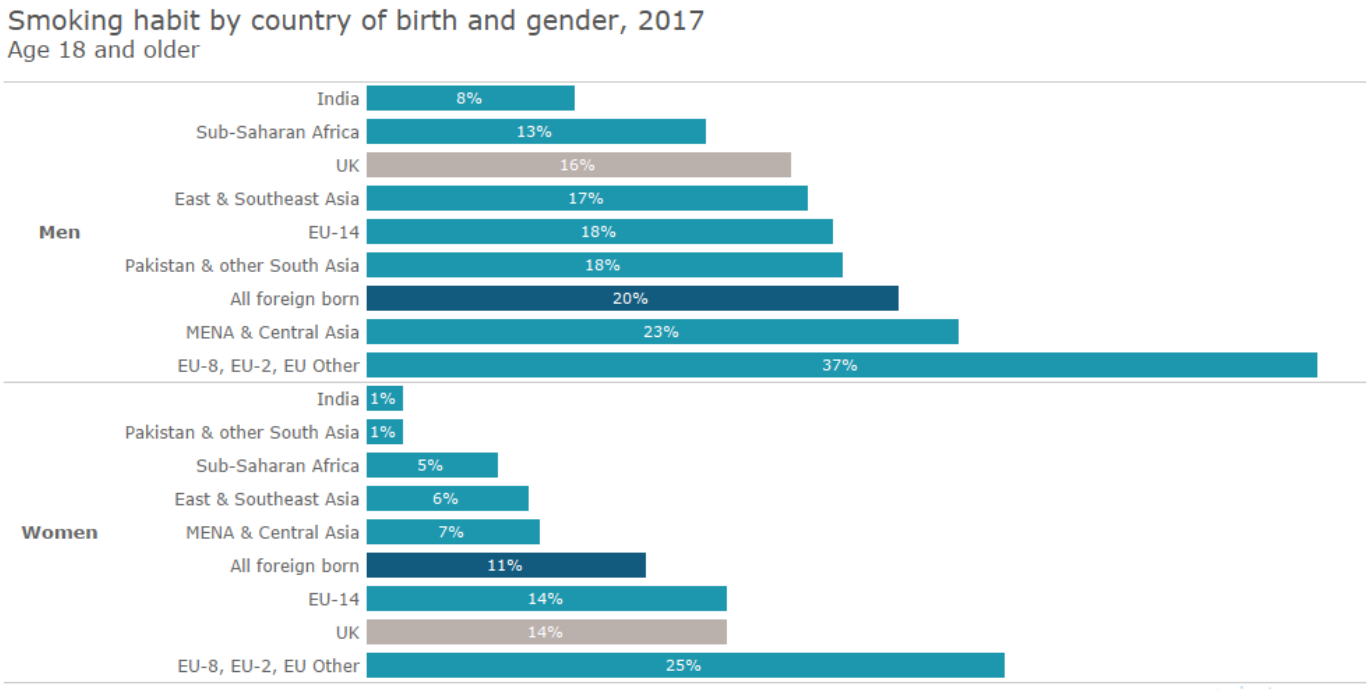


Source: Migration Observatory analysis of the Labour Force Survey 2018.
Note: data on health problems lasting or expected to last at least 12 months. Includes both limiting and non-limiting health problems

Foreign-born men are more likely to smoke than UK-born men, but the opposite is true among women

Smoking is a major risk factor for health. Overall, women are less likely to smoke than men and this is true of both migrants and the UK born. However, migrant women are less likely to smoke than UK-born women (11% vs. 14%). The opposite is true when comparing foreign-born men with the UK born (16% vs. 20%). Residents born in new EU accession countries have the highest share of smokers while those born in India have the lowest (Figure 5).

Figure 5



Source: Migration Observatory analysis of the Annual Population Survey 2017
Note: the chart displays the share of people who reported smoking cigarettes regularly

Evidence gaps and limitations

A drawback of LFS health data that is shared with other data sources on health outcomes is that they rely on self-reported measures instead of on objective indicators. Some other surveys, such as the UKHLS, have collected data on the bio-medical profile (e.g. blood pressure, weight, height, body fat, lung function, etc) of respondents sampled in the first wave of the survey. Unfortunately, this information has not yet been collected for the immigrant boost sample, as they were not part of the initial sample when the survey was launched. Collecting this type of health information for a large sample of the population is very expensive, as only qualified nurses can do it.

This briefing does not differentiate the foreign born population by reason of migration. Recent research has, however, shown that those who migrated for employment, family and study reasons have better health outcomes than the UK born, but this is the opposite for those who migrated to seek asylum (Giuntella et al., 2018)

References

- Antecol, H., & Bedard, K. (2006). Unhealthy assimilation: why do immigrants converge to American health status levels?. *Demography*, 43(2), 337-360. Available online
- Benzeval, M and Bond, L and Campbell, M and Egan, M and Lorenc, T and Petticrew, M and Popham, F (2014) How does money influence health? Joseph Rowntree Foundation. Available online
- Elo, I. T. (2009). Social class differentials in health and mortality: Patterns and explanations in comparative perspective. *Annual review of sociology*, 35, 553-572. Available online
- Equality Act 2010, c. 15 Available at: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf
- Giuntella, O., Kone, Z. L., Ruiz, I., & Vargas-Silva, C. (2018). Reason for immigration and immigrants' health. *Public health*, 158, 102-109. Available online
- Gujral, U. P., Pradeepa, R., Weber, M. B., Narayan, K. V., & Mohan, V. (2013). Type 2 diabetes in South Asians: similarities and differences with white Caucasian and other populations. *Annals of the New York Academy of Sciences*, 1281(1), 51-63. Available online
- Jasso, G., Massey, D. S., Rosenzweig, M.R. & Smith, J.P. (2004). Immigrant health: selectivity and acculturation (No. 04/23). IFS Working Papers, Institute for Fiscal Studies (IFS). Available online
- Layte, R., Whelan, C. t. (2014) Who Feels Inferior? A Test of the Status Anxiety Hypothesis of Social Inequalities in Health, *European Sociological Review*, 30(4), 525–535, https://doi.org/10.1093/esr/jcu057
- Luthra, R., Nandi, A., & Benzeval, M. (2018). Unravelling the 'immigrant health paradox': ethnic maintenance, discrimination, and health behaviours of the foreign born and their children in England. *Journal of Ethnic and Migration Studies*, 1-22. Available online
- ONS (2010). Standard Occupational Classification 2010: Volume 1 Structure and descriptions of unit groups.. Available online
- Palloni, A., & Arias, E. (2004). Paradox lost: explaining the Hispanic adult mortality advantage. *Demography*, 41(3), 385-415. Available online
- Pampel, F. C., Krueger, P. M., & Denney, J. T. (2010). Socioeconomic disparities in health behaviors. *Annual review of sociology*, 36, 349-370. Available online
- Week, A., Fallows, A., Broad, P., Merad, S., & Ashworth, K. Non-response Weights for the UK Labour Force Survey? Results from the Census Non-response Link Study. Survey Methodology and Statistical Computing, Office for National Statistics. Available online

Thanks to Alita Nandi and Carlos Vargas-Silva for comments on an earlier draft of this briefing

The Migration Observatory

Based at the Centre on Migration, Policy and Society (COMPAS) at the University of Oxford, the Migration Observatory provides independent, authoritative, evidence-based analysis of data on migration and migrants in the UK, to inform media, public and policy debates, and to generate high quality research on international migration and public policy issues. The Observatory's analysis involves experts from a wide range of disciplines and departments at the University of Oxford.

COMPAS

The Migration Observatory is based at the Centre on Migration, Policy and Society (COMPAS) at the University of Oxford. The mission of COMPAS is to conduct high quality research in order to develop theory and knowledge, inform policy-making and public debate, and engage users of research within the field of migration.

www.compas.ox.ac.uk

About the authors

Mariña Fernández Reino

Researcher, The Migration Observatory

marina.fernandez-reino@compas.ox.ac.uk

Press contact

Rob McNeil

Head of Media and Communications

robert.mcneil@compas.ox.ac.uk

+ 44 (0)1865 274568

+ 44 (0)7500 970081

Recommended citation

Fernández Reino, Mariña "The health of migrants in the UK"
Migration Observatory briefing, COMPAS, University of Oxford, UK; June 2019

This report was produced with the support of the Paul Hamlyn Foundation. The Paul Hamlyn Foundation is an independent funder working to help people overcome disadvantage and lack of opportunity, so that they can realise their potential and enjoy fulfilling and creative lives.